

**SEXUAL PRACTICES AND THE CULTURAL MEANINGS OF RURAL
PEOPLE IN ZIMBABWE IN THE ERA OF THE HUMAN
IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED
IMMUNODEFICIENCY SYNDROME (AIDS) EPIDEMIC:
A SOCIAL CONSTRUCTIONIST PERSPECTIVE**

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Abstract

Notwithstanding a myriad of interventions put in place over three decades to combat the HIV/AIDS pandemic, the incidence and prevalence are still unacceptably high in southern Africa. There is a need to broaden the HIV/AIDS research agenda by exploring the nuanced socio-cultural contexts within which mundane social and sexual encounters occur. The thesis explored the sexual practices and cultural meanings of seventy rural Zimbabwean men and women using a social constructionist approach informed by the voice-relational methodology.

Findings of the study show that the construction of meaning around HIV/AIDS is subjective and influenced by social contestations around space, gender, type of relationship as well as the social sanctions or support mechanisms available at a particular moment. Some of the cultural factors that facilitate the spread of HIV include gender roles that disapprove of sexual concurrency for women but tolerate this practice among men. The study also highlighted the vulnerability of young women, in secretive relationships, to sexual violence perpetrated by their male partners, lack of social support for women who participate in socially disapproved practices including pre-marital sex, and involvement in commercial sexual activities.

Prevention efforts should be located in people's experiences and interpretation of their lifeworlds, paying particular attention to the language people use to construct meaning around the HIV/AIDS epidemic. The interventions must navigate structural, spatial, personal, and familial contestations for relevance and effectiveness.



Declaration

I, **Tom Zhuwau (Student Number: 982198050)**, do hereby declare that this thesis is my original work and that where use has been made of the work, ideas and text of others in support of my work, it has been duly acknowledged and referenced. I, therefore, remain solely responsible for the contents of this thesis. The thesis is submitted in fulfilment of the requirements of the Doctor of Philosophy Degree in the Graduate School of Psychology, Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa.

I have not submitted the thesis before for any degree or examination, or to any other academic institution.

Signature

Date



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To my family I say thank you so much for your perseverance, support and belief. You made life so much easier for me through your unconditional love and sacrifice



Thesis dedication

To my beautiful and loving family



List of Acronyms

AAC	AIDS Action Council
ABC	Abstain, be faithful, and use condoms strategy
AIDS	Acquire Immuno-Deficiency Syndrome
ARV	Antiretrovirals
AU	African Union
AZT	Zidovudine
BSAC	British South Africa Company
CDC	Centers for Disease Control
CIA	Central Intelligence Agency
COMESA	Common Market for East and Southern Africa
CSO	Central Statistical Office
ECA	East African Community
ECOWAS	Economic Community of West Africa
GFAMT	Global Fund on AIDS, Malaria, and Tuberculosis
GPA	Global Programme on AIDS
HAART	Highly active antiretroviral treatment
HIV	Human Immuno-Deficiency Virus
HSRC	Human Sciences Research Council
IDU	Injecting drug use
IEC	Information, education, and communication strategy
IMF	International Monetary Fund
KABP	Knowledge, attitudes, behaviour and practices
MOWAG & CD	Ministry of Women Affairs, Gender and Community Development
MDA	<i>Manicaland</i> Development Association
MSF	Medicins sans Frontieres
MSM	Men having sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Council
NACP	National AIDS Control Programme
NMF	Nelson Mandela Foundation
NEPAD	New Partnership for African Development
OAU	Organisation of African Unity
PEPFAR	Presidential Emergency Programme and Fund for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
SADC	Southern Africa Development Community

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CHAPTER 1

INTRODUCTION

HIV/AIDS remains a major international health and social concern (Avert, 2009; du Lou, 1999; UNAIDS, 2009). The world has started to witness stabilisations and declines in HIV prevalence. Haiti, India, Kenya, Senegal, Thailand, Uganda, and Zimbabwe have reported declining national HIV prevalence (Asiimwe-Okiror, Opio, Musinguzi *et al.*, 1997; Cheluget, Baltazar, Orege, *et al.*, 2006; Hayes & Weiss, 2006; Hallett, Aberle-Grasse, Bello, Boulos, *et al.*, 2006; Kilian, Gregson, Ndyabangi, Walusaga, *et al.*, 1999; Kumar, Jha, Arora *et al.*, 2006; Gaillard, Boulos & Cayemittes, 2006; Gregson, Garnett, Nyamukapa, Mahomva *et al.*, 2006; Mahomva, Greby, Dube, Mugurungi, Hargrove *et al.*, 2006; Nelson, Celentano, & Eiumtrakol *et al.*, 1996; Stoneburner & Low-Beer, 2004; UNAIDS/WHO, 2005). However, HIV infections continue to rise and level-off at high levels in most of sub-Saharan Africa (Avert, 2010; Hayes & Weiss, 2006; Ray & Madzimbamuto, 2006; UNAIDS/WHO, 2005). As Ragnarsson, Townsend, Ekstrom, Chopra and Thorson (2010, p. 1) observe:

Despite several legislative and policy changes that have been undertaken in the area of reproductive health since, 1994, the outcomes of HIV behavioural interventions have largely been inadequate and ineffective, and HIV incidence remains unacceptably high.

The AIDS pandemic is severely negating the primary health care gains that African countries have laboriously attempted to achieve, as set out in the World Health Assembly's Alma Ata Declaration of "Health for All by the Year 2000" (WHO, 1978; WHO, 1979) and subsequently endorsed by the Organisation of African Unity's (OAU, now the African Union) Bangui Declaration (OAU, 1979).

The "Health for All by the Year 2000" declaration, set to make health accessible to all citizens, aimed to improve potable water deliveries, reduce maternal, infant and child mortality, improve sanitation, and improve life expectancy for people in the developing world. In 1981, three years into the Alma Ata declaration, the first AIDS cases were reported in San Francisco among the gay community (Merson, O'Malley, Serwadda & Apisuk, 2008; Parker & Ehrhardt, 2001) and the heterosexual communities of Uganda as slim disease (Serwadda, Sewankambo, Carswell, Bayley, Tedder, *et al.*, 1985). The epidemic was simultaneously and silently unfolding in many parts of the world (Merson, *et al.*, 2008; Treichler, 1999). Almost three decades on, AIDS has become a serious global health problem severely challenging health services in the developing world, especially sub-Saharan Africa. The advent of antiretroviral treatment has transformed AIDS into a clinically manageable chronic disease in the Western world, yet it remains fatal in most of the developing world due to inadequate health services.

People in the prime of their lives are the most affected. Most of them, especially women, are getting infected at an early age (Gayle & Hill, 2001; Glynn, Caraél, Auvert, Kahindo *et al.* 2001; Gregson & Garnett, 2000; Gregson, Nyamukapa, Garnett, Mason, Chandiwana & Anderson, 2002; Ray & Madzimbamuto, 2006)). In the absence of a cure or vaccine, behavioural change remains the best hope in mitigating the spread and impact of the AIDS epidemic (Akwara, Diamond & Madise, 2001; Cohen, 2008; Cohen, Hellmann, Levy, DeCock & Lange, 2008; Pequegnat & Stover, 2000). The biggest challenge, especially in sub-Saharan Africa, is that AIDS is largely a sexually transmitted disease and, as with all matters sexual is subject to myths, taboo, cultural stereotypes, and misunderstandings (Castañeda, Brindis & Camey, 2001; Cohen, 2008; Leclerc-Madlala, 2008; Kakuru & Paradza, 2007; Ray & Madzimbamuto, 2006).

Biomedical, epidemiological, and demographic studies single out sexual behaviours that pose the greatest risk of acquiring HIV infection (Boerma, Gregson, Nyamukapa, & Urassa, 2003; Boerma & Weiss, 2005; Caraél & Holmes, 2001; Lewis, Donnelly, Mare, Mupambireyi, Garnett & Gregson, 2007). Unprotected sex with casual partners, multiple and concurrent partners, individuals from a high-risk group constitute a high risk for infection (Cohen, 2008; Hallett, Garnett, Mupambireyi & Gregson, 2007; Kalichman, Ntseane, Nthomang, Segwabe, Phorano & Simbayi, 2007; Lopman, Nyamukapa, Hallett, Mushati, Spark-du Preez, Kurwa, Wambe & Gregson, 2009; Garnett, White & Ward, 2008; Hayes & Weiss, 2006; Merson, Dayton & O'Reilly, 2000). Yet people continue to engage in unprotected sex as evidenced by the continued incidence of HIV infections and sexually transmitted infections (UNAIDS, 2002).

The concept of “risky sexual behaviour” needs to be unpacked for a clear picture of what drives people into having unprotected sex to emerge. The unpacking of “risky sexual behaviour” in prevention epidemiology has led to the paying of greater attention to the role of concurrency of sexual relations in spreading HIV infection in sub-Saharan Africa (Green, Mah, Ruark & Hearst, 2009; Mbizvo, Siziya, Olanyika & Adamchak, 1997; Nshindano & Maharaj, 2008). There is also a need to focus on those aspects of intervention that will ensure sustainable behaviour change that effectively addresses the impact of the pandemic.

Besides the biomedical and clinical responses to the HIV and AIDS epidemics, the global community has responded with a host of other innovative programmes aimed at combating the spread of the pandemic. Programmatic interventions have largely utilized the information, education, and communication (IEC) model in the development of prevention strategies. The aim of the model is to raise awareness within targeted population groups. The availing of a number of prevention choices such as condoms, treatment of STDs, voluntary counselling and testing, and reproductive health services follows information dissemination. As LeBlanc (1993, p. 23) noted, we still need to verify “the direct relationship between recipient characteristics and health-related knowledge.” We also need to ask which channels of health information are more successful and useful in order to understand the factors that affect diffusion of HIV-related information. Unfortunately, this kind of information is significantly lacking in the fight against the spread of HIV infection.

Current national intervention strategies rely heavily on the media and health personnel for coverage of information about HIV. Such strategies, on their own, are unlikely to be sufficient to bring about the necessary reductions in high-risk behaviour among rural based populations. For example, radio or television coverage assumes access to these media and the audiences' ability to comprehend the messages given. A look at the socio-economic indicators of most rural people in sub-Saharan Africa shows that very few families own a television or radio, or read newspapers. Moreover, early HIV/AIDS educational campaigns were criticised for taking a seemingly populist approach towards information on HIV/AIDS (Crewe, 2000; Ray & Madzimbamuto, 2007).

Research problem

Contextualizing research methods is gaining recognition as an important tool for cultural understanding of study populations (Kakuru & Paradza, 2007). Parker and Ehrhardt (2001) observed that the urgency of establishing effective prevention programmes brought with it the realization that prevention efforts were doomed if they failed to be cognisant of the deeply embedded cultural and social context of relevant behaviour patterns. Cohen (2008) makes a similar assertion about HIV prevention efforts in Botswana. Leclerc-Madlala (2008) in her reviews of intergenerational sexual relationships in sub-Saharan Africa argues for a clear

understanding of the cultural, social and contexts of such relationships and wisely cautions against simplistic and superfluous conclusions and dismissal of the contexts and reasons under which they take place.

As the AIDS epidemic rages on, there is a pressing need to re-examine our prevention strategies and research methodologies. Further, we need to question which ones have served us well and which ones have not. Alternatively, are there any other factors facilitating the spread of HIV infection which we have missed altogether or misunderstood in our prevention efforts? HIV is an infection transmitted primarily through unprotected sexual encounters that involve high-risk behaviour. A clear understanding of the factors sustaining and fuelling risky behaviours can lead to targeted interventions and possible changing of the risky behaviours. Pequegnat and Stover (2000, p. s2) remark:

There are multiple factors associated with rapid HIV/STD transmission that must be addressed in effective behavioral prevention programs. If people do not perceive that they are at risk for HIV/STDs, they will take no precautions (e.g., using condoms and clean needles).

The caution by UNAIDS (2005) that HIV prevalence declines in Uganda, Zimbabwe and elsewhere should not lull the world into a false sense of hope and security is instructive. Hayes and Weiss (2006, p. 621) observe that:

HIV incidence and prevalence remain extremely high in many countries and, despite the evidence that HIV incidence may now be declining in some parts of southern and East Africa, HIV prevention must remain a key priority for international public health. There is growing concern that, even in countries where HIV prevalence has declined, risky patterns of sexual behaviour may be increasing again, and there is an urgent need to revitalize prevention efforts to avoid resurgences of the epidemic.

HIV infection is complex. Our limited understanding of human sexuality further complicates the HIV infection dynamics (Chan, 2006). Commenting on the importance and complexity of information on sexual behaviour for intervention, Wellings, Columbian, Slaymaker, Singh, Hodges, Patel and Bajos (2006, p. 1706) note:

Information about sexual behaviour is essential to the design and assessment of interventions to improve sexual health. Importantly, too, empirical evidence is needed to correct myths in public perception of behaviours. Yet despite being scrutinised everywhere, sexual behaviour poses challenges for scientific enquiry. The same paradox is seen in relation to intervention; sexual activity is strongly regulated in virtually every society, but its modification to improve sexual health has proved difficult.

There is a public health need to understand why certain sexual behaviours considered risky and harmful are persistent and how people negotiate their daily lives and sexual health in the face of the HIV and AIDS epidemic (Akwaru, *et al.*, 2001; Chan, 2006; Kalipeni & Thiuri, 1997; Poulin, 2007; Wijgert, Mbizvo, Dube, Mwale Nyamapfeni & Padian, 2001). Lurie and Rosenthal (2009, p. 18) remark:

... HIV epidemic dynamics are complex and unlikely to be explained by a single variable. Instead a combination of factors likely drives the epidemic – with some factors playing a more important role in some geographic areas than in others. Nevertheless, understanding the main drivers of the epidemic

is important in shaping future outreach programs, prioritizing interventions, and determining appropriate resource allocation.

The heterogeneity in the spread of HIV in sub-Saharan Africa further compounds our understanding of the epidemic and the difficulty of coming up with appropriate interventions and has led to the emergence of the theory of proximate determinants of HIV infection. Boerma, Gregson, Nyamukapa and Urassa (2003) observe that:

Large differences exist between and within countries, and a range of biologic, behavioural, and contextual arguments have been advanced to explain these differences. Biologic explanations include those that focus on different subtypes of HIV-1 and variation in the prevalence of other sexually transmitted infections (STIs). Male circumcision, inextricably linked with cultural practices, is an important biologic factor. Differences in sexual practices, whether in relation to the response to the epidemic, have also been considered as important factors, as have differences in underlying factors such as mobility, infrastructure, and poverty.

The variability of HIV's intensity and timing further compounds the heterogeneity of the epidemic. Morris and Kretzschmar (1997, p. 641) note:

There is now considerable variation in the timing and intensity of the HIV epidemic in different regions of the world. Explanations for these differences, especially for the rapid and pervasive spread among heterosexual populations in sub-Saharan Africa, have focused on three factors: the rate of sexual partner acquisition, the impact of certain 'core groups', and the presence of other sexually transmitted diseases (STD) that may amplify HIV transmission. We investigate the potential impact of another factor: concurrent (or simultaneous) sexual partnerships. Concurrency need not change the rate of partner acquisition; it simply affects the overlap of partners over time. It represents an alternative to sequential monogamy, a different pattern in the general social organization of sexuality rather than a feature of 'core groups'.

The dynamics of the epidemic and the persistence of risky sexual behaviour against reports of HIV declines are not only problematic but also paradoxical. Hence, the reported declines in HIV prevalence raise questions about the factors causing the observed declines (Asiimwe-Okiror *et al.* 1997; Bello *et al.* 2006; Brody 1996; Cheluget *et al.* 2006; Green 2003; Green *et al.* 2006; Gregson *et al.* 1998; Gregson *et al.* 2006; Gregson *et al.* 2010; Hallet *et al.* 2006; Kilian *et al.* 1999; Nelson *et al.* 1996; Parkhurst 2002; Stoneburner & Low-Beer, 2004).

Justification for the research

The HIV and AIDS epidemics are presenting serious demographic, social, political and economic challenges in the sub-Saharan Africa region. They are likely to continue to do so for a long time to come (Ashford, 2006; Barnett & Whiteside, 2002; Beresford, 2001; Boerma *et al.*, 2003; Grant & Palmiere, 2003; Gregson *et al.*, 1996; Hunter & Williamson, 2000; Kalichman *et al.*, 2007; Marcus, 1999; Pharaoh & Schönteich, 2003; Ray & Madzimbamuto, 2006; Robertson, Gregson, Madanhire, Walker, Mushati, Garnett & Nyamukapa, 2008; Shell, 2000; Whiteside & Loewensen, 1997). The epidemics are so severe that they will alter the population structures and dynamics in sub-Saharan Africa (Anderson *et al.*, 1991; Ashford, 2006; Bongaarts, 1996; Chin *et al.*, 1990; Gregson, 1994; Lagarde *et al.*, 1996; Whiteside, 1998).

Life expectancy is expected to fall dramatically in most southern African countries (Barnett & Whiteside, 2002; Feeney, 2001; Ray & Madzimbamuto, 2006; UNAIDS, 2008). Life expectancy at birth is set to drop to below 40 by 2010 in the worst affected southern African countries because of AIDS-related mortality (Ashford, 2006; Feeney, 2001; Pharaoh & Schönsteich, 2003; Shell 2000). According to Lamptey, Wigley, Carr and Collymore (2002, p. 17), “average life expectancy has dropped to age 40 or less in eight countries: Angola, Botswana, Lesotho, Mozambique, Rwanda, Zambia and Zimbabwe”. Demographic projections by the Zimbabwe National AIDS Council (2004) estimated that there were about 1.7 million fewer persons in Zimbabwe because of AIDS-related mortality. Recent analyses of the early demographic projections of the HIV and AIDS impact show that some of the projections were over-stated or completely wrong (Ashford, 2006; Gregson, Nyamukapa, Lopman, Mushati, Garnett, Chandiwana & Nyamukapa, 2007; Robertson, Gregson, Madanhire, Walker, Mushati, Garnett & Nyamukapa, 2008). These commentators argue that the existing high levels of fertility in sub-Saharan Africa are able to offset demographic losses due to AIDS mortality. However, there is still evidence of the negative impact of HIV infection on fertility in sub-Saharan Africa (Glynn, Buve, Caraél, Kahindo *et al.* 2000; Gregson, 1994; Terceira, Gregson, Zaba *et al.*, 2003).

As the HIV/AIDS pandemic rages on there is a growing recognition that the problems posed by this pandemic across the globe go beyond medical approaches and diagnoses. Pool *et al.* (1996, p. 203) remark;

From a medical perspective, AIDS is problematic because there is, as yet, no cure and no vaccine. It is also problematic from a social science perspective because its social aspect centres on sex, a form of social behaviour that has not received much attention from the social sciences... before the AIDS epidemic.

Studying sexual behaviour is problematic because sexual behaviour is a private domain. It is anathema to disclose one's sex life and experiences to outsiders (Konigs, 1994; Pickering, 1988). Human sexuality is complex, as are the sexual relationships that people form. The distinction between risky and non-risky sexual behaviour compounds the human sexuality issue. Society regards sexual matters and experiences as private and public taboo (Lear, 1997).

The majority of adult HIV infections in Africa are predominantly through heterosexual sex (Bassett & Mhloyi, 1991; Caldwell *et al.*, 1992; Carael *et al.*, 2000; Davis & Weller, 1999; Lewis *et al.*, 2007; Meekers, 1994; UNAIDS, 2002). This has raised questions about the nature of sexual activity and sexual relations in sub-Saharan Africa, especially the unequal gender relations (Caldwell *et al.*, 1997; Caldwell *et al.*, 1999; Makinwa-Adebusoye, 1992; Meekers, 1994; Orubuloye *et al.*, 1992; Watts, Ndlovu & Kwaramba, 1998).

Human sexuality and (sexual) behaviour, that permeates all aspects of social life and the AIDS problem, must be fully understood by those concerned with the fight against HIV/AIDS (Eyre, 1997). The complexity of human sexuality further constrains our efforts to understand the dynamics that constitute risky sexual behaviour. Lear (1997) and Kakuru and Paradza (2007) observe that the study of human sexuality is not only problematic in terms of its inaccessibility but also because of the gendered meanings, expectations, and social class surrounding human sexuality.

Pool *et al.* (1996, p. 203) highlighted the difficulty and complexity of trying to change human sexuality, noting that "... just like smoking and drinking, sex gives short-term satisfaction, and because many people are basically hedonistic, possible consequences in the distant future do not weigh heavily." The complexity of human sexuality adds to the complexity of trying to come to terms with the HIV/AIDS pandemic. There are divergent forms and degrees of expressing one's sexuality. The labelling of sexual behaviour as risky or non-risky accentuates the complexity of human sexuality. Different kinds of unions, with their associated obligations and expectations for partners and their families, affect the range of sexual behaviours that occur before and outside the union, elements that are important for understanding sexual behaviour overall and the transmission of HIV in particular (Carael & Cleland, 1994).

Gendered roles, cultural values and norms define the expected behaviour of men and women and the interpersonal relationships in which sexual behaviour and encounter occur. Heterosexual men continue to have multiple sexual relationships. The need to obtain some income, goods, status, and security coerce young girls and unmarried women into disparate sexual relationships, which expose them to the risk of HIV infection (Ahlberg *et al.*, 2001; Bassett & Mhloyi, 1991; Berer & Ray, 1994; Beresford, 2001; Hunter, 2002; Leclerc-Madlala, 2008; Meekers, 1994; Meursing & Sibindi, 1995; Smeltzer, 1992; Walker & Gilbert, 2002). Supportive of this observation is that HIV infection levels have been reported to be highest among and women aged 15-29 years (HSRC/Nelson Mandela Fund, 2002; UNAIDS, 2004). This is reflective of the forced lifestyles and types of sexual unions women enter into in order to survive.

Caldwell, Caldwell and Orubuloye (1993) suggest that the HIV infection patterns are reflective of the African social and cultural system(s). They claim that anthropologic and ethnographic studies done in West Africa showed extensive sexual networking among the people. This, they argue, clearly shows a distinct African sexuality model that was remarkably distinct from the Eurasian sexuality model. The thesis interrogates this claim by arguing that the African sexuality thesis is a fallacy and totally misplaced in the fight against HIV and AIDS.

Hence, the social and cultural factors of HIV infection are as important as the medical and biological factors in our understanding of the epidemic (Berer & Ray, 1994; Beresford, 2001; Boerma *et al.*, 2003; Campbell, 1995; Campbell, 1997; Gilles, 1996; Hickson & Mokhobo, 1992; Joffe & Dockerell, 1995; Lewis *et al.*, 2007; Mechanic, 1990; Nicoll, 1993; Prieur, 1995; Ulin, 1992). There is a critical need to understand how these factors intertwine and affect the HIV/AIDS epidemic and the lives of infected and affected individuals.

Earlier studies in Zimbabwe (Gregson *et al.*, 1995; Gregson & Zhuwau, 1995; Gregson *et al.*, 1996) show that the HIV epidemic spread rapidly within rural areas of Zimbabwe. Gregson *et al.* postulated that men returning from urban areas, due to labour redundancies, and labour migrants based in rural areas were accelerating the rapid spread of HIV infection by acting as conduits for the disease between high and low infected areas, meaning between urban and rural areas. Most rural people then regarded AIDS as an urban scourge (Mulder *et al.*, 1994). There was a perception that rural communities were safer than urban areas. Rural communities were preserves of indigenous culture, perceived to act as a deterrent on high-risk behaviour (Kakuru & Paradza, 2007).

Serwadda *et al.* (1992) challenge the notion. They argue that early African studies on HIV and AIDS were conducted mostly in urban populations, and in clinical, or high-risk behaviour groups. Little was known about factors determining the risk of HIV infection in rural areas (Hudson, 1996; Lagarde *et al.*, 1996). Rural communities could differ from urban populations in patterns

of sexual behaviour, and heterogeneity in sero-prevalence between rural villages could further modify the risks associated with behavioural factors (Akwara, 2001; Boerma *et al.*, 1998; Lagarde, 1996; Nnko, 2000). It is therefore important to examine individual risk factors in non-urban settings to develop efficient, targeted preventive strategies (Gregson *et al.*, 2001; Ntozi *et al.*, 2003; Wilson *et al.*, 1990).

Early studies by Gregson *et al.* (1995; 1996; 1997) found little evidence of conscious behaviour change among rural populations in Zimbabwe despite high levels of awareness of HIV and AIDS. Research-based evidence has shown that provision of information about HIV/AIDS alone is insufficient to bring about the necessary protective behaviour changes (Green *et al.*, 2009; Shelton, 2007; Waver *et al.*, 1994), such as, reduced partner change, consistent condom use, and early treatment of sexually transmitted diseases. For example, Wilson *et al.* (1990, p. 613) observed that commercial sex workers in *Bulawayo*, Zimbabwe's second largest city, "... viewed lack of control over health behaviour as a major impediment to HIV prevention, stating that in many cases they were unable to persuade clients to use condoms."

Anecdotal and empirical evidence suggested that male clients of female commercial sex workers paid more in order to have unprotected sex (Machekano *et al.*, 1994; Wilson *et al.*, 1992). Health educators, psychologists, and epidemiologists are frequently at a loss to explain why people seem not able to understand and adopt "simple" health messages (Madan, 1987; Mechanic, 1990; Stone, 1992). Commentators argue that most of the health promotion and behaviour change messages ignore cultural factors in health development (Airhihenbuwa, 1991, 1993, 1994; Stone, 1992).

Stone (*ibid.*) further argues that developments in health promotion in the past twenty years or so tell us more about the "culture" of the health "developers than about the cultures of the communities that they seek to transform. Asthana and Oostvogels (1996) observed a similar problem in their work with female sex workers in Madras, India. They argued that most of the health prevention approaches in HIV/AIDS came from the gay communities in America and Australia. These communities are reportedly homogenous, quick to mobilize and respond to crises that threaten their networks. The question is whether the same holds among different groups and different social contexts.

Prevention efforts should go beyond the simplistic message; "use a condom when having casual sex", or the "wrap it or zip it" campaign that has been spearheaded by American hip-hop and R 'n B music artists. The "ABC" (abstain, be faithful, and use condoms) strategy has been around for more than two decades and continues to be highlighted on billboards along national highways and urban centres of many countries. The fixation by health educationists and policymakers with this strategy is puzzling given that it is criticised as moralistic, simplistic, generation specific, and has not fully driven home the need to change risky sexual behaviour (Brody, 1996; Brown, 2002; Campbell, 1998; Dworkin & Ehrhardt, 2007; Green & Herling, 2006; Heald, 2002; Kelly & Lawrence, 1990; Lachenicht, 1995).

The strategy communicates the negative message that infection with HIV shows anti-social, unhygienic, and irresponsible behaviour (Lawless *et al.*, 1996; Ray & Madzimbamuto, 2006). There is a need to take into account the culture, prevailing socio-economic factors, the heterogeneity of communities, and individual differences in coming up with relevant and effective health strategies. The ABC strategy worked among the gay communities in the Western world largely because they are highly homogenous communities with great levels of community mobilization (Joseph, Montgomery; Emmons, Kirscht *et al.*, 1987; McKusick, Conant, & Coates, 1985; Parker

& Erhardt, 2001). There is a compelling need to understand and contextualise the behaviour patterns and determinants of behaviour change so that they can be addressed in HIV and STD control programmes (Hudson *et al.*, 2001; Kelly & Lawrence, 1990; Parker & Carballo, 1990).

In the case of Zimbabwe, condoms are actively promoted, socially marketed and are widely available (Adetunji, 2000; Napierala, Kang, Chipato, Padian & van der Straten, 2008; ZNFPC, 1990; ZDHS, 1995; Zvinavashe, 1996). However, studies show that there is greater variability in condom use in Zimbabwe and elsewhere in the world (Davis & Keller, 1999; Estrin, 1999; Manning, Longmore & Giordano, 2000; Finer, Darroch & Singh, 1999; Macaluso, *et al.*, 2000; Olenick, 2000; Rwenge, 2000). Uganda, through its “zero grazing” strategy, was the only country in sub-Saharan Africa to report almost universal condom use by those engaging in casual or risky sexual behaviour (UNAIDS, 1998). Elsewhere, Thailand also reported universal condom use by patrons of brothels and commercial sex workers (Knodel *et al.*, 1997; Lindan *et al.*, 1995; Sittirai *et al.*, 1996).

Regular condom use cannot be achieved only through the supply of condoms without the accompanying individual desire to use them (Anderson *et al.*, 1994; Forste & Morgan, 1998; Grinstead *et al.*, 1993; Klepinger *et al.*, 1993; Knodel & Pramulratana, 1996; Riess, Achieng, Otieno, Ndinya-Achola & Bailey, 2010). There are well-documented cultural and social barriers to the use of condoms in most African cultures (Adamchak & Mbizvo, 1990; Gage-Bradon & Meekers, 1993; Piotrow, 1992; Maharaj & Cleland, 2004; Temin, *et al.*, 1999). For instance in Zimbabwe, condom use was viewed as an admission of promiscuity or unfaithfulness, especially for married couples (Ray, 1995; Wilson *et al.*, 1989; Zvinavashe, 1996). One consequence of this is that a woman is still most likely to be unsuccessful in persuading her male partner to use condoms, even if she fears or suspects that he may have contracted HIV infection during an extramarital relationship.

There is an urgent need to understand and address the factors that influence sexual behaviour and behaviour change in HIV and STD prevention work. However, as pointed out by Lindan *et al.* (1993), the obstacles to behaviour change are still not well understood. Parker *et al.* (1991) made similar observations in their study of sexuality in Brazil. They observed that very little is known about the wide variations in sexuality and their implications in the study of sexual behaviour in cultures outside of the West.

Different health and behaviour change models developed in the United States have identified psychosocial and behavioural variables that predict behaviour change and provide a conceptual framework for understanding and evaluating people’s ability to adopt safer practices (McKusick *et al.*, 1985). A primary requirement is to understand human patterns of behaviour and the reasons for the behaviour. Wilson *et al.* (1990) found that commercial sex workers had rational justifications for seemingly irrational behaviour. Thus, HIV prevention programmes must provide rational explanations for the need to change behaviour that relate to people’s own circumstances, and must suggest and support strategies for avoiding infection that are viable within this context (Lawless *et al.*, 1996). Lachenicht (1995) remarks that behavioural interventions without accompanying changing structural inequalities are not enough and are doomed to fail. Bayer (1994) argues ethical issues in addition to structural issues are equally problematic in HIV behavioural intervention.

Williams and Popay (2001) argue that the biomedical and clinical perspectives have largely dominated scientific research in the field of HIV and AIDS. The biomedical and clinical perspectives are largely experimental in design and based on simplistic notions of causality. In turn, the notion of causality removes the variation and complexity of real-life health and disease

processes. It is here that grounded research is required to explore how ordinary people are living their lives in a world infected and affected by HIV and AIDS (Harrison *et al.*, 2001; Lawless *et al.*, 1996). There is a need, therefore, to understand their lived world experiences and the meanings people construct around life-threatening illnesses (Crawford, 1994; Gordon & Paci, 1997; Hodgetts & Chamberlain, 2000; Williams & Popay, 2001; Willig, 1998; Wood *et al.*, 1997). There is need for more research to explore and help explain sexual behaviour in ways that can influence sustained behaviour change and policy in Zimbabwe and help preserve the recent declines in HIV prevalence. Most of the prevention strategies have largely focused on sexual technology such as condom use and the early treatment of sexually transmitted diseases without considering the cultural and gender implications that define the interpersonal domain within which sex occurs (Amaro, 1995 in Kelly, 1998).

Gender, masculinity and AIDS

A key question that needs to be addressed in the fight against HIV/AIDS in sub-Saharan Africa is “why are women becoming more vulnerable to HIV infection than men?” (Turmen, 2003, p. 411). An analysis of data from national surveys of eight sub-Saharan countries, Burkina Faso, Cameroon, Ghana, Kenya, Lesotho, Malawi, Tanzania and Uganda, conducted between 2003-2005 showed that women had “a higher HIV prevalence than men in all countries except Burkina Faso” (Mishra, Bignami-Van Assche, Greener, Vaessen, Hong, Ghys, Boerma, Van Assche, Shea & Rutstein, 2007, p. S20). The reasons for this phenomenon are varied. The reasons range from the biology of women, transmission efficacy, gender relations, and masculinity to structural factors such as poverty, education, and culture (Amaro, 1995; Campbell & Mzaidume, 2002; Djamba, 2003; Gupta, 2000; Gupta 2002; Gillespie, Kadiyala & Greener, 2007; Gillespie, Greener, Whiteside & Whitworth, 2007; Kim, Pronyk, Barnett & Watts, 2008; Lopman, Lewis, Nyamukapa, Mushati, Chandiwana & Gregson, 2007; Pronyk, Harpham, Morison, Hargreaves, Kim, Phetla, Watts & Porter, 2008, Shannon, Kerr, Allinott, Chettiar, Shoveller & Tyndall, 2007).

Wellings, Collumbien, Shaymaker, Singh, Hodges, Patel and Bajos (2006, p. 1716) observe that:

Poverty, deprivation, and unemployment work with gender relations to promote change of partner, concurrency, and unprotected sex. Economic adversity restricts the power of men and women to take control of their health; deprivation and unemployment might drive men and women to sell sex or travel greater distances to work. Being away from home is associated in both developed and developing countries with concurrency of partnerships and an increase in risk behaviours. Possibly the most powerful influences on human sexuality are the social norms that govern its expression. Morals, taboos, laws, and religious beliefs used by societies worldwide circumscribe and radically determine the sexual behaviour of their citizens. The scale of the regional diversity in sexual behaviour is matched only by the range of cultural constraints on practice. In some societies, for example, homosexual behaviour is celebrated in public parades of pride; in others it carries the death penalty. In some countries, such as Brazil, condoms are available to young people in schools; in others, for example parts of Indonesia, their possession is a criminal offence. Such strictures hinder attempts by men and women to protect their sexual health. The sexual double standard, whereby restraint is expected of women, whereas excesses are tolerated for men, compounds the problems for both men and women.

These factors are the proximate determinants of HIV infection (Boerma, Gregson, Nyamukapa & Urassa, 2003; Boerma & Weiss, 2002; Lewis, Donnelly, Mare, Mupambireyi; Garnett & Gregson, 2007). The proximate determinants framework proposes three interlinked hierarchical

levels of factors affecting the spread of HIV infection. Boerma *et al.* (2003, p. 780) explaining their observations of the proximate determinants in studies conducted in Tanzania and Zimbabwe wrote:

Three hierarchical levels are considered for the study of factors affecting the spread of HIV. The underlying sociodemographic factors included education, mobility, and marriage patterns. The proximate determinants, through which all underlying factors must operate to affect HIV transmission included factors affecting transmission efficiency (condom use, male circumcision, other STI prevalence and treatment utilization) and those affecting the risk of exposure to an infected person (onset of sexual intercourse, sexual partnership formation, and sexual mixing). Population-based HIV prevalence was used as the biologic outcome.

The interplay between these factors is extremely critical in terms of acquisition of HIV. However, the differently applied cultural strictures to men and women are staking the odds against women in HIV infection prevention. This “sexual double standard” as alluded to by Wellings *et al.* (2006) presents serious challenges to the development of effective, gender sensitive prevention strategies. The thesis intends to explore whether the “sexual double standard” exists among rural people in Zimbabwe and how it is exposing them to HIV infection (Mungwini, 2008; Mungwini & Matereke, 2010).

Feminist and development discourse points at the social and gender imbalances that exist in most African societies as facilitating the disproportionate levels of HIV infection between men and women (Amaro, 1995; Ankrah, 1991; Gupta, 2001; Oppong, 1998; Plumridge *et al.*, 1997). Women are portrayed as docile recipients of infection from their cavorting spouses (Nnko, Boerma, Urassa, Mwaluko & Zaba, 2004). Feminist and development discourse challenges the cultural notions of masculinity and gendered behaviour seen as disempowering women and thereby curtailing their ability to live their lives independent of male hegemony (Brems & Griffith, 1993; de Koning & Martin, 1993; Espin, 1995; Leclerc-Madlala, 2000; Mungwini 2008; Mungwini & Matereke, 2010).

The skewed notion of the woman as passive and the man as dominant in sexual relations is another cultural conception that puts women at risk of HIV infection (Bianco, 2001; Castaneda *et al.*, 2001; Mungwini & Matereke, 2010; Ray *et al.*, 1995; Turmen, 2003). However, Brown, Sorrell & Marcella (2005) in their study of masculinity, sexuality and HIV/AIDS caution against exaggerating the powerlessness of women by citing the observed power of Owambo women of Namibia over their sexual lives. Kimuna and Djamba (2005) made a similar observation in their study of the Bemba people of Northern Zambia. Addai (1997) made similar observations in Ghana. Brown *et al.* (2005, p. 590) observed that the power of Owambo women in negotiating their sexual lives is challenged by hegemonic masculinities:

Several informants noted that in Owambo culture the road to marriage allowed men to have multiple sexual partners; after marriage, polygamy also permitted men to have multiple sexual partners. An important element of contemporary masculinity, which may represent a reinterpretation of these traditional practises, is the importance of having girlfriends and non-marital sexual partners.

Owambo culture deems a man who has only one sexual partner as poor, lowly in status and having weak manhood (Brown, *et al.*, 2005). Therefore, among the Owambo the desire to prove ones manhood probably negates the dangers of HIV infection from concurrency of sexual partners. Acknowledging the influence of time and one’s personal agency on the changing

Owambo culture, concurrency was spoken of as a celebrated rite of passage. It is important to note that the multiplicity of sexual partners among the Owambo was tied to ownership of material things such as cattle, size of agricultural field, which have been supplanted with having money, many girlfriends, and a car. Parallels to the Owambo culture can be drawn from other sub-Saharan African countries. Studies conducted in the Democratic Republic of Congo, South Africa, Zambia, and Zimbabwe confirms the link between material acquisitions and concurrency (Albertyn, 2003; Djamba, 2003; Djamba, 1997; Ragnarsson, Townsend, Ekstrom, Chopra & Thorson, 2010; Selikow, Zulu & Cedra, 2002; Sitawa & Djamba, 2005; Taruberekera, Kaljee, Astatke, Mushayi, Chommie & Shekhar, 2008).

Doyal (1994) argues that giving primacy to male desires (Leclerc-Madlala, 2000; Gupta, 2002; Selikow, Zulu & Cedra, 2002; Turmen 2003) gives women less power to negotiate sexual encounters (Davila & Brackley, 1999; Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004). Cultural practices serve to reinforce this perception by labelling any woman who seeks to explore different sexual experiences (Plumridge *et al.*, 2001). The interplay of poverty, masculinity and gender inequalities make women vulnerable on several levels; it limits their ability to negotiate safe sex because of economic dependence, it exposes them to gender violence and makes them more susceptible to disease (Barnighausen, Hosegood, Timaeus & Newell, 2007; Doyal, 2001; Hargreaves, Bonell, Morison, Kim, Phetla, Porter, Watts & Pronyk, 2007; Kim, Proynk, Barnett & Watts, 2008; Lopman, Lewis, Nyamukapa, Mushati, Chandiwana & Gregson, 2007). Gupta (2002, p.183) commenting on the inter-relationship of heterosexual infections, poverty, and gender inequalities, notes:

Most of these infections occur through unprotected heterosexual interactions. Women are limited in their ability to control these interactions because of their low economic and social status and because of the power that men have over women's sexuality. Most of the world's women are poor and most of the world's poor are women. Women make up almost two thirds of the world's illiterate people and are often denied property rights or access to credit...Women's economic vulnerability and dependence on men increases their vulnerability to HIV by constraining their ability to negotiate the use of a condom, discuss fidelity with their partners, or leave risky relationships.

Evidence is also emerging suggesting that the link between poverty and HIV is not always a given causal link (Gillespie, Kadiyala & Greener, 2007; Gillespie, Greener, Whiteside & Whitworth, 2007; Holtgrave & Crosby, 2003; Mishra, Bignami-Van Assche, Greener, Vaessen, Hong, Ghys, Boerma, Van Assche, Khan & Rutstein, 2007; Potts, Halperin, Kirby, Swidler, Marseille, Klausner, Hearst, Wamai, Kahn & Walsh, 2008). However, it is the mix between biological sex, social gender, socio-cultural factors (such as violence; lack of education, lack of opportunities), poverty and the resultant gender stereotyping that make women more vulnerable to HIV infection (Doyal, 2001; Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005; Turmen, 2003).

Gender stereotyping is extremely problematic and needs to be openly challenged in dealing with HIV across the global community. Doyal (1994) argues that male behaviour prevents women from engaging in safe sexual behaviour. Men dump or abuse women who challenge male hegemony and male sexual behaviour. In the case of HIV infection prevention, the very technology (i.e. the condom) promoted to protect women from unwanted pregnancy, sexually transmitted infections and HIV infection is seen as challenging male virility and manhood (Ali, Cleland & Shah, 2004; Amaro, 1995; Davila & Brackley, 1999; Maharaj & Cleland, 2004; Turmen, 2003).

Hegemonic masculinities are possibly driving the rampant HIV epidemics in sub-Saharan Africa (Barker & Ricardo, 2005; Brown, Sorrell & Raffaelli, 2005; Gilbert & Walker, 2002; Hunter, 2002; Gupta, 2002; Kambarami, 2006; Mungwini & Matereke, 2010; Poundstone, Strathdee & Celentano, 2004; Ragnarnasson, *et al.*, 2010; Selikow, Zulu & Cedra, 2002; Turmen 2003). Kelly (1998) argues that cultural narratives of masculinity drive male sexuality, which in turn influences the kinds of interactions between men and women. Kelly (1998, p.21, citing Connell, 1995) explains;

Masculinity, to the extent that it can be defined at all, is simultaneously a place in which gender relations, the practices through which men and women engage, ... and the effects of these practices in bodily experience, personality and culture.

Therefore, gender is shaped neither individually nor socially. Rather the individual actively shapes his or her gender by drawing-off multiple cultural resources, discourses or interpretative repertoires (Burr, 1995). As Turmen (2003, p. 411) observes:

People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles. Gender, in its broadest sense, concerns 'what is meant to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships'.

Primarily the cultural resources available in a society determine masculinity, which the individual actively draws upon. As Worth (1990, p. 112) observes:

Behavioural change ...cannot be promoted successfully without understanding the structural determinants (e.g. acculturation and education) and their influence on gender behaviour, sexuality, drug use and health behaviour related to the prevention of AIDS.

An understanding of gendered experiences and their implications for HIV infection and vulnerability is vital. This understanding is achieved by listening to the narratives people tell about their lives. There is a need to broaden the research agenda by exploring the socio-cultural context within which sexual encounters occur.

People's life-worlds, health and illness beliefs need to be explored in order to understand the meanings they attach to health and illness. Armstrong (1984) notes the importance of exploring the patient's view of his or her illness. The way people construct meaning around their social contexts and how they communicate their experiences becomes a key concept in understanding how communities are coping with HIV/AIDS (Bury, 2001; Hyden, 1997; Kagee & Nixon, 2000; Mills, 2006; Mungwini, 2008; Reissman, 2002). Bruner (1991) and Murray (1997) talk of understanding the narratives and stories people tell regarding their lived experiences and life-worlds. There is a need to understand the general worldview of the people whose lives we are trying to study (Kagee & Nixon, 2000; Gwanzura-Ottmoller & Kesby, 2005; Zea, Reisen & Diaz, 2003). In the case of this thesis, researching the *Manyika* people's socially constructed meanings of health and illness, representations of illness, and common beliefs is crucial for understanding how they are dealing with the HIV/AIDS epidemic (Wilkinson, 1998).

HIV infection prevention models and theories

In the absence of a cure for HIV infection, efforts to change high-risk sexual behaviours remain the only available means to prevent HIV infection. This has led to the development of several HIV infection prevention models and theories. The premise for the models is that, because HIV

is transmitted largely through sexual behaviour and the sharing of drug injection equipment, individual practice of risk reduction behaviour is the primary avenue for prevention. The health belief model, the social learning theory and the theory of reasoned action have been widely used to inform health behaviour and to inform HIV prevention strategies. DiClemente and Peterson (1994, p. 1) have, however, warned that “the risk behaviours responsible for HIV infection, however, occur in the context of people’s interpersonal relationships and pose many social, psychological, and cultural obstacles to curtailing the epidemic.”.

HIV-infection prevention approaches

There has been an increase and high visibility of HIV prevention programmes over the past two and half decades. While HIV prevention information is critical and necessary, it is not by itself sufficient to motivate behaviour change. Attention needs to be given to other factors related to HIV infection prevention, such as perceptions of personal vulnerability to disease and peer norms, beliefs about the value of prevention behaviour, recognition of high-risk behaviour, behavioural intention, and self-efficacy (Poundstone, Strathdee & Celentano, 2004). As Latkin and Knowlton (2005, p. 1) put it:

To be effective and sustainable, HIV-prevention interventions need to be sufficiently powerful to counteract prevailing social norms and diffuse through the targeted community to provide social reinforcement for behaviour change. Social structural and environmental factors are major influences on HIV-related behaviours yet the dearth of conceptualization and operationalization of the factors impede progress in intervention development.

Latkin and Knowlton (2005, p. 1) further note that:

Behavioural HIV-prevention programmes in the first decades of the pandemic have tended to be individual-focused, based on assumptions that risk behaviours are conscious decisions, the result of rational choices. With growing awareness of the role of social structural and environmental influences on HIV risk behaviours, structural-focused interventions are increasingly being proposed.

Ragnarsson *et al.* (2010, p. 1-2) make a similar analysis:

In the last 25 years, HIV prevention efforts have predominantly sought to influence the individual; targeting knowledge, attitude and practices of people, whereas structural factors, e.g. socio-cultural, organisational, legal and policy aspects of the environment that impede or facilitate an individual’s efforts to avoid HIV infection, have been given less attention. Previous research have demonstrated the usefulness of adding cultural orientation when aiming to predict health behaviours, as the HIV epidemic needs to be tackled through more innovative approaches. This is especially important when addressing structural factors that affect sexual relationships and the transmission of HIV because individual autonomy is by no means culture-free and the mode of transmission has to be understood within existing explanatory systems, particularly in terms of associated images, symbols and representations.

An understanding of the ecological and social contexts of HIV-infection is important in the design of appropriate HIV-prevention strategies. Poundstone *et al.* (2004, p.23) observe that “cultural context, social networks, neighbourhood effects, and social capital” as key social-level factors in the epidemiology of HIV-prevention. The eco-social environment proscribes individual choices and behaviours. Acceptable sexual behaviour is a social construct circumscribed by a cultural and gendered norms and expectations. Deviation from these prescribed norms and

expectations invokes social sanctions such as labelling and at times violence in all its manifestations.

The interplay between risk behaviour, social network, and social ecology is by no means random. As Latkin and Knowlton (2005, p. 2) comments:

Risk behaviours are not randomly distributed within a population; rather, risk behaviours are generated and perpetuated through socially or environmentally structured social interactions. This dynamic helps explain why HIV, as with many other infectious diseases, often clusters within certain sub-populations. Furthermore, social behaviours are not rational choices based on objective information but are socially prescribed; that is, behavioural decision-making is based on bounded rationality, or practical constraints (cf. March & Simon, 1959). Information gathered for decision-making is often elicited from main social ties through social comparison or social control processes, considerations of meanings of behavioural options, and social rewards and punishments consequent to behavioural decisions.

The “bounded rationality or reality” needs to be unpacked for a greater understanding of the social dynamic surrounding the HIV pandemic. This thesis argues for a greater understanding of the meanings that people attach to their lives and social circumstances in the prevention of HIV infection (Bury, 2001; Bruner, 1990; Kakuru & Paradza, 2007) in order to come up with appropriate interventions that speak to the lived realities of the rural Zimbabweans.

Sexual abstinence and condom use

While sexual abstinence is the most obvious method of preventing sexual transmission of HIV, a substantial proportion of adults and adolescents fail to adopt this strategy (Anderson *et al.*, 1990; Catania *et al.*, 1990; DiClemente, 1990; Lachenicht, 1995). The assumption that abstinence is a permanent option for many is itself problematic. The inherent problems with this assumption have fuelled the need for sexual technology to cater for those for whom abstinence is not an option.

The personal and cultural relevance of the condom has not been fully investigated despite the fanfare that accompanies its social marketing campaigns. DiClemente and Peterson (1994, p. 2) note:

Changing high-risk sexual behaviour is a particularly difficult problem, however, because the decision to use condoms occurs in the context of people’s social relationships and lifestyles. A number of factors may influence the decision to use condoms during sexual intercourse including age, gender, and cultural differences regarding sexuality and sex-role relationships.

Socio-economic status and perceptions of masculinity can also influence the decision to use a condom (Campbell & Williams, 1998; Castaneda *et al.*, 2001; Worth, 1999). The challenge then lies in coming up with innovative prevention efforts that do not rely solely on providing risk information. Fisher and Fisher (1992) remark that there is a dearth of information demonstrating the impact of behavioural interventions on behaviour change. The same challenge confronts us in our efforts to curb the spread of HIV infection.

Research aims and questions

The broad aim of the study is to understand the sexual practices and cultural meanings the *Manyika* people in rural Zimbabwe attach to their sexual practices in the face of the HIV/AIDS pandemic. This is done by applying a social constructionist paradigm to the research (Mungwini, 2008; Mungwini & Matereke, 2010). A narrative approach and a relational method of data analysis is used (Mauthner & Doucet, 1998).

The study seeks to explore the following research questions:

- How has HIV/AIDS affected the lives of the *Manyika* people of Makoni and *Mutasa* areas?
- What are the social and cultural constructions of the disease within the two communities?

Methodology

The study utilises the social construction paradigm and qualitative methodologies, namely the narrative and voice-centred relational approaches (Denzin & Lincoln, 1994; Gilligan, 1991; Mauthner & Doucet, 1998; Patton, 1990) in the telling of the lived experiences of rural Zimbabweans in the face of the HIV/AIDS pandemic (Kakuru & Paradza, 2007, Mungwini, 2008). Chapter 6 of the thesis discusses the study methodology in much detail.

The utilisation of social constructionism (Burr, 1995) and qualitative methodology is necessitated by several factors. First, the need to understand sexual behaviour within the social and cultural context in which it occurs (Abramson & Herdt, 1990; Eyre, 1997; Parker & Carballo, 1990; Tobias, 2001). Several studies on sexual behaviour have utilised this methodology in assessing HIV sexual risk and studying sexual behaviour (Parker & Ehrhardt, 2001; Prieur, 1990). Second, qualitative approaches are most likely to provide sensitive information likely not be uncovered in surveys of structured interviews (Lear, 1997). The rapport possible in a qualitative interview is conducive to more accurate reporting of intimate experience, providing data not available in any other way, and offering validity checks on the interpretation of quantitative data. Qualitative methods help to understand the implicit meanings embedded in behavioural patterns – and that may prove crucial to behavioural change (Parker & Carballo, 1990).

Outline of the thesis

The thesis is organised into eight chapters as follows: Chapter 1 introduces the study and its significance. Chapter 2 gives a global overview of the HIV and AIDS epidemics, while Chapter 3 contextualises the HIV and AIDS epidemics as it explores issues of policy, socio-economic factors, and current debates surrounding HIV/AIDS in Zimbabwe. Chapter 4 looks at culture and sexuality in Zimbabwe. Chapter 5 looks into the theoretical perspective underpinning the thesis. Chapter 6 looks at the study methodology. Chapter 7 discusses the study results with reference to the literature review, theoretical perspective and methodology informing the study. Chapter 8 provides a conclusion to the study by looking into issues it raises in terms of theory development, policy, and future research on HIV/AIDS in rural Zimbabwe.

Conclusion

The chapter gives a general overview of what the study seeks to explore and the challenges posed by the HIV and AIDS pandemic. It notes that the understanding of human sexuality is complicated by the fact that sexual behaviour is largely viewed as a private matter; people are not keen to talk openly about it. Despite the private and sensitive nature of human sexuality, there are still questions that need to be asked in order for society to come up with effective intervention strategies to curb the spread of HIV infection. We need to define what constitutes risky sexual behaviour in the context of the everyday realities of rural Zimbabweans and in order to do this we need to have a fair grasp of people's life-worlds and employ egalitarian and phenomenological approaches in researching their lived experiences. This study will use a social constructionist paradigm to look into the meanings the *Manyika* people in rural Zimbabwe are attaching to their everyday sexuality in the face of the HIV/AIDS pandemic.

CHAPTER 2

HIV/AIDS: A GLOBAL SYNOPSIS

A global overview of the HIV/AIDS pandemic in sub-Saharan Africa is given in this chapter. Past and current issues surrounding HIV and AIDS are examined and their relevance and contribution to the understanding of the pandemic explored. The chapter gives an overview of the global morbidity and mortality statistics of HIV infections and AIDS cases. The chapter highlights some of the debates around treatment, care and prevention of AIDS.

Overview

The recently reported declines in India and Zimbabwe (Gregson *et al.* 2006; Kumar *et al.* 2006; UNAIDS, 2005) and stabilisations of the HIV epidemic in most sub-Saharan African countries (UNAIDS, 2008) have brought a degree of optimism to the world community in the fight against the HIV/AIDS pandemic. The reported declines indicate that some of the prevention investments are beginning to pay some dividends. However, the stabilisations of HIV/AIDS at high levels means it remains a major worldwide health and social epidemic (Avert, 2009; UNAIDS, 2009). The declines and stabilisation of the HIV epidemic is accompanied by warnings that there is recent evidence that risky behaviours were increasing in countries that witnessed early declines (Hayes & Weiss, 2006; UNAIDS, 2008). Prevention programmes need to be reinforced to ensure that the declines in HIV prevalence are sustained worldwide (Cohen, 2008).

Three decades on HIV/AIDS has become a major global health emergency, especially in sub-Saharan Africa where it is massively altering the demographic profile of several countries, especially in southern Africa (Schlagenhauf & Ashraf, 2003). This is despite the massive investments into programmes designed to limit the spread of HIV infection. The advent of anti-retroviral treatment has since transformed AIDS into a clinically managed chronic disease in the Western world but the disease remains largely fatal in sub-Saharan Africa.

In 2009, the Joint United Nations Programme on AIDS (UNAIDS) estimated that 33.4 million people worldwide were living with HIV/AIDS (UNAIDS, 2009). Slightly over half of the people living with AIDS, 15.7 million, were women. In 2008, children under 15 years accounted for 2.1 million of people living with HIV infection. An estimated 2.7 million new infections occurred worldwide, 430 000 of these infections were among children. Two million deaths attributable to AIDS were reported in 2008 (see Table 1 below).

Table 1: Global Summary of the HIV/AIDS Epidemic, December 2008

Total number of people living with HIV/AIDS	33.4 million
Women	15.7 million
Children under 15 years	2.1 million
Annual new infections	2.7 million
AIDS deaths	2.0 million

Source: Adapted from UNAIDS 2009

The majority of the infections were from low and middle-income countries, most of them sub-Saharan countries. Most worrying were the increasing HIV infection levels in the 15 to 24 year age group and HIV prevalence that are consistently high in rural populations (*ibid.*). UNAIDS (2008, p.33) noted, “[y]oung people aged 15-24 account for an estimated 45% of new infections

worldwide". The rise in infections in young people is disconcerting given the reported delays in sexual debut and increase in condom use amongst this age group (*ibid.*).

Global infection patterns show fairly well defined regional routes of infection (UNAIDS, 2004). In North, South America and Western Europe the infection route is mainly through men having sex with men (MSM), bisexual males and injecting drug users (IDUs). In the former Soviet States and Central Asia the virus is spread mainly through injecting drug use (IDU) but heterosexual infection is on the rise (UNAIDS, 2009). Sub-Saharan Africa is the only region with a predominantly heterosexual infection route.

Sub-Saharan Africa

Sub-Saharan Africa remains the region worst affected by the epidemic. The UNAIDS (2009) report estimates that 22.4 million adults and children were living with HIV in the sub-Saharan region alone. An estimated 1.4 million people in the region died from AIDS in 2008. Around 1.8 million children were living with HIV in the region. An estimated 14.1 million children in the region had lost one or both parents to the epidemic (Avert, 2009). The epidemic still disproportionately affects more women than men in Africa (Gregson, Nyamukapa & Mlilo, 2000; Kalipeni, 2000; Kiragu, 2001; Leclerc-Madlala, 2000; Olayinka, Alexander, Mbizvo & Gibney, 2000; UNAIDS, 2002, UNAIDS 2008; Walker & Gilbert, 2002).

In 2008, countries in southern Africa still formed the continental epi-centre of the pandemic. In Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, national HIV prevalence rates were between 15 and 28 percent (UNAIDS, 2008). It meant that on average one in five adults was living with HIV in Southern Africa. The epidemiologic, biomedical and social factors facilitating the rapid spread of HIV have been extensively documented (Airhihenbuwa, 1991; Bongaarts, 1996; Finer, Darroch & Singh, 1999; Gregson, *et al.*, 1996; Lagarde *et al.*, 1996; Larson, 1990; Leclerc-Mdlala, 2000; Nicoll *et al.*, 1997; Prieur, 1990; Sanders & Sambo, 1992; Setel, 1995; UNAIDS, 2002). Studies have explained the proximate determinants of the HIV infection implosion in sub-Saharan Africa (Boerma *et al.*, 2003; Boerma & Weiss, 2005; Lewis *et al.*, 2009) witnessed especially in East and southern Africa where HIV prevalence range from 5 percent to 25 percent (UNAIDS, 2009).

Lewis *et al.* (2009, p. 62) observe that:

Many characteristics of the individual, the population they are from and the infection itself contribute to determining the risk of exposure and acquisition, and there will be causal pathways linking social, demographic, economic, cultural, behavioural and biological variables.

Pervasive poverty in sub-Saharan Africa (Boerma *et al.*, 2003; Kalichman *et al.*, 2007; Ray & Madzimbamuto, 2007) and the personal, social, communal, economic and political conflicts it generates possibly provide the perfect conditions for the rapid spread of HIV infection. Cultural, political, historical, socio-economic factors have fuelled the HIV epidemic in sub-Saharan Africa. The factors range from disrupted and dysfunctional social systems, dislocated familial, economic and interpersonal reproductive/productive systems, repressive political regimes, poverty, hegemonic masculinities, unbalanced gender relations, to poor social infrastructure (Ankrah, Mhloyi, Manguyu & Nduati, 1994; Beresford, 2001; Campbell, 1998; Connell, 1995; Farmer, Lindenbaum, DelVicchio & Good, 1993; Larson, 1990; Setel, 1995). As such, the focus has been on the social groups most at risk of HIV infection owing to their social and economic vulnerability. Women and children have been identified as most at risk owing to their low and poor social status in most African societies (Campbell, 1995; Campbell, 1998; Gupta, 2001; Heiss & Elias, 1995; Mitchell & Smith, 2001; Stevens & Doerr, 1997; Ulin, 1992; Gupta & Weiss, 1993).

Iliffe (2006) notes that the unsurpassed HIV infection levels witnessed in sub-Saharan Africa are most likely to have been caused by widespread labour migration; high ratio of men in urban populations; low status of women; lack of circumcision, and high prevalence of sexually transmitted diseases. Lurie (2006) writes about the role of internal and external labour migration to urban mining towns in the spread of HIV infection in South Africa and southern Africa. He explains that it is the circular and oscillating migration by men in southern Africa that act as bridges of HIV infection between communities (Lurie, 2006). Decosas and Adrien (1997) discuss the link between circular and oscillating migration, and the AIDS epidemic and point out that it is men who work away from home who bring the virus back home to their partners.

Several studies point at sexual mixing patterns as a feature that distinguish the sub-Saharan Africa AIDS epidemic from those occurring elsewhere (Boerma *et al.*, 2003; Boerma & Weiss 2005; Green *et al.*, 2009; Kalichman *et al.*, 2007; Lewis *et al.*, 2007; Lopman *et al.*, 2007; Lurie, 2006; Nshindano & Maharaj, 2008). These studies have identified multiple and concurrent sexual partnerships as the major drivers of the epidemic in sub-Saharan Africa. Sex workers, long distance truck drivers, traders and military personnel provide the bridge for HIV infection between high risk groups and the rest of the population because of their mobility, likelihood of acquiring sexually transmitted diseases and partner concurrency (Chin, 2007; Iliffe, 2006, UNAIDS, 2006). Consequently, unsafe sex between these populations is the primary mode of transmission of HIV infection (WHO, 2003)

The toll of HIV/AIDS on sub-Saharan Africa national economies is enormous (AIDS Care; 2008; Europa World, 2002; IMF, 2002; Grant & Palmiere, 2003; Scemo, 2002). At the turn of the decade, HIV/AIDS accounted for more than 50 percent of all adult hospital admissions in these countries, in addition to a significant number of paediatric admissions (White House, 1999; Kiragu, 2001; UNAIDS, 2002). “The social and economic consequences of the AIDS epidemic are widely felt, not only in the health sector but also in education, industry, agriculture, transport, human resources and the economy in general. The AIDS epidemic in sub-Saharan Africa continues to devastate communities, rolling back decades of development progress” (Avert, 2010 p§). According to Avert, sub-Saharan Africa faces a triple challenge:

- Providing health care, antiretroviral treatment, and support to a growing population of people with HIV-related illnesses;
- Reducing the annual toll of new HIV infections by enabling individuals to protect themselves and others; and
- Coping with the impact of nearly one and a half million annual AIDS deaths, on orphans and other survivors, communities, and national development.

Socio-economic and demographic impact of HIV/AIDS

The HIV/AIDS epidemic continues to present serious demographic, social, political and economic challenges in sub-Saharan Africa. The social, economic, demographic, and political impacts have been explored by several studies (Gregson *et al.*, 1996; Whiteside & Loewensen, 1997; Beresford, 2001). The epidemic is so severe that by the 1990s it was already altering population structures and dynamics in Africa (Anderson *et al.*, 1991; Bongaarts, 1996; Carael *et al.*, 1999; Chin *et al.*, 1990; Dorrington, Bourne, Bradshaw & Timaeus, 2002; Gregson, 1994; Gregson *et al.*, 1996; Timaeus, 1998; Whiteside, 1998). Life expectancy has fallen in most southern African countries due to HIV/AIDS related mortality (Avert, 2010). Life expectancies at birth, which rose from 44 years in the early 1950s to 59 in the early 1990s, dropped to about 45 between 2005 and 2010 because of AIDS-related mortality. Nowhere was this more dramatically shown than in Zimbabwe where life expectancy fell from 62 years to about 35 years by 2010 (Avert, 2010).

Impact of HIV/AIDS on children in sub-Saharan Africa

According to the United Nations Joint Programme on HIV/AIDS there were 15 million AIDS orphans worldwide (UNAIDS, 2008). By 2002, sub-Saharan Africa had close to 13 million orphans (Grant & Palmiere, 2003). To highlight the devastating impact of the HIV/AIDS epidemic on children, a joint report by the United Nations' Children Fund (UNICEF), United States Agency for International Development (USAID), UNAIDS and WHO projected that by the end of 2010 sub-Saharan Africa will be having 18 million orphans due to AIDS-related deaths (UNICEF, UNAIDS, WHO, USAID, 2003). The verification of these projections is critical. The HIV/AIDS pandemic not only alters household composition "but also exact a heavy toll on the socio-economic well-being of households and communities" (Grant & Palmiere, 2003 p. 213).

The HIV/AIDS epidemic continues to disintegrate and destabilize the African family system. The number of orphaned children forced to fend for themselves on the streets of sub-Saharan urban centres or in child-headed households highlights the disintegration of the extended African support system (Avert, 2009). The Foundation for Democracy in Africa (2003, p. 4), commenting on the impact of HIV/AIDS on children, remarks:

As their parents die of AIDS, these large numbers of African children become orphans who are abandoned, and as a result, they have been forced to seek help in the streets, begging for money. Because housing, schools and food are not provided to the children, as a consequence they become vulnerable to abuse. The girls turn to prostitution to survive and most likely become infected just like their parents, thus perpetuating the vicious cycle.

AIDS mortality is still rising in sub-Saharan Africa especially in southern Africa (Whiteside & Barnett 2001; UNAIDS 2009). This is despite the availability of treatment. As a result, there is a parallel rise in the number of AIDS orphans. An interesting aspect is the geographical distribution of orphans within countries in sub-Saharan Africa. The spatial variability of the epidemic means that orphan numbers are highest and most concentrated in the urban and peri-urban centres (Webb, 1995).

Several countries in the region have carried out national situational analyses to establish the status of orphans. Uganda, Malawi, Zambia, Zimbabwe, and Kenya are some of the countries that have carried out a national profile of orphans. Other countries use projections from their vital national statistics to project the orphanhood burden. AIDS induced orphanhood has become a severe burden for the region. In Zambia, Uganda and Tanzania (Webb, 1995) as well as in Zimbabwe (Foster *et al.*, 1997; Gregson *et al.*, 1996) the trend is one of a predominance of paternal orphans. As the epidemic matures, there will be a rise in the number of children who would have lost both biological parents.

The plight of orphans deepens per definition of their orphanhood, maternal, paternal, or double orphan. Though sharing common concerns the gravity of their situation worsens in relation to which parent they would have lost. However, given that female-headed households were becoming the norm rather than the exception in most sub-Saharan communities (Asike, 1991; Bourdillon, 1993; Gregson *et al.*, 1996) it is fairly reasonable to assume that the loss of a mother has serious implications for the children in comparison to the loss of a father. The vulnerability of double orphans can only be worse. The difference in welfare status between the orphan groupings is a matter of further research (Webb, 1995). Studies of orphans indicate that food, security, shelter, health, education, and psychological well-being were major concerns (Bledsoe *et al.*, 1988; Foster *et al.*, 1997; Gregson *et al.*, 2005; Kang, Dunbar, Laver & Padian; 2008; Marcus,

1999; Miller & Murray, 1999; Mulenga *et al.*, 1993; Nyamukapa & Gregson, 2005; Nyamukapa *et al.*, 2008; Rossi *et al.*, 1995; Schietinger, 1998; Stein *et al.*, 1999; UNICEF, 1999). Marcus (1999, p. 1) notes that:

One of the major AIDS-derived social crises that is going to affect contemporary southern African societies centres on caring for and attending to the well-being of children. The institutions that have historically attended to the needs of children -- family and kin networks, the church and the state -- are each on their own, poorly placed to respond to what is anticipated to be an unprecedented need for care.

The traditional view of the extended family acting as a safety net and form of social security (Ankrah, 1989; Asike, 1991; Bourdillon, 1993) is threatened by contemporary socio-economic events and social change. Extended families and communities can no longer be assumed to be cohesive, interactive, and mutually supportive entities (Marcus, 1999; Oppong, 1981). The anthropologically defined African extended family no longer exists. It has since given way to adaptive familial arrangements necessitated by the capitalistic mode of modern day living. Families are becoming nucleated though still maintaining loose extended family links. Caring for orphans and their needs in the modern African extended family should be viewed in this changing context. The socio-economic status of many African families dictates their ability to take in or not extended kith and kin.

Studies on the impact of HIV/AIDS on children sometime overlook the fact that children do not start suffering only when they are orphaned. Their health development and emotional well-being are at risk long before either parent dies (Nyamukapa, Gregson, Lopman, Saito, Watts, Monasch & Jukes, 2008). The predominant social system in traditional African societies is the patriarchal system where the father is the traditional breadwinner. In the case of peasant rural families, death of a father will most likely lead to the family losing its usufruct rights to land use¹. In urban settings, the death of a parent could set-off a negative social and economic chain reaction such as loss of lodgings, income, medical insurance, and schooling. Parents' response and coping with their HIV status is affected by economic, cultural, social and religious factors. Parents worry over their deteriorating health status and the social stigma attached to HIV/AIDS. HIV infected and affected parents find it extremely difficult to communicate the nature of their illness to their children (Marcus, 1999; Miller & Murray, 1999). This heightens the anxiety in children as they see their parent(s) demising from a disease they do not understand.

It is difficult for parents living with HIV to provide adequately for the physical and emotional needs of children given the debilitating nature of their illness. The social stigma surrounding HIV/AIDS can lead to feelings of guilt, shame, remorse and anger further complicating the parent-child relationship (*ibid.*). Children may have worries, unattended by others, as they watch their parents become ill and die. HIV illness could lead to unbalanced family relationships as needs go unattended or unnoticed. As noted by UNICEF (1999) and Nyamukapa *et al.* (2008), a child whose mother or father has HIV begins to experience sorrow and suffering long before the parent's death.

Even more worrying is that as AIDS kills the economically active adults it leaves affected children in the care of elderly grandparents (Marcus, 1999). Grandparents themselves are vulnerable and needing care. They usually do not cope with the extra burden of looking after their orphaned grandchildren (Lorey & Sussman, 2001). Most sub-Saharan countries do not have a welfare system in place that can cushion the needs of orphaned children and the elderly. The two social

¹ Zimbabwe has produced two feature films on this phenomenon: *Neria* and *Everyone's Child*.

groups are socially and economically dependent on the age groups that HIV/AIDS is wiping out (Foster *et al.*, 1998).

Some countries have turned to non-relational fostering, community orphan support and institutionalisation as strategies to care for children orphaned by AIDS. Institutionalisation and non-relational fostering are not keenly received strategies because African culture and taboo shun them (Ayieko, 1997). However, there are child-fostering cases that have been a success. According to UNICEF (1999), Botswana, Malawi, Zambia and Zimbabwe have come up with community-based orphan care initiatives that have taken off the ground. The need to keep orphans within their social and cultural environment and have the local community assist them is the principle behind community orphan care. It is argued that transplanting orphan children from their social environs affects negatively their personal and social development (Marcus, 1999; Smart, 1999).

However, limited resources compromise the effectiveness of these interventions leaving many children in vulnerable circumstances without adequate help (Ayieko, 1997; Marcus, 1999). A glaring indication of the inadequacies is the emergence of child-headed households. Child-headed households are families where siblings look after each other (Foster *et al.*, 1998; Smart, 1999) after the death of their parents. Foster *et al.* (1998) have written extensively on the emergence of child-headed families in Zimbabwe. The most noticeable phenomenon is that the girl child usually becomes the locus of support for her siblings. Of course, there are also child-headed households run by the boy sibling. The oldest sibling acts as the guardian of the younger siblings. This helps stabilize the family and fill the care-taking needs of family members (Stein *et al.*, 1999). This phenomenon is known as parentification. Stein *et al.* (1999, p.193) define parentification as “children or adolescents assuming adult roles before they are emotionally or developmentally ready to manage those roles successfully”.

Studies (Cates, 1990; Smart, 1999; Stein *et al.*, 1999) have raised critical questions about the long-term impact of parentification of children. Parentification in child-headed households may lead to role strain in the short-term, and negative consequences such as role reversal, and poor identity formation in the long-term.

HIV/AIDS and the youth

HIV infection is increasing alarmingly among young people despite reported declines of HIV infection among the 15-24 year olds in some countries. In 2007, young people aged 15-24 accounted for an estimated 45 percent of new infections globally. “HIV is a big problem for young people, as well as adults...and globally AIDS is the second most common cause of death among 20-24 year olds” (Avert, 2010, no page). HIV disproportionately infects more young women compared to their male counterparts in most of sub-Saharan Africa (Napierala *et al.*, 2008; UNAIDS, 2009). Population based HIV surveillance studies confirm this gender bias in infections (UNAIDS, 2009).

There are models that possibly explain the disproportionate infection rates among teenagers. These are the social and biological models. The social model looks at the cultural, behavioural, economic, and demographic factors. Sexual mixing patterns between teenage girls and older men likely explain the discrepancy in HIV infection rates between boys and girls (Gregson, Nyamukapa, Garnett, Mason, Carael, Chandiwana & Anderson, 2002). The sexually experienced older men are most likely to have multiple partners, to be infected and to pass on HIV infection to teenage girls. The biological model looks at biomedical aspects of HIV infection such as sexually transmitted diseases and other epidemiological co-factors. The biology of girls makes

them more likely to be infected during vaginal intercourse with an infected partner (UNAIDS, 2000).

The rise of HIV infection among adolescents and young adults challenges our interventions in dramatic ways. Several questions around youth sexual behaviour beg answers. Many would find the answer for the rapid spread of the HIV/AIDS pandemic in Africa's almost universal taboo towards open discussion of matters sexual. Some blame it on structural imbalances within African societies that restrict women's sexuality whilst freeing that of men. Others blame it on the desire for unprotected sex. Blame should also be apportioned on the silence and mystery that still surround HIV/AIDS in many African communities (Leclerc-Madlala, 2000). She argues further that the silence has much to do with heterosexual power and masculinities, whose structure and meaning are contoured by what is often called "culture".

HIV/AIDS is threatening the survival of African institutions. There is a need to understand why in the face of all the information, education and communication campaigns put in place sex is still regarded by teenagers as necessary, and a natural expression of love, as well as an activity proscribed by peers. The abstinence, be faithful, and use condoms (ABC) strategy has limitations (Airhihenbuwa & Obregon, 2000; Green, 2009; Napierala *et al.*, 2008)). There is urgent need to deal with the pressures that adolescents face regarding their sexuality. There is need also to understand why teenagers engage in behaviours that put them at risk of HIV infection. The youth are confused with the mixed messages coming from both the adult world and their own. In the midst of the confusion, HIV/AIDS is claiming yet another generation.

Owing to cultural barriers, many African parents cannot discuss sexual matters with their children. Uganda has probably come up with a successful model of preventing HIV transmission among young people. Its "zero grazing" campaign based on total sexual abstinence appears to have been a major success as incidence of HIV infection has reportedly gone down (Asümwe-Okiror *et al.*, 1997). Zero grazing alone would not have achieved dramatic results without the accompanying high profile involvement of President Yoweri Museveni and his cabinet. Other high profile role models were brought in and they played significant roles in shaping attitudes towards sex and HIV/AIDS. Probably one of the most influential factors was the impact AIDS-related death had among Ugandan teenagers. This generation had grown up surrounded by death of loved ones, parents, siblings, teachers, neighbours, church members, and so forth. The outcome was the effect of positively shaping the sexual attitudes of a completely young generation that started valuing delaying onset of sexual activity, monogamy, and protected sex.

Other countries of the region have come up with youth-centred programmes to curtail the spread of HIV/AIDS among the youth. Senegal is reported to have successfully implemented a programme that encourages the use of condoms in unsafe sexual encounters (UNAIDS, 1998). South Africa, responding to rising infections among its teenagers, has several programmes such as *Lovelife*, targeting the youth (Warren, 2008). The programmes seek to provide teenagers with skills to be confident, assertive, ability to withstand negative peer pressure, and knowledge to deal with their sexuality. The programmes utilise the electronic and print media and involve perceived role models the youth can identify with to relay positive lifestyle messages. Some ethnic groups in South Africa are also reviving cultural practices such as virginity testing to ensure chastity among their youths. South Africa has since reported a drop in HIV/AIDS prevalence within the 15-24 year age group (UNAIDS, 2002, UNAIDS 2009).

It is clear that the HIV/AIDS epidemic creates equally devastating concomitant disasters in its wake. People in the prime of their lives are most affected. More people are becoming infected at an early age (Gayle, 2000). Its impact on the most productive age group, 15 – 49 years, weakens

the productive and reproductive potentials of countries' economies (Barnett & Whiteside, 1999; Setel, 1995; Whiteside & Sunter, 2000). The productive sector is losing skilled labour, and the ripple effects go on to affect many interlinked sectors. AIDS distorts the dependence ratio by narrowing the productive base. Other linked social and economic sectors are affected as well.

The greatest challenge confronting sub-Saharan Africa is that AIDS is largely a heterosexually transmitted disease and, as with all matters sexual, subject to myths, taboos, cultural stereotypes, and misunderstandings (Castaneda, Brindis & Camey, 2001; Gregson, *et al.*, 1996; Larson, 1990; Sanders & Sambo, 1992; Setel, 1995).

A deep understanding of the forces and factors promoting the spread of HIV/AIDS in sub-Saharan Africa will help create better-informed responses needed to tackle the epidemic (Green *et al.*, 2009). Whatever the responses are they have to deal with social and cultural institutions resistant to change. They need to challenge attitudes, behaviour, and beliefs systems surrounding the institution of sex, sexuality, and marriage. They also need to be cognisant of the hegemonic social systems such as patriarchy and masculinity that have historically predisposed women to male dominance. There are several over-arching issues, such as condom use and availability, treatment of STDs, reproductive health choices, and access to health infrastructure, that influence the magnitude of the HIV/AIDS epidemic and unless they are adequately addressed the disease will continue to spread in Africa.

Responses to the HIV/AIDS epidemic

The magnitude of the HIV/AIDS pandemic in sub-Saharan Africa requires just more than a country response. AIDS is no longer a particular country's sole responsibility. AIDS is a threat to humanity. It knows not national borders, respects no ethnicity, geo-locality, or social class. It transcends political conflicts and economic disparities. AIDS requires international, regional, and multi-sectored intervention and co-operation. The multi-lateral and bilateral agencies, non-governmental organisations, and civil society have to pool their resources and expertise for them to contain the epidemic.

Sub-Saharan countries do not have adequate financial and human resources needed to curtail the spread of HIV. Combined efforts are required at continental and regional economic and political levels. Bodies such as the African Union (AU), Southern African Development Community (SADC), Common Market for East and Southern Africa (COMESA), Economic Community for Africa (ECA), Economic Community for West African States (ECOWAS), and the New Economic Partnership for African Development (NEPAD) are platforms used to spearhead the fight against HIV/AIDS in Africa. Major funding of some of the initiatives is by international philanthropic organisations and overseas development assistance.

Multilateral initiatives on HIV/AIDS

The United Nations has responded to the HIV/AIDS pandemic by creating the Global Fund for AIDS, Malaria, and TB (GFAMT) as a means of harnessing resources and global efforts and policy in the fight against HIV/AIDS. The United Nations General Assembly's Special Session on HIV/AIDS (UNGASS) in June 2001 adopted the Declaration of Commitment on HIV/AIDS that commits world governments to time-bound targets. The Declaration adopted by 189 countries agreed to regional yardsticks in monitoring efforts to prevent and mitigate the spread and impact of HIV/AIDS (UNAIDS 2002). The United Nations (UN) pledged a total of US\$1.2 billion dollars to the Global Fund whose tripartite mission is to fight HIV/AIDS, malaria and tuberculosis (TB). This was in addition to the work UNAIDS does with individual countries' AIDS programmes and regional health bodies.

As a legacy of its predecessor, the World Health Organisation's Global Programme on AIDS (WHO/GPA), UNAIDS continues to put emphasis on condom use, monogamy, and early treatment of STDs as major strategies in curtailing the spread of HIV infection (Hudson, 1993; Mertens & Low-Beer, 1996). As much as it has managed to move away from the knowledge, attitude, beliefs and practice type of surveys that were the mainstay of GPA, UNAIDS still relies on reported national HIV prevalence and AIDS cases as indicators of the magnitude of the pandemic. Given the weak, but improving, national data management systems of most countries in sub-Saharan Africa these indicators tend to underestimate or overestimate the magnitude of the epidemic. In the late 90s UNAIDS had started working with national researchers to undertake representative population-based sero-surveys as a way of understanding the dynamics of HIV within general population other than antenatal clinic attendees and sexually transmitted disease patients (Carael *et al.*, 1999).

HIV/AIDS Treatment Issues

One of the biggest challenges facing the management of HIV and AIDS has been the slow rolling out and uptake of treatment, especially in sub-Saharan Africa due to a number of reasons ranging from poor diagnosis, poor health infrastructure, and unwillingness to be tested to the cost of treatment. For example, of the 400,000 people who were receiving treatment in 2003 only 50,000 were from Africa (Fleck, 2003). In the same year the World Health Organisation (WHO), alarmed by the slow pace in rolling out treatment, announced the target of putting at least 3 million people on treatment by 2005 (Kapp, 2003). This led to the launch of the 3 by 5 strategy. In 2004, the United States of America announced the Presidential Emergency Plan for AIDS Relief (PEPFAR), which committed funding to at least 15 countries for AIDS prevention and treatment programmes.

At the end of 2005 there were 1.3 million people worldwide receiving antiretroviral treatment. This was a relative success but far short of the 5 million-target set by the World Health Organisation (WHO). Encouraged by the relative success of the 3 by 5 strategy the WHO announced the Universal Access to Treatment programme. The aim of the programme was to put 80 percent of people in need of treatment in each country on a treatment programme by 2010. In 2006, 28 percent of people in need of treatment in the developing world were accessing it (Avert, 2010). At the end of 2009, four million people outside Western Europe were receiving treatment and a further 9.4 million were in urgent need of treatment. The Universal Access to Treatment is the Millennium Development Goal (MDG) #6 of the United Nations.

The progression of HIV/AIDS from a fatal disease to a clinically managed syndrome has created both hope and anguish for people living with HIV/AIDS worldwide. Hope in the sense that in high income countries individuals are able to access highly active antiretroviral therapy (HAART), also referred to as antiretrovirals (ARV), and anguish because, presently, few developing economies can afford to provide a sustainable HAART treatment without outside help. HAART are combination drugs that act against the ability of HIV to multiply within the infected human cells by weakening the virus' capacity to bind with new white blood cells enabling the body to maintain its immune system intact for a considerable period of time (WHO, 1998).

However, for people in the developing world the antiretroviral (ARV) drugs are still prohibitively expensive (Cohen, 2008) and at times inaccessible to those most in need who happens to be the poorest members of society. Western pharmaceutical countries that hold the patent rights to these drugs had for a long time insisted on brand market prices rather than offer them as subsidised generics. This made it impossible for countries that are signatories to the World Trade Organisation's (WTO) trade related aspects of intellectual property and patent rights (TRIPS)

agreements to break the HAART codes and manufacture generic copies of the drugs (SANASO, 2001). Countries have to wait for a mandatory twenty years before they can obtain the trade rights to break the patents rights of drugs registered under TRIPS. Brazil and India are two countries that do not recognize intellectual property rights and have been able to manufacture generic anti-retroviral drugs for use by their citizens at a much lower and affordable cost (Kiragu, 2001).

Developing countries, led by South Africa, had to resort to expensive and protracted lawsuits against international pharmaceuticals to force them to allow importation of generic anti-retroviral drugs (De Young, 2001). Some countries struck individual deals with the pharmaceuticals that allowed them to buy the drugs at cost (SANASO, 2001). Countries like Uganda, Costa Rica, and Thailand benefited from this scheme mainly with Zidovudine (AZT) and Nevirapine, drugs that prevent mother-to-child transmission (MTCT) of HIV.

Several initiatives, some outside the orbit of national governments and others in partnership with governments spearheaded treatment issues around the world. The charity Oxfam led a campaign asking WTO to change its patent rules that restrict access to life-saving drugs. Oxfam also urged pharmaceutical conglomerates to drop their lawsuits against countries such as Brazil that had made generic copies of AIDS drugs by breaking patent rights. Oxfam argued that HIV/AIDS was a national emergency and as such, countries could invoke constitutional provisions that allow them to bypass patent rules in cases of a national emergency. This was the argument South Africa used in its defence against a lawsuit by GlaxoSmithKline.

Medicins Sans Frontieres (Doctors without Borders, MSF) mobilized resources to offer AIDS drugs free of charge to ten nations as a pilot phase. It intended to roll out the programme as it acquired more resources. Some pharmaceutical companies agreed to offer their drugs to MSF at a cost as long as they were distributed for non-profit reasons. In the United States, Phyto-Riker announced the creation of \$250 million fund to buy and distribute AIDS drugs free of charge in Africa.

Civic society in South Africa led a concerted campaign against the government's position not to avail anti-retroviral drugs to people living with HIV/AIDS and to HIV positive pregnant mothers (Mitchell, 2001a; SANASO, 2001). The campaign was spearheaded by the Treatment Action Campaign (TAC), a non-profit organisation whose efforts to make treatment accessible to ordinary South Africans received worldwide recognition and support. South Africa eventually agreed to a programme that would make anti-retroviral drugs available to all in need (Balela, 2003). Botswana was, initially, the only African country to make anti-retroviral drugs available to all its citizens as part of the national health delivery system (Cohen, 2008; UNAIDS, 2002). Other governments in the region have incorporated anti-retroviral treatment into their national AIDS policies but are battling with poorly resourced programmes and health services.

Antiretroviral drugs require strict monitoring in order to check for drug resistance, compliance, and effective drug combinations. Setting up of facilities for such monitoring is a daunting task for most sub-Saharan African countries because of the non-existence of a functional public health sector system. The public health sector is usually understaffed, poorly resourced and suffering from chronic shortages of essential drugs (Airhihenbuwa, 1991; Sanders & Sambo, 1992).

Voluntary counselling and testing, and sexually transmitted diseases treatment

The issue of treatment is not just about availability of antiretroviral drugs and treatment of opportunistic infections. People need to have a willingness to know their HIV status and seek appropriate voluntary testing and counselling services (Zoysa, Phillips, Kamenga, O'Reilly, Sweat, White, Grinstead & Coates, 1995). The voluntary counselling and testing (VCT) facilities have to be in place and accessible to those in need of such service. Population Services International (PSI) and the United States Agency for International AID (USAID) have collaborated on a project that has seen the former working with national AIDS councils (NAC) or civic bodies to set up VCT centres in many urban parts of Africa. The aim is to make VCT centres part of the primary health care system.

Treatment of STDs is an integral component of HIV/AIDS prevention (Grosskurth *et al.*, 1995a; Grosskurth *et al.*, 1995b; Aral & Peterman, 1996; Gregson *et al.*, 1999). Syndromic management of ulcerative STDs is a central focus of STD treatment (Olenick, 2000). Health delivery services need to be set up where they do not exist and revamped in areas where they have fallen apart.

However, the biggest obstacle to treatment and voluntary counselling is the almost universal stigma and discrimination attached to AIDS (Maclean, 2004; Ray & Madzimbamuto, 2006; Regnerus & Salinas, 2007). Several studies have discussed the role of stigma in all its forms and the accompanying discrimination (Dlamini, Kohi, Uys, Phetlhu, Chirwa, Naidoo, Holzemer, Greeff & Makoae, 2007; Emler, 2007; Hartwig, Kissioki & Hartwig, 2006; Jewkes, 2006; Kalichman, Simbayi, Cain, Jooste, Skinner & Cherry, 2006). Commentators believe that stigma and discrimination of people living with HIV/AIDS is deeply rooted because of cultural practices (Mills, 2006) as well as a legacy of the misinformation that accompanied the early days of the HIV/AIDS epidemic (Avert, 2010).

Prevention of Mother-to-Child Transmission

Mother-to-child transmission (MTCT) of HIV in Africa is a major area of concern (Bulterys & Goedert, 1996). An estimated 15.7 million women between the sexually reproductive ages 15 to 49 years and 2.1 million children under 15 years worldwide were living with HIV/AIDS by December 2008 (UNAIDS, 2009). Estimation of the risk of peri-natal infection ranges, if not prevented, between 15 to 45 per cent, with the highest probability in sub-Saharan Africa (WHO, 1995). Mothers living with HIV infect their children during pregnancy, childbirth, or breastfeeding.

The discovery in 1999 of Nevirapine dramatically changed the course of mother-to-child transmission of HIV in the world. The World Health Organisation made the provision of a single dose of Nevirapine to pregnant women living with HIV and their newly born infants an integral component of antenatal care and primary health services in the developing world. This has drastically reduced the number of infants likely to acquire HIV infection from their mothers during birth.

The WHO issued a new set of treatment guidelines in 2006 recommending that pregnant mothers should also receive AZT at 28 weeks of pregnancy in addition to the single dose of Nevirapine during labour. In addition to the administration of AZT and Nevirapine, the WHO is promoting a tripartite programme aimed at preventing infection of young women, unintended pregnancies among people living with HIV/AIDS, and access to antiretrovirals as means to prevent peri-natal transmission (Kiragu, 2001).

Low levels of take up of voluntary counselling and testing services in sub-Saharan Africa remain a critical challenge to prevention-of-mother-to-child transmission (PMTCT). The WHO (2009) reported several challenges ranging from mothers not visiting antenatal care clinics during pregnancy; mothers not returning to health services to collect their results and getting the necessary preventive treatment, and the sheer lack of antenatal health services in some communities. In 2009, an estimated 64 percent of the 125 million pregnant women in low and middle-income countries did not receive an HIV test. This is a staggering challenge given the stranglehold HIV infection has in these regions. The developing world has to quadruple its current coverage in order to reach all pregnant mothers. Innovative approaches such as physician initiated testing need to be supported together with voluntary testing and counselling in the provision of PMTCT.

Prevention

The World Health Organisation (2003) affirmed that unsafe sex remains the key driver of HIV in Africa. This affirmation reminded the world community that in spite of exciting advances in the treatment and management of HIV, prevention of infection remained the cornerstone of global efforts to contain the epidemic. The prevention efforts have ranged from condom use, encouragement of sexual abstinence and monogamy to male circumcision. Recent evidence seems to suggest that central to the reported declines in HIV prevalence is the reduction of multiple sexual partners and early treatment of sexually transmitted diseases rather than condom use. As Green *et al.* (2009, p. 63) observe:

Ecological and associational evidence from generalized epidemics points to a consistent pattern of significant decline in the proportion of men and women who report having had more than one sex partner or one or more casual partners in the previous year, followed by population-level declines in HIV infection occurring three to five years later. No other behaviour changes for which we have data, including increased condom use, show this strong pattern of association across multiple generalized epidemics.

Green *et al.* (*ibid.*) note that:

Unfortunately for the progress of effective AIDS prevention, this striking pattern of declines in multiple sexual partnerships has often been overlooked; AIDS-prevention debates have focused on abstinence versus condom promotion among young people rather than on effective population-wide strategies.

The role of multiple and concurrent sexual partnerships in the transmission of HIV infection in East and southern Africa is compounded by the low male circumcision rates. The sexual behaviour of African populations is no different from that of populations in other parts of the world (Green *et al.*, 2009). However, the mixture of low rates of male circumcision plus multiplicity and concurrency of sexual partnerships have led to the implosion of the HIV epidemic in East and Southern Africa in comparison to other regions in sub-Saharan Africa (Weiss, 2008).

Conclusion

The chapter gave an overview of the global picture of the HIV/AIDS pandemic. International strategies and programmes put in place to address the problem were discussed. The issues involved in the fight against the pandemic are intricate and the limited synopsis provided is not exhaustive. The overview contextualizes the AIDS problem and the need for better-informed strategies in dealing with the pandemic at a global level.

CHAPTER 3

HIV/AIDS in ZIMBABWE

Zimbabwe is recognised as the first southern African country to report a substantial drop in HIV prevalence rate (UNAIDS, 2005; Gregson *et al.*, 2006; Mahomva *et al.*, 2006). Adult prevalence rates in Zimbabwe have declined from a high of almost 30 percent in the late 90s to the current 14.26 percent prevalence rate. Despite the declining HIV prevalence, Zimbabwe is still in the clutches of a deadly HIV epidemic. An estimated 1.3 million Zimbabweans were living with HIV/AIDS at the end of 2008 (UNAIDS, 2009). The chapter provides some insights into the HIV/AIDS epidemic in Zimbabwe. It looks into the national response with a view to understanding the course the HIV/AIDS epidemic has taken in Zimbabwe. It looks into the political economy, socio-economic, demographic, and cultural landscape of Zimbabwe in order to understand the AIDS crisis in Zimbabwe. An analysis of policy responses by Zimbabwe is given and the critical issues arising thereof.

The political economy of Zimbabwe

The 2002 national census put the population of Zimbabwe at about 12 million (CSO, 2003). Zimbabwe has a predominantly young population. Close to 43 percent of the population was below 15 years, while the 15-64 year age group constituted an estimated 53 percent of the population.

Figure 1: Map of Zimbabwe



Source: CIA Factbook, 2009

Zimbabwe is the land between the Zambezi river in the Northwest, the Limpopo river in the South, and Pungwe and Save rivers in the East. Its land area measures roughly 390 757 square kilometres and lies between latitudes 15° 30" and 22° 30" South of the Equator and between longitudes 25° and 33° 10" East of the Greenwich Meridian. Mozambique to the East, South Africa to the South, Botswana to the West and Zambia to the North and Northwest border it.

Zimbabwe is vastly savannah country and landlocked. The central part of Zimbabwe is the 650 kilometres long and 80 kilometres wide high plateau stretching almost the entire breadth of the country. It lies at an altitude between 1 200 and 1500 metres above sea level. On each side of the central plateau lies the middle veld with an altitude between 600 and 1200 metres above sea level. Beyond this lies the low veld whose altitude is below 600 metres above sea level. The mountainous region bordering Mozambique constitutes a fourth region known as the Eastern Highlands.

The Khoi-San (controversially referred to as the Bushmen, a term that will not be used in this thesis,) are believed to be the early inhabitants of present day Zimbabwe before the arrival of Bantu speaking people during the late 15th to early 16th centuries (Beach, 1980). The presence of rock paintings in the high veld plateau of Zimbabwe is testimony to these early inhabitants. The arrival of the Bantu speaking people who were farmers rather than food gatherers and hunters led to the forced migration of the Khoi-San people across the Limpopo River into modern day Botswana, Namibia, and South Africa (Beach, 1980; Bhila, 1982).

The Bantu people who settled in now Zimbabwe migrated in two waves. The one wave is believed to have come from the area that is present day Tanzania and the other wave came from the Central African region (presumably the Congo today) (Beach, 1980; Bhila, 1982). The Bantu people were empire building and dynastic and had paramount chieftainships. Several ethnic dynasties rose and fell and the most famous were the Mbire, Rozvi, Karanga, and Munhumutapa empires, not in this chronology though. These Bantu people, who came to be known as the *Shona* people (Holleman, 1969) because of their shared dialect, were famous miners (Bourdillon, 1987; Gelfand, 1973). They mined chrome, gold, and iron. Not only were they keen miners; they were also renowned for their pottery and architectural skills. The Great Zimbabwe ruins and many smaller ruins scattered all over present day Zimbabwe attest to this architectural skill. They were traders in ivory and precious metals. Several Arab and Portuguese traders stationed on the Indian Ocean coast visited the various dynastic kingdoms to trade (Beach, 1980; Bhila, 1982; Ranger, 1989).

The term *Shona* is believed to have been a derogatory term given to the tribes of the high veld plateau by the Nguni-speaking Ndebele people who settled in the southwestern parts of Zimbabwe (Holleman, 1969). The Ndebele people formed part of the great mfecane (literally, the great crushing, said to have been initiated by the revolt from Shaka's rule) of the Nguni speaking people who fled from Shaka's Zulu kingdom and migrated north across the Limpopo river to settle in present day Malawi, Mozambique, Tanzania and Zimbabwe in the mid 18th century (Jeater, 1993).

The white settlers shortly followed the coming of the Ndebele people into this region. Prior to their arrival white missionaries and hunters had made several forays into the country. The discovery of gold in Johannesburg's Witwatersrand in 1886 led to an influx of white men in search of mining concessions in South Africa. The pressures and tension created by this influx led the British South African Company (BSA Co.) led by Cecil John Rhodes to trek northwards of the Limpopo river in search of more mineral deposits. However, the land north of the Limpopo river did not yield gold deposits in similar quantities to the Witwatersrand but the soils

were rich and suitable for agricultural production. By 1890, the Great Trek north of the Limpopo river intensified and the BSA Company laid claim to Zimbabwe on behalf of the British Empire. The local Ndebele and *Shona* people led a protracted resistance to the settling of the white settlers. However, the Ndebele and *Shona* tribes were defeated by the military might of the BSA Company army. Imperial Britain entrusted the administration of the newly acquired land to the BSA Company. The land north of the Limpopo river and south of the Zambezi river became known as Rhodesia.

The BSA Company established towns, mining, agricultural and manufacturing industries (Jeater, 1993). The introduction of a wage economy, Western religion, and lifestyle transformed the social landscape of the indigenous people. Migration to the centres of economic activities intensified albeit ably assisted by forced labour and taxation laws put in place by the colonial administrators keen to break the simmering resistance to their rule and presence by the locals. The expansionist policies of the BSA Company led to the formation of the Federation of Northern, Southern Rhodesia and Nyasaland, that is, modern day Zambia, Zimbabwe and Malawi, respectively, in the early 1950s. The British Commonwealth oversaw the administration of these territories by appointing governors, and later Prime Ministers, to administer the day-to-day political affairs of the colonies.

The rise of nationalist politics saw the independence of Malawi in 1963, followed by Zambia in 1964. This effectively killed off the Federation. Ian Smith as leader of the Rhodesian Front led white Rhodesian settlers in a unilateral declaration of independence from the British government in 1965.

The internal political conflict in Rhodesia intensified and an armed struggle for independence ensued under two ethnically aligned liberation movements. The liberation movements were the Zimbabwe African National Union (ZANU) predominantly *Shona* and the Zimbabwe African People's Union (ZAPU) predominantly Ndebele. A thirteen year armed struggle ensued leading to the Lancaster House agreement of 1979 and Zimbabwe's independence in 1980.

Zimbabwe: socio-economic synopsis

At the attainment of independence massive donor aid poured into the country under the Zimbabwe Construction and Rural Development (ZIMCORD) programme of 1980. A national five-year development plan was created that set out national development targets. The government set about to improve the quality of life of the majority black people by constructing roads, clinics, dams, schools, literacy campaigns, water and sanitation programmes under the national "Equity in Health" strategy. The Plan sought to transform the colonial health system, which was largely curative to one that was primarily preventive.

The transformation of the health system was outlined in the "Zimbabwe Health for All Action Plan." The government undertook national immunisation campaigns to immunize all children from the five childhood killer diseases, namely tetanus, diphtheria, tuberculosis, polio, and whooping cough. Maternal and child health programmes were launched and Zimbabwe became a best practice case in the World Health Organisation's efforts to lower maternal, child mortality, and morbidity in developing countries. The government compiled an essential drugs list to assist in the acquisition, supply, and management of basic drugs. A functional health care system was set up. More than 85 percent of the country's population had access to clean potable water and improved sanitation (CSO, 1998a). Health became accessible and free to people below a particular wage income. Extensive programmes to control vector borne diseases were intensified. Education was universal and free and Zimbabwe enjoyed some of the best literacy rates in the developing world.

Most sectors of the economy recorded significant growth despite the socialist command economic policies pursued by the government from 1980 to 1989. However, by the early 90s the government, under immense pressure from the Bretton Woods institutions, reluctantly adopted a series of economic structural adjustment programmes to reinvigorate an economy that had begun to stagnate (Grant & Palmiere, 2003). The economic structural adjustment programmes, commonly referred to in Zimbabwe as ESAP, were a bitter pill to swallow for both the government and the people. As part of ESAP package government had to reduce its bureaucracy, reign in its expenditure, introduce market reforms, remove subsidies on basic commodities, allow market forces of supply and demand to determine prices, change its welfare approach by introducing hospital and school fees, and service its external debt as per agreed schedules (Bassett, Bijlmakers & Sanders, 1997). That this programme coincided with one of the worst droughts in Zimbabwean history did not help matters. Labour and students, after feeling the pinch of the economic reforms, protested and clashed with the government on several occasions. Social and political tensions rose to unprecedented levels. The government and the labour movement broke rank following critical policy differences. The economic meltdown in Zimbabwe worsened after the government decided to shelve the World Bank/IMF drawn economic recovery plan.

Shortages of basic commodities became commonplace as the country reeled from a political fallout following disputed parliamentary and presidential elections as well as a highly controversial land reform programme. Agriculture, which was the mainstay of the economy, greatly reduced its output due to disruptions from the land reform programme resulting in the folding up of many agro-businesses. The country fell behind in its foreign debt servicing making it almost impossible to make international borrowings or access the major international credit facilities.

The economic meltdown has negatively affected the livelihoods of ordinary Zimbabweans (Mutangadura, 2001). Survival has become a daily struggle for many families. By 2009, more than 75 percent of Zimbabweans were living in abject poverty (Nsingo, 2009). The economic hardships have increased the vulnerability of the poor and particular social groups in Zimbabwe. Women, the elderly, and children are the most affected given their already poor socio-economic status and vulnerability (Grant & Palmiere, 2003; Mutangadura, 2001). This is extremely tragic given the devastating HIV/AIDS epidemic ravaging the country. The twin impacts of poverty and HIV/AIDS in Zimbabwe led to an upward of mortality and morbidity indicators (Ministry of Health & Child Welfare, 1999; CIA Factbook, 2009; US Department of State, 2008).

Manicaland: the study area

Manicaland province is one of the ten provinces in Zimbabwe. It is the province on the eastern side of Zimbabwe bordering Mozambique. It derives its name from the *Manyika* people who were the dominant traditional settlers in this area. It is suggested that the *Manyika* people migrated into the present day *Manicaland* around 1 000 A.D. (Bhila, 1982). There are varying accounts of the origins of the *Manyika* people and their settling in eastern Zimbabwe (*ibid.*). The word *Manyika* is presumed to be of Portuguese origin. The *Manyika* people have been successively under the rule of the *Mutasa* dynasty. *Mutasa* is regarded as the paramount chief of the *Manyika* people. However, this fact is often times hotly disputed by some of the chiefs who are under the paramount authority of the *Mutasa* dynasty (personal communication with Chief SaMushonga in 1994). Bhila (1982) acknowledges the dispute.

A province is an administrative unit of the local government and is politically presided over by a Resident Minister, assisted by a provincial governor, who has the same official rank as a cabinet minister. A provincial administrator, who is the highest-ranking civil servant at the provincial

level, administers it. Each province is divided into smaller administrative units called districts. The district falls under the administrative authority of a district administrator who reports to the provincial administrator. The district is divided into smaller administrative units called wards under the leadership of a ward chairperson. A ward is usually made of five or six villages, the smallest administrative unit in the local government hierarchy. Each village is under the authority of a village chairperson. However, the system described here is a political one for there exists also a traditional system of government under the authority of traditional chiefs, headmen, and kraal-heads in rural Zimbabwe (Bhila, 1982).

The districts that comprise *Manicaland* province are Buhera, Chimanimani, Chipinge, Makoni, Mutare Urban, Mutare Rural, *Mutasa*, and Nyanga. Mutare city is the largest commercial city in the province. There are other small towns in the province namely, Nyanga, Rusape, and Chipinge. *Manicaland* province is the most populous of all the provinces in Zimbabwe (Central Statistical Office, 2003).

In terms of geography, *Manicaland* has one of the most diverse topography in Zimbabwe. Bhila (1982) gives a detailed description of the geography of *Mutasa* and *Honde* areas. It is home to the highest mountain in Zimbabwe, Mount Nyanga. *Manicaland* is home to some of the country's rain forests. It boasts of timber, tea, coffee, fruit growing and canning, and sugarcane industries. Tourism was one of *Manicaland's* fastest growing industries in the 80s and 90s.

The mushrooming of hotels, chalets, and tourism companies in the region in the 80s and early 90s bore witness to this growth. The diversity of *Manicaland's* economy has had a pull-push effect on labour from surrounding rural villages (Gregson *et al.*, 1995). Labour in this region is seasonal, circular, and oscillating. During peak labour demand periods, many of the able-bodied young men and women find employment on neighbouring commercial estates as fruit or tea pickers. At the end of the season, the migrant labourers return to their respective rural homes. The labour migratory cycle repeats itself every season. It is highly suspected that this migratory labour has been the conduit of HIV infection into the villages of rural Zimbabwe (Foster & Makufa, 1997; Gregson *et al.*, 1995; Gregson *et al.*, 1996, Gregson *et al.*, 1997). Lurie (2007) attests to similar HIV infection patterns between rural KwaZulu-Natal and the mining industry of the Witwatersrand.

The HIV/AIDS context in Zimbabwe

In 2009, one in ten adult Zimbabweans was infected with HIV. HIV made its way into Zimbabwe in the late 70s and early 80s. Since HIV is a silent epidemic, it was only in the mid-80s that it manifested as a serious public health and social problem in Zimbabwe. At the same time, HIV was acknowledged as a global problem that had gone beyond the gay communities in North America or the "prostitutes" of Kampala, Uganda (Treichler, 1999).

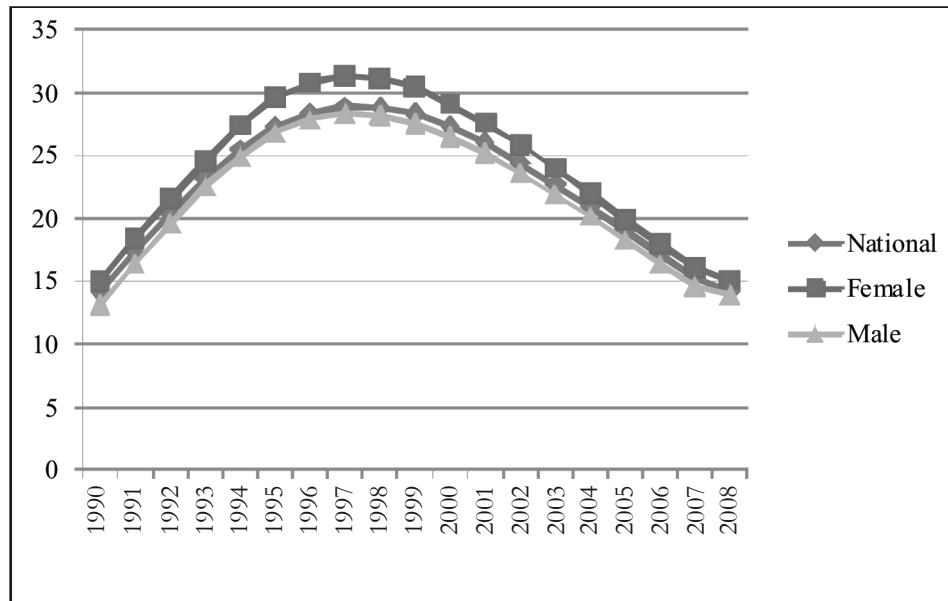
Before the recent declines the HIV/AIDS situation in Zimbabwe had been variously described as catastrophic (Pitts, 2001), genocidal (Marash, 2002), grim (White House, 1999), rampaging (UNAIDS, 2002), an emergency (ACTA, 2000), a pending major health, social and economic disaster (Benchmark Report, 1999), and a major threat to development and to human society (Piot cited in Beresford, 2001).

In 2002, the Zimbabwe government declared the HIV/AIDS epidemic a national emergency to underscore the gravity of the problem. By 2004, an estimated 1.8 million Zimbabweans were infected with HIV (NAC, 2004). Of that number an estimated 350 000 were in need of antiretroviral treatment. By 2007 slightly over 80 000 Zimbabweans were accessing antiretroviral treatment through the public health sector (NAC, 2007). Fifty-nine percent of all pregnant

mothers presenting at an antenatal facility in 2009 received drugs to prevent the transmission of HIV from the mother to the infant.

The adult national HIV prevalence in 2009 was 15.3 percent of the adult population aged 15 years and older (NAC, 2009). In a period of ten years, the HIV prevalence in Zimbabwe has declined by more than 50 percent from a high of 33.1 percent in the 1999 to the 2009 levels. In fact, the 2009 HIV prevalence levels have come down to the same level as twenty years ago (see Figure 2 below).

Figure 2: HIV Trends in Zimbabwe, 1990 - 2008



Source: National AIDS Council, 2009

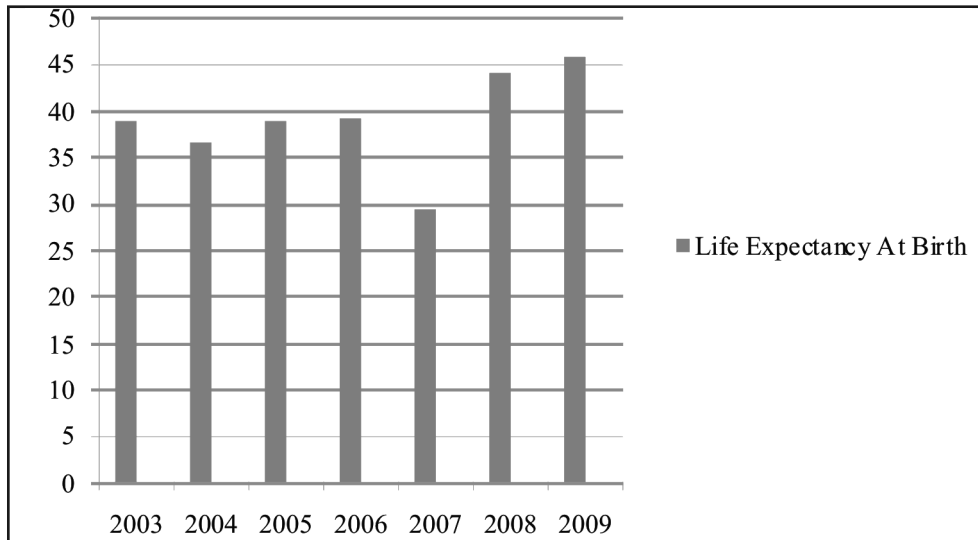
There are observable sex differentials in HIV prevalence in Zimbabwe with more women than men infected (Gregson, Nyamukapa & Mlilo, 2000; NAC, 2009; UNAIDS, 2008). The sex differentials have been the trend throughout the epidemic in Zimbabwe and the whole of sub-Saharan Africa. HIV infection patterns also peak differently in men and women. Ten years ago the HIV infection pattern showed the infection rates peaking in the 15 to 29 year age group for women (Gregson, *et al.*, 2000; Mutangadura, 2001; USAID, 2000), and in the 30-39 year age group for men (NACP, 1998). HIV infection levels in women in the 15-24 year age group were five times higher than in their male counterparts in the same age band (Gregson, *et al.*, 2000; USAID, 2000). Evidence from elsewhere in sub-Saharan Africa noted similar infection patterns (Gregson & Garnett, 2000, Hunter & Williamson, 1999; UNAIDS, 2002). The current infection patterns in Zimbabwe show the persistence of the trend. The National AIDS Commission (2006) reports that the ratio of young women (15-24 years) living with HIV was three times higher than that of males in the same age cohorts. Females between 15-19 years are especially more vulnerable. Mahomva *et al.* (2006) report similar findings. The possible reasons for this phenomenon will be discussed in Chapter 4. The epidemic in Zimbabwe is heterosexual. Vertical transmission of HIV is the major source of paediatric infections. Vital statistics estimate that about 3000 Zimbabweans were dying every week due to AIDS-related causes (NAC, 2009). That translated to roughly under five hundred Zimbabweans succumbing to AIDS-related causes everyday (see Table 2 below for some of the vital statistics for Zimbabwe).

Table 2: Vital Statistics for Zimbabwe, 1990, 2003-2008

Indicator	Vital Statistic
Under-5 mortality rank	38
Under-5 mortality rate, 1990	79
Under-5 mortality rate, 2008	96
Infant mortality rate (under 1), 1990	51
Infant mortality rate (under 1), 2008	62
Neonatal mortality rate, 2004	36
Total population (thousands), 2008	12463
Annual no. of births (thousands), 2008	378
Annual no. of under-5 deaths (thousands), 2008	36
GNI per capita (US\$), 2008	340
Life expectancy at birth (years), 2008	44
Total adult literacy rate (%), 2003–2008*	91
Primary school net enrolment/ attendance (%), 2003–2008*	88
% share of household income 2000–2007*, lowest 40%	13
% share of household income 2000–2007*, highest 20%	56
Estimated adult HIV prevalence rate (aged 15–49), 2007	15.3
Estimated number of people (all ages) living with HIV, 2007 (thousands), estimate	1300
Estimated number of people (all ages) living with HIV, 2007 (thousands), low estimate	1200
Estimated number of people (all ages) living with HIV, 2007 (thousands), high estimate	1400
Mother-to-child transmission, Estimated number of women (aged 15+) living with HIV, 2007 (thousands)	680
Paediatric infections, Estimated number of children (aged 0–14) living with HIV, 2007 (thousands)	120
Prevention among young people, HIV prevalence among young people (aged 15–24), 2007, male	2.9
Prevention among young people, HIV prevalence among young people (aged 15–24), 2007, female	7.7
Prevention among young people, % who have comprehensive knowledge of HIV, 2003–2008*, male	46
Prevention among young people, % who have comprehensive knowledge of HIV, 2003–2008*, female	44
Prevention among young people, % who used condom at last higher-risk sex, 2003–2008*, male	68
Prevention among young people, % who used condom at last higher-risk sex, 2003–2008*, female	42
Orphans, Children (aged 0–17) orphaned by AIDS, 2007, estimate (thousands)	1000
Orphans, Children (aged 0–17) orphaned due to all causes, 2007, estimate (thousands)	1300
Orphans, Orphan school attendance ratio, 2003–2008*	95
<i>Source: UNICEF, March 2010</i>	

Morbidity and mortality indicators for Zimbabwe have shown an upward trend in recent years, most of it attributable to the HIV/AIDS pandemic (CIA Factbook, 2009; Gregson *et al.*, 2007; Ray & Madzimbamuto, 2007; UNAIDS, 2008; UNICEF, 2009). Life expectancy in Zimbabwe fell from around 60 years in 1990 to about 46 years in 2009 (CIA Factbook, 2009). Figure 3 below shows the life expectancy trend for Zimbabwe for the period 2003 to 2009.

Figure 3: Zimbabwe's Life Expectancy at Birth, 2003 - 2009

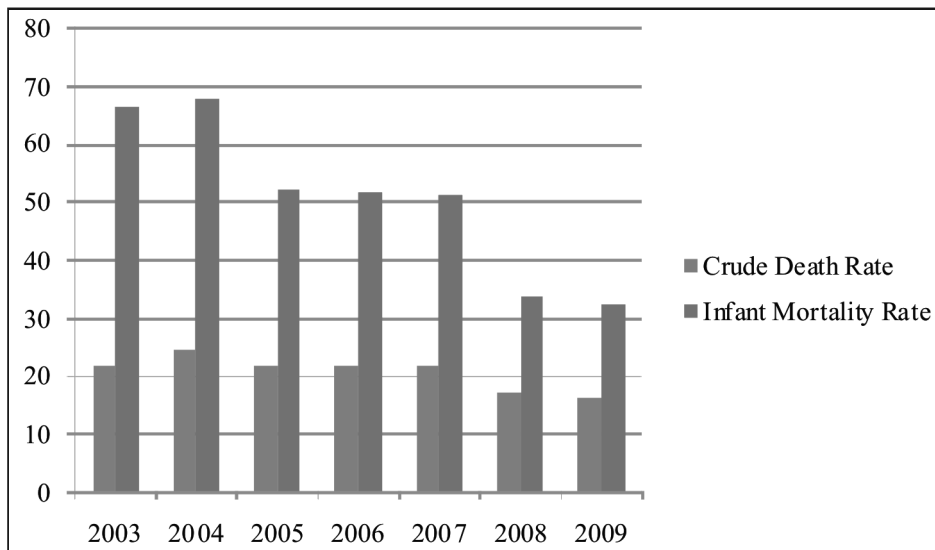


Source: *Indexmundi*, 2009

Estimates by USAID (2001) showed that the crude death rate in Zimbabwe was more than 200 per cent higher in 2005 than it was in 1990. In fact it is estimated that Zimbabwe's population decreased by four million between 2002 and 2006 (Avert, 2010). As Kerkhoven and Sendah (2000) observed, there had been a significant rise in "pauper burials" in Zimbabwe. The pauper burials, which the government discontinued owing to cost implications, amounted to over a 1 000 per week. Pauper burials are carried out by the State in the event of families failing to collect bodies from the mortuary for burial or to unidentified persons. To create space in mortuaries, a body not claimed within a set period is disposed off by the State through a pauper burial.

Figure 4 below shows the crude death and infant mortality rates for Zimbabwe for period 2003-2009.

Figure 4: Crude Death and Infant Mortality Rates for Zimbabwe, 2003 - 2009



Source: *Indexmundi*, 2009

One in four children in Zimbabwe is an orphan due to AIDS (NAC, 2009). By 2007 there were an estimated one million children orphaned by AIDS in Zimbabwe. Children orphaned by AIDS were the largest and fastest growing group of children in “difficult circumstances” in Zimbabwe (UNICEF, 1999). Approximately 8 percent of children below 15 years of age in the Zimbabwe had lost their mothers to AIDS by the end of 1996. Studies by Gregson *et al.* (1996, 2009) found that there were more paternal than there were maternal orphans in rural areas of Zimbabwe. Their explanation of this phenomenon was that male Zimbabweans were becoming infected much earlier than female Zimbabweans and succumbing to AIDS first resulting in more orphans that are paternal.

Zimbabwe’s response to the HIV/AIDS epidemic

Zimbabwe had a grudging acceptance of the HIV/AIDS epidemic (Kerkhoven & Sendah, 1999; Mutangadura, 2001; Zvinavashe, 1995). As a result its initial reaction to the epidemic was lukewarm and confused (Jackson, 1999), and reactive (Kerkhoven & Sendah, 1999). The official response in Zimbabwe was disbelief and denial that HIV/AIDS existed in Zimbabwe (Ray & Madzimbamuto, 2007). According to Ray and Madzimbamuto (2007), several reasons could have influenced the Zimbabwe government’s position. First, the belief that an admission to AIDS’ existence in Zimbabwe would negatively affect its booming and fragile tourism industry was real. It was believed that Western tourists would not want to travel to an AIDS-ravaged African country.

Not that such reasoning was illogical for indeed the Western media and early scientific thought pointed to Africa as the place of origin of HIV (Chirimuuta & Chirimuuta, 1987; Larson, 1990). People of African descent or Europeans who had had sexual contact with Africans were advised by their national health authorities not to donate blood to their national blood banks. The position of the United States of America against Haitian immigrants or that of South Africa against Malawian and Mozambican migrant workers reinforced the stereotyping (Avert, 2009; Chirwa, 1998). Africans were viewed as diseased and needing to be tested for the virus before embarking on long-term study in several Western countries. A number of Zimbabwean students in the former Soviet Union and Cuba were sent home after their blood samples tested positive for HIV antibodies (Ray & Madzimbamuto, 2007). The government responded by dismissing the editor-in-chief of the *Sunday Mail* newspaper who broke the news to the nation.

Second, initial medical information surrounding the disease was associated with prostitution and loose morality; the media wrote many poorly informed articles that vilified certain social groups and lifestyles and led to a lot of social stigma and discrimination (Larson, 1990; Sontag, 1989). HIV/AIDS became synonymous with promiscuity and death. It was a disease of homosexuals, prostitutes, and Western sex tourists. People were ashamed to come out and openly admit that they were living with the disease. Open admission to being infected risks social ostracism or even personal harm from ill-informed community members (e.g., the case of Gugu Dlamini in KwaMashu, KwaZulu-Natal, South Africa)².

The media in Zimbabwe fuelled initial misconceptions about the disease by misreporting the medical facts about the epidemic (Ray & Madzimbamuto, 2007). Some of the misconceptions persist to this day. Besides the late Vice-President Joshua Nkomo openly admitting that AIDS had affected some members of his family, no other prominent Zimbabwean public figure has openly admitted to living with HIV. Even if a prominent person is known to have died due to AIDS-related causes, the official government refrain is “the person died after a long illness”. Long illness has become a euphemism for HIV/AIDS in Zimbabwe.

² Gugu Dlamini was a South African AIDS activist who was murdered by community members after openly declaring her HIV status.

Third, an ill-prepared government was concerned by the wider social implications of the disease, as individuals were afraid to donate blood, share utensils, and public spaces. Everyone was in a state of panic. Nowhere was the panic better exemplified than in the medical and personal insurance industry in Zimbabwe. The insurance industry reacted with a whole lot of new regulations that sought to limit HIV positive people from accessing insurance benefits. However, these fears were later allayed as accurate information about the disease became available and people began to better understand it (Jackson, 1988).

Fourth, conspiracy theories regarding HIV/AIDS were swirling all over Zimbabwe and other countries of the developing world. AIDS was seen as a Western strategy to wipe off Africans or to discourage them from procreating (Treichler, 1999). Worse still some individuals even doubted the existence of HIV, the virus causing AIDS³. Fifth, a debate was going on in the medical fraternity on the proper diagnosis of AIDS. In 1987 the WHO came up with a clinical definition of an AIDS case that included both symptomatic and laboratory criteria. In 1993, the CDC further improved upon this definition by including several opportunistic infections, especially Kaposi sarcoma, and a CD4 count. African countries adopted a much more simplified case definition that relied more on clinical presentations than laboratory confirmation⁴.

Zimbabwe reluctantly admitted to the HIV/AIDS problem in 1986. In that year, it submitted its first AIDS statistics to the World Health Organisation. It reported only eight AIDS cases (Shea, 1996). This figure was met with disbelief within the health fraternity. In 1989, the country reported 1,311 AIDS cases to the World Health Organisation. However, most health workers met this with disbelief. Clinicians noted that they had attended to more AIDS cases than the reported figure.

It was difficult to collate HIV/AIDS statistics because AIDS was not a notifiable disease in Zimbabwe by then. An unofficial moratorium existed on the publication of AIDS figures. By 1994 Zimbabwe had reported 10,647 cumulative AIDS cases (CSO, 1998a). Disbelief greeted this figure once more. Under-reporting and poor surveillance of AIDS cases were suspected (Gregson *et al.*, 1996; Shea, 1996). The actual figure was expected to be ten times higher than the official figure. The National AIDS Control Programme admitted that the national surveillance system was not working well enough to capture the exact magnitude of the problem (Kerkhoven & Sendah, 1999).

The exponential growth of HIV prevalence in Zimbabwe continued despite an almost near-universal awareness of the disease (ZDHS, 1994). According to early projections of the HIV/AIDS epidemic in Zimbabwe, the national adult HIV prevalence was expected to level off at around 25 percent (NACP, 1998). However, by the late 90s the prevalence rate was as high as 30 percent of adults 15-49 years old surpassing the projected level by five percentage points. Even more worrying was that rural areas were beginning to record higher levels of infection compared to urban centres. According to Kerkhoven and Sendah (2000), this is due to the high levels of circulatory migration in Zimbabwe. There is constant movement of people from rural areas to urban areas and vice versa in Zimbabwe.

³ Nowhere is this amply highlighted as in South Africa where President Thabo Mbeki and a number of his ministers questioned the existence of HIV and its relationship with HIV.

⁴ There had to be at least two major and one minor sign for a clinical confirmation of an AIDS diagnosis. The major symptoms were 1) unexplained weight loss >10 per cent of total body weight, 2) chronic diarrhoea >1 month, 3) kaposi sarcoma, and 4) prolonged fever > 1 month. The minor signs were 1) persistent dry cough >1 month, recurrent herpes zoster, 3) disseminated herpes simplex, 4) generalized pruritic dermatitis, 5) oral candidiasis, and 6) generalised lymphadenopathy.

Projections of the impact of the epidemic on Zimbabwe painted a grimmer picture (NACP, 1998). Sexually transmitted diseases (STDs) continued to rise as well. They represented 5.9 percent of national outpatient health facilities attendance in 1996 (CSO, 1998a). The link between STDs and HIV infection is established (Cameron *et al.*, 1989; Cochran, Keidan & Kalechstein, 1990; Cohen, 1998; Eng & Butler, 1997; Gelmon & Piot, 1996; Green, 1994; Gregson *et al.*, 1999; Grosskurth *et al.*, 1995a; Grosskurth *et al.*, 1995b; Kreiss, Coombs *et al.*, 1992; Laga, 1993; Latif *et al.*, 1989; UNAIDS/WHO, 2000). The persistently high levels of STDs in the early years of the epidemic attested to the continued practice of unprotected sexual intercourse in Zimbabwe.

Tuberculosis (TB), a highly opportunistic disease manifest in most immuno-suppressed AIDS patients in Zimbabwe, was on the rise as well. Zimbabwe, besides endemic India, had one of the highest incidences of TB in the world, more than 500 cases per 100, 000 persons (Pitts, 2001). According to Kerkhoven and Sendah (2000), TB incidence rose from 60 to 299 cases per 100, 000 persons between 1982 and 1996. Given that most of the TB cases go unreported and at times undetected, the incidence of TB could even be higher than the reported rate. Other morbidity indicators also showed an upward trend. "Clinical malaria cases rose from 40.4/1 000 in 1982 to 139.9/1 000 in 1996" (Kerkhoven & Sendah, 1999, p. 14).

Zimbabwe's HIV/AIDS policy evolution

Given the early misinformed and stigmatising reactions to the epidemic, Zimbabwe's initial policy response was limited to fighting discrimination and protecting the privacy of people who were living with HIV/AIDS. However, the policy has gradually evolved into targeted programmes over the years.

The Zimbabwe government's early policy response to the HIV/AIDS epidemic was multi-faceted. They were 16 provisions in the policy response (NACP, 1998). First, the government encouraged a national multi-sectoral approach to tackling the epidemic. It called for political, social and economic resource mobilisation. It ensured that all sectors and organisations integrated HIV/AIDS into their planning. Second, the government encouraged all its citizens to go for voluntary testing and counselling and to disclose their HIV status to those who had reason to know. In this regard, it also encouraged openness about HIV/AIDS in order to reduce stigma and discrimination.

Third, the government emphasised the centrality of the marriage institution in the fight against HIV/AIDS. Fourth, the promotion of interventions that reduced sexual transmission of HIV, and ensuring the safety of blood and blood products through quality control and provision of appropriate health services.

Fifth, the policy aimed at delivering quality condoms that are affordable and easily accessible through multiple distribution channels. Sixth, the policy provided support to HIV-positive women to make informed decisions about pregnancy planning and reducing the risk of mother-to-child transmission of HIV. Seventh, the policy sought to strengthen the capacity of the health care delivery system through the provision of adequate resources and making essential drugs available. This included undertaking efforts to increase the accessibility of antiretrovirals and ensuring their safety and equitable management.

Eighth, the policy committed to the provision of community home-based care services to families and individuals living with HIV/AIDS. This included promoting orphan care within the community. Ninth, the policy sought to establish and provide voluntary counselling and testing services throughout Zimbabwe. The tenth provision of the policy was the safeguarding of the human rights of people with HIV/AIDS. This involved protecting them from discrimination by service providers such as insurance companies, employers, etc.

The eleventh provision of the policy encouraged partners to notify each other of their HIV sero-status to make joint informed decisions about prevention and their welfare. Twelfth, the policy sought to protect young children from sexual abuse as enshrined in the Charter on Children's Rights as well as by the Zimbabwean constitution. It also encouraged the adoption and fostering of orphans. Thirteenth, the passing of legislation to prosecute the wilful transmission of HIV and defining what is wilful transmission even in marriage.

Fourteenth, the policy recognised the role commercial sex work plays in the transmission, spread of HIV in Zimbabwe, and committed to finding appropriate ways to facilitate prevention efforts within the industry. This involved the use of peer education programmes. Fifteenth, the policy aimed at strengthening treatment of sexually transmitted disease services and utilisation of the syndromic management of sexually transmitted infections strategy. Sixteenth, the development and promotion of a national HIV/AIDS research agenda and action plan under the coordination of the National AIDS Council (NAC).

In 1987, the mushrooming of AIDS services in Zimbabwe led to the creation of the National AIDS Coordination Programme (NACP). The NACP was to serve as the official conduit for all HIV/AIDS related activities and information. In 1990, as part of its AIDS monitoring activities, the NACP set up HIV sentinel surveillance systems at selected antenatal clinics (ANC) and sexually transmitted diseases (STD) treatment facilities in order to monitor the spread of HIV infection among sexually active Zimbabweans. This involved anonymous, unlinked testing of blood drawn for syphilis serology. The surveillance involved testing of STD clinic attendees for HIV antibodies. Zimbabwe was one of the first countries in the world to screen blood donors for HIV antibodies through its WHO accredited national blood laboratory as early as 1985 (Gregson *et al.*, 1996). Data gathered from these surveillance systems informed government's policy response to the HIV/AIDS epidemic.

The Zimbabwe government drew up several short and medium-term plans to implement its national HIV/AIDS policy through the National AIDS Coordination Programme (NACP). Table 5 below shows the chronological development of Zimbabwe's AIDS policy response.

Table 3: Timeline of Zimbabwe's AIDS Policy

Year	Policy Initiative/Event
1983/4	First AIDS case identified in Zimbabwe
1985	Routine screening of blood for HIV at the national blood bank
1986	AIDS Advisory Committee (AAC) established
1987	AAC re-structured to form the Zimbabwe AIDS Health Expert Committee
	National AIDS Control Programme (NACP) established
	National AIDS Co-ordinator appointed
	Launch of NACP awareness campaigns
	NACP Emergency Short Term Plan launched
	AIDS declared a reportable disease
	Multi-sectoral National AIDS Council established
1988	Medium Term Plan 1 (1988-93) launched
1989	Zimbabwe AIDS Network initiated
1990	Appointment of new Minister of Health and Child Welfare who vows to make AIDS a national priority
1993	Medium Term Plan II launched
1998	Government introduces AIDS Levy
1999	National AIDS Council (NAC) in the Office of the Presidency created to oversee AIDS Levy
2000	Launch of National Strategic Framework, 2000-2004
	NAC becomes operational
	Formation of the decentralised AIDS structures (Provincial, District, Ward and Village AIDS Action Committees)
2001	Declaration of HIV/AIDS as a national emergency
2002	Launch of the Zimbabwe Business Council on AIDS
2004	First National HIV Conference
2005	Review of the Zimbabwe National Strategic Framework
2006	Zimbabwe National HIV and AIDS Strategic Plan 2006-2010
2007	Zimbabwe National HIV and AIDS Annual Plan
Source: <i>National AIDS Council, 2008</i>	

The initial plan was a short-term plan that operated from September 1987 to March 1988, followed by a medium-term plan from 1988 to 1993. The second medium-term plan started in 1993 until 1998. At the end of the second medium-term plan a national consultative review process was undertaken and input invited from various stakeholders and interested parties. The consultative process recommended a third medium-term plan. All the plans had specific mandates to implement and goals to achieve within their life cycle.

The initial short-term plan aimed at educating the nation about HIV/AIDS and raising awareness. In tandem with the “risky group” thinking that prevailed in the mid 1980s to early 1990s the government targeted its message towards perceived risk groups like commercial sex workers, uniformed forces, truck drivers, and STI patients. Its health promotion emphasized the benefits of partner reduction, treatment of STDs, and condom use using awareness campaigns.

The first medium term plan for HIV/AIDS focused its effort on setting up of programmes aimed at addressing specific needs such as enhancement of blood safety, counselling services, community home-based care programmes, and improving the diagnosis and treatment of STDs. The second medium-term plan aimed at consolidating the various targeted programmes initiated under the first medium-term plan. The third medium-plan looked into the topical issues of mother-to-child transmission, treatment and care, antiretrovirals as well as sustenance and evaluation of programmes initiated through the first and second medium-term plans.

In 1998, the Zimbabwe government introduced a national AIDS levy. The levy is a fund known as the National AIDS Trust Fund implemented by the national treasury and administered by the National AIDS Council (NAC), a statutory body created in 1999. The thinking behind the levy is that AIDS is a national emergency and therefore every Zimbabwean with a taxable income has to contribute towards the fund. The NAC funds directly the programmes of non-governmental and community-based organisations involved in HIV/AIDS activities. The motivation behind the policy response by the Zimbabwean government was to counter the enormity of the epidemic and its socio-economic implications across the whole gamut of Zimbabwean society (Jackson, 1999). This involved legislation to safeguard the human rights of people living with HIV/AIDS and those affected by the epidemic.

Until the recently reported HIV prevalence declines, it was very difficult to evaluate or measure the success rate of the national HIV/AIDS policy. The HIV prevalence rates remained stubbornly high throughout the 90s and early into the millennium. In terms of raising awareness around the HIV/AIDS pandemic, the Zimbabwe government had done remarkably well. Surveys in the early and late 1990s reported consistently high levels, more than 90 percent, of HIV/AIDS awareness (Kerkhoven & Sendah, 1999; Kim *et al.*, 2001). Condoms were available in more than 88 percent of designated dispensing points (Adetunji, 2001). The female condom was successfully launched (Ray & Bassett, 1995).

Less than ten percent of women who had a regular partner reportedly used condoms consistently despite the high level of awareness and condom availability, (Adetunji, 2000; Kerkhoven & Sendah, 1999; Marash, 2000). The reality is that the underlying social, economic and cultural dynamics which act as the proximate determinants of HIV infection (Boerma *et al.*, 2003) have remained largely unchanged and unaffected by the health promotion strategies in place hence the need to look into the social and cultural issues facilitating the rapid transmission of HIV in Zimbabwe.

Socio-economic challenges to HIV/AIDS policy responses

Early in the millennium the southern African region faced severe shortages of food due to famine (UNAIDS, 2002). The famine threatened about six million Zimbabweans (WFP, 2002). There were chronic shortages of all basic foodstuffs (*ibid.*). Some families reportedly went without a meal for days (Financial Gazette, 2002). Coupled with HIV/AIDS infection, a starving, immuno-suppressed Zimbabwean had very limited chances of survival. The HIV epidemic was intimately connected to the poverty of the country as well (Pitts, 2001). Basic drugs were in short supply. Compliance with treatment was minimal, as patients reportedly did not want to take medication on an empty stomach (*ibid.*). This further created a problem of drug resistance and poor patient treatment outcome.

Families are disintegrating as poverty and HIV/AIDS increases the social vulnerability of poor Zimbabwean families. An indicator of this phenomenon is the ever-increasing number of children living on the streets, commonly referred to “street kids”, in Zimbabwe. The emergence

of street children is testimony to the collapse of the social institutions that are supposed to cushion children in need of support and security. Many of the glue-sniffing children living on the streets of most towns in Zimbabwe will end up being victims of abuse themselves. Local media has reported on cases of sexual abuse of children living on the streets (Mutangadura, 2001; Nzenza-Shand, 2002).

Zimbabwe has had to confront a number of severe crises in the past few years, including an unprecedented rise in inflation (in January 2008 it reached 100,000%), a severe cholera epidemic, high rates of unemployment, political violence, and a near-total collapse of the health system (Avert, 2010). The collapse of the Zimbabwe economy and the resultant runaway inflation and job losses brought serious hardships to the livelihoods of many Zimbabweans. The concomitant political meltdown of the country did not help the situation either. An estimated three million Zimbabweans have left the country to live in neighbouring countries or abroad because of the economic and political meltdown. Ray and Madzimbamuto (2007, p. 229) describe the economic and political situation as follows:

The economic crisis in Zimbabwe, as well as the collapse of the health services, has worsened the impact of poverty on the HIV epidemic. Childhood and maternal mortality are soaring as infectious diseases go untreated and immune systems are weakened by poor nutrition. Loss of livelihoods means loss of means to pay for basic medications such as antibiotics or pain relief.

The economic meltdown and near collapse of the public health system has given rise to endemic corruption and soliciting of bribes has brought untold suffering to patients and families trying to access treatment through the public health system. The dollarization of the Zimbabwe economy has added an extra dimension of hardship in a country where an estimated 68 percent of the economically active population is unemployed. Avert (2010, unpagged) remarks:

The increasing cost of antiretrovirals has led to a number of problems, such as the selling of fake drugs at flea markets. An article published in 2006 even reported that government officials who were HIV positive had been given priority access to the drugs. While doing so, they had intercepted drugs meant for public hospitals for their own use. More recently, there has also been the severe threat brought about by interruptions of regular supplies of ARVs. Reports of breakdowns in drug delivery and theft of drugs by government officials, as well as physicians switching patients on established regimens due to lack of drug availability could all lead to drug resistant HIV strains developing.

The political and economic situation in Zimbabwe between the mid-90s and late 00s was so dire that when Zimbabwe reported declines in national HIV prevalence rate (Gregson *et al.*, 2006; Mahomva *et al.*, 2006; UNAIDS, 2005) it was met with initial scepticism and disbelief. It seemed improbable that a country in the grip of unprecedented economic and political upheaval could record declines in the national adult HIV prevalence rate. Zimbabwe insists that the decline is due to sexual behaviour change and increased condom use, especially among young adults 15-29 years. These Zimbabwe Demographic Health Survey (ZDHS) of 2005-6 corroborates this observation. The ZDHS (2005-2006) reports increased condom use with non-regular sexual partner and a reduction in the number of sex partners among young adults as well as delayed sexual debut. These findings seemingly rebut any suggestion that the HIV declines in Zimbabwe are due to the natural course of the epidemic. However, commentators on Zimbabwe's HIV epidemic call for the exercise of caution when interpreting the cause of HIV declines in Zimbabwe. Mahomva *et al.* (2006, p i46) caution:

The sexual behaviour data must be interpreted with caution because these data were subject to various biases. Sexual activity may be underreported. This is seen from the HIV prevalence of 8.3 % and 2.5% among 15-24 year old females and males, respectively, who reported in the YAS (Young Adults Survey) that they had never had sex.

Intriguingly, the reasons offered for the decline of the epidemic in Zimbabwe seem not to have had a similar impact on Botswana, a country with one of the highest HIV prevalence rates in southern Africa as observed by Cohen (2008, p 529):

Botswana has encouraged people to have fewer partners, delay the age of first sex, increase their condom use, and adopt other behavioral changes, but none has made dramatic progress.

There are other possible underlying factors driving the epidemic differently in Botswana and Zimbabwe. On all probability, Botswana should present better programmatic outcomes than Zimbabwe given its huge investment into national HIV and AIDS programme.

Sexual behaviour is the key to understanding the epidemic spread of HIV in sub-Saharan Africa, especially in southern Africa. Multiple and concurrent partnerships have been singled out as the major behaviours driving the HIV epidemic in sub-Saharan Africa (Green *et al.*, 2009; Nshindano & Maharaj, 2008). However, Green *et al.* (2009, p. 64) remark:

The number of sex partners alone does not account sufficiently for epidemic dynamics and differences among epidemics. One hypothesis is that biological factors may account for some of the striking differences observed in HIV prevalence around the globe.

Green *et al.* (*ibid.*) back up their hypothesis by observing that:

Most surveys conducted in sub-Saharan Africa have not shown that individuals in these populations have more sex partners than do those in populations in other regions of the world...Other aspects of partnership dynamics may be critical, such as types of sex partnerships. The high-prevalence generalized epidemics seen primarily in East and Southern Africa differ from other epidemics of sexually transmitted HIV in their high rates of multiple and concurrent sexual partnerships.

Green and colleagues believe that the high rates of multiple and concurrent sexual partnerships coupled with negligible male circumcision rates in Southern Africa explain the explosion of HIV in this region. They reinforce their argument by arguing that similar sexual behaviours are observed in West Africa as in Southern Africa but that the epidemic in West Africa has been held back by the high rates of male circumcision in the region. However, both Botswana and Zimbabwe have negligible male circumcision rates yet the epidemic has recently presented differently in the two countries. There are still some unknowns in the evolution of the epidemic and the factors fuelling it. Hayes and Weiss (2006, p. 621) further caution that:

There is growing concern that, even in countries where HIV prevalence has declined, risky patterns of sexual behaviour may be increasing again, and there is an urgent need to revitalize prevention efforts to avoid resurgences of the epidemic.

Mahomva *et al.* (2009 p. i46) commenting on Zimbabwe note that:

Despite the decline in HIV prevalence, Zimbabwe continues to have one of the highest HIV prevalence in the world. Continual investment of technical and financial resources to maintain and build the public health infrastructure in Zimbabwe will help build our existing data sources, improve our ability to monitor trends in the HIV epidemic, and provide insights into how to strengthen and target the next generation of interventions.

The high levels of HIV incidence and prevalence in Zimbabwe and elsewhere in Africa attest to the importance of HIV prevention as “a key priority for international public health” (Hayes & Weiss, 2006 p.621).

Conclusion

The recent declines in HIV prevalence in Zimbabwe have given hope that some of the prevention messages were reaching home. The epidemic still remains generalised and at high levels in Zimbabwe. The reported changes in sexual behaviour in Zimbabwe have raised hope that despite official hesitancy, economic and political turmoil, the right prevention messages and programmes can bring the desired changes in lowering the incidence of the epidemic. The reported reductions in sexual partners in a region where multiple and concurrent partnerships are widespread is a critical development in building solid prevention programmes to address HIV infection. However, challenges remain in ensuring that the noted declines in HIV prevalence in Zimbabwe are not reversed.



CHAPTER 4

CULTURE and SEXUALITY

Introduction

Despite noted declines in HIV prevalence in some countries Africa still bears a disproportionate HIV burden worldwide. Africa accounts for an estimated 67 percent of people living with HIV in the entire world (UNAIDS, 2008). The number of new infections continues to outstrip the number of people put on HIV treatment worldwide (Shelton, 2007). The raging HIV epidemic is mainly concentrated in East and southern Africa which is “home to less to less than 2 percent of the global population but at least one-third of all HIV-infected people. Infection rates among adults in South Africa, Swaziland, Botswana and western Kenya range from 20% to at least 30%, roughly an order of magnitude higher than anywhere else in the world, outside of Africa” (Halperin & Epstein, 2007, p. 19). This statistic is worrisome when put into comparison with the concentrated epidemics of the West, where for example, the HIV infection rate in the United States has never exceeded one percent (Sanders, 2008).

The HIV epidemics in east and Southern Africa are unique. They are unique in terms of their mode of transmission and severity. The epidemics are highly generalised and largely heterosexual. These are sub-Saharan regions where the spread of HIV is not strongly associated with risky sexual behaviour in select population groups but to the general population. Halperin and Epstein (2007, p. 19) note that:

The highly generalised HIV epidemic in southern and east Africa is uniquely severe. Elsewhere, HIV transmission continues to be strongly associated with especially high-risk activities, namely use of injectable drugs, male-to-male anal sex, and sex work, and the most effective means of prevention are now generally recognised. Although HIV has been present for nearly two decades in much of Asia, Latin America and Eastern Europe, extensive heterosexual spread has seldom occurred in those regions. While there is concern over the possibility that it could occur, for the foreseeable future southern Africa will certainly remain by far the most severely affected region of the global pandemic.

Zimbabwe has recently recorded declines in HIV prevalence rates. The HIV declines in Zimbabwe are attributed to changes in sexual behaviour. Three key behaviours, namely delay of sexual debut, reductions in non-regular sexual partners and increased condom use with non-regular partners have been isolated in explaining the decline in HIV prevalence in Zimbabwe (Gregson et al, 2006). Not clear are the factors that have triggered the observed sexual behaviour change in Zimbabwe (Avert, 2009). Several factors have been suggested as possible reasons for the declines in HIV prevalence in some countries in Africa. Foremost is the epidemiological argument that the HIV declines are a natural course of the HIV epidemic where its infectivity intensity weakens over time (Parkhurst, 2002; Brody, 1996; Richens, Imrie & Copas, 2000).

As we attempt to understand the complexities of the Zimbabwean culture, we firstly need to define exactly what it is we mean by “culture”, especially the notion of a Zimbabwean culture. We also need to disengage ourselves from umbrella definitions of “African” culture. The African culture, as we know it, has been an evolution of contestable anthropological and political definitions couched in binary racial undertones of savage versus civilised, dark versus enlightened, developed versus underdeveloped, white versus black and immoral versus chaste, etc. This leads one to ask if indeed there is a universal African culture.

Defining Culture

Culture has been defined variously as a way of life (Wiredu, 1991 in Verhoeff & Michel, 1997; Myers, 1993), the meanings which people create, and which create people, as members of societies (Hannerz, 1992). Goodenough (quoted in Geertz, 1971, p.11) says culture “consists of whatever it is one has to know or believes in order to operate in a manner acceptable to its members”. In this regard, culture is akin to propaganda. The cultural propaganda makes individuals belong to a certain social group without seeking to question why they do so. Geertz (1971, p. 5) argues that the concept of culture is semiotic, since

...man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental [process] in search of laws but an interpretive one in search of meaning.

Geertz's (1971) analysis of culture implies that it is not a static but dynamic force. It is constantly in a state of flux shedding of redundant aspects and acquiring new ones in order to compete for survival in an ever-changing social environment. In other words, there is constant dialogue between meaning and action. The actions members of a particular culture engage in are given legitimacy or logical reason by meanings in place to justify those actions. Culture is therefore the energising force that drives a group of people sharing common beliefs, meanings and space (not always spatial). Westen (1985, p. 219) states that “two structures, *culture real* and *culture ideal*, form that which, along with an integrating function between the two, will be considered culture” (Emphasis original).

Culture *real* provides an emic (reference values) image of reality (maintains social homeostasis), whilst the culture *ideal* refers to the actual (etic) goal ranges which reference values should ideally, but frequently do not, approximate (Westen, 1985, p. 220). This analysis conveys an image of a constant balancing act between the emic and the etic resulting in social equilibrium. Individuals have to keep referencing their personal goals and lifestyle to the shared common values and those who transgress are dealt with in a manner that seeks to enhance the social equilibrium. Society approves or disapproves actions that it construes as enhancing or threatening maintenance of balance and order.

Therefore, people who share an ethnic identity and geographic space can describe Zimbabwean culture as tacitly agreed upon customs and norms. These agreed upon norms and culture prescribes a national identity. Zimbabweans identify themselves as such because they share an ethnic, geographic, and national identity. This identity relates to language, customs, beliefs, and social organisation. However, one has to caution against an implicit assumption that these norms and rules are universally agreed upon. Tensions exist in cultural norms, as culture itself is a contestable terrain.

Human sexuality and (sexual) behaviour, which permeate all aspects of social life and the HIV/AIDS problem, need to be understood by those concerned with the fight against HIV/AIDS. The complexity of defining culture is amplified when one has to define sexual culture and sexuality. Parker *et al.* (1991, cited in Taylor, 1998, p.79) define sexual culture as “the system of meaning, of knowledge, beliefs and practices, that structure sexuality in different contexts.”

Lear (1997) notes that the study of human sexuality is not only problematic in terms of its inaccessibility but also because of the gendered meanings, expectations, and social class surrounding human sexuality. Human sexuality is complex. Human sexuality is expressed in several divergent forms with a variety of meanings and so are the sexual relationships that people

form. Sexual desire is often described as instinctual, a drive which humans share with other animals.

Human sexual behaviour has been explained in terms of evolutionary processes. Proponents of this view argue that “male promiscuity” and female monogamy are the direct consequence of conflicting evolutionary strategies: for men, to sow their seeds as widely as possible; for women to select the mate with the best genes and the most to invest in offspring (Willig, 1998). Preferences for quantity (for men) versus quality (for women) of sexual encounters are conceptualised as psychological adaptations to the pressures of natural selection that are different for women, who can only have a limited number of children in their lifetime, and men, whose reproductive potential is much larger.

In the classical argument of socio-biology, sexual behaviour and the emotions associated with it such as love and passion are often contrasted with rationality and forward planning (Clark, 1990; Clark & Hatfield, 1989; Gupta, 2000). However, how much of this sexual construction is a Western European artefact? Does the framing of sex and sexual relations in this way explain sexuality in sub-Saharan Africa or Zimbabwe? The heterogeneity of African society implies heterogeneity of sexual forms of expression that defy a bipolar categorisation and analysis.

Meanings constructed around sexual activity can vary both within similar cultural and geographic groups (Bauni, 1990; Willig, 1998). Such constructions have implications for sexual behaviour. Discourse legitimises or privileges particular practices and individuals are positioned differently by different constructions. As Dowsett (2003) observes there are dominant notions attached to sexuality. These are notions of sex hierarchy, male virility, and power. Dowsett further argues that normative conceptions of male sexuality portray it as unrestrained and uncontrollable. “Real” sex is penile-vaginal penetrative intercourse and other sex acts are not sex and are unnatural (Epprecht, 1998). Furthermore, certain sexual acts place a man in a more powerful position vis-à-vis a woman.

The dominant discourses and notions surrounding sex are problematic in that they are not context free. The context itself assumes a multiplicity of forms, social, cultural, economic, and even political. The context either empowers or disempowers particular sexual acts, for example, the insistence by some Zimbabwean men on “dry sex” despite the negative health consequences associated with it, such as tearing and bruising (Bagnol & Mariano, 2008; Pitts, Runganga, & McMaster, 1994; Runganga, Pitts & McMaster, 1992, Wijgert, *et al.*, 2001). What makes some men insist on having unprotected penetrative sex even if they are well aware of the likelihood of contracting a sexually transmitted infection? Why do some women engage in vaginal drying and douching when it makes sexual intercourse painful? Holland *et al.* (1991) observed that a woman’s request for condom use during sex could constitute a challenge to dominant constructions of heterosexual activity.

According to Connell (1995), the dominant discourse of hetero-sex sees the male as aggressive and dominant; the first to make indications towards sex, and the female is seen as passive and receptive. Male sex drive is spontaneous and inexorably driven by primitive biological urges. A woman is held responsible for deciding how far things will go and for contraception (Gilligan, 1992). There is a rational need to understand how people construct risky sexual behaviour and negotiate safer sexual relationships.

The complexity of human sexuality adds to the complexity of trying to come to terms with the HIV/AIDS pandemic. The complexity is accentuated when sexual behaviour is labelled as risky or non-risky. Different kinds of unions, with their associated obligations and expectations for partners and their families, affect the range of sexual behaviours that occur before and outside

the union, elements that are important for understanding sexual behaviour overall and the transmission of HIV (Carael & Cleland, 1994).

The variable social and historical contexts of risk behaviour contribute to the difficulty of predicting human sexuality and disease transmission. For instance, how does one analyse African sexuality given the cultural and ritual diversity accompanying sex in sub-Saharan Africa? When African sexuality is examined should it be done outside the influence it has had from contact with other cultures? In other words, is there such a thing as an African sexuality? These are all questions we need to provide answers to for us to better understand the HIV/AIDS pandemic and develop better and effective prevention strategies.

HIV/AIDS and the African Sexuality Theory

The late 80s gave rise to a school of thought that there is a distinct African sexuality as evidenced by the predominantly heterosexual spread of HIV infection in sub-Saharan Africa. Unsafe heterosexual sex is the major route of HIV infection in sub-Saharan Africa. More than ninety-five percent of adult HIV infections in Africa are a result of unprotected sex, predominantly heterosexual sex (UNAIDS, 2002). This raises serious questions about the nature of sexual activity and sexual relations in sub-Saharan Africa.

Caldwell, Caldwell and Quiggan (1989) suggest that the HIV infection patterns in Africa are reflective of the African social and cultural system(s). They argue that anthropologic and ethnographic studies done in West Africa indicate extensive sexual networking among the people. They argue that despite missionary and colonial attempts to “civilise” or more specifically, westernise Africa, sexuality has remained largely cocooned in traditional norms and “permissive”. In support of their theory they cite evidence of women “selling sex” at trade markets, women marrying off at very young ages, and sex outside the marriage union as being the norm, and the laxity surrounding illegitimacy of children in African societies (Hunter, 2002).

Caldwell *et al.* (1989) further argue that Africans have a distinct sexuality that can be contrasted to the Eurasian model of industrialised Western and Eastern societies. Sexual networking is very pervasive and uninhibited in sub-Saharan Africa. Sexual networking is the indulgence in sexual relations amongst people who are connected either by kinship (a cultural taboo in many communities in Africa), communal or social bonds. Caldwell *et al.* argue that their experience in Nigeria and most West African societies indicated an ever-expanding sexual network and this was the likely determinant of the rapid spread of sexually transmitted diseases and HIV within these societies. Alluding to anthropological literature from elsewhere in Africa, Caldwell and his team conclude that other African societies outside West Africa have similar sexual networking patterns.

They also review demographic data to ‘prove’ that the high prevalence of infertility in many East and Central African women can be linked to the high incidence of untreated STDs which result in infertility. Since HIV is a sexually transmitted disease they conclude that a high prevalence of STDs naturally explain the high prevalence of HIV in the region. Leaning towards the sensationalised “high-risk” group theory, they argue that prostitution was widespread in Africa because African female sexuality was blatantly free and devoid of moral responsibility. Women could “sell their bodies” and engage freely in sex without drawing the kind of social disapproval it would elicit in Western society. Later studies would reveal that pervasive male circumcision might have possibly prevented West Africa from experiencing explosive epidemics as those witnessed in Southern Africa (Brewer, Brody, Drucker, Gisselquist, Minkin, Potterat, Rotherberg & Vachon, 2003; Green, Mah, Ruark & Hearst, 2009; Halperin & Epstein, 2007; Potts, Halperin, Kirby, Swindler, Marseille, Klausner, Hearst, Wamai, Kahn & Walsh, 2008).

Reviews of early anthropological monographs by Setel (1995) and Bauni (1990) on African culture seem to support the Caldwell analysis of African sexuality. An extensive review of anthropological and demographic literature on sexual behaviour and sexuality in Africa by Bakilana (2000) revealed several interesting findings. She found out that there was demographic evidence showing that premarital fertility was on the increase in many African communities. Early initiation of sexual activity, early onset of menarche and long periods of adolescence were some of the reasons given for this fertility trend. Bakilana (2000) citing data on sexual practices of various traditional African communities, pointed out the variability of sexual practices within sub-Saharan Africa. Different traditional African societies had different ways of proscribing sexual activity. For example, the *Maasai* encourages early sexual activity among girls but this is done according to strictly observed age-set rules. Even early *Nguni* speaking tribes, though encouraging strict chastity before marriage, allowed boys and girls to simulate non-penetrative sex with each other, a practice known as *ukusoma* (thigh sex) (Buthelezi, 2006; Xaba, Kunene & Harrison, 2000).

Demographers and anthropologists argue that the high levels of mortality and the need to propagate the clan meant that most traditional African societies encouraged early onset of sexual activity and marriage (Bakilana, 2000; Bauni, 1990). This was done purely for survival reasons rather than sexual promiscuity (Ahlberg, 1994). It was an adaptive response to historical and environmental needs presenting themselves in the given period.

Several scholars have reacted to Caldwell *et al.*' (1989) theory of African sexuality (Ahlberg, 1994; Bakilana, 2000; Chirwa, 1998; Heald, 1995; Le Blanc, Meintel & Piche, 1991; Setel, 1995). They argue that Caldwell *et al.* model judge African sexuality and culture from a Eurocentric perspective. African sexuality has been a victim of uncontested Western stereotypes (Gesheker, 1999). The stereotypic accounts surrounding African sexuality are exemplified by anecdotal and impressionistic evidence such as preference for dry sex by certain African males, uninhibited sexual cravings, and so forth (Kalipeni & Opong, 1999; Mrwebe, 1996; Pickering, Okongo, Nnalusiba, Bwanka & Whitworth, 1997).

Gesheker (*ibid.*) argues, however, that such insinuation about African sexuality remains analytically useless for a continent as diverse as Africa. He criticizes the narrowness of the Victorian Judeo-Christian culture of the West for its shortsightedness and eccentric view of other cultures. The Judeo-Christian view claims that Africans do not conceptualise sex, love and disease the same way as the Western civilisation. "Thus, AIDS 'educators' counter 'shame' in African sexuality through conservative appeals to restraint, empowerment, negotiating safe sex and a near evangelical insistence on condom use" (Gesheker, 1999, p. 4).

Historically, Africans were viewed as irrational, uninhibited, and indulging in sexual excess. Early travellers' accounts regaled people in Europe with accounts of primitive and savage males of the 'dark African continent' performing "carnal feats with unbridled athleticism, with black women who were themselves sexually insatiable" (Gesheker, 1999, p. 4). These Victorian misconceptions of African sexuality still find their way indirectly into public health discourse on the impact of the HIV/AIDS epidemic in Africa. As much as there is no empirical evidence to back up the view that the African male indulges in multi-partner sexual escapades no more than his European counterpart, the misconception somehow still persists (Advocates for Youth, 2008). It has become a self-perpetuating myth in the lexicon of public health discourse. Querying the so-called early AIDS belt -- Rwanda, Uganda, Kenya, Zaire (DR Congo), Malawi, and Zambia-- Gesheker (1999) questioned whether men in this region were more sexually active than men in Cameroon, Ghana, Nigeria and Liberia, countries with huge populations but very low reported AIDS cases. This very West African region led Caldwell *et al.* (1989) to conclude

that the Africans had a very distinct sexuality that was different from the Eurasian one. The root of this sexual stereotype most likely lie in the trans-national application of public health disease prevention models that are not culturally sensitivity and relevant for outside cultures other than the one it was developed for. Gesheker (1999, p. 4) remarks:

They assume that AIDS cases in Africa are driven by a sexual promiscuity similar to what produced – in combination with recreational drugs, sexual stimulants, venereal disease, and the over-use of antibiotics – the early epidemic of immunological dysfunction among a sub-culture of urban gay men in the West.

A model developed to deal with an epidemic within a particular sub-culture, engaging in distinct sexual lifestyle, cannot be universally applied to heterogeneous communities as diverse as those in found Africa. There are ideological and cultural differences that challenge such an application. However, Western science and media have been oblivious to the melancholic analyses they perform on African culture, preferring to perpetuate an image of African sexuality that fits with the Western mindset (Anderson, 1998; Chirwa, 1998).

Many African and non-African scholars of African morality and moral reasoning have critiqued Eurocentric interpretation of African culture (Ahlberg, 1994; Heald, 1995; Ikuenobe, 1998; Myers, 1993; Sempebwa, 1983; Verhoef & Michel, 1997). African and Western people do not view and interpret the world and social phenomena in the same manner (Ikuenobe, 1998). Hence, a Western critique and interpretation of African culture is limited by the divergent views of African and Western lifeworlds.

Ahlberg (1994) reviewed Caldwell *et al.*'s (1989) African sexuality thesis on three major aspects. First, its blatant disregard of behavioural and ethical contradictions manifest in moral systems. Second, the thesis overlooks the impact of Western civilisation on African traditional customs regulating sexuality and social behaviour. Third, it presupposes that African moral systems are primitive and inferior to Western civilisation. The attempt by Caldwell *et al.* (1989) to project Africans as *Homo ancestralis* fixated with family continuation (Heald, 1995) negates the central role that rites of passage played in African social institutions. Sex was not a free for all enterprise; it was regulated by custom and taboo (Buthelezi, 2006). As Verhoef and Michel (1997, p. 394) observe;

Morality within Africa is evolves from the process of living and is rooted in the context of communal life. The distinction between religion and morality is never distinct; it is never an abstraction of reality as it is in the West. Thus, the only way to understand morality in Africa and among Africans is to understand the African conceptualisation of the world or the African ethos.

Ikuenobe describes the functioning of the African ethos or way of life (1998, p. 30) as follows:

The elder displays his or her knowledge to children by providing explanatory and evidential foundations for moral principles. The foundations are represented in the form of anecdotes in real life experiences, or stories in the form of folklore and proverbs which speak to experiences from which children can draw knowledge and learn the probable utility of particular actions in given circumstances.

Traditional African systems did not distinguish between social and religious rules (*ibid.*). In other words, whatever action or duty one performed within the community the act was viewed from a unitary perspective that embodied both the religious and social aspects of life. When applied to the duties of procreation, a sexual relationship was not seen as a means of gratification of carnal urges between couples but a union that had to be sanctioned by the community or else

the moral and religious rules would be violated. The urge and ability to have sex was strictly proscribed by the community ensuring that one was mentally, spiritually and physically ready for the institution of marriage.

There is no recorded evidence of recreational sex in traditional African communities. Evidence abounds of procreational and ritual sex (Holleman, 1969; Gelfand, 1973). Even among the East African communities such as the *Nyakyusa*, *Maasai*, *Kikuyu*, *Chaaga*, etc., what early social anthropologists interpreted as permissive sex among “young men and women” was actually part of the traditional ritual of preparing the adolescence for the demands of married life and their procreation duties to the community (Ahlberg, 1994).

Bauni (1990) explains the difficulties faced by anthropological studies of sexual behaviour in sub-Saharan Africa. He cites three major difficulties; first, generalisation of results or observations. He argues that there is a paucity of consistent information on sexual behaviour, noting that even people from the same tribe differ in their attitudes towards sex. Second, the studies lack a time reference. People’s sexual behaviour has changed over time in response to the prevailing historical, social, economic and religious circumstances. Third, HIV/AIDS prevention has used an egalitarian approach that fails to distinguish between different lifestyles, e.g. urban versus rural. It is therefore critical to put into context any comment on of African sexuality before labelling it as permissive or immoral.

Social dislocation and anomie

African culture has undergone some of the most dramatic and traumatic transformations of modern times owing to the upheavals and social uprooting brought about by colonialism and modernization. The most significant of these was the introduction of migrant labour that separated spouses and their families. Ahlberg (1991) argues that the highest concentrations of HIV/AIDS are in specific geographic localities that have a large migrant labour force. These are centres of rapid social and economic change where, because of the erosion of social control systems, new sexual lifestyles have emerged⁵.

Marital separation, imposed by the migrant labour system, led to the expansion of men’s sexual activities to encompass casual relationships near their workplaces, while the wife (wives) remained in the rural home (Bauni, 1990; Jeater, 1993). Basset and Mhloyi (1991) noted that men’s long periods of absence increased the instability of family life, and urbanisation reduced the social control exercised by family unit over the sexual behaviour of both men and women. Capitalism brought with it a new form of sexuality - survivalist sex. The point here is not to deny that prostitution existed in Africa but to distinguish it from the more recent survivalist type of commercial sex.

Commercial sex became a commodity bought on the open market just like any other good in the capitalist economy. Consequently, it became the preferred mode of sexual expression since it was devoid of any demands beyond those of a commercial transaction. This resulted in access to money and the need for necessities of life being the deciding factors on the number of sexual partners one could have at any given time. The most poor and vulnerable members of society, women and children in particular, had no goods to purvey in the marketplace other than their bodies. A significant number of married men continue to have extramarital relationships, and both young girls and unmarried women venture into sexual relationships to obtain some income or goods (Meursing & Sibindi, 1995; Taruberekera, Kaljee, Astatke, Mushayi, Chommie & Shekhar, 2008).

⁵ The South African gold and diamond mines are a point in case. See the work of Campbell *et al.* (1998) and also Morrell’s edition on homosexuality in South Africa.

Unprotected sex is not always due to the desire for income or material things. As reported by Runganga (2001), cultural expectations around conception, procreation and desire for children undermine the need to engage in safer sex in Zimbabwe. She further notes that many of her respondents readily admitted to engaging in unprotected sex in order to overcome social stereotypes arising out of failure to conceive children. In this regard taking a health risk is less problematic than enduring the stigma of failing to procreate.

The *Shona* people of Zimbabwe attach great social significance to rituals surrounding giving of birth and procreation (Bourdillon, 1987; Gelfand, 1957). Manhood is defined in terms of sexual virility and failure to physically demonstrate one's virility leads to social ostracism and constant ridicule from peers. In other words, one's sexuality is constantly challenged and one cannot be given due social recognition unless they conform to these expectations. As noted by Muhwava (2003, p.121), "powerful norms about masculinity discourage condom use in marital relationships and encourage male sexual risk-taking." We therefore need to explore the cultural expectations placed on both men and women in Zimbabwe to understand the decisions they take regarding their sexuality. Such an understanding could possibly put us on a path towards unravelling the HIV epidemic in Zimbabwe and, probably, the region.

Prevention discourse and HIV prevalence in Zimbabwe

Gregson *et al.* (2006) in their paper on the HIV declines in Zimbabwe, published in *Science*, offer sexual behaviour change as the possible reason for the observed HIV declines. The changes in sexual behaviour took place in three significant areas. First, they believe that the age of sexual debut has changed in Zimbabwe with more people reporting a delayed sexual debut. Second, they argue that there is an observed reduction in the reported number of non-regular and casual sexual partners by both sexes, and third, more females are reporting having protected sex than ever before.

However, commentators have argued for and against the reasons offered by Gregson *et al.* (2006) as contributing towards the decline in HIV prevalence in Zimbabwe. Those arguing against claim that sexual behaviour change alone cannot possibly explain the observed marked declines in HIV rates in Zimbabwe. They believe that the reasons offered by Gregson *et al.* (2006) do not tell what really triggered off the observed declines. In other words, what is it that has made Zimbabweans to change their sexual behaviour now when for over three decades of HIV/AIDS the same behaviours appeared resistant to change?

Cohen (2008) best captures the sexual behaviour change dilemma. Commenting on the successful massive rollout of Botswana's antiretroviral programme and the stubborn resistance to change sexual behaviours, Cohen (2008, p. 529) notes that:

Botswana has encouraged people to have fewer partners, delay the age of sex, increase their condom use, and adopt other behavioral changes, *but none has made dramatic progress.* (Italicised emphasis is mine)

Yet the very same sexual behaviour change paradigm is attributed to the dramatic drop of HIV rates just across the border in Zimbabwe. Brewer *et al.* (2003, p. 144), commenting three years earlier than Gregson *et al.* (2006) on the decline of bacterial sexually transmitted infections (STI) in Zimbabwe observed that:

During the 1990s HIV propagated rapidly in Zimbabwe, increasing at an estimated rate of 12% annually. At the same time, the overall sexually transmitted infections (STI) burden declined an estimated 25% and while there

was a parallel increase in reported condom use by high risk persons (prostitutes, lorry drivers, miners, and young people). This example frames the problem: why would a relatively low efficiency sexually transmitted virus like HIV outrun more efficiently transmitted STI? ... It is of concern that many key sexual transmission variables are not associated with a large HIV epidemic in Africa, yet do correlate, as expected with other STIs.

Brewer *et al.* (2003) further argue that African sexual behaviour is not inherently unique from that of the West or anywhere else in the world. If this is the case then something else, other than sexual activity, explains the explosive epidemics seen in east and southern Africa. They argue that putting too much emphasis on sexual behaviour resonates well with the “risky sexual behaviours paradigm that has always sought to explain the explosive levels of HIV infection in sub-Saharan Africa in terms of deviant sexuality that predisposes Africans to increased risk of HIV infection” (Brewer *et al.*, p.144). Sanders (2008, pp. 1-2) argues that:

Contrary to many stereotypes regarding African sexual behaviour, studies have shown that Africans are no more promiscuous than men and women in the Western world. Children in Africa, Europe and the United States usually become sexually active around the same age – late teens. In addition, African males usually report fewer lifetime partners than do heterosexual men in the West.

Brewer *et al.* (2003, p. 145) argue similarly:

Levels of sexual activity reported in a dozen general population surveys in Africa are comparable with those reported elsewhere, especially in North America and Europe. Perhaps more importantly, there appears to be little correlation with the level of risky sexual behaviour shown in these surveys and the epidemic trajectories observed in these countries.

The observations and figures around HIV infection rates simply do not add up and cannot be solely explained by the risky sexual behaviour paradigm. Halperin and Epstein (2007, p. 20) observe that data from Demographic and Health Surveys and other studies they looked at suggest that, “on average, African men *typically* do not have more sexual partners than elsewhere.” (Italicised emphasis is mine)

Several other reasons are given for the explosive HIV epidemic in Zimbabwe in the late 80s and early 90s and the subsequent drop reported recently. One of the theories trying to explain the reported decline is the social proximity theory proposed by Macintyre and Kendall (2006). The social proximity theory argues that the reality of seeing kith and kin dying from HIV related illnesses has brought home the message and reality much closer into the lives of ordinary Zimbabweans forcing a change in their sexual behaviour. Hence, the reported declines could be attributed to Zimbabweans modifying their sexual behaviour in the face of the HIV/AIDS onslaught (Adetunji & Meekers, 2001; Mansergh *et al.*, 2000). Increased HIV/AIDS related mortality might have necessitated a reality check by Zimbabweans.

Avert (2009) comments on claims that young Zimbabweans emigrated due to the economic and political turmoil that engulfed the country in the late 90s thereby reducing the HIV prevalence rate. Hayes and Weiss (2006) allude to internal migration caused by the drastic land redistribution and resettlement programme in Zimbabwe as a possible factor in the HIV declines observed in Zimbabwe. However, other commentators caution against overly attributing HIV infection patterns to migration (Coffee *et al.*, 2005; Lurie & Rosenthal, 2010).

Lurie and Rosenthal aptly summarise the complexity and confusing nature of the HIV infection and prevention debate in Africa (2010, p. 17):

Demographers and epidemiologists have been puzzled for decades over what factors explain the vastly different epidemics seen across the globe. Some of the many plausible factors include high rates of other sexually transmitted infections which facilitate HIV acquisition and transmission, poor access to quality health care services, insufficient or ineffective prevention programs, poverty, high levels of migration and lack of male circumcision.

Brewer *et al.* (2003) as well as Cohen (2008) are critical of the poor-access-to-medical-care argument with the former observing that quite to the contrary the countries of southern African that have recorded the highest rates of HIV infections are ironically the countries with some of the best health care in Africa.

Potts *et al.* (2008) reject the poverty-HIV infection paradigm. They argue that recent evidence from Demographic Health Surveys (DHS) from eight African countries actually show a strong correlation between HIV infection and wealth. A National AIDS Council report alludes to the same finding among unmarried and middle class women in Zimbabwe (NAC, 2010). Sanders (2008) as well as Potts *et al.* (2008) observe that some of Africa's most impoverished, war-torn and parasite-infested countries have lower rates of infection than the richer, more peaceful countries of the region.

Potts *et al.* (2008) further argue that the evidence supporting the traditional prevention strategies is very weak. They argue for a re-evaluation of the mainstream prevention strategies as their effectiveness is suspect. For them the traditional pillars of prevention: condom use, HIV testing and treatment of STIs are not as effective as assumed. Their argument is supported by a number of HIV commentators (Brewer *et al.*, 2003; Green *et al.*, 2009; Halperin and Epstein, 2007; Shelton, 2007).

Shelton (2007) in an article in the *Lancet* titled "Ten Myths and one truth about generalised HIV epidemics", gives an exposé of HIV prevention strategies' misconceptions. He argues that despite evidence of falling HIV incidence in Uganda, Kenya and Zimbabwe, the epidemic rages on. Shelton argues that it is a myth that HIV spreads like wildfire. He argues that about 8 percent of people whose partners have HIV go on to acquire the infection each year. Evidence from discordant couples appears to support this observation. He goes on to argue that it is a myth that sex work is the problem. He further argues that the problem either. Neither are adolescents the problem nor does the answers lie in HIV testing. Treatment cannot possibly be the answer as no clear effect on HIV has emerged from treatment programmes, neither are vaccines, microbicides and prophylactic antiretrovirals. He argues that it is a myth that sexual behaviour will not change. Drawing evidence from the gay communities of the USA, he argues that quite to the contrary sexual behaviour will change as the reality of dying from HIV infection confronts people.

Writing in *Science*, Potts *et al.* (2008), just like Shelton (2007) question the efficacy of prevailing prevention strategies. Potts *et al.* (2008, p. 749) argue that condom use:

Is effective in epidemics spread mainly through sex work, as in Thailand and also, to some extent, among other high-risk groups such as MSM [Men having sex with men]. Although condom use has also likely contributed to HIV decline in some generalized epidemics, there is no evidence of a primary role. This is because consistent condom use had not reached a sufficiently high level, even after many years of widespread and often aggressive promotion,

to produce a measurable slowing of new infections in the generalized epidemics of Sub-Saharan Africa.

Commenting on HIV testing as a prevention measure, Potts *et al.* (2008, p.749) remark:

Unfortunately, reviews of many studies have shown no consistent reduction in risk for those who test HIV-negative, although risk reductions in some who test positive have been reported. Several HIV and STI incidence studies in Africa have found no population-level impact of VCT. Although a critical link to life-long treatment, HIV testing is therefore unlikely to substantially alter the epidemic course ...

Potts *et al.* (2008) review evidence showing the poor efficacy of vaccines and microbicides as well as sexual abstinence as HIV prevention strategies. If so, we need the real reasons for the decline in HIV in some countries of Africa.

The challenge presented by these critical reviews to the wisdom of conventional HIV prevention strategies presents a huge dilemma to the international AIDS community. Is it that the world community has spent billions of dollars and time on prevention strategies whose efficacy is questionable? Hayes and Weiss (2008, p. 621) say, quite to the contrary, "HIV prevention is thus more, and not less, important than ever before."

A joint Southern Africa Development Community and UNAIDS meeting in Maseru in 2006 concluded that the region needed to pay particular attention to the high levels of multiple and concurrent sexual partnerships, characterized by inconsistent and irregular condom use, and low levels of male circumcision. The meeting ended with two resolutions. According to Halperin and Epstein (2007, p.19) these were to "(i) '[s]ignificantly reduce multiple and concurrent partnerships for both men and women', and (ii) '[p]repare for the potential national rollout of male circumcision ..."

Concurrency is multiple sexual relationships that overlap in time. Epidemiologists have turned their attention to concurrency after observing that it is not the number of partners but the nature of concurrent sexual relationships that African men and women enter into that present the greatest risk for the acquisition of HIV infection (Green *et al.* 2009). They postulate that the answer lies in sexual behaviour change and male circumcision.

Male circumcision is not part of the Zimbabwean culture and the reported declines in HIV rates in Zimbabwe occurred in the absence of a national rollout of male circumcision or wholesale changes in concurrency (Taruberekera *et al.* 2008). Male circumcision is not a silver bullet to the HIV infection panacea. Neither is the reduction in sexual concurrency. Lurie and Rosenthal (2010) argue that the evidence base for the assertion that concurrent sexual relationships were the major drivers of the HIV epidemic in Africa was very weak. Brewer *et al.* (2003) argue that the focus on sexual behaviour in Africa, which has proved no different from that of the rest of the world, is misplaced and counter-productive. They argue that the role played by sexual behaviour is perhaps overstated.

Conclusion

The chapter explored the HIV/AIDS context in Zimbabwe. It highlighted some of the cultural issues that have influenced the HIV/AIDS epidemic in Zimbabwe. The chapter highlighted the complex intertwining of cultural expectations and personal choices Zimbabweans have to make in order to protect themselves from HIV infection. It also explored the present prevention discourses and their implication. Most importantly, the chapter showed the need for the

interrogation of the personal agency of rural Zimbabweans as they negotiate their daily lives in the midst of the HIV/AIDS pandemic. The social construction of life and the meanings people attach to the constructs shape the decisions they take regarding their lives. It is also important to note that these constructs are not static or social bona fides but are constantly negotiated, reconstructed, reinforced and renegotiated (Mungwini, 2008).

The dropping HIV prevalence in Zimbabwe attributed to changes in sexual behaviour, high condom usage with non-regular partners and the delay of sexual debut needs to be unpacked. To unpack the drop in prevalence we need to answer the research questions that this study is asking, more so given the social milieu surrounding sexual behaviour and sexuality among the rural Zimbabweans, especially the *Manyika* people. It is, therefore, important to understand how the ecosocial factors at multiple levels “– from the microscopic to the societal – contribute to the creation of population-level patterns of HIV/AIDS” (Poundstone *et al.*, 2004, p. 23). More importantly, there is a critical need “to understand how new [a] sexual behaviour[s] may be socially acceptable and meaningful” (Latkin & Knowlton, 2005, p. 4). Such an understanding informs better programming, relevance and sustainability in the prevention of HIV-infection in resource-constrained Zimbabwe and probably in the rest of sub-Saharan Africa.

CHAPTER 5

THEORETICAL PERSPECTIVES

This chapter presents a critique of the theoretical perspectives underpinning the thesis. It gives the rationale and critique of the social constructionist research paradigm that informs the methodology used in this research. Furthermore, it looks into the use of narrative as an appropriate tool for gathering information on people's life experiences and social constructions of human sexuality, condom use, risk perception, and HIV/AIDS. The chapter examines three dominant theoretical models underpinning current HIV/AIDS prevention strategies. It argues that the dominant paradigms informing sexual and health behaviour change are Eurocentric, culture-specific and individualistic and do not take into account non-western cultural differences, especially the African worldview to life (Kagee & Dixon (2000)).

The chapter also reviews social constructionism as a theory and methodology for studying human sexuality in the African cultural context in general and Zimbabwe in particular. The chapter concludes that, despite its limitations, social constructionism as a paradigm can help us gain insight into the cultural and social factors facilitating the rapid transmission of HIV in Zimbabwe. It also allows the exploration of risk construction in Zimbabwe and its implications for HIV infection and prevention (Karuru & Paradza, 2007; Mungwini, 2008; Mungwini & Matereka, 2010).

Rationale of HIV prevention

In the absence of a cure for or vaccine against HIV, infection efforts to change risk behaviours remain the only available means to prevent HIV infection. This has led to the development of several HIV infection prevention models and theories. The premise for the models is that, because HIV is transmitted largely through unprotected sex with an infected person, and the sharing of drug injection equipment, individual practice of risk reduction behaviour is the primary avenue for prevention. However, sexual risk behaviour does not occur in a social vacuum. Sexual negotiation is a social phenomenon proscribed by prevailing social norms and ideology. For example, prevailing power relations, gender and position of women determine how they negotiate safer sex in any society.

Early efforts to curtail the epidemic were largely information-based approaches that sought to highlight the dangers of risky sexual behaviour and drug injection. The efforts were premised on raising awareness using the fear arousal approach (McEwan & Bhopal, 1991). Studies have shown that increasing knowledge may not always change risky behaviours (Mapingure, Msuya, Kurewa, Munjoma, Sam, Chirenje, Rusakaniko, Saugstad, Vlas & Stray-Pedersen, 2010; Vaughan *et al.*, 2000). Despite increased public awareness of HIV transmission, there has not been a corresponding change in sexual risk behaviours (Kenyon, Dlamini, Boule, White & Badri, 2010). While HIV risk information may be necessary, it is not sufficient to motivate behaviour change. Attention to other individual traits related to HIV infection avoidance, such as perceptions of personal vulnerability, norms, beliefs about the value of prevention behaviour, recognition of high-risk behaviour, behavioural intention and self-efficacy is therefore necessary.

Abstinence and sexual technology

While sexual abstinence is seemingly the most obvious method of preventing transmission of HIV, a substantial proportion of sexually active adults and adolescents fail to use this strategy (Anderson *et al.*, 1990; Catania *et al.*, 1990; DiClemente, 1990). The assumption that celibacy is

a permanent option for many is itself problematic. The unrealistic nature of this assumption has fuelled the need for sexual technology to cater for those for whom celibacy is not an option. The condom, as a sexual technology, has assumed a much-acclaimed position that at times almost borders on idolatry. However, the personal and cultural relevance of the condom has not been properly investigated amidst the fanfare that accompanies its social marketing campaigns (McEwan & Bhopal, 1991). Metz and Fitzpatrick (1992, p. 3) argue that in heterosexual relationships “the reproductive and relational significance associated with condoms” remains largely unexplored. Runganga (2001) and Muhwava (2002) both reported on the reproductive pressures that force men in Zimbabwe not to use condoms. Condom use within the marital relationship is perceived as a lack of trust in one’s partner or as a sign that one has been unfaithful (Watts *et al.*, 1998; Wawer *et al.*, 1996). The meaning and symbolism of condoms in a relationship, within the Zimbabwean heterosexual context, needs to be addressed to overcome negative social connotations.

Changing risky sexual behaviour is a particularly difficult problem because the decision to use condoms occurs in the context of people’s social relationships and lifestyles (Brown *et al.*, 2005; Dunkle *et al.*, 2004; Gilbert & Walker, 2002; Hunter, 2002; Wojcicki & Malala, 2001, Worth, 1999). Several factors such as age, gender, and cultural differences regarding sexuality and sex-role relationships may influence the decision to use condoms during sexual intercourse (DiClemente & Peterson, 1994). It has been widely reported that socio-economic status and perceptions of masculinity and feminism can also influence the decision whether to or not use a condom (Campbell & Williams, 1998). Consequently, this complex decision-making process is likely to be understood if the multiple influences, and the interactions between them, are considered in developing and implementing interventions to reduce high-risk sexual behaviour (DiClemente & Peterson, 1994 p.2).

The challenge then lies in coming up with innovative prevention efforts that do not rely on providing risk information alone. This observation led Fisher and Fisher (1992) in the early 1990s to remark that there is a dearth of studies, which demonstrate the impact of behavioural interventions, on behaviour change. The same challenge still confronts us in our efforts to curb the spread of HIV infection.

Behaviour change models

Several behaviour change models and theories have been proposed and extensively reviewed in health promotion literature (Mechanic, 1990; Kelly & Lawrence, 1990; Wilson *et al.*, 1990; Airhihenbuwa, 1991; McEwan & Bhopal, 1991; Tulloch & Chapman, 1992; Edgar, Fitzpatrick & Freimuth, 1992; Terry, Gallois & McCamish, 1993; Macdonald 1998). Most of the behaviour change models have their roots in social psychology. The theories have developed “largely in response to the frustration resulting from repeated failures to predict behaviour from traditional measures of attitude” (Fishbein cited in Terry, Gallois & McCamish, 1993). The traditional measures of attitudes such as those of Thurstone, Likert, Guttman scales and semantic differential scales fail to examine the link between beliefs and attitudes (*ibid.*). Fishbein further argues that it is generally assumed that beliefs and attitudes are highly correlated.

The aim of behaviour change models is to change or positively influence health choices. Although the models have evolved separately they are not mutually exclusive and many have been applied simultaneously (McEwan & Bhopal, 1991). The models have five key variables: (1) perceived susceptibility to HIV infection; (2) perceived severity of AIDS; (3) perceived benefits of prevention behaviours; (4) perceived barriers of adopting prevention behaviours, and (5) the individual’s perceived ability to adopt the prevention behaviour (Vaughan *et al.*, 2000). The major

assumption is that humans are rational beings and therefore sexual behaviour is a rational behaviour. This view has been widely challenged by many critics who argue that human beings are not always reasonable creatures (Ainslie, 1995; Hortensia & Amaro, 1995). Three key behaviour models widely applied in health education and promotion are discussed below.

Health Belief Model

The health belief model (Becker, 1974; Rosenstock, Stretcher & Becker, 1988) assumes that an individual's behaviour is guided by expectations of consequences of adopting new practices. It has four concepts: (1) susceptibility - does the person perceive vulnerability to the specific disease?; (2) severity - does said person perceive that getting the disease has negative consequences?; (3) efficacy - what are the positive and negative effects of adopting a new practice?; and (4) health motive - does the individual have concern about the consequences of contracting the disease? (Hornik, 1991; Fisher & Fisher, 1992)

The health belief model has been the paradigm of choice in explaining health behaviour in Graeco-Roman cultures (Macdonald, 1998). It assumes an individualistic perspective in decision making on health matters. The model also assumes an empowered and informed individual divorced from disabling social phenomena. As Macdonald (1998, p.33) notes, the health belief model is Eurocentric and by no means a culture-free entity; "it is solidly based, for instance on the concept of 'individual autonomy' and that is by no means a universal outlook on the condition of humankind."

There is need to engage the model critically when applying it in different cultural settings. It is also necessary to question the underlying assumptions regarding health promotion as a psychological construct and, hence, to challenge its appropriateness in informing health behaviour change in Zimbabwe, a non-western and predominantly collectivist society (Kambarami, 2006; Mester, 2008).

Theory of Reasoned Action

Ajzen and Fishbein (1975; 1980) proposed the theory of reasoned action. It incorporates most of the variables constituting the health belief model. According to the theory, behaviour is substantially a reflection of behavioural intentions; it is an indication of the probability that the person will perform the behaviour. Behavioural intentions reflect attitudes toward performing the behaviour (behaviour will lead to certain outcomes) and perceived social norms (social pressure to perform or not perform the behaviour) (Fishbein, Middlestadt, & Hitchcock, 1994).

This theory of reasoned action employs a cost-benefit analysis as explained by Kashima, Gallois and McCamish (1992, p. 25):

Attitude is a summary of the perceived costs and benefits (often called *evaluations*) of enacting the behaviour and is predicted by the sum of these costs and benefits, each multiplied by its perceived likelihood of occurrence. Intention is also predicted by the subjective norm with regard to the behaviour, which is a summary statement of what the actor believes other people think he or she should do. Subjective form is predicted by the sum of these normative beliefs for each significant other person, multiplied by the actor's motivation to comply with that person.

However, the theory of reasoned action needs to be localised and contextualised (Terry, Gallois & McCamish, 1993). Different people perceive a cost or benefit differently depending on their normative circumstances and particular need(s). Behaviour might be more under normative influence than attitudinal control and vice versa (*ibid.*). Personal norms also play a significant

role in the cost-benefit analysis of a particular behaviour and its outcome. A married woman in a patriarchal society might choose to have unprotected sex rather than risk losing her marriage, security and social standing. There is a need to engage normative expectations when applying the theory to individual choices. The question to address in the application of this theory in Zimbabwe is what are the normative values proscribing health behaviour in Zimbabwe.

Social Learning Theory

Bandura (1977) developed the theory of social learning. The theory emphasizes modelling (the process by which behaviour is influenced through observing others), perceived efficacy (the belief that a given behaviour will result in a given outcome) and self-efficacy (an individual's belief that he or she can effectively carry out a desired behaviour in a particular setting) (Hortensia & Amaro, 1995). Incentive is the perceived value of an outcome.

Self-efficacy, when applied to sexual behaviour, posits that risk reduction is affected by the knowledge of steps that must be taken to avoid risk, motivation to avoid risk based on the perceived benefit of the protective action, and a belief that the protective action will be effective (Bandura, 1989).

Unlike other approaches that focus on cognitive processes, social learning theory stresses the social aspects of risk behaviours, such as societal pressures (e.g., peer pressure, social norms and media), and the importance of building skills (e.g., communication and negotiation) to resist such external pressure (Hortensia & Amaro, 1995; Eyre *et al.*, 1998). Social learning theory's assumption that teaching people negotiation skills will sufficiently empower them enough to say 'no' to harmful and negative behaviour, is suspect. It fails to take into consideration structural factors like poverty and gender relations that erode people's ability to practice safe sex and leave them vulnerable to HIV infection.

Critique of the theories

The models have been successful with gay communities (Elford *et al.*, 2002) and adolescents (McEwan & Bhopal, 1991) in the Western world. A strong infrastructure that gives the individual wide choices and free expression in a safer and informed environment has helped in successfully applying the models. To date there is no record of their wider application in most of sub-Saharan Africa beyond the knowledge, attitudes, beliefs and practices surveys (KABP) that flourished in the late 1980s only to later lose significance as it became obvious that there was a programmatic need to move beyond KABP surveys in order to combat the AIDS pandemic.

The models have been criticised for their lack of sensitivity to cultural and contextual factors that shape the reality of sexual behaviours and the potential for sexual risk reduction (Melkote, Muppidi & Goswami, 2000). The individualistic conceptualisation of behaviour greatly limits their application to most developing world societies whose sense of community ascends beyond the individual self. They fail to consider the broader cultural and social context of sexuality. An analogy is drawn from Gasa's (2000) thesis on the meanings and challenges for informed consent in a collectivist community of *KwaHlabisa*, South Africa. She argues that in collectivist societies individual self-consent to HIV vaccine is constrained by the collectivist notion of consent.

The notion of the solo individual as able to take and make decisions around his or her life choices is not practical in societies such as Zimbabwe because of their emphasis on collective identity. Gasa (2000) remarks that Western researchers, commenting on informed consent in rural settings in South Africa, have argued for female household heads to consent to research in the absence of their migrant husbands. She argues that such a position is based on Western understanding

of the concepts of autonomy and independence and bears no reality to the experiences of rural African female household heads.

A married woman's desire to start a family best exemplifies communal decision-making. Her decision on when to and not to conceive is not hers and her husband's alone in most extended family systems (Muhwava, 2002). The extended family can make that decision on their behalf depending on family rites such as the need to have a child to be named after a departed family member. In some cases, even the decision when to become sexually active is not by the individual but by the family or community. Thus, the models overlook the way in which cultural forces and expectations, as well as more immediate social norms and patterns in the individual's social network and specific situational factors, affect sexuality and sexual choice (Hortensia & Amaro, 1995). Structural conditions influence the kind of sexual behaviours that people indulge in or develop. Several studies have shown that a significant number of women are forced into commercial sex work because they need money to support themselves and their families (Wilson *et al.*, 1991; Campbell & Williams, 1998).

Gender roles, cultural values and norms sometimes define the expected behaviour of men and women and the interpersonal relationships in which sexual behaviour and encounter occurs (Ehrhardt & Wasserheit, 1991). For example, male values of penetrative sex largely determine condom use in Zimbabwe (Muhwava, 2002; Runganga, 2001) and dominance over women. The quest for dry sex among some African males (Civic & Wilson, 1996; Mrwebe, 2002; Nzenza-Shand, 2002), and reciprocal vaginal drying by females (Bagnol & Mariano, 2008; Civic & Wilson, 1991; Runganga, *et al.*, 1992; Wijgert, *et al.*, 2001) needs to be explored further and could provide useful insights to understanding the dynamics of the spread of HIV in certain communities. Individualistic information-based models cannot tackle these behaviours successfully as the behaviours defy assumed psychological rationality.

Most sexual behaviours are largely an outcome of learning and social reinforcement (Hortensia & Amaro, 1995). Macdonald (1983, p. 43) refers to the structural and cultural differences often overlooked by health promotion initiatives based on Eurocentric values:

Whereas the classical European model of health promotion is predicated as evolving through the individual gaining sufficient self-esteem to work with others (neighbourhood advocacy) and sufficient autonomy to arrive at his or her own health agenda and then negotiating with such authorities as the police, local council, social workers, etc., to realise a community health initiative, none of this would be relevant in most third-world societies. For one thing, most societies are compelled by poverty to be highly authoritarian and to de-emphasise the individual autonomy.

Airhihenbuwa (1993, 1994) argues that Western health promotion models trivialise the effect of cultural diversity within many African societies by placing so much emphasis on Western models of learning and discourse based on the written word. As argued by Macdonald (1983, p. 40):

The western preoccupation with print, based on the assumption of widespread literacy, imposes its own approach to linear thinking and sequencing. These do not apply in a society in which information is spread literally, through communal intercourse, rather than from books distributed by an authoritative repository of knowledge.

The shortcomings of Western models of prevention have led to a shift from the individual change theories to peer and community-based empowerment and development education programmes (Campbell & Williams, 1998). These programmes have largely emphasized the use of peer teaching. The rationale is that peers speak to each other horizontally rather than vertically

and understand one another's needs (Elford *et al.*, 2002). Community-outreach programmes have focused on putting a human face to the AIDS disease by teaching acceptance, caring and compassion and treatment of sexually transmitted diseases. Peer and community-based approaches are touted as effective tools in fighting stigma associated with the AIDS disease (Gregson, Terceira, Mushati, Nyamukapa, & Campbell, 2004; Nyamukapa & Gregson, 2005).

Despite innovate prevention and treatment approaches, HIV continues to affect thousands of lives every day in sub-Saharan Africa (UNAIDS, 2002). This has led to calls for the need to explore new paradigms of HIV prevention and efforts to understand how people construct the concept of risk in their lives. This study, therefore, proposes to use a social constructionist approach to try to understand why some people change their risk sexual behaviours and why others do not in the face of HIV infection in Zimbabwe.

Postmodernism: an alternative methodology

The dawn of postmodernism heralded a challenge to the grand theories or meta-narratives that dominated knowledge of the world for centuries. Postmodernism rejects both the idea of an ultimate truth and of structuralism - the idea that the world as we see it is the result of hidden structures. Postmodernism emphasizes, instead, the coexistence of a multiplicity and variety of situation-dependent ways of life. This opens up the world to entirely new methods of scientific analysis. No particular method of inquiry can claim dominance any more. The most exciting product of this scientific renaissance has been the emergence of new paradigms in the study of human life and social phenomena. One of the new paradigms is qualitative research. As noted by Parker (1998 p. 1), "Qualitative methods have emerged in psychology only fairly recently as an array of alternative approaches to those in the mainstream."

The contribution of social scientific research to HIV/AIDS prevention has of late been a subject of scholarly scrutiny (Gillies, 1996; Lear, 1997; Madlala-Leclerc, 2000). Reasons for the inquiry have centred around dissatisfaction with the over-reliance on quantitative survey research, lack of exploration into the social context of behaviour and poor elaboration of concepts of sexuality, and culture (Gillies, 1996).

During the early decade of the epidemic, psychology emerged as the dominant conceptual approach used in studies of HIV prevention, emphasizing individual determinants of sexual behaviour and assuming that behaviour is rational. Predominant factors in these analyses are beliefs, attitudes, perceptions, motivations, and intentions. The notion of the "social" is expressed in a relatively unsophisticated manner limited to providing reinforcing "cues" for individual behaviour. Psychology as a discipline is obsessed with the individual. The social is relegated to a silhouette against which the profile of the individual is cast. This is the notion rejected by postmodernists.

The postmodernist psychological "renaissance" has led to the questioning of knowledge, truth, personality, etc. It has seen the emergence of narratives and language as dominant paradigms in understanding social reality. Narratives have become the tool for social investigation in seeking to understand how individuals construct meaning and identity (Riessman, 1993).

Social constructionism: an overview

Scholars from Latin America and of Latin American sexuality have extensively used social constructionism to understand various aspects of Latina/Latino sexuality. For example, Villanueva (1997) carried out a social constructionist study of female sexuality in Puerto Rico. Richard Parker (1998) used social construction to study homosexuality in Brazil. Ivonne Szasz (1998) employed it to look at masculine identity in Mexico. Cataneda *et al.* (2001) examined the

construction of risk in Mexico. Behar (1994) applied it to his analysis of gays in Cuba, while Bao (1993) used it to study homosexuality in Argentina.

Constructionism has been applied to the study of moral discourse in Zimbabwe (Jeater, 1993), masculinity in Zimbabwe (Shire, 1994), cultural metaphors (Taylor, 1996) and homosexuality (Epprecht, 1998, Aarmo, 1999). This study is the first to use social constructionism to investigate the cultural and social contexts facilitating the transmission of HIV in Zimbabwe.

Social constructionism asserts that personal identity and social reality are not mutually exclusive but interdependent (Burr, 1995; Gergen, 1998). The person constructs reality and reality in turn constructs the person (Berger & Luckman, 1967). People produce discourses about themselves but discourse is a product and process of social construction. Personal discourses are bound inextricably with social discourses; the personal and the social are mutually constitutive (Schou & Hewison, 1998).

Social processes

Social constructionism focuses on interaction and social practices. It asserts that explanations are to be found neither in the individual psyche nor in social structures, but in the interactive processes between people. Discourse is central to the theory. It challenges the concept of personality as viewed by traditional psychology. Traditional psychology, in the philosophy of Descartes' *cogito ergo sum*, views personality as a coherent, rational artefact. Social constructionism argues that a person is not a system of coherent elements. We behave, think and feel differently depending on whom we are with, what we are doing and why we are doing what we are doing. Personality is neither static nor stable over time. People have a multiplicity of selves (Hermans & Kempen, 1995) that are relational and interdependent (Mwamwenda, 1989).

Echoing the postmodernist tradition, social constructionism questions objective truth and scientific empiricism. It argues for a subjective reality constructed through language. Gergen (1999, p. 4), commenting on the tensions arising out of the emergence of the postmodernist tradition, writes:

As many see it, we are perhaps witnessing a shift in cultural beliefs that is equal in significance to the movement from the Dark Ages of Western history to the Enlightenment. For many the present transformation is catastrophic. It represents the erosion of beliefs central to our ways of life, including our sense of truth and morality, the value of the individual self, and promise of a better future. Traditions of democracy, religion, education, and nationhood are all placed under threat. Yet, for many others this same shift is pregnant with potential. As many feel, the traditional Western beliefs – for example, in truth, rationality, and the self – are severely limited. In the globalized world of today, they seem increasingly parochial, and possibly deadly in implication. Further, the grand institutions of science, religion, government, education – designed for the benefit of all – have not only fallen dramatically short of their aims, but often seem to generate oppression, environmentally degrading, and armed warfare.

Social constructionism is largely concerned with the processes by which people account for the world and for themselves (Gergen, 1985). The movement in social constructionism departs from induction as the basis of knowledge and the belief that categories and understandings are created through observation, towards a social epistemology that sees understanding as an active, cooperative enterprise of persons in relationships (*ibid.*). All theories and concepts are linguistically constrained. Terms themselves are “social artefacts,” “products of historically

situated interchanges among people,” and their meaning is derived from their context of use (Schou & Hewison, 1998).

Social processes are the key to understanding human life. We are subjective in our lived experiences as human beings. The individual himself/herself is not a single monologous self but a dialogic self (Day & Tappan, 1996; cf. Bakhtin, 1984) living in a multiverse rather than a universe (Harrison, 1995, cf. Real, 1990). The implication of this viewpoint is that it is never possible to obtain a complete meta-perspective of any social interaction (Hamilton, 1995).

Conception of self

Most critically, social constructionism questions the modernist conception of self. It questions our “sense of self as rational agents, who make choices and direct our own actions” (Gergen, 1999, p. 6). Nevertheless, are we really free moral agents or are we rational beings? Do we, like Descartes, ever doubt rationality? Do we challenge the truth as given or told to us? This is the question at the heart of the postmodernist tradition. History is replete with vivid examples of human beings showing non-conformity to the given order. The very issue of doubt is proof that human beings are of more than one mind. According to Gergen (1999, p. 8) there are “three conceptual problems at the heart of the presumption of individual minds: the problem of two worlds, of individual knowledge of the world, and of self-knowledge.”

Human beings have a dualistic ontology. We have a perceived internal psychological self as well as an external material worldview (Gergen, 1999; Tap, 2001). If we are of two worlds, how do the dual worlds influence each other? Tap (2001 p. 23) citing Durkheim asserts that the two worlds coexist in us:

The first one, the *individual being*, represents our private universe, our personality features, our heredity, our experiences and memories, and our personal history; the second one, the social being, corresponds to the internalized ideas, feelings, habits, values, and norms that originated in our social group.

Social constructionists have a problem with such a humanistic and essentialist view of humankind. They argue that there is no such thing as human personality (Burr, 1995).

Knowledge acquisition

Social constructionists question how individuals acquire knowledge of the objective world. This is the issue of epistemology (Gergen, 1999). The central question is how do subjective beings acquire knowledge of the objective world? Is the human mind a mirror of nature? The tradition of empiricism is brought into focus. Empiricism states that all knowledge derives from experience. Unless we experience something, we have no knowledge of its existence. If this is the case, why do we talk of the solar system, feelings or emotions as commonly experienced phenomena? In order to answer this assertion a different school of epistemology appears. This is the school of thought known as rationalism. It appeals to our cognitive abilities and asserts that human beings are equipped with innate mental processes that allow them to form concepts about the objective world. Gergen (1999, p. 11) refers to this assertion as the nativist explanation of the world and argues that it still does not explain the “thorny problem of how material events cause mental events.”

The third problem that postmodernism has with the objective world hypothesis is that of self-knowledge. The fundamental question is how do we become aware of our mental states or even more poignantly do we have mental states? As Gergen (1999, p. 12) asserts, “This is the *problem*

of *self-knowledge and it poses difficulties no less profound and intractable as those of dualism and individual knowledge*” (emphasis original).

Social constructionists, buoyed by a postmodernist philosophy, then, question the Western conceptualisation of the self, objectivity, truth and knowledge. They argue that the Western fixation with the individual mind, rationality and morality is misguided and erroneous. Gergen (1999) refers to this obsession as cultural imperialism. He remarks:

As elsewhere, we in the West typically presume the universality of our truths, reasons, and morals. Our scientific truths are not “ours” in particular, we hold, but candidates for universal truth. That the world is made up of atoms and individuals who possess emotions is not for us a matter of cultural belief. Any reasonable person would reach the same conclusion. Yet, as we presume the reality and truth of our own beliefs, so do we trample on the realities of others. We unwittingly become cultural imperialists, suppressing and antagonizing.

There are critical historical and cultural limitations to the modernist conceptualisation of life, knowledge, truth, rationality, objectivity and morality. Not all cultures perceive the world from a Western cultural lens. The Western perception of the self is severely limited in that it fails to recognise how the self is perceived in non-Western societies. Postmodernists argue that the solution to all our problems lie in language and its deconstruction. Language is viewed as a picture or map of events of the world (Gergen, 1999). Nothing exists beyond and outside language. Our knowledge of the world does not derive from the nature of the world. It can be asked that if nothing exists beyond language, how then we claim to have knowledge. Burr (1995 p. 4) remarks:

The social constructionist answer is that people construct it between them. It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated. Therefore social interactions of all kinds, particularly language, are of great interest to social constructionists.

The social nature of human life is central to the acquisition of knowledge and according to Wittgenstein (1978) amongst others; this social aspect of life is represented by language. This understanding finds support from a number of scholars, the best examples being those who adopt the view that human life in general and human beings in particular are essentially dialogic (Hermans & Kempen, 1993; cf. Bakhtin, 1984). Their modes of description, explanation and representation are derived from the dialogical nature of human relationships (Gergen, 1999). That is, self-understanding does not arise *ex nihilo*, from within the person; it is in our encounter with the world around us that we come to understand who we are and this is an ongoing process. According to Gergen (1999, p. 48) meaning to all phenomena is derived within relationships:

The individual mind (though, experience) does not thus originate meaning, create language, or discover the nature of the world. Meanings are born of coordinations, among persons – agreements, negotiations, affirmations. From this standpoint, relationships stand prior to all that is intelligible. Nothing exists for us – as an intelligible world of objects and persons – until there are relationships.

Language proscribes all human activity. Our thinking and relations are bound by history, culture and language. Our broader social practices determine the kind of relationship we have with others including how we think of ourselves; the discourses we have about ourselves inevitably reflect the social worlds that we have internalised and continue to refine through dialogue (cf. Bakhtin's (1984) argument on the selection appropriation of others' views to become part of

ourselves). All of this points to the sharedness of language and meaning. Social relations allow us to continuously generate meaning and thereby sustain our traditions. It is in this regard that social constructionism invites “*generative discourses*” (Gergen, 1999); “ways of talking and writing (and otherwise representing) that simultaneously challenge existing traditions of understanding, and offer new possibilities for action” (Gergen, 1999, p. 48). The process of generating discourse and meaning requires awareness of alternative discourses and meanings that lie outside our ambit. There are myriad discourses simultaneously taking place in the world, each one of them equally valid under acceptable moral, cultural and political guidelines. The simultaneous discourses call for negotiated understandings. Burr (1995) says:

These ‘negotiated’ understandings could take a wide variety of different forms, and we can therefore talk of numerous possible ‘social constructions’ of the world. But each different construction also brings with it, or invites, a different kind of action from human beings.... Descriptions or constructions of the world therefore sustain some patterns of social action and exclude others.

Knowledge and fact are socially negotiated and determined. Berger and Luckmann (1966) refer to this process as the social construction of reality. Shared subjective experiences become social reality and fact. This process involves the socialisation of human beings into socially maintained understandings of the world (Gergen, 1999).

Anti-essentialism

Social constructionism challenges the notion of objective social research. It argues that in fact we can never know what social reality is. It postulates that the self is not pre-given or essential in nature; it is socially constructed (Hamilton, 1995). This flies in the face of the essentialism of traditional psychology disciplines such as trait theory and psychoanalysis that pre-suppose a “pre-given content” (Burr, 1995). Social constructionism argues, “There are no ‘essences’ inside things or people that make them what they are” (Burr, 1995, p. 5). The view of emotions as recognizable states within people of all cultures is discounted; instead, it suggests that emotions are socially constructed in interactions between people (Hamilton, 1995). The self does not have a definable and discoverable nature influenced by the so-called nurture/nature debate (Burr, 1995). Social constructionism rejects biological determinism, an important position when we explore issues such as gender.

Having rejected the notion of universal scientific truth as an artefact of Western cultural imperialism (Gergen, 1999), postmodernists call for cultural epistemology. They argue for close attention to culturally specific truth (Polkinghorne, 1992). Doherty (1991), quoted in Hamilton (1995), says that instead of the search for universal laws, there need to be more investigations of local phenomena. The movement towards local meaning and truth has been variably called neo-pragmatism (Polkinghorne, 1992) and cultural ontology (Mauthner & Doucet, 1998), since it suggests focusing on what has worked practically and in specific contexts (Hamilton, 1995).

Interpretation, human agency, and self-awareness are central interlinked concepts in social constructionism. So too is the inseparability of the self from the other, and the concept of intersubjectivity. This notion emphasizes the fundamental concept that human life is group life and is built on shared understandings (Prus, 1996). In this regard, language plays the critical role of “both shaping and being shaped by human experience” (ibid. p. 17). We are products of language as we live in a languaged world.

Discursive positioning

Language becomes central in social interchange (Harrison, 1995). Words obtain meaning, not through their capacity to reflect an objective reality, but through their use in social interchange (*ibid.*). It is through interacting with others that we create meaning, “human activity occurs in the understanding that is created through social construction and dialogue” (Anderson & Goolishian, 1993 cited in Harrison, 1995 p. 25). Davies and Harrè (1990) refer to the phenomenon of socially created and negotiated meaning as discursive positioning, the process of negotiated account-generation. Social texts, rather than the voice of internal cognitive mechanisms or personal characteristics, are central to understanding human nature. The individualism of a social psychology dominated by the perspective of social cognition is, thus, rejected (Schou & Hewison, 1998).

Social constructionism argues, “all forms of knowledge are historically and culturally specific” (Burr, 1995 p. 6). Social constructionism urges the postmodern investigator to take stock of the circumstances of inquiry (Gergen, 1992). The postmodern social scientist is encouraged to question the objectivity of taken-for-granted fact (Gergen, 1999), to beware of its cultural embeddedness (Burr, 1995; Gergen, 1999; Shweder, 1991) in particular historical epochs, and to explore its implications for society (Hamilton, 1995). This anti-realism aspect of postmodernism questions the very notion of scientific “givens” and instead proposes that all knowledge and reality are socially constructed: “Knowledge is therefore seen not as something a person has (or does not have), but as something that people do together” (Burr, 1995, p. 8).

Language, narrative and self

The development of postmodernist thinking has led to a renewed interest in language, narrative and the self as central to understanding social phenomena (Hamilton, 1995). Rabinow and Sullivan (1979), cited in Hamilton (1995 p. 34), note that:

There has been a general disillusionment in social science with traditional conceptions of scientific knowledge. During the modern era there was an expectation that the social sciences would soon be able to leave behind their preoccupation with values, judgement, individual insight, and attain the maturity of natural sciences. The strength of the natural sciences were seen by Kuhn (1970) as their ability to move beyond discussions about methodology and data and to develop shared paradigms that defined their areas of study. However, investigators in the social sciences have never been able to come to agreement about the principles underlying their respective fields.

The resultant disillusionment with logical empiricism and rationalism has led to the renaissance of new forms of literary conventions in which scientific understanding is informed by non-objective factors (Gergen & Gergen, 1984).

Postmodernist research argues that scientific knowledge in the social sciences can never be objective and value-free (Gergen & Gergen, 1984; McNamee & Gergen, 1993). This has led to a renewed interest in the historical and social processes that bring certain ideas forward whilst discouraging others (Hamilton, 1995). Social processes now increasingly define taken-for-granted “objective” accounts of phenomena in the real world (Bruner, 1991). The subjective interpretation of the languaged world has gained prominence in the viewing of the world.

Grammatical and narrative self

The realisation that formulations about the world are guided by and limited to the systems of language in which one lives has generated great interest among social constructionists (Hamilton, 1995). There are two positions of presenting the self as constructed by language (*ibid.*). The first position, the grammatical self, posits that human understanding of selfhood is formed by beliefs about being a person that are inherent in our language (Harrè, 1989). This position is influenced by the philosophies of Wittgenstein and Kant. The second position “sees our sense of personal history and identity as arising out of culturally available narrative forms” (Burr, 1995 p. 125), thus the narrative self.

The grammatical-self position argues against a cognitive development of language skills. It sees language skills arising out of social and linguistic traditions embedded in a culture (*ibid.*). For psychologists to understand human beings they need not look further than this. According to Burr (1995 p. 130) we are:

... [P]redisposed to organise our experience in some way, to make sense of it, to pull it together within a framework. Not doing so would result in chaotic, meaningless experience, and our concept of selfhood is the result of this structuring. However, the nature of selfhood, the particular kind of structuring we adopt, is culturally and linguistically specific. It is governed by the grammar, or logic, of the language we are born into.

The understanding of selfhood that we acquire comes from the grammar, logic or underlying metaphors present in our language (*ibid.*).

The narrative-self position (Sarbin, 1986) argues that human beings impose a narrative structure on their experience. The narrative structure is present both in our accounts of our shared experiences and ourselves. We organise our accounts in terms of stories (Burr, 1995). Sarbin (1986) sees the narrative way of structuring our lives as the *sine qua non* of all human life and experience. We live storied lives. He goes further to argue that the way we tell our life stories is organised into themes. We choose which aspects to tell, when to tell them, and to whom to tell them “We engage in much ‘smoothing’, choosing and moulding events to fit the theme of our life story” (Burr, 1995). The emergence of narrative in human thought is evidence of and dependent upon the perception of time. The social aspect of narrative means that we are dependent upon others in the sanctioning and support of our version of events.

The notion of reality

The notion of there being no reality beyond language severely challenges the position of empiricist meta-theory. This meta-theory holds that theories about the world are formulated or constrained based on systematic observation. By rigorously employing systematic empirical procedures, it is believed, one can emerge with theoretical maps to successfully guide one’s actions in the world (Gergen & Gergen, 1984). The biggest drawback of meta-theory is its incessant need to justify its premises. This continual need to justify further weakens the empiricism of meta-theory, subjecting it to a continuous criticism (Gergen & Gergen, 1984).

This critical premise guides the precision with which scientific theoretical terms can refer to world events and subject to unambiguous empirical assessment. If unambiguous reference cannot be established (Gergen & Gergen, 1984), then objectivity is beyond the capacity of scientific theory: “If one cannot determine the referents for theoretical terms, it is impossible to falsify such theories by objective means” (Gergen & Gergen, 1984, p 23).

How then does this postulate challenge or is challenged by the “no reality beyond language” argument? We need therefore to explore critically the relationship between word and referent. We need to demonstrate that our use of a word goes beyond a basic agreement of the descriptive qualities of the word but also hold exactly the same conception(s) of the object itself.

Wittgenstein (1963) draws attention to the limitation of the word-object ambiguity; the limitations placed on the way a term is used depend substantially on the linguistic context in which the term is used. To understand the linguistic context in which a term is used demands a critical understanding of who uses the term, how it is used, the manner in which it is used, its reference to the self and to the social, and its meaning (verbal and non-verbal). Objects or events of the world are not independent of the concept of understanding with which one approaches them (Hanson, 1958 in Gergen & Gergen, 1984). We are in a language trap. As much as we want to believe that we are in charge of language, language is actually taking charge of us (Kvale, 1992 in Hamilton, 1995).

This position has gained momentum in recent decades in theories of literary criticism – most particularly within the deconstructionist movement (Culler, 1982, in Gergen & Gergen, 1984). Deconstructionist theory argues that our experiences colour our linguistic interpretations. It is reasoned that what a reader brings to a text in terms of expectations, skills, and affective dispositions are major determinants of the text’s meaning (Derrida, 1972; DeMan, 1978 in Gergen & Gergen, 1984).

Words gain their meaning not through their ability to represent reality, but through their utilisation in social interchange (Hamilton, 1995). Thus, for example, the experience of an emotion such as happiness is not determined by the objective fact of happiness but by conventions of talk about happiness in the given culture (Gergen, 1999). To be happy does not only mean what is said to be happiness, but also the physical actions and cultural exchanges that accompany happiness. To engage in happiness is then, for Gergen and Kaye (1993), to participate in a form of cultural dance. Happiness is, thus, a metaphor that conveys a culture-inscribed experience (Hamilton, 1995).

Anderson and Goolishian (1993, cited in Hamilton (1995, p. 36) “point to a hermeneutic position of language that emphasizes the meanings created by individuals in conversation with each other.” Human systems are always involved in language generation and, hence, meaning generation (Hamilton, 1995). Meaning generation becomes, then, a road upon which language engages self and other.

Narratives give meaning and understanding to our lives (Kerby, 1991). Deconstructive discourse has allowed us to be sceptical of beliefs and myths about knowledge and power often taken for granted in contemporary Western culture and literature (Hamilton, 1995). It is through the development of a narrative about self that identity formation is based. Narratives are reflexive. This reflexivity challenges any notion of a stable or fixed self (Lax, 1993 cited in Hamilton, 1995). The self is continually seeking and engaging new forms of meaning and knowledge.

The position of social constructionism appears problematic to the cultural understanding of illness and life. How does social constructionism explain the social and cultural construction of illness in general and HIV/AIDS in particular if there are no metanarratives/theories of illness, as social constructionists argue? If meaning is socially embedded, gendered, and entangled in relations of power: how does this relate to HIV prevention efforts? Studies in Latin America have explored this phenomenon and offered insights into the cultural and social construction

of illness and sexuality (Behar, 1994; Cuba & Bao, 1993; Parker, 1997; Szasz, 1998). As cited elsewhere in this chapter, Villanueva (1997) carried out a social constructionist study of female sexuality in Puerto Rico. Her findings were that there were no metanarratives of sexuality but several competing narratives and constructions of sexuality dependant on one's social class, relationship and role.

The contextualised subjectivity of reality and life gives eminence to social constructionism. In Zimbabwe several studies have applied some elements of constructionism to study moral discourse (Jeater, 1993), masculinity (Shire, 1994), cultural metaphors of illness (Taylor, 1996), and homosexuality (Aarmo, 1999; Epprecht, 1998). There is a need to understand and analyze the cultural construction of HIV/AIDS in Zimbabwe, a country possibly with a different narrative of gender and the self from Latin America.

What is a narrative?

There are several definitions of a narrative. No single structural definition can account for the wide range of items that people accept as stories. A prototypical story includes a teller, a predicament, an attempt to resolve the predicament, the outcomes of such attempts, and the reactions of the teller and the listener to the outcomes (Hamilton, 1995). Causal relationships are usually also identified in the prototypical story. As Gergen and Gergen (1984, p. 26) observe, "Perhaps the most essential ingredient of narrative accounting (or storytelling) is its capability to structure events in such a way that they demonstrate, first, a connectedness or coherence, and second, a sense of movement and direction through time." Gergen and Gergen (1984) further suggest two related ingredients for a successful narrative. First, a goal or valued endpoint must be established: "With the creation of a goal condition, the successful narrative must then select and arrange events in such a way that the goal state is rendered more or less probable" (*ibid.*). All events in a successful narrative are related by virtue of their containment within a given evaluative space. They seek coherence and a sense of directionality. Second, narratives must have a sense of movement and direction. Narratives are not static. They have a life and body and are creative. Epston *et al.* (1993, p. 97) define a narrative as:

A unit of meaning that provides a frame for lived experience. It is through these stories that lived experience is interpreted. We enter into stories; we are entered into stories by others; and we live our lives through these stories.

Bruner (1986) identifies three major elements of a narrative: story, discourse and telling. The story comprises an abstract sequence of events systematically related to each other. The discourse is described as the text in which the story is embedded, and implies a particular medium. The telling is the act of narration or communicative process that produces the story (Hamilton, 1995).

Rules for narrative construction guide our attempt to account for human actions across time. They do so through informal relationships, where we attempt to make ourselves intelligible to each other (Bertaux & Kohli, 1984; Mancuso & Sarbin, 1983), and scientific attempts to describe and explain human behaviour. Given our everyday battle "to make sense," what are the constraints on our means of explaining life through narrative? Gergen and Gergen (1984, p. 27) try to answer this question:

The successful narrative is one that arranges a sequence of events as they pertain to the achievement of a particular goal state, then there are only three prototypical or primitive narrative forms: those in which progress toward the goal is enhanced, those in which it is impeded, and those in which no change occurs.

Gergen and Gergen (1984) call these narrative prototypes progressive narrative, regressive narrative, and stability narrative, respectively. In terms of HIV prevention or intervention efforts, Gergen and Gergen (1984) narrative prototypes offer interesting positions. How would the person who upholds any one of the four narratives define his or her situation in the face of the HIV onslaught? In the case of the villagers of *Mutasa* and *Sherukuru*, which of the prototypes would they adopt to deal with the devastating impacts of HIV/AIDS? We need to answer these questions when explaining the construction of HIV/AIDS among rural communities of Zimbabwe.

Narratives are culturally defined (Fawcett, 1984 cited in Cortazzi, 1993). Culture superimposes itself on narrative. Narratives are intricately woven in the rich texture and fibre of social and cultural meaning. Yet culture does not proscribe the individual and the search of self and meaning. Individually generated narratives become social as we seek to share them with others. Once in the social domain, the narratives assume a self-defined momentum that catapults them into the realm of culture whereby they become forms of social identity. This intricate synergy of self, society and culture makes narrative rich and unique in terms of understanding human phenomena. However, narrative does not seek to claim consensus of meaning but rather enhances diversity, emotion and life drama.

Need for narrative

The quality of human experience through time means that narrative form alone can capture the full temporality, tensions, surprises, disappointments, and achievements of lived experience (Mair, 1989). However, the unequal and unjust world we live in means that not all narratives are equal. There are dominating narratives that overshadow alternative discourse.

The dominant narratives of any particular culture and historical period are described as important interpretive instruments to organise and communicate about human experience. Their power lies in the fact that they go largely unexamined and is taken for granted because they are dominant. The danger is that often such dominant narratives do not reflect individual experience very accurately (Bruner, 1986). The submerging of individual narratives threatens the very survival of the dominant narratives, as they themselves are a tapestry of individually lived experiences.

Narratives are units of power as well as meaning and have a clear political dimension (Bruner, 1986). Narratives are the primary vehicle of ideology (Kerby, 1991). Therein lurks the danger of dominant narratives (Hamilton, 1995). Such narratives led to systematic Nazi genocide against the Jews, the Tutsi genocide in Rwanda, Apartheid in South Africa, and anthropological and demographic claims that the “permissiveness” of African sexuality explains the implosion of HIV infection in sub-Saharan Africa.

Alternative and competing narratives are often suppressed in the public or mainstream. They are not allocated (or, “are not to be allocated”) public space for their telling and must seek expression in dissident media and private space (Bruner, 1986b). Therefore the graffiti in the ghettoes, the writings on the toilet walls of universities, and the tattoos on prisoners are all narratives engaged in a distinct discourse /story telling understood by the actors involved. This kind of discourse has found alternative expression because it is sanctioned in the mainstream. The ability to tell one’s own story has significant political implications (Sluzki, 1992). It may signify a clear challenge to the dominant narrative(s) (Hamilton, 1995). All stories are told in a particular time, place and culture (Mair, 1989). All stories are thus political in the sense that they reflect hidden structures of power and privilege.

The use of narratives in everyday life makes them a useful tool for negotiation (Hamilton, 1995). Their subjectivity creates a tolerance of different stories without the need to obtain a standard “true” narrative (Bruner, 1991). Bruner (1986, p.15) describes three features of a narrative:

The first is the triggering of presupposition, the creation of implicit rather than explicit meanings. For with explicitness, the reader’s degrees of interpretive freedom are annulled. The second is what I shall call subjectification: the depiction of reality not through an omniscient eye that views a timeless reality, but through the filter of consciousness of protagonists in the story... The third is multiple perspective: beholding the world not univocally but simultaneously through a set of prisms of which each catches some part of it.

The argument is for contextualisation of narratives (Maxwell, 1998). Narratives should be viewed within their conceptual context in terms of the theory, observation and preliminary research that has informed them.

A critique of social constructionism

The enduring weakness of social constructionism is its “vagueness about concepts such as society or culture” (Bayer, 1998, p. 5). The strength of social constructionism has been its ability not to position itself as a core psychology (Bayer, 1998). However, social construction as a discipline has had its fair share of struggle and criticism. As Bayer (1998, p. 1) comments, “there are certainly struggles and contests over meanings and meaning making amongst social constructionists, not to mention between constructionists and non-constructionists.”

She poses the following questions (Bayer 1998, p. 2):

Is social construction above or beyond the very entanglements of culture, history, technology, or politics that it so astutely unravels in psychology’s theories of the subject, its epistemology or disciplinarity? Is social construction sufficiently reflexive to supply a critique of its own workings and to move from these transformations?

Each historical epoch, or phase of human beings’ technological evolution from Stone Age to cyberspace, has influenced and contributed towards science and knowledge. Attention needs to be paid to how technological developments have influenced our notion of subjectivity. Social construction is not immune to techno-language, political or historical developments. A poignant example is the development of cyber language used in the virtual world (Brown, 2001). As Bayer (1998, p. 3) argues, “Social construction cannot claim any special residency outside of culture, history, movements, technology, or politics.” How then does this relate to social constructionism’s position that nothing exists outside the word: the vehicle of culture and social reality, the lived world?

Social constructionists reject traditional psychology notions, based on positivist influences, of viewing the world as “out there” waiting to be discovered (Bayer, 1998 p 3). We create the world we live in. We are relational; we are in and of the world (*ibid.*). We are knowers (DuBois, 1983). We are embodied beings (Sampson, 1998). Social constructionism rejects the notion of grand theories or metanarratives to explain the world. We cannot view the world from a distance for we are part of the world we create through discourse and language.

Social constructionism and personhood

Social constructionism denies the existence of personality as viewed by traditional psychology (Burr, 1995). It rejects the essentialist view of personality. As human, we are accustomed to the

idea that we have particular traits, ideas, experiences, opinions and beliefs that originate in us and therefore make us unique. These traits identify and separate us from one another. They allow us to believe that we make decisions and take responsibility for the kind of person we have become. However, social constructionists say there are no such identity-defining traits; rather, we are the product of language, manufactured out of discourse (Burr, 1995).

Social constructionists take up a Foucault's position that nothing has an "essential, independent existence outside of language; discourse is all there is" (Burr, p. 57). Human beings are not a unique combination of psychic material. Such a position brings about troubling questions about personal agency or accountability. At stake, here is the problem of moral justification, which, though it is beyond the scope of this thesis, remains an essential one especially in the study of HIV/AIDS and culture. Without pretence at a definitive answer, the following section touches briefly, on how a social constructionist reading would view matters of personal agency.

Personal agency

What is the relationship between the individual and society? Who influences whom? In what sense can human beings be said to have agency? Burr (1995 p. 59) observes that through social construction's emphasis on discourse:

The actions, words and thoughts of human beings appear to be reduced to the level of by-products of bigger linguistic entities of which we may be unaware. Our hopes, desires and intentions become the products of cultural, discursive structures, not the product of human agents...We see the world changing and imagine that human intention and action is at the root of it but this is an illusion.

Human beings lose authorship of their actions. Rather we have to accept the socially constructed, relational character of people's subjectivities, their selves, their identities, their structures of consciousness (Shotter, 1998). In an attempt to address this question, Day & Tappan (1996) draw from Bakhtin's (1984) work and argues that, though we are exposed to others' discourses which become part of the self, such discourses are not merely assimilated wholeheartedly. Rather they undergo through a process of selective appropriation, which involves an ongoing questioning and reflection, based on what we already know. It is by means of this process of selection appropriation, argues Day and Tappan (1996), that individuals can claim authorship or responsibility for their actions.

What is reality?

Social constructionism's claim that nothing exists outside language creates difficulties when it comes to understanding reality and truth (Burr, 1995 p.59):

The claim that 'discourse is all there is' is a logical conclusion of the argument that language does not label discrete entities in the real world that exist independently of it. All that language can do, then, is to refer to itself. Language is a 'self-referent' system. This means that any 'sign' can only be defined in terms of other signs existing in the same language system.

Our subjectivity opens us up to sometimes different and conflicting discourses. If we have competing discourses, which discourse can then be regarded as the truth or reality? Burr (1995, p. 60) writes:

Given that there are numerous and conflicting discourses surrounding any 'object', we are left with no notion of 'truth' (i.e. the discourse that can be

said to describe the object correctly, all the others being false). All we have is a variety of different discourses or perspectives, each apparently equally valid.

From Burr's argument, truth becomes relative. She opines, "The claims of each discourse are simply relative to each other, and cannot be said to be either true or false when compared to 'reality'" (*ibid.*).

Reality becomes as relative and subjective as truth. Since we have competing discourses and, therefore truths we also compete to be heard. Gergen (1989) refers to this phenomenon as "warranting voices." According to Gergen (1989), subjectivities present constructions of themselves that maximise their standing and offer legitimacy. In other words, subjectivities present constructions that are "most likely to warrant voice" (Burr, 1995 p. 90).

If we have multiple realities, how do we deal with things that are independent of language like the economy, or our bodies? The same applies to the world we live in. Relativism puts us into a philosophical *cul de sac*. Social constructionism has to grapple with the concept of relativism and offer enduring theoretical explanations to issues of reality and truth. Possibilities to address the issue exist in hermeneutic philosophy, the works of the Gadamer (1975) and Habermas (1972) in particular, in which the problem of moral justification features prominently. As mentioned above, however, critical engagement with these arguments falls beyond the scope of the current work.

Hence, this study seeks to explore the sexual practices and the cultural meanings of rural Zimbabweans in the face of the HIV/AIDS pandemic. It argues that sexual practices and the cultural meanings attached to them can either expose or protect one from possible HIV infection. The thesis also argues that the narratives of rural Zimbabweans give us an insight into their worldview and how rural Zimbabweans are constructing and reconstructing their lives as they deal with the devastating implications and effects of the HIV/AIDS pandemic (Karuru & Paradza, 2007; Mungwini, 2008; Mungwini & Matereka, 2010). It is important and justifiable that we understand these constructions of sexuality in order to better inform prevention programmes in Zimbabwe and sustain the current programmatic gains. This is against a background of dropping HIV prevalence levels in Zimbabwe (UNAIDS, 2006).

Conclusion

This chapter gives an overview of the theoretical positions that guide the research. It begins by highlighting the paradigms that have influenced health behaviour change and promotion: the health belief model, the theory of reasoned action and social learning theory. It acknowledges that, though hugely successful in Western cultures, the paradigms have serious shortcomings in their application in non-Western societies. They are Eurocentric and individualistic and hence ignore the collectivist nature of non-Western societies. The chapter then proposes social constructionism as an appropriate theoretical model for understanding the cultural and social factors facilitating the rapid transmission of HIV infection in Zimbabwe. It argues that the strength of the social constructionism lies in its rejection of the concept of objective truth. It emphasises the subjective lived experiences of persons. People construct the world they live in through language. The chapter also explored some of the challenges of using the social constructionist paradigm in trying to understand the meanings people attach to their lives, experiences and words.

CHAPTER 6

STUDY METHODOLOGY

The chapter describes the study design and methodology. It highlights the conceptual and methodological considerations that led to the choice of the methods and design used by the study. It also looks into the methodological problems and weaknesses encountered in conducting of the study. The study used the voice-centred relational method of data analysis (Doucet & Mauthner, 1998; Gilligan, 1991). The voice-centred relational method is an ontological methodology grounded in listening to the voices of respondents and reflexivity on the part of the researcher. It is a qualitative method of research into people's experiences and lived realities (Sofaer, 1999). The chapter also discusses issues of validity and reliability in qualitative research (Maxwell, 2004; Mays & Pope, 1995), especially research that involves accounts sexual behaviour (Kakuru & Paradza, 2007; Zea, Reisen & Diaz, 2003).

Background

This study arose out of an ongoing longitudinal intervention in the *Mutasa* and *Makoni* rural districts of *Manicaland* province in Zimbabwe (Gregson *et al.*, 1995, 2001, 2006). The longitudinal intervention study is the *Honde-Mutasa Project*. *Honde* is the name of a valley in the *Mutasa* district of *Manicaland* province where a previous research project was conducted (Gregson & Zhuwau, 1995). It was realised then that the epidemic had not spared the rural areas of Zimbabwe, long considered safe from the HIV/AIDS epidemic ravaging the urban areas (Gregson *et al.*, 1996). A follow-up intervention study was initiated (Gregson *et al.*, 1997). The follow-up intervention study had three components; 1) a biomedical, 2) a demographic, and 3) a social science component. The study described herein is a small part of the social science component.

Sampling process: the study communities

Employing non-probability, purposive sampling the study selected two typical rural villages in the *Mutasa* District of *Manicaland* Province. These two villages were part of several villages that were already participating in the biomedical study component of the *Manicaland HIV/STD* Prevention Project (Gregson & Zhuwau, 1995; Gregson and Chandiwana, 2001). Purposive sampling predominates in qualitative research (Creswell, 1997; Denzin & Lincoln, 1994; Devers & Frankel, 2000; Lincoln & Guba, 1985; Malterud, 2001; Marshall, 1996; Miles & Huberman, 1994; Ragnarsson *et al.*, 2010; Riess, Achieng, Otieno, Ndinya-Achola & Bailey, 2010; Wojcicki & Malala, 2001). Purposive sampling was preferred because the study was typically concerned with description rather than generalisation of the experiences of rural Zimbabweans in the midst of the HIV/AIDS pandemic (Barbour, 2001; Fossey, Harvey, McDermott & Davidson, 2002; Mays & Pope, 1995b; Polkinghorne, 2005).

The first village selected was *Mushonga* village of *Honde valley*. The second village selected was *Sherukuru* near Bonda mission. Bonda mission is an Anglican Church mission station. *Mushonga* village is one of several villages in a basin commonly referred to as the *Honde valley*. It is under the traditional authority of Chief *SaMushonga*. *Honde valley* is in the north east of *Mutasa* district and separated from Mozambique by the Pungwe and *Honde rivers*. *Sherukuru* village is west of *Honde valley*. At the time of conducting the research *Mushonga* village had an estimated population of about 300 people and *Sherukuru* had a population of about 350 villagers of varying age groups. The distance between the two villages is about 85 kilometres. The mountainous terrain of the region makes it almost impossible for the two villages to have regular contact, unless one travels by car or bus.

Several comparative factors influenced the selection of the two villages. *Sherukuru* village is on a much higher plateau and in a dry belt of the *Mutasa* region. Both villages practice subsistence farming, although *Honde valley* specializes more in cash cropping (Gregson *et al.*, 1996). They both speak the *Manyika* dialect of the *Shona* language, which is the language spoken by the majority of Zimbabweans. There were no major infrastructure differences between the two villages. Both villages were within close proximity of a hospital. *Musbonga* is close to *Hauna* District hospital and *Sherukuru* to the *Bonda* Mission hospital. They both had access to major highways. *Sherukuru* village accessed easily the Rusape–Nyanga highway and *Musbonga* village had access to the Nyanga–Mutare highway. Gregson and others (1996, 1997 & 2001) have given detailed description of these areas. Both villages had exposure to the Ministry of Health and Child Welfare’s HIV/AIDS information, education and communication (IEC) awareness campaigns. This was a critical factor to the study as it ensured that the villages selected had heard about HIV/AIDS and could therefore share their experiences of the pandemic. The HIV/AIDS awareness campaigns were through the radio and print media. Furthermore, village community workers and community nurses conducted HIV/AIDS awareness campaigns in these villages. At the time of conducting the research, the awareness campaigns could at best be described as piece-meal and erratic. They were not visible and consistent throughout but only gained episodic annual momentum towards the World AIDS Day or some special event such as the opening of a clinic or the launching of a health programme.

Sampling: study participants

The designs of many structured surveys of the HIV/AIDS epidemic cause them to fail to capture the depth and underlying causes of the epidemic. They do not allow for in-depth exploration of the answers that respondents give and have a usually pre-determined response range (Graneheim & Lundman, 2003; Pope & Mays, 1995; Zea *et al.*, 2003). This has led to the observation that “studying matters as delicate as HIV/AIDS calls for a qualitative, investigative approach” (Woudenberg, 1998, p. 18). Woudenberg (1998, p. 18) reaches this conclusion because “AIDS is not only a lethal disease; it also stems from a highly stigmatised condition.” Stigma is a negative social artefact embedded in human understanding and meaning of disease or social phenomena (Dlamini, Kohi, Uys, Phetlhu, Chirwa, Naidoo, Holzemer, Greeff & Makoae, 2007; Emler, 2007; Hartwig, Kissioki & Hartwig, 2006; Kalichman, Simbayi, Cain, Jooste, Skinner & Cherry, 2006; Maclean, 2004). This realization profoundly limits the methodology of choice. Methodological biases creep into the study because of the uniqueness of the condition under study. Sampling or study design becomes severely restricted because of the need to find people willing to come forth and talk about a disease that carries stigma.

A similar challenge confronted this study. People were not comfortable with their random selection. They would ask why they been had selected and not the other person. Did we suspect them of having HIV or AIDS? In close-knit rural communities of Zimbabwe, it is impossible to carry out an interview without the neighbours getting wind of it. Subsequently, they would approach us and implore us to interview them as well. If we turned them down, they were most likely to spread malicious rumour concerning the study and the participants. In order to limit this problem, we employed purposive sampling in selecting the study participants. Study participants had to volunteer after an initial meeting that introduced the aims and purpose of the study.

We recruited respondents who were willing to be interviewed after approaching through the village health workers. The village health worker is hierarchically the lowest ranking public health official working at village level. During their community meetings, the village health workers

would spread word about the study and ask for volunteers. The volunteers would then approach the researcher, who would fully explain the study to them before recruiting them as study participants. Most critically, we explained to the respondents that the study was about their everyday life experiences, how they lived their lives, decisions they made daily, challenges that confronted them and how these were resolved. We informed the respondents that participation was not compulsory and that we would treat all information shared anonymously and without reference to any personal or descriptive identifiers (Tobias 2001).

The study sample was drawn from the two villages, *Mushonga* and *Sberukuru*, respectively. The aim of selecting two villages from the same district was to see whether there were any observable and comparable differences in their experiences of the HIV/AIDS epidemic. A sample of 60 villagers, i.e., 30 from each village, was selected. In addition, the study also recruited ten female commercial sex workers using the snowball sampling technique (Riess *et al.*, 2010; Wojcicki & Malala, 2001). The 60 villagers comprised of 30 men and 30 women, aged between 18-55 years. Fifteen men and 15 women were selected from each village, respectively. All the villagers had at least primary school education. The highest level of education was four years of secondary school education. Of the 60 respondents, two were community leaders (or elders), two were religious leaders, three boys and two girls were high school students and the rest were ordinary villagers. Their primary economic activity was seasonal subsistence farming. Most notably all the adult male respondents had a history of migrant labour. Some had been casual labourers on the tea, citrus and forestry plantations that predominates the area and others had worked in hotels that are also common in the area.

The age range of the commercial sex workers was 22 – 45 years. They were all residents of *Mutasa* District either by birth or through a previous marriage. Nine of the commercial sex workers were born and raised in the *Honde valley*. All the commercial sex workers operated from the *Hauna* business centre in the *Honde valley*. The commercial sex workers freely volunteered to participate in the study after the researcher approached them at the local beer-hall⁶.

The age of majority in Zimbabwe of 18 years justified the selection and interviewing only of respondents of 18 years and above. Women between 15-49 years are the standard range in reproductive health research. Epidemiologic evidence from studies in Zimbabwe and elsewhere confirms this observation (Ashford, 2006; Basset & Mhloyi, 1991; Gregson *et al.*, 2001; Gregson, Zaba & Hunter, 1999; Hosegood, 2009; Mbizvo & Adamchak, 1993; Tobias, 2001; UNAIDS, 1998; 2000; 2008). The rationale for interviewing males and females was to try to see if there were any sex and gender differences regarding the lived experiences of men and women of *Mutasa* and *Makoni* Districts in the face of the HIV/AIDS pandemic. The literature reviewed by this study pointed to gender differences in the way societies dealt with the HIV/AIDS pandemic (see Chapters 1, 2 & 3).

The rationale for interviewing sex workers was informed by the knowledge that sex workers have always been central to the epidemic as a special reference group in the epidemiology of the disease (Amaro, 1995; Brewer, *et al.*, 2003; Davila & Brackley, 1999; Gilbert & Walker, 2002; Gupta, 2002; Kambarami, 2006; Shannon *et al.*, 2007; Turmen 2003; Wojcicki & Malala, 2001). It was one of the stated objectives of this study to explore how commercial sex work was viewed in rural Zimbabwe given the high levels of HIV prevalence and the earlier AIDS discourse that sought to blame “women prostitutes” for spreading the “killer disease” (Kakuru & Paradza, 2007; Ray & Madzimbamuto, 2007, Runganga, 1992).

⁶ Beer-halls are normally local council (municipality) run beer outlets in urban and rural centres.

Methods

The study was qualitative in its design (Cresswell, 2007; Denzin & Lincoln, 2005; Graneheim & Lundman, 2004; Maxwell, 2004; Miles & Huberman, 1994; Pope & Mays, 1995; Sofaer, 1999). The appeal of qualitative research in the postmodernist social inquiry tradition arises from four key concerns. These are “1) research conducted in the ‘real world’, 2) a recognition of the central role of language and discourse, 3) life and research perceived as processual or as a set of dynamic interactions, and 4) a concern with persons and individuals rather than actuarial statistics and variables” (Smith, Harre` & Langenhove, 1995, p. 3).

Face-to-face, open-ended interviews, and spontaneous, informal interviews with key-informants (Woudenberg, 1998) were chosen as appropriate methods of data collection. The methodology of Campbell *et al.* (1998) and Woudenberg (1998) informed the choice of methodology. In their innovative research, the Carltonville AIDS Research Project, Campbell *et al.* (1998) used the life story interview as a methodology to investigate the dynamics of sex and sexuality within the South African mining industry. Campbell *et al.* (1998) in turn, acknowledge the influence of University of Zimbabwe Project Support Group (Dube and Wilson (1996), on their choice of this methodology for HIV/AIDS research. Woudenberg (1998) applied a similar methodology in her study of a group of HIV positive women in Zimbabwe. Several other studies have applied the life story interview to study the impact of the HIV/AIDS epidemic (Gwanzura-Ottmoller & Kesby, 2005; Kakuru & Paradza, 2007; Kesby, Gwanzura-Ottmoller & Chizororo, 2006; Ngoshi & Pasi, 2007).

As Plummer (1995, p. 50) explains, life stories seek to explore “the subjective meanings of lives as they are told in the narratives of participants”. It is the subjective aspect of narratives of personal lives that reminds us that as much as they are formative, they can sometimes equally be deformative and it is that dichotomous aspect of life histories that make them appealing (Rosenwald & Ochberg, 1992). The subjectivity allows for a process of dual reflexivity, with both the researcher and the subject reflecting on their experiences of each other’s life, circumstances, position, and situation (Manji, 1996; Parker, 1994). This relational experience demands one to locate self within dialogic processes in motion. This in turn requires the rejection of a value-free or neutral position (Manji, 1996). The experiences shared with the respondents will have to affect the researcher for her or him to be able to understand and write about them. Subjectivity in qualitative research becomes an ethical enterprise between the researcher and the participant (Parker, 1994).

One of the key tenets of qualitative research is demystification of the researcher and the researched as objective instruments of data production (Manji, 1996). Instead, qualitative research is a liberating experience that allows the researcher and the researched to mutually enjoy the research process and share experiences. Mies (1983) says that, in order for knowledge to be liberating, it has to emerge through dialogue rather than one sided questioning. It has to be non-hierarchical and this requires the researcher to view research participants as collaborators and co-creators of knowledge (Villanueva, 1997).

The limited research on sexuality and HIV/AIDS warrants qualitative approaches to establish a foundation for evaluating sexual practices by situating them within their social and cultural realms (Abramson & Herdt, 1990; Parker & Caballo, 1990). Lear (1997) argues that qualitative approaches could provide sensitive information that cannot be uncovered in surveys using structured interviews, and can be used as an end or to further inform other methods. Mauthner and Doucet (1998) emphasize the relational ontology of qualitative research.

We developed interview guides for the villagers and the commercial sex workers, respectively (Appendices 1 & 2). Separate interview guides were required because the very nature of commercial sex work necessitated additional questions that related to their work as sex workers. The questions looked at the commercial sex workers' interactions with clients, sexual preferences of clients, charges, meeting places, violence and personal safety, etc. The research questions, literature review and the need to develop a narrative of the respondent's life rather than the simple collection of data guided the development of the interview guides (Good, 1994; Mattingly & Garro, 2000; Synder & Ingram, 2000). The interview questions were open-ended and allowed for interaction as a means of generating discourse (Potter & Wetherell, 1987, Wetherell & Potter, 1992; Willig, 1999).

Pilot testing

The interview guides were pilot tested on four Zimbabwean students who were studying at the University of KwaZulu-Natal's Pietermaritzburg campus and eight residents of *Hauna* Growth Point⁷ in *Honde valley*. All the University of KwaZulu-Natal students spoke the *Manyika* dialect of the *Shona* language. Their valuable input and comments helped further refine the research guides in terms of wording, flow of questions and focus. The residents of *Hauna*, on whom the pilot testing was done, mirrored the targeted study sample's socio-economic characteristics. The pilot testing assisted in giving an understanding of how the study sample population was likely to comprehend the study. The pilot also enabled the interviewers to test their verbal translation of the English interview guides into the *Manyika* dialect. This was not difficult given that the two interviewers spoke the dialect and had previous working interactions with the study communities. The pilot test with residents of *Hauna* showed that each interview was approximately an hour long. There was, therefore, a need to be sensitive to the requirements of the interview and the demands on the respondents' daily schedules.

Data collection

A qualified and experienced female research assistant helped with the field data collection. The research assistant, a social science graduate from the University of Zimbabwe, received two weeks on how to conduct the interviews. The training of the research assistant was made easier by the fact that she had worked in the area before and had outstanding rapport with the villagers. She was also extremely competent in the local *Manyika* dialect. The research involved asking people about their personal life narratives hence the need to have a female interviewer who could talk to the female respondents freely and confidentially. She interviewed all the female respondents except the commercial sex workers and the male respondents who were interviewed by the researcher. The commercial sex workers made it clear that they were comfortable being interviewed by a male researcher than a female researcher. This was in direct contrast to Karuru and Paradza (2007) experience in Uganda and Zimbabwe where some sex workers were comfortable with being interviewed by female researchers. The possible reasons for this observation are discussed, in detail, in Chapter 7 of this study.

The interviews were first carried out in *Musbonga* village and then in *Sherukuru* village. Village health workers acted as guides to the study team. They assisted with spreading information about the study and with daily logistics of the study such as setting up appointments with potential interviewees on the researchers' behalf.

Respondents were required to consent to the interview by signing the study consent form. All the interviews were voice-recorded. None of the participants objected to being voice-recorded.

⁷ Growth points are rural commercial hubs usually boasting grocers, post office, beer outlets, schools and a police post. They also serve as a transport hub to hinterlands in rural areas of Zimbabwe.

Interviews took anything between one to two hours to complete. The time taken per interview was dependent on the respondent. Upon completion of the interview, each respondent was given monetary compensation as a token of appreciation for time spent on the interview. The ethical implications and rationale for monetary compensation of study respondents are discussed in subsequent sections of this chapter.

Study bias

A possible source of bias in the study was interviewer effect (Fowler & Mangione, 1990). It arose out of the influence the researchers had on the respondents. The impact on respondents, though not intended, occurred naturally because of the relational aspect induced by the interview process. The study sought to minimize this bias by maintaining a relaxed, trusting relationship with the respondents. This was done through establishing an informal but respectful atmosphere during the interviewing process. The respondent decided when and where to be interviewed. We cannot completely rule out study bias. However, the relational method of data analysis allows one to reflect on the possible impact of one's socio-cultural position on the process and thereby reduce the level of bias.

Data management

All the interviews were audio taped (Ragnarsson *et al.*, 2010; Riess *et al.*, 2010; Shannon *et al.*, 2007). Unique identifiers, labels, and dates were for data management. All the recorded tapes were kept securely locked up by the researcher. Only the transcribers had access to the tapes after the researcher had first gone through them all to remove any personal identifiers that might have crept into the interviews. The tapes were disabled so as not to allow them to be copied before being sent to transcribers. Two professional transcribers who worked independent of each other transcribed the audiotapes. This was done to crosscheck the reliability of the transcriptions. The original tapes were returned to the researcher after transcription. The researcher also listened to the tapes several times in order to validate the transcriptions. Discrepancies were discussed and clarified with the transcribers. The differences were mostly over word preference, skipping of grunts, giggles or not indicating pauses in the interview transcript. Tapes were swapped between the transcribers to ensure quality of transcription.

Ethical considerations

One of the concerns of studies involving human subjects is the need to demonstrate beneficence and the need to protect participants from harm (Newman, 1993). Internal review boards of funding or research agencies have developed very strict ethical considerations aimed at protecting participants from harm or malpractices. According to the Nuremberg Code of 1947 and the Helsinki Declaration of 1964 by the World Medical Association, all research involving human subjects has to respect the subject's right to privacy, informed consent, confidentiality, protection from harm and any form of pressure to participate in the research.

The Wellcome Trust, a United Kingdom based charitable funding organisation, committee on reproductive health and population studies approved the study by agreeing to fund it as doctoral studies research. The University of KwaZulu-Natal's Higher Degrees Committee, through its Humanities and Social Sciences Research Ethics Committee, also approved the study as meeting its doctoral research requirements and ethical considerations. The Provincial and District Medical Directorates of *Manicaland* province were informed of the study and raised no objections.

Informed consent was sought from all participants. The study's objectives were clearly explained to the respondents and they were asked to take their time and carefully decide whether they wanted to participate in the study. The blessings and permission of the village leadership was

sought first before approaching individual villagers. The researcher presented himself before the headmen of the two villages and explained in detail the study, its objectives and conduct. Invariably, the headmen asked for time to consult with their advisers before granting the study the go-ahead it needed. The village health workers then also informed other significant village elders of the research in order to enlist their support. The significant elders granted us permission to conduct the study.

Those who agreed to participate in the study signed a consent form that was in the vernacular (see Appendix 3). For purposes of confidentiality, no other person was allowed to sit in the interview. The researcher explained to the household heads the reasons for conducting the interviews in privacy and the confidentiality of the information volunteered. Traditional custom and social etiquette of Zimbabweans demand that one should seek permission of the household head before interviewing anyone in his or her household. Ijsselmuiden and Faden (1992) have commented on the challenges of research and informed consent in Africa. Gasa (2000) in her study of communities of Hlabisa's involvement in an HIV vaccine trial, highlighted the need for community consent in addition to individual consent. She explained that personhood in traditional Zulu communities was communal rather than individualistic. In other words, individual decisions were based on the collective view. Kakuru and Paradza (2007) refer to similar experiences in their work in Uganda and Zimbabwe.

Arrangements were made with respective respondents as to the appropriate time and day to carry out the interviews. We took great care to ensure that the respondent was in no way inconvenienced by the scheduling of interviews. All interviews were carried out during daytime and in privacy (Strain & Chappell, 1982; Villanueva, 1997).

Compensation of Respondents

A major ethical dilemma that confronted the study was compensation of respondents for participating in the study. Some studies conducted in Africa have given a monetary token of appreciation to respondents (Ragnarsson *et al.*, 2010; Reiss *et al.*, 2010; Shannon *et al.*, 2007). An underlying problem in the study of the *Mushonga* and *Sherukuru* communities was that a consumer marketing research group had previously paid people in the area for participating in its product market research. We explained that the study was not a commercial marketing enterprise but an academic undertaking. The possible benefits deriving from the study were the advancement of knowledge on health issues relevant to the local communities. Knowledge that could be used to design health interventions, assisting community-based organisations in programmatic interventions, as well as help policymakers better understand public health concerns. We decided to give each respondent some monetary compensation at the end of our stay in the study communities to compensate for time invested in the interview. This decision was not communicated to the participants prior to the commencement of the study. Each participant was given an equivalent of \$3 (United States dollars) at the end of the data collection phase. Giving participants some cash incentives before or immediately after completion of an interview was likely to be perceived as an inducement. A study carried out in Zimbabwe faced a similar ethical dilemma (Zvinavashe-Gava, 1996).

I was also ethically bound to demonstrate study beneficence to the communities involved in the study. I undertook to acknowledge their primary role in the study and to return to them with my findings.

Data analysis: the process

A growing body of literature that has utilised qualitative research methods to study people's lived experiences (Gilligan 1982; Miles & Huberman, 1985; Woudenberg, 1998; Atkinson 1998;

Campbell 1998; Girden, 1996; Vlaenderen & Cakwe, 2002; Villanueva, 1997; Mischler, 1986; Strauss & Corbin, 1990, Glaser & Strauss, 1967; Guba & Lincoln, 1989; Denzin & Lincoln, 1994; Doucet & Mauthner, 1998; Schou & Hewison, 1998; Willig, 1999). The study had initially intended using a computer-based qualitative data analysis programme, NVivo, for data analysis. The NVivo programme proved to be very complex and difficult to use in the analysis of the data collected for this research study. This was partly due to doubts over the programme's ability to capture the nuances embedded in the *Sbona* scripts. The data was losing some of its appeal and meaning.

At about the same time, I became aware of the work of Gilligan (1991), and Doucet and Mauthner (1998). Gilligan's work on the caring voice as well as Doucet and Mauthner's work on the voice-centred relational method of data analysis. The works are on the self-in-relationships, voice, culture and power.

The study eventually used the voice-centred relational approach (Denzin & Lincoln, 1994; Doucet & Mauthner, 1998; Gilligan, 1991) complemented by thematic analysis for data analysis. The analysis of qualitative data has always been problematic because of the lack of literature on the fundamentals of analysing interview transcripts (Doucet & Mauthner, 1998). Doucet and Mauthner (1998, p. 1) voice their concern with the recent trend in qualitative analyses of using computer-based programmes:

Moreover, there appears to be an increasing move to equate computer coding with qualitative data analysis, with several recent texts on qualitative data focusing on the use of computer programs and which software package to employ.

The aim of data analysis in qualitative research is "keeping respondents' voices and perspectives alive, while at the same time recognizing the researcher's role in shaping the research process and product" (Doucet & Mauthner, 1998, p.1). This produces tension and a dilemma to the research process that needs to be resolved, albeit challenging the notion of objectivity (Gilligan, 1993; Manji, 1996). According to Doucet and Mauthner (1998, p. 1) researchers need to explain and account for:

the processes through which we transform respondents' private lives into public theories, and our role as researchers within these processes, are critical to assessing the validity and status of these theories.

Data generated by the study were about personal experiences of the respondents. The personal experiences were very divergent and needed to be captured and preserved in a way that maintained their uniqueness. Woudenberg (1998) acknowledges the complexity of trying to synthesize responses in a manner that does not distort their uniqueness.

Openness in qualitative research

Chenail (1995) laments the woeful lack of openness in the description of qualitative research's method-creation process. He finds it disconcerting that a discipline which prides itself of its "skills at description, explanation, and interpretation, qualitative researchers are often woeful on applying these abilities in their presentations of their methods" (Chenail, 1995, p. 1). He argues that qualitative analysis must be a public event that allows sharing of methods, decisions and rationales for the choices we make in our data analysis. He further states that we need to give our readers ample opportunity to query our inquiry in terms of how we constructed the study, the steps in forming the research questions, selecting a site, generating and collecting data, processing and analyzing data, and selecting the data exemplars for the presentation. This is supported by Crawford and Valsiner (2002, p. 92) who assert that methodology be seen not as

“a given set of methods – toolbox of ready-made instruments” but as “a process of conceptually linking theoretical frameworks and their guiding assumptions, phenomena, and methods.” Data ought to be derived than merely collected (*ibid.*).

Chenail (1995, p. 2) exhorts the qualitative researcher to involve ‘the other’ in the research process:

Be open with what it is you are going to do, give the details of your design and process as best as you can, and then follow the plan each and every time you collect data, or transcribe, or categorize, and so forth. If through the process you decide that it would make sense to adjust what it is you are doing, note the change, describe it in detail, and follow through with the new plan. Throughout this process, you invite the reader and \or co-participants in the study to dialogue with you as to how you are doing with your description of what it is you are doing and the actual carrying out of plan.

There are two important reasons for openness in the qualitative research process: 1) it enhances validity, and 2) allows sharing of one’s inquiry (Chenail, 1995).

Data analysis: the voice-centred relational method

As mentioned in the preceding section, the study utilised the voice-centred relational method for data analysis. The voice-centred relational approach is a paradigm that has emerged from the work of Brown and Gilligan at Harvard University (Brown & Gilligan., 1992; Gilligan, 1993), and Doucet and Mauthner (1998) at Cambridge University. The roots of this approach are in developmental psychology, educational research, and clinical practice with women (Doucet & Mauthner, 1998). The voice-centred relational approach “holds at its core the idea of a relational ontology” (Doucet & Mauthner, 1998, p. 4). It rejects the notion of “a separate, self-sufficient, independent and rational self” (*ibid.*, p. 5). It views human beings as relational, interdependent selves interacting and living in a complex social world.

The voice-centred relational method draws upon the philosophical works of Ricoeur (1979) and Dilthey (1976). The philosophical works of the two were concerned with the lived meaning of human experience. The method also draws heavily from the works of the Russian linguist Bakhtin. Bakhtin (1981) proposed the concept of the dialogical account of human functioning that emphasises the unavoidably relational nature of our being-in-the world. Doucet and Mauthner (1998, p. 5) note:

The voice-centred relational method represents an attempt to translate this relational ontology into methodology and into concrete methods of data analysis by exploring individuals’ narrative accounts of their relationships to the people around them and their relationships to the broader social, structural and cultural contexts within which they live.

The method is reflexive. It seeks insight into people’s accounts of their lives. It locates, positions and situates knowledge. The person is situated within knowledge production through narrative accounts of his or her lived experience. The person is viewed as an engaging embodiment of situated knowledge. The section below briefly discusses the basic steps of the voice-relational approach.

The Voice-Relational Method: the Reading Process

The basic steps of the voice-centred relational approach are:

- Reading for the plot and the researcher’s response to the narrative – to identify the main events, the protagonists, and the subplots. Recurrent themes, images, words, metaphors and

contradictions are listened to. The researcher then queries how he or she is responding emotionally and intellectually to the respondent. This involves confronting one's prejudices, experiences, class and philosophical dispositions;

- An understanding of how the respondent experiences, feels and speaks about herself. This means listening for personal pronouns, I, me, we, in interview scripts as amplifications of the storyteller's experiences and identity; and,
- Detailed case-studies of the researcher's thoughts and analyses about a particular respondent (Doucet & Mauthner, 1998).

Table 4 below is a diagrammatic representation of the reading of the interview scripts using the voice relational method.

Table 4: Diagrammatic Representation of the Reading of Script Using the Voice-centred Relational Method

Plot	Self: "I"; "We"	Self-Relational: Other	Social, Cultural, Structural Issues	Emerging Themes/Issues
<ul style="list-style-type: none"> ▪ Images ▪ Location ▪ What's happening? <ul style="list-style-type: none"> • subplots ▪ Summary of reading 	<ul style="list-style-type: none"> ▪ How does the person speak of self? <ul style="list-style-type: none"> • Confidence • Self-esteem • Self-blame • Dejection • Happiness ▪ How is the person situated in relation to his or her story? ▪ Voice of the person vs. voice of the group <ul style="list-style-type: none"> • identify emerging tensions between self, i.e., "I" and "We" 	<ul style="list-style-type: none"> ▪ Who else is present? ▪ What happens between character and those present? ▪ Question relationships <ul style="list-style-type: none"> • Personal agency • Power? ▪ Dominance? ▪ Submission ▪ Negotiation <ul style="list-style-type: none"> • Feelings • Actions • Outcomes 	<ul style="list-style-type: none"> ▪ Dominant social beliefs, narratives, etc., as they impinge upon; <ul style="list-style-type: none"> • Sexuality • Gender relationships • Social space • Social agency • Motherhood • Religion • Reproduction • Production, etc., 	<ul style="list-style-type: none"> ▪ Resistance to condom use ▪ Need for procreation ▪ Social capital ▪ Social networks ▪ New identities ▪ New sexual meanings

Adapted from Mkhize (2003)

Reflexivity in the Reading Process

Qualitative research acknowledges a complex and dynamic social world (Tindall, 1994). As noted by Tindall (1994, p. 142):

It is theory generating, inductive, aiming to gain valid knowledge and understanding by representing and illuminating the nature and quality of people's experiences. Participants are encouraged to speak for themselves. Personal accounts are valued, emergent issues within the accounts are attended to. The developing theory is thus firmly and richly grounded in personal experiences rather than a reflection of the researcher's *a priori* frameworks. In this way, insight is gained to the meanings people attach to their lives.

Qualitative research is personal, relational and contextual. As a process of personal reflexivity I (the researcher) had to acknowledge who I was, my individuality as a researcher and how my personal interests and values were going to influence the research from conception to outcome (Tindall, 1994). As Tindall (1994, p. 150) puts it:

This centralises, rather than marginalises or denies, the influence of the researcher's life experience on the research and the construction of knowledge. In turn, the experience of exploring personally relevant topics, and being actively engaged with participants, feeds back into their life experiences.

Thus, I have to acknowledge that, in the course of my research, the lives of the villagers of *Mushonga* and *Sberukuru* touched me in a personal way. As a highly urbanised and educated male, I was at times guilty of failing to relate to the discipline required to live a simple country life. I saw country life as monotonous, routine and solidly boring. However, upon interaction with my respondents I realised the daily difficulties and challenges they had to overcome in order to eke out a living from a seemingly unforgiving environment. I saw despondency through their eyes. I began to realise how the environment influenced the daily decisions they make regarding their lives. For example, I also started to question my insensitivity to gender issues prior to the research. As a Zimbabwean male, I unquestioningly took the existing status quo as the dictated cultural order. Listening to the "anguished" voices of the female respondents, I became aware of the pain the status quo was causing them. This affected me in profound ways and most likely coloured forever my perception of gender in the Zimbabwean society.

According to Wilkinson (1988, in Tindall, 1994, p. 151) functional reflexivity entails "continuous, critical examination of the practices/process of research to reveal its assumptions, values and biases." Who we are shapes the direction and assumptions we make about our research. As I mentioned above, my social location as an urban male with some university education influenced my theoretical approach to my research. I chose social constructionism as a theoretical framework of investigation but this choice was not made together with my respondents. I now had the onerous task of shaping and directing the course of research using a predetermined theoretical assumption. In recognition of this, Tindall (1994, p. 151) opines:

Reflexivity, then, is about acknowledging the central position of the researcher in the construction of knowledge,... that all findings are constructions, personal views of reality, open to change and reconstruction.

Likewise, DuBois (1983, in Tindall, 1994, p.151) notes "the knower is part of the matrix of what is known." As I engaged with the respondents, I became aware, as Crawford and Valsiner (2002, pp. 93-94) note, that methodology:

[I]s not simply 'one stop' on the road to empirical results. Rather, methodology is a cycle that unites all sides of the research process, as well as the subjective world of the researcher, who experiences all sides of the process.

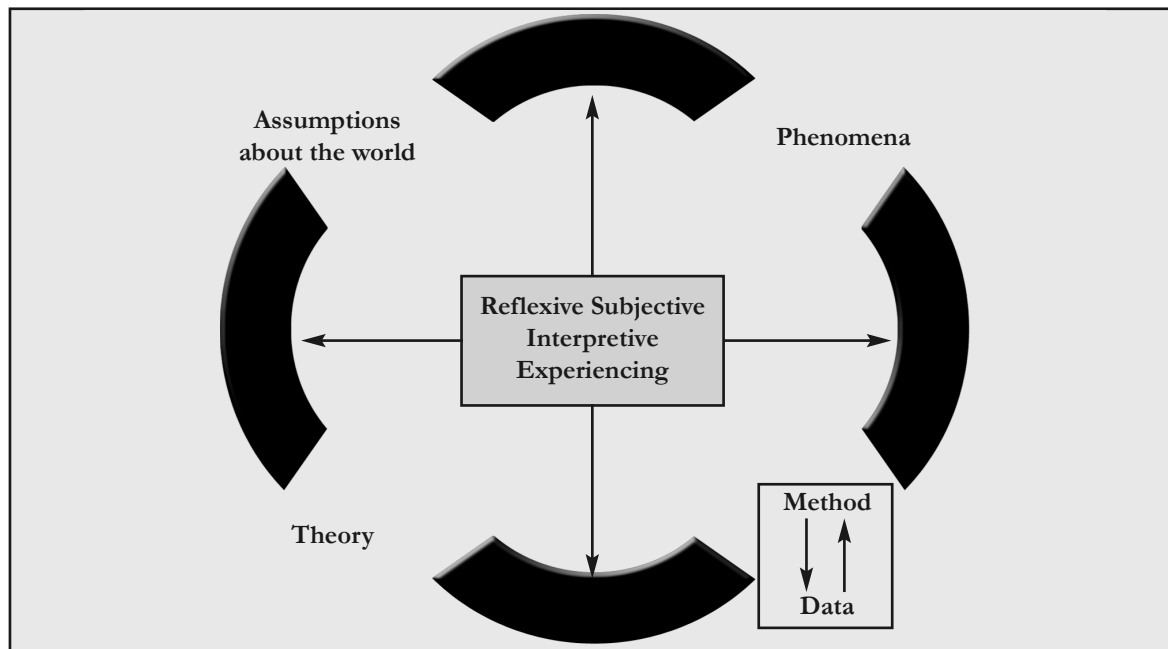
This realisation influenced the way I interacted with the respondents as well as viewed the data that I was gathering. I also became very conscious how my being also influenced the way in which the narrator narrated their story.

Determining Experiences: Narrator and the Narrative

As mentioned above, the voice centred relational method allows us to be reflexive about our data analysis process by constantly asking of us to check our assumptions, our influences and theoretical locations (Doucet & Mauthner, 1998). The approach rejects the notion of the independent self and posits the notion of self-in-relation (Allen & Bagozzi, 2001; Benhabib, 1987; Day & Tappan, 1996; Hermans & Kempen, 1993; Markus & Kitayama, 1991; Triandis, 1995). Central to the methodology is the relational aspect of human life. Human beings are engaged in daily exchanges that define their social existence. These exchanges give ultimate meaning to human lived experience. The section below describes in detail the determination of the narrator's experiences.

Figure 5 below, captures the concept of reflexivity in my research process.

Figure 5: Reflexivity in Qualitative Research



Adapted from: Crawford & Valsiner, 2002

As Figure 5 shows, my interpretation of the data was a relational process with the data informing the method as much as the method informed the data. The blue blocks representing the various unknowns at each stage of data analysis had to be unpacked, explored and explained. My own experiences as a researcher were at the centre of the research as they influenced the methodology and theoretical persuasions I chose. My interactions with the respondents and colleagues, as well as the choice of the study design, were largely influenced by my personal experiences – “the who I am” part of my research interests. However, this was not a rigid but fluid process. It acted based on feedback from the socio-environment. I had to listen to the narratives as told and understood why the narrators chose to tell the stories in the manner they told them. What did the stories mean to the narrators? How did they want me to understand their narrative? What influence, if any, did I have on the way the narrative was told?

In my readings, I therefore followed the four reflexive steps suggested by Doucet and Mauthner (1998): (1) locating myself socially in relation to my respondent; (2) attending to my emotional responses to that person; (3) examining my theoretical interpretation of the respondent’s narrative; and (4) documenting these processes for others and myself.

Reading 1: Reading for the plot and my response to the narrative

I first read the interview text for the overall plot and story being told by the respondent. I wanted to know and understand the main events, the protagonists, and the subplots. I listened for cultural metaphors, words, recurrent images and tensions in the narrative Doucet & Mauthner, 1998). Some of the cultural metaphors centred around “good” and “bad” woman and manhood, disease and its causes, family tensions, social deviance and punishment. I also read for myself in the text in order to understand my background, history, and experiences, in relation to my respondent (Doucet & Mauthner, 1998; citing Taylor, 1995). I was an urban educated university graduate and I assumed that I more informed about the HIV/AIDS pandemic. I never realised the proximity of the pandemic to my own life until I started listening to the stories and experiences

of the ordinary villagers and got insight into how their everyday ordinary decisions have some bearing on how disease affects our lives irrespective of who we are.

Readings 2 and 3: The self and the self-in-relation

My second and third readings paid particular attention to the emergence of the self and use of the “I”, “Me” and “We”. These terms refer to the self in relation to others. The “we” refers to the social reference group we belong to whereby the self is conceptualised more or less wholly in relation to the family, the community, whereas the “I” strives towards independence from these systems. Tensions are bound to occur, however between the two. For example, I was interested in when and how the respondents moved in between these two states. Did these tensions arise when the respondents were uncomfortable with confronting cultural stereotypes of owing to some personal agency? I also became interested in reading for the self in relationship to others. The self-in-relation has also been referred to as the dialogical self (Day & Tappan, 1996). Cushman (1990, p. 599) explains the self as follows:

By the self I mean the concept of the individual as articulated by the indigenous psychology of a particular cultural group, the shared understanding within a culture of ‘what it is to be human’. . . . The self embodies what the culture believes is humankind’s place in the cosmos: its limits, talents, expectations, and prohibitions. . . . There is no universal, trans-historical self, only local selves; no universal theory about the self, only local theories.

In view of the cultural location of the self, Doucet and Mauthner (1998) explain that the second reading seeks to give voice to the person while also acknowledging the social position of the speaker. It looks at the narrator’s “multi-layered voices, views and perspectives” (ibid, p. 8).

The reading also allowed me to listen to the tensions, self-construals, and presence of the other (Mkhize, 2003). Mkhize (2003) considered the following questions during the reading:

- Who else is present in the narrative?
- What is their relationship to the narrator?
- Is it a relationship of harmony or tensions?
- What are the power relationships?
- Whose voice is dominant?
- How does the narrator feel and act about the relationship and what are the outcomes?

In my analysis, these related to the real people present in the narrators’ lives such as wife, husband, children, parents or others whom the narrators share particular feelings. For example, most of the commercial sex workers shared “feelings” of motherhood and how seeing their children go hungry made them feel “bad” and forced them into taking “action”, in this case prostitution but at the same time having “ambivalent feelings” about this action.

Reading 4. The social and cultural setting

This reading of text looked at the dominant social and cultural beliefs and narratives and their interplay with gender relationships, masculinity, femininity, sexuality, morality, religion and social networks among the *Manyika* people. I also drew upon literature from studies conducted on various aspects of the *Manyika* people. As Cushman (1990, p. 601) states: “Humans are incomplete and therefore unable to function adequately unless embedded in a specific cultural matrix”. Humans are relational (Day & Tappan, 1991). Burr (1995) writes that our self-narrative is a product of social interaction emerging out of negotiated meanings. Davies and Harré (1990) refer to meaning negotiating as discursive positioning. The issue is to understand how individuals,

through their subjective experiences, define, redefine, dismiss, understand, experience, use, abuse, and talk about 'culture' and, in turn define and construct 'self' (Bandlamudi, 1994).

There is a need to locate human action in culture and hence the reading process finds support in the work of Cushman (1990). Noting the dynamic interdependence between self, mind, action and culture, Cushman (1990, p. 599) comments:

Culture 'completes' humans by explaining and interpreting the world, helping them to focus their attention on or ignore certain aspects of their environment, and instructing and forbidding them to think and act in certain ways.... Culture is not indigenous clothing that covers the universal human; it infuses individuals, fundamentally shaping and forming them and how they conceive of themselves and the world, how they see others, how they engage in structures of mutual obligation, and how they make choices in their everyday world.

The artefacts we socially construct as a culture shape us "in subtle and unseen ways" (Cushman, 1990, p. 599). The relationship of culture and human development is one of creating and extracting meaning from the social world (Baumgartner & Rappoport, 1996). Historical changes within a culture may significantly alter the self-conceptions of its inhabitants (cf. Geertz, 1979, quoted in Cushman, 1990.)

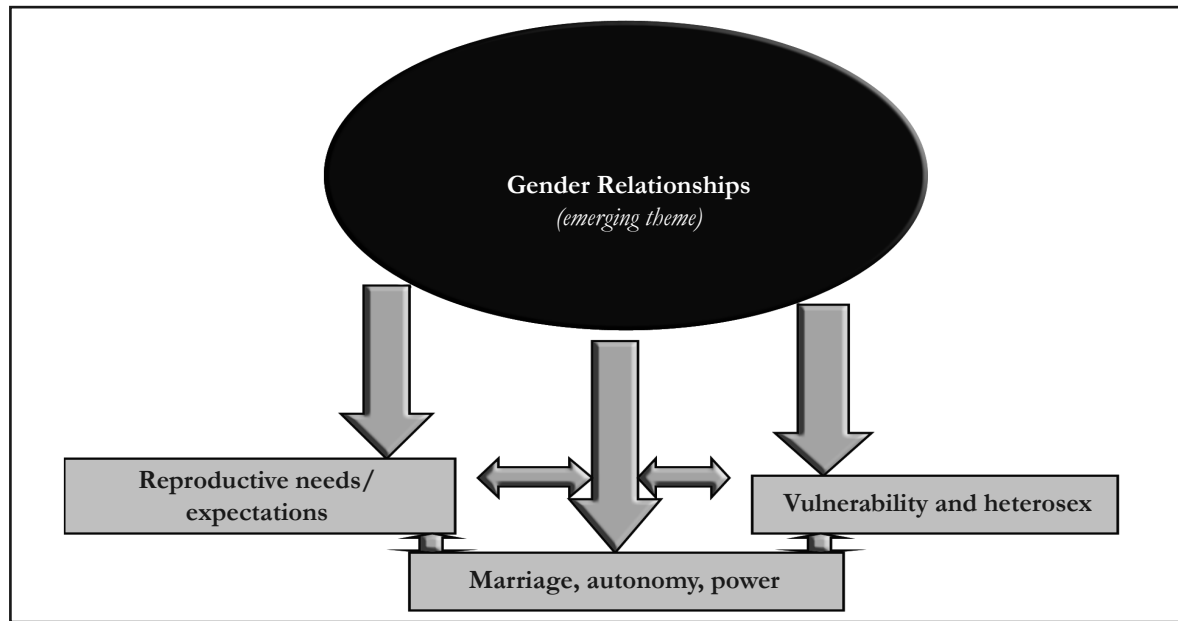
Emergence of themes

As part of the data analysis process, I read transcripts of the interviews no less than thirty times in three years. This enabled me to become aware of emerging themes and sub-themes (see Figure 6 below). Tapes were listened to several times to verify subtle points or to clear lingering doubts over the emerging themes. I held numerous consultations with colleagues in the School of Psychology, University of KwaZulu-Natal, over some of the points that were either doubtful or needed independent confirmation. Their insight and comments helped me gain an independent view on my data and it enriched the data analysis process through their confirmation of my data observation and queries.

The emerging themes were further analysed highlighting the dominant, conflictual and recurring narratives. The thematic analyses provided a coherent way of reading text in relation to my specific research questions. The readings were organised under thematic headings in such a way that they duly reflected the needs of the study, as well as the overriding concerns of the respondents (Burman, 1994). The interconnectedness of the emerging themes was actively explored and analysed. Figure 6 below depicts the interconnectedness of themes and issues as I experienced them. I have used the example of the emerging theme of gender relationships. My reading of the text highlighted that when looking at this theme in the context of villagers in *Manicaland*, I had to be cognisant of the underlying themes such as the need to procreate and how this in turn is influenced by marriage, social norms, autonomy, and power.

For example, looking at the emerging theme of gender relationships I became aware of the intricately connected issues of marriage, conjugal needs, motherhood, fatherhood, gendered spaces, reproductive needs, power dynamics, vulnerability and heterosexuality. I therefore could not just superficially look at gendered relations without significantly engaging with the power relations that ebbed and flowed through issues of reproduction, domestic violence, and vulnerability, among others. One cannot speak of gender relations without tackling the issue of culture and social expectations. The reading of the texts increasingly drew me into trying to understand the way culture had the potential to make people vulnerable to HIV infection simply because they happened to be of a particular gender.

Figure 6: Diagrammatic Representation of Reading of Emerging Themes



Coding of data and its presentation

Various symbols were used as a way of guiding my reading of text during the data analysis process. These symbols were consistently applied throughout my readings. They acted as guides to issues that I needed to pay particular attention to as they linked with my theoretical framework. Each emerging theme was colour-coded differently while the sub-themes and their connectivity were highlighted using different colours.

The presentation of the data was heavily influenced by what Chenail (1995) called juxtaposition and rhythm. This refers to an exhortation to qualitative researchers to “create a template for representing [one’s] data so that there is a recognizable pattern throughout the Analysis or Findings section of [one’s] paper” (Ibid, p. 5). He said the reason for this was for the reader to read the work in a rhythmic fashion. Following Chenail (*ibid.*), first the distinctive findings are presented and then supported with data exemplars. This is followed by critical commentary on the exemplars in relation to the key findings and the literature.

The most important aspect of Chenail’s model of data analysis is the emergence of a clearly distinct and discernible pattern of results presentation.

Design validity and reliability

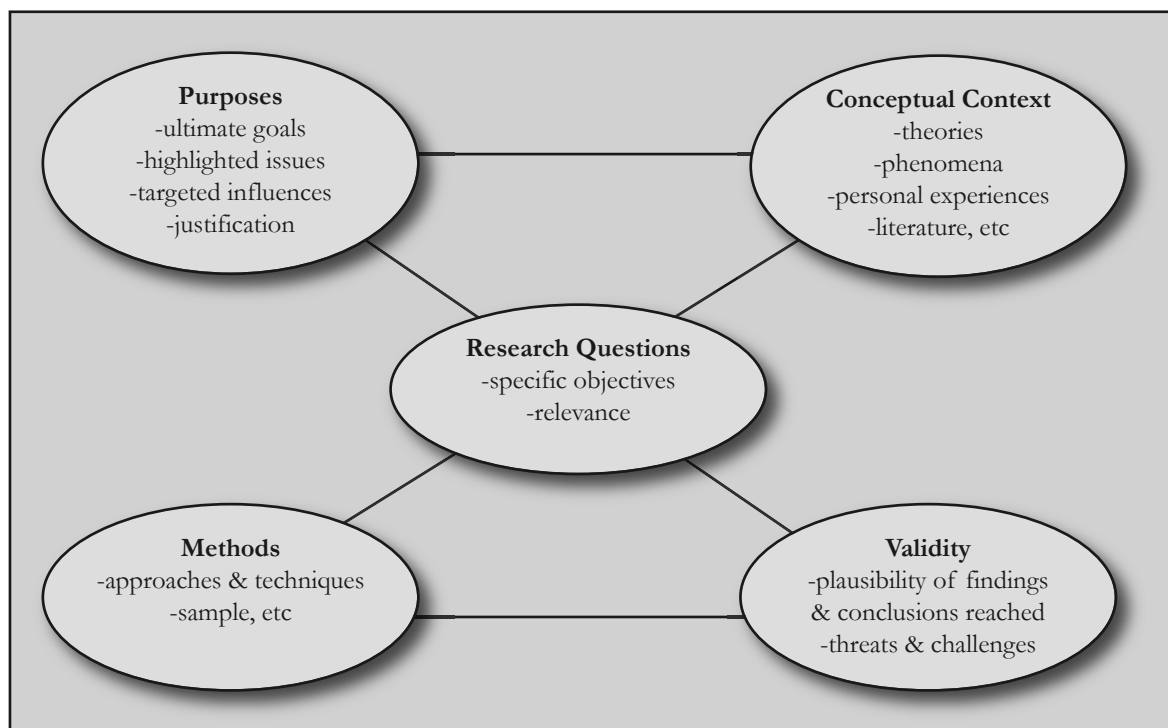
The *Manyika* of *Mutasa* are renowned for their conservatism (Bhila, 1982) especially when interacting with outsiders. When I approached Chief *Mutasa* to seek permission to conduct the study in his area, he actually chuckled when I explained to him that I intended to talk to his subjects about their sexual histories and lifestyles. He wished me good luck. Zimbabweans generally shy away from discussing personal and sexual matters with strangers (Woudenberg, 1998; Zvinavashe-Gava, 1996). This aspect introduced the element of social desirability bias in the study. How much of what we were being told was a result of the respondents deciding that was the appropriate information to give to outsiders? How would we verify the validity of the information generated by the interviews? Researchers have tried to deal with this form of bias through methodological triangulation (Gregson *et al.*, 1995; Pickering, 1998; Wilson & Hutchinson, 1991).

Issues of validity and reliability always confront qualitative research (Mays & Pope, 1995; Barbour, 2001). A body of literature has evolved that seeks to show that issues of validity and reliability that confront qualitative research are not different from those that confront quantitative research (Bauer, Gaskell, & Allum, 2000; Campos, 1998; Denzin & Lincoln, 1994; Doucet & Mauthner, 1998; Kvale, 1995; Maxwell, 1998; Miles & Huberman, 1994; Mischler, 1990; Potter, 1998; Tsourvakas, 1997; Winter, 2000;).

Maxwell (1998) proposes an interactive model of research in qualitative research. The model has five key interlinked components. At the centre of the model are the research questions, which in turn drive the conceptual framework of the study, methods, aims and objectives (which Maxwell calls the study purpose), and validity of the study. Figure 7 below gives a diagrammatic representation of Maxwell's interactive model of research design. It argues that qualitative research designs are equally as valid as quantitative research designs, as long as they are able to self-critique and show how the various components of the research are coherently linked, explored and explained. Coherence between the various components of the model is central to the study's validity and reliability.

As far as the *conceptual framework* is concerned, my research started with a literature review of the impact of HIV and AIDS on Zimbabwe. I looked at how the interplay of social, economic, and cultural issues put individual Zimbabweans at risk. I asked the *central question*: what social and cultural factors were conducive to the spread of HIV infections in rural Zimbabwe? I then asked what the protective factors were. As I engaged with this question, I realised that I had to examine the overarching structural issues that permeated society in Zimbabwe. The quest to unravel and understand the structural issues, whether social, cultural or political, provided purpose to my study. The iterative process involved constant querying and searching of accessed information and observations. It also gave shape and focus to my study goals in that it helped me understand the phenomena I needed to study and the methodology to do so. This process is what Maxwell (1998) refers to as the conceptual or theoretical context.

Figure 5: Maxwell's Interactive Model of Research Design



Source: Maxwell (1998)

Source: Maxwell (1998)

The *study purpose* emerged from the conceptual context for the study. I became aware of the gender, age, and geographic differentials in HIV infections. I also became aware of the policy limitations in terms of addressing the epidemic. As I queried the information, I began to ask the question; why were these observed differences in HIV infection in Zimbabwe? What theory or conceptual framework was going to help me understand this phenomenon? As Maxwell (1998, p. 4) puts it, there are four main sources for theory development: “your own experience, existing theory and research, the results of any pilot studies or preliminary research that you’ve done, and thought experiments.”

In my case, I had several years of working in the public health sector, especially in the field of HIV/AIDS. My interest stemmed from that I had previously conducted research on the demographic impact of HIV/AIDS (Gregson *et al.*, 1996) and this had created interest in me to further explore the cultural and social dimensions of HIV infection. The literature search showed that a great deal of knowledge, attitude and practice, and epidemiologic studies have been conducted in Zimbabwe. However, it also revealed that very little work has been done on the construction of meaning around HIV/AIDS in Zimbabwe.

I then decided upon conducting a qualitative study on the cultural and social factors facilitating the rapid transmission of HIV infection in rural Zimbabwe. The study adopted a narrative approach, as I wanted people to narrate their life stories, their lived experience. I wanted them to be actors, whose words gave meaning to their life-worlds. I wanted them to share with me their experiences with a ravaging disease, HIV/AIDS. How did they construct meaning around such a deadly disease? How were they (re)negotiating their normative roles in the face of the HIV/AIDS onslaught? Did they see their culture as a protective factor or was it an inhibiting one in terms of prevention from infection?

Lastly, I grappled with the issue of validity (Barbour, 2001; Malterud, 2001; Morse, Barrett, Mayan, Olson & Spiers, 2002). How valid were my enquiries? What if I was wrong in my queries, what would be the alternative and plausible explanation of what was going on with my study communities? I took solace in the postmodernist argument that validity must be about lived experiences that are honestly and truthfully reported (Kvale, 1995).

Kvale (1995, p. 1), echoing Dilthey’s (1977) polemic, argues that in postmodernist research the concept of validity as viewed by empiricists is somehow outdated: “A modernist notion of true knowledge as mirror of reality is replaced by a postmodern understanding of knowledge as a social construction.”

Kvale (1995) argues that inquiry, communication, and action are the basis of qualitative research. Validation is perceived “as investigation, as communication and as action” (Kvale 1995, p. 1). Postmodernism rejects the notion of a universal truth while acknowledging, “the possibility of specific local, personal, and community forms of truth, with a focus on daily life and local narrative” (*ibid.*, p. 2). Validity starts in the lived world and daily language of the actors. As Miles and Huberman (1994, p. 8) put it, “Human activity was seen as “text”- as a collection of symbols expressing layers of meaning.

Kvale (1995) has further argued that, in the broad sense, validity should be based on whether a method investigates what it is intended to investigate. Maxwell (1998, p. 86) concurs that validity of one's results, in the real world, is not guaranteed by following some prescribed procedure:

Instead, it depends on the relationship of your conclusions to the real world, and there are no methods that can assure you that you have adequately grasped those aspects of the world that you are studying.

Validity therefore refers to “the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account” (Maxwell 1998, p. 87). Maxwell presents a typology for qualitative research that has three types of understanding: description, interpretation, and theory. As one describes and interprets, qualitative data theory is generated as well, which in turn helps further describe the phenomena under study.

In order for qualitative research to be valid, it should accurately depict respondents' experiences without trying to predict anything further (Acker *et al.*, 1983; Du bois; 1983; Mischler, 1986; Villanueva, 1997). It should depict a portrait of the socio-cultural context around the experience (Hogg & Abrams, 1990; Strauss & Corbin, 1990). Qualitative research allows the researcher to have a feel for the data and an understanding of the complexities embedded in the life histories of the respondents.

Postmodernist research argues that, in order for a researcher to understand a cultural artefact in a given culture, the culture needs to be understood first; and that in order to understand people, their language needs to be understood also (Rosenblatt & Fisher, 1993 cited in Villanueva, 1997). The researcher becomes an instrument of data collection (Mertens, 1998). In the case of this study, the research team, having previously worked in the area (Gregson *et al.*, 1996), had the ability to understand the *Manyika* culture, its possible influences on the respondents, and “the culturally rich phrases that have a different meaning than their surface ones” (Villanueva, 1997, p. 31). The research team acted as both insiders and outsiders to the culture (Peck & Furman, 1992). It had a deeper understanding of the cultural life of the research area, yet it was not constrained by the social tensions and dynamics of everyday life in the communities (Reinharz, 1992). Collection of the study data was in *Shona* and the respondents had an opportunity to express themselves without the possibility of being misunderstood, or the danger of not finding the appropriate words to express their feelings and meanings about their life stories.

Conclusion

The chapter looked into the study methodology. It looked into the study background, aims and objectives, and the research questions. It gave a description of the study area and the development of the research process. It highlighted the theoretical paradigm that influenced the data analysis. It also discussed the methodological constraints, such as validity, reliability and ethical issues that confronted the study.

CHAPTER 7

RESULTS and DISCUSSION: THE SOCIAL CONSTRUCTION OF HIV/AIDS IN RURAL ZIMBABWE

Overview

I introduced my study purpose and objectives in Chapter 1. I then broadly reviewed the global picture (cf. Chapter 2) as well as Zimbabwe's picture (cf. Chapters 3 & 4) of the HIV/AIDS pandemic. In Chapter 5, I presented the theoretical framework informing my study. In Chapter 6, I reviewed the study methodology used by the study. These reviews were largely broad brushstrokes to provide a background to the personal narratives of rural Zimbabweans in the face of the HIV/AIDS pandemic.

This chapter presents the study results and discusses them with reference to social constructionism and the personal narrative. The results are discussed with reference to key literature and personal understanding of the narrative. Reference is made also to the theoretical perspective that underpinned the study in the discussion of the results. The chapter highlights the limitations of the cognitive thinking informing health education and promotion in the face of the HIV/AIDS epidemic in Zimbabwe.

The study posed two related research questions:

- How had HIV/AIDS pandemic affected the lives of the *Manyika* people of *Makoni* and *Mutasa* areas?
- What were the social and cultural constructions of the pandemic within these communities?

The research questions sought to understand how the HIV/AIDS epidemic has affected the lives of villagers in *Makoni* and *Mutasa* areas of *Manicaland*, Zimbabwe, through the personal accounts of their experiences with the pandemic. This quest to know required that I approach my study with no preconceived ideas of the HIV/AIDS situation in *Makoni* and *Mutasa*. This was a marked departure from the 'mainstream' scientific dispensation of undertaking a research study with some preconceived notions of causality. Researchers are neither context free nor are the subjects' personal narratives. We need to acknowledge the historical, class and cultural contexts of personal narratives (Riessman, 2002).

My study aim was to explore and understand the cultural and social contexts facilitating the spread of HIV infection in rural *Manicaland*. In the process of this exploration, I began to appreciate that my pre-conceived questions and probes had to change as per the respondent's life experiences and story. I also acknowledge that my questions and probing could have possibly influenced some respondents to narrate their life stories differently. I paid particular attention at how they constructed meaning within their lifeworlds.

I took note of the predominant themes that emerged and these were the deep feelings of cultural anomie, gender relations and lack of agency. The major subplot that emerged was that of individuals struggling to come to terms with their selves and the world around them, individuals who had to position themselves against a multiplicity of possible selves in trying to define and understand selfhood in the midst of the HIV/AIDS epidemic and social disruptions. One's personhood was defined by an interdependent self-construal that was in need of balance and maintenance whilst staying in harmony with one's relationships with important others and in

groups (Cross, 1995 cf. Markus & Kitayama, 1991). There were marked gender differences in the perception of selfhood and its relational ontological nature. Men and women of *Manicaland* had different reference groups in terms of definition of self and understanding of personhood.

These differences were simply explained away as cultural dictates.

The presentation of the results begins with extensive transcripts of three interviews. The choice of the three transcripts does not negate, in any way, the value of the other interviews but succinctly captures the essence of the villagers' narratives as they were told to me (Doucet & Mauthner, 1998). The three extensive extracts are supported by exemplars from the rest of the interviews (Doucet & Mauthner, 1998).

I also began to realise that each individual's narrative warranted its own in-depth analysis and write-up. However, the constraints of my thesis could not afford me the immediate opportunity to do so. I had to settle for common themes, plots and subplots emerging out of the narratives and stories as told to me by the villagers (Villanueva, 1997).

Dominant social and cultural narratives

The reading of text looked at the dominant social and cultural beliefs and narratives and their interplay with gender relationships, masculinity, femininity, sexuality, morality, religion and social networks among the *Manyika* people. I also drew upon literature from studies conducted on various aspects of the *Manyika* people.

As Cushman (1990, p. 601) states: "Humans are incomplete and therefore unable to function adequately unless embedded in a specific cultural matrix". Humans are relational. Burr (1995) writes that our self-narratives are products of social interaction emerging out of negotiated meanings. Davies and Harre` (1990) refer to meaning negotiation as discursive positioning.

The point is to understand how individuals, through their subjective experiences, define, redefine, dismiss, understand, experience, use, abuse, and talk about 'culture' and, in turn define and construct 'self' (Bandlamudi, 1994).

The artefacts we socially construct as a culture shape us "in subtle and unseen ways" Cushman (1990). The relationship of culture and human development is one of creating and extracting meaning from the social world (Baumgardner & Rappoport, 1996). Historical changes within a culture may significantly alter the self-conceptions of its inhabitants (cf. Geertz, 1979 quoted in *ibid.*)

My thinking going into the interviews was informed by the epidemiological and biomedical determinants responsible for the spread of HIV/AIDS. One of the key epidemiological explanations of HIV infection is unprotected sex with an infected person. Given that more than 98 percent of HIV infections among sexually active adults in sub-Saharan Africa occur through this mode of transmission (UNAIDS, 2002), the primary focus of prevention has been safe sex. Safe sex is sex using a condom, sticking to one faithful uninfected partner and avoidance of unprotected sex with groups labelled as high risk. High-risk groups are described invariably, as commercial sex workers, long distance truck drivers, the military, men having sex with men, injecting drug users, and people suffering from ulcerative sexually transmitted infections. Unprotected sex with any person falling within these categories is perceived as risky sexual behaviour.

The labelling of some sexual behaviour as risky and other as not likely leads to stigmatisation of the individuals engaging in behaviour labelled as risky. This was the case in Zimbabwe where commercial sex workers were labelled as "HIV carriers" during the early years of the epidemic

(Ray & Paradza, 2007). The causal or vector link of disease, which predominates the biomedical health paradigm saw commercial sex workers as the high transmission link into the general population hence the obsession with the “commercial sex worker” in HIV/AIDS public health discourse in Zimbabwe.

However, my research experience with the people of *Manicaland* show that the public health discourse around HIV/AIDS in Zimbabwe and perhaps most of the developing world needs to be critiqued for its exclusionary approach to the disease. The biomedical paradigm of disease ignores the social, economic, and structural determinants that affect public health matters in the developing world.

Several key issues emerged from the research. These were the continued social vulnerability of women, the hierarchical gendered social order, economic inequalities, lack of financial independence, factors influencing condom use in marriage, hegemonic masculinities, marriage dissolution and withdrawal of family support, use of children as a bargaining chip in abusive marital relationships, and power differentials as well as generational gaps in public health discourse. Fitzgerald-Husek, Martiniuk, Hincliff, Aochamus and Lee (2011) made similar findings in their study of sex workers in Northern Namibia. They argue that educational and behaviour change targeting high-risk individuals are likely to be ineffective because they do not address the gendered social imbalances and inequalities. Fitzgerald-Husek *et al.*, (2011, p. 2) note that:

It is likely that these programs do not effectively target the main factors influencing condom use, including the economic asymmetries, dominant patriarchal socio-cultural practises and resulting power differentials between men and women, all of which may influence the agency of women to actively and effectively negotiate safer sex practices, including condom use.

Similarly the gendered experiences of women in Northern Namibia (Fitzgerald-Husek *et al.*, 2011) echo across the socio-cultural landscape of sub-Saharan Africa and beyond. The social and sexual interactions of men and women need to be understood in a much broader sense than the narrowly defined parameters of the biomedical/epidemiological paradigm of the HIV/AIDS pandemic (Thomas, 2008; Schoepf, 2004). We cannot afford to ignore that the social order is not a smooth playing field for both men and women (Iliffe, 2006). It is therefore important to understand the social dynamics that are at play in rural Zimbabwe, exposing men and women to HIV infection.

I interviewed all my respondents on their personal experiences in relation to the HIV/AIDS epidemic. My probing questions covered a wide range of issues related to HIV/AIDS within their respective communities and in their personal lives. They had varied experiences and each had a personal story to tell regarding how HIV/AIDS had touched their lives. The emerging narratives are presented later in the chapter. My analysis was, therefore, not about the essence of the individual narrative per se but the picture of possible factors associated with HIV/AIDS emerging from the interweaving of these personal narratives.

These narratives are fluid, influenced by particular historical circumstances and selectively or entirely depending on the context and time the story is told. Karuru and Paradza (2007, p.290) commenting on the experiences of rural women in Uganda and Zimbabwe note that:

Each person’s interpretation of their history changes as they move through life. Particular circumstances of life processes influences not only the way a person tells their story but also how the researcher elicits the same. Some episodes or circumstances have more biographical relevance than others. For women in this study these included family events such as death, birth, initiation

ceremonies (naming, marriage, and religious ceremonies), and events that undermined or strengthened the welfare of their families.

My writing of the analysis and the results could not cover all the scripts generated by the narratives. Neither was my choice of script to use nor to leave out, in emphasizing the emerging themes, influenced by anything other than its similarity to the rest of the scripts and the emerging story of HIV/AIDS in rural Zimbabwe. I painstakingly tried not overplaying or downplaying any narrative as told to us. However, the public discourse on HIV/AIDS naturally influenced the themes emerging from the data analysis that drew my immediate attention. One of the dominant public “health” discourses has been that of the commercial sex worker as a conduit of infection. I wanted, naturally, to explore this discourse with rural Zimbabweans given the social proximity of rural life and the specificity of the geographical space defined as rural in Zimbabwe. I, however, constantly reminded myself not to overestimate or underestimate awareness of the HIV/AIDS in rural Zimbabwe. As Karuru and Paradza (2007, p.291) warn:

Researchers working in rural communities in Uganda and Zimbabwe should not underestimate awareness of HIV and AIDS, or overestimate stigma towards those affected by the disease. We were frequently informed that deceased family members had died from AIDS, pneumonia, meningitis, and other opportunistic infections normally associated with the pandemic, without any probing.

Mindful of this warning, I embarked on my journey of understanding the worldview and lived experiences of rural Zimbabweans amidst a generalised HIV/AIDS epidemic (Thomas, 2008). I wanted to understand how they constructed and reconstructed meaning and self in relation to everyday realities of the epidemic. I was also interested in understanding how the self-construals and reconstructed selves positioned themselves in the social relations sphere and whether this positioning exposed rural Zimbabweans to HIV infection or not.

Several inter-linked themes emerged from the narratives in relation to the social and cultural impact of HIV/AIDS in rural Zimbabwe. The dominant emerging themes were: the social vulnerability of women in marital relationships; moral-religious constructs; young women and sexual exploitation; subjective positioning of women; inter-generational conflict; gendered spaces and social capital; and the *Shona* worldview.

These dominant narratives had several related sub-themes: marital conflict; marital violence; marital dissolution; man as the *de facto* head of the family, man as the breadwinner, single motherhood and personal choices; blame; transgression; punishment; social dislocation and anomie; accusation; gendered spaces; poverty, economic hardships and inter-generational sex; condom use; and the new “social order”. The narratives had multi-layered meaning dependent on the person’s lived experience, personal, and social contexts (Thomas, 2008).

I present, below, exemplars from extracts supporting the emerging narratives in relation to the broad research questions of the study.

How had HIV/AIDS pandemic affected the lives of the *Manyika* people of Makoni and *Mutasa* areas?

Social vulnerability of women in rural Zimbabwe

The following extract comes from an interview with Tsitsi⁸, a 24-year-old divorced mother of two and working as a commercial sex worker. The narrative is about her as a woman, mother,

⁸ Name changed to protect the respondent’s identity.

daughter, wife, and not a commercial sex worker. Tsitsi's narration of her marital problems and the course her life had taken shook me. I did not know Tsitsi's sero-status and I really did not bother to do so because that was not my primary focus. All I thought about then was to find a commercial sex worker willing to spend time answering my questions. I failed then to see Tsitsi as a person in dialogue with seeking, through language, to make me see her beyond the label society has attached to 'women of her ilk'. Tsitsi was seeking voice (Gergen, 1989), a caring voice (Gilligan, 1991). Her personal insights reminded me that she was a mother, a wife, a daughter, a neighbour, and a woman whose life took a particular course owing to certain life changing decisions she had to make in response to her personal circumstances.

The intersection of Tsitsi's life with the geographical space defined as rural made her come face to face with a particular types of male masculinities reinforced by the notions of culture and the family. For a glimpse of the intersecting of these experiences, I use the following excerpt from our interview with Tsitsi.

Tsitsi: I was married and living in Nyanga with my husband and our two children. At first things were fine and we were quite happy in our marriage. However, over time I started noticing some changes in my husband's behaviour. He was behaving strangely, like coming home late and becoming irritable with me and the children. At first I thought it was stress from his work which involved a lot of physically exerting manual labour. Then he started verbally and physically abusing us. (She exhales deeply).

Researcher: By physical abuse you mean what exactly?

Tsitsi: *Kwaisave kurova ikoko. Asi kuponda chaiko!* (It was not just a beating. It was attempted murder!)

Researcher: What do you think changed your husband from being a loving and caring father to an abusive one?

Tsitsi: At first I didn't know but then I was tipped off that he was having an affair. I confronted his lover and beat her up. This did not go down well with him. He actually declared: "*Manje watotichatisa*". (You have actually solemnised my affair with her by beating her up). He then would spend days away from home and stopped giving the family money for our daily upkeep. I followed him to his workplace and his superiors were not helpful either as they sent me from pillar to post. *Varume ndevamve vanorvirana* (Men always rush to each other's defence). I went to the courts to seek a maintenance order. When he found out he went berserk. He reported me to my parents that I was disrespectful and did not accord him the respect due to him as a man and head of our family. All the relatives ganged up against me saying there must be something wrong⁹ with me as there was no way such a "lovely" husband could simply decide to abandon his family.

Researcher: How did you feel?

Tsitsi: I felt hopeless. I then wondered how it was possible for my husband to desert me for another woman. Surely, there had to be something wrong with me. *Kuda ndakange ndashapa* (Maybe I had become stale and was not sexually good anymore). (See Rohleder & Gibson, 2005). Then I got so angry because everyone believed his version of our marital problems yet I knew I was innocent and he

⁹ Underline denotes emphasis by the narrator and applies throughout all the extracts.

was the one messing up our marriage. I packed all my belongings and left him. I came here to *Honde* to live with my parents.

Researcher: What was your parents' reaction?

Tsitsi: My parents said we should give him time to clear his head before they could convene a meeting to try to resolve the dispute. Just two weeks after I had left him, my husband pitched up at my parents' home. He brought groceries for my parents and bought me a dress as well. He charmed my parents and told everyone that he had mended his wayward behaviour and wanted me to give him a second chance. "After all *pane vana*" (We have children together) he pleaded. Since I loved him, I decided to go back with him to our marital home in Nyanga.

Researcher: And you returned to your marital home in Nyanga.

Tsitsi: (Laughs) *Li, shiri ine muriro wayo haiuregedzi* (He was a creature of habit). Just a few weeks upon our return he again started not sleeping at home. Our fighting resumed and got worse and worse. Then I discovered that he had infected me with "drop" (a discharging sexually transmitted disease). I confronted him and he had the audacity to blame it on me. He accused me of infecting him with a sexually transmitted disease because I was of very loose morals. That is when I really got mad! I had never slept with any other man in my entire life and he knew it. He claimed that when I ran away it was because I was itching to see "*zvikomba zvangu*" (my secret lovers) who then had infected me with an STD! Yet it was him who was having an adulterous affair and I knew that his lover was "*dihwino remurume wese-wese*" (she was a pool in which any willing man could take a dip). *Ndakafunga vana vangu kuti zvino ndikafa nemukondombera vanosara vachichengetwa nani* (I thought about my children and wondered who would look after them were I to die of AIDS). It was then that I decided to pack my bags again and leave him forever.

Researcher: Where did you go this time?

Tsitsi: I went back to my parents' home. They reluctantly accepted us back. I could see they were disappointed with me because I had failed in my marriage. My father was okay. My mother did not take it well. They were worried about the village gossip and the moral impact my separation would have on the whole family.

Researcher: Did the situation improve overtime?

Tsitsi: No, my husband never followed us but actually moved in with his girlfriend. My parents gradually came to terms with my failed marriage. A year went by and it was sometime during the second year that problems between my mother and me came to a head. *Munogozivavo kuti vakadzzi vaviri havabiki chikari chimwe* (Too many cooks spoil the broth). [Here Tsitsi uses a *Shona* proverb used to remonstrate people contemplating polygamy]. My mother and I started having endless squabbles. She would insult me over my failed marriage. She always reminded me that I had become an economic burden. *Sevanbukadzi tine twunhu twatinoda twandisingagone kukumbira kuna baba vangu* (As a woman I have certain private things I need that I cannot request from my father). It forced to have an affair with a bus driver plying our village route. I kept it a secret from my family. I would sneak out and come back in the early hours of the morning before my parents were awake. The bus driver would give me some money and buy me

groceries. He was very nice. Then the bus company transferred him to another route very far from our village and that is how the affair ended. Life became tough, I was suffering a lot, and I could not take it anymore.

Researcher: What did you do?

Tsitsi: (She giggles and chides me). *Aa, imi unobvunzisisawo imi!* (Aa, you ask too many questions!). I ended up where you found me today. I am working here at the growth point¹⁰ tending to the needs of men.

Researcher: You told me earlier that you had to leave your husband because you were afraid of getting infected with HIV and dying of AIDS. Are you not afraid now?

Tsitsi: (Laughing). *Ko makondomu basa ravo ndereyi?* (What are condoms for then?). I use condoms with all my clients because I do not want to die. At least in this job I have a choice. If a client does not want to use condoms, I tell him to forget it. Yet when I was married, I could not even mention the word “condom”. I was very naïve and trusting of my husband. I thought condoms were for prostitutes only. Look, I got my first STD from my husband. Since I have been doing this job I have never contracted an STD. I am much safer doing this job than when I was a wife. Of course, I do have to be strong and sometimes fight with clients when they do not want to pay after offering them my services. However, my children are able to eat and go to school.

Researcher: How do you feel about what you are doing to earn a living?

Tsitsi: What else can I do?

Researcher: No, I did not mean it that way. I am sorry if the question sounded judgemental. I am trying to understand your life a little bit more.

Tsitsi: I am not happy. Yes, deep down I am not happy. Nevertheless, what else can I do? Should my children starve before my eyes? I know people here bad-mouth us a lot and it sometimes hurts pretty badly but none of them ever offered us a meal. I have to fend for my children and myself. I cannot get a job, my husband rejected me and I could not get along with my mother. It is actually not being able to get along with my mother that hurts the most. As a woman herself, she should have understood my plight and empathised with me.

Several critical issues arise from this narrative. Tsitsi’s narrative reveals the dichotomous view of ‘bad woman’ versus ‘good woman’ pervasive in Zimbabwe’s public discourse well before the advent of the HIV/AIDS pandemic (Bourdillon, 1976; Gaidzanwa, 1985; Jeater, 1993) but has since being amplified by the pandemic (Jackson, 2000; 1993; Kesby, 1999; Mungwini, 2008; Mungwini & Katereke, 2010; Runganga, 2001; Shire, 1994). Tsitsi’s excerpt reveals much nuanced issues of male hegemonic masculinities (head of household, breadwinner, owner of everything in his house, swaggering, violent, unfaithful, manipulative, and purveyor of conflicting messages, i.e. demanding faithfulness in marriage but refusing to practice it).

These gender contradictions in *Shona* society are observable in other societies. Mitchell (2001, p.6) in describing the cultural experiences of Andean women of Ecuador, remarks “how indigenous women’s daily lives do not often mesh with the prevailing discourse on gender” and

¹⁰ Growth points are economic centres in rural districts boasting of key infrastructure such as a hospital, post office, etc. Their creation by government was meant to be a nexus for economic development in rural areas of Zimbabwe.

calls it “contradictory consciousness”, a term borrowed from Gramscian theory. Mitchell (*ibid.*) argues, “the normative social expectations and the embodied experience of women seem divergent.”

The social construction of a woman who challenges the multiple hegemonic masculinities (Morrell, 1995) is that of labelling them as bad, ill mannered or loose (Bujra, 2000; Runganga, 2001; Shire 1994). These labels draw varying responses depending on their socially perceived severity. The most extreme of these reactions can, and usually does, take the form of violence (in all its forms) (Davila & Brackley, 1999; Doyal, 2001; Gupta, 2002; Mungwini, 2008; Selikow, Zulu & Cedra, 2002; Shire, 1994). The real losses from confronting these violent hegemonic masculinities can be catastrophic and of seismic proportions to women in certain geographic spaces and contexts (Mungwini, 2008).

In Tsitsi’s case, she lost the support of her entire family, and most tellingly the support of her mother, when she chose to walk away from an abusive marriage. The conflicting roles of women as enforcers of patriarchy on one hand and victims of patriarchy on the other hand is played out in the lives of Tsitsi and her mother. Commentators have commented on the roles of women in the *Shona* society explaining this dichotomous role of women (Gaidzanwa, 1985; Jeater, 1993; Mester 2008).

To understand the context of Tsitsi’s social and personal loss one needs to understand how the *Shona* peoples view womanhood. According to Mester (2008, p. 1) “the *Shona* peoples are known as a patrilineal culture with a classic Omaha Type terminology.” Womanhood among the patrilineal and patriarchal *Shona* is closely linked to pleasing the man by satisfying him sexually (Kambarami, 2006; Kesby *et al.*, 2006) and bearing him children (Bourdillon, 1987; Jeater, 1993, Kambarami, 2006; Kesby *et al.*, 2006; Mester, 2008; Mungwini, 2008). As Kambarami (2006, p.2) notes:

In the *Shona* culture, from a tender age, the socialization process differentiates the girl child from the boy child. *Shona* males are socialized to view themselves as breadwinners and heads of households whilst females are taught to be obedient and submissive housekeepers. The cause of such differentiation and discrimination is the fact that society views women as sexual beings and not as human beings.

A newspaper article on HIV/AIDS headlined “Are females having more sex than males?” by Melody Gwenyambira (2011), a female journalist, captures how the sexual objectification of women is even perpetuated by women subconsciously prescribing to the good woman’ versus ‘bad woman’ social construction that is commonplace in Zimbabwean gender discourse. She so titled her article because of the reported high incidence of HIV infection in females than males in Zimbabwe (NAC, 2010). As much as Gwenyambira’s article headline was meant to be a tongue in cheek, questioning of the phenomenon of high infections in women her article unintentionally succumbs to the sexual objectification of women by surreptitiously implying that women have unbridled sexual desire that exposes them to high levels of HIV infection. This gendered objectification of women is common in everyday discourse in Zimbabwe and very often goes unchallenged for its hegemonic nuances.

Critically, the woman’s role in *Shona* culture is mainly recognised in terms of wife and mother. Both roles are associated with procreation. Any role outside of procreation is viewed with suspicion and oftentimes even with violence (Runganga, 2001). These social attitudes are catastrophic for rural women especially in a patriarchal society with a skewed socio-economic profile and generalised HIV epidemic like Zimbabwe. In interviews carried out with urban women seeking social welfare services in Harare, Kambarami (2006, p. 2) remarks:

Most women who sought grants from the Government answered the question “Why do you need assistance from the Government?” with answers like “My husband died so I have no-one to look after me” or “I was deserted by my husband, so I have no-one to look after me” or further still, “I do not have a husband”. All the answers given by these women spelled out how patriarchy creates dependence on males to the extent that in the absence of males, many women cannot manage to support themselves financially as they were socialized to believe that, males should play that role.

Tsitsi’s narrative provides an exemplar of the cultural, social and economic consequences likely to befall most women in Zimbabwe who are perceived to have behaved outside the expected social norms. Tsitsi narrates how she lost both social and economic support because she challenged patriarchy and its cultural proscriptions. The dependence on men is a critical factor and possibly a major contributor to the infection of women with HIV in rural Zimbabwe. Davila and Brackley (1999) commenting about this phenomenon among Hispanic men attribute it to power. Davila and Brackley (1999, p. 350) describe power as:

Power is the process by which an individual gains or maintains the ability to impose his or her will on another. Power can withhold rewards as well as threaten punishment... Power can be divided into three primary domains of power bases, processes and outcomes. *Power bases* are culturally defined and consist of personal assets (e.g., male gender, socioeconomic status) on which an individual’s authority or control is based. Within the Hispanic culture, females because of their male gender accord males respect and deference and, more often than not, greater financial resources... *Power processes* are the interactional techniques (e.g., persuasion and influence, assertiveness, coercion, and violence) that are used by an individual to establish or maintain control within a specific situation. *Power outcomes* are related to which individual makes the final decision within a specific situation ...

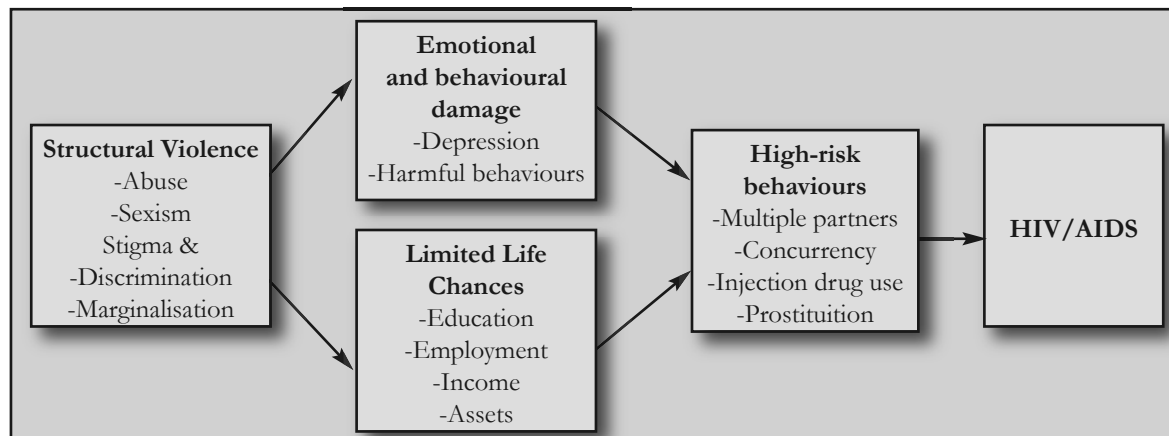
Tsitsi’s experiences with male power resonate with women in many parts of the globe, from Mexico, India Papua New Guinea, and South Africa to Tanzania (Bujra, 2000; Davila & Brackley, 1999; Dunkle *et al.* 2004; Gupta, 2002; Selkow et al, 2002). In her case, the power base demanded that she accords her husband respect because he was the head of the family as well as the breadwinner. As she puts it:

Tsitsi He then would spend days away from home and stopped giving the family money for our daily upkeep. I followed him to his workplace and his superiors were not helpful either as they sent me from pillar to post. *Varume ndevamwe vanorwirana* (Men always rush to each other’s defence). I went to the courts to seek a maintenance order. When he found out, he went berserk. He reported me to my parents that I was disrespectful and did not accord him the respect due to him as a man and head of our family. All the relatives ganged up against me saying there must be something wrong with me as there was no way such a “lovely” husband could simply decide to abandon his family.

Her challenging the power base led to physical violence and abandonment. The husband resorted to violence and withdrawal of economic support to maintain control over Tsitsi and reassert his authority. Tsitsi became a victim of the power processes at play in a patriarchal society -- coercion and violence. Traditionally the man in Zimbabwe has the final say on all nuclear family matters (Mungwini, 2008). He is an authority figure who demands respect and if it is not voluntarily given, he seeks to assert it forcefully and oftentimes violently. Poundstone et al (2004, p. 27) has explored the “pathways which various forms of structural violence might influence the risk of

human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS)", as shown in the figure below.

Figure 6: Pathways through which various forms of structural violence might influence HIV/AIDS



Adapted from Poundstone *et al.* (2004)

The interplay of these structural factors is highlighted, once again, by Tsitsi's exemplar. She faced abuse in her marriage and was entirely dependent on her husband for economic survival. Her family rejected her. This severely depressed her and she had to look for ways of supporting herself and her children. She was forced to start a secret sexual relationship with a bus driver in order to sustain herself and her children:

As noted by Caldwell *et al.* (1989) many women end up exchanging sex for survival because of economic marginalisation. Selling their bodies becomes the only means of sustenance and increases their risk of acquiring sexually transmitted infections, including HIV/AIDS. Hunter (2002, p. 101), in his study looking at transactional sex in Isithebe informal settlement and Sundumbili Township of Mandeni, KwaZulu-Natal, South Africa, notes how sex in the Mandeni Township was linked to material needs either through sex for subsistence or "sex linked to consumption." Hunter (*ibid.*) explains:

... this distinction – although not clear-cut - can be attributed to both the structural positions of women and the varied social meanings associated with the areas. On the former, the processes of industrialisation, de-industrialisation, and migration, ... created acute gendered inequalities, producing an extremely vulnerable group of low paid or unemployed female migrants, the majority of whom live in the informal settlements. The marginalisation of these women comes together with masculine discourses ... to fuel transactional sex, often for subsistence needs. In the township, different dynamics operate. Here, most of the large youth population is able to secure subsistence from its parents or guardians. In the urban spaces of the township, though, fashion is highly valued and young women invoke discourses of 'rights' to justify their freedom of movement, thus facilitating relations with men that include sugar daddies. Typically it is gifts of cash, or consumption goods such as cellphones, that sustain these ...

The "socio-spatial place" (*ibid.*) as well as structural factors are critical in determining the sexual relations women engage in and the kinds of choices they make regarding these types of sexual relations. Again, in Tsitsi's exemplar, she was forced to go into a particular sexual relationship with a bus driver because she needed to survive, to subsist and to take care of her children. Hers was a secretive subsistence transactional sex. She felt she had no other choice. The lack of choice speaks to several engendered social and structural factors.

The complex and intricate forces subjecting women to these choices are deeply rooted in cultural practices and the male control of access to resources, material or otherwise, which in turn expose women to a greater risk of HIV infection. Ray and Madzimbamuto (2007, p. 229) decry the unequal gender relationships:

The influence of gender relationships is found throughout the story of HIV in southern African countries. The main risk that young women face is their dependence on men for economic survival but also for the social status that comes with being 'a wife'. Sexual relationships are often formed as a buffer to socio-economic insecurity. Women more often work in the informal sector, in seasonal and insecure employment. They are more likely to have poor and insecure housing tenure, especially if they are in informal relationships as girlfriends or mistresses of married men who pay their rent.

As observed by Hunter (2002, p. 115) in his Mandeni study:

In Mandeni, as elsewhere in South Africa, there exists a huge paradox: while there are high levels of awareness about AIDS, unsafe sexual practices are still common. This article argues that it is the dominance, and indeed taken-for-grantedness of transactional sex that is crucial and little understood factor fuelling the HIV pandemic in the area. Gendered material inequalities provide a material basis for such transactions. Masculinities are also central, and these must be seen as being constructed through historically rooted practices and contestations and not, as some (racially grounded) discourses imply, signifying some kind of innate African 'promiscuity'. At fault here, and more broadly in many well-intentioned but often disappointingly ineffective AIDS 'education' campaigns, is a fundamental conceptual weakness: *the abstraction of sexual relations from the social relations and historically rooted dynamics and practices*".

This abstraction of sexual relations is indeed a key message in Tsitsi's narrative. Her marital and familial relations demanded that she stays in an abusive relationship because that is how a "good wife" was supposed to conduct herself. The likelihood that her husband's sexual behaviour of multiple and concurrent partners was likely to expose her to the risk of HIV infection was inconsequential to her family. What mattered most to them was for Tsitsi to stick to expected social norms, dynamics and practices. The societal and familial tolerance of the environment of concurrency in Tsitsi's life is deeply problematic and troubling given the link between concurrency and high levels of HIV infection in southern Africa (Avert, 2009; Cohen, *et al.*, 2008; Garnett & Anderson, 1993; Garnett, White & Ward, 2008; Green, *et al.*, 2008; Halperin & Epstein, 2004; Hayes & Weiss, 2006; Hudson, 1993; Morris & Kretzschmar, 1997).

Tsitsi's life story resonates with the life stories of many women in different parts of the world. Davila and Brackley (1999, p. 348), in their study of Mexican and Mexican-American women in a battered women's shelter, report that:

The women in the forms of name-calling, character defamation, and the humiliation and degradation of their self-respect and dignity experienced psychological abuse. For many of the women, psychological abuse was a common occurrence in their everyday lives ...

Davila and Brackley (*ibid.*) further report that:

Another common form of psychological abuse was partner accusations of a woman's infidelity. These accusations were often associated with a woman's refusal to have sex with her partner or request for condom use by her partner. Within the analysis, condom negotiation appeared to be especially [a] value-laden topic associated more frequently with extramarital or casual sex than with safe sex.

Davila and Brackley's (1999) observation resonates with Hunter's (2002) observations in South Africa. Hunter (2002, p. 109) remarks:

Male coercion, however, is often mediated through subtle discourses of persuasion. Men will convince women that using a condom represents 'unfaithfulness' and that true love is symbolised by *inyama enyameni* ('flesh to flesh' sex) ...

Indeed Mexican, South African and women elsewhere share similar experiences with Tsitsi as outlined in the following extract:

Researcher: You told me earlier that you had to leave your husband because you were afraid of getting infected with HIV and dying of AIDS. Are you not afraid now?

Tsitsi: (Laughing). *Ko makondomu basa ravo ndereyi?* (What are condoms for then?). I use condoms with all my clients because I do not want to die. At least in this job I have a choice. If a client does not want to use condoms, I tell him to forget it. Yet when I was married, I could not even mention the word "condom". I was very naïve and trusting of my husband. I thought condoms were for prostitutes only. Look, I got my first STD from my husband. Since I have been doing this job I have never contracted an STD. I am much safer doing this job than when I was a wife. Of course, I do have to be strong and sometimes fight with clients when they do not want to pay after offering them my services. However, my children are able to eat and go to school.

Shona culture treats unmarried women with great suspicion and cultural disdain (Jeater, 1993; Mungwini, 2008). It is therefore ironic that Tsitsi felt safe outside marriage. This is at odds with the social perception that marriage provides status and security. As Mungwini (2008, p. 206) points out:

For the *Shona* being a married woman and therefore being somebody's wife gives the woman respectability because of the strong presupposition that a married woman is necessarily constrained in her behaviour while a single woman living alone is perceived as a freelancer who does what she likes. The fact that there is no husband to put brakes in her social interaction turns her into a potential danger to society. The *Shona* are uneasy about unmarried women. The state of being unmarried is regarded with so much suspicion or scepticism unless there are clear reasons such as health problems. Because of their metaphysics the *Shona* explain being unmarried for females as something unusual to such an extent that all sorts of mysterious accounts or stories are generated to explain that status of being single.

Addressing social, structural and gender inequalities and sexism in Zimbabwe remains critical as it was three decades ago at the beginning of the HIV/AIDS pandemic (Poundstone, *et al.* 2004). The reality is that many women in Zimbabwe still find themselves in a similar situation like Tsitsi despite several progressive policies and programmes to address the impact of structural inequalities on women (Langen, 2005). The social and structural drivers of HIV infection in sub-Saharan Africa and their impact on women remain a major factor in the spread of HIV infection, as indeed is the case for women in rural Zimbabwe.

Secretive disparate relationships: young women and sexual exploitation

Another key narrative that emerged on the cultural and sexual meanings of HIV/AIDS in rural Zimbabwe was the sexual exploitation of young women in rural areas. Both the *Mutasa* and *Makoni* communities expressed deep concern about the sexual behaviour of young women and

the increase of children conceived out of wedlock. More disconcerting to the communities was the perceived weakening of customs and norms around the sexual behaviour of young people, especially women. The apprehension of the *Mutasa* and *Makoni* communities is not isolated. Parallels can be drawn across many societies in the world (Brown, 2000). Bauni (1990) highlighted the social upheaval resulting from the changing sexual patterns in Kenya in the era of the HIV/AIDS epidemic.

A recent study by the Ministry of Women's Affairs, Gender and Community Development in Zimbabwe (2011) found that women and young girls constituted 62 % of people living with HIV in Zimbabwe. The biomedical explanation of this statistic would be that women are engaging in unsafe sex and being infected more than men are. However, the sexual behaviour argument to explain the statistic is not that simplistic (Mapingure, Msuya, Kurewa, Munjoma, Sam, Chirenje, Rusakaniko, Saugstad, de Vlas & Stray-Pedersen, 2010; Ray & Madzimbamuto, 2007). Sexual behaviour alone cannot explain off the observed differences in HIV infection levels. The high infection levels among women in Zimbabwe reveal the social and cultural asymmetries still confronting the Zimbabwean society. These asymmetries are amplified in rural areas given the traditional and patriarchal contexts of social relations in that space. The economic meltdown and the rise in sexual concurrency in Zimbabwe are worsening these asymmetries (Taruberekera *et al.*, 2008). The role of economic asymmetries in the spread of HIV/AIDS infection in Africa has been explored (Dinkelman, Lam & Leibbrandt, 2007; Djamba, 1997; Djamba, 2002; Djamba, 2003; Nshindano & Maharaj, 2008).

I use an interview I had with Violet in the *Mutasa* community to explain the social and personal contexts in which these asymmetries find expression. Violet is a 25-year-old unmarried young woman with one daughter. She narrates her story about how she was duped by a married teacher into having a relationship that resulted in her having a child. Her story traverses the emotional trauma and violence she experienced because of the relationship. I am telling this story as it was told to us to highlight the gendered nuances of decision-making it so vividly captures.

Researcher: You told me that the teacher was married when you started going out, how did you find out?

Violet: I met him when he was teaching at a local primary school. We met at *Sabumani*. His school was having some sporting activities and my uncle had sent me to his school. My uncle's daughter, that is my cousin, taught at the same school. I was with my friend on the day and he approached and started talking to us. He then started asking me out. He would visit my home, pursuing me. I just told myself there was no reason for me to carry on staying without a boyfriend so I started going out with him. Since he was teaching at the same school with my cousin I would go visit my cousin and spend time there. Apparently, my cousin also did not know that he was married. It also never occurred to me that he might have a wife back home. The affair grew stronger and I started going to Rukwima more often pretending I was visiting my cousin. We ended up having sex and I fell pregnant. I informed my cousin about my condition. My cousin advised me to inform my boyfriend in person about the pregnancy. I made the blunder of writing him and telling him that I was coming to see him. He just disappeared from the scene. Everyone thought he had just gone away for the weekend. I waited for him but he did not come back. I stayed with my cousin waiting for him to come back but then schools were about to close, I think it was just a week away from end of school term. He never pitched up. It was now very difficult for me to keep waiting for him since I had told my parents that I would come

back home after a few days stay. I went back home. Schools were closed then. My cousin and her husband went away for the holidays. That is when he took advantage, came and collected all his belongings and went away. He somehow managed to get a transfer over the school holidays and never came back to that school again. When my cousin was going back I went with her intending to go and confront him only to find out that he had left a letter explaining that he had found it difficult to tell me in person that he was married. He had a wife and child at home. If I was prepared to be his second wife then I could go with him. I realised that if he had really wanted me to become his second wife he would not have run away in the first place! He would also have had the courage to talk to me in person. I just thought going there would be getting me into trouble. It was clear that he did not mean what he was saying. I told my cousin that I did not want to go. My cousin said we had to wait for him to see if he would come back. He went to teach at another school and wrote me from there accusing me of ignoring his first letter. He said he was coming to resolve our differences. The thing that put me off was his letter. He had enclosed a photograph of his wife and child as proof of his marriage. To me it looked like he was showing off. I decided to ignore him. The truth is I went through a very tough time! I did not even tell my parents. Not a single person knew about the pregnancy except for my cousin. It was like a miracle pregnancy. Up until I gave birth, I was still wearing my normal clothes.

Researcher: Nobody noticed that you were pregnant!

Violet: None at all. My eating habits never changed like what normally happens with pregnant women. Some women adopt many habits when pregnant but for some reason I never did. I would only feel the pain of my predicament when I was alone and thinking about my circumstances. At one point, my cousin tried to talk me into telling my parents but I refused. I was so scared of my father. My father has a very nasty temper. I even threatened my cousin that was she to tell anyone I would commit suicide. I had promised myself that if anyone were to ask me I was going to tell the truth. If they tried to be hard on me, I would just kill myself like what my sister had done. [Violet's sister had committed suicide at the age of 12].

Researcher: Did you think that was the solution?

Violet: I just told myself that life was not easy and there was nothing else to do than kill myself. My parents only found out that I was pregnant the day I gave birth. I delivered her right here in the kitchen. I only called my mother when the labour pains started. She then started crying saying I should have at least told someone about my pregnancy. I should have talked to my aunts because this was going to get her into trouble with my father. She went and told my uncle. My father had already gone to bed then. My uncle is more understanding than my father is, so when he came, he woke up my father and talked some sense into him. My father was mad all the same. He chased me away from home and I went to stay with my uncle.

Researcher: Umm!

Violet: After I had gone to stay with my uncle, community members started to talk about my father's attitude towards me. They told him that I was not the first person to have a child out of wedlock. I am sure after some time he started to feel bad over the way he had treated me. He asked my mother to bring me back home.

Several themes emerge in Violet's narrative. It highlights how "naive" young rural women are been exploited by men. The teacher who impregnated Violet withheld key information from Violet that would have enabled her to make informed personal choices. The little she knew about him proscribed her choices. Violet alludes to him putting "pressure" on her until she eventually agreed to a sexual relationship. Even more telling in Violet narrative is the veil of secrecy surrounding the sexual relationship. He ensured that no one knew. His reasons could have been to protect his job as a teacher as the law in Zimbabwe prohibits any sexual relations between a pupil and a teacher. But teachers continue to have sexual relations with students. Newspaper reports in Zimbabwe as well as in South Africa periodically highlight this issue. The illegality of the sexual relations between pupil and teacher means that these relationships operate under the radar to avoid social sanctioning providing a fertile ground for exploitation and infection. HIV/AIDS thrives on silence and secrecy (Leclerc-Madlala, 2008; Ray & Madzimbamuto, 2007).

The silence and secrecy also takes away the social support systems needed when confronted with the challenge of living and coping with HIV infection. In the case of Violet, she had to cope and battle alone with pregnancy without the social support system. Her family did not know that she was pregnant. The teacher had disappeared. The only person she told about her pregnancy was her cousin whom she swore to secrecy not to tell the family. In traditional *Shona* customs, the mother plays a critical support and advisory role during her daughter's first pregnancy. Violet could not tell her mother that she was pregnant and therefore self-excluded herself from family support. She feared her father's reaction to her out of wedlock pregnancy. Therefore, the vicious cycle of secrecy and silence that started with having a sexual relationship with a teacher continued to play out in her life ostracising her from family and social support systems.

Many young women likely find themselves in similar situations in rural Zimbabwe. The exemplar from Tsitsi attests to this. Tsitsi lost familial and social support because she dared to challenge the *status quo*. The social and gender asymmetries found in the traditional *status quo* exclude women from support systems. Exclusion from social support systems leads to personal vulnerability. Personal vulnerability then predisposes women to HIV infection because of the choices they are then forced to make. Violet wanted to commit suicide. She eventually settled on silence and self-imposed exclusion because she knew of the heavy price she was going to pay for going public about her pregnancy. Tsitsi did not want to keep silent. She confronted the traditional behemoth and paid the heavy price of social exclusion. Whereas Violet was socially excluded by her silence, Tsitsi was socially excluded by her refusal to be silent. Ironically, Tsitsi ended up being a victim of silence and self-exclusion as well.

Tsitsi: "I was forced to start an affair with a bus driver plying our village route. I kept it a secret from my family. I would sneak out and come back in the early hours of the morning before my parents were awake. The bus driver would give me some money and buy me groceries. He was very nice. Then the bus company transferred him to another route very far from our village and that is how the affair ended. Life became tough and I was suffering a lot and I could not take it anymore."

Understanding the interplay of male-female relationships, social exclusion and vulnerability of women is important in the prevention of HIV infection in women in rural Zimbabwe. Violet's exemplar gave very broad brushstrokes of some of the nuanced ways in which these factors manifest in young women's lives. Young women in rural areas are at crossroads of the old and the new social orders. On one hand, the new order is exposing them to high levels of HIV infection because it keeps perpetuating the social, structural asymmetries forcing young women to exchange sexual favours for their survival. On the other hand, the old order condemns women to more vulnerability by punishing and excluding those who are perceived to have strayed from the established cultural norms and *status quo*. Therefore, narratives on sexual exploitation, social exclusion and social relationships are important in understanding the spread of HIV infection rural areas of Zimbabwe.

The moral-religious narrative and HIV/AIDS in rural Zimbabwe

HIV/AIDS is a disease that disrupts personal and social life in dramatic ways. It was therefore critical for me to understand the ways in which rural Zimbabweans were re-ordering their lives around the HIV/AIDS pandemic given the personal and social disruptions the pandemic was causing to the lives of Zimbabweans. AIDS related morbidity was rising. Public health facilities were discharging bed-ridden patients in order to free up hospital bed occupancy and for families to care for the terminally ill. By 2005, Zimbabweans were burying close to 3 000 people a week due to AIDS related mortality (NAC, 2006).

A key emerging socio-cultural narrative on HIV/AIDS in rural Zimbabwe is the moral-religious narrative. The moral framing of disease in Africa is a historical and cultural artefact (Ikunobue, 1998; Ingstad, 1990; Mwamwenda, 1989; Sempebwa, 1983; Verhoef & Michel, 1997; Western, 1985; Wiredu, 1980). In African philosophy, there is *de facto* defaulting to moral-religious explanations of phenomena that threaten human existence such as the HIV/AIDS pandemic. However, the moral-religious paradigm also does blame those perceived to have transgressed agreed upon social norms and punishes them with misfortune of social ostracism.

HIV infection and its accompanying illnesses have connotations of perceived and ascribed stigma (Dlamini *et al.*, 2007; Emler, 2007; Hartwig *et al.*, 2006; Jewkes, 2006; Kalichman *et al.*, 2006; Mills, 2006; Naidoo *et al.*, 2007; Regnerus & Salinas, 2007; Rohleder & Gibson, 2005). It is important to understand the link between HIV/AIDS and stigma in the context of African communities given their traditional reliance on familial and community support in times of tragedy and illness (Airhihenbuwa, 1995; Altman, 1994; Ankrah, 1991; Ankrah, 1993; Naidoo *et al.*, 2007; Nyamukapa & Gregson, 2005). I discuss stigma in rural Zimbabwe in order to demonstrate the narratives of moral, religion, social and personal exclusion, discrimination, blame, accusation, weakness and pollution linked to HIV/AIDS (Bury, 2001; Thomas, 2008).

The *Honde* and *Bonda* areas where I conducted my field study are areas dominated by Anglican Church mission stations as well as a number of African Apostolic churches (Gregson, *et al.*, 1999). The greater majority of Zimbabweans subscribe to Christianity albeit with varying degrees of religiosity (CSO, 1992). The influence of Christianity in the lives of Zimbabweans is profound, shapes their thinking, and views on personal and social issues.

The role of the church in mitigating the impact of HIV/AIDS has been somewhat mixed. Ray and Madzimbamuto (2007) say this should not be surprising in Zimbabwe where AIDS continues to be perceived as a disease of personal moral laxity. The church has not helped much the situation in Zimbabwe by continuing to equate HIV infection with moral decadence. As Ray and Madzimbamuto (2007, p. 220) remark: "Church leaders have not shown by example the

compassion deserved by those of their congregations who were struggling with the stigma of living with HIV.”

The link between the personal narrative and illness in Zimbabwe becomes quite apparent given that the *Shona* language uses particular essentialist metaphors to describe illnesses that are potentially stigmatising like HIV. For example, most of the villagers interviewed never mentioned the word AIDS but would just refer to it as *chirwere chemazuvano* or “*icho chakati kunya ichi*” literally translated as “this new terrible diseases we don’t understand” and too painful to mention. Stigmatising names such as *mukondombera* or *chakapedza mbudzi* (the disease that wipes off your entire herd or generation) are widespread in everyday reference to AIDS in Zimbabwe.

According to Bury (2001, p. 263), moral narratives: “... provide accounts of (and help to constitute) changes between the person, illness and social identity, and which help to (re) establish the moral status of the individual or help maintain social distance”. Bury (2001, p. 274) asserts that the key feature of moral narratives is:

... their evaluative dimension into the links between the personal and the social. Here, valuations enter the picture, as sufferers seek to account for and perhaps justify themselves in the altered relations of body, self and society brought about by illness. If narratives represent an ‘ordering of experience’ in the face of disruptive experiences they also give expression to (sometimes) concealed ‘dynamic relations’ between people and their social contexts.

The social construction of morality and religiosity in rural Zimbabwe and elsewhere in sub-Saharan Africa is deeply embedded in culture rendering the strict distinction between morality and religiosity very fuzzy and superficial (Takyi, Fosu & Gyimah, 2005). The emergence of the moral-religious narrative is a critical factor in this study simply not because of “the effects of religious beliefs on individual health behaviour and outcomes [but] on religion as a social force that shapes social, cultural and institutional responses to health conditions and health disparities” (Munoz-Laboy, Garcia, Moon-Howard, Wilson and Parker, 2011 p. S127). Munoz-Laboy *et al.* (*ibid.*) note:

Religious meaning systems, practices and institutions have been central to the articulation of projects for social change of diverse types in response to HIV/AIDS. Sometimes, religious cultures have reproduced values and practices that have seriously impeded effective approaches to mitigate the epidemic. At other times, religious movements have provided the most powerful force for the mobilisation of individuals and communities in response to the social vulnerability, economic exclusion and public health risk associated with HIV.

The following extract, from an interview with Mr Mbetsa, highlights the juxtaposition of religion, culture and morality in the lives of rural Zimbabweans. Mr Mbetsa is a married family man, grandfather and church elder. His narrative on HIV/AIDS was based on a moral-religious axis. He made constant reference to culture, the Bible and morality. He shared with me the following perceptions and thoughts.

Researcher: Have you ever heard of AIDS?

Mr Mbetsa: I have heard so much about it. Everyone talks about it these days.

Researcher: Do you think this disease is new or it has always been there?

Mr Mbetsa: I would say this disease is new because if we look back, men never had to wear condoms when having sex. If you read the Bible, there is nowhere it says people have to wear condoms. I think it is a new disease. I cannot say where it came from. Long ago diseases were there but they were curable. This is one of its own kind.

Researcher: Would you have an idea where it came from?

Mr Mbetsa: I would say it originated from too much mingling among different people. Long ago, we would just reside in one area but nowadays the population has grown so big, we have to spread out in search of greener pastures. As we grew up, we were taught to stay away from women. These days you can never tell someone that and expect to be given any attention. Children are now being taught differently in school. The teachings they get at school and what we teach them about our culture are different.

Researcher: Looking at this problem, what do you think should be done?

Mr Mbetsa: You have just reminded me of a time when I was still with the *Manicaland* Development Association. Some people came giving out condoms and were actually encouraging people to take them. I told them the best medicine was faithfulness. People are not supposed to go after every woman that they see.

Researcher: What is really happening, what has changed?

Mr Mbetsa: I cannot really comment on that. It is difficult because our children are no longer trustworthy. You children now think that wherever you go you must have to sleep with different women. Even animals are behaving better than humans are these days! Human beings think that you have to have sex daily. You change women the way you change your pants. It is a problem really. The law of God does not allow you to go into bed wearing shoes but nowadays it is happening.

Researcher: Umm, what do you mean by that?

Mr Mbetsa: Nowadays instead of me going after a woman, it is now vice versa. You would not be surprised that tomorrow, if there are women who saw you coming here, they would be knocking on the door looking for you. Back then, no woman went after a man! The man had to go after the woman and it was not an easy process. It could take you months or even years before a woman said yes to your advances. However, today it is a same day affair.

Researcher: What do you think has brought about this change?

Mr Mbetsa: I can say this change is largely due to money. Back then, children did not have anything to do with money unlike today. Even women did not keep money. It is now a case of too much love for money and wanting luxury things.

Researcher: I want us to talk a little bit more about condoms. What impact are they having on people's behaviour?

Mr Mbetsa: I was speaking about this issue last week. A little boy helps us around here. I saw him with condoms and I was very troubled by it. I asked him why he needed them but he could not answer me. I feel the issue is not really the condom here. At times, I also feel that if you cannot control yourself then maybe it is better to

use them. Why should you need to use them in the first place? Just do not do it and then do not use them. They push people to indulge in sex because there is always this feeling of protection. Things have now changed. Long ago, we used to withdraw and let out the sperm outside the woman's body but it was not done every time. The law did not allow it. The condoms are being misused and that is the problem.

Several poignant themes emerge from Mr Mbetsa's exemplar. The exemplar highlights the disjuncture between the new and old social orders, the perceived loss of control over women by men due to women's economic emancipation, the generational gap in public health discourse in Zimbabwe, and lack of sexual control due to "laxity" of moral and sexual norms. These themes need to be engaged with to show that the HIV/AIDS discourse in Zimbabwe is not linear as what the public health discourse around HIV/AIDS would have us believe.

The public health debates tend to abstract sexual relations from the everyday realities of people's lifeworlds. Yet the playing out of sexual relations is embedded in deeply rooted social and historical dynamics. This is the case in rural Zimbabwe where the church, in its various forms, is a powerful institution influencing the social order in significant ways that cannot be ignored in the HIV/AIDS discourse.

The positioning of Mr Mbetsa's narrative in a moral-religious dichotomy is very revealing and insightful given the pervasiveness of the Christian doctrine in the lives of ordinary Zimbabweans (Thomas, 2008). The exemplar gives the picture of an influential man who was still living in the old order where things were explained in a linear way. In Mr Mbetsa's world, the husband was the *de facto* head of the household and his decisions could not be challenged or defied (Mungwini & Matereke, 2010). As the patriarch of the family, Mr Mbetsa's role was to guide and ensure the survival of the family by sticking to the blueprint passed on from generation to generation. The generational wisdom was the glue and whipping stick that he used to keep the family together. As far as he was concerned, things ought to be that way and any tampering with this order was a recipe for disaster. His perception of the individual, family and community was in relation to the established social order. Any deviation from this order invoked the wrath of God and ancestors.

The exemplar gives very interesting analogies on the breakdown of the old social order. Mr Mbetsa talks of "people jumping into bed wearing shoes". The pictorial analogy of this statement is quite telling. Common *Shona* etiquette requires one to take off their dirty shoes when entering the house and it was unheard of that a person can then go to sleep wearing shoes, irrespective of the shoes being clean or dirty. Mr Mbetsa is using metaphors to describe the breakdown in social order. He expresses his disgust at the new tendency of women accosting men for sex. Given the patriarchal tendencies of the *Shona* society, a woman accosting a man for sex signifies a total rapture of morality and social order.

Uncontrolled desire was sinful and so was deviation from the social order. God or ancestors' wrath manifests in the form of social disintegration, diseases, famine and moral purgatory. This led Mr Mbetsa to explain off AIDS as a curse from God because the modern generation had uncontrolled sexual desire and was forever seeking immediate sexual gratification. Price and Granger (2005 p. 5) remark:

As sexual activity is motivated by desire, Christian and biblical categorisations of desire as sinful can impose costs on sexual activity....The sexual analogues are straightforward: Sexual lust is overindulgence in sexual intercourse, sexual gluttony is excessive love of sexual pleasure, and Sexual greed is having more sex than one has need for. Violation of each of these sexual sins manifests

itself in either the frequency of sexual intercourse, and/or the number of sexual partners.

In Mr Mbetsa's view the breakdown in exercising authority over women and lack of sexual control were manifesting themselves in the dreaded HIV/AIDS disease. Mr Mbetsa laments the laxity of sexual personal control and the centrality of the condom in people's sexual lives. He does not subscribe to the public health paradigm that the condom is an efficacious prevention method against the sexual acquisition of HIV/AIDS. To him the condom offers people a ready excuse to indulge in reckless sex because they put their faith in the condom and "falsely" believe in its protective qualities.

Central to the moral-religious paradigm is the concept of being clean or dirty. Thomas (2008) notes the existence of the concept of contamination or pollution in explaining deadly and wasting diseases in southern African communities. Her commentary on the HIV/AIDS narratives of the people of the Caprivi Region of Namibia cogently captures how the narrative of pollution and pollutants was dominant in expressing the rise in mortality in the region. She (2008, p. 237) explains pollution or contamination as arising out of the breaking of certain cultural taboos linked to sexual relations:

Contact with "pollutants" through the breaking of taboos is considered both a cause and an explanation of illness in Caprivi Region. Unbalancing the accepted *status quo* through contact with tabooed matter creates: "disorder" ...leading to contamination, illness, and possible death ... "pollutants tend to be found within bodily fluids such as blood and semen and through contact with death. As avoidance of contact with such "pollutants" is not always possible, adherence to stringent moral codes and protective rituals are considered necessary so people can attempt to both defend themselves and restore "order". However, changes regarding behaviour and expectations, particularly among young people, compromise their ability and willingness to adhere to such moral codes and rituals, therefore creating "disorder" exemplified through increasing illness. Violation of a taboo is thought to cause illness within the perpetrator, but may also be transmitted to another person with whom they come into contact with through sexual relationships,...

Jeater (1993) make similar commentary about sexual pollution in Zimbabwe arising from breaking of cultural taboo around sexual relationship. In my interviews, the elderly men and women of *Manicaland* constantly referred to how the young people were no longer respecting long standing cultural norms. This was creating social tension and problems. This tension is clearly detectable in Mr Mbetsa's narrative.

Traditionally, a break from cultural norms required performance of specific cleansing rituals for one to be admitted back into the community (Thomas, 2008). The elders of rural Zimbabwe believe that the supplanting of the established old order with the new social order that has no respect for the traditional moral-religious views is to blame for the rapid spread of HIV/AIDS in Zimbabwe:

Mr Mbetsa: I cannot really comment on that. It is difficult because our children are no longer trustworthy. You children now think that wherever you go you must have to sleep with different women. Even animals are behaving better than humans are these days! Human beings think that you have to have sex daily. You change women the way you change your pants. It is a problem really. The law of God does not allow you to go into bed wearing shoes but nowadays it is happening.

The moral-religious narrative on HIV/AIDS in Zimbabwe seeks to preserve the old order. It blames the new order for transgressing the cultural taboos resulting in social dislocation and anomie. Transgression is followed by severe punishment. A person who is dislocated from his or her community draws parallel with an animal. To be compared with an animal in Zimbabwe is a grave rebuke or insult because animals are perceived to have no soul and of a lower moral order.

Inter-generational tensions: the “manjombo” narrative

Thomas (2008) commenting on illness narratives in Namibia, talks about the existence of tensions between the old and the young generations in the Caprivi Region. Thomas observed that the old generation blamed the new generation for bringing incurable diseases into the lives of traditional Namibians and the younger generation blamed the older generation for being out of touch with modernity. Thomas (2008, p. 231) notes that:

During focus groups with elderly men and women and interviews with traditional authorities and church leaders, interviewees frequently stated that the increase in illness and deaths in the region since Independence was directly linked with the changing attitudes and behavior of young people. While relationships and marriage had previously been overseen by the two families concerned, elders and church leaders reported that the term “marriage” is now often used to mean that a person is in a sexual relationship, without any marriage ceremony taking place and without payment of *lobola* (bridewealth). They stated that a recognized commitment and ceremonial marriage was no longer a prerequisite for sexual relations among young people, and many parents commented that they did not even know that their children were “married” until the woman became pregnant. Older people also reported that since their children were better educated than themselves, they [the children] no longer listened to them. Formal education has brought a shift in the concept of “knowledge” in the Caprivi, such that the knowledge of the elders, based on life experience, is no longer considered relevant to a younger generation which requires other information to overcome livelihood pressures and gain salaried employment. Social pressures placed on young people to conform to modernist ideals and the economic need to get by were reported to have resulted in a breakdown of generational hierarchies and, among young girls, an increase in more casual relationships which offer reward and support. Seen as a breaking down of order by dominant religious and customary belief, such changes were found to reinforce blame directed against younger people for both the spread of HIV and AIDS and the significant socio-cultural and economic upheavals that have taken place since Independence was gained in 1990.

I have quoted this long text from Thomas to drive home the parallels between the Caprivi communities in Namibia and the *Manicaland* communities in Zimbabwe. In Thomas’s text, one can read Mr Mbetsa and all the elderly community members of the communities I interviewed and their sense of loss of control over the younger “permissive” and “rude” generation. One can also read Tsitsi’s conflict with the established patriarchal norms and customs when she decided to walk out of her marriage and the subsequent reaction of her family. Also evident is Violet’s exemplar in this text when she started a casual sexual relationship with the teacher that resulted in pregnancy outside wedlock.

Mr Mbetsa's exemplar expresses the narratives of anguish of the elders of the *Makoni* and *Mutasa* communities:

Mr. Mbetsa: A little boy helps us around here. I saw him with condoms and I was very troubled by it. I asked him why he needed them but he could not answer me. I feel the issue is not really the condom here. At times, I also feel that if you cannot control yourself then maybe it is better to use them. However, why should you need to use them in the first place? Just do not do it and then do not use them. They push people to indulge in sex because there is always this feeling of protection. Things have now changed. Long ago, we used to withdraw and let out the sperm outside the woman's body but it was not done every time. The law did not allow it. The condoms are being misused and that is the problem.

Mr Mbetsa represents the old order in the village. When I talked to the younger generation, they had no problems with using condoms. Now contrast Mr Mbetsa's narrative with the narratives of Gibson and Munyaradzi who are both young men.

Gibson: *Tinoshandisa manjombo* (We use gumboots [condoms]). We get them from the village health worker. It is sometimes embarrassing because they know us very well but they do not ask too many questions. Even peer educators hand out condoms and you can always approach them.

Munyaradzi: *Akaita nhumbu ine 'mahwani'* (It will be a big problem if she were to fall pregnant). *Handisati ndave kuda kuroora* (I am not yet ready to marry). Therefore, we use condoms. *Ugh!* I trust her and the only reason we use condoms is to avoid *'mapuregi'* (pregnancy).

What I find most interesting in these narratives is the general convergence between the older and younger generation that condoms were not ideal (Marindo, Pearson & Casterline, 2003). This is unique in the sense that Mr Mbetsa is very explicit that there is absolutely no need for condoms as one is not supposed to sleep around (the old order reality). Mr Mbetsa's message resonates with the abstain, be faithful (A, B without the C) message of HIV prevention which has found support in the United States President's Emergency Plan and Fund for AIDS Response (PEPFAR). The influence of the conservative Christian patriarchies and lobby groups in the dropping of the C (condom use) has been debated (Green, 2008).

The older generation and married males view condoms as anathema. Muhwava (2003 p. 121) remarks:

The condom has not gained much popularity as a contraceptive method, but in the era of HIV/AIDS, there is need to look at the condom as a prophylactic. Although condoms are highly effective in preventing unwanted pregnancy and infections, it does not seem that they are gaining popularity among married couples.

Hickson and Mokhobo make a similar observation (1992 p. 13):

... few concepts are as deeply ingrained in the African psyche as the need to reproduce. In many cultures an infertile man is ostracized and a barren woman shunned. Consequently, Africa's preoccupation with virility forms a major barrier to the use of condoms.

Epprecht (1998, p. 634) talking of the *Shona* people's functionalist approach to marriage and fertility, says, "The appearance of fertility was one of the most important elements in a proper marriage and in the social definition of adulthood for both men and women."

The emphasis on fecundity puts pressure on women not to insist on condom use. In Tsitsi's exemplar, she was infected by a sexually transmitted disease because she felt powerless to ask an unfaithful husband to engage in protective sex. Not only was she powerless to prevent herself from being infected but she was blamed for being the source of the infection:

Tsitsi Then I discovered that he had infected me with “drop” (a discharging sexually transmitted disease). I confronted him and he had the audacity to blame it on me. He accused me that I had infected him with a sexually transmitted disease because I was of very loose morals. That is when I really got mad! I had never slept with any other man in my entire life and he knew it. He claimed that when I ran away it was because I was itching to see “*zvikomba zvangu*” (my secret lovers) who then had infected me with an STD! Yet it was him who was having an adulterous affair and I knew that his lover was “*dihwino remurume wese-wese*” (she was a pool in which any willing man could take a dip). *Ndakafunga vana vangu kuti zvino ndikafa nemukondombera vanosara vachichengetwa nani* (I thought about my children and wondered who would look after them were I to die of AIDS).

Tsitsi admits to naivety in terms of condom use within marriage. Her constructions of the condom were shaped by the need for fecundity and never the need to protect herself. Only after walking out of her marriage did she feel empowered to insist on condom use with her clients. The emphasis on pleasing the male also shifts sexual attention from women to men. This is known in *Shona* tradition as lovers bedroom discourse (Shire, 1994). The lovers' discourse aim is to sexually psyche up the male by praising his sexual prowess and performance in the bedroom. The discourse is very explicit and uses words that would be regarded as coarse in everyday language (*ibid.*). The discourse emphasizes the need for the wife to be left satiated and feeling the husband's blood coursing inside her. The discourse precludes protection and marriage becomes a risk factor for HIV infection in the case of unfaithful married couples.

According to Runganga *et al.* (2001) Zimbabwean males in infertile marital relationships complained of wasting their male seed. For them sex was not recreational; they expected their wives to conceive. Taken in the context of Jeater's (1993) 'mixing of blood' requirement among the *Shona* it becomes apparent that the use of a condom is not paramount in marriage. A man ejaculating into a condom and thereby preventing his semen ('blood' among the *Shona*) from mixing with his wife's secretions was committing an affront and risked provoking the anger of the ancestral spirits. The following excerpt from Mr Mbetsa puts this belief into perspective:

Mr Mbetsa: Long ago, we used to withdraw and let out the sperm outside the woman's body but it was not done every time. The law did not allow it. The condoms are being misused and that is the problem.

There is a generational gap in terms of how condoms are perceived (Adetunji, 2000; Agha *et al.*, 2001). The young are seemingly readily using them in premarital sexual relations because they provide protection not against STDs but unwanted pregnancy and early parenthood. However, embedded in the youth narratives are images of filth, dirt and pollution associated with sex. I have called this *manjombo* complex. *Manjombo* refers to rubber gumboots manual labourers wear to protect their feet from dirt, filth, pollution, and injury. Why are the rural Zimbabwean youth drawing parallels between condoms and gumboots? The notion of dirt or pollution is significant here. However, what the narratives did not clarify for me was what is it that was dirty or polluted? Was it the young girls they were having pre-marital sex with or the sex act itself that was dirty? The narratives of the younger men in *Manicaland* show a generation that is happy to have sex but quick to label the indulgence as dirty and polluting therefore requiring one to get *manjombo*

for protection. Embedded in the *manjombo* narratives are stereotypes of the woman as a source of death and disease or contamination. The blaming of women for illness is not new (Thomas, 2008). The stripping of a woman of her dignity through implied or acted upon sexual desire in Zimbabwean society has been documented (Mungwini, 2008; Mungwini & Matereke, 2010; Shire, 1994).

The social constructions around the condom need to be understood and engaged with as failure to do so will keep the condom as a contested issue, subject to misconceptions (Muhwava, 2003). The generational information gap and stereotypes remain critical challenges in HIV prevention.

What were the social and cultural constructions of the pandemic within the Makoni and Mutasa communities?

Subjective positioning of women in rural Zimbabwe

As I listened to the narrative of the *Manyika* villagers it struck me as to how gendered their stories were. Gender as a construct and the meanings attached to it became central to my understanding of the cultural dynamics of the *Manyika* people. Gender is an identity that is socially constructed and fluid (Blackwood, 1999). Blackwood (1999, p.182) argues that we need to view “gender as a subjective experience and gender as a cultural category”. She states:

Viewing gender as a cultural category foregrounds the social structural and ideological processes that make it seem bounded – all the more so in a “scientific” age replete with minute diagnostics of human experience. Studying gender as a cultural category highlights normative representations of gender and the way they are legitimated, privileged, and hegemonic.

Blackwood (*ibid.*) argues that whereas viewing gender as a subjective experience:

...exposes all the processes of negotiation, resistance, manipulation, and displacement possible by human subjects. Gender in this sense constitutes a set of identities multiple shaped from and through cultural contexts and representations....Viewing gender as a subset of possible social identities allows us to do two things, first, to remove gender as a fundamental aspect of sexed bodies, and second, to investigate the way culturally constituted categories shape, inflect, and infuse gender identities.

In view of Blackwood’s (1999) argument, my primary interest was to see how gender roles were negotiated among the *Manyika* people and whether they were any social tensions and conflicts arising out of the negotiation. If indeed, there were tensions how were they resolved to maintain cultural equilibrium? I was also interested in finding out if the need to have cultural equilibrium was exposing the *Manyika* people to HIV infection and thereby becoming, itself, a cultural risk factor. I had to listen to the voices of both men and women.

Tsitsi’s narrative provides interesting synopses into the construction of gender among the *Manyika*.

Tsitsi: He then would spend days away from home and never gave us money for our daily upkeep. I followed him to his workplace and his superiors were not helpful at all. They send me from pillar to post. *Varume ndevamwe vanorwirana.* (Men always jump to each other’s defence). I even went to the courts to seek a maintenance order. When he found out, he went berserk. He reported me to my parents’ that I was disrespectful and did not accord him the respect due to him as a man and head of our family. All our relatives ganged up against me saying there must be

something wrong with me as there was no way such a “lovely” husband could simply decide to abandon his family.

In this exemplar, Tsitsi tells of the violence she faced from her husband after questioning his alleged infidelity. Tsitsi was a wife and mother relying on her husband for her survival. The reliance on her husband became the nexus of abuse once he became involved in an adulterous relationship. When she tried to address the issue she received no support from her family and significant others. No one questioned him over the abuse. Tsitsi was blamed “there was something wrong with her”. Studies have shown the existence of the phenomenon of locating the responsibility for violence within the victim (Althusser, 1970; Stamp & Sabourin, 1995). Tsitsi’s husband claimed she was disrespectful towards her and therefore deserving of the violence he meted against her. Tsitsi, by choosing to confront her husband had “threatened” his perceived manhood and authority. She had challenged his space.

She then tries to justify the change in her husband’s behaviour by alluding to her possible failure in sexually pleasing him. The exemplar below from Tsitsi puts this into perspective.

Tsitsi: I felt hopeless. I then wondered how it was possible for my husband to desert me for another woman. Surely there had to be something wrong with me. *Kuda ndakange ndashapa.* (Maybe I had become stale and wasn’t sexually good anymore).

Jeater (1993, p.23) writing on moral discourse among the *Shona* people, the *Manyika* belong to this ethnic grouping, describes the role of a traditional *Shona* woman as follows:

A good wife was primarily one who was a good worker and a good mother, but the emphasis on pleasing her husband found in a girl’s education indicates that wives were also expected to be good sexual partners.

Shire (1991) and Runganga (2001) talk about the discourse of sexuality among the *Shona* people. The discourse was in the form of praise poetry sung by women that alluded to the maleness and sexual prowess of their husbands. Tsitsi’s discomfort can be understood when placed against the *Shona’s* emphasis on the ability of the wife to sexually please her husband of which failure would lead to desertion. She dutifully wonders if she had become stale, unattractive, and displeasing to her husband. Rohleder and Gibson (2005) report a similar lament in their study of HIV positive women in South Africa. Tsitsi was torn apart by the fact that her husband left her for a “woman of loose morals who had sex with any man” – she uses the analogy of a public pool in which any man could take a dip. What was more painful to Tsitsi was perhaps the humiliation of husband leaving her for another woman she perceived as of loose morals and not her equal.

Tsitsi’s husband did not tell me his story. I know from Tsitsi’s narrative that he deserted her for a woman of “loose morals”. Tsitsi derisively refers to her rival as a “common pool in which any willing man could take a dip”. However, it did not stop her husband from leaving her for the “loose morals” woman. Did it mean that her husband’s perception and construction of the other woman was positioned differently from that of Tsitsi’s (Burr, 1995)? He contracted an STD; that we know from Tsitsi because she subsequently got infected. Yet that did not stop him from moving in with his lover. Tsitsi had to move out and found herself eventually in the same position as the woman she so heavily despised. She started selling sex in order to fend for herself and her children.

Her role as a mother was exposing her to choices that made her vulnerable for HIV infection. She showed personal agency outside of her marital relationship by insisting on condom use during intercourse. Her former role as a compliant wife was similarly exposing her to HIV

infection, as she could not negotiate condom use with her husband (Muhwava, 2003; Runganga, 2001).

Tsitsi's discursive position was fluid. She had moved from being a wife, to being a commercial sex worker. She was a caring and loving mother because she was involved in commercial sex work out of a desire to feed her children. However, the conflict and the lack of support from her mother hurt her the most. She expected her mother, "as a fellow woman", to understand her plight. Yet she received no solidarity from her. Her father was more understanding. The tense relationship with her mother forced Tsitsi to move out and find her own place to stay.

Tsitsi's reported conflict with her mother raises serious implications for HIV/AIDS prevention programmes in Zimbabwe that are gender-based and focus specifically on women. The programmes assume that there is solidarity among women and hence treats women as a unit. However, Tsitsi's narrative tells a relationship fraught with tension. Her relational and dialogic experiences with her mother lacked the solidarity she expected from a mother and a fellow woman. As she narrates:

Tsitsi: A year went by and it was sometime during the second year that problems between my mother and me came to a head. *Munogozivavo kuti vakadzji vaviri havabiki chikari chimve* (Two women cannot cook the same pot as there is bound to be a conflict of recipes). [Here Tsitsi uses a *Shona* proverb used to remonstrate people contemplating polygamy]. My mother and I started having endless squabbles. She would insult me over my failed marriage. She always reminded me that I had become an economic burden to her.

In positioning gender, one has to pay closer attention to issues of class, power, and race. Not all women share similar experiences and conversely their self-construals differ. It follows then that the self-in-relation to others plays a significant role in how women position themselves vis-à-vis HIV/AIDS prevention debates. The development of the discursive self is language determined and changes from position to position depending on the relational other. Thus, Tsitsi is a divorced mother, a caring mother, a disrespectful wife, and a commercial sex worker. The multiplicity of selves in cultures that are collectivist pose challenges to the egalitarian approach to health education and promotion premised on the unitary, independent self.

The Shona worldview: the self-in-relation to others

I paid particular attention to the emergence of the self and use of the "I", "Me" and "We" in the narratives of the villagers. I also became interested in reading for the self in relationship to others. The self-in-relation has also been referred to as the dialogical self (Day & Tappan, 1996).

The dialogical self is culture specific. In view of the cultural location of the self, Doucet and Mauthner (1998) explain that the second reading seeks to give voice to the person while also acknowledging the social position of the speaker. It looks at the narrator's "multi-layered voices, views and perspectives" (p. 8). The reading for the personal pronoun and the ontological subjectivity are the key features of the methodology.

The reading allows you to listen to the tensions, self-construals, and presence of the other. Who else is present in the narrative? What is their relationship to the narrator? Is it a relationship of harmony or tensions? What are the power relationships? Whose voice is dominant? How does the narrator feel and act about the relationship and what are the outcomes? We need to pay particular attention to the language people use to describe themselves and their relationships, the notion of the grammatical self (Harre 1989).

The *Shona* believe in a cosmic world (Bourdillon, 1987). The cosmic world is the giver of life, the regenerative force responsible for all spheres of life such as reproduction, fertility (human, animal and inhabitants of the earth), production and sustenance. The *vadzimu* (ancestors) oversee life. Religion is embedded in everyday living as all our activities are sanctioned by the overseeing spirits. Life is cyclical, regenerative and communal. Aarmo (1999, p. 264) comments: “Traditional Zimbabwean culture was centered on the cult of fertility and regeneration of life”. Nsamenang (1999, p. 25) makes a similar observation regarding African social thought:

Every cultural community has a worldview that includes an image of human nature and ontogeny. African ontogeny visualises a cyclical nature of the human life course. Whereas the infant is entering the world of the living, the aged person is expected to leave it eventually through death.

In *Shona* ontogeny, the primacy of fertility is emphasized. Runganga (2001, p. 317) wrote:

In *Shona* cosmology, the meaning of life is linked closely to collective identities, the individual's role in reproduction, the past and the afterlife {Beach, 1980; Bullock, 1950}. A woman's birth canal represents a temple for creation. It signifies fertility, symbolic growth of the clan and clan families and sometimes the fertility of the land.

The temple analogy by Runganga (2001) for the woman's birth canal points at a sexual culture that had religious and ritualistic meaning far beyond recreational pressure. Procreative sex was a religious and spiritual duty that was culturally central but restricted in terms of expression. Jeater (1993 p. 26) comments:

Although the expression of sexual desire was fairly flexible, the channels through which it could be expressed were much more limited. In other words, it was not so much *what* was done as *with whom* it was done that attracted concern. (Emphasis is original).

Jeater's commentary explains Mr Mbetsa's outrage over the level of “promiscuity” in his community.

Mr Mbetsa: Even animals are behaving better than humans are these days! With people, you think you have to have sex daily. You change women the way you change your pants. It is a problem really.

One can then understand the anger that engulfed Violet's father when she gave birth out of wedlock. She had even concealed the pregnancy from her family thereby denying them their ritualistic role in the procreation and birth giving process. Violet tells of her father's rage upon hearing that she had just given birth on the kitchen floor.

Violet: My uncle is more understanding than my father, so when he came, he woke up my father and talked some sense into him. My father was mad all the same. He chased me away from home and I went to stay with my uncle.

Shona custom regards sex as a bond tying together not only the copulating partners but also their respective lineages. Jeater (1993, p. 28):

Sexual relationships had to be acknowledged by the lineages involved, and it was the absence of such acknowledgement which constituted the offence. In *Shona* terms, the danger in illicit sexual relations was that the relationship had not been approved by the ancestors, and a dangerous ‘mixing of blood’ would take place. Marriage rituals opened the way for ancestral worlds of the different lineages involved to come safely into contact.

Violet had mixed the blood of her lineage with that of the teacher's lineage outside the sanction of her family. This was an affront to the ancestral spirits. Dire consequences would follow her disregard. She had to be disconnected from the other (her family) to save the whole family from misfortune. The disconnection is very symbolic. African worldview emphasises the connectedness of the individual to the universe and the other. "The reality of the communal world takes precedence over the reality of individual histories" (Menkiti, 1984 in Vlaenderen & Cakwe, 2003). This is the dialogic and embedded nature of the African self. Violation of the rules regarding sex results in contamination. This could explain why main Zimbabweans still prefer to use metaphors when speaking about HIV/AIDS.

Metaphors are culturally meaning rich and serve to convey a deeper message. During my interviews metaphors such as *mukondobera*, *chakapedza mbudzi*, *shuramatongo*, *utachiwana* and *icho chirwere chemazuva ano* kept appearing in the narratives. Interestingly these AIDS metaphors all allude to fate that befalls anyone who has transgressed the customary laws of the land. They are excommunicated or disconnected from the social milieu. Specific rituals have to be performed for them to be readmitted into the community and fellowship of the communal self. A disconnected soul is a wandering soul and needs the intervention of the living to bring it back into the custody of the spirits.

This has far-reaching implications when viewed against the HIV/AIDS epidemic. First, HIV infection could be viewed as a punishment by the spirits for sexual transgressions and therefore beyond the powers of the living. Second, it invokes images of being dirty (*tsvina*) in some sections of the Zimbabwean society: the manjombo narrative of the youth in Zimbabwe. Third, the metaphor of contamination and dirtiness creates stigma. Stigmatised individuals are less likely to enjoy the benefits of programmes in place to assist them. This could be access to early treatment, counselling, and social support services. This helps drive HIV underground and its continued spread.

Lastly, breaking of *Shona* taboos and customs would result in one being stripped of personhood. One becomes disembedded and disembodied. The concept of personhood (*unhu*) is so ingrained in the *Shona* and transects all aspects of life. It is root syntax in all Bantu languages for the person (*'ntu'* in *Nguni* and *Chewa* languages, *nhu* in *Shona* and similar languages). As the following extract from one of the female respondents shows:

Tsitsi: *Haasi munhu asi mbuka chaiyo. Munbukadzi anorara newese wese murume anganzi ane bunhu* (She is not a person but an animal. A woman who sleeps with any men does not have any morals).

In the above example, a Tsitsi uses the word *munhu* to describe personhood or self and *unhu* to describe morality or human essence. A person who has lost human essence becomes an 'animal' in *Shona* thinking, hence Mr Mbetsa's remark that humans were now worse than animals. *Shona* cosmology sees the spirit of human beings as sacrosanct compared to lesser spirits of animals. Animals have no spiritual essence unless when used in rituals. Therefore, to be called an animal means you are a lesser being. You have no personhood. Rituals accompanied by the slaughter of animals (lesser spirits) have to be performed in order for you to attained personhood. Accordingly, all who practice deviant' sexualities are 'animals' and pose a greater danger to 'proper' human beings. Epprecht (1998, pp.647-8)) commenting on the rise of violent homophobia in Zimbabwe, remarks:

The sudden upsurge of invented homophobic 'traditions' has in fact resonated among the wider population, particularly among those threatened by the rapid changes in gender relations. These changes are real and frightening. AIDS kills

an estimated 800 people every week whilst a quarter of the sexually active population is infected with HIV. This alone has contributed to the emergence of radically dangerous sexual behaviours including women's and men's predation upon younger and younger children supposedly to avoid HIV but also, in the case of men at least, to assert the power to refuse to wear a condom, rape of virgins (to cure the disease), and a fatalistic sexual consumerism (we are all going to die anyway, so why not indulge in the most conquests?). In addition, longstanding fears about 'uppity women' now manifest themselves in a virulent misogyny expressed, for example, in public stripping of women in short skirts.

Conversely Hickson and Mokhobo (1992 p.12) decry the breakdown of African traditional customs and morality caused by urbanisation and capitalistic economies:

Urbanization, the migrant labour system, and poverty have all had their influences in undermining family relationships as well. This has resulted in a marked increase in premarital sex and a higher incidence of teenage pregnancies. Such sexual practices and their consequences are not necessarily frowned upon. Sexual excesses, especially when practiced by urban men, are generally hallowed and viewed as prestigious.

Although I find Hickson and Mokhobo's observations on African urban sexuality to be too simplistic, I do accept their thesis that urbanisation has had an alienating and disconnecting influence on the African. In other words, the self in African thought has been under siege from various historical forces starting with violent colonialism, capitalism, nationalism to globalisation. We cannot speak of the self as unresponsive and immune to historical antecedents and forces. Our definition of the African self has to acknowledge that the self is fluid and transitory and has to be defined as such. We are a constituent of multiple nuclei and embedded in relational networks (Nsamenang, 1999).

Given that, we are a multiplicity of possible selves, can one then claim to understand the African self fully? If we do, how do we then reach these multiple selves with health promotion messages. To me this is the challenge HIV/AIDS prevention faces. For the message to be successful, it first has to understand the recipient.

Hegemonic masculinities: implications for HIV infection and prevention

The notion of masculinity has received considerable attention (Cornell, 1994; Cornwall & Lindisfarne, 1994; Morrell, 1998) but attained little consensus as to what exactly can be pinned down as masculinity, or to be precise, masculinities (Gutmann, 1997). Masculinities are fluid, social constructs. As Morrell (1998, p. 607) puts it: "There is not one universal masculinity but many masculinities". Masculinity is about men as engendered and engendering subjects (*ibid.*). Commenting on the concept of hegemony, Blackwood (1999, p.183) writes:

Hegemonic or dominant gender ideologies define what is permissible, even thinkable; they serve as the standard against which actions are measured, producing codes, regulations, and laws that perpetuate their definition of a particular ideology. Dominant ideologies generate discourses that further stabilize, normalize, and naturalize gender, although within any dominant ideology there are emergent meanings, processes, and identities vying for legitimacy, authority, and recognition.

Gutmann (1997, p. 386) suggests four anthropological ways of looking at masculinity and its related notions of male identity, manhood, manliness, and men's roles. He comments:

The first concept of masculinity holds that it is, by definition, anything that men think and do. The second is that masculinity is anything men think and do to be men. The third is that some men are inherently or by ascription considered “more manly” than other men. The final manner of approaching masculinity emphasizes the general and central importance of male-female relations, so that masculinity is considered anything that women are not.

Masculinities are often bound together by their need to dominate. Patriarchy as defined by Connell (1994) is located in production, sexuality, reproduction and socialising children. Hegemony is the manner by which patriarchy plays itself out in the public and private domains of our lives. Masculinity is a social construct and is constructed differently across cultures and history. Masculinity is not homogenous but heterogenous within and across cultures.

In exploring issues of masculinities and patriarchy among the *Manyika* I make extensive reference to Shire’s (1994) polemic on masculinities in Zimbabwe. Shire (1994) gives a historical and cultural account of masculinities in Zimbabwe. I also refer to Epprecht (1998) who locates his account of masculinities on the contested issue of homosexuality in Zimbabwe. Epprecht (1998) and Aarmo (1999) polemics argue that homophobia in Zimbabwe is a hegemonic masculine construct nourished by dominant nationalistic discourse that has no reference to culture.

Shire (1994, p. 147) begins his autobiographical account of masculinities by defining the fragmentary context of Zimbabwean culture. He points out that:

General terms like ‘Zimbabwean’, ‘*Shona*’ and masculinity mask fragmentary contexts. There is no universalized ‘Zimbabweanness’ or ‘*Shonanness*’, just as there is no single, universalized masculinity. I use the term ‘masculinities’ here to examine male preoccupations as celebrations of ideals of maleness, pluralized to render a definition as fragmented as the many domains in which men are constructed as ‘men’ through language and space.

The lack of a unitary definition of what is Zimbabwean poses challenges to the definition of a Zimbabwean culture. Aarmo (1999, p.264) notes that:

Black Zimbabwean culture presents a complicated picture. Zimbabwe is a multi-ethnic country with a variety of local cultural traditions and influences introduced by colonial administration and Christian missionaries that intersect and parallel each other.

Social life in Zimbabwe is binary in terms of gender. The linearity of social life is reinforced by normative values of male and female spaces. Mr Mbetsa bemoans the erosion of gendered spaces in modern day living arrangements. To many of us his views on women are backward and chauvinistic. However, to him that is how things out to be:

Mr Mbetsa: What used to happen long ago is that we used to have what we called *matare* (male social and judicial courts). We would sit together as men in the evenings and discuss different things, bring ideas together. This is no longer happening. Instead, we sit in the kitchens with our wives. You cannot discuss sound ideas with women.

In *Shona*, traditional society dare (singular for *matare*) was an important male space. The female space was defined by the kitchen. Shire (1994, p. 150) writes about his experiences of the *dare*:

As I grew up the most important male space was the *dare*. As boys, we started to spend more and more time in the *dare*, moving between this ‘outside’ space and the ‘inside’ space of the hut, the domain of women. The *dare* was used to structure various ideas about maleness. It was a place used to debate and assess

masculine ideals, for judicial matters and for relaxation. The dare was always located far away from the women's spaces, such as the kitchen or the women's sleeping quarters. Women were not denied access to this space, but their approach was limited to those occasions when they entered the dare as victims, victimizers or jurors in judicial matters or when they brought in food for the men.

Mr Mbetsa decries the cultural anomie that has set in his village because of the erosion of normative values underpinning the interaction of men and women. He feels highly embarrassed by having to sit in the kitchen (men moving into women's space). This challenges his notions of manhood and maleness. The symbolism of a kitchen is something female in *Shona* customs (*Manyika* people are part of this grouping). Sitting in the kitchen and interacting with women reduces him to a woman. In *Shona* custom to be called a woman when you are a man is regarded as an insult.

As Shire (1994, p. 151) points out:

The *dare* was also the space in which men exchanged experiences and learnt about making love and pleasing women. Men did not exclude boys from these conversations, or from hearing about their physical or sexual problems, unless they were seen as spending too much time in women's spaces. Gossip was something that took place only in the female domain, so the talk of men was regarded as something that needed to be contained to prevent its transformation into gossip.

The self-construal of the modern *Shona* man is that of a man having conflict with self and the opposite gender. Personal tensions arise out of the need to affirm his masculine identity and the lack of male spaces to do so. He is no longer in control of the self in relation with the other, specifically the female. The *Shona* man is faced with an identity conflict and a dilemma in terms of his place and agency in the social universe.

The challenge for current HIV/AIDS prevention messages is how to reach a man who is struggling to understand his manhood and no longer in harmony with his worldview because the symbols of manhood in his life no longer exist or have been alienated by technology and social change. The alienation is not only faced by *Shona* men but by *Shona* women as well. The female spaces have disappeared under modern living arrangements, e.g., men straying into the kitchen.

In traditional *Shona* society, sexual knowledge was imparted within gendered spaces. Men and women never mixed during the imparting of sexual knowledge (Jeater, 1993; Runganga; 2001; Shire, 1994). It was taboo to do so. When I asked Mr Mbetsa why HIV/AIDS had become such a serious issue in his community he strongly attributed it to the alienation caused by modern education. Here is what he said:

Mr Mbetsa: As we grew up we were taught to stay away from women. These days you can never tell someone that and expect to receive any attention. Children are being taught differently in school. The teaching they get there and what we teach them is different.

Manyika men and women position themselves differently in the gendered spaces in relation to self and the other. Notwithstanding that, the gendered spaces have now become contestable and unclear. The language used in these spaces is both gender exclusive and gender specific.

How do men seeking to impose their masculinity in contested spaces react? It is most likely that the blurring of gendered spaces results in gender violence. In urban Zimbabwe, men seeking to

reaffirm their masculinity and manhood resorted to violence. Stripped of their totemic masculinities, urban males inhabited a masculinity that regarded women as *mabure* (whores) whose presence in male spaces, such as *beer-halls*, evoked extreme misogyny. Any form of violence against women was legitimised within the male space of the beer-hall (Shire, 1994, p. 152-3).

In the case of women who went into *beer-halls*, sexual violence was permissible in that space. Whilst conducting an interview with Tsitsi in the shade at her lodgings, men would walk up and demand to know when she was going to be free or pass very explicit sexual remarks. It struck me as very unusual that my presence did not deter them at all. Tsitsi simply brushed them off by remarking: "*Haina, vanopenga tavajairira*" (Oh, they are crazy and I am used to their behaviour). Gender violence in this space exposes both men and women to risk of HIV infection. It is in the same space that condom use has to take place. The condom negotiation process is situated in a space of potential masculine violence (Muhwava, 2003) against the female commercial sex worker.

Discussion

The exploration of the narratives of the *Manyika* people of *Makoni* and *Mutasa* areas of Zimbabwe in the context of the HIV/AIDS epidemic indicate that ordinary rural people, though aware of the HIV/AIDS epidemic, live their daily lives without foregrounding the epidemic in their day-to-day living. Their daily lives are characterised by the struggle to eke out a living. The prevailing social *status quo* is not challenged. The *status quo* is explained away as 'culture'. Yet there is no consensus on what constitutes *Manyika* culture except shared dialect and geographical locality. It is the personal relationships that the *Manyika* people engage in that have relevance to their daily lives more than anything else does. The personal relationships take many forms of expression. Their expression creates either vulnerability or protective factors against the HIV/AIDS epidemic. As Thomas (2008) found with the Owambo people of Namibia, the localized understandings of the HIV/AIDS epidemic are critical in the development of effective interventions for treatment, care and prevention.

The complexity of people's personal lives and relationships means that there is no common worldview on any phenomena, HIV/AIDS included. The early models of HIV prevention, utilising the equally maligned ABC strategy, assumed rationality in people's sexual behaviour and responses to a disease threatening their well-being and health. However, people's responses to life threatening events are not always rational. Evidence does exist that despite the presence of HIV or even the encouraging declines in HIV incidence and prevalence, risky behaviour patterns are increasing (Hayes & Weiss, 2006). The persistence of risky behaviour patterns speaks to underlying factors that militate against safer sexual behaviour. These broad structural factors impede behaviour change or adoption of safer sex practices.

The narratives or discourses people tell and their worldviews informed by their lived experiences become critical (Bury, 2001) in developing a better understanding of how people negotiate their daily lives around the HIV/AIDS epidemic. Material gifts, everyday transactions, status symbols, social status, wealth or lack of it -- what Hunter (2002) termed the "materiality of everyday sex" -- are seen as normal everyday social transactions by the actors and never in the context of the vulnerability to HIV infection they pose (Djamba, 1997; Fitzgerald-Husek *et al.*, 2010; Leclerc-Madlala, 2008; Thomas, 2008). The actors in these social transactions do not necessarily view them in the manner outsiders do. Whereas outsiders see them as prostitution, transactional sex or survival sex, the local actors see them as normal relationships (Caldwell, *et al.*, 1989; Hunter, 2002; Leclerc-Madlala). The actors attach meanings to these social interactions that are rational

and socially acceptable. Kaplan (1999) argues that the social environment provides a window into understanding people's health choices. Krieger (2001) proposes a social epidemiology to the understanding of diseases such as HIV. My thesis tried to understand the social transactions, social environment and social epidemiology of the *Manyika* people as they live with the HIV/AIDS epidemic; the *Manyika* worldview on HIV/AIDS.

The chapter highlighted the narratives of the *Manyika* people and their everyday social transactions, which are likely to be exposing them to the risk of HIV infection. The narratives of the *Manyika* people provide a window into understanding their personal and social environments. The personal and social environments determine their worldview as well as their lifeworlds (Kagee & Dixon, 1999; Thomas, 2008). Their lived experiences shape their worldview and the narratives they tell. Thomas (2008) implores us to be mindful of the social environment in which the narrative is told.

More so, the personal illness experiences people tell about a disease offer insight into understanding how they construct meaning about and deal with particular diseases. The social construction of meaning around a disease influences the likely measures or steps people are going to take in seeking or not seeking treatment, even prevention of reoccurrence of the disease. Social constructionism provided a theoretical platform for exploring the personal and social environments of narratives of the *Manyika* people, especially their sexual practices and meanings, in the era of the HIV/AIDS pandemic.

The personal narratives explored in this thesis suggest that HIV infection occurs in particular contexts: personal; social; cultural; economic; religious; and structural. The interplay of these factors is intricate and complex. For example, structural factors can manifest in the form of gender violence, unequal access to resources or poor health service delivery. The personal context influences the perception and meaning of risk. The cultural context determines practices around marriage, etc. Egalitarian approaches to HIV prevention often do not take these contexts into perspective. They focus on a "rational" individual usually divorced from his or her personal and social contexts. The narratives of Tsitsi, Mr Mbetsa, and Violet raised critical and social factors coloured by their life experiences.

Tsitsi's narrative is of an abused woman who found no support in the family support system. Her husband was cheating. Her husband infected her with a sexually-transmitted disease. This was so because Tsitsi's role as a wife within the *Manyika* culture meant that she was powerless to protect herself from sexually transmitted infections. The ABC prevention strategy was not appropriate for Tsitsi as it is for most married women in Zimbabwe. Tsitsi knew about condoms but could not dare use them in her marriage as this would have elicited more domestic violence or led to her being accused of being unfaithful in her marriage. She reveals that she stayed in this abusive relationship because of "her children." Tsitsi's narrative is representative of women in Zimbabwe who stay in abusive relationships because "they have children" with the abusive partner. In other words, having children and being in an abusive relationship is a double jeopardy for Zimbabwean women. At the same time there are societal pressures placed on women who choose not to have children.

This double jeopardy exposes women to a level of vulnerability that a condom or being faithful to their marriage cannot prevent.

The nature of the personal and social relationships is exposing women to vulnerabilities that likely lead to exposure to HIV infection. Again, in Tsitsi's narrative she reveals that she got involved in secretive sexual relations in order to fend for her children and herself. She eventually

ended up as a sex worker. The limited opportunities in Tsitsi's life caused by structural and social factors forced her to become a sex worker exposing her to the likelihood of more violence and vulnerability. In Tsitsi narrative, you read the voice of many women in Zimbabwe. Not all women in Tsitsi's position end up as sex workers but personal circumstances coupled with social and structural factors force women into positions of vulnerability. Vulnerability takes away women's voice and renders them susceptible to infection, violence and exploitation.

The narrative of Violet highlights the complexity of women's susceptibility to exploitation in a gendered society. Violet got involved in a relationship that thrived on secrecy and exclusion. This was an age disparate relationship (Leclerc-Madlala, 2008), which operated under the radar in order to protect the boyfriend from losing his job. The secretive nature of her relationship placed the burden of protecting the relationship on her alone. Hunter (2002) and Leclerc-Madlala (2008) present different arguments around transactional sex. Hunter (2008, p.100) argues that the construction of multiple partners "as 'girlfriends' or 'boyfriends' and not 'prostitutes' and 'clients'" is a risk factor that exposes people to HIV infection because the constructions determine the subsequent actions people take to avoid infection. Leclerc-Madlala (2008) argues that some young women actively seek age disparate and transactional relationships as a means of attaining social mobility. She argues that these relationships can actually be empowering.

Violet's narrative, however, tells a different story. She was a 'girlfriend' involved in a relationship with a teacher who was older than she was. There is no mention of exchange of gifts in her narrative. Hers was not a transactional relationship. She sought neither social mobility nor expecting gifts. In fact, she was oblivious to the world of transactional sex. All she knew was that she had fallen in love with an older teacher and had to keep the relationship a secret. For her, the secrecy surrounding her relationship as well as her young age made her vulnerable to exploitation. We know that she had unprotected sex with an older man as she got pregnant. We know that she even contemplated suicide when she realised that she had been duped. She also discovered that she had been exposed to a concurrent sexual relationship. HIV/AIDS literature has highlighted the dangers of sexual concurrency (cf. chapters 1 & 2). Violet's narrative was one of sexual exploitation leading to possible vulnerability to HIV infection owing to the unprotected sex.

The *Manyika* cultural context makes women like Tsitsi and Violet vulnerable. The old social order represented by Mr Mbetsa is struggling to adjust to the new order of Tsitsi and Violet's generation. Elders like Mr Mbetsa feel alienated by the new order. Thomas (2008) found similar evidence among the Owambo elders in Namibia. As a means of countering social anomie, the elders invoke the narrative of rigid morality and religiosity. This is a narrative of blame. It blames the new order for bringing new diseases like AIDS. It blames women's economic freedom on the market forces. According to Mr Mbetsa, women and young people had no need for money. The patriarchy of the family was supposed to be responsible for bringing money, a theme that resonates with the middle class theory of an industrialised husband and a domesticated wife. Yet the study communities were by no means middle class but ordinary subsistence villagers.

Christian religion teaches that the family patriarchy is the source of sustenance for the family. Mr Mbetsa and many elders of the study communities strongly believed in this view. They were at a loss at how fast the world was changing around them. They did not see the need and relevance of condoms even when acknowledging the presence of AIDS in their communities. They blamed the need for condom use on the inability of the young generation to control sexual urges; the "*manjombo*" dialogue of the young generation. To this old order generation, the young generation was rebellious and invoking the wrath of God and the ancestors. Teenage pregnancies

were on the rise and the youth were entering into relationships without sanctioning from their families. As far as they were concerned, the rebellion by the youth was the root cause of the social ills their communities were facing. The disapproval of certain relationships by the old generation meant that the young generation like Violet are forced into secretive sexual relationships with serious negative consequences.

The sex workers in *Hauna* spoke of the challenging environment they worked in. They spoke of the hostility they face from other women in the community. Ironically, the sex workers felt well protected from HIV/AIDS as they could negotiate condom use free from the restrictions imposed by being a wife or girlfriend. They made it clear that sex was only on their terms and conditions. For the sex workers their greatest concern was the violence they encounter in the space they work in – the beer halls. They complained that the beer hall patrons were abusive and violent when they turned down their sexual advances. The patrons felt that they were entitled to sexual favours since the sex workers operated in a male space.

The thesis, therefore, argues that local efforts in fighting the epidemic have to be contextualised. The personal, social, cultural, and economic contexts all influence the HIV/AIDS epidemic (and even determine who is infected or affected by the disease). HIV transmission occurs in personalised contexts – people having a sexual relationship, sharing injecting drugs, or a mother giving birth – relationships which determine who gets infected or not.

However, personal relationships do not occur in a vacuum. People relate as boyfriends, girlfriends, husbands, wives, mothers, fathers, etc. These relationships require different personal positioning, power and interpretation. The personal positions are contestable and oftentimes gendered an unequal. The contestation of power and its expression profoundly affect gender and generational relationships in the *Manicaland* area. Most importantly, attention must be paid to the language and discourse the *Manyika* people use to express their lifeworlds and experiences with the HIV/AIDS epidemic.

Conclusion

The chapter discussed the results of the study through exploration of the social and cultural factors exposing people to HIV infection in rural Zimbabwe and the sexual meanings that people attach to the factors. Informed by a social constructionist perspective, the study looked at how the *Manyika* people constructed the self and their worldview in the midst of the HIV/AIDS pandemic that was disrupting individual, family and social lives in Zimbabwe. The study asked two broad and related questions:

- How had HIV/AIDS pandemic affected the lives of the *Manyika* people of *Makoni* and *Mutasa* areas?
- What were the social and cultural constructions of the pandemic within these communities?

In Chapter 1, 2 and 3, I acknowledged the global and local efforts in fighting the HIV/AIDS pandemic. I highlighted the global community's several groundbreaking steps in the fight against the pandemic. Success stories are emerging around treatment, prevention and care issues. The epidemiology of the disease is fairly understood. Biomedical efforts aimed at better understanding the disease were going on across the globe in response to the disease.

The thesis argued that, despite reports of declining HIV levels in some countries of the world, the prevalence levels in sub-Saharan Africa remained very high and were a cause for concern. This was especially the case for southern Africa where the epidemic was levelling off at high levels. Even more disconcerting were reports that risky behaviours were on the increase in

countries that had reported early declines in HIV prevalence. This raised the need to understand what was fuelling the persistent risky behaviour as well as understand how local people viewed their personal risk to HIV infection.

The study provided broad brushstrokes of the major narratives emerging in rural Zimbabwe in the context HIV/AIDS. It sought to highlight how rural people were responding to the epidemic. Several inter-linked themes emerged from the narratives in relation to the social and cultural impact of HIV/AIDS in rural Zimbabwe. The emerging themes, among many, were the social vulnerability of women in marital relationships; moral-religious construct; young women and sexual exploitation; subjective positioning of women; inter-generational conflict; gendered spaces and social capital; and the *Shona* worldview.

These dominant narratives had several related sub-themes: marital conflict; marital violence; marital dissolution; marital conflict; man as the *de facto* head of the family, man as the breadwinner, single motherhood and personal choices; blame; transgression; punishment; social dislocation and anomie; accusation; gendered spaces; poverty, economic hardships and inter-generational sex; condom use; and the new “social order”. The narratives had multi-layered meanings reflective of the lived experiences, personal and social contexts of the *Manyika* people. Notions of masculinities and patriarchy were explored and how these concepts were putting both men and women at risk of HIV infection in Zimbabwe. The study argued that the conceptions of masculinities in the *Shona* culture were mostly influenced by on space and gender relations.

The persisting gender, economic, social, and structural asymmetries in rural Zimbabwe need to be confronted as a step to developing socially appropriate and culturally relevant HIV prevention strategies in Zimbabwe.

CHAPTER 8

CONCLUSION, IMPLICATIONS and FURTHER RESEARCH: GLOBAL EPIDEMIC, LOCAL RESPONSES

The HIV/AIDS pandemic is a complex global public health phenomenon. The complexity of the HIV/AIDS pandemic is unique in that it requires both localised and personalised actions to deal with it. The HIV/AIDS pandemic affects differently between and within countries. Very personalised actions and choices are required in dealing with the pandemic and in ensuring that one stays uninfected. Similar choices are required for those who find themselves living with the virus and the diseases related to the HIV infection. These complex choices cannot be fully explored by a study of this nature given its academic necessities.

I started my thesis by acknowledging that HIV/AIDS was a critical health and social problem in Zimbabwe and indeed for the rest of the world. I acknowledged the existing efforts to mitigate the spread and impacts of HIV/AIDS and the recent declines in HIV prevalence. However, HIV infection levels are still high in Zimbabwe. The continued high level of HIV infection in Zimbabweans, especially among young women, is a cause for concern (MOWAG & CD, 2011). It is also an indication that egalitarian approaches to HIV/AIDS prevention in Zimbabwe are severely limited in the light of the continued onslaught from the epidemic.

The information, education and communication (IEC) strategy, informed by Eurocentric models of behaviour change, worked well to bring about heightened public awareness of the HIV/AIDS epidemic in Zimbabwe. HIV prevalence is dropping in Zimbabwe pointing to success of some of the prevention efforts. However, Zimbabweans still do not fully understand the sexual behaviours and contexts that expose them to the risk of HIV infection. There is limited discourse on how Zimbabweans perceive, interpret and negotiate meaning around HIV/AIDS. There was need to engage the “contextual frameworks within which different actors interpret and respond to HIV/AIDS” (Thomas, 2008, p. 227).

HIV/AIDS prevention strategies that recognise the self and the African worldview are appealing because they are connected to the traditional African psyche (Nsamenang, 1999, Verhoef & Michel, 1997). Traditional Africans (it can be argued that there is no more the archetypal traditional African) or to be more precise Zimbabweans in my thesis, are by nature fundamentally experiential and oral in knowledge transmission. This experiential grounding creates barriers in terms of accessing media-based HIV/AIDS prevention messages. The media-based prevention messages are therefore alienating to the average Zimbabwean.

Human beings are by nature relational. We get a sense of our being from experientially interacting with the other. I have argued in this thesis that the African self is relational, dialogic and interdependent. The African is eco-systemic, i.e. the African self is interconnected with the universe: the environment and the spiritual realm. The African self cannot therefore be defined in terms of traditional psychological constructs of the individual.

Social constructionism argues that a person is not a system of coherent elements. We behave, think and feel differently depending on whom we are with, what we are doing and why we doing what we are doing. Personality is neither static nor stable over time. People have a multiplicity of selves (Hermans & Kempen, 1995) that are relational and interdependent (Mwamwenda, 1989).

I argued in this thesis that social processes are the key to understanding human life. We are subjective in our lived experiences as human beings. The individual himself/herself is not a single monologous self but a dialogic self (Day & Tappan, 1996; cf. Bakhtin, 1984) living in a multiverse rather than a universe (Harrison, 1995, cf. Real, 1990). The implication of this viewpoint is that it is never possible to obtain a complete meta-perspective of any social interaction (Hamilton, 1995).

The HIV/AIDS epidemic caught Africans unawares. The initial efforts to prevent HIV infection emerged from the West, specifically the USA and Australia, as it tried to contain the spread of HIV within the gay communities. Prevention models that worked in homosexual contexts were transported wholesale to the heterosexual context of sub-Saharan Africa. This was inevitable, given the role of Western social psychologists in the development of appropriate health education approach, to develop models of prevention that were premised on individualistic orientation and motivation of behaviour change, the Western worldview (Markus & Kitayama, 1991; Triandis, 1995; Day & Tappan, 1996).

There are calls for culture-based appropriate theoretical frameworks of knowledge (Allen & Bagozzi, 2001; Benahabib, 1992; Baumgardner & Rappoport, 1996; Cross, 1995; Markus & Kitayama, 1991; Singelis & Brown, 1995; Shweder, 1991). Commentators on African knowledge systems and thought have consistently argued for theoretical paradigms that acknowledge the African self, worldview and relational embeddedness (Hickson & Mkhobo, 1992; Mkhize, 2003; Mboya, 1999; Nsamenang, 1999; Vlaenderen & Cakwe, 2003; Verhoff & Michel, 1997). These scholars inspired by African tradition and philosophers have unanimously stated that Western knowledge systems are alienating and disengaging because they are historically and culture specific. Cushman, (1990) refers to the 'empty self' in the West. Hickson and Mkhobo (1992, p. 3) argue that:

For these reasons, an understanding and appreciation of the African worldview and appropriate strategies that incorporate the African psychological orientation to life, nature, institutions, other people and things are necessary ingredients in an AIDS prevention approach. An understanding of African worldview can make explicit values, beliefs, and suppositions about AIDS.

This study explored the sexual practices and cultural meanings facilitating the spread of HIV/AIDS in rural Zimbabwe. The study specifically explored the social construction of HIV risk of the *Manyika* people of Zimbabwe. It acknowledged the African ontological paradigm of connectedness (Mkhize, 1999) as well as the relational aspect of African collectivism. The study, with its emphasis on language, drew upon the dialogic self-concept as well as subjectivity. My thesis argued that an understanding of the meaning and dialogic relations of the *Manyika* would give insight into their perceptions of HIV infection risk and how they were negotiating the risk in their lives. As Polkinghorne (1992) suggested, my thesis was a call to neo-pragmatism. It sought to understand what worked in the local context and the factors that made it to work.

Conclusions about the research questions

The study posed two linked research questions:

- How had HIV/AIDS affected the lives of the *Manyika* people of *Makoni* and *Mutasa* areas?
- What were the social and cultural constructions of the disease within the two communities?

A narrative approach to data collection was used (Miles & Huberman, 1994; Reissman, 1993; Neuman, 1997; Silverman, 1994). The data analysis followed the voice-centred relational method (Mauthner and Doucet, 1998). This method of data analysis was chosen because it places emphasis on ontological understanding and interpretation of meaning. It allows for subjectivity and is dialogic. The method argues that people, especially women, do not always speak with a singular voice of *justice* as proposed by Kolberg's cognitive moral development tradition but also with the voice of *care* (cf. Gilligan, 1991; Day & Tappan, 1996). For example, women involved in sex work show that they do not construe self in a single voice. Rather, they are many voices constituting the self, e.g., self as a caring mother, wife, and daughter. Gilligan's method is culturally adaptable and allows one to be culture and context specific. I used it because I wanted to listen to the private voices of the *Manyika* people separate from the dominant narratives of society.

There are six linked key messages of this thesis. Most critical message is that HIV/AIDS is linked to the lived experiences of the *Manyika* people. The lived experience expresses itself in how they interpreted phenomena such as illness in the context of their culture and social relations. It emerges from the study that gendered expectations were exposing rural *Manyika* women to the risk of HIV infection. Their social vulnerability expresses through the institution of marriage and its accompanying expectations on the woman. Marital conflict, marital dissolution, marital separation, and marital violence in rural *Manyika* communities are exposing women to high levels of social vulnerability. Challenging the *status quo* leads to blame, punishment, and social exclusion. Social exclusion strips women of social support and livelihoods forcing them into survival strategies that expose them to HIV/AIDS infection.

A second key message of this thesis is the sexual exploitation of young women in rural Zimbabwe. Both the *Mutasa* and *Makoni* communities expressed deep concern about the sexual behaviour of young women and the rise in children conceived out of wedlock. More disconcerting to the communities was the weakening of customs and norms around the sexual behaviour of young people, especially women. The apprehension of both the *Mutasa* and *Makoni* communities is not isolated. Parallels can be drawn across many societies in the world (Brown, 2000).

The high infection levels among women in Zimbabwe reveal the social and cultural asymmetries still confronting the Zimbabwean society. These asymmetries are amplified in rural areas given the traditional and patriarchal contexts of social relations in that space. The economic meltdown and the rise in sexual concurrency in Zimbabwe are worsening these asymmetries (Taruberekera *et al.*, 2008). More worrying is that the sexual exploitation of young women by older men takes place under a veil of secrecy and silence. The veil of secrecy and silence self-excludes the young women from any available support systems. In so doing, it makes them even more vulnerable to HIV infection. The piper is calling the tune, so to speak.

A third key message is the dominance of the moral-religious paradigm in the rural *Manyika* communities. The moral-religious paradigm seeks to reinforce and re-impose the old social order on the new generation. This is being done through traditional patriarchal and Christian tendencies of blame and punishment. The older generation is struggling with the pace of change and feels alienated. On the other hand, the younger generation feels unnecessarily burdened by the irrelevant patriarchal customs of the old generation. The old generation blames the emergence of diseases like HIV/AIDS on the promiscuity of the younger generation.

Closely linked to the moral-religious narrative is a key fourth message. There is a widening inter-generational information gap in rural Zimbabwe. Access and interpretation of information is disparity between generations co-existing in rural *Manicaland*. The older generation perceives condoms as the ultimate testimony that the world has gone morally bankrupt whereas the younger generation are seemingly readily using them. However, the narratives of young men around the condom surprisingly draw from the discourse of pollution and defilement.

A fifth message of the thesis is the issue of gender and masculinity. Men and women in the *Manyika* culture are positioned differently. Issues of gender and masculinity were central to the dialogic relations between men and women. Culture is used to explain gendered actions and meanings as well as to preserve gendered asymmetries. The self as “I” was overshadowed by the self as “we” or other. This made personal agency problematic to interpret or understand. It possibly gives justification to Harre’s (1989) questioning of the relevance of the concept of agency to people in non-Western societies. Non-Western societies are relational and interdependent and the self is viewed in a dialogic manner. Within the communal concept of life in Africa, the sum is greater than its part. Therefore, the community is greater than the individual is. In this study the self in relation was stressed regardless of its disempowering potential in societies and communities at crossroads; neither “traditional” African nor fully Westernised.

A final key message of the thesis is the notion of gendered space and violence arising out of masculinity and patriarchy. Gender violence occurs within male spaces and seems to be condoned. It is argued that gendered spaces make women vulnerable to males whose traditional concept of masculinity is under siege from modernity. The refusal to use a condom in non-monogamous sexual relations is an oft-cited example (Pool *et al.*, 1996; Muhwava, 2003; Nzenza-Shand, undated). The “silence” of rural women in the face of gender violence is a cause of concern.

Lack of solidarity among women increased their vulnerability as well. This resonates with Vlaenderen & Cakwe (2003) finding that women seeking to break away from traditional gender roles need support from “like-minded women”.

Unique contribution of the study

The study lays claim to being the first to use the voice-centred relational method within a social constructionist paradigm to look into issues of vulnerability and HIV infection in rural Zimbabwe. Although several social constructionist and qualitative studies have been carried out before in Zimbabwe, this was the first study to look at HIV/AIDS factors in Zimbabwe from a narrative perspective using a relational method of analysis. The method allows the researcher to listen to the tensions within the self as people narrate their life stories giving meaning to their subjectivity. It allows reflexivity, thus the researcher and narrator can both reflect on the intersection of their experiences thereby enriching the narrative. It acknowledges that people position themselves differently within different discourses owing to their multiple possible selves (Markus & Nurius, 1986). The method gives voice to the self. We are consistently and constantly in dialogue with self and other. We are a dialogic self (Day & Tappan, 1996).

The study’s unique contribution is that it linked vulnerability to HIV infection to a disjuncture in the discourse of masculinities. A rapidly changing and disempowering society finds the rural people of Zimbabwe faced with cultural anomie. There is a masculine and patriarchal longing for the past. The study, from my knowledge of current literature on Zimbabwe, is the first to look at the relational self, agency and positioning and implications for HIV infection in rural Zimbabwe.

Implications for policy, research and practice

The study highlighted the need to situate gender empowerment within appropriate spaces. Programmes that do not take into context gendered spaces risk perpetuating gender violence and vulnerability, especially of women within historical masculinities. However, research into gendered spaces and masculinities does not need to pity men against women but understand how men as men and women as women interpret and negotiate gendered spaces. Sexual behaviour change programmes now need to move away from the “one size fits all” messages to messages that tackle structural issues as well as existing discourses of power, gender and masculinity (Huygens *et al.* (1996) quoted in Taylor,1998).

The macro socio-political structure has to be considered in the quest to understand vulnerability at community or individual levels. Female respondents in this study indicated that they adopted lifestyles that exposed to the risk of personal violence and infection because of lack of employment opportunities

In an environment of pervasive poverty and deep-seated structural inequalities, calls to use condoms become meaningless. The economic hardships besetting Zimbabwe are well known. The struggle to survive by “all means necessary” makes people vulnerable. Women are worse off because they have to struggle for survival in a patriarchal society that privileges men. Therefore, their risk to HIV infection significantly increases.

Piecemeal efforts, strategies masquerading as empowering, and development projects to mitigate the impact of HIV/AIDS need to be scrutinised and analysed when they operate in a structural-environment that does not support sustainable social capital. As Kieffer (1984, p.12) remarks: “Throughout the broad literatures of citizen participation and community organization, there is a striking absence of attention to issues of individual empowerment.”

Development efforts often assume that whatever benefits accrue from community programmes will cascade to the individual and empower him or her. This is far-fetched in communities where patriarchal notions are widespread and the dominant political discourse strips people of their civil rights.

Further research is needed on the discourses of vulnerability and HIV/AIDS in Zimbabwe. This could be helpful in designing appropriate HIV prevention approaches in Zimbabwe.

Implications for theory

The thesis argued the limited relevance of Eurocentric models of HIV/AIDS prevention in rural African, particularly Zimbabwean, contexts. It critiqued the unqualified generalisation and application of Western psychological artefacts, including conceptions of the self, to non-western settings including rural Zimbabwe. Eurocentric models of personhood and worldview in general were criticised for failing to recognise the relational and experiential worldviews of non-Western societies (Airhihenbuwa, 1993; Macdonald, 1998).

Macdonald (1998) has gone a step further to allege that the continued dominance of Western psychological interpretation of human behaviour is cultural imperialism. African thought processes, interpretations and understandings of phenomena are left to cultural anthropology, which for a long time has been dominated by Western anthropologists fixated on exotic and distant societies. Rarely has the discipline of psychology, both traditional and social psychology, paused to ask whether African interpretations are similar to the dominant Euro-American viewpoints. It is only in recent times that calls have been made for cultural psychology (Shweder, 1991, p. 74):

The basic idea of cultural psychology is that, on the one hand, no sociocultural environment exists or has identity independently of the way human beings seize meanings and resources from it, while, on the other hand, every human being's subjectivity and mental life are altered through the process of seizing meanings and resources from some sociocultural environment and using them.

The connected and highly complex understandings of the self in African settings, rich with their spiritual, time and space dimensions, point to the need to explore African philosophies as points of departure in psychological theorising, and ultimately, interventions. A deep understanding of the multidimensional, dialogical (i.e. the self that is always in contact with its surroundings, past and present), and highly nuanced view of self-understanding in African societies might unlock the key to influencing behaviour change in the face of the HIV/AIDS onslaught. Health educators who design models and theories of HIV/AIDS prevention need to take cognisance not only of the mutual inseparability of self and culture but the interventions as well (Airhihenbuwa & Obregon, 2000). The link between African conceptions of self-other relationships and the surrounding environment informs the thesis's proposal of an eco-systemic understanding of the multiplicity of African approaches to selfhood.

The ecosystem theory: a proposal

The complexity and multi-dimensional nature of the African worldview, the connectedness of the self to the social milieu in particular, has led me to propose an ecosystem theory of understanding the self in African contexts. The proposal builds upon Krieger's (2001) proposal for an ecosocial approach in understanding the social epidemiology of HIV/AIDS. Krieger believes that risk factors that predispose one to HIV infection are multilevel and prevention strategies should look beyond the individual. The proposed ecosystem theory's basic premise is the recognition that the self in African thought is multi-dimensional in space and time. Contrary to what some cognitivists would have us believe, the self is not located internally, within the person; it is inalienably tied to the cosmos. This is because of the non-separation of the physical from the spiritual in African metaphysics; a logic that allows for the mutual co-existence of divergent and even incompatible points of view, within a single person. Not only is African selfhood spiritually connected but it is ecologically conscious as well. The holistic and relational nature of self-understanding in African thought implies that we dare not separate it from its cosmic and ecological grounding. In Chapters 5 and 7, I referred to the concept of *unbu* (personhood) in *Shona* morality and showed that *Shona* people do not attach value to physiological aspects of personhood but more to intrinsic values of personhood and morality (cf. Mkhize (2003) for similar findings on the *Zulu* people). You can be physically human but fail to receive recognition as a human because of lack of connectedness to the *Shona* social and moral universe. HIV/AIDS prevention paradigms and strategies have to engage the intrinsic relationality of the self in African thought, its multiplicity and location in space and time, for them to have a meaningful impact on health-related behaviour.

Study limitations

This study had several limitations. First, my sample size was very small and the results of the study hold largely true of the people interviewed and cannot be generalised to the larger rural *Manyika* and Zimbabwe population. Second, the sampling procedure used was purposive and selection biases were likely to occur. Third, social desirability was likely in a study of this nature. Respondents were more likely to tell their life stories in a socially desirable manner not necessarily

reflecting their life experiences. Fourth, researcher bias could have possibly occurred in the selection and emphasis of interviews and questions during the research process. The researchers brought their own life experiences into the research process. However, bias was limited by engaging in self-reflexivity. Lieblich (1994) has explored the issue of self-reflexivity in qualitative research.

The study used the narrative approach informed by the social constructionist theoretical perspective. As much as narratology resonates with the African oral tradition, the issue of objectivity keeps emerging. Qualitative traditions have always argued that when dealing with people's lives it is misplaced to ask for objectivity as what we seek is their subjectivity (Bayer, 1994). The voice-centred relational method of data analysis and interpretation was a completely new experience to African scholarship and I (cf. Mkhize, 2003). The methodology, which is ontological, is very demanding in terms of time and process (Doucet & Mauthner, 1998). I did not have a prior opportunity to test the methodology before engaging with it. However, the process of using it became a very enabling experience and it would be of scholarly benefit if other African scholars adopt and adapt it to their own research inquiries.

The biggest handicap faced with an English second language speaker conducting interviews in the vernacular and then translating them into English is the likelihood of loss of the narrative power of expression. There are indigenous words one can never fully translate yet keeping them in the vernacular means losing your English readership. In Southern Africa, English is the major language of academia. I therefore had to conduct my study interviews in *Shona* but translate them into English for analysis and write up. As much as I tried to retain some of the narratives in the vernacular, I am sure, I lost a few of the poignant expressions of the narratives, given that the bulk of them were translated. The loss through translation means I possibly might have misrepresented some of my narrators' views and narratives.

Possible future research

Several possible future researches arise out of the observations of this study. Primarily it is very clear how little we understand cultural dynamics in traditional societies. We have premised ourselves on populist views of African cultures and proceeded to attach various labels. A proactive engagement of African cultures using hitherto unexplored methodologies such as the relational method is called for. Second, we still do not fully understand why gendered spaces result in violence. Research needs to be conducted on gendered spatial violence and how it is contributing to the spread of AIDS in Zimbabwe.

If egalitarian methods of prevention have failed us what are the alternatives? Research into alternative, culturally embedded methods of prevention is called for. I suggest that in so doing we need to appreciate the sexual and personal identities emerging in environments of rapid social change (van Vlaendren & Cakwe, 2003). The "one-size-fits-all" approaches predominant in the African HIV/AIDS prevention landscape have failed to stem the tide. Neither has the adoption of empowering and efficacy models, based on Western social psychological constructs, worked effectively with gay nor with marginalised communities in the West. This assertion is supported by the emergency of a phenomenon known as the "down low" among heterosexual black-American men, who do not consider themselves as gay, having unprotected sex with other men (Gaskins, 2005; King & Hunter, 2004). We need to situate prevention efforts in people's experiences and interpretations of their social worlds, i.e., their lifeworlds (Day & Tappan, 1996).



Lastly, and of extreme importance, other scholars are likely to see potential research opportunities arising out of my methodological or analytical weaknesses or attempts to understand the social and cultural factors in the spread of HIV infection in rural Zimbabwe using a narrative approach and how people socially construct risk of HIV infection.



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APPENDIX 1: CONSENT FORM

School of Psychology, University of KwaZulu-Natal

The sexual practices and the cultural meanings of the Manyika people in rural Manicaland, Zimbabwe: a social constructionist perspective

Introduction

Hello, my name is Tom Zhuwau. I am a doctoral student with the School of Psychology, University of KwaZulu-Natal in South Africa. I am carrying out a research study on the prevention of HIV/AIDS in the *Mutasa* and *Makoni* districts of *Manicaland*. The local traditional and political authorities have given me their permission to conduct the study. At the national level, the Ministry of Health and Child Welfare have cleared the study. The Wellcome Trust, United Kingdom, is funding the study. The Higher Degrees Ethics Committee of the University of KwaZulu-Natal provided ethical clearance to the study.

Background and objectives

HIV/AIDS is a serious public health problem in Zimbabwe. There is currently no cure for HIV infection although treatment to manage the disease is available in hospitals. Prevention against infection remains critical as HIV is transmitted mainly through sexual contact in Zimbabwe.

The study seeks to find out how you perceive the HIV/AIDS problem. We seek to find out what the local communities are doing about this epidemic in terms of prevention efforts. HIV/AIDS is a personal as well as a community problem. This study will therefore ask very personal questions about your life and the lives of people around you. It will ask questions about sexual behaviours. Some people feel uncomfortable talking about sexual matters and/or HIV/AIDS. You are compelled neither to participate in this study nor to answer any question you are uncomfortable with answering. We apologise for any question or manner of questioning perceived as intrusive or too sensitive. It is not our intention to offend anyone.

Anonymity and confidentiality

Since the information we are asking is very private and personal we are required by ethical laws not to disclose your name or anything that might identify you to third parties. All information you are going to share with us will be treated with the strictest of confidence and security. Access to the information will strictly be restricted to us only. As per Zimbabwean law, anyone below the age of 18 requires parental or guardian consent to participate in research studies. Please do not be offended if we ask for proof of your age.

We emphasize again that we are not medical doctors but social scientists asking you some questions about your perceptions on health issues, especially about HIV/AIDS. The study results are going to be published as a doctoral thesis by Tom Zhuwau for submission to the University of KwaZulu-Natal, South Africa. However, study findings will be disseminated in the form of scientific reports as well as feedback to relevant structures.



Your consenting to participating in the study will protect us from any indemnity. If you have read and understood carefully this consent form and wish to participate in the study, please kindly append your signature below. (NB. *Appropriate arrangements should be made for respondents who cannot read or write. Kindly read and explain **the consent form** to them. Ask them to attach an **X** on the form as a signature of consent*).

I, _____, have carefully read (or has been fully explained) the contents of the consent form and the nature and objectives of the research study and still wish, at my sole discretion, without coercion in the form of threats or incentives, to participate in the study.

Signature of Respondent: _____

Date: _____



APPENDIX 2: INTERVIEW GUIDE

School of Psychology, University of KwaZulu-Natal

The sexual practices and the cultural meanings of the Manyika people in rural Manicaland, Zimbabwe: A social constructionist perspective

Part 1. Introduction: negotiating consent and interview conditions

Introduction. Say out your name clearly, whom you are working for, what you are working on, why in that particular village and who do you intend interviewing – community leaders, ordinary villagers, etc.

We will be asking them questions about health and community issues. We are not medical doctors but social scientists interested in the social and behavioural aspects of human life and their implication on health, in particular, and life in general. For this reason, we will be asking the respondents questions about their life – life history, family, work, the community, and so forth. They are not compelled to answer every question we ask, though doing so would significantly help the study.

The interview is long – can take between an hour to complete. We are free to have refreshment breaks in-between. If you feel the interview is going to interfere with their daily routine please let them know so that they can agree to a suitable arrangement.

Since the interview is long, writing down everything they say is going to be time consuming. For that reason we must ask their permission to tape record the interview to enable us to capture properly all the information.

Remind the respondents that the information will be treated with the strictest of confidence and anonymity. No third parties will have access to the interviews and all personal identifiers will be removed from the interviews during analysis. (*Introduce the consent form here*).

Are there questions or any clarification you would like to ask before proceeding with the interview?

Part 2: Life history

Details about birth

- ask informant about date of birth, place of birth, place of origin, home language, sibling history, parents, etc.

Family

- relationship with parents, siblings, friends, special childhood memories.

Community

- how is like living in this community?
- any special memories of relationship with friends, neighbours and any other significant persons?

Education

- did you go to school, highest grade/standard/level passed?
- school experiences – negative or positive?
- if you left school, what were your reasons for leaving?

Relationships in life

- are you currently married?
- if not married, have you ever had a special partner(s)?
- history of significant relationships – place of meeting, partner(s) history, duration of relationship(s), nature of relationship, reasons for termination or sustenance.

Children

- have you ever had children?
- how many?
- where are the children?
- how many boys and girls?
- what are their ages?
- are there any who passed away?

Religion

- do you go to church?
- which church do you go to?
- how did you become a member of this particular church?
- how often do you go to church?
- what is it that you like most about your church?
- if you do not go to church, what is the reason for not doing so?

Employment history

(Ask the questions retrospectively for those currently unemployed)

- are you formally employed?
- what work do you do?
- are you satisfied with your work?
- how much do you earn per month?
- do your earnings meet all your family's basic needs?
- if not, how do you manage to meet the other needs your earnings can't meet?

Current community

- who do you live with?
- how are you related to the people you live with?
- what is your relationship with these people?

Part 3: General perceptions of health and ill health**Personal health history**

- how is your health?
- would you define yourself as a healthy person?
- what are the most serious health problems you have ever had?

Household health history

- the people that you live with, what is their health like?
- the healthy ones; how do they manage to keep healthy?
- the unhealthy ones; what ails them and for how long have they been unwell?

Health seeking behaviour

(ask questions about each case of ill-health they mention)

- what has been done about this particular problem?
- who have you sought help from?
- who did you go to first?
- what did they do? did it help?
- who did you/they go to next?
- why did you seek help from them?

*By now you may have a list of different **health care options** {e.g. traditional healer, doctor, hospital, clinic, faith healer}. Go through each of these and ask the following questions:*

- what are the good things about this form of intervention in relation to your particular family members?
- what are the disadvantages of this form of intervention in relation to your family?
- You have already mentioned A, B and C as serious health problems affecting your family.
- are there any other problems affecting your family or community that you have not mentioned?

Part 4: HIV/AIDS

Now that we are talking about health problems affecting you, your family and community; I would like us to talk about a serious health problem facing our country at the moment, HIV/AIDS infection.

Perceptions

- have you heard about AIDS?
- what is it?
- where did it come from?
- how does one become infected with HIV, the AIDS virus?
- some say we get it from touching, sharing utensils or living in the same house as a person living with HIV, what do you think?
- can you tell by looking who has got HIV infection?
- how long does it take for an HIV infected person to develop AIDS?
- do you know someone who has this problem?
- some people say AIDS is a curse for humankind from God (or ancestors), what do you think about this?
- can AIDS be cured?

Health care options

- how does one find out whether s/he is infected with HIV?
- have you ever had an HIV test?
- if so, why?
- what was the result?
- is there anything that you can do to protect yourself against this disease?
- what interventions are available?
- which ones are the best?
- what are the three best things are about these interventions?
- have you ever used a condom? if so, why? if not, why?

- some people don't like condoms others do; what is your view?
- What is your source of information about HIV/AIDS?

Part 5: Gender and sexuality

Now we would like to move on to a different topic from the one we have been discussing to a new topic. We are interested in getting your views about issues of gender and sexuality as they affect you, your family and community.

Perceptions on gender

- do you prefer a male or female child?
- why such a preference?
- does this community attach importance to gender?
- what are the advantages or disadvantages of being a male in this community?
- what are the advantages or disadvantages of being a female in this community?
- what justifies these differences?
- do you agree with this justification? if so, why? If not, why not?
- are there tasks in your family or community that are strictly gender based? If so, why?
- is there anything that can be done to improve the gender relations in your community?

Perceptions on sexuality

- at what age do people in this community generally become sexually active?
- has this always being the age for initiation of sexual activity in this community?
- can you remember when you yourself became sexually active?
- what changes have occurred in people's sex life over the years?
- are they good or bad changes? why do you say so?
- could these changes be contributing to the sexual diseases that confront us today?
How is this so?
- how long can men go without having sex?
- how long can women go without having sex?
- how long can you go without having sex?
- what are your views on multiple sexual partners?
- are you in a monogamous relationship?
- who have a greater say in a relationship, men or women? Why is this so?
- what is the attitude of your partner towards using condoms?

Part 6: Language and disease

Now I would like to talk to you about your language, how you perceive it, and your ability to effectively communicate in it.

- what is your mother tongue?
- what other languages/dialects do you speak?
- is your mother tongue your main medium of daily communication? If not, why not?
- are you comfortable saying certain words in a second language that you are not comfortable saying in your mother tongue?
- give us an example of such words?
- are you comfortable mentioning private body parts in your mother tongue?
- if not, what proxies do you use to mention the private body parts?
- in which areas do you find your language limiting your ability to express yourself?

- some health messages may need to be very explicit, would you rather have them in your language or a second language? why is this so?
- does language affect the way you relate to HIV/AIDS? (ask respondent to explain their answer)

Part 7: Self-efficacy

Now I would like us to talk about a subject that deals with how you perceive yourself as a person. (NB. The aim of the questions is not for yes or no answers but to act as probes into a more meaningful discussion of self-efficacy and control).

- how do you view your personhood?
- are you able to make decisions about your life on your own?
- how do you deal with internal conflict?
- how do you, as a person, relate to your community?

Part 8: Social capital

Introduce social capital. Briefly explain that the section deals specifically with community relations: agency and structure.

- would you say you know most of the people in your community?
- what are the most important community occasions?
- do people in this community trust each other?
- how would you describe the community leadership?
- what is the degree of reciprocity in the community?
- can you give us a few areas where the community practices reciprocity?
- what are the checks and balances put in place to maintain reciprocity?
- are there any voluntary associations in this community?
- do you belong to any one of them?
- is the “sense of community” very strong in this community?
- why do you think people live in communities?
- what can be done to improve this community?

Part 9: Feedback

Do not rush over this section. It is important to take time and synthesize the interview.

- how has it been like to be interviewed?
- are there sections you had difficulty with or couldn't understand at all?
- what are your views about the time it took to complete the interview?
- would you be able to recall the aims of this study?
- what are your views about the importance of the study?

End of the interview

If interviewing a commercial sex worker proceed to the CSW interview guide. Thank respondent and give them an opportunity to comment. *(Always end interview on a polite and positive note).*

APPENDIX 3: INTERVIEW GUIDE FOR SEX WORKERS

School of Psychology, University of KwaZulu-Natal

The sexual practices and the cultural meanings of the Manyika people in rural Manicaland, Zimbabwe: a social constructionist perspective

Part 1: Introduction

Kindly remind the respondent that the information will be treated with confidence and anonymity. No third parties will have access to the interviews and all personal identifiers will be removed from the interviews during analysis.

We have already talked about some things in your life. We now like to ask you a few questions related to your personal sustenance as a single woman. We accept that some of the questions could possibly be uncomfortable for you. Please kindly let us know which question it is and feel free not to answer it. We will respect your wish not to answer any questions you uncomfortable about answering.

Do you have any questions or clarifications you would like to ask before proceeding with the interview?

Part 2: Sex work

- How long have you been working as a sex worker in this community?
- How is it like working as a sex worker in this community?
- Do you encounter any specific problems and challenges as a sex worker?
- What are these challenges and problems?
- How do you deal with the challenges and problems?
- Do you have any support networks that interact with?
- Which networks are these?
- Have you ever experienced any violence in your work?
- If you did, what type of violence was it?
- How did you deal with?
- Do you use condoms with all your clients?
- If not, why don't you use condoms?
- Have you ever suffered from a sexual transmitted disease?
- If yes, did you seek treatment?
- How much money do you make per week on average?
- What do you do with the money you earn?
- Are your clients local or non-local men?
- If presented with an alternative to sex work would you consider it?
- What would be the most appealing alternative to you?

End of the interview

We have come to the end of our interview. Thank you so much for taking time to answer these questions. Your cooperation is deeply appreciated. Are there any comments you would like to make regarding the interview?