ORIGINAL RESEARCH ARTICLE

Indigenous sexual and reproductive health practices by girls in Makhado Municipality: A qualitative study

DOI: 10.29063/ajrh2024/v28i1.7

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Abstract

Cultural practices are passed from one generation to the other. There has been limited evidence of willingness to use indigenous practices to enhance sexual and reproductive health among the youth in resource-constrained settings. This study aimed to explore the possibilities of reintroducing indigenous practices to enhance sexual and reproductive health education among girls. The study adopted a qualitative approach through participatory action research. Non-probability, purposive sampling was used to recruit girls aged 9-18. Data were generated through focus group discussions and key informant interviews. The study findings revealed that indigenous practices were beneficial in delaying sexual debut and nurturing self and peer respect. Additionally, girls appreciated indigenous knowledge and preferred introducing innovative approaches to promoting it. Youth involvement in indigenous knowledge and practices on sexual and reproductive health practices is paramount. The need to introduce critical dialogue to introduce innovative approaches to promoting indigenous practices to enhance sexual and reproductive health is imperative. *(Afr J Reprod Health 2024; 28 [1]: 65-74).*

Keywords: Action research, culture, initiation schools, innovation, social norms, youth

Résumé

Les pratiques culturelles se transmettent d'une génération à l'autre. Il existe peu de preuves d'une volonté d'utiliser des pratiques autochtones pour améliorer la santé sexuelle et reproductive des jeunes dans des contextes aux ressources limitées. Cette étude visait à explorer les possibilités de réintroduire les pratiques autochtones pour améliorer l'éducation à la santé sexuelle et reproductive des filles. L'étude a adopté une approche qualitative à travers une recherche-action participative. Un échantillonnage non probabiliste et raisonné a été utilisé pour recruter des filles âgées de 9 à 18 ans. Les données ont été générées par le biais de discussions de groupe et d'entretiens avec des informateurs clés. Les résultats de l'étude ont révélé que les pratiques autochtones étaient bénéfiques pour retarder les premiers rapports sexuels et favoriser le respect de soi et de ses pairs. De plus, les filles appréciaient les connaissances autochtones et préféraient introduire des approches innovantes pour les promouvoir. La participation des jeunes aux connaissances et pratiques autochtones en matière de santé sexuelle et reproductive est primordiale. Il est impératif d'instaurer un dialogue critique pour introduire des approches innovantes visant à promouvoir les pratiques autochtones visant à améliorer la santé sexuelle et reproductive. *(Afr J Reprod Health 2024; 28 [1]: 65-74).*

Mots-clés: Recherche-action, culture, écoles d'initiation, innovation, normes sociales, jeunesse

Introduction

Sexual and reproductive health rights (SRHR) is defined as a state of physical, emotional, mental, and social well-being concerning all the aspects of sexuality and reproduction, and not merely the absence of disease, dysfunction or infirmity[1]. To maintain their sexual and reproductive health and rights, people need access to accurate information, and safe, effective, affordable, and acceptable contraception methods of their choice[2]. SRHR entails family planning and counselling services, prevention of sexually transmitted infections (STIs) including Human Immune Virus (HIV), safe and effective abortion care, and the prevention of sexual and gender-based violence, child marriage, teenage pregnancy, and other adverse sexual reproductive health conditions[3]. Such comprehensive services improve adolescents' reproductive health and reduce unwanted pregnancies and the risk of

contracting STIs. They also promote SRHR responsibility and accountability and help to build a life-long culture of responsible sexual behaviours[4].

In many African countries, the SRHR needs of youth are often under-served and underestimated, despite their demonstrated need and the urgency of these services[5]. Adolescents and young people aged 15-19 years, representing 20.3% of the African population are at risk of early and unintended pregnancy, leading to unsafe abortion, STIs and dropping out of school[6]. Social beliefs and cultural values have been cited as the main factors influencing on adolescents' access to sexual and reproductive services such as contraceptives and safe abortions[7].

Cultural norms set the standard to govern sexual behaviors between sexes, shaping the understanding, beliefs, and behaviors related to the sexuality of adolescent girls, thereby impacting their SRHR. The cultural perspective plays a crucial role in influencing how adolescent girl gain access to SRHR services, encompassing contraception, maternal and childcare services, prevention and diagnosis of STIs, and their use of informational services[8].

Extant literature shows that ageism (age-based prejudices and exclusions) has been a major hindrance to service access among youth for several decades[9;10]. When SRHR services are not easily accessible, there is evidence that adolescents tend to seek assistance from unsafe options such as street abortions[7].

Globally, there are efforts to promote access to SRHR services and information. The South African government has implemented various strategies such as increasing access to free contraceptives to adolescents, including barrier contraceptives namely condoms, initiating school health programmes focused on sexual education and reproductive health for adolescents, establishing youth-friendly services clinics, and aligning health services with Sustainable Development Goals (SDGs) 3 and 5[11,12].

Private and public health facilities are at the forefront of efforts to provide services such as contraceptives, and maternal and child health services, which include the choice of termination of pregnancy. These services are important to youth and adolescents, and they help to promote access to SRHR[13,14]. However, such services appear ineffective because some adolescents lack relevant information about sexuality, which makes them fall prey to misinformation and myths shared by peers and other unreliable sources[15,7].

Sexual debut and sexual activities vary widely by region or country and ethnic groups. Boys and girls reach puberty at an earlier age, and they often engage in sexual activities at a younger age than what has historically been the case[13]. Adolescent SRHR is strongly linked to their social, cultural and economic environment[16;17]. Research has shown that globally, the earliest sex debut among young people is 12-14 years[18,13]. Adolescents' knowledge and access to reproductive health services are vital to their physical and psychological well-being[7].

Cultural norms and values discourage girls from either playing with boys or participating in premarital sex, however these measures were not considered to be entirely effective. Discussions on topics such as sexual matters with adolescents are often considered taboo. Contrastingly, in Uganda, girls are initiated by their paternal aunts who teach them about sexual matters, including pre-menarche practices, pre-marriage preparation, erotic instruction and reproduction[19]. Typically, the onset of menarche is considered the key signal for initiation readiness[20] and guidance on sexual reproductive health. Among the Vhavenda community in South Africa's Limpopo province in the north, guidance on the sexual reproductive health of adolescent girls is traditionally provided by elderly women within the village [20,21].

Furthermore, AmaXhosa in the Eastern Cape province engages in *intonjane* initiation for girls, commencing with the onset of menarche, signifying the transition from childhood to womanhood[19]. Through the initiation, girls are taught about socially acceptable behaviour and physiological body changes, sexuality, hygiene, menstruation and avoiding sex before marriage. Sexual health communication is only facilitated during organised peer group meetings, where girls and boys gather and teach each other about sexuality, relying on guidance from older relatives[22]. Among the Vhavenda, girls pass through various stages of rites, which relate to developmental ages. These range from *musevhetho*

for girls aged 8-12 years, *vhusha, tshikanda, ludodo* to *domba* for adolescents or young men and women[23,24]. The learning content includes social morals, respect for self and others, and abstaining from sex until marriage[25,26].

Universal health coverage is achieved if the sexual and reproductive health needs of the population are met[10]. It forms part of the 2030 agenda aligned with the Sustainable Development Goal (SDG) 3, which is to attain good health and well-being. However, it is concerning that globally, over 4 billion sexually active people cannot access SRHR services. Several factors that include fear, inadequate information and financial constraints were cited as barriers to accessing the services[27]. In South Africa, the Department of Basic Education (DBE) and the Department of Health (DoH) are jointly implementing the Integrated School Health Programme that will extend, over time, to the coverage of school health services for all learners in primary and secondary schools. The programme offers a comprehensive and integrated package of services including SRHR services for older learners.

The objective of this study was to explore indigenous knowledge among adolescent girls in the rural areas of Makhado in Limpopo, South Africa through Participatory Action Research (PAR).

Methods

Study approach and design

The study used a contextual qualitative, exploratory and descriptive design. The researchers used PAR, following a spiral process[28]. Furthermore, focus group discussions helped obtain rich and extensive data about the indigenous practices employed to enhance the SRH education of girls in Makhado.

Population and recruitment strategy

The target population comprised girls aged 9-18 resident in Makhado municipality. A non-probability snowball sampling technique was used to recruit the girls. Data collection spanned from April to July 2020 during the COVID-19 lockdowns. To adhere to lockdown regulations, the customary protocol of consulting gatekeepers such as the Chief of the village, was modified. Instead of the traditional visit to the Chief's palace, a telephonic appointment was arranged with the Acting Chief, a person who is temporarily nominated and validated to exercise authority and power in the community[29] to facilitate the researcher's project debriefing sessions and select the research committee[30]. The collaboration with traditional leadership in this study was not only a way of seeking entry into the community but also to invite their contribution as stewards of the several initiation schools in the community. Among the native African groups, initiation or rite of passage rituals are organized on the authority and powers of traditional Chiefs[15,31,23,26]. Additionally, collaboration with the traditional leadership is to create a platform to enhance the openness in speaking about SRHR with youth in the community. This is based on the known traditional and cultural restrictions on open discussions on sexuality matters with youth among adults[22]. Such a collaborative approach has been implemented with positive results among the Maasai communities in Kenya[31].

Data generation methods and instruments

Data generation methods included focused group discussions (FGDs) and key informant interviews (KIIs) using the vernacular Tshivenda language. The key informant interview participants were elderly women who knew the Vhavenda customs traditions, and indigenous practices. All the participants were residents of Roda village, willing to take part in the study, and had provided signed informed consent and assent forms. KII participants were elderly women knowledgeable about Vhavenda indigenous practices and the passage of rites. The researchers, as local insiders, reflected on the sociocultural norms around communication between minors, which may be power-laden and may sanction the voices of girls[32]. The discussions varied between parents and girls at separate meetings to protect the rights of girls. Meetings were held at the locations chosen and preferred by the young girls, which were either at the local school or under a tree. This was done to ensure social-cultural sensitivity and to regard participants

as experts in the experiences and social contexts[33]. Throughout the meetings, all conversations were recorded with permission from the participants, and field notes were kept to remind the researchers about areas of interest for further probing[34]. All the recordings were translated into English, and the authors ensured that the original meaning of the shared information was not lost.

Key informant interviews

Two in-depth interviews were conducted privately at the elderly women's homes. The researchers had an initial introductory visit for debriefing and seeking permission to collect data. Thereafter, a date and time were set to meet them at their respective homes for their convenience.

The researchers initiated the interview by posing a central question:

> *"Please share with us the indigenous practices used to enhance sexual and reproductive education for girls among the Vhavenda communities?"*

This was followed by probing questions to clarify the participants' initial responses as well as to ensure depth and richness of data.

The follow-up questions included:

-"What kind of training was given to youth to enhance abstinence or teenage pregnancy?"

The data were recorded with a digital audio recorder. The participants permitted to be audio recorded. Field notes were also taken during the dialogue to document unstructured observational data.

The focus group discussions

Three FGDs were conducted with Vhavenda girls aged between 9 and 17 years (Table 1), their parents and women from the community who had experiential knowledge of indigenous practices around sexual and reproductive issues. In essence, the discussions with girls and adults were important because this was a great opportunity to impart traditional knowledge and practices used by indigenous in the past. On average, all the FGDs lasted nearly one hour and thirty minutes. All the FGDs were conducted on Saturdays or after school at nearby schools according to the arrangement with the local leaders. Each FGD was comprised of four girls and three women. The discussions varied between parents and girls at separate meetings to protect girls' rights. Researchers held preparatory meetings with girls and women separately to get an understanding of how each group perceived indigenous practices on SRH. The separation of groups was done to enhance freedom of expression among girls so that their thoughts and preferences on indigenous practices are not clouded or coerced by the presence of adults. Thereafter, a combined meeting of girls, parents and other community women was held. During the meetings, girls received first-hand information on native Vhavenda historical practices to impart knowledge and preparedness to SRHR matters. The researchers exchanged formal greetings and conducted debriefing sessions. Thereafter, a first opening question was posed,

> *"Dear parents; Can you share how girls in your time were prepared and given information on sexual and reproductive matters?" This was followed by further probes such as,*
> *"You shared that boys and girls would go on a play retreat by themselves, how safe were intimate encounters among youth prevented during the retreat?"*

The FGDs stimulated a lot of interest among girls as they wanted to know about the dress code during initiation schools, venues, and the duration. The researcher followed up with question to such as:

> *"Is it possible to revive the initiation schools?"*
> *"What would be the preferred approach?"*

The relaxed discussion marked the importance of merging data received from KIIs, which created an avenue for further meetings. Further, young girls showed interest in learning about their cultural practices and revisiting the practices. The discussions on rethinking initiation schools were appreciated by the elders as well. Reflectively, the discussions with girls and adults were important because this was an opportunity to impart traditional knowledge and practices used in the past.

Table 1: Biographic information of the participants

Participant Pseudonyms	Gender	Age	Level of Education
1. Ronewa	Female	09 years	Primary level
2. Rendani	Female	13 years	Secondary level
3. Thendo	Female	10 years	Primary level
4. Livhu	Female	11 years	Primary level
5. Tendani	Female	13 years	Secondary level
6. Dakalo	Female	13 years	Secondary level
7. Fulu	Female	12 years	Primary level
8. Phindulo	Female	15 years	Secondary level
9. Tshimangi	Female	10 years	Primary level
10. Wavhudi	Female	15 years	Secondary level
11. Florah	Female	17 years	Secondary level
12. Grace	Female	15 years	Secondary level
13. Linah	Female	11 years	Primary level
14. Joyce	Female	17 years	Secondary level
15. Nancy	Female	17 years	Secondary level
16. Gloria	Female	14 years	Secondary level
Key informants			
17. Vho-Masindi	Female	85 years	Informant
18. Vho-Makwarela	Female	79 years	Informant

Data analysis

The data were analysed using the qualitative content analysis method. The data generation method was aligned with the research objectives, research questions and the theoretical framework of the study, which was the Sociocultural Learning Theory[35]. [The audio recordings of the interviews were transcribed verbatim. The transcripts were carefully read and compared with the audio recordings to ensure data accuracy. The main author (BNH) initiated the data analysis by identifying the main themes, which were verified by the other two authors and an independent coder, an expert in qualitative research. Similarities were identified and consensus was reached on themes and sub-themes. No contradictions between the authors and the independent coder were recorded regarding the themes and categories that emerged after using Tesch's method of data analysis[36].

Ethical considerations

Data were generated after ethical clearance was granted by Sefako Makgatho Health Sciences University (Protocol number: SMUREC/H/207/2020). The Chief as the community gatekeeper had granted permission for the study to be conducted. Before the data collection session commenced, parents signed the consent forms and assent forms for those who were under 18 years of age. Thereafter, participants less than 18 years old signed assent forms to get their affirmative agreement to participate in the study. The participants who were aged 18 years and above signed informed consent forms, to serve as evidence that they were provided with adequate information about the study and that they voluntarily agreed to participate in the study[37]. The researchers maintained the principles of justice, beneficence, privacy, and confidentiality.

Results

Three themes emerged from the data analysis namely community-arranged interaction with peers, the role played by various social structures and deconstruction of traditional structures.

In this study, KIIs revealed that in the past, knowledge about sexuality was obtained through engagement with elders at traditional initiation schools, playing with peers, and monitoring and guidance from community elders. The focus was on immediate information given to empower teenagers to delay sexual debut until marriage. The participants explained that community elders and families collaborated in ensuring virginity

preservation, which was the pride of the girl's family and future families during marriage life. Additionally, girls were educated about personal hygiene, moral uprightness, self-care during menstruation, and abstinence from sex. The inclusion of elderly participants in this study is aligned with World Health Organization's (WHO) call to amplify the voices of the older population to promote universal health coverage. Additionally, collaborations with children and young people in sharing indigenous practices promote inclusive and contextual practices to promote access to affordable health services.

> Vho-Makwarela: "*Musevhetho* is to take girls away from boys for girls to play on their own. The purpose of *musevhetho* is playing together as a play school."

Community-arranged interaction with peers

Data from the KIIs revealed that girls and boys were not allowed to play together unsupervised. However, there were activities wherein they were exposed to community-arranged play called *bepha* or mahundwane (childrens' play) where they would spend days away from home mimicking a family setting under the observation of elders. Interaction and playing with boys were allowed under adult supervision. Elders allowed boys and girls to interact as they learnt about how to communicate and attain self-control as children. The community activities further enforced social cohesion to cultivate cultural patronage.

> Vho-Masindi: "*Bepha* is when a boy or girl visits the uncles with a group of some girls and boys. The visit can take 2–4 days depending on the amount of food available."

> Vho-Makwarela: "They can spend days there, but they will never do any kind of mischief such as fornication. During *bepha*, some elderly people would accompany the boys and girls, and they made sure that they behaved well and respected those elderly people who would have accompanied them to *bepha*."

The role played by the family and community structures

The roles that social relations and culture play are evident in social groups. The family is the unit that motivates the girl to attend the traditional … school and supports her with everything needed. Roles that social relations and culture play in an African girl-child's life emerge into two categories namely roles of the family and community structures. As components of societal structures and family, both have an essential role to play in the smooth running of the whole community and transferring social skills to young women.

Role of the family

The role of the family was one of the categories that emerged from the central theme of roles that social relations and culture play in a girl child's life. As expressed, participants, once menarche is reported, girls would be given education, support, and counselling to enhance their knowledge about reproductive issues. As gatekeepers, the parents had to ensure that their daughter was safe at home.

> Vho-Masindi: "Once a girl experiences menarche, she reports to her aunt who then reports the development to *vhakoma* (community steward), so that *vhusha/vhukomba* (initiation) is conducted. This is where the girl-child is educated about self-care and how to handle herself during menstruation."

Deconstructing traditional structures

Deconstructing traditional structures of initiation schools such as musevhetho and vhusha, there was a suggestion for the innovation of the initiation venue and indigenous attire that emerged from the main theme of the generated data. In this study, discussions revealed that the girls were willing to learn about indigenous SRH practices to be empowered about reproductive-related issues. Girl participants responded as follows:

> Dakalo: "In terms of cultural awareness, it's better to be done at school."

> Rofhiwa: "A retreat to a secluded location can be good where girls will be taught about good morals and cultural practices of which we are not aware."

> Nancy: "I also feel that I will not be comfortable wearing *shedo*."

> Rofhiwa: "It is better to use a short skirt, bra or vest to cover our breasts instead of using *shedo* but using Venda traditional colours (*nwenda*)."

It is interesting and reassuring that girls in this study recommended that some practices be modernized by changing the dress code and the initiation venue from the headman's kraal as culturally practised to a school where meetings will be held for specified days. On such occasions, health workers should be invited to give scientific health advice.

Discussion

This study reflected on the role played by traditional social institutions to enhance SRHR among Vhavenda girls. The findings indicated that there were communal efforts organized by community leaders and elders to preserve and promote cultural practices related to SRHR.

Historically, there were communal efforts to ensure that children and youth were psychologically prepared and orientated in the transition from childhood to adolescence. Community elders ensured that orientation was tactfully introduced from childhood through play and initiation schools to align with the social norms and values of the Vhavenda people. In alignment with Daswa[28], the initiation sessions that were implemented either during play or formal traditional classes such as those conducted among the Vhavenda and AmaXhosa enhance peer relations and a cohesive friendship framework with positive long-term effects in adulthood[23,28]. In the case of community involvement in initiations, the community's cohesive framework instills respect for self, adults, and peers equally, thus minimising delinquency. The socialisation to respect the self and community leaders, has far-reaching implications. It can be a lifestyle wherein youths that are raised in such a way will have respect for others, which may reduce other social ills such as genger-based violence.

The findings provide evidence that social norms passed through initiation schools and peer interaction during special events such as *bepha*, which were never taken as opportunities for a sexual debut. These findings contradict those of Pichon *et al*.[18] where interaction with the opposite sex was an influencing factor towards unacceptable social actions such as fornication. Evidently, through the indigenous ways of teaching SRHR in the past, young people were socialised in such a manner that they developed values about sex and reproductive choices. Studies affirmed that social norms learned at home also influence adolescents' sexual and reproductive health[23,28,39]. These findings imply that, if SRHR are to be promoted and are made accessible to all, it is important that a collaborative approach where all community members are focused on such knowledge sharing and transfer. Creating safe spaces for all is important in this culturally sensitive area.

The findings of this study revealed that the family unit plays a pivotal role in the girl child's life, from an early age until the passage to marriage. A family is a group of people living in one household because of blood relations, marriage or other bonds, living together to share the necessities of life[40]. In essence, families are custodians of community norms and culture. Hence, properly raised children often demonstrate good morals, are respectful and responsible citizens, and are resilient. Family is the main educator in the girl child's life, and it is the foundation for moral education and religious life[40]. Various factors were reported as the determinants of early sexual debut, which include peer influence, parental connectedness, drug and alcohol abuse, and societal norms[41]. In essence, if parents use homes as safe spaces to share and transfer SRHR knowledge through available resources such as culturally accepted community institutions, such efforts will have lasting outcomes when young people interact outside the home space.

Further, findings on the role played by various societal structures in the education of the girl child in this study illustrated that social structures such as initiation schools played a vital role to enhance indigenous practices on SRH education in the life of girls. Through *vhukomba*, girls were expected to maintain their virginity, which was checked on special nights during the rites of passage. Maintaining virginity was upheld as the pride of the girl, the family and the community, and a way to avoid pre-marital sex and STIs. Although virginity checking displays infringement of the girl's right to privacy, the practice helps to promote abstinence and a host of other negative outcomes of early sexual debut.

According to Vygotsky's Sociocultural Theory[35], every function in a child's cultural development appears on the social and individual levels. In view of the promotion of girls' SRHR, there is a need to collaborate with leaders of cultural institutions to find safe ways to promote virginity without such infringements of one's rights. There are positive and encouraging efforts in Kenya among the Maasai to end genital mutilations[31], which can serve as a benchmark across nations.

The findings reflected on deconstructing traditional structures, indicating the need to revisit functional practices that resulted in good social practices but were marginalized due to cultural diffusion. According to Tshikukuvhe *et al*[24], inventions such as television and social media improved access to information among youth and the general community. It is worth noting that through critical dialogue, girls and elders identified areas of changes on the old practices such as dress code during initiation schools and venues to align with current trends in the contemporary community and mitigate possible threats. This study revealed that the researchers' interaction with girls and community elders provided lessons that girls are willing to learn sociocultural practices if allowed to critically apply their thoughts.

In general, the study provided empirical findings demonstrating that through critical dialogue, the youth are willing to learn and appreciate their own culture. Girl participants who also served as co-researchers in this study showed their willingness to adopt indigenous practices and learn about reproductive and sexual education when some adjustments are made to suit their preferences. These include changing the traditional venue of meetings and modernizing the attire used during these important traditional ceremonies. This study further confirms that the 21st-century girls are willing to embrace indigenous knowledge to promote SRHR, which may contribute to achieving universal health coverage. The inclusion of the voices of girls in SRHR and the appreciation of indigenous knowledge aligns with the third component of essential primary health care (PHC) - "*empowered people and communities*"[3] when no one is left behind through innovative knowledge sharing. The study findings suggest that achieving universal health coverage calls for the inclusion of all voices to enhance contextually relevant and socially acceptable health practices. The current study can potentially empower rural girls; and promote awareness creation and advocacy programmes for both adolescent schoolgirls and the public in terms of knowledge on indigenous as well as sexual and reproductive health practices.

Conclusion

The objective of this study was to explore indigenous knowledge among adolescent girls in a rural setting, Makhado through Participatory Action Research. This was achieved through the collaboration with community leaders, elders as key informants and young girls as recipients and users of indigenous knowledge.

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