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CONTINUUM *Complete*

International

ENCYCLOPEDIA OF SEXUALITY

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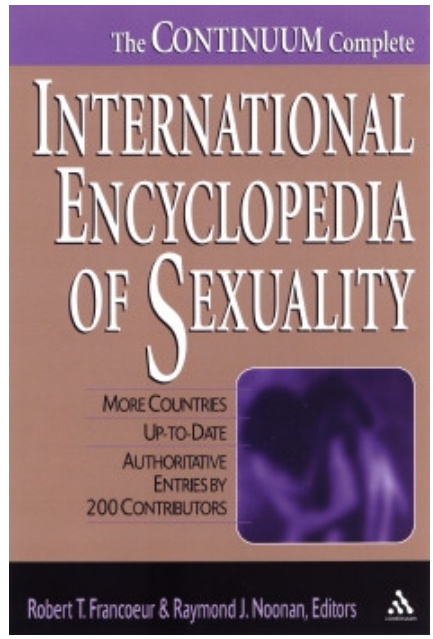

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South Africa

(The Republic of South Africa)

Lionel John Nicholas, Ph.D.,* and
Priscilla Sandra Daniels, M.S. (Part 1)
Mervyn Bernard Hurwitz, M.D. (Part 2)
*Updates by L. J. Nicholas, Ph.D.***

Contents

Demographics and a Brief Historical Perspective

ROBERT T. FRANCOEUR

A. Demographics

The Republic of South Africa is situated at the southern tip of the African continent and extends over an area of 471,011 square miles (1,219,912 km^2), about twice the size of the state of Texas. The country surrounds the nation of Lesotho and is bordered on the north by Namibia, Botswana, and Zimbabwe, and by Mozambique and Swaziland on the east. The large interior plateau has few major lakes and rivers. Rainfall is sparse in the west and plentiful in the east. The climate is mostly semiarid with subtropical along the eastern coast. Days are sunny and the nights cool.

(CIA 2002)

In July 2002, South Africa had an estimated population of 43.65 million. These estimates explicitly take into account the effects of excess mortality because of AIDS. This can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected. (All data are from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: *0-14 years*: 31.6% with 1.01 male(s) per female (sex ratio); *15-64 years*: 63.4% with 0.94 male(s) per female; *65 years and over*: 5% with 0.6 male(s) per female; *Total population sex ratio*: 0.94 male(s) to 1 female. The age profile for whites is more evenly spread across age categories. Half of the black population and a third of the white population are under 20 years of age. There are many more children between the ages of 5 and 9 than in any other age group. The white population is aging, with 13% over the age of 60, whereas only 6% of the blacks fall into this age cohort.

Life Expectancy at Birth: *Total Population*: 45.43 years; *male*: 45.19 years; *female*: 45.68 years. [*Update 2001*: According to a UNAIDS projection, by the year 2010, the AIDS epidemic will have reduced the average life expectancy of South Africans to 36 years, a drop of 47% from the average life expectancy of 68 years projected without AIDS. (*End of update by L. J. Nicholas*)]

Urban/Rural Distribution: 63% to 37%, with 90% of whites and coloreds, 95% of Asians/Indians, and over 60% of blacks living in urban areas.

Ethnic Distribution: Black: 75.2%; white: 13.6%; colored: 8.6%; Indian: 2.6

Religious Distribution: Christian: 68% (including most whites and coloreds, about 60% of blacks, and 40% of Indians); Muslim: 2%; Hindu: 1.5% (60% of Indians); indigenous beliefs and animists: 28.5%

Birth Rate: 20.63 births per 1,000 population

Death Rate: 18.86 per 1,000 population

Infant Mortality Rate: 61.78 deaths per 1,000 live births

Net Migration Rate: –1.56 migrant(s) per 1,000 population

**Communications*: Lionel Nicholas, Ph.D., University of the Western Cape, Centre for Student Counseling; (home address: 601 Villa D'Este Private Bag X17, 257 Beach Road, Bellville, 7535 South Africa; LNicholas@uwc.ac.za.

** The updates by Dr. Nicholas are based on the preliminary report of the South African Demographic and Health Survey completed in September 1998. The survey is nationally representative and the sample was selected from the 1996 census data. A total of 12,247 households were surveyed and 11,735 women were individually interviewed.

Total Fertility Rate: 2.38 children born per woman
Population Growth Rate: 0.02%

HIV/AIDS (1999 est.): *Adult prevalence*: 19.94%; *Persons living with HIV/AIDS*: 4.2 million; *Deaths*: 250,000. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (*defined as those age 15 and over who can read and write*): Overall: 81.8; whites: 99%; Asians: 69%; coloreds: 62%; Africans: 50%. Only 10% of blacks have a secondary high school education and only 6% have any education beyond high-school level. In 1993, there were 105 colleges with 60,000 students, 21 universities with 337,120 students, 15 technical colleges with 130,000 students, and 128 technical colleges with 93,000 students (Cooper et al. 1994).

Per Capita Gross Domestic Product (*purchasing power parity*): $9,400 (2001 est.); *Inflation*: 5.8%; *Unemployment*: 37% (unemployment is a major and ever-increasing problem); *Living below the poverty line*: 50% (2000 est.)

South Africa's first democratically elected government is currently grappling with unemployment, violence, illiteracy, and numerous other problems. It does, however, have tremendous natural resources, a well-developed industrial, educational, and transportation network, and enough skilled workers to start redressing the economic havoc apartheid has wreaked on South Africa. Many diverse ethnic, cultural, and religious groups make up the South African landscape, and these groups continue to influence one another, as they are in turn being influenced by the international community. Internal migration is a problem in South Africa, as socioeconomic and political factors force large segments of the population to leave rural areas and crowd into the cities.

B. A Brief Historical Perspective*

The roots of today's Republic of South Africa stretch back to the Dutch East India Company's arrival on the Cape of Good Hope in 1692. By the end of the 18th century, Boer or Afrikaner colonists numbered only about 15,000. Britain occupied the Cape colony in 1814 at the end of the Napoleonic wars, bringing another 5,000 settlers. Anglicization of the government and the freeing of black slaves drove about 12,000 Afrikaners to make the "great trek" northeast into African tribal territories, where they established the republics of the Transvaal and the Orange Free State. The discovery of diamonds in 1867 and gold in 1876 brought an influx of "outlanders," whose presence spurred Cecil Rhodes to plot annexation of the British Cape and Natal colonies. A three-year war between the Boers and the British, 1899 to 1902, resulted in 1910 in the formation of the Union of South Africa, joining the two former republics and the two colonies.

South Africa became a charter member of the United Nations in 1945, but refused to sign the Universal Declaration of Human Rights. Apartheid—racial segregation—dominated domestic politics as the nationalists gained power and imposed greater restrictions on the Africans, coloreds, and Asians. In 1949, apartheid became national policy. Afrikaner opposition to South Africa's membership in the British Commonwealth ended on May 31, 1961, with the declaration of the Republic of South Africa and the severing of all ties with the Commonwealth. In 1963, South Africa established the Transkei, the first of four partially self-governing republics, territories, or "homelands" for blacks. The Transkei consists of three discontinuous enclaves in the southeast. The seven areas of Bophuthatswana were joined in a northern Homeland in 1977. The Venda Homeland, with two discontinuous areas in the northeast, was established in 1979. In the southwest, Ciskei became a homeland republic in 1980. None of these territories has international recognition as a republic. In 1991, following negotiations between the government and the African National Congress, the Parliament scrapped the country's apartheid laws that limited ownership of property, required registration of South Africans at birth by race, and supported minority rule.

Editors' Note: This unique history poses a different kind of challenge for sexologists. Fortunately, Mervyn Hurwitz, the only South African member of the Society for the Scientific Study of Sexuality, accepted the editor's invitation to prepare a chapter on his country. Equally fortunate—and unexpected—Ted McIlvenna, founder of the Institute for the Advanced Study of Human Sexuality, introduced the *IES* editor to Lionel Nicholas at the 1994 meeting of the Society in Miami, and Dr. Nicholas agreed to work with a woman colleague to provide a black perspective that complements the perspective provided by Dr. Hurwitz. The two parts of this chapter are two windows on sexuality in South Africa.

PART 1: A PERSPECTIVE ON THE PEOPLE OF COLOR

LIONEL JOHN NICHOLAS and
PRISCILLA SANDRA DANIELS

1. Basic Sexological Premises

A/B. Gender Roles and the Sociolegal Status of Males and Females

South Africa is a strongly male-dominated society where violence against women is at a high level. Gender equality and freedom to express one's sexual orientation is enshrined in the new constitution of South Africa, but it is widely acknowledged that we have far to go before getting near to this ideal.

In general, women and men negotiate their lives differently, as well as express their sexual vulnerabilities differently. In a patriarchal society like South Africa, one may expect these differences to be more prevalent than reported in the relevant international literature. Sex counseling will have to take into account the differing sexual socialization experiences of women and men in societies that institutionally and structurally accept the dominance of men, and where many women and men may also have accepted sexist stereotypes (Nicholas 1994a, 6).

C. General Concepts and Constructs of Sexuality and Love

The concepts and constructs of sexuality and love differ markedly between urban and rural communities for all groups in South Africa. Much of this difference is influenced by the greater visibility of particular love or sexual behaviors and observable traditional practices in rural areas that are protected from new urban practices. The following example of peer pressure to have sexual intercourse is cited from Preston-Whyte and Zondi:

> They laugh at you and say you are old-fashioned not to sleep with a boy, and they tell you that you are not in the country now, with the peer group watching to see you only do ukusoma—that was 'external' intercourse. No mothers in town examine one to see if you are a virgin—just let them try! (Preston-Whyte & Zondi 1992, 235)

African and colored groups are likely to have developed a larger range of "nontraditional" sexual behaviors because of the massive efforts to destabilize these communities, including removing parental figures through an enforced migratory labor system and high mortality rates. White and Asian groups have had more-intact family and extended-family systems in both urban and rural settings, which increased the capacity of these groups to monitor and regulate

sexual practices of their members. These groups do, however, experience the same challenge to the concepts and constructs of sexuality and love mainly informed by religious guidelines of chastity.

Loubser (1994) reported that Afrikaner junior high school pupils regularly watched pornographic videos and engaged in sexual intercourse, and many of those who were virgins anticipated that their status would change in the near future.

While all groups would consider the seduction of a young woman as a situation where reparation has to be made, the acceptable reparation would differ widely across groups, especially if a pregnancy has resulted from the seduction. The different African groups have elaborate formal negotiations involving family members on both sides. A go-between would also negotiate the amount of bridewealth on behalf of the man's family before marriage takes place.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

A. Source and Character of Some Typical Religious Values

According to the 1996 census, non-Christian religious affiliation was only 3.8% (Islam 1.5%, Hinduism 1.5%, Judaism 0.2%, and other faiths 0.6%). Some 12.9% indicated no religion. The largest religious groups were Zion Christian 10.7%, Dutch Reformed 9.8%, Apostolic 9.8%, Catholic 9.5%, Methodist 7.8%, and Pentecostal/Charismatic 6.1%. Hindu, Islamic, and Jewish traditions are also major influences in particular geographic areas. The most vociferous support for censorship has come from representatives of a range of religious denominations led by the Dutch Reformed Church. The religious-influenced taboos around sexuality are particularly strong in South Africa. Public discourse on sexuality has been severely restricted by legal, political, religious, and social norms. Stringent censorship has been a central and a bizarre feature of South African life. For example, in 1965, a film, *Debbie*, was initially banned because the chairman of the censor board believed that Afrikaner women do not get pregnant while unmarried.

Every month, bookshops and libraries throughout South Africa receive a list of banned books and objects that also contains recently unbanned materials and those undergoing review. The two main foci of censorship have been sex and politics. The work of sex counselors, and access to accurate sex information, have been most adversely affected by the draconian censorship on sexuality. Liberalization of the censorship laws was presented to Parliament in 1995. The draft legislation advocates a ban on: 1. child pornography, defined as involving children younger than 16, 2. the depiction of extreme violence including rape, 3. depiction of bestiality, and 4. promotion of religious hatred (Swayer 1994).

The history of South Africa's only recently discarded miscegenation laws and prohibitions on a wide range of books on sexuality have effectively exacerbated the sex-related problems experienced, through the official encouragement of ignorance about sexuality. For example, in 1992, several books on sexuality, vibrators, and objects, such as a penis tip attached to a condom, were banned by the censor board.

Standard methods of intervention with sexual problems have not been available to sex counselors and their clients in South Africa. One cannot advise the use of a vibrator to assist in treating inhibited orgasm, because it may be illegal to own a vibrator. Similarly, the range of informative books on sexuality easily available in other countries are not available in South Africa. Some films were restricted to those over 21 years of age; films that included birth scenes or sex education had to be shown to male or female audiences separately. Certain films were also limited to whites.

A censorship board, appointed by the President of South Africa, for example, made the decision that: "a massage instrument whose manufacturers obviously intend it to be used for purposes of masturbation does therefore not fall under the Act unless it is shaped for example like a male organ" (Van Rooyen 1987, 22). The implication here is that it is the duty of the censor board to disapprove of masturbation, but it will enforce its legal powers only if provoked.

The controversy around formal sex education is predicated on the erroneous belief that instruction about sexuality will increase premarital sexual behavior. It may in fact, however, make visible the sexuality that parents try to deny that children possess, and vice versa. When parents are considered as the ideal location for the dissemination of sex information, it is often overlooked that many children do not have both parents available to them, and that fathers have always had minimal involvement in the transmission of sex information in two-parent families.

Nicholas and Durrheim (1994) reported that negative attitudes towards homosexuality were significant, but only weakly associated with negative attitudes toward AIDS, high knowledge of AIDS, and high religiosity in a study of AIDS and knowledge, attitudes, beliefs, and practices of 1,817 black South African students. The sample was divided into those with high or low scores on Rohrbaugh and Jessor's (1975) religiosity scale (excluding virgins) by selecting individuals falling below the first quartile of the distribution of religiosity scores. The low scorers experienced their first sexual intercourse at a younger age (M = 15.92 years) than did the high scorers (M = 17.25 years). The high religious group was also less satisfied with their first sexual encounter, less likely to intend to be sexually active, less likely to make use of safe-sex practices, engaged in sexual intercourse with fewer partners during high school, and used condoms less frequently than the low religious group.

In a survey of 2,206 black South African students (Nicholas 1994a), 16.3% (361) of respondents indicated that they did not use condoms during sexual intercourse, because it was against their religion. While sexual stereotypes of the various ethnic groups in South Africa flourish, the paucity of research on sexuality in South Africa precludes any firm conclusions on various ethnic sexual practices. Black students who have consulted the first author have ascribed folk religious practices as being the cause of their sexual problems. It would not be uncommon to find a client consulting an indigenous healer for a sexual problem ascribed to witchcraft, in the belief that many approaches to the same problem would bring more-effective relief. These beliefs could be located within Christian faith healing, Islamic faith healing, or African herbal or psychic remedies.

[*Update 2003*: Sishana and Simbayi's (2002) national household study found that 35% of males were circumcised, with the mean age of circumcision being 15 years. Some 3.4% of married respondents (n = 3,594) reported that they were in polygamous relationships. Some 50.2% of those who were married (n = 3,374) reported that *lobola* or dowry had been paid when they got married. Some 57% of widows (n = 467) indicated that they were required to abstain from sex during the mourning period and 53% (256) indicated that they were required not to have any relationships with men. (*End of update by L. J. Nicholas*)]

B. Source and Character of Ethnic Values

The sociopolitical context of South African blacks, and South African black higher education students, renders them very vulnerable to sexuality-related problems. Most

black schools provide very poor guidance to their pupils, and sex education is the exception in schools. This lack of guidance and other resources is politically determined, in that the bulk of the financing for these resources had been reserved for whites. Even in 1993, there still existed a disparity in the allocation of resources to blacks and whites at all educational levels. Political decisions have also ensured that blacks lived in extremely crowded conditions by legally allowing blacks residential access to only 13% of the land of South Africa. These factors contribute significantly to sexual abuse, divorce, age-inappropriate exposure to sexual contact, and other high-profile sexuality problems prevalent in the black community (Nicholas 1994a, 4).

3. Knowledge and Education about Sexuality

A/B. Government Policies and Programs, and Informal Sources

Failure to use contraception is a critical problem on university campuses and in schools. While sex counseling is being neglected at schools in South Africa, it is likely to take up an increasing amount of resources elsewhere. For example, parents and religious leaders attacked the introduction of sex education in South African Indian schools as a pilot program in 1993, expressing fears that their children would be corrupted. Such programs had not been taught before in these schools (Chothia 1993). Cilliers (1989) found that all the school departments he consulted supported the idea of the school as a means for AIDS prevention, yet it is evident that sex education does not have similar support (Kagan 1989). Some sex and AIDS education programs have been initiated in the 1990s, but these are experiencing some opposition from parents and others (Gevisser 1993). In 1992, service points at which family planning was provided numbered 65,182 (Cooper et al. 1994). As a result of these programs, 2,301,152 women were using contraceptives.

Intrafamial Communications

The following findings regarding intrafamilial communication about sex in South Africa were obtained in 1990 from 1,902 black first-year students at a South African university (Nicholas 1991).

Age at Which Sex Information Was Acquired. Table 1 shows how respondents to questions on age at which sex information was acquired reflect the small percentage of students who first learned certain concepts before the age of 10 years, and the relatively large percentage who learned about these sexual concepts when they were 16 years and older.

Statistically significant gender differences existed in the acquisition of sex information for the terms shown in Table 1, except for the acquisition of information on pregnancy, female prostitution, and male and female homosexuality.

Manner in Which Sex Information Was Acquired. Males and females in this sample acquired their initial learning about these concepts from different sources (see Table 2). Friends and the mass media are consistently ranked as the major source of initial sex information for this study, whereas school training showed severe limitations.

Preferred Source of Information about Sexuality. The preferred source of sex information for this sample is school training, 27.5%; friends, 26.7%; and mother, 17.7%. Fathers were chosen as the preferred source only by 5.1%: 4.5% of male respondents and 0.6% of females. The high percentage of students with a preference for friends points to the potential value of peer counseling programs for sexuality-related issues.

Parental Provision of Sex Information. Thirty-eight percent of respondents indicated that they had received no sex information from their mothers; 8.2% of females and only 3.8% of males indicated that they received much information from mothers. As expected, 65.5% of respondents indicated that fathers had given no sex information; 4.5%, 3.1% of males and 1.4% of females, reported their fathers provided much sex information.

Provision of Sex Information at School. Sixty-two percent of respondents indicated that they received no sex information at primary school, whereas only 10.9% indicated that they received no sex information at high school. Guidance teachers seem to provide much of the sex information at school, with 30.3% of respondents indicating that they received much information from guidance teachers.

Approval for Sex Education. A large percentage of students are against the provision of sex education in kindergarten (69.5%). Almost a quarter of respondents (23.4%) are against provision of sex information in primary school, 1.8% are against sex education in high school, and 2.6% are against sex education at the university.

Attitudes Toward Premarital Intercourse. Forty-five percent of respondents disapprove of premarital intercourse

Table 1

Age at Which Sex Information Was Acquired (in Percentages)

Topic	Before Age of 10	After Age of 16
Sexual intercourse	17.6	1.8
Pregnancy	16.6	21.9
Abortion	1.8	36.6
Venereal disease	0.6	44.8
Menstruation	3.8	22.9
Female prostitution	4.7	32.4
Erection	12.9	32.5
Condoms	1.0	43.3
Male homosexuality	2.6	42.4
Female homosexuality	1.3	45.5
Fertilization	1.7	42.9

Table 2

Main Sources of Sexual Information (in Percentages) for 1,902 First-Year Black University Students

	Source					
			Friends		Mass	
Topic	Mothers	Schools	Same Sex	Other Sex	Media	Other
Intercourse			33.4	20.7		
Pregnancy	28.7			24.3		
Males	8.3					
Females	20.4					
Abortion		21.2	c. 21.7		30.1	
STDs		28.5	c. 17.1		27.2	
Menstruation	28.2		c. 33.0			
Erection			c. 38.0			20.8
Female prostitution			c. 27.3		37.0	
Male homosexuality			c. 20.9		43.0	
Lesbianism			c. 23.5		57.0	
AIDS			c. 4.5		61.0	

(17% male and 28% female). As expected, males have significantly higher approval ratings for engaging in premarital intercourse than females.

Sex Myths. The endorsement of sex myths by male and female students were statistically significantly different for 30 of 49 myths included in the survey. Large percentages of students also indicated "don't know" to many of the questions, with females indicating "don't know" more frequently than male students for most of the questions. The "don't know" responses are consistent with the lack of sex-information resources, the inadequacy of sex education programs in the schools where they exist, and the writer's experience of counseling and teaching hundreds of university students who did not possess extremely basic sex information.

Summary. Because males and females do experience sexual socialization differently, it can be expected that females will endorse sex myths differently, or discuss sexuality differently, from men. Programs designed to intervene in problem behaviors stemming from beliefs in sex myths may have to target male and female students separately. A large percentage of students used the "don't know" option, indicating that hardly any discussion on those topics had taken place for those students within the family or school system, and that they may be genuinely uncertain.

South African students in this sample are less knowledgeable about sexuality and AIDS than North American students as indicated by North American research studies. South African students have less access to a range of sexuality resources that may better inform them, and researchers have to acknowledge that many students may simply not have been exposed to sex information in a number of areas related to sexuality.

Mosher (1979) contends that there may be more "heat" than "light" in the sex lives of university students in the U.S.A., making the point that the North American student may not be very knowledgeable about sexuality even with access to a variety of resources. It is clear from the results of this study that South African students are even less knowledgeable about sexuality than North American students.

Male students were more knowledgeable at the age of 9 or younger about all the terms listed than female students in this sample, except for menstruation. Very few students had acquired knowledge of these terms by age 10 compared to similar EuroAmerican studies. The percentage of knowledgeable students in this sample ranged from 0.6% for knowledge of venereal disease to 17.6% for knowledge about sexual intercourse.

It is generally assumed that children and young people are learning about sex at considerably younger ages than did their parents and grandparents. Gebhard (1977) verified this assumption, comparing unpublished data collected by the Kinsey Institute for Sex Research between 1938 and 1960 with data collected in the mid-1970s. No such earlier South African data exist to compare with the recent study, but comparison with the two samples in Gebhard (1977), called the "Kinsey Sample" and the "Recent Sample," illustrates the comparatively late acquisition of sex information of the 1990 South African sample on all items of sex knowledge acquisition. Initiatives are therefore necessary to establish the extent of late acquisition of sex knowledge and its implications for safer-sex practices and the development of sexuality-related problems, and they should enjoy high priority among research initiatives.

The implications of this study for research and education point to the potential usefulness of same-sex peer sexuality counseling as a primary method of prevention and intervention. Those who have not had access to sex resources may more readily accept advice in same-sex groups or present themselves for participation in such groups on sexuality.

This study confirms the fathers' lack of involvement in intrafamilial communication about sexuality, and emphasizes the need for research on South African fathers in this regard. Mothers are the most-preferred source of information about sexuality for female respondents, and school training is the most-preferred source for all respondents. The dynamics of mother-daughter communication about sexuality requires investigation in the South African context, as mothers may be a useful resource to school- and university-based sexuality programs, either by supporting such programs or through actively becoming part of campus-based extracurricular programs.

The overwhelming disapproval of the provision of sex education in kindergarten by 69.5% of respondents reflects the myth of the asexual child. A priority of sex education and sexuality courses should, therefore, be the acknowledgment of childhood sexuality. Myths that parents and teachers may hold in this regard also need to be investigated.

Forty-eight percent of respondents indicated experience in premarital sexual intercourse, while only 30% approve thereof. It is likely that the number of first-year students who experience premarital sex will increase during their first year of study on campus. Counselors are required to prepare students for that probability and offer resources to facilitate decision making about engaging in premarital intercourse.

Of respondents, 75.6% consider abortion as an unacceptable means of terminating pregnancy. Yet a number of respondents will find themselves either pregnant or responsible for a pregnancy, given the high pregnancy statistics at the campus serving as a site for this study. Abortion is illegal in South Africa and counselors cannot, therefore, advocate this as an option, except in rare cases. Providing information and resources to promote safer sex should therefore be a high priority for campus counselors in South Africa.

These studies present findings of significant differences between male and female students in their experience of a range of sexuality-related problems. In South Africa, where sexuality programs are not well established, counselors may be advised to structure intervention groups on a same-sex basis in the first stage of intervention for some problems.

The significant differences for gender that have been found for most sexuality-related concerns in this study require that a sex-counseling program includes a focus on particular gender-related needs of students. More emphasis may need to be placed on homophobia, prejudice, contraception, and belief in sex myths for male students, and emphasis on sex and AIDS knowledge acquisition, safety, and assertiveness for female students in such a program.

A 1994 study of 1,737 black South Africans in their first year attending a university conducted by the first author adds to the understanding of sexual education and the sources on sex information among black South Africans (Nicholas 1994a). The mean age of the subjects was 20.4 years with a range from 16 years old to 50 years old. Peers were reported as the overall primary first source of learning about sexual intercourse (see Table 3). Male and female respondents received the information much more from opposite-sex friends, 35% and 25.2%, respectively, than from same-sex friends, 18.2% and 19%, respectively. Together with reading, this accounts for 73% of the sources of learning for this topic.

Although peers are still ranked as the preferred source of information about sexual intercourse, approximately only half of the respondents who indicated peers as their first source of knowledge also include it as their preferred source (see Tables 4 and 5). The respondents indicated a much greater role for the school or guidance teacher (18.3%),

mothers (18.2%), and fathers (5.1%). Peers are the preferred source of sex information for only a quarter of respondents. Peers are also supplanted by "reading" as the most important source of sexuality information. The father's current role in imparting important sexuality information is negligible, but he is the preferred source for 8.1% of males, rivaling the same-sex peer that is the preferred source for 8.3% of male respondents.

4. Autoerotic Behaviors and Patterns

A survey of 1,896 black university students revealed that 34.2%, 348 males and 288 females, worried about the effect of masturbation (Nicholas 1993b). Of these students, 28.7%, 348 males and 190 females, also believed that women commonly insert foreign objects into the vagina. Over half, 51.9%, did not know whether or not masturbation causes pimples and acne, while 8.5% believed it does have these consequences. Fourteen percent of respondents believed that sexually fulfilled, mature adults do not masturbate, while 54.5% indicated "don't know." Similarly, 16.5% believed that most adults do not masturbate, and 58% indicated they did not know on this point.

Table 3

Sources of Learning About Sexuality (in Percentages): Most Important Source of Sexuality Information

Source	Male	Female	Total
Reading	33.0	27.2	30.3
Same-sex friend	17.0	14.0	15.5
Opposite-sex friend	14.1	12.7	13.5
School/guidance teacher	17.0	19.4	18.1
Mother	4.8	13.4	8.9
Mass media	7.5	3.9	5.8
Other	2.6	0.4	4.4
Other relative	1.8	2.2	2.0
Father	2.2	0.7	1.5

Statistically significant gender differences: $\chi^2 = 37.34$; $df = 8$; $p = 0.0000$

Table 4

Preferred Source of Sexuality Information (in Percentages)

Source	Male	Female	Total
Same-sex friend	8.3	9.8	9.5
Opposite-sex friend	19.8	11.5	15.9
Reading	19.8	22.8	
School/guidance teacher	21.1	17.2	19.3
Mother	8.4	29.2	18.2
Father	8.1	1.7	5.1
Mass media	6.6	2.5	4.6
Other	4.4	3.9	4.2
Other relative	2.4	1.5	2.0

Statistically significant gender differences: $\chi^2 = 89.63$; $df = 8$; $p = 0.0000$

Table 5

First Source of Information about Sexual Intercourse (in Percentages)

Source	Male	Female	Total
Same-sex friend	18.2	19.0	18.6
Opposite-sex friend	35.0	25.2	29.3
Reading	21.3	29.2	25.1
School/guidance teacher	7.2	10.2	8.6
Mass media	9.0	3.7	6.5
Mother	2.7	6.7	4.6
Other	5.2	4.0	4.6
Other relative	3.4	1.2	2.4
Father	0.0	0.7	0.4

Statistically significant gender differences: $\chi^2 = 36.28$; $df = 8$; $p = 0.0000$

5. Interpersonal Heterosexual Behaviors

A/B. Children and Adolescents

A 1995 survey of South African teenagers by a national newspaper revealed the following. Of respondents whose average age was 16 years,

- 41% considered sex before marriage as unacceptable,
- 54% accepted it only with someone they cared about,
- 5% said it is something to experience with as many people as possible,
- 81% considered contraception as both partners' responsibility,
- 80% considered gay-bashing unacceptable,
- 10% indicated that they had a gay experience, and
- 71% thought that they will make a better job of marriage than their parents.

Sixty-seven percent of the respondents were female, but the number of respondents was not indicated in this anonymous 1995 report.

A 1992 survey of 7,000 adolescents found that 17% had engaged in sexual intercourse, with a median age of 15 years at first intercourse (Cooper et al. 1994). (Dating customs, sexual activities, and relationships before college are described in the discussion of first-intercourse experiences.)

Some insights into the sexual behavior of adolescent black South Africans can be drawn from a study of first intercourse and contraceptive experiences of 1,737 black South Africans conducted during their first year in a university (Nicholas 1994a). The mean age of the 754 females and 959 males was 20.4 years (with 24 missing cases). The age range was 16 years old to 50 years old. Of the sample, 37.7% spoke an African language, 28.1% spoke Afrikaans, 27% spoke English, and 7.2% indicated "other." Of respondents, 96.5% indicated that they were single. This discussion will focus on the 894 single students, 47.1% male and 52.9% female, who indicated that they had experienced sexual intercourse.

While females experienced first intercourse with a partner who was 2.5 years older, males reported experiencing first intercourse with a partner who was 1.0 year younger. Male respondents' mean age at first intercourse was 15.5 years and their partners' age was 14.5 years old. Female respondents' mean age was 17.8 years and their partners' mean age was 20.3 years old. Obviously, the first sexual partners of the female respondents were mainly outside the research group.

Most respondents indicated that they experienced their first intercourse with a steady friend. Males were, however, much more likely than females to have had their first intercourse experience with an unknown partner or casual acquaintance. It is a cause for concern that 4.1% of the sample indicated that first intercourse was experienced with a close relative (see Table 6).

Males were more likely than females to have sexual intercourse again with their first partner (see Table 7). Although most respondents had further sexual intercourse

with their first partner, 35.5% of females reported no further intercourse with their first partner, as compared to only 20.6% of the male respondents. Almost 70% of respondents had sexual intercourse between 1 and 5 times with the first partner, which points to the short-lived nature of the sexual relationship with the first sexual partner for most respondents. First intercourse may have, therefore, influenced the relationships of the 60.6% of respondents who indicated "steady friend" as their first intercourse partner, because for at least half of this group, sexual intercourse occurred only 1 to 5 times during the "steady" relationship. Of respondents, 46.3% had had one sexual partner in high school and 20.8% had had the first intercourse experience after leaving high school, but before entering university (see Table 8). Males reported significantly higher numbers of high school partners than females.

Twice as many males as females indicated that they greatly enjoyed their first sexual intercourse experience (see Table 9). A third of respondents disliked or greatly disliked their experience of first sexual intercourse, 14.4% of males and 56.9% of females.

[*Update 2000*: Only 3% of teenagers surveyed in the 1998 South African Demographic and Health Survey were married. More than half of the respondents indicated never having had sexual intercourse, and 60% indicated having no sexual partner in the year prior to the interview. About one in five teenagers had sex in the month preceding the survey. Average age at first intercourse was reported as 18 years and age at menarche for most teenagers was below 15 years. By age 19, 35% of all teenagers have been pregnant or have had a child. One in eight teenage deliveries is by cesarean section. Among sexually active teenagers, almost two thirds are currently using a modern contraceptive, with injection/implants being the most popular (50%). One in every five teenaged women reported using a condom in their last sexual intercourse. Sishana and Simbayi (2002) found that some 24.7% of females and 30.3% of males used a condom during their last sexual intercourse. Younger respondents and those with multiple partners were more likely to use condoms than others. (The 1998 South African Demographic and Health Survey was a nationally representative sample selected from the 1996 census data. A total of 12,247 households were surveyed, and 11,735 women were individually interviewed.) (*End of update by L. J. Nicholas*)]

Table 6

Partner Relationship in First Sexual Intercourse (in Percentages)

Relationship of Partner	Male	Female	Total
Engaged partner	6.7	5.7	6.2
Steady friend	44.6	75.5	60.6
Casual acquaintance	24.0	5.7	14.5
Unknown partner	8.4	2.6	5.4
Close relative	5.3	3.1	4.1
Other	5.4	7.5	9.2

Statistically significant gender differences: $\chi^2 = 89.40$; $df = 9$; $p = 0.0000$

Table 7

Times Intercourse Took Place with First Partner (in Percentages)

Number of Times	Male	Female	Total
Once	20.6	35.5	27.2
2-5 times	46.4	36.0	41.8
6-10 times	10.4	8.4	9.5
11-25 times	4.9	6.1	5.4
26 or more times	17.6	14.0	16.09

Statistically significant gender differences: $\chi^2 = 23.30$; $df = 4$; $p = 0.0001$

Table 8

Number of High School Sexual Partners (in Percentages)

Number of Partners	Male	Female	Total
None	13.4	29.4	20.8
1 partner	37.6	56.3	46.3
2-5 partners	30.4	12.4	22.0
6-10 partners	8.5	0.7	4.9
11 or more partners	10.1	1.2	6.0

Statistically significant gender differences: $\chi^2 = 134.9$; $df = 4$; $p = 0.0000$

[*Puberty Rituals and Male Virginity Testing*

[*Update 2002*: Traditionally, boys in one of South Africa's biggest townships, KwaMashu, north of Durban, undergo virginity testing, a controversial custom widely carried out among girls in KwaZulu-Natal. The idea of extending female virginity testing to teenage and unmarried males on a monthly basis is being promoted by Isivivane Sama Siko, a group promoting African traditional cultures and a return to traditional customs. Traditional beliefs claim that young boys have a kind of hymen, a white lacy skin on the foreskin. If the foreskin on the penis slips away easily, it means this "hymen" is gone. If the foreskin is sore and hard to move, then it means he is still a virgin. Other methods include checking for a certain vein on the penis. The only time the vein can disappear is when a boy sleeps with a virgin, because her vaginal opening is still tight. Local belief also holds that a boy is a virgin if he can urinate straight up into the air. If the urine sprays, he has had sex before. Another clue used by male virginity testers is the color of the knees: If a man's knees are dark, it is believed he is not a virgin.

[Local physicians maintain: "There is no scientific basis for this. Men don't have hymens and what happens if a guy masturbates, . . . it makes the foreskin looser. Some men are very hygienic and retract the foreskin to clean the penis; they are very diligent with cleaning under the foreskin and get rid of those secretions—then the foreskin will also slip back easily." Dr. Suzanne Leclerc-Madlala, a lecturer at the University of Natal, noted that one effect of virginity testing is to "create fear" among teenagers to prevent them from having sex. "Virginity testing in no way helps halt the spread of AIDS unless part of the testing is done with sex education." (Kenya Community Abroad 2/19/02. kca-aids@yahoogroups.com). (*End of update by R. T. Francoeur*)] (See also Section 1, Basic Sexological Premises).

Table 9

Characteristics of First Sexual Intercourse and High School Sexual Experience (in Percentages)

Satisfaction	Male	Female	Total
Greatly enjoyed	40.5	10.2	26.3
Enjoyed	45.1	33.0	39.4
Disliked	10.7	39.0	23.9
Greatly disliked	3.7	17.9	10.3

Statistically significant gender differences: $\chi^2 = 196.5$; $df = 3$; $p = 0.0000$

C. Adults

Sexual Behavior and Relationships of Single Adults

Very little published South African data are available on various interpersonal heterosexual behaviors. Much of the data currently cited, especially in anthropology texts, do not accurately reflect current sexual practices that have been tremendously influenced by modern Western practices. In ten years of sex counseling, the first author found that various sex practices, like anal sex, fellatio, and cunnilingus, were not uncommon. Approximately 40% of these clients had tribal affiliations.

Marriage and Family Structures

The migratory labor system has been undeniably destructive for the black African marriage and family structure. A consequence of introducing wage earners, forced to live in single-sex hostels in close proximity to impoverished communities with high levels of unemployment, is the inevitable bartering of sex and domestic chores for food and bed; similarly, with long-distance truck drivers and their "traveling wives."

In South African women's magazines, the problems of comarital and extramarital relationships, sexual satisfaction, and sexual outlets and techniques are openly and regularly discussed in advice columns. Among Muslims and Africans, polygamy is still being practiced.

[*Update 2003*: For whites and coloreds, more marriages were solemnized by religious ceremonies than by civil ones, with the reverse for Africans and Indian/Asians. The non-recognition of traditional and religious rites forces these couples to also have a civil ceremony. The number of officially recorded marriages in 1999 was 155,807, an increase of 6.2% on the 1998 figure. This excludes marriages solemnized under customary and religious rites. The 1996 census estimates that 32.2% of all marriages are traditional and that 46.5% of African marriages are traditional. After 2000, these marriages have been included in the civil registration system, enabled by the Recognition of Customary Marriages Act (Statistics South Africa). (*End of update by L. J. Nicholas*)]

Sexuality and the Disabled

The sexual needs of the disabled are still very much a neglected topic, and the sexual rights of the disabled are not very well served in South Africa (Nicholas 1994a).

Divorce

[*Update 2003*: In 1999, 37,098 divorces were officially recorded, some 83.4 per 100,000 of population, involving 45,360 minor children. The highest percentage of divorces occurs for marriages lasting between five and nine years of marriage, 28.1%, followed by those lasting between zero and four years. Of the registered divorces occurring among Africans during 1999, 31.1% were for marriages that had lasted 5.9 years, and 18.7% were for marriages that had lasted zero to four years. This divorce peak at five to nine years of marriage is found among all the other population groups, except for whites, where the peak number of divorces is for marriages lasting zero to four years (Statistics South Africa). (*End of update by L. J. Nicholas*)]

6. Homoerotic, Homosexual, and Bisexual Behaviors

Isaacs and McKendrick (1992, x) claim that an estimated one out of ten South Africans has a homosexual identity, even if this identity is disguised, denied, or suppressed. The formal gay movement, as represented by the Gay Association of South Africa (GASA), is now defunct as a result of political and social divisions. Splinter nonracial groups, such as the Gay and Lesbian Organization of the Witwatersrand (GLOW) and the Organization of Lesbian and Gay Activists (OLGA), attempt to address gay issues in parallel with human rights (Isaacs & McKendrick 1992, 158). *Link/Skakel*, the most widely read local newspaper published by GASA, ceased publication in 1985 (Isaac & McKendrik 1992, 157). David Moolman initiated the publication of a private gay newspaper, *Exit*, which was criticized for its sexist, homoerotic, and political biases (Isaacs & McKendrick 1992, 157). A new column called "Outspeak" was introduced to expand coverage of the subject matter in *Exit*, and dealt more explicitly with issues of gay liberation and organization (Gevisser & Cameron 1994, 227).

There are only two formal organizations in South Africa that deal specifically with homosexual crises from the perspective of the crisis-intervention model. These are the Radio 702 Crisis Clinic and the GASA 60-10 Counseling Center in Cape Town (Isaacs & McKendrick 1992, 220). Homosexuals now feel safer about declaring their sexual preferences, and there have been gay-pride marches advocating gay and lesbian rights in the major cities of South Africa.

The first South African gay telephone directory was launched in Johannesburg, and the listing includes gay and gay-friendly businesses and services. The directory allows gay people to make use of the services of people who do not object to their lifestyle (Naidoo 1994).

There are not many referenced accounts of bisexual life in South Africa, but according to Zubeida, it is extremely difficult to be bisexual in a heterosexual society. The following excerpt from an interview with her illustrates her feelings:

> I guess I feel oppressed as a bisexual person. Most lesbian and gay organizations don't really cater for bisexuals—I think largely because bisexuals are even less visible than homosexuals. There is also so much distrust of bisexuals in the homosexual community. Sometimes we are seen as sitting on the fence and enjoying the best of both worlds; usually we are seen as being unable to come out of the closet. (Gevisser & Cameron 1994, 191)

Local university counselors are frequently confronted with ignorance about homosexuality in the campus environment, which may exacerbate the problems their homosexual clients present. A 1990 study of 1,902 first-year students at a black university revealed the following about homophobia and prejudice. Forty-three percent of the sample, 25.5% of the males and 17.9% of the females, believe that homosexuality is immoral. Twenty-seven percent of the sample, 13.7% of the males and 13% of the females, believe that a homosexual person cannot be a good religious person. Forty-six percent, 20.8% of the males and 19.4% of the females, believe that homosexual people could become heterosexual if they chose to. A quarter of the males and 21.8% of the females believe that homosexuality is not an acceptable orientation. A campus environment pervaded with highly homophobic beliefs such as these, is hardly one that provides support for homosexual clients or those struggling with their sexual identity (Nicholas 1994a, 73-74).

7. Gender Diversity and Transgender Issues

A survey of 2,209 black university students in 1994 revealed that 8.8% of the respondents (n = 194) indicated a moderate need for help with issues of sexual identity, and 8.3% (n = 183) of the respondents indicated a high need for help with sexual identity (Nicholas 1994b).

The Groot Schuur Hospital in Cape Town offers medical services for transsexuals who would like to undergo surgery to change their sex. The program includes an assessment by a psychiatrist who evaluates the candidate and makes a recommendation whether or not the surgery should be performed. After surgery, the patient continues counseling with a psychologist and social worker. Medical services for intersexual children are provided at the Red Cross Children's Hospital. The child's sexual orientation is assessed by a psychiatrist who makes a recommendation of the sex that would be most suitable for child. Again, postsurgery counseling and support are provided.

8. Significant Unconventional Sexual Behaviors

A. Sexual Coercion

Rape and Sexual Abuse

In 1992, 15,333 cases of child abuse were reported to the Child Protection Unit. Of this number, 3,639 involved rape and 4,135 involved sexual abuse, including sodomy, incest, and other forms of sexual assault (Cooper et al. 1994). [*Update 2003*: Some 52,860 cases of rape and attempted rape were reported (120.1 per 100,000) (Kane-Berman 2002). The Early Sexual Experiences checklist was completed by 1,434 South African first-year students in 2002 to assess their victimization by pedophiles and exposure to sexual abuse (43%). Some 268 respondents (18.7%) indicated that they had had unwanted sexual experiences before their 16th birthday, and 97 respondents (0.68%; 62 female, 31 male, and 4 missing data), met the *DSM-IV-TR* criteria for experience of pedophilia; some 148 indicated abuse after the age of 16. Of respondents, 62% indicated that they were moderately to extremely bothered by the experience when it occurred, and 59% indicated that they were still moderately to extremely bothered by the experience.

[Neither the relationship between gender and the perpetrator relationship nor the number of times the behavior occurred was significant. The relationship between language group and the perpetrator relationship is significant. The biggest differences between observed and expected frequencies are in the relative and friend/acquaintance categories of Afrikaans, the friend/acquaintance category of English, and the relative and stranger categories of African language. When all those who indicated abuse, 416 (205 males and 204 females), are analyzed, a different picture emerges. Women respondents were more bothered at the time, and when completing the questionnaire, than male respondents. Those experiencing relatively severe experiences were more bothered than those experiencing relatively less-severe experiences at the time, though this was not the case currently. Language remained not significant in relation to how bothered respondents were by their experience. The long-term negative effects of sexual abuse are borne out by this study for both relatively severe and less-severe victimization (Nicholas 2002). (*End of update by L. J. Nicholas*)]

The inquiry into legislation on rape (Havenga 1985) was regarded as presenting resistance to genuine reform. This inquiry was launched in May 1982, and was found to have certain inadequacies, mainly the emphasis on sexual aspects in the definition of rape (in contrast with the feminist emphasis on the violence aspects), the failure to make the definition of rape gender-neutral, and the failure to include oral and anal sex and penetration by means of an object. The recommendation that the law stating that a man could not be found guilty of raping his wife be rescinded was qualified by the requirement that prosecution in such cases cannot proceed without permission from the attorney general. The previous sexual history of a rape victim/survivor can still be entered in evidence in camera.

The convictions for child sexual abuse for the years 1989 to 1992 were as follows: 1989, 1,086; 1990, 1,061; 1991, 1,345; and 1992, 1,124.

[*Update 2003*: In 2000, 21,438 rapes and attempted rapes of children under the age of 18 were reported. Some 113 cases of incest and 4,027 cases of indecent assault were reported (Kane-Berman 2002).

[The South African Law Commission made the following final recommendations regarding rape to the Justice Minister:

1. Intentional nondisclosure of infectivity by a life-threatening STD prior to sexual intercourse amounts to sexual relations by false pretenses, and would, therefore, constitute rape.
2. The definition of rape would be broadened to include anal penetration.
3. Men could be rape victims and women could be convicted of rape.
4. The state would no longer have to prove lack of consent, but that penetration occurred under coercive circumstances.
5. Two new crimes will carry the same penalties as rape:
   a. where any object was used to penetrate the anus or genital organs in conditions similar to rape.
   b. Oral-genital sexual violation, where genital organs or that of an animal penetrates the mouth in rape-like circumstances (SAPA 2003, 1, 3). Hiding HIV could turn sex into rape. (*End of update by L. J. Nicholas*)]

[*Update 2001*: According to the South African Demographic and Health Survey (1998), 4% of women who had ever been pregnant reported that they had been physically abused during pregnancy. One in eight women reported having been beaten by a partner, 6% reported abuse in the last year, and of these, 43% reported needing medical attention. Only 4% of all women reported ever having been raped. (*End of update by L. J. Nicholas*)]

B. Prostitution

Prostitution is illegal in South Africa but has flourished in all major cities and townships for decades. In Cape Town, up to 200 prostitutes were allowed to work in the harbor area and were registered by the authorities as "port hostesses." They were recently banned from plying their trade, ostensibly because of safety concerns such as smoking on board ships carrying hazardous cargo (Underhill 1995). Daily newspapers have several columns devoted to advertisements for "escort services" that are fairly explicit offers of sexual services.

The socioeconomic status (SES) of black students has an influence on whether they are tempted to trade sexual favors for financial or educational gain. The difference in the SES between teachers and pupils led them to believe that they could have access to this perceived affluence through a sexual relationship. Pupils who trade sexual favors for financial gain are sworn to secrecy by allies and co-conspirators. In one case we are familiar with, Moses acknowledged that sex had taken place between a group of boys of whom he was one and their male teacher, but that they would "get" anyone who spoke out, as they were all "paid well."

Socioeconomic circumstances can lure pupils into prostitution, as in the case of five standard eight girls (age 15 to 16 years old) who were absent from school for three months and were subsequently found at a brothel. Female students also mentioned trading sex for grades. While these reports

may not be completely accurate, it is sufficient for such allegations to gain currency in a school to damage seriously the confidence of pupils in the grading system. The lack of opportunities to discuss sexuality openly in school would, therefore, further exacerbate this serious problem (Nicholas 1994a, 4-5).

C. Pornography and Erotica

South Africa now has local versions of *Penthouse*, *Playboy*, and *Hustler*. The censor board keeps a vigilant eye on these and other similar publications and recently lost a case against *Hustler* under the new constitution's freedom-of-speech provision. A new swingers' magazine, *X pose*, with graphic closeups of male genitals and female vulvas, was recently launched (Chapel 1995). Pornographic movies are not openly available, but have a wide underground distribution. See also comments in Section 1A/B, Basic Sexological Premises, Gender Roles and the Sociolegal Status of Males and Females, above.

9. Contraception, Abortion, and Population Planning

A. Contraception

In a study of 1,737 first-year black South African students, first intercourse was primarily characterized by the lack of contraceptive use, with 35.7% of the males and 32.8% of the females indicating non-use of contraceptives, and 12.3% of the males and 7.1% of the females indicating "don't know" (see Table 10). A further 6.2% reported using the unreliable withdrawal method (Nicholas 1994a, 88-94).

The major reasons given for not using a contraceptive were that the first sexual intercourse was unplanned (36.8%) and that no thought was given to contraception at the time of the first intercourse act (38.1%) (see Table 11). The belief that if one only has intercourse "a few times," contraception is not essential, was endorsed by 31.6% of respondents. The erroneous belief that having sexual intercourse only once or a few times protects one from the risks associated with unsafe sex, may significantly influence students to make the transition from virginity to nonvirginity without using contraceptives.

The opinion of significant others also influenced respondents' use of contraceptives. Male and female respondents almost equally were uncomfortable being too prepared (23.6%). Mothers' discovery of contraceptive use was cited by 18.8% of respondents, and fathers' displeasure was cited by 17.9% of respondents, as reasons that prevented contraceptive use. Of respondents, 18.1% indicated that contraceptive use was impractical when engaging in "many rounds of sex." Most safer-sex messages assume a single encounter requiring a single condom and neglect those who continue sexual activity after the first orgasm.

Table 10

Contraceptive Practices at First Sexual Intercourse (in Percentages)

Contraception Used	Male	Female	Total
No method	35.7	32.8	34.3
Pill	14.6	22.8	18.5
Condom	19.5	13.3	16.6
Withdrawal	7.4	4.8	6.2
Rhythm	1.1	0.5	0.8
Condom & contraceptive	6.8	11.9	9.2
Other	2.7	6.9	4.7
Don't know	12.3	7.1	9.8

This study revealed that 54.2% of female respondents and 55.5% of male respondents had experienced sexual intercourse. Darling et al. (1992) cite relevant research indicating that, while males experience first sexual intercourse at a younger age than females, the average age for females is also declining to around 16 years of age. Further research is required to establish a trend towards gender convergence among South African students. Female respondents in this sample experienced first intercourse at 17.8 years old, compared to Darling et al.'s (1992) report of 17.7 years old. Male respondents initiated first intercourse at 15.5 years old, 2.3 years younger than the sample of Darling et al. (1992). No similar South African studies on first intercourse have been done to facilitate local comparisons.

This study found that many students do not use contraception during first intercourse. Similar to other studies, this reflects the unplanned nature of first sexual intercourse. Peers are reported as the primary first source of learning about sexual intercourse and are also considered the preferred source by respondents. "Reading," however, was indicated as the most important source of information about sexuality. More emphasis should be placed on the gender differences for peers' provision of sexuality information. This study found that opposite-sex friends are more likely to be the first source of sexuality information, as well as the preferred source of sexuality information. The same-sex friend was, however, considered the most important source of sexuality information. Peer sexuality programs could be guided by the preferred source of sexuality information in relation to gender.

The provision of information on safer sex has been found to be inadequate in facilitating desired behavior change (Keeling 1991). Those students who have not developed a

Table 11

Factors Preventing Contraceptive Use During First Sexual Encounter: Response to Statement, "What Prevented the Use of a Contraceptive During Your First Sexual Encounter?" (Rank Ordered; in Percentages)

Reason Given	Male	Female	Total
I used a contraceptive	18.0	23.2	41.2
I did not think about it	21.6	16.5	38.1
I did not intend to have sex	14.8	22.0	36.8
I only did it a few times	18.0	13.6	31.6
I feared the side effects	12.6	11.8	24.2
I was uncomfortable being too prepared	11.6	12.0	23.6
There was none available	15.2	8.2	23.4
It is against my religion	9.8	9.8	19.6
I feared that my mother would discover my use of contraceptives	7.6	11.2	18.8
It is impractical for many rounds of sex	14.1	4.0	18.1
I feared my father would be displeased	8.1	9.8	17.9
It makes sex unpleasant	13.0	3.8	16.8
It is not my responsibility	6.5	8.2	14.7
I thought it was the wrong time of the month	2.9	5.4	8.3
It is too expensive	5.6	2.0	7.6
I thought I was sterile	4.0	2.7	6.7
I was drunk	3.6	0.3	3.9
I wanted to cause a pregnancy	2.4	1.3	3.7

pattern of risky sex practices may be more amenable to early intervention before high-risk patterns of sexual behavior set in. Students who have yet to make the transition to nonvirginity, as well as those who have had only a few sexual experiences, may be more open to establish patterns of safer-sex behaviors through early intervention by counselors.

Starting in 1990, the first author and several colleagues have conducted an annual survey of first-time entry, first-year university students enrolling at a predominantly black university (Nicholas 1994b, 1993a, 1993b, 1992, 1991, 1990; Nicholas & Orr 1994; Nicholas, Tredoux, & Daniels 1994; Nicholas & Durrheim 1994). All consenting first-year students who attended the orientation program completed a structured questionnaire on intrafamilial communication about contraception. In 1990, 1,986 students completed questionnaires that included 829 male students and 948 female students (18 missing cases). In 1991, 2,069 students completed questionnaires, 1,029 males and 1,040 females. In 1992, 1,558 students completed questionnaires that included 684 male and 834 female students (32 missing cases).

Forty-eight percent of the 1990 sample (885) indicated that they had had sexual intercourse. Fifty-four percent of the 1991 sample (1,115) indicated that they had had sexual intercourse. Fifty-three percent of the 1992 sample (793) indicated that they had had sexual intercourse. Less than 30% of the total sample indicated approval of premarital sexual intercourse, while more than 50% of the sample indicated nonvirgin status.

Table 12

Response to Statement, "If I Had a Problem Concerning Contraceptive Matters, I Could Count on My Mother/Father to Be Understanding"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	532	273	712	349	585	284
	(28.5%)	(14.7%)	(35.2%)	(17.5%)	(38.3%)	(18.8%)
False	736	977	698	991	545	803
	(39.4%)	(52.8%)	(34.5%)	(49.8%)	(35.7%)	(53.2%)
Don't know	600	601	615	650	396	423
	(32.1%)	(32.5%)	(30.4%)	(32.7%)	(26.0%)	(28.0%)
Column Totals	1,868	1,851	2,025	1,990	1,526	1,510
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

Table 13

Response to Statement, "My Mother/Father Has Never Given Me Any Information about Contraceptives"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	1,060	1,424	1,123	1,563	835	1,160
	(56.5%)	(76.4%)	(55.3%)	(77.6%)	(54.6%)	(76.6%)
False	747	346	853	384	673	306
	(39.8%)	(18.6%)	(42.0%)	(19.1%)	(44.0%)	(20.2%)
Don't know	68	94	56	66	22	48
	(3.6%)	(5.0%)	(2.8%)	(3.3%)	(1.4%)	(3.2%)
Column Totals	1,875	1,864	2,032	2,013	1,530	1,514
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

Table 14

Response to Statement, "If I Were to Use a Contraceptive, I Would Prefer That My Mother/Father Not Know about It"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	921	1,090	944	1,169	711	871
	(49.5%)	(58.8%)	(46.5%)	(58.5%)	(46.6%)	(57.5%)
False	666	404	826	477	628	376
	(35.8%)	(21.8%)	(40.7%)	(23.9%)	(41.2%)	(24.8%)
Don't know	275	359	258	352	186	268
	(14.8%)	(19.4%)	(12.7%)	(17.0%)	(12.2%)	(17.7%)
Column Totals	1,862	1,853	2,028	1,998	1,525	1,515
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

Approximately twice as many respondents felt that their mothers would be understanding about a problem concerning contraceptive matters, as opposed to fathers (see Table 12). The percentage of students responding affirmatively about their mothers' understanding increased from 28.5% in 1990 to 38.3% in 1992. The percentage of respondents responding affirmatively about their fathers' understanding increased by only 4% from 1990 to 1992. Most students, therefore, do not consider their parents as understanding about a problem concerning contraception. Gender differences are significant at the probability level greater than .00001 ($p. > .00001$) level for respondents surveyed in all three years.

Over three quarters of respondents indicated that their fathers had not given them any information about contraception, compared to approximately 55% of respondents who indicated that their mothers had not provided such information (see Table 13). There was no significant difference for gender in the 1991 and 1992 samples. For the 1990 sample, $p = .0004$. Slightly more males than females had received information about contraceptives from their fathers. On average, more than twice the respondents received this information from mothers than fathers. More males received information about contraception from mothers than fathers, emphasizing the lack of involvement of fathers in these discussions.

More students preferred that their fathers not know about their use of contraceptives than they did their mothers (see Table 14). Twice as many female respondents disagreed with this statement than did male respondents. Gender differences are significant at the $p < .00001$ level for all three years.

Approximately three quarters of respondents indicated that they had not discussed contraception thoroughly with their mothers, and almost 90% of the respondents indicated this to be the case in relation to fathers (see Table 15). Fathers were conspicuously absent as far as thorough discussion of contraception is concerned. Gender differences are significant at the $p < .00001$ level for all three years.

Approximately a third of respondents believed that their mother's estimation of them would not decrease if the mother knew they were using a contraceptive (see Table 16). Approximately a quarter of respondents be-

lieved their father would not disapprove if he knew. Gender differences are significant at the $p < .0001$ level.

Three times as many respondents were encouraged to use contraceptives by mothers as by fathers (see Table 17). Most students, however, have not been encouraged by parents to use contraceptives. Gender differences are significant at the $p < .00001$ level.

Few students indicated that they shared the same ideas and beliefs about contraceptives as their parents, with more of such sharing being evident in relation to mothers than fathers (see Table 18). A large percentage of respondents also indicated "don't know," indicating the basic lack of communication between parents and children.

Table 15

Response to Statement, "I Have Discussed My Contraceptive Use Thoroughly with My Mother/Father"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	302	84	377	118	302	86
	(16.3%)	(4.6%)	(18.9%)	(6.0%)	(20.0%)	(5.7%)
False	1,417	1,610	1,518	1,758	1,138	1,345
	(76.3%)	(87.7%)	(76.1%)	(89.1%)	(75.3%)	(89.7%)
Don't know	137	142	99	98	71	68
	(7.4%)	(7.7%)	(5.0%)	(5.0%)	(4.7%)	(4.5%)
Column Totals	1,856	1,836	1,994	1,974	1,511	1,499
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

Table 16

Response to Statement, "If My Mother/Father Knew I Used a Contraceptive, Their Estimation of Me Would Go Down"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	576	638	566	643	487	543
	(31.0%)	(34.7%)	(28.6%)	(33.0%)	(31.9%)	(36.0%)
False	611	435	711	467	542	367
	(32.8%)	(23.6%)	(35.9%)	(24.0%)	(35.5%)	(24.3%)
Don't know	673	767	703	838	498	599
	(36.2%)	(41.7%)	(35.5%)	(43.0%)	(32.6%)	(39.7%)
Column Totals	1,860	1,840	1,980	1,948	1,527	1,509
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

Table 17

Response to Statement, "My Mother/Father Has Encouraged Me to Use Contraceptives"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	301	113	380	116	327	109
	(16.2%)	(6.1%)	(19.2%)	(5.9%)	(21.5%)	(7.2%)
False	1,460	1,583	1,510	1,734	1,116	1,308
	(78.5%)	(85.6%)	(76.3%)	(88.9%)	(73.4%)	(86.8%)
Don't know	99	154	89	101	78	90
	(5.3%)	(8.3%)	(4.5%)	(5.2%)	(5.1%)	(6.0%)
Column Totals	1,860	1,850	1,979	1,951	1,521	1,507
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

In a study to identify barriers to condom use among 700 high school students, Abdool Karim et al. (1992) found that the students were not using condoms to any significant degree, felt that condoms limited sexual pleasure, felt that condom use indicated a lack of trust in one's partner's faithfulness, challenged the male ego, and/or may indicate that one has an STD. Condom use was not well understood, and they were not accessible or available when required. Oral contraceptives cost about $30 per month and condoms $3 a piece. Both are available free at community clinics.

Implications for Counselors

Sex counseling as a discipline is not widely practiced in South Africa. The university's obligation to provide such a resource has been de-emphasized, influenced by the unresolved debate on the appropriate location of sex-counseling resources and the taboos around sexuality. The possibility that intrafamilial communication about contraception might make a major contribution towards eliminating unwanted pregnancy is slim, given the minimal involvement of parents in the provision of information about contraception, especially that of fathers. Schools are unlikely to make any major contribution to contraceptive education, and the thousands of university-bound students requiring guidance on contraception will become the responsibility of campus counselors.

The effective shouldering of this responsibility requires a knowledge of local circumstances and resources. For example, until 1996, abortion was illegal in South Africa, so counselors' efforts had to be largely focused on prevention. This would include facilitating programs that involve larger groups of students gaining access to contraceptive information, while still remaining accessible to individual clients. Knowledge of the incidence of sexual-related problems at a particular university is crucial in making students aware of the risks of unprotected sexual intercourse that could directly affect them. The availability of postcoital contraception for use up to 72 hours after sexual intercourse should also be made widely known in the campus community.

Advice on condom usage by counselors has to be specific as to local availability and practices. Sidley (1991) found that choosing a brand of condoms in South Africa is bedeviled by a range of factors. Only one brand is produced locally, Crepe de Chine, and the rest are imported without being subjected to tests before being placed on the market. The 24 brands, which the South African Bureau of Standards (SABS) tested two years ago, failed. Up to 33% of the condoms tested by the Johannesburg City Health Department failed the trials.

The SABS tests for dimensions, mass, tensile strength, elongation, breaking point, aging, freedom from holes, and leakage, but does not make a standard mark compulsory. None of the imported brands bear the quality mark of their country. Three suppliers meet SABS specifications: Vulco, which is South African, F.T.C. Aircraft, manufactured in Thailand, and

Freedom, made in Korea. One spermicide, Rendells, contains oil that can cause a rubber condom to blister and burst (Sidley 1991). Counseling clients with regard to condom usage, whether for prevention of pregnancy, STDs, or HIV transmission, has to take into account the many risks associated with condom usage (Masters & Johnson 1986). These include the care that has to be taken in avoiding having preejaculatory fluid spilling onto the labia, spillage of semen when the condom is removed or during detumescence, and the residue of semen on the penis that may come into contact with the vagina.

Effective contraceptive programs for university students must, however, not stop at providing accurate information about contraception. The acceptance of self and others as sexual beings, and of contraception as primarily a sexual rather than a reproductive decision, is essential for effective contraception programs among South African blacks.

[*Update 2001*: Half of the women in the South African Demographic and Health Survey (1998) are currently using a contraceptive method, and almost all women who have ever used contraception have used a modern contraceptive. The most widely used method is the injection/implantable (27%), followed by the pill and female sterilization (9%). Asian women are most likely to use contraception, followed by whites, coloreds, and Africans. Asian and white women tend to use the pill and female sterilization, while African and colored women tend to use injections. Male sterilization is commonly used by white couples. Only 53% of women were aware that abortion is legal in South Africa. (*End of update by L. J. Nicholas*)]

B. Teenage (Unmarried) Pregnancies

In a survey at a local hospital, Sapire (1988) found that 75% of the pregnancies were unintended and 20% of the pregnant women were under 19 years of age. The seriousness of the problem is exemplified by requests for pregnancy tests and the morning-after pill at black universities (Nicholas 1994a, 63).

In Cape Town in 1987, of 2,800 teenage mothers, 2,300 were unmarried. The biggest increase in illegitimacy was among whites, where the percentage has doubled since 1982. In 1986, the percentage of white illegitimate births was 11.3% of all white births in Cape Town; in 1987, this increased to 17.2%. For coloreds, the number of illegitimate births increased from 6,700 in 1986 to 7,100. The percentage of illegitimate babies born to black, colored, and Asian women in Cape Town was 47.5% in 1987 (Stander 1988). A special clinic was instituted at a local hospital for pregnant teenagers, 90% of whom were unmarried, so that they would not have to attend with married women (Burman & Preston-Whyte 1992). Ample evidence exists that a stigma is attached to teenage pregnancy while unmarried for both the mother and child in all sections of South African society. Pregnant pupils consequently conceal their pregnancy from parents who are often absent. Burman (1992, 31) quotes a nurse in this regard:

> Parents or teachers may discover when she gets labor pains that she is pregnant, and it is only then that she can be rushed to a hospital. Schoolgirls don't want to book in advance as this will require them to attend clinics on certain days, which will mean that they are absent [from school] . . . The focus will be on them and the classmates can guess their problem and will laugh at them. They don't want to be seen by neighbours frequenting the clinic as they will talk badly of them (Interview of November 23, 1988).

While stigma is attached to teenaged pregnancy, fertility also has a cultural value, as is illustrated in the following example of a 17-year-old African girl who became pregnant at 16:

> I knew I might get a baby, and the sister at school warned me also. But I had been going with my boyfriend for over a year and my girl friends were beginning to laugh at me. They whispered that I must be inyumba—that is, how you say, sterile. Even my boyfriend asked why I was not having a baby. Then, when I did get pregnant, my mother and father were very cross, but I was pleased as it showed everyone I can have a baby after all. (Preston-Whyte & Zondi 1992, 237)

C. Abortion

The Abortion and Sterilization Act No. 2 of 1975, which was the law until late 1996, allowed abortions only for instances of rape, incest, or when there is a danger to the physical health or life of the woman. The procedure for allowing a legal abortion was often so cumbersome that many who qualified opted for illegal abortion or went to another country where abortion is legal to have the operation performed.

In November 1996, a new abortion law passed its final legislative hurdle, clearing the way for President Nelson Mandela to replace one of the world's toughest abortion laws with one of the most liberal. The Choice of Termination of Pregnancy Bill was approved by a vote of 49 to 21 in the South African Senate. Twenty senators were absent when the vote was taken. The African National Congress insisted that members who could not support the new law absent themselves from the vote. The white-separatist Freedom Front, the National Party, and the Inkatha Freedom Party opposed the measure, as did Doctors for Life, which promised an immediate appeal to the Constitutional Court.

Under the new law, women and girls are entitled to a state-financed abortion on demand during the first 12 weeks of pregnancy if they have no private medical insurance. This support also applies between 12 and 20 weeks of pregnancy, subject to widely defined conditions. Physicians and midwives are required to advise a minor female to consult her parents, but the law specifically states that abortion cannot be denied if the minor refuses to inform her parents.

In 1986 and 1987, respectively, 770 and 810 legal abortions were performed in South Africa. During the same period, 26,062 and 35,882 operations for the removal of residues of a pregnancy were performed. These opera-

Table 18

Response to Statement, "I Think That My Mother's/Father's Ideas and Beliefs about Contraceptive Use Are Very Similar to My Own"

	Sample Year					
	1990		1991		1992	
Response	Mother	Father	Mother	Father	Mother	Father
True	735	507	716	473	617	417
	(39.5%)	(27.4%)	(36.3%)	(24.3%)	(40.6%)	(27.7%)
False	407	472	423	504	326	396
	(21.9%)	(25.2%)	(21.5%)	(25.8%)	(21.4%)	(26.3%)
Don't know	718	871	832	969	578	692
	(38.6%)	(47.1%)	(42.2%)	(49.8%)	(38.0%)	(46.0%)
Column Totals	1,860	1,850	1,971	1,944	1,521	1,505
	(100%)	(100%)	(100%)	(100%)	(100%)	(100%)

tions usually follow an illegal abortion and account for an unknown proportion of illegal abortions in South Africa. In 1992, 1,027 legal abortions had been performed in the first nine months, and 82 people were convicted between July 1988 and June 1991 of performing illegal abortions. [*Update 2003*: Some 155,624 abortions were performed in public hospitals and clinics between February 1997 and January 2001 (Kane-Berman 2002). (*End of update by L. J. Nicholas*)]

Of the 1,902 first-year students at a South African university, 75.6% were against abortion (35.8% male and 39.8% female). Only 15% of respondents felt that abortion is an acceptable way to terminate a pregnancy (8.6% male and 6.4% female).

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

In South Africa as elsewhere, sexually transmitted diseases (STDs) constitute a major public health problem. The annual caseload seen only at state/municipal clinics and in private practice is estimated at more than a million patients in a population of 40 million. Management of this endemic is worsened by the wide range of STDs encountered in South Africa, where the common Western STDs of syphilis, herpes, gonorrhea, and nongonococcal urethritis (NGU) coexist with tropical and subtropical entities like chancroid, lymphogranuloma venereum (LGV), and granuloma inguinale (Donovanosis). This poses a considerable number of diagnostic and therapeutic problems, especially among the people of color, the poor, and rural people.

In South Africa, considering the character of the primary healthcare and its context where access to laboratory facilities is limited, diagnosis and treatment are based more on a clinical pathology grouping of ulcerative, discharge, lymphadenopathy, and pelvic inflammatory disease (abdominal pain and infection) than on laboratory tests for specific causative organisms. Diagnosis in South Africa is often by exclusion of other similar infections (gonorrhea), as laboratory facilities are often limited or inaccessible. Combination treatment of NGU and gonorrhea is usually cheaper than the laboratory costs.

Table 19 shows the results of research on STDs at a South African university for the years 1989 to 1991 (Nicholas 1994a).

Black secondary and post high-school students are at high risk of acquiring STDs, because they are mostly single and the highest incidence of infection occurs in people between the ages of 15 and 24. Studies have shown, however, that the STD-infection rate decreases as education increases. Still, STD-infection rates for nonspecific urethritis, trichomoniasis, and herpes may be more common in college-educated people (Nicholas 1994a, 35).

Table 19

New Cases of Sexually Transmitted Diseases (First Infection by Year)

Disease	1989	1990	1991
Syphilis	47	46	31
Gonorrhea	337	325	312
NGU	67	79	107
Other	202	239	479
Total cases	653	687	929

Total student population: 13,000

A sample of general students surveyed reported a prevalence rate of STD of 18%. Studies at another South African university revealed an STD-prevalence rate of 19.9% to 23.8% for the years 1991 and 1992. For both years, the prevalence of STD was higher than the 13% reported by the nearby general local hospital.

In another study of 1,902 black first-year students at a South African university, 17% believed that only promiscuous people contract STDs; 11% did not believe that people are ethically bound to warn potential sexual partners if they have a sexually transmitted disease, 82% of students would not have a relationship with someone who had an STD, and 35% of students indicated that if they found out someone close to them had an STD, it would negatively affect their opinion of him or her (Nicholas 1994a).

B. HIV/AIDS

The total South African AIDS budget decreased from $6,076,337 in 1992/1993 to $6,045,556 in 1993/1994, a real decrease of 11%. According to the World Health Organization (WHO), South Africa should be spending $40 million a year on AIDS (Preston-Whyte 1995; Schoepf 1995).

Between April and September 1993, 488 cases of AIDS were reported in South Africa. Of these reported cases, 81% were African heterosexual men and women and 7% were infants. In nearly all the new cases of AIDS, the virus had been transmitted by heterosexual intercourse, in comparison with the period 1982-1986, when 88% of cases of the virus had been transmitted by homosexual intercourse. The Department of National Health and Population Development has reported that 550 people in South Africa were being infected with HIV daily in 1993. About 7,000 people were expected to develop AIDS in 1993. In 1995, the rate of HIV infection was expected to rise to 2.8% for men and 4% for women (Cooper et al. 1994). Table 20 provides an overall picture of HIV infection and AIDS in South Africa.

Table 20

AIDS Cases According to Method of Transmission, Race, and Sex: 1982-1993 (Cooper et al. 1994)

	Homo- & Bi-sexual	Hetero-sexual	Hemo-philiac	Other Blood Trans-fusion	IV-Drug Users	Pedi-atric	Total
African							
Male	3	313	3	4	1	99	423
Female	0	336	0	0	0	82	418
Unknown	0	6	0	0	0	4	10
Colored							
Male	21	13	1	1	0	0	36
Female	0	12	0	1	0	0	13
Indian							
Male	4	1	0	0	0	0	5
Female	0	0	0	0	0	0	0
White							
Male	61	14	13	12	1	0	401
Female	0	4	0	4	0	0	8
Unknown	0	1	0	1	0	0	2
Total							
Male	389	341	17	17	2	99	865
Female	0	352	0	5	0	82	439
Unknown	0	7	0	1	0	4	12
Grand Total	389	700	17	23	2	185	1,316

Analyzing results of an anonymous structured questionnaire designed to obtain baseline data on knowledge and attitudes of first-year black university students about AIDS and their attitudes towards homosexuals in 1990, 1991, and 1992 (*n*s = 1,902, 2,113, and 1,558), it is obvious that the students' knowledge of AIDS was inadequate, and misconceptions about AIDS transmission abounded. Prejudiced and exclusionary beliefs about people with AIDS were also common. Little difference was evident on any of the scales over the three-year period (Nicholas et al. 1994).

An AIDS-knowledge survey of 2,209 black university students in 1994 revealed striking misinformation about the risk of contracting AIDS by giving blood (41.5% said yes, 10.5% were unsure), contracting AIDS from a toilet seat (6% said yes, 8.1% were unsure), by masturbating oneself (2.9% said yes, 26.2% were unsure), and a high risk through blood transfusion (57.4% said yes, 22.5% were unsure (see Table 21).

In 1994, the newly appointed national AIDS director stated that previous AIDS-awareness programs only served to heighten fear and increase the stigma attached to AIDS, resulting in infected people's being reluctant to disclose their status. She promised to rebuild the AIDS program (St. Leger 1994). (See also Section 10B, HIV/AIDS, in Part 2 of this chapter.)

[*The Incidence of HIV/AIDS in South Africa*

[*Update 2003*: The first antenatal survey in 1990 provided a baseline from which HIV trends have been assessed annually. Anonymous, unlinked, cross-sectional surveys were conducted among first-time pregnant women attending public antenatal clinics during October. October was selected because surveys undertaken by Statistics South Africa indicated that, during this period, the population tends toward more stability and is less mobile. A weighted, systematic-cluster, random sample was used, which, in 2000, surveyed 16,607 women from 400 sites. Public antenatal clinics are attended by 80% of pregnant women in South Africa, of whom 85.2% are African (Tshabalala-Msimang 2000). In the Western Cape, 4% of attendees refused to be tested (Shaikh & Adendorff 2000). Of the 16,607 women, 24.5% were infected with HIV, an increase from 22.8% in 1998 and 22.4% in 1999. Blood specimens were tested with

Table 21

Responses to Knowledge of AIDS Scale Items

	Yes		No		Unsure	
All items commence with "Do most experts say . . ."	**%**	**(*n*)**	**%**	**(*n*)**	**%**	**(*n*)**
1. . . . there's a high chance of getting AIDS by kissing someone on the mouth who has AIDS?	7.1	156	84.3	1,851	8.6	189
2. . . . AIDS can be spread by sharing a needle with a drug user who has AIDS?	88.9	1,947	7.0	132	5.1	112
3. . . . you can get AIDS by giving blood?	41.5	907	48.0	1,049	10.5	229
4. . . . there's a high chance that AIDS can be spread by sharing a glass of water with someone who has AIDS?	3.6	78	89.9	1,969	6.5	143
5. . . . there's a high chance you can get AIDS from a toilet seat?	6.0	132	85.8	1,879	8.1	178
6. . . . AIDS can be spread is a man has sex with a woman who has AIDS?	97.6	2,137	1.4	31	1.0	21
7. . . . AIDS can be spread if a man has sex with another man who has AIDS?	84.6	1,855	3.0	65	12.4	273
8. . . . a pregnant woman with AIDS can give AIDS to her unborn baby?	96.4	2,116	1.7	37	1.9	41
9. . . . you can get AIDS by shaking hands with someone who has AIDS?	1.4	30	96.9	2,124	1.8	39
10. . . . a woman can get AIDS by having sex with a man who has AIDS?	96.6	2,116	2.8	62	0.6	13
11. . . . you can get AIDS when you masturbate yourself?	2.9	64	70.8	1,546	26.2	573
12. . . . using a condom (rubber) can lower your chance of getting AIDS?	92.4	2,020	3.7	80	4.0	87
13. . . . there's a high chance of getting AIDS if you get a blood transfusion?	57.4	1,255	20.1	440	22.5	491
14. . . . prostitutes have a higher chance of getting AIDS?	89.7	1,958	3.1	68	7.2	158
15. . . . eating healthy foods can keep you from getting AIDS?	7.2	158	77.0	1,684	15.8	345
16. . . . having sex with more than one partner can raise your chance of getting AIDS?	96.2	2,104	2.3	50	1.5	32
17. . . . you can always tell if someone has AIDS by looking at them?	3.5	76	84.1	1,837	12.4	272
18. . . . people with AIDS will die from it?	86.8	1,898	7.9	173	5.3	115
19. . . . there is a cure for AIDS?	5.3	115	86.6	1,805	12.1	265
20. . . . you can have the AIDS virus without being sick from AIDS?	54.4	1,188	18.1	395	27.5	601
21. . . . you can have the AIDS virus and spread it without being sick from AIDS?	52.2	1,138	20.0	437	27.8	607
22. . . . if a man or woman has sex with someone who shoots up drugs, they raise their chance of getting AIDS?	55.9	1,218	12.9	282	31.2	679

Sample: 889 women; 1,318 men; Mean age: 20.6 years (*sd* = 4.2)

Mean Total Knowledge of AIDS Scale Score: 17.1 (*sd* = 3.3) *N* = 2,209

one ELISA (enzyme-linked immunosorbent assay), except in the Western Cape, where two ELISAs were used because of the low HIV-prevalence rate. Given these results, it is estimated that approximately one in nine South Africans are infected with HIV (Tshabala-Msimang 2000). (See Table 22.)

[*Update 2003*: Sishana and Simbayi (2002) conducted the first national household HIV/AIDS prevalence study. The cluster sampled 14,450 potential participants, of whom 13,518 were visited. Some 9,963 (73.7%) persons agreed to be interviewed, and 8,840 (65.4%) provided an oral-fluid specimen for an HIV test. The results for whites, adults and youths, living in informal settlements, should be treated with caution, because the estimates are at the statistical borderline. Some 32% of white households declined to be listed in phase 1 of the study. The researchers found an estimated prevalence of 11.4% (females 12.8% and males 9.5%). Some 5.6% of children were HIV-positive, 0.3% of those between 15 and 24 years old and 15.5% of those over age 25 years. Table 23 shows the overall prevalence of HIV by sex and race. The study found that the HIV-infection rate among men is 74% that of women, and the HIV prevalence in pregnant women is much higher than in nonpregnant women (24.0% vs. 14.5%). HIV estimates in South Africa that have been based on antenatal surveys have, therefore, overestimated HIV prevalence in the general population. HIV prevalence is also lowest in rural areas and highest in urban areas, particularly urban informal settlements. Statistics South Africa (2002) reported the following for a 12% stratified random sample of death notification forms for 1997 to 2001, yielding 279,581 death records. The proportion of deaths because of HIV nearly doubled from 4.6% in 1997 to 8.7% in 2001. (*End of update by L. J. Nicholas*)]

[*Infant Mortality and Pediatric AIDS*

[*Update 2001*: In 2000, South Africa's infant mortality rate was estimated to be 45 deaths per 1,000 live births. One in about every 22 children born in South Africa died before reaching its first birthday. The infant mortality rate has shown an upward trend after declining before the 1990s, mainly because of HIV/AIDS infection. Only 8% of women reported that their partner had used a condom during their last intercourse. This figure doubled for those whose last intercourse was with a casual acquaintance or a boyfriend, but this is still very low. Overall, condom use is highest among African women and lowest among Asian women, who are, however, more likely than colored or white women to use condoms with their husbands. (*End of update by L. J. Nicholas*)]

[*AIDS Prevention and the Churches*

[*Update 2002*: According to a news release of the European News Service, the Religious Coalition for Reproductive Choice launched a church-based HIV/AIDS initiative in South Africa in conjunction with local churches and Jewish groups. The Anglican primate of the Church in the Province of Southern Africa endorsed the initiative, saying that "discussing issues of faith and religion in relation to HIV/AIDS gives new hope."

[The coalition, established in Cape Town, opened in February 2002 with a staff coordinator assisted by a corps of volunteers. Modeled on the coalition's successful Black Church Initiative, the South African program will assist churches in reducing teenage pregnancy and AIDS infections among youth, and hold forums for clergy to introduce the initiative. Training workshops will be offered for "Keeping it Real!" the coalition's faith-based sexuality education curriculum. Plans are to expand the initiative beyond Cape Town to other major cities, such as Johannesburg, Port Elizabeth, and Durban in the next two years. (*End of update by L. J. Nicholas*)]

[*HIV Prevention Programs*

[*Update 2002*: In February 2000, Lionel Mtshali, head of the provincial government of Kwa-Zulu-Natal Province, Durban, defied the national government by announcing his plan to distribute lifesaving drugs to every pregnant woman infected with the AIDS virus in this province in an effort to save their newborn babies. This announcement reinforced a widening campaign to challenge the national government's policy of restricting the distribution of AIDS drugs in public clinics and hospitals. Meanwhile, a small number of doctors and nurses began quietly distributing generic AIDS drugs purchased in Brazil in open defiance of South Africa's patent laws. National health officials have limited the drug to a handful of sites in each province, even though research has shown that it significantly reduces a pregnant woman's risk of transmitting HIV. Every year, 70,000 babies are born HIV-positive in South Africa, which has more people infected with the AIDS virus than any other nation. One tablet of nevirapine taken during labor—along with a single dose for the newborn—can reduce the risk of transmission by as much as 50%.

[The national government's program to distribute the drug reaches about 90,000 women a year, about 10% of those who give birth annually. In December 2001, a High Court judge ordered the government to expand the program, after advocates for AIDS patients sued. The government appealed that decision, saying it needed time to set up HIV testing and counseling and to assess the safety of the drug. Advocates for AIDS patients suspect that the government's position reflects President Thabo Mbeki's concerns about the side effects and toxicity of AIDS drugs and his widely publicized musings about whether HIV really causes AIDS. The cost of the drug is not a factor, since the drug's Belgian manufacturer has offered nevirapine for free.

[By early 2002, some government officials had acknowledged that the public outcry was mounting, as doctors, ministers, and politicians demanded a rapid expansion of the nevirapine program. These advocates say government officials are keeping a desperately needed program out of hospitals that could provide testing, counseling, and support. Government critics

Table 22

HIV Trends in Prevalence Percentages in the Western Cape, KwaZulu-Natal (KZN), and National for the Decade of 1990 to 2000 (Adapted from Tshabalala-Msimang 2000)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
West Cape	0.1	0.1	0.3	0.6	1.16	1.66	3.1	6.3	5.2	7.1	8.7
KZN	1.6	2.9	4.5	9.5	14.4	18.2	19.9	26.9	32.5	32.5	36.2
National	0.8	1.4	2.4	4.3	7.6	10.4	14.2	16.0	22.8	22.4	24.5

Table 23

Overall HIV Prevalence by Sex and Race, South Africa 2002

Sex and Race	*N*	HIV+ (%)	95% CI
Total	8,428	11.4	10.0-12.7%
Male	3,772	9.5	8.0-11.1
Female	4,656	12.8	10.9-14.6
African	5,056	12.9	11.2-14.5
White	701	6.2	3.1-9.2
Colored	1,775	6.1	4.5-7.8
Indian	896	1.6	0-3.4

have pointed out that nevirapine was approved and found safe by the United Nations and the World Health Organization (WHO).

[With an estimated 36% of adults infected with HIV based on antenatal studies in Kwa-Zulu-Natal, Mtshali approached his provincial health minister and asked him to expand the nevirapine program, which is only available in two large sites here. This health minister explained that the national government would only consider expanding the program in 2003. Faced with this postponement, the provincial government announced plans to rapidly roll out the nevirapine program by the end of 2002. The national government—which expressed reservations at first—has accepted the plan. Other provinces, including the Western Cape and Gauteng, have also forged ahead with the government's permission. Still other provinces, with fewer resources and fewer established hospitals, will adopt a slower timetable (Swarns 2000). (*End of update by R. T. Francoeur*)]

[*Update 2002*: UNAIDS Epidemiological Assessment: National sentinel surveillance surveys of antenatal clinic attendees have been conducted in South Africa since 1990 and surveillance data is available by province and at the national level. Antenatal clinic HIV prevalence in South Africa increased rapidly from 0.7% in 1990 to 10.5% in 1995, and then to 22.8% in 1998. HIV prevalence among antenatal clinic attendees was 22.4% and 24.5% in 1999 and 2000, respectively. Age-specific analysis shows a modest decline in HIV-infection rates among 15- to 19-year-old antenatal clinic attendees from 21% in 1998 to 16.5% in 1999, and continuing to decline in the year 2000. However, antenatal clinic attendees in their early 20s still exhibit HIV prevalence of over 25%. In KwaZulu-Natal, Mpumulaga, and Gauteng provinces, HIV prevalence is still exhibiting an upward trend; HIV prevalence rose rapidly from 7.1% in 1990 to 36.5% in 2000. In other provinces, HIV-infection trends seem to be stabilizing at high rates, ranging from 11.2% to 27.9%. Results from the 2001 antenatal clinic sentinel surveillance survey were not readily available at the time of the writing of this report.

[HIV prevalence among sex workers tested in Natal increased from 50% in 1997 to 61% in 1998. Among male STD clinic patients tested in Johannesburg, HIV prevalence increased from 1% in 1988 to 19% 1994. Similarly, HIV prevalence increased among female STD patients from 2% in 1988 to 25% in 1994. In 1999, 11 million STD episodes were reported.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	4,700,000	(rate: 20.1%)
Women ages 15-49:	2,700,000	
Children ages 0-15:	250,000	

[An estimated 360,000 adults and children died of AIDS during 2001.

[At the end of 2001, an estimated 660,000 South African children under age 15 were living without one or both parents who had died of AIDS. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

As mentioned several times earlier, particularly in Section 1, the sexual denial and repression maintained by the South African government and its censorship policies have severely limited the development of the facilities and properly trained personnel necessary if the average citizen is to have access to the diagnosis of sexual problems and dysfunctions, sexual counseling, and therapy. Broad-ranging government censorship of all books on sexuality, coupled with bans on vibrators and other sexual objects, the lack of sexual-education programs, and the absence of public discussion of sexuality issues severely affected the provision of sexuality counseling and therapy in the past.

Very little government support and public funds are available for research and education on sexuality issues. Without studies of sexuality among the indigenous populations of South Africa, sexual counseling and therapy is, of necessity, exercised by health professionals trained abroad using EuroAmerican models. Sexual counseling and therapy is available only to those who can pay private practitioners, or have access to the limited counseling available while they are attending the universities, colleges, technical colleges, and schools that currently fulfill only a peripheral role in primary prevention of the development of sexuality-related problems through research and consultancy services. Primary prevention services in the area of sexuality are meager, and campus sex counselors have to assume that hardly any students would be "unaffected" by sexuality-related problems. Only the degree to which students are affected by these problems will differ (Nicholas 1994a, 116-117).

12. Sex Research and Advanced Professional Education

The sexual behavior of blacks has been misrepresented to such a degree that an objective discussion is very difficult. The paucity of sociological and psychological studies is striking, with even the landmark studies of Kinsey and Masters and Johnson paying scant attention to the sexuality of black Americans. An important, but still limited, remedy to this lack has been undertaken by the authors of this chapter at the University of the Western Cape and other black institutions in South Africa.

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PART 2: ANOTHER PERSPECTIVE

MERVYN BERNARD HURWITZ

1. Basic Sexological Premises

A/B. Gender Roles and General Concepts of Sexuality and Love

The different ethnic groups have diverse concepts of gender roles. In the black traditional community, the male plays a dominant role. He is allowed more than one wife. When his wife is no longer able to bear children, he is allowed to find a younger, fertile wife to bear more children. This lifestyle is more prevalent in the rural areas. In the urban areas, the blacks are more Westernized and polygamy is less prevalent, with the male having a monogamous relationship with only one wife (Burman & Preston-Whyte 1992).

Traditionally, the black woman does not demand sex from her partner, nor does she make advances towards him. There is little foreplay, and once the male has been satisfied, there is little afterplay. However, recently, the urbanized black woman is becoming more demanding in her sexual relationship and the male is losing his secure dominant role. The women's liberation movement is gradually reaching the black urban woman. However, the man is still the traditional leader and plays a dominant role in decision making in the family, expecting his wife to be totally subservient (Monnig 1983).

Black males commonly become migrant laborers in the mines or in the city, leaving their wives in the rural areas to tend the farms and raise the children. The husband is usually the sole monetary supporter of the family. He returns to his rural home if there is illness or bereavement in the family, usually visiting only once or twice a year. He seldom allows his wife or family to visit him in the city.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

The South African community is made up of separate ethnic groups with different identities and affiliations and cannot be lumped together as one group. The white population is made up of two large groups, namely the Afrikaners (Boers) and the English-speaking people.

Afrikaners adhere to a strictly Calvinistic view. Sex is not taught at schools. Any discussion on sexuality is frowned upon and the topic is largely seen as taboo. In this male-dominated society, the woman has been assigned a secondary role. However, with the influence of the media and the gradual lifting of the censorship of sexually explicit information, the men are threatened by the changing role of women, who are becoming more sexually assertive. In a 1987 survey comparing English-speaking and Afrikaans-speaking white South Africans, Louise Olivier found that 72.8% of Afrikaans-speaking women and 69.2% of English-speaking women could discuss sexual matters with their mothers. Only 4.4% of women could discuss sexual matters with their fathers.

In the black communities, 6 million out of nearly 18 million people are affiliated to the Church of Zion or other independent Protestant churches. Many blacks still subscribe to ancestor worship and tribal ritual, despite the strong influence of the missionaries who have tried to inculcate a Christian monotheism and ethic.

Muslim and Hindu influences are found among the Asian minorities.

3. Knowledge and Education about Sexuality

A. Government Policies and Programs

In the white population, sex education has been viewed as the parents' responsibility, with few health professionals becoming involved other than on a consultative basis.[1] Sometimes, sexual education is provided by the family doctor, who is approached when a young person becomes sexually active and wants counseling and instruction about the use of suitable contraception.

There is no formal sex education in either the white or black schools. Representation has been made to the Minister of Education in an effort to introduce sex education into the schools, but this has met with strong resistance. The Dutch Reformed Calvinistic approach indoctrinated by the church has been opposed to sex education in schools, and all discussion of sexuality is frowned upon. Private (nongovernment-controlled) schools do have sex-education classes. Lectures are given to pupils in the 11- to 17-year-old age group, usually by social workers and counselors at the Family Life Center, as well as by the author and other sex educators.

B. Informal Sources of Sexual Knowledge

In 1992, television programs on sexuality were initiated, directed primarily at the youth. Panel discussions sponsored by the media have been held to look at sex education and to expose various topics of sexual interest.

However, there is very strict censorship in South Africa, and many of the sex books that are freely available overseas are banned in South Africa. There is thus a very limited number of books on sex education or explicit books on sex. Talk shows are becoming frequent on television, and phone-in shows are available on radio. There is, however, a move afoot to ban all these sources of sexual information.

The ritual passage for black girls in the traditional tribal situation is very secretive. In the Pedi tribe, Monnig reports that these rituals are conducted by the girl's mother or grandmother. The girl is told about menstruation and informed that she must avoid sex during this time. She receives detailed instruction on the work and duties of a woman, particularly in her relationship with a man, and is instructed on sexual matters. The young Pedi girls assist one another in stretching their own labia minora, which is said to ensure greater sexual gratification for men.

4. Autoerotic Behaviors and Patterns

There is no literature or data pertaining to autoerotic behavior and patterns in South African children, adolescents, or adults. "Blue movies" and autoerotic literature are banned. Pornographic programs and books are heavily censored. Studies of autoeroticism are discouraged by the church and schools. People returning from overseas with erotic literature have the publications confiscated at the airport and are liable to be punished.

In the English-speaking universities, some lectures and courses on sexuality have been introduced. Lectures in sexuality for medical students were introduced in the mid-1980s. Workshops on sexuality are given to doctors, nurses, social workers, and allied professionals to encourage them to feel more at ease with sexuality and to be able to discuss sexual problems with their patients.

5. Interpersonal Heterosexual Behaviors

A. Children

Forty percent of South Africa's population is under 15 years of age. Children of preprimary school age often attend nursery schools or crèches where the sexes are mixed. They share common toilet facilities, are taught basic gender differences, and stereotypic gender-role models are reinforced. Both teachers and parents report that children play doctor-patient games and tend to explore one another. This is often a source of great anxiety to both parents and teachers.

In the black communities, there is overcrowding and a lack of privacy. The children often have to sleep in the same room as their parents, and many share a bed with parents or siblings. This early exposure to parental sexual activity sometimes causes anxiety and confusion that can affect their own sexual identity.

B. Adolescents

Puberty Rituals

Pubertal rituals are carried out in many black tribes. Male circumcision in the black communities is common in both urban and rural areas and is seen as a prerequisite for manhood. The age of circumcision varies in different tribal groups from 9 to 22 years.[2] In the Xhosa tribe, for example, males are circumcised between the age of 18 and 22 years, in a ritual ceremony celebrated twice a year.[3] In most tribes, there is no anesthetic given for pain; the boy is simply given only a piece of wood to bite on. The youth is indoctrinated to believe that he has to endure pain to prove that he is fit to be called a "man."

Because of poor techniques and inexperienced or poorly trained traditional healers or *sangomas*, the complications of circumcision are sometimes serious, even functionally irreparable. Gangrene is not an infrequent complication following ritual circumcision.[4]

Courley and Kisner described 45 cases of youths who required hospitalization following ritual circumcision.[3] All 45 cases were septic on admission. In 5% of cases, the entire penis was necrotic; the mortality rate was 9%. Septicemia and dehydration are frequent causes of such mortality.

The chief cause of penile injury is a dressing that is too tight and applied for too long. The hemorrhage is controlled by applying leaves around the penile shaft and then binding the organ with a strip of sheepskin leather. A concerted effort is being made to educate the traditional healers in the use of commercial medicines and dressings rather than traditional leaves and sheepskin.[3]

Female circumcision is not carried out in South Africa, although some tribes, such as the Pedi, encourage the females at puberty to stretch the labia minora.

Premarital Sexual Activities and Relationships

Focusing on adolescent black children and teenagers, Preston-Whyte and Zondi found that both boys and girls admitted experiencing sex before their 12th or 13th year.[5] Some had experienced penetration before they reached physical maturity. By age 13, most had been sexually active, if not regularly, then at least on a number of occasions. Full penetration was the rule.

In a predominantly white South African survey, Olivier found that 30% of his respondents under age 17, 24 of 80, were still virgins. In the colored community, Burman and Preston-Whyte (1992) found that 30.5% of all births occurred in teenagers, with 5% below the age of 16. Eighty-one percent of the teenage group had out-of-wedlock children.

There are no figures available on the number of teenagers who are involved in ongoing relationships while indulging in sexual activities. Peer pressure in the urban black community encourages sexual encounters that are often monitored by older teenagers.

The double standard is evident in the black communities. When a man's unmarried daughter becomes pregnant, he is enraged. Yet, when a son makes a girl pregnant, the father may be secretly and even overtly pleased. Among his peers, a boy who has many girlfriends, and who is known to have fathered a child or a number of children, is admired. His father often shares this attitude. The pressure is therefore towards, rather than away from, teenage sexual involvement. The relationship between a boy and girl who are "going together" is normally one that involves full intercourse (Burman & Preston-Whyte 1992).

C. Adults

Premarital Courtship, Dating, and Relationships

The formal ritual of dating and courtship familiar to Western civilization is more prevalent in the white South African community, which tends to be more affluent and able to afford movies, discos, and weekends away on vacation. There are several singles clubs, discos, and bars catering to adolescents and young adults looking for dates or a "one night stand." With the incidence of sexually transmitted diseases, the educated and affluent groups are more inclined to be selective and less promiscuous in their relationships than their less-educated brothers and sisters from a lower socioeconomic class.

Marriage and the Family

Monogamy is more commonly accepted amongst the white group than the black group. Traditional black men who have not accepted the doctrine of Christianity are allowed to have more than one wife. In the rural setting, a man's wealth is assessed by the number of children and cattle he owns, and thus he may take a second wife. Cohabitation is common in the white society in nonreligious couples, but is frowned on by the church, particularly the strong Calvinistic elements of the Dutch Reformed Church. In the black traditional rural setting, marriage is not primarily concerned with legalizing sexual relations between two individuals, but rather with establishing paternity and giving the husband the right to sexual relations with his wife. In this value system, extramarital intercourse is possible and even socially accepted and provided for culturally (Monnig 1983).

Laws prohibiting interracial sex and marriage were repealed in 1985.

Incidence of Oral and Anal Sex

There are no figures available for the incidence of anal sex, fellatio, or cunnilingus. In my experience, anal intercourse is engaged in by a very small proportion of heterosexual couples. On the other hand, more than half the couples attending the Sexual Dysfunction Clinic at the Johannesburg Hospital reported engaging in cunnilingus and fellatio. Most men reported being happy to indulge in cunnilingus. Some women reported feeling uncomfortable with fellatio. In Olivier's 1987 survey, a surprising finding was that few women reported enjoying oral sex, only 9.2% in the 17- to 25-year age group and 5.9% in the over-age-25 cohort. From my personal experience in my private gynecological practice, I feel that these figures are low and that the overall figure is well over 30%.

6. Homoerotic, Homosexual, and Bisexual Behaviors

In Olivier's survey of 2,842 women, 89.7% were heterosexual, 0.3% were lesbian, and 2.5% were bisexual. Most of the women in this survey, 2,711 of 2,842, were white females. There is no legal status for lesbian or homosexual couples in the South African society. In 1992, homosexuality was more acceptable and less frowned upon than previously. Gay advice bureaus are available, but there is no legislation to protect the rights of homosexuals.

The incidence of homosexuality in the black population is low. This is borne out by the low incidence of HIV-positive homosexual black males (0.6%), compared to 31% of homosexual or bisexual white males.[6,7]

7. Gender Diversity and Transgender Issues

Transvestites, transgenderists, and transsexuals have no legal standing. There are very few centers available in South Africa for the treatment of these patients, and surgical operations are very rarely performed. At least two years of psychiatric treatment and evaluation are needed before any operative procedure is considered.

8. Significant Unconventional Sexual Behaviors

A. Coercive Sex

Sexual Abuse

The Department of Health and Welfare keeps a social welfare register on all children who are abused. Legislation requires doctors, nurses, social workers, police officers, and members of the public to report cases of abuse. It would appear that sexual abuse is becoming more prevalent in all sectors of the community. This correlates with the escalating violence encountered throughout South Africa. Conviction for sexual abuse and rape carries a penalty of a lengthy prison sentence. In their study of teenage mothers, Burman and Preston-Whyte found that pregnancies occurred at a younger age among abused children than in the control group.

Incest

Incest is taboo in all groups in South Africa (Zulu report by Burman and Preston-Whyte; Pedi report by Monnig). If a pregnancy results from incest, a legal abortion may be performed.[8] There are no available statistics for the incidence of pedophilia, but it is a punishable offense.

Sexual Harassment

With the increase of feminism, more cases of sexual harassment are being reported in the workplace. South African men are known to be chauvinistic and to "put down" women both verbally and in terms of job opportunity. There is only recourse to the law in terms of discrimination and not in terms of harassment.

Rape

Rape cases are reported daily. However, in cases of family rape, they often are unreported. There is still a stigma attached to the rape victim and, despite attempts at educating the public, the rape victim is still often seen as inviting the sexual advances of the male. In black urban areas, two to three rapes are reported daily and many more are unreported. These rape cases are often committed by strangers or casual acquaintances.

B. Prostitution

Prostitution is rife, particularly in the larger cities. Escort agencies provide a front for prostitution, which is illegal in South Africa. No figures are available of the number of practicing prostitutes or their activities. With the present high rate of unemployment, estimated at over 25% in the black community, prostitution is on the increase. As prostitution is illegal, there are no facilities for regular medical examinations of prostitutes to control STDs or other infections.

C. Pornography and Erotica

As mentioned above in Sections 3B and 4, the Calvinist tradition has been very effective in maintaining severe restrictions on all pornographic and erotic material.

9. Contraception, Abortion, and Population Planning

A. Contraception and Teenage Unmarried Pregnancies

Family-planning clinics are available in many areas and provide a free service. There is a reluctance among the black males to allow their partners to use contraception. Among the more-educated population, there is an attempt to limit the size of the family and to use some form of contraception.

Adolescent pregnancies are common in the black communities. Contraception is seldom used. The reasons given for failure to use contraception include cost, not admitting sexual activity, unplanned coitus, a belief that they are too young to become pregnant, fear of the effect of contraceptive methods, and subconsciously wanting to become pregnant.

The earlier the age of menarche, the earlier the first coitus occurs.[8] Van Coeverden found that when the menarche occurred before the age of 12, 56% of teenagers attending a family-planning clinic experienced coitus by the age of 15.[9] If menarche occurred after the age of 13, then 42% were sexually active by the age of 17.

There are no statistics available as to whether the sexually active teenagers have multiple partners or are involved in steady exclusive relationships. Personal observation suggests that promiscuity is common. Peer pressure often forces teenagers to have sexual contact in order to avoid being ostracized by their peer group. Unstable home and socioeconomic factors, as well as poor school attendance, boredom, drugs, and alcohol abuse, are some factors related to the early onset of coitus.

Premarital sexual relations vary considerably between the various racial groups in South Africa. Children raised in crowded ghetto conditions often lack parental control and have fewer recreational facilities to occupy their spare time and energy. Above all, for many black girls, there is very little to look forward to except childbirth.[5]

B. Abortion

Although abortion was illegal in South Africa until late 1996, the Abortion and Sterilization Act of 1975 allowed for legal abortions under four well-defined circumstances:[8]

1. Where the continuation of a pregnancy poses a serious threat to the mother's physical and/or mental health;
2. Where a risk exists that the child will be seriously handicapped, physically or mentally;
3. In cases of rape or incest;
4. In cases of unlawful carnal intercourse with a woman who is permanently mentally handicapped.

A 1994 review covering a six-year period quotes the number of legal abortions in South Africa as being about 1,000 per annum and the registered number of instances where products of conception were found at surgery as being about 35,000 per annum.[10] The number of "back street abortions" performed annually is estimated at between 10,000 and 40,000. Many of the more-affluent patients travel overseas to countries where abortions are legal to have their preg-

nancies terminated. (See discussion of the new legislation adopted in November 1996, in Section 9C, Contraception, Abortion, and Population Planning, Abortion, of Part 1.)

10. Sexually Transmitted Diseases and HIV/AIDS

A. Sexually Transmitted Diseases

Sexually transmitted diseases constitute a major public health problem in South Africa. It has been estimated that over one million patients seek treatment for sexually transmitted diseases each year at community clinics, and that more are seen at hospital outpatient departments and primary healthcare clinics. STDs in South Africa conform largely to Third World patterns. Pelvic inflammatory disease, mainly because of STDs, is the commonest reason for acute emergency admission to the gynecological wards and is the most common disease syndrome seen in gynecological outpatient departments.[11]

A survey in Alexandra township, a poor urban black township in Johannesburg, estimates that 20% of the population over the age of 15 is treated at least once a year for an STD.[6] A second study of patients seen at a university clinic in Alexandra township revealed that 10% of all patients seen were referred with an STD, 53% being men and 47% women.[7] Fifty-four percent of the patients were between the ages of 20 and 29. Most men presented with urethritis or an ulcer, while the women presented with pelvic inflammatory disease or a discharge.

Gonorrhea remains the most common cause of acute urethritis. Twenty percent of all cases also harbor chlamydia trachomatis, the commonest cause of nongonococcal urethritis (NGU).[11] The commonest organisms found in females with pelvic inflammatory disease are *Neisseria gonorrhoeae* in 65% of cases, *Mycoplasma hominis* in 53% of cases, and *Chlamydia trachomatis* in 5% of cases.

Mixed infections are common and anaerobic superinfections occur in 82% of cases.[11] Men are more likely to be repeat attendants for STD, and are more likely to report multiple sex partners. Professor Ron Ballard states that there are upwards of three million new cases of STDs each year in our population of 26 million.[12]

There are poor resources available for the treatment of STDs. Attempts are being made for a wide-ranging communication campaign to attempt to educate the population to reduce the number of sexual partners.

A major factor affecting the availability of contraception, abortion, and the diagnosis and treatment of STDs and HIV/AIDS is the state of the country's national healthcare system. In the January 1995 annual healthcare and education report, the South African bishops conference warned that the country's national healthcare system is close to collapse. The system, the report stated, is in a chaotic state because of poor coordination of services, inadequate resources, and injustice. Only 19% of South Africa's 41 million people have medical coverage through private systems. Public hospitals that offer inexpensive care to uninsured patients are crowded and understaffed. Health Minister Nkosazana Zuma initiated a study of a national health insurance plan that would provide universal coverage. This study includes examination of successful models from Kenya and Namibia that stress preventing illness by teaching healthy living habits through community health organizations.

B. HIV/AIDS

In all of Africa, HIV infection is spread mainly through heterosexual intercourse.[13] Concomitant STDs, particularly genital ulcers, are implicated as cofactors in the transmission of the HIV virus.[14] The World Health Organization estimates that there are 5 million HIV-infected individuals in Africa. This epidemic has only recently reached South Africa, but there is every indication that the prevalence of HIV may reach alarming proportions in the future, and no field of medicine will remain unscathed.[15] It is estimated by the Department of National Health that there are currently 300,000 HIV-positive people in South Africa and 400 new cases per day.[16] The latest available statistics of AIDS in South Africa as of September 1992, total 27,389 confirmed cases.[17] However, AIDS is not a reportable disease in South Africa, and thus many cases are not recorded. (See Tables 24 and 25.)

A survey carried out at the Baragwanath Hospital, in Soweto, a black town adjoining Johannesburg, has revealed that between July 1988 and December 1990, 426 HIV-positive individuals were identified.[15] Eighty-five percent of these cases were traced to heterosexual transmission, 0.6% to homosexual contact, and 12.6% to perinatal maternal infection. In this study, a total of 111 HIV-positive women were diagnosed in the maternity units of Baragwanath Hospital, and 51 symptomatic children with perinatally acquired HIV infection were admitted to the pediatric wards.[18] Late 1994 data from the Baragwanath Hospital showed that 8% of patients in the prenatal clinic were HIV-positive. At the Johannesburg Hospital, 10% of the prenatal clients were HIV-positive; a similar incidence was reported in late 1994 by the Johannesburg City Council for the inner-city population that was HIV-positive. In 1994, the number of HIV-positive South Africans doubled in 12 months.

According to McIntyre, the rate of HIV-positive pregnant women in 1992 was 4/100, with the rate doubling every nine to 12 months.[19] As a result of these alarming statistics, an HIV clinic has been started in the maternity unit of Baragwanath Hospital. The most-recent figures show that at least two HIV-positive women give birth daily at the hospital; 200 HIV-positive women were identified in the first eight months of 1992.

The major brunt of the HIV epidemic in South Africa is expected to be borne by black heterosexual adults and by infants.[20] A total of 181 HIV-positive black adults were admitted to the medical wards of Baragwanath Hospital between August 1987 and December 1990. Equal numbers of both sexes were seen, of which 34% have died.

There are no statistics of lesbian HIV-positive women in South Africa. All age groups in both sexes are at risk of ac-

Table 24

AIDS Risk (as of September 1992)

AIDS Risk Category[16]	Percent of Total
Heterosexual	50
Homosexual/bisexual	31
Pediatric	15
Blood transfusion	1.9
Hemophiliacs	1.4
IV-drug users	0.1

Table 25

Percent of AIDS Cases[14] (as of September 1992)

	Percentage of Cases by Race	Percentage of Nation's Population
Black	62.4	68.3
White	33.2	17.1
Colored (mixed race)	3.7	11.0
Asian	0.4	3.2

quiring HIV infections.[21] Tuberculosis is the commonest infectious complication of AIDS in South Africa.[22]

In South Africa, the HIV virus is most commonly transmitted by sexual intercourse. Transmission of the virus from mother to child is the second commonest mode of spread in all African countries, including South Africa.[23] Homosexuality is relatively uncommon among black South Africans, but is a common form of transmission of the HIV virus in the white population. Homosexuality, however, does not play a major role in the pandemic spread of the HIV virus in any African country.[24]

In the African context, black promiscuous men are very reluctant to use condoms and complain about the cost and inconvenience of the use of condoms. Since status is equated to fertility, the use of condoms and contraception is frowned upon. Condoms cannot be prescribed in the Health Service, but they can be obtained free of charge from Family Planning Clinics. Doubts have been expressed about the advisability of media advertisements on the use of condoms in South Africa, prompted by pervading Calvinistic reticence (Lachman 1990). AIDS education is available in many black schools but is not permitted in state-controlled schools for predominantly white pupils. In the conservative Calvinistic white community, AIDS is seen as a problem experienced only among homosexuals or the black community.

In a survey of 122 black mothers in the Durban area, it was found that these mothers were at a high risk of acquiring AIDS.[24] Urban black mothers seldom discuss the risk of unprotected sex with their daughters, despite their knowledge of transmission modes and of ways to prevent HIV infection. Fifty percent of these mothers had children by the same consort, whereas 44% had more than one partner. Ninety-two percent of these mothers stated that they would like their partners to use condoms, yet all the mothers said that they had not experienced intercourse where their partners had used condoms.

In 1989, the Johannesburg City Health embarked on an AIDS-awareness campaign using messages placed on the outside of 30 city buses.[25] The role of health education is to provide the entire community with a means to prevent HIV infection. A toll-free dial and listening service is available to anyone who has access to a telephone. Callers can choose to hear this information in any of the eight major languages in South Africa.

In recognition of the seriousness of the AIDS problem, the Department of National Health and Population Development recently established an AIDS unit. The unit consists of a multidisciplinary team. There are AIDS clinics in all the major cities of South Africa but these are already insufficient for the needs of the community. Counseling HIV-positive patients embodies the principles of counseling and care for all patients who have an incurable disease. It is different in that no other medical condition carries the stigma, moral censure, and societal consequences that accompany AIDS.[26]

An April 1995 Update: Early results of a Department of Health survey showed that two out of 25 South Africans are HIV-positive. In 1995, an estimated 850,000 to one million South Africans were infected, with over 700 new cases every day. The infection rate in Kwazulu Natal is almost three times that of the rest of the country; the number of AIDS cases for the first quarter of 1995 was double that for the same period in 1994. An estimated 15% to 19% of the people in Natal were infected in April 1995. The least-infected regions of the country were the North West and Northern Cape. The epidemiological director cautioned that the extent of underreporting was not known.

In a July 1996 report at the 11th international conference on AIDS, South Africa had an estimated 1.8 million cases of HIV infection, second only to India's 3 million cases. In June 1996, Dr. Peter Piot, head of the United Nations Joint Program on HIV-AIDS, reported that 10% of the South African population is believed to be infected with HIV. In the province of Kwazulu Natal, the infection rate had reached 16% (Preston-Whyte 1995; Schoepf 1995). The rate was even higher in nearby Zambia and Zimbabwe, where 17% of the population lives with the virus. In South Africa's northern neighbor, Botswana, 18% of the people are infected. No one can explain this rapid rise in HIV infection in southern Africa, especially considering the fact that the infection reached South Africa later than it did other regions of Africa, and the efforts of the Mandela government in making AIDS prevention a national priority.

11. Sexual Dysfunctions, Counseling, and Therapies

A. Concepts of Sexual Dysfunction

Any problem related to sexuality that may negatively affect either the male or the female, both as individuals or in a relationship, is viewed as a sexual dysfunction. In the male, the most common reasons for referral to the Sexual Dysfunction Clinic or to a sex therapist are premature ejaculation and loss of libido. Orgasmic dysfunction in the female and loss of libido are the most common sexual dysfunctions seen at the Sexual Dysfunction Clinic. In the black population, most males are worried about their performance, their ability to sustain an erection for an often-unrealistic length of time, or the inability to have intercourse up to 4 to 5 times a night.

B. Availability of Diagnosis and Treatment

The root of many of the problems is basic ignorance. Thus, patients are given information about basic sexual anatomy and physiology. At the Sexual Dysfunction Clinic in Johannesburg, patients are preferably seen as couples by the team consisting of a gynecologist, social worker, and nurse. All patients are examined physically, and the female patients are given a complete pelvic exam. The partners are encouraged to participate in these physical examinations.

All males attending the Sexual Dysfunction Clinic at the Johannesburg Hospital are checked by Doppler flow for penile blood flow and penile blood pressure. Serum testosterone and prolactin levels are routinely carried out at the clinic on males with any form of sexual dysfunction. A urologist is available for consultation. Some couples or individuals prefer to be counseled privately and are seen by a single therapist in private practice who may be a gynecologist, urologist, psychiatrist, psychologist, social worker, or general practitioner.

Sex therapists in South Africa have been trained locally and often internationally. They attend international workshops and congresses. Sex therapists in South Africa come from many disciplines, all of which have an interest in the field of sexology.

12. Sex Research and Advanced Professional Education

There is very little research in the field of sexology in South Africa. There are no facilities to carry out major research programs. However, some individuals conduct sporadic research into various aspects of sexual dysfunction.[27,28] There are no available institutes or programs for research.

Medical students at the various medical schools receive lectures on sexual dysfunction as part of their medical curriculum. Students at the University of the Witwatersrand are encouraged to attend the Sexual Dysfunction Clinic at the Johannesburg Hospital. There are sexual dysfunction clinics at the Johannesburg Hospital, Groote Schuur Hospital in Cape Town, and the H. F. Verwoerd Hospital in Preto-

ria. There are no postgraduate facilities available for the advanced study of human sexuality.

The Sex Society of South Africa is in the process of being formed at press time. *The Medical Sex Journal of South Africa* is published quarterly by the South African Academy of Family Practice and Primary Care. The address of the editorial offices is: P.O. Box 23195, Joubert Park, Johannesburg, South Africa.

Additional information on sexuality is available from: Planned Parenthood Association of South Africa, Third Floor, Marlborough House, 60 Eloff Street, Johannesburg 2001, South Africa. Tel.: 27-11/331-2695.

Conclusion

In the early 1990s, South Africa is faced with a major upheaval, both politically, socially, and economically. The uncertain political, social, and economic future of South Africa, faced with the transition from a white-dominated government to a multiracial or black government, poses many challenges for the country. Violence has become a way of life. Sexual abuse is common, as is murder, rape, and anarchy. The future of the medical and paramedical services is in a state of flux. It is not likely that the situation of sexology will improve significantly in the near future, simply because most of the nation's resources and the people's energies will, of necessity, be devoted to more pressing and urgent challenges, including the need to provide primary healthcare, food, housing, and basic necessities to the underprivileged masses.

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