

**The management of the risk of HIV and AIDS in marriage and cohabiting
relationships: Reflections from a study in a rural Eastern Cape setting**

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DECLARATION

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of Applied Human Science, Discipline of Psychology, University of KwaZulu-Natal,
Pietermaritzburg, South Africa.

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Abstract

This study explored the risk of HIV infection to married and cohabiting partners in a rural setting in the Eastern Cape. This study focussed on the personal, relationship, and cultural demands and expectations in marriage and cohabitation, and power inequality in relationships, and their effect on HIV prevention.

A qualitative research approach was adopted in this study. The study used data from a broader study including interviews with eight men and women between the ages of 26 and 60 years, as well as five focus group discussions with men and women within this age range and two mixed groups of adult members of the community. Thematic analysis was utilised to analyse data using the integrated theory of gender and power.

Findings revealed that condom use is not a common practice in marriage and cohabiting relationships. Many factors influence condom use in marriage and cohabiting relationships, such as unequal gender positions, power inequality, and cultural expectations. For one, power differences between married and cohabiting men and women influenced the women's ability to protect themselves from HIV infection by their partners. Furthermore, gender norms prescribed by culture allowed men to have more sexual partners and to use condoms less often, thereby increasing the risk of HIV infection. Additionally, societal norms guided women to accept their partners' promiscuity, to be tolerant and obedient, resulting in silence and an increasing vulnerability to HIV infection.

In this study, most men and women acknowledged that there are power inequalities in heterosexual relationships and that they are aware that this affects HIV prevention. Findings also suggested that women who lack the power to control sexual activities did not always consent to sex. Policies that focus on protecting women's rights are therefore of utmost importance. Future research should focus on analysing the effects of power inequalities in married and cohabiting partners. Community leaders, older community members, traditional leaders and men should also be encouraged to partake in future research projects that will focus on analysing the negative effects of gender norms on women's sexuality. This will help raise awareness about the effects of gender norms on HIV prevention in marriage and in cohabiting relationships.

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Chapter 1 Introduction

HIV/AIDS is a major health problem worldwide, and particularly in South Africa. According to the most recent global report from the Joint United Nations Programme on HIV and AIDS (UNAIDS, 2018), approximately 36.9 million people are HIV positive, 21.7 million are on antiretroviral (ARV) treatment, and approximately 940 000 people died of HIV/AIDS-related illness globally by 2017. Sub-Saharan Africa in particular is severely affected by HIV/AIDS, with approximately 19 million people who are HIV positive in 2017 (UNAIDS, 2017). The Human Sciences Research Council (2018) midyear report states that in South Africa, the estimated HIV and AIDS prevalence rate is approximately 7.09 million.

In Sub-Saharan Africa, HIV is most often contracted by heterosexual sex (Jewkes & Morrell, 2010). A recent study conducted in Gauteng, South Africa, identified unprotected sex in marriage and in cohabiting relationships as the major driver of HIV infection (Dube, Nkomo, & Khosa, 2017). Shisana et al. (2014) revealed that multiple sexual partnerships are more common among African men than women, particularly in men above the age of 50 years. According to UNAIDS (2016), people above the age of 50 years do not adhere to HIV prevention strategies such as partner communication about HIV and HIV testing, thus placing them at risk for HIV infection. Shisana et al. (2014) also argue that failure to know your partner's HIV status before the sexual relationship starts also increases the risk of HIV infection in heterosexual relationships.

Sex is argued to be the main driver of HIV infection (MacPhail & Campbell, 2001). Consequently, it needs to be contextualised, as it is not only learned through individual sexual exploration, but through cultural influences, ideas, beliefs and societal values. For example, social norms guide sexual practices of married men and women (Kippax & Race, 2003). In the African culture, having multiple partnerships is an accepted male sexual practice and if a woman practices it, this is viewed as taboo and she is labelled socially as 'loose' (Delius & Glaser, 2004). Furthermore, gender imbalances between men and women such as different gender roles, different gender expectations, and power inequality contribute to the HIV/AIDS epidemic (Jewkes & Morrell, 2010). According to Jewkes and Morrell (2010), women who are dominated by men also tolerate intimate partner violence such as sexual violence. Since condoms are not used in relationships where there is violence (World Bank, 2006), and intimate partner violence is associated with non-consensual sex (Freeman, 2010), the risk of HIV infection increases.

Lack of economic resources among women also influences condom use in heterosexual relationships, especially in rural areas (Tolan, 2005). Tolan (2005) found that married women in the rural areas of South Africa lack economic resources and are financially dependent on men. Tolan (2005) further argues that women who are financially dependent on men are unable to negotiate and assert their sexual needs. In the research area of this study (i.e. rural Eastern Cape), job opportunities are scarce. Some men work in neighbouring towns or in other provinces, and most married women are housewives.

This study adopted the theory of gender and power founded by Connell (1987) and further developed by Wingood and DiClemente (2000). Connell (1987) mentioned three structures that generate the exposure to risk of HIV infection that influence women's health, namely (1) the sexual division of labour, (2) the sexual division of power, and (3) the structure of cathexis also known as the structure of social norms and affective attachments. Wingood and DiClemente (2000) reason that, these structures consist of practices, which influence HIV/AIDS prevention and women's health. They argue that the social norms prescribed for men and women contain inequalities that influence safe sex practices. For this reason, sexual practices cannot be understood only through focusing on individual factors such as the level of knowledge about HIV infection or condom use. Kippax (2010) points out that "People act according to social and cultural influences produced with the historical content and in a geographical region embedded in the specific locations and social formation such as gender" (p. 5). As sex is socially and culturally informed, sexual practise is learned.

Research has focused on youth at risk of HIV infection and very little has focused on adults aged 26 to 60 years old who are in long-term relationships. This study therefore focused on understanding the manner in which adults aged 26 to 60 years manage the risk of HIV infection. The study aimed to develop a critical understanding of the way in which the cultural practices of the respondents relate to sexual relationships and the manner in which HIV risk can be managed. I used a secondary data from a broader study that was conducted in the Eastern Cape. In order for the researcher to identify the risks of HIV infection for married and cohabiting people, this study sampled interviews and focus groups with married and cohabiting men and women from the broader dataset. The study focused on understanding sexual activities, including risky sexual behaviour, practiced by married and cohabiting people in a rural Eastern Cape setting. Analysis of this data entailed the analysis of the identified themes by using the integrated theory of gender and power to understand the risk of HIV/AIDS infection to married and cohabiting people in this Eastern Cape setting.

This section has served as an introduction to this thesis. I provide a brief overview of HIV/AIDS as an epidemic in Sub-Saharan Africa and South Africa and also review the theoretical framework adopted in this thesis. Subsequent to a review of the literature, I discuss the methodology (e.g. the data collection process, the data analysis process, and ethical considerations). I then present the findings of this study. Finally, I discuss the findings and provide a conclusion and recommendations for future research.

Chapter 2 Literature Review

This section presents literature and theory related to the research question. It begins by demonstrating the impact of HIV infection in Sub-Saharan Africa and in South Africa. The theory of gender and power founded by Connell (1987) and further developed by Wingood and DiClemente (2000) is adopted to guide the development of this study. This review presents a brief overview of the prevalence of HIV/AIDS in Sub-Saharan Africa and in South Africa. I then discuss the theoretical framework employed in this research, namely, the theory of gender and power, and its three structures: (1) the sexual division of labour, (2) the sexual division of power, and (3) the structure of cathexis or social norms and affective attachments. The risk factors for HIV infection and their relation to the structures of the framework are subsequently discussed. The first topic focuses on the effect of gender positions and economic dominance on non-condom use using the structure of sexual division of labour. The second topic focuses on power inequality and male dominance using the structure of the sexual division of power. Thirdly, I focus on how cultural and relationship expectations create exposure to risk of HIV infection using the structure of cathexis or social norms and affective attachments.

2.1. HIV/AIDS in Sub-Saharan Africa and South Africa

Approximately 66% of people in Sub-Saharan Africa are HIV positive (UNAIDS, 2017). In South Africa, approximately 30% of adults above the age of 50 years are HIV positive (UNAIDS, 2017). According to UNAIDS (2016), adults above the age of 50 years are sexually active and engage in multiple partnerships, and are less likely than the youth to know their HIV status by testing for HIV, have low rates of condom use, and do not engage in HIV communication with their partners. Furthermore, when compared to other races, African men have higher HIV prevalence rates.

2.2. Theoretical framework: the theory of gender and power

The theory of gender and power, proposed by Connell (1987), consists of three structures, namely (1) the sexual division of labour, (2) the sexual division of power, and (3) the structure of cathexis or social norms and affective attachments. Wingood and DiClemente (2000) further developed the theory of gender and power, and reason that these structures

consist of practices, which influence HIV prevention and women's health. In the section to follow, I discuss these three structures and their relation to risky sexual practices occurring in marriage and cohabiting relationships.

2.2.1. The sexual division of labour. In the structure of sexual division of labour, Wingood and DiClemente (2000) argue that economic inequalities between men and women exist. They also argue that economic resources of men and women are unequally distributed at a societal level and that this leads to women's lack of access to, and control of, economic resources. Furthermore, at a societal level, women are allocated to unpaid jobs such as housework, and they have limited access to education, while men have access to paid jobs, and in some areas, men have educational opportunities (Wingood & DiClemente, 2000). Consequently, men's work is valued and they have paying jobs which afford them a higher status than women.

According to van Niekerk and Koppelman (2012), there is an increase in unemployment and the number of people living in poverty in rural areas. Take, for example, the research site of this research: Approximately 48.1 % of the men and women living in this area (i.e. the local municipality) are unemployed (Stats SA, 2017). Notably, previous research indicates that, in rural areas of the Eastern Cape Province, more men are employed than women (Tolan, 2005). Consequently, we see economic powerlessness among women and economic dominance among men. This is problematic, as economic powerlessness and dominance are HIV risk factors. For example, it affects condom use (Tolan, 2005). Safer sex practices seem to be affected because women feel they have to defend their economic means of survival (i.e. financial support by their partners). Socio-economic factors linked to the sexual division of labour can therefore act as a HIV risk factor among married and cohabiting partners (Wingood & DiClemente, 2000).

2.2.2. The sexual division of power. The focus of this theory was to analyse the effects of power differences between men and women. According to Connell (1987), in relationships where there are inequalities in power between men and women, men are violent, and coerce and abuse women emotionally. Violence is used to assert power. Connell (1987) furthermore argues that male power over women emerges in the form of intimate partner violence and it leads to a lack of sexual consent in intimate relationships. Freeman (2010) conducted a study with married and unmarried women in Namibia, and defined physical abuse as a violent act or use of force by men to force their decisions over women. Women are also sexually abused by their boyfriends and husbands and endure violent acts such as being stripped and beaten when they refuse to engage in sexual intercourse with them (Stern,

Buikema, & Cooper, 2016). These violent acts also include verbal threats, which most often occur when the male partner is drunk (Wingood & DiClemente, 2000).

Importantly, gender-based violence and high HIV infection among women are linked (Freeman, 2010). For example, when women are physically abused, their sexual negotiation power for condom use becomes low (Freeman, 2010). Married women are also unable to protect themselves from infection if they have a low self-efficacy, making it difficult to bargain and insist on condom use successfully (Wingood & DiClemente, 2000). These factors constrain women's agency, increasing the risk of HIV infection.

Additionally, in the African culture, women are socialised to be sexually passive, to respect men, and to be submissive (Mugweni, Omar, & Pearson, 2015). When women get married, their in-laws expect them to be obedient to their husbands and to their family. When this behaviour is adopted and applied by women, it can result in low self-esteem and lead to women being sexually passive (Mugweni et al., 2015). This belief is influenced by the acceptance of culture and tradition by the in-laws and the married partners. Social norms thus play an important role in shaping femininity and masculinity principles, and this influences sexual behaviour (Jewkes & Morrell, 2010). The relationship between social norms and HIV prevention will be discussed next.

2.2.3. The structure of cathexis or of social norms and affective attachment. In this structure, gender, cultural norms, traditional beliefs and their effects on women's health are analysed (Wingood & DiClemente, 2000). Wingood and DiClemente (2000) use the structure of cathexis to analyse the sexual behaviour of women and define it as being comprised of societal expectations and as guided by societal norms. According to them, women are expected to be "emotionally and sexually attached to men" (Wingood & DiClemente, 2000, p.544). Women also accept that there are unequal gender expectations between men and women and that their sexual behaviours differ from that of male partners. Furthermore, Stern et al. (2016) argue that there are gender beliefs that guide men and women's sexuality in that men are sexually active whereas women are sexually passive. Wingood and DiClemente (2000) argue that women who accept these cultural beliefs do not propose condom use, as they fear being seen as sexually active and promiscuous. They further argue that women's sexuality is also guided by social expectations such as the sexual conduct, which guide them to be sexually ignorant.

In the African culture, there are cultural and family influences that expose women to risk of HIV infection. Clark (2004) argues that the family influences women's sexuality by expecting them to marry at a young age. Marriage exposes women to risk of HIV infection as

a young woman sometimes marries a HIV positive man (Sonke Gender Justice Project, 2008). Other cultural expectations among married and cohabiting partners such as a need to conceive, increases the risk of HIV infection in marriage and in cohabiting relationships as condoms are not used (Dube et al., 2017). If condoms can be used consistently in marriage, a married woman will fail to fulfil her cultural obligation and the expectation to reproduce children.

2.3. Exposure to the risk of HIV Infection

The structures of the sexual division of labour, the sexual division of power, and the structure of cathexis or of social norms and affective attachment link to form risk factors and expose women to the risk of HIV infection in marriage and in cohabiting relationships. In this section, I will discuss risk factors that influence HIV prevention in marriage and in cohabiting relationships.

Bhagwanjee et al. (2013) argue that the HIV epidemic is gendered in nature, suggesting that gender roles contribute to HIV infection. The three structures in the theory of gender and power are used to guide the discussion. I will discuss the effects of gender positions and economic dominance (structure 1), power inequality and male dominance (structure 2), and compliance with cultural norms and relationship expectations (structure 3) as forms of exposure to the risk of HIV infection in marriage and in cohabiting relationships.

2.3.1. The sexual division of labour: gender positions and economic dominance.

An argument can be made that different gender positions occupied by men and women are associated with risk for HIV infection. At an institutional level, two social roles can be considered. The first role is the social role of a man as a breadwinner or provider (Mfecane, 2008). The second role is that of the expectation of a woman to be caring and nurturing (Hoosen & Collins, 2004). To elaborate, Hoosen and Collins (2004) conducted a study among a sample of women in KwaZulu-Natal and found that a woman's role entails nurturing and/or working at home or in the domestic sphere, doing chores such as cleaning the house and cooking food. They furthermore found that women are also expected to be carers, which entails raising their children and taking care of sick family members, in-laws, as well as their husbands. As a result of the two social roles, the social status of women is low and women are often financially dependent on men (Tolan, 2005).

There is a need to uplift the economic standard of living for women (van Niekerk & Koppelman, 2012). For one, women's financial dependence on men results in vulnerability to punishment by their male partners when they fail to submit to male sexual desires (Tolan,

2005). Additionally, male power is also expressed in the form of violence and affects condom use (Freeman, 2010). Moore (2015) argues that women have to strive to be self-sufficient. This fits with a type of femininity called an 'alternative femininity'. In this type of femininity, women strive for economic independence by finding alternative opportunities such as seeking jobs, uplifting their level of education, and engaging in other income generating projects (Moore, 2015). According to Moore (2015), such women seek financial stability and equal opportunities to stabilise their economic status and foster enough strength to oppose male sexual subordination.

2.3.2. The sexual division of power: power inequality and male dominance.

Power is the ability to negotiate your wishes and to influence the other person to understand those wishes (Dube et al., 2017). Mash, Mash and De Villiers (2010) conducted a study in South Africa and identified that power in heterosexual relationships is a male domain. Jewkes and Morrell (2010) argue that men protect their power and they resort to use of violence when their power is challenged.

Strebel et al. (2006) conducted a study with married women in Cape Town, South Africa, and found that the unequal power relations between men and women increase the risk of HIV infection. For example, unequal power relations in sexual relationships affect condom negotiation and condom use (Stern et al., 2016). Hoosen and Collins (2004) argue that while condoms are accessible and that women take the responsibility to ensure that safe sex is practiced during sexual contacts with their partners, they cannot successfully influence men to use them when they engage in sexual intercourse.

Essentially, power differences between men and women lead to disempowerment of women (Connell, 1987). In cases where women desire to use protection by using a condom, their wishes may fail due to their lack of power to assert their sexual desires. Additionally, male control and aggression also affects condom use (Stern et al., 2016). Unprotected sex forced through the use of violence limits the women's potential to assert safe sex practices (Freeman, 2010). Condom use therefore fails in marriage and in cohabiting relationships in cases where women are exposed to violence. Hoosen and Collins (2004) argue that when women are exposed to male violence, fear dominates them and this leads to silence and to submission in response to male power.

Male power over women also affects HIV disclosure and HIV treatment. For example, when women are infected by their male partners, they worry that disclosing their HIV status may lead to more violence and rejection (Freeman, 2010). As a result, women lack power to challenge male domination and to protect themselves from being infected by

HIV/AIDS (Stern et al., 2016). HIV prevention can therefore be better addressed if there can be power equality in sexual relationships.

2.3.3. The structure of cathexis or of social norms and affective attachments: compliance with cultural norms and relationship expectations. This section discusses the compliance with cultural norms and the relationship expectations in marriage and cohabiting relationships, and how these relate to HIV prevention. Wingood and DiClemente (2000) argue that men and women are expected to conform to social norms in order to meet cultural expectations. Women are expected to be married, to reproduce, and to have good morals (Wingood & DiClemente, 2000). There is also an expected sexual behaviour (i.e. expectation of sex without a condom) in marriage and in cohabiting relationships (Dube et al., 2017). As will subsequently be seen, these two factors, namely compliance with cultural norms and expected sexual behaviour, contribute to increased risk of HIV infection.

2.3.3.1. Compliance with cultural norms. As discussed earlier, the family can initiate and guide marriage. Mulaudzi (2013) argues that marriage can be viewed as a cultural obligation in the African culture, as men and women are expected to be married. African families arrange early marriages for young girls to get married from 13 years of age, as can be seen, for example, in a sample of adolescent girls living in Sub-Saharan Africa (Clark, 2004). In some communities, arranged marriage is recognised as a norm (Delius & Glaser, 2004). Delius and Glaser (2004) found this to be true for communities in the Eastern Cape Province of South Africa. They found that, in some communities, young girls were forced to marry against their will as parents made the choice of a partner. Delius and Glaser (2004) describe the concept of ‘abduction’ or ‘*ukuthwala*’, which refers to “distasteful marriage to girls” (p. 88), and is viewed as a threat to life as it sometimes leads to suicide. Refusal of marriage is not allowed by the girls, and sexual contact can therefore be non-consensual. Marriage is not recognised as a space for expressing love and intimacy but to establish the paternity for children (Delius & Glaser, 2004).

Some researchers view marriage as a sexual institution that exposes women to risk of HIV infection (e.g. Dube et al., 2017). While Clark (2004) argues that, the girl’s family believes that when she marries a man she is safe from being infected by diseases, this author questions the safety of an early marriage as HIV prevention is not taken into consideration. Clark (2004) argues that young girls sometimes marry older men who have previously dated many women before marriage. Consequently, some men may already have been infected by previous HIV positive partners (Clark, 2004). Once the young girls are married, they are

expected by their husbands to have frequent unprotected sex with them. This frequent unprotected sex increases the risk of HIV infection.

Previous research suggests that marriage in the African culture is more beneficial to men than women (Mugweni et al., 2015). For example, Duffy (2005) conducted a study with married men and women in Zimbabwe and found that a married man gains marital rights after he has paid the bride price. Sexual decision-making is also not shared with women. This makes it difficult for a woman to prevent HIV infection by using condoms. Additionally, male promiscuity is supported by African culture (Delius & Glaser, 2004). Married women are expected to tolerate their husband's infidelity, and in this way, they are exposed to diseases contracted from their partner's multiple partners. Moreover, Leclerc-Madlala (2009) conducted a study with married men and women in Durban, South Africa, and found that married women are expected to tolerate men's sexual demands or wishes. Tolerance in marriage also entails tolerating vulnerability to the diseases marriage may bring.

Married women are also not expected to leave marriage (Mulaudzi, 2013). According to Leclerc-Madlala (2009), a married woman is expected to endure the difficulties she experiences in marriage. Tolerance in marriage is an expected cultural behaviour of a married woman, and failure to tolerate the constraints of marriage leads to stigmatisation by society (Jewkes & Morrell, 2010).

Respect is also a cultural expectation of a married woman (Jewkes & Morrell, 2010). A study conducted by Cozien (2014) with married women in Cape Town indicated that women are expected to be passive receivers of their husband's demands. Cozien refers to a "woman's language of respect" or "*isihlonipho sabafazi*" (p.1). The language of respect referred to here emphasises the importance of abiding to the principles of femininity and that women should negotiate their sexuality in a passive way (Cozien, 2014). Dowling (1988) argues that this language affects HIV prevention as condom negotiation fails. For example, when the language used does not suit a man, it is ignored. Women therefore have to choose language that is appropriate. Consequently, they have to negotiate safe sex practices under particular constraints, as they have to abide by the cultural standard set in the social norms that guide women's sexuality. As a result, the cultural expectation to be passive exposes them to increased risk of HIV infection.

2.3.3.2. Relationship expectations. There are also obligations that await partners in the sexual relationships. When the sexual relationship develops from being casual to a stable relationship (e.g. cohabiting relationships and marriage), sexual safety is also affected (Parker, Makhubele, Ntlabati & Connolly, 2007). In stable relationships, the expected type of

sex is unprotected sex, as the sexual partners want to establish their relationship as stable (Parker et al., 2007). Condoms are therefore not used during sexual encounters in stable relationships.

Condom use is also associated with lack of trust or it means one cannot be trusted (Parker et al., 2007). Requesting that a condom be used is therefore avoided because of what it suggests. Unprotected sex is used as evidence that partners trust one another in stable relationships (Rhodes & Cusick, 2000). Rhodes and Cusick (2000) argue that in stable relationships trust is also viewed as a symbol of oneness and it symbolizes the presence of love. Requesting that a condom be used in a stable relationship therefore puts the security of the relationship at risk. Sexual partners that are in stable relationships seek to protect the standard of a relationship by engaging in unprotected sex; they avoid 'downgrading' it to a less serious relationship by requesting condom use (Parker et al., 2007).

Additionally, condom use is not a favoured HIV prevention strategy in stable relationships because it affects the physical contact and sensitivity between partners (Tavory & Swidler, 2009). Tavory and Swidler (2009) conducted a study with married and unmarried men and women living in rural Malawi. In this sample, male partners in stable relationships disapproved of having protected sex by using a condom. This is because participants associated condom use with a loss of erection as it diminishes the desired mood and alters sensation and pleasure.

Infertility is seen as burden and is unacceptable to both men and women (Mulaudzi, 2013). For one, the cultural expectation of a married woman to reproduce is also important to consider, and it requires that partners engage in unprotected sex (Wingood & DiClemente, 2000). African culture views conception and child-bearing as a cultural expectation of a married woman (Mulaudzi, 2013). Eaton, Flisher, and Aarø (2003) conducted a study with a sample of South African youth, and found that unmarried girls have to prove their fertility before marriage so that they are recognized for marriage. Women's sexuality is in this way controlled and sex is meant for procreation. A woman that cannot conceive and reproduce is labelled as having a womb with salt water that harms the foetus (Farrar, 2013).

There is also a cultural expectation for men to have children (Bond & Dover, 1997). Bond and Dover (1997) conducted a study in a sample of men and women living in rural Zambia and found that the family becomes concerned if married partners cannot reproduce, and attempts are made to investigate the quality of the semen of a man. Men who cannot reproduce children are even advised to use traditional herbs to do away with infertility. Mulaudzi (2013) argues that in the African culture, when the family identifies that the

husband cannot reproduce, arrangements are made in secret for someone else to impregnate the wife to prevent the disgrace of male infertility. Proof of fertility is a cultural, societal, and family expectation and, if it fails, partners are stigmatised (Mulaudzi, 2013).

Fertility is associated with virility and it increases the status of a man (Eaton et al., 2003). Virility and fathering children helps to maintain the expected masculine status of a man. A man that cannot have children is socially stigmatized and labelled as having an inadequate penis (Farrar, 2013). Bond and Dover (1997) argue that because fertility and virility affirm the man's status, men initiate sex and women's sexual preferences are ignored. The need for married and cohabiting partners to conceive and reproduce reduces the use of condoms. This exposes married and cohabiting women to increased risk of HIV infection if the male partner is promiscuous (Dube et al., 2017).

2.4. Gender norms: hegemonic masculinity and acquiescent femininity

Hegemonic masculinity and acquiescent femininity contain specific gender norms (Jewkes & Morrell, 2010). In this section, I discuss the way in which hegemonic masculinity and acquiescent femininity contribute to high HIV infection in marriage and in cohabiting relationships. In doing so, behavioural risk factors for HIV infection such as engaging in multiple partnerships, alcohol use, and condom use will be discussed in relation to one another.

2.4.1. Hegemonic masculinity: multiple and concurrent partnerships. Hegemonic masculinity refers to “a set of social norms and practices men are encouraged to subscribe to in order to be legitimised as men and imposes on all other forms of masculinity and femininity, meanings, about their own position and identity” (Connell, 1995, p.47). Mfecane (2008) conducted a study with married men in Gauteng and he analysed hegemonic masculinity (i.e. the notion of being a man and male sexuality). He found that men engage in multiple sexual partnerships in order to be viewed as sexually active and to gain social recognition. In a different study conducted in a sample of men in the rural Eastern Cape, men who engaged in multiple partnerships did so as they wanted to be desirable to women (i.e. sexually successful or virile; Jewkes & Morrell, 2010). The practice of multiple partnerships is, however, problematic; the problem with this practice is that men are exposed to infections such as HIV and sexually transmitted infections as they favour unprotected sex and they fail to attend to healthcare when they are infected by these diseases (Bhagwanjee et al., 2013).

Multiple and concurrent partnerships are defined by someone having two or more sexual partners concurrently. It entails having multiple, overlapping casual and serious

partners and the act of changing them frequently (Parker et al., 2007). Stern and Buikema (2013) argue that men's understanding of love and sex is that they detach their feelings in sex, treat sex, and love separately. Their sexual expression is not based on feelings but on their biological needs such as seeking sexual satisfaction. Men might therefore seek sexual satisfaction with different partners.

According to Parker et al. (2007), men who practice concurrent partnerships, have two types of partners – a casual partner and a stable partner in a more serious relationship. Casual relationships are characterised by a lack of love and commitment. Casual partnerships also entail having sexual intercourse without having a relationship (e.g. a one-night-stand), what Parker et al. (2007) refer to as a “just for sex relationship” (p.31).

Mfecane (2008) argues that the problem with the practices which fall under the norms of hegemonic masculinity is that they are risky and facilitate the spread of HIV infection. For example, risky sexual activity can occur in shebeens and sometimes occur when people are drunk. In periods of high alcohol consumption, condom use fails which exposes sexual partners to the risk of HIV infection (Simbayi et al., 2004). It is in this sense that the notion of ‘being a man’ undermines HIV prevention strategies such as the ABC model. In this model, A stands for Abstain, B- Be faithful and C- Condomise (Van Dyk, 2008). As Mfecane (2008) explains, abstinence from sex cannot be favoured under the norms of hegemonic masculinity, as men have to have sex to avoid being devalued and be seen as ‘lesser’ men. Additionally, men who adhere to the norms of hegemonic masculinity cannot be faithful to one sexual partner. Instead, they have to prove their sexual prowess to peers by engaging in sex with many sexual partners (Mfecane, 2008). Men also engage in unprotected sex in order to satisfy women and to ‘beat’ the competition that might arise from other men (Jewkes & Morrell, 2010). These risky behaviours are therefore harmful gender norms that affect HIV prevention (Rose-Innes, 2006).

Delius and Glaser (2004) conducted a study in rural communities in the Eastern Cape and focused on male and female sexuality amongst *isiXhosa*-speaking married partners. They found that polygamy principles became influential for African males and set up expectations of multiple partnerships. To elaborate, in Xhosa culture, multiple partnerships are supported and there is a belief that men cannot be satisfied by one woman. According to these authors, in this tradition, there is a belief that men are meant for all women but a woman must relate to one man. Delius and Glaser (2004) criticised this notion of masculinity as it guides men to develop their masculine status by having extramarital partners openly without being regarded as committing adultery. *IsiXhosa*-speaking men are never reprimanded for acting

promiscuously as this is not seen as a transgression. They are only reprimanded when they fail to support their wives because this is their cultural responsibility (Delius & Glaser, 2004).

According to Delis and Glaser (2004) married women are encouraged to endure practices such as their partners having multiple sexual partners; they are reprimanded if they show jealousy, and are encouraged to manage their jealousy. According to these authors, a woman's responsibility as a wife is not to control male sexual behaviour, but to satisfy male sexual needs when needed, to do the domestic work and to take care of the family. Jewkes and Morrell (2010) called this type of femininity acquiescent femininity. In this framework, women are encouraged to be tolerant of their husbands' sexual behaviours.

2.4.2. Acquiescent femininity. Acquiescent femininity describes the type of femininity followed by women who comply with the decisions of their husbands and comply with the cultural expectations associated with femininity (Jewkes & Morrell, 2010). They avoid societal sanctions associated with the violation of cultural expectation such as stigmatisation. For example, they tolerate the husband's infidelity and still provide the 'right sex' (i.e. sex without a condom). Delius and Glaser (2004) argue that when a woman leaves her marriage she loses her respectable status and she is labelled as *inkazana*. This is the *isiXhosa* word given to older unmarried women and to divorced women (Delius & Glaser, 2004). An older unmarried woman or divorced woman is expected to offer sexual favours to married men as extramarital partners (Delius & Glaser, 2004). One argument then is that women tolerate abusive marriages because they do not want to lose their social status and possibly become *amankazana* (a plural word for *inkazana*).

Jewkes and Morrell's (2012) study illustrated a different form of femininity they refer to as femininities in transition. It characterises what these authors call the "emerging feminist consciousness" (Jewkes & Morrell, 2012, p.12). In this type of femininity, women oppose being passive victims of men and confront men's risky sexual behaviour, oppose violence, and strived for mutual control. This type of femininity might change the vulnerable position of women. Vance (1989) argues that women that seek to oppose women's subordination by men are able to break the sexual silence. They are able to take care of their own sexual health, unlike women who adopt the norms of acquiescent femininity, who cannot protect themselves from HIV infection, who struggle to disclose their HIV status, and who cannot guide HIV prevention on their own terms.

2.5. Summation

HIV/AIDS is a serious health problem worldwide and in South Africa. There are several HIV prevention programs, which include awareness campaigns and distribution of condoms in public places, but they have not succeeded in substantially reducing the incidence of HIV (Van Dyk, 2008). The theory of gender and power identifies unequal economic status between men and women, unequal power relations between men and women, and unequal gender expectations in heterosexual relationships, as risk factors for HIV infection in marriage and in cohabiting relationships.

2.6. Rationale for research

Several HIV/AIDS prevention programs are in place in the Eastern Cape Province of South Africa. Despite this, research shows that Eastern Cape Province is the second highest HIV prevalence in South Africa with approximately 68% people that are HIV positive (Human Sciences and Research Council, 2018). People still engage in risky sexual behaviour. This study seeks to identify factors that potentially facilitate HIV infection in married and cohabiting people between the ages of 26 and 60 years living in a rural setting in the Eastern Cape, South Africa. The exposure to risks of HIV infection will be analysed using the theory of gender and power to identify dynamics that affect safe sex practices for married and cohabiting partners.

2.7. Aims

This study had the following aims:

1. To identify the challenges that married and cohabiting men and women between the ages of 26 and 60 years living in a rural area in the Eastern Cape face with regards to engaging in safe sex practices in their sexual relationships.
2. To identify the factors which affect condom use and condom negotiation by married and cohabiting men and women between the ages of 26 and 60 years living in a rural area in the Eastern Cape.
3. To identify cultural factors which influence safe sex practices for married and cohabiting men and women between the ages of 26 and 60 years living in a rural area in the Eastern Cape.

2.8. Research questions

The main question is as follows:

1. In a sample of men and women between the ages of 26 and 60 years living in a rural area in the Eastern Cape, what are the challenges married and/or cohabiting men and women face with regards to engaging in safe sex practices in their sexual relationships?

The main question is simplified into three sub-questions:

1. What are the dynamics related to condom use for married and cohabiting men and women between 26-60 years old?
2. What factors affect condom use and condom negotiation for married and cohabiting men between 26-60 years old?
3. How do culturally assigned roles for married and cohabiting men and women between 26-60 years old relate to the risk of HIV infection?

This study used data from a broader study that aimed to explore and change actions in response to HIV amongst the residents of a rural area in the Eastern Cape, South Africa. The methodology employed is subsequently discussed.

Chapter 3 Methodology

3.1. Research design

This study used a qualitative design to understand and to make sense of people's meanings, perceptions and their experiences of the social world (De Vos, Strydom, Fouche, & Delport, 2002). This study used a qualitative design because it seeks to understand, the sexual risks that lead to HIV/AIDS infection by married and cohabiting partners. Terre Blanche, Durrheim, and Painter (2006) argue that a qualitative study enables the researcher to understand the meaning of people's experiences by interacting with them and listening to their personal experiences in relation to the context in which they occur. The subjective experience of the participants can be understood by exploring reality from the insider's perspective (De Vos et al., 2002). In this study, I explored the participants' culture, values, and beliefs regarding sexual practices. I used transcripts from semi-structured and in-depth interviews, focus groups, as well as from the mixed-groups of adult community members that were in the form of workshops to explore the risk of HIV infection for married and cohabiting partners.

I investigated this topic using data that was already collected in an NRF Thuthuka funded study, which was conducted in 2012 and 2013. The name of the research site is kept confidential to protect the identity of the participants. In the broader study, the research site has been given the name Ematyholweni. The research site was chosen because the findings of a previous study revealed that youth and adults at Ematyholweni engage in risky sexual practices such as unprotected sex and multiple partnerships. The research site is in a rural area, which has a high rate of unemployment. I explored the risk of HIV/AIDS infection among married and cohabiting partners residing in this same area, Ematyholweni, using the data from the broader study.

3.2. Sample

De Vos et al. (2002) argue that a sample is composed of the elements of the population a researcher considers for inclusion in the study. A study conducted in Ematyholweni in 2000-2003 by Dr. Van der Riet and her research team identified that the research participants engaged in risky sexual behaviour that needed further investigation (Msweli, 2014). De Vos et al. (2002) argue that in a qualitative study, researchers select the research participants and consider the setting where the processes under study occur. This

means that the inclusion criteria are the research site, the risky sexual behaviours such as the practice of multiple partnerships, unprotected sex, and early sexual debut.

These factors were used as the inclusion criteria of the broader study.

In the broader study, sampling was done from the 14 villages in the area. The criteria for selecting the villages included the availability of resources near to those villages such as schools and clinics, and the prevalence of youth and adults in those villages. Being a resident of *Ematyholweni* was another inclusion criteria. Sampling was done from the participants that were youth, married and unmarried adult men, and women residing in this area of study. In *Ematyholweni*, some men have to work as migrant workers far away from their families because jobs are scarce in this area.

The Chief and the Residents Association chairpersons were consulted about access to residents at *Ematyholweni*. Permission to conduct research was obtained by sending a letter to the Chief asking for his permission to conduct the research project (see Appendix 1A for the *isiXhosa* version and Appendix 1B for the English version of the letter). A meeting was held and the objectives of the research were explained to the Chief, and he agreed that the study could take place. The Residents Association chairpersons were also gatekeepers and they assisted the research team in identifying research participants. The study coordinator identified key informants who helped with the recruitment of research participants in all the villages. When the potential participants of the project were identified, the researchers went to their homes and informed them about the study and the contact details of those that were interested were recorded. Participants were also recruited via visiting a soccer tournament and a choir practice to access the youth.

3.2.1. Sampling for the broader study. Purposive and convenience sampling methods were used in the broader study. Purposive sample was chosen as a sampling strategy because it could take into account the features, criteria, and the guidelines of the study which were used as inclusion criteria to select the research participants (De Vos et al., 2002). Convenience sampling allowed the researchers to select the available participants for the broader study (De Vos et al., 2002). When sampling the participants, the researchers of the broader study used the following age ranges (in years): 10-13, 14-17, 18-25, 26-35, 36-45, and 46-70. For interviews, the researchers of the broader study sampled participants from age ranges 18-25, 26-35, 36-45, 46-70 years. Seventy-five people were sampled for interviews and 20 focus groups that were composed of 5-10 research participants in each group. The mixed-groups of men and women consisted of up to 20 participants in each group.

3.2.2. Sampling for this study. Married and cohabiting partners that were between 26 and 60 years of age, that reside in a rural setting were relevant participants for this study as they are more likely to engage in risky sexual practices such as unprotected sex (Dube et al., 2017). I selected married and cohabiting women that were between 26 and 60 years of age because they are more likely to engage in unprotected sex, as it is a requirement in these relationships and they are at risk of acquiring HIV infection from their partners (Dube et al., 2017).

I used purposive sampling as it was relevant to my study and it allowed me to sample participants according to the characteristics of the population of interest. It helped me to meet the aims of my study such as analysing the risk of HIV infection in marriage and in cohabitation. I selected transcripts of interviews, focus groups, and from a workshop with a mixed group of adult married and unmarried men and women with participants aged 26-60 years who were married and/or in cohabiting relationships. This helped in the current study to understand the different views of male and female participants when they discuss issues related to sex. The mixed-group enabled male and female research participants to raise different gender-specific issues and to raise their concerns about risks in relationships and problems that affect safe sex were discussed.

I sampled interviews, focus groups and mixed-groups with people from three age ranges: 26-34; 35-45 and 46-60 years. By the age of 26 years, people have reached adulthood, they have established their relationships and some of them are already married. By the ages of 35-45 and 45-60 years, people are mostly settled in stable relationships or married. Due to the nature of the data that was available to me, and my research aims, there were 8 individual interviews that were selected, 4 with women and 4 with men. For focus group discussions, there were 5 focus groups, 3 with women, 2 with men. There were also 2 mixed-groups (the workshops with adult men and women). Demographic information for participants in interviews (Table 1) and focus group and mixed groups (Table 2) are presented below.

Table 1
Demographic Characteristics of Interview Participants

Category	Age Range (Years)	Men	Women	Total
Interview	26-34	-	1	1
Interview	35-45	1	1	2
Interview	46-60	3	2	5
Total number of participants	-	4	4	8

Table 2
Demographic Characteristics of Focus Groups Participants

Category	Age Range (Years)	Men	Women	Mixed: Men and Women	Total
Focus group	26-34	-	1	-	1
Focus group	35-45	1	1	-	2
Focus group	46-60	1	1	-	2
Mixed group	26-60	-	-	2	2
Total number of focus groups	-	2	3	2	7

3.3. Data collection

Two data collection methods were employed. The first of these was interviews. De Vos et al. (2002) define interviews as a conversation between the researcher and the participant aiming to unfold the meaning of people's experiences. Interviews allow participants to describe and reflect on their experiences. Interviews can thus be considered a meaning-making process (De Vos et al., 2002). Interviews allowed participants to attach a meaning to sex and their sexual practices. Interviews also allowed participants to identify risky sexual behaviours in their relationships.

Focus groups were also employed. According to Kelly (2006), focus groups are used for groups of people that share a similar experience. Focus groups provide a platform for self-disclosure among the participants and at the same time, the researcher can investigate and explore perceptions of the participants about the research questions (De Vos et al., 2002). Focus groups allowed participants to explore sexual practices in marriage and in cohabiting relationships, and to share and discover risk in sexual practices.

3.3.1. Interviews. Interviews entail a one-on-one interaction between the researcher and the participants, and enable a confidential space for the participants so that they can discuss their experiences freely. Interviews were beneficial in the broader study because they allowed both men and women to discuss their sexual experiences and practices confidentially with the researchers. In the broader study, in-depth interviews and semi-structured interviews were used. In-depth interviews refer to an extended and a formalised conversation that allows the researcher to understand the meaning of people's experiences (De Vos et al., 2002). In-depth interviews involve a conversation with a purpose that allows the researcher to know people and understand how they think and feel (De Vos et al., 2002).

As mentioned earlier, sex is a sensitive issue to discuss. Cain (2007) comments on how in the Xhosa tradition the language that is used to refer to sexual intercourse and the private parts of the body is respectful in nature. Cain (2007) argues that this can create difficulties when one communicates about the risk of HIV. However, in this study, one-on-one interviews were used in order to allow participants to speak freely about sex in a confidential way. In this study, interviews allowed participants to share their deepest feelings and their experiences about sex and the dynamics in their relationships that place them at risk of HIV infection without feeling judged. This might particularly have been facilitative of women's voices as conventionally women do not speak about sex. The interview format also allowed respondents to express the meaning of their metaphors and difficult words that have a specific meaning in the culture of *amaXhosa*. In-depth interviews were also used as a way of asking for more clarification related to the information which was generated through the focus groups.

The semi-structured nature of the interviews allowed the researchers to have a prepared schedule and to be flexible in asking questions during the interview. Issues related to HIV are a sensitive matter and the interview process occurred in a safe place to ensure that confidentiality was maintained. This also allowed the research participants to explain the risks of HIV infection they are facing in their sexual relationships. Semi-structured interviews were conducted with parents and married people (see Appendix 2A for the *isiXhosa* schedule and Appendix 2B for the English schedule). Unmarried people that were in long-term relationship were also interviewed (see Appendix 3A for the *isiXhosa* schedule and Appendix 3B for the English schedule). Interviews were conducted with married and unmarried people to obtain different perspectives or similar and shared experiences surrounding the problem of HIV/AIDS.

Before data collection commenced, the researchers explained the aims of the broader study to the research participants to ensure that they knew that participation was voluntary and that they had a right to withdraw from the research. Participants were given an information sheet (see Appendix 4A for the *isiXhosa* version and Appendix 4B for the English version). The interview process, its purpose, and its duration were clarified to the participants, and they signed an informed consent form (see Appendix 5A for the *isiXhosa* consent form and Appendix 5B for the English consent form). The researchers explained to the participants that the interviews would be recorded in order to be able to transcribe what was discussed. Confidentiality was emphasized by ensuring that their names were not revealed and that, upon completion of the transcription, the recording was deleted. Upon agreement to record interviews participants signed a consent form (see Appendices 6A in *isiXhosa* and 6B in English version).

3.3.2. Focus groups. A focus group is used to facilitate group interaction and to discuss topics determined by the researcher (De Vos et al., 2002). In the broader study, focus groups helped the researchers to investigate the different perceptions of men and women, married and unmarried, of their sexual health, risks, and their response to HIV/AIDS. Focus group discussions are potentially empowering to groups and could create a supportive environment as well as a space for sharing the life experiences encountered by the research participants (De Vos et al., 2002).

In this study there were two types of focus groups: Male or female only participants and mixed-groups consisting of both males and females. The mixed-groups consisted of up to 20 adult members of the community, were run as workshops. They were useful in this study as they dealt with gender inequalities that affect HIV prevention. Male and female participants were able to discuss their experiences in sexual relationships. Female participants were able to express the manner in which the male sexual role regarding condom use affects their sexual wishes. Men and women had a platform for debate about matters relating to sex, which is rare in the Xhosa culture (Cain, 2007). Focus group discussions were useful for my study as they illustrated how the participants explored the risk of HIV infection in marriage. This is because focus groups facilitated the sharing of social norms and cultural dynamics associated with sexual practices in marriage. Focus group discussions helped in facilitating self-disclosure of married and cohabiting women in the presence of other participants that encounter the same problem (De Vos et al., 2002). Focus group discussions helped as the research participants had a space to discuss topics such as social norms, gender inequalities and risky sexual practices freely.

Focus groups need to be carefully planned. The place where the focus group discussions will be held, transporting of participants to the research site, and the questions to be asked need to be planned (De Vos et al., 2002). In the broader study, the research team arranged transport for participants to the research site. Semi-structured focus group schedules were drafted (see Appendix 7A for the *isiXhosa* version and Appendix 7B in English version). Participants were allocated to groups according to gender, age, and marital status, to allow group members to share social norms that are age, gender- and stage-appropriate, that guide sexual health and their response to HIV/AIDS.

Focus groups were conducted in *isiXhosa* by the Xhosa-speaking researchers. An informed consent sheet was drafted in *isiXhosa* and was issued to the participants before the focus group discussions started, clarifying the aims of the study. Participants were informed that participation was voluntary and that they were free to leave the focus group discussion if they felt overwhelmed or lose interest. An information sheet was given to the participants (see Appendices 4A in *isiXhosa* and 4B in English). When participants agreed to participate in the focus group discussions, they signed a consent form (see Appendices 8A in *isiXhosa* and 8B in English). Participants were informed that focus group discussions would be recorded so that they can be transcribed later. Upon agreement, they signed consent for recording (see Appendices 6A in *isiXhosa* and 6B in English). Focus group discussions have limitations such as the risk that participants will not keep information discussed in the group confidential. Participants were informed that group discussion must be kept confidential and should not be discussed outside the group. This still does not guarantee confidentiality, but group members were sensitised to avoid revealing group members' personal experiences. Participants were asked to sign a confidentiality pledge (see Appendix 9A for the *isiXhosa* version and Appendix 9B for the English version).

3.4. Data processing

Recorded interviews and focus groups were transcribed into a written form so that they could be analysed. Transcriptions were verbatim which meant typing participants' conversation word for word. This includes putting signs for the non-verbal indicators such as the pause, sniffing, unfinished sentences, and for laughing (Bailey, 2008). The data was transcribed by using transcription conventions that were taken from the Jefferson system (Antaki, 2011) - (see Appendix 10). They were used to transcribe the audiotaped recordings of the discussions and interviews in order to understand the spoken text of the participants. When the conversations of the research participants were written down, their comments were

separated by their utterances, semicolons, three dots for an untimed pause, and double quotes to express bodily movements. These conventions are reflected in the extracts used in my study.

Data was collected in *isiXhosa* – the first language of the research participants. The data was translated into English by the research team. As part of managing the data and to prepare for data analysis, data transcription was done in *isiXhosa* and then translated into English. Two translators translated the transcriptions using a method called back-translation (Brislin, 1970). The first translator translated the data from its original version that is the taped conversation in *isiXhosa* into English. The second translator translated part of the English version back to the original *isiXhosa* in order to verify if the translated information was a true version of the participant's conversation and to identify if there were any discrepancies.

3.5. Data analysis

Thematic analysis was used as a data analysis tool. This method allowed me to explore various aspects of the research topic within the dataset. I identified patterns in the data that were used to analyse and report the findings of the study (Braun & Clarke, 2006). I identified factors that posed a risk of HIV infection. The integrated theory of gender and power was used to analyse data using factors the participants have identified as posing risks of HIV infection in their daily sexual practices.

I analysed the data by following the six steps that were proposed by Braun and Clarke (2006). In the first step, I read and re-read the data in order to be familiar with it and to identify patterns within the data. This was done by reading and re-reading the transcripts and by listening to the recordings of the interviews and focus group transcripts in *isiXhosa*. For step 2, I identified features that were interesting and related to the research questions, and they were used to generate codes. Key words and phrases such as 'skin on skin sex' and 'using a plastic' were seen as having the same meaning and coded together. For step 3, main themes were formed by grouping together codes that had a similar meaning such as 'not feeling what I'm doing,' and 'skin-on-skin' were grouped together as non-condom use in marriage and in cohabiting relationships. For step 4, I reviewed all the identified themes by checking their relationship to the coded data that was taken from the transcripts. For step 5, themes were defined and named. Each theme and its subthemes were defined. The final step, step 6, involved producing the findings and producing a report.

I used the theory of gender and power to identify the descriptive codes that indicated the risk factors that leads to HIV infection in marriage and in cohabiting relationships. The descriptive codes are the factors and the reasons leading to unprotected sex practices such as rejection of condom use due to a need to prove fertility. This code is supported in the theory of gender and power as the expectation of women and it also emerged as a descriptive code in this study. I reviewed the already existing themes that describe the participants' sexual practices to identify the common sexual practices and the overlap between themes. Related themes were grouped together to identify dominant themes such as cultural and relationship expectation in marriage (e.g. a combination of the expectation of men and women to procreate and the expectation for men to demonstrate virility). This gave an overview of how the participants described their engagement in risky sexual behaviour and the manner in which the risky sexual practices of the participants potentially fuelled HIV infection in marriage and cohabiting relationships in a rural setting in Eastern Cape.

3.6. Strategies to ensure the trustworthiness of the study

Any study needs to be accurate with findings that are logical and that can give answers to the research questions, conclusions, and recommendations. Every system that asks about or investigates the human condition must be able to establish the truth and value of the study meaning – that it must be applicable, consistent, and neutral (De Vos et al., 2002). Marshal and Rossman (1995) point out that it is important to evaluate the trustworthiness of the project to ensure that it is credible, transferable, replicable, and if its findings are reflective of the subject's views. In qualitative design, one needs to consider trustworthiness, credibility, dependability, transferability, and conformability to ascertain the accuracy of the study (De Vos et al, 2002).

3.6.1. Credibility. The researcher must enhance the credibility of the study by screening its internal validity by ensuring that subjects were accurately identified (Lincoln & Guba, 1985). In order for the study to be credible, it must test what it was intended to test (Shenton, 2003). In the broader study, the researchers strengthened the credibility of this study by familiarising themselves with the context before the first data was collected. Dr. Mary van der Riet and the research team visited the villages to be investigated prior to the start of the research process and some of the research team resided in this area to ensure that they engage properly with the participants (Msweli, 2014). This engagement aimed at ensuring that trust was established between the research team and the research participants.

In this study I accessed the data set and familiarised myself with it by reading the transcripts presented in individual interviews, focus groups, and in the mixed-group workshop. This helped me to identify the subject accurately and to understand the social group and the culture of the research participants.

Triangulation. Shenton (2003) emphasised the importance of understanding the phenomenon by using different data collection strategies. In the current study, triangulation was used. I used individual interviews, focus groups, and the mixed focus groups that were conducted in the form of workshops. Individual interviews and focus groups have their strengths and limitations. The mixed focus group workshop helped the researcher to analyse gender-specific discussions and the manner in which some of the male participants defended their roles (e.g. the sexual decision-maker role). The interviews provided personal experiences of participants, and the group discussions provided a reflection of the social interactions of men and women in relation to the risk of HIV/AIDS. The use of different data collection methods is a strength and improved the credibility of the current study.

3.6.2. Dependability. Dependability is defined by Shenton (2003) as the extent to which similar results can be found by future researchers in the same context using the same methods with the same participants. This can be problematic in a qualitative study due to the changing nature of the phenomena that is investigated. In this study, I enhanced dependability by providing sufficient detail of the research process, the research design and data collection methods so that future researchers can understand the processes that were followed.

3.6.3. Transferability. Shenton (2003) defines transferability as the extent to which one's findings can be transferred to similar participants in similar settings. De Vos et al. (2002) argue that transferability of study findings is difficult in a qualitative study as the findings are specific to a particular environment. Shenton (2003) argues that the researcher can overcome this challenge by reporting the theoretical framework, the data collection process, and how the data analysis was done. In my study, I have explained the theoretical framework, the aims of my study, and the research site in detail. I provided details about the research fieldwork, the sampling procedure in the current study, and the data collection process which was used. The current study involved secondary analysis of the data from the broader study. I was not involved in the data collection process.

3.6.4. Conformability. Shenton (2003) defined conformability as the ability of the investigator to be objective when reporting the findings of the study.

According to this author, the researcher can achieve this by reporting only the experiences and the ideas of the research participants not her or his own preferences.

In the current study, I used triangulation and this data collection method allowed different research participants to express their views. The use of three different data collection methods, namely individual interviews, focus groups and a mixed-group workshops, enabled me to answer the research questions. I have acknowledged the research data. The process of data analysis used in this study was adopted from the broader project. This should allow the reader to determine which steps I followed and how I reached the findings of the current study.

3.7. Ethical considerations

Ethical clearance for the broader NRF funded study as well as for this study was granted by the University of KwaZulu- Natal's Humanities and Social Sciences Research Ethics Committee (see Appendices 11 and 12, respectively). Wassenaar (2006) argues that a study must be conducted in a manner that respects and protects the privacy of people by using pseudonyms to ensure that the identities of the research participants are protected. Research participants of the larger project and those selected in my study have their names and the research setting anonymised. After the transcripts have been used for this study they will be deleted from the students' hard drive, and will not be used for any other research process to maintain confidentiality.

The larger project and the current study explored the sensitive topics of HIV/AIDS, sex, and risky sexual behaviour. This topic had the potential of creating discomfort. Direct and indirect harm to participants of the larger study were mediated by setting up a referral network to offer psychological interventions to those left distressed. A procedure to do a referral was approved as stated in the information sheet (see Appendices 4A in *isiXhosa* and 4B in English).

Wassenaar (2006) argues that the research and its aim should be of social value by addressing interventions that will be beneficial to the participants and to the society. Questions that are of value to the research setting under study were addressed by the larger project and by the current study. The larger project and the current study have potential social value to the research participants as they addressed the risk of HIV infection in a rural setting in the Eastern Cape, South Africa.

The research participants in the broader study could benefit indirectly and directly from the study. The larger project enhanced awareness of the risk of HIV in long-term

relationships. Participants potentially benefited from the study as it enabled them to discuss issues related to managing the risk of HIV infection and to explore the existing sexual patterns that make them vulnerable to HIV infection. Participants were offered a gratuity of R30.00 as compensation for the time given to each interview or focus groups or workshops. The broader study also aimed to help inform policy makers about the HIV epidemic in a rural setting in the Eastern Cape. This could potentially assist in developing strategies to address the risk of HIV infection in long-term relationships.

3.8. Data storage

The supervisor of the broader project has kept the data from the broader study secure for a minimum period of five years. It is kept in the format of anonymised transcripts; each transcript has an allocated code or a number and the participant's age group. In the current study, I used the codes that link the extract used in this study with the original transcripts. These transcription codes/numbers are also listed in table format (see Appendix 13).

No identifying information related to the participants or research site was available to me. The names of participants and the identity of the site will not be published or presented in workshops, case conferences, or cited in journals or theses. After the transcripts have been used for this study, they will be deleted from the students' hard drive.

This section presented research methodology in terms of recruitment, sampling, data collection, and data analysis of the broader study and the current study. Strategies of ensuring trustworthiness, ethical consideration and data storage and dissemination of the results were also presented. The next section presents the results of the study.

Chapter 4 Results

This section presents an analysis of the interviews and focus group discussions. Individual interviews enabled the participants to share their personal experiences. In individual interviews, participants discussed their personal life experiences and the factors that exposed them to the risk of acquiring diseases. Focus group discussions allowed participants to share in a group the personal, social, and cultural dynamics that affect safe sex practice in marriage and cohabiting relationships. In the analysis, the researcher identified three themes. The first theme focuses on analysing the factors that affect condom use in marriage and in cohabiting relationships and how they affect HIV prevention. The second theme analyses the power differences between men and women that affect communication. The third theme focuses on risky male sexual practices such as having multiple partnerships and unprotected sex. I also discuss other risky male sexual practices such as alcohol abuse and male engagement in unprotected sexual practices when drunk. Additionally, I discuss the influence of social norms that guide women to be tolerant of these male sexual practices.

The ‘I’ used in transcripts refers to the interviewer, the ‘P’ refers to the participant, XXXX refers to the name of the participant and X refers to the name of a place or town. Transcription conventions are outlined in Appendix 10. The line numbers refer to the line numbers of the original transcripts as transcribed in the broader project. In each extract, the age range and gender of the participants are mentioned.

4.1. Factors affecting condom use in marriage and in cohabiting relationships

In this study, most of the participants were aware of the HIV risk factors and factors that affect condom use. Most of the research participants seemed to be aware of the factors that lead to increased risk of HIV infection, and that one of these factors is the failure to adhere to HIV prevention strategies at the beginning of marriage. There are also other factors that emerged such as the age difference between partners. Most male and female participants have identified the need to be trusted, loved, and the meaning attached to sex as having a negative impact on condom use. Another HIV risk factor that affects condom use in marriage and cohabiting relationships is procreation. In this section, factors that affect condom use in marriage and in cohabiting relationships will be discussed in detail.

4.1.1. Failure to adhere to HIV prevention strategies before marriage. During an individual interview, one participant, a married woman between 35 and 45 years of age, expressed an understanding that testing and knowing your partner's HIV status are important aspects of HIV prevention, but acknowledged that they (she and her partner) did not honour these procedures. Her statement suggests that she did not use a condom, and that she did not get tested before her sexual relationship started. Her statement also indicates that she was in a cohabiting relationship before she married her husband. The statement of this female participant explained the way her relationship developed from being casual, to a cohabiting relationship until it progressed to marriage. Her sexual practices are illustrated in the extract below. She acknowledged that she was drunk when she met her boyfriend. The participant's statement seems to indicate that they had an unprotected sex before marriage and that their relationship progressed to marriage.

Extract 1

- 16 P : I met him in that drunken state, the following day I didn't even know how I met up
17 : with my husband. We stayed together, then I wanted to leave him but then I decided not to
18 : because he was a person that knew me.
19 I : uh hh
20 P : We stayed together. We fell in love. We fell in love. We started dating in 1999.
21 I : uh hh
22 P : We had a child in 2000.
23 I : uh hh
24 P : We stayed in love. We got married last year...year before last...two years back?

Extract 1 explains the manner in which the female participant's relationship started; it suggests that they engaged in risky sexual behaviour as they were in a drunken state (line 16). The participant mentions that they had a child (line 22) which indicates that they had unprotected sex while they were in a cohabiting relationship (although this is not directly mentioned in the extract). Her statement also suggests that the relationship existed without love and that love developed gradually and led to marriage (lines 20-24).

For some participants condom use before the relationship starts does not seem to be considered by the sexual partners. Extract 2 was taken from a mixed focus group workshop with men and women (older men and women in the community). In Extract 2, the male participant shows an awareness that condom use and testing before marriage and cohabitation start are safer sexual practices and should occur.

Extract 2

344 P : okay this is XXXX, I would say, this thing, according to how I see it right, you first be in
345 : love, you first have the love from the outside before you get married before you become husband
346 : and wife so that means this thing you didn't even begin with it from the start when you got
347 : married that's why it will result into a problem, but if you started with it from the beginning and
348 : know maybe you do go and test maybe after certain months when you were just in a relationship
349 : then when you married I would say it would be something that is right whether you married or
350 : not you should continue to keep your lives safe then now it won't be difficult when you are
351 : married now when maybe you want to use a condom you continue to use a condom all the time

In Extract 2, the male participant reflects on the process of building a relationship and marriage (line 345) and suggests that HIV prevention such as testing should be discussed at the beginning stage of a relationship (lines 347-348). According to him, safety occurs when partners ensure that they know their HIV status (lines 348-350). He seems to admit that HIV testing does not occur by referring to it as a problem (line 347) if it was not proposed at the beginning of marriage (lines 346-347).

The awareness raised in Extract 2 about HIV prevention such as testing does not seem to be considered at the beginning of marriage as is illustrated in extract 3. Extract 3 was taken from an individual interview with a 35-45 year old married woman. She discusses how she met her partner and how the marriage proposal occurred. Extract 3 summarises the types of marriages and the main issues that were considered by her husband's sister before marriage.

Extract 3

21 P : He then told his sister that he had come to a point where he could take a wife
22 I : okay
23 P : and now with his previous relationships he had not seen anyone that could grow
24 : him
25 I : okay
26 P : he then ask if there wasn't anyone that she knew
27 I : uhh. uhh
28 P : [that she can perhaps show him=...
31 P : his sister said that there is a young girl by the name of XXXX and I trust that she can stay
32 : with you
33 I : uh
35 P : And the way that I see her at her home she is very mature and she know to work and
36 : so on and so forth. (h) And indeed that happened. He called me...
49 P : then I asked brother what your problem was? He then said: no I am looking for a
50 : wife.

51 I : yes
 52 : ((shuffles))
 53 P : then I said huh, brother how is this going to go, my Lord, he asked me why-I said
 54 : I have a child (.)
 55 I : okay
 56 P : and my intentions were to stay with my child and raise my child, work for my
 57 : child]. He then said: I love you with your child.

Extract 3 explains the marriage procedure for this participant. The procedures that were followed before marriage are contradicting with the HIV prevention strategies as explained in Extract 2, as safety measures such as testing was not discussed as part of the marriage arrangement. Her husband's sister suggested a suitable girl for marriage with expected characteristics such as maturity (line 35), being young (line 31), trustworthiness (line 31), and the ability to work in the domestic sphere (line 35). Her husband wanted to marry her (lines 49-50), and this suggests that she also met his criteria as he was looking for someone that would enable him to grow (lines 23-24). She was not forced into marriage. She was part of the decision-making process as he could propose marriage and she was given a chance to discuss her views about this marriage proposal (lines 49-57).

In Extract 4, the marriage procedures followed indicate that sexual safety before marriage was not considered as the participant's marriage was not consensual. Some participants indicated that forced marriage is no longer practiced, which suggest that it is not a norm. Extract 4 was taken from a focus group discussion of married and unmarried women aged 35-45 years.

Extract 4

432 P : like that, that you were married off to someone by choice
 433 I : married off by choice
 434 P : you'll cry until you give up
 435 P : ((unclear)) it still happens in other places where children are married off to older people
 436 : because of parents who want cattle
 437 P : mm
 438 P : no with us it's not common-
 439 P : it's common you see me I am young but my husband is a grandpa...

In Extract 4, participants commented about the non-consensual marriage that used to happen a long time ago (line 432) and that women's feelings were not considered as one

participant explains that you would ‘cry until you give up’ (line 434). The participant comments that this practice still happens in other places; in some places ‘children are married off to older people’ (line 435) for economic interest (i.e. because ‘parents who want cattle’; line 436). However, they argue that it does not happen at the research site (line 438; ‘with us it’s not common’). One female participant disagrees and says that it happened to her. She suggests that she did not consent to her marriage as she highlights that the age difference between her and her husband is big (line 439). From Extract 4, one might reason that if marriage is not consensual, then safe sex practices before marriage such as testing and negotiation about condom use were not considered. In this relationship, being young was considered as an important criterion for consideration for marriage. Sexual safety seems to be affected in this sexual relationship,

4.1.2. The age of a sexual partner. Extract 5 was taken from a workshop with adult unmarried and married male and female participants (i.e. older community members). A female participant highlights the age difference between partners as another HIV risk factor affecting safe sex practices. Large age differences between partners affects HIV prevention strategies such as condom use.

Extract 5

159 P : and XXXX uh uh I’m saying with this age
 160 : thing, like the gap, it speaks as a person because another person is able to overpower you
 161 I : sorry?
 162 P : I mean if ever maybe she is saying that I mean with this thing that another person says that I
 163 : am leaving the condom, I mean they are not putting it on anymore, you see, it’s about trust you see
 164 I : okay ok so it’s because of the age gap
 165 P : that age gap has a role that it plays >because if ever< he says that no I’m not going to use it
 166 : otherwise you see, and there is nothing that she is going to do because she is afraid of
 167 : him mos
 168 I : yes
 169 P : because he’s older than her

In Extract 5, the research participant suggests that there is no consensus regarding condom use as she mentions that she is overpowered (line 160). This statement suggests that young women lack power to act against the decision of their male partners regarding condom use (lines 165-166). For example, she suggests that she is scared of opposing a sexual partner (line 166). The female partner’s reaction to her failure to insist on condom use indicates helplessness; ‘there’s nothing she is going to do because she is afraid of him’ (line 166).

In a workshop of adult married and unmarried men and women, one female participant highlighted two factors such as the age of the partners and the level of education as factors that affect condom use.

Extract 6

418 P : yes, XXXX I do concur too, but remember at old age there are two kinds there are those
419 : whom are 'primitive', I am not judging anyone, who are 'primitive' like who are uneducated
420 : these things are hard for them, a person is old, I mean it won't come easily it won't be easy for it to
421 : be a norm, of using this plastic, 'husband' (refer to the *isiXhosa* slang for a condom) it has
422 : many names I mean to other old people it would be easy to get used to, but there are those kinds
423 : of old people that will never be easy for them to get used to it thank you

In Extract 6, a female participant indicates that older people find it difficult to use a condom consistently or as a normal practice (line 421). The age of a partner determines the ability to use a condom as it might be considered as foreign because it is impractical to be used by old people (line 421). She objectifies it by referring to it as a 'plastic' (line 421). She also concludes that it would be difficult for them to become familiar with condom use (line 423).

A majority of the participants acknowledged that negotiations and agreement about suitable sexual practices does not occur at the beginning of relationships, which make condom use difficult. There are also some men and women who agree that condoms are not used in marriage and in cohabitation. Condom use does not seem to be a common practice in marriage and in cohabiting relationships. Other reasons also result in the failure to use condoms in marriage and in cohabitation, such as being financially dependent on the male partner.

4.1.3. Non-condom use and women's financial dependence on men. In a focus group discussion with married and unmarried women aged 26-34 years, a woman revealed the negative consequences she faces when she refuses to have sex with a male partner. In Extract 7, female participants reflected on their inability to refuse sex.

Extract 7

409 I : Ok. so if you say that you don't want to have sex with him is that when he tells you that
410 : he's going to go somewhere else to get sex?
411 P : if you really don't want to and you are firm about it, you won't continue, he will say okay
412 : then leave it then. He will say no leave it
413 P : and he ends up going somewhere else

414 P : he knows that he's going to go somewhere else...

In Extract 7, the female participant suggests that sexual negotiations do not occur as she is not allowed to negotiate about not having sex (line 411). If she 'won't continue' her husband threatens to leave her and look for sex from someone else (lines 411-413). This statement suggests that being assertive about what she wants might lead to a loss of a partner. A woman also fears of losing her husband because she is aware that she competes with other women. She might then engage in unprotected sex with her partner to prevent him from going elsewhere.

In a focus group discussion with married women aged 46-60 years, some married women indicated their need to protect themselves by using a condom, but that their request fails because of their need for financial support by their husbands. In Extract 8, these female participants argue that this affects condom use in marriage.

Extract 8

573 P : and most of the time you see that as a woman you are not even working and here are your
574 : children. And so, if you are going to say that he must go away because he does not want to use a
575 : condom what are you going to be left with? He is going to tell you that I am leaving with my money I
576 : am going to those that do not want a condom...
590 P : because she is trying to hold onto this money because he is going to leave her with these
591 : children, what is she going to do with these children?

In the extract above, some female participants argue that condom use is difficult in their marriages because their husbands refuse to use them (line 574). Their discussion suggests that they are powerless because they fear of being abandoned by their husbands. Their statements also suggest that they are threatened when they suggest condom use (line 575). These female participants fear losing financial support as they will struggle to support their children (line 591). She comments that 'because she is trying to hold onto this money because he is going to leave her with these children, what is she going to do with these children' (lines 590-591). Lastly, they seem to be competing with extramarital partners. The participant says the husband will say 'I am leaving you with my money, I am going to those that do not want a condom' (line 576).

Condom use does not seem to be a common practice in marriage. In sexual relationships where women are financially dependent on men, they choose to protect the safety of their relationships in order to maintain their financial safety rather than sexual safety.

4.1.4. The meaning attached to sex and love affects condom use. In this theme, the safety of the relationships seems to be maintained by different factors such as love, trust, or a need to be trustworthy. Extract 9 was taken from a focus group discussion with married women aged 46-60 years. Here a few married women identified sex as an important part of marriage and as something that should happen; that it is almost unavoidable as it is natural. In Extract 9, female participants mentioned that they sometimes use a condom but also acknowledge that sexual safety by using a condom is affected in their sexual relationships. The meaning they attach to sex as well as their sexual needs are the reasons for their failure to use a condom.

Extract 9

- 770 P : you see now that's why I was saying that you are not having sex to procreate only. You will
 771 : count the years when you want to have a baby and in between you are using a condom. Because in
 772 : between you will never not have sex, because it is natural to have sex...
 776 P : you have sex even if you have closed yourself, and you reckon that you won't have any more
 777 : children but you still have sex
 778 P : ((laughter))
 779 P : sex is the one thing that makes the love grow

In Extract 9, sex with a condom is seen as a birth control method and this participant seems to consider managing the risk of pregnancy through condom use (lines 770-771). Their statements also suggest that condoms are used inconsistently, in-between having children (line 771). The participants view sex as natural (line 772). Some female participants believe that sex is favourable in their relationships because it enables love to grow (lines 776-779).

4.1.5. Trust in marriage and cohabiting relationships affects condom use. The development of a sexual relationship is seen by most male and female participants as important and that trust enables it to grow. Trust or being trustworthy seems to exist when condoms are not used. Most female participants indicated that introducing condom use in marriage and in cohabitation is not easy and this is related to trust. Participants discuss issues that affect condom use in relationships that are characterised by trust. The meaning of being in a trustworthy relationship and its effects on condom use is discussed in Extract 10.

Extract 10 was taken from a workshop with adult married and unmarried men and women. One female participant seems to suggest that partners want to be trusted, and that since introducing condom use suggests a lack of trust, it is difficult for partners to do so.

Extract 10

- 193 I : uhm, so the issue of trust that you were raising could you maybe say a little more
194 : about, so if you are in a relationship with someone and you want to use a condom, what does that
195 : say about trusting and not trusting, could maybe say a little bit more about that?
196 I : so she wants to know about this thing about trust, if you don't want to use a condom what
197 : does it mean about, about trust, what happens about issues of trust?
198 P : it's because if I ask him where the condom is he's going to say it's clear that I am saying that
199 : there is someone or there are people that he is sleeping with on the side besides me, or that maybe
200 : there is something that I am doing on the side

In line 200, one married woman indicates a dilemma associated with introducing condom use. She mentions that the introduction of condom use suggests suspicion of infidelity or admission of guilt that one is unfaithful.

Extract 11 below was taken from an individual interview with a married man (between 46 and 60 years of age). In this interview he comments that men break the trust by being unfaithful. He admits to engaging in risky behaviour such as consuming alcohol and that he is unfaithful (line 208). He admits that there is a need to use a condom with his wife.

Extract 11

- 207 P : yes a condom is the one thing. Worse and worse us men cannot be trusted
208 : because I am loose and I drink and sometimes I am blinded by other people and I am=you
209 : see that. And I say that hey I was with so and so then it is necessary to have a condom

In an individual interview with a married woman aged 35-45 years, a female participant seems to be aware that trust sometimes does not exist. In Extract 12, this married woman mentions another factor that affects trust: The physical distance between partners as a result of migration for work.

Extract 12

- 166 I : uh .hh uh. But then you said that you and your husband chose not to use
167 : condoms. So is there another way in which you can protect your selves from these diseases
168 : without the use of a condom?
169 P : There isn't sisi
170 I : There isn't. You still trust each other?
171 P : Maybe it's because we still trust each other.
172 I : Okay. ↑But you have not thought about asking to use a condom with your

173 : husband?
 174 P : (.2). I want to. I must ask him
 175 : ((Laughter))
 176 I : You Wa(h)nt to?
 177 P : Yes
 178 I : What makes you say you want to?
 179 P : There are many things. And like I said he travels a lot all the while I'm here at
 180 : home. He's always out and I don't know what he gets up to there.
 181 I : uh hh.
 182 P : I'm here, do you understand? That's where the condoms comes in because I'm
 183 P : here at home, he comes and goes I don't know what he gets up to.

A married woman indicates that she experiences some difficulty in marriage as she cannot trust her husband due to the distance between them. She also does not ask for condom use, although she wants to ask about condom use because she knows he may have been unfaithful (lines 182-183).

A few married women seem to link the physical distance between them and their male sexual partners with a lack of trust. In a workshop with adult men and women, a married woman indicated concerns caused by the distance between her and her husband caused by migration, and the need for protection.

Extract 13

316 P : I want to say it true because even us while we are old mothers like this the fathers of our
 317 : homes who come from Gauteng do not want to use these things. So now it would be good for us to
 318 : get female condoms so that we can get help because really a woman is stronger than a man you can
 319 : quickly hide it without the man seeing it

In Extract 13, trust also seemed to be affected by to the physical distance between this married participant and her husband who is a migrant worker. This married woman indicates her wish to be protected by using a female condom (lines 317-318). The participant's need to use a female condom suggests that she might suspect her husband's infidelity even though this is not directly mentioned in the extract. She also indicates a need to be in control of condom use (by using a female condom) and that this might prevent infection by diseases (although this is not directly mentioned in the extract). This might be the reason why the participant is also appealing for help to use a female condom even if she hides it from her husband.

A few men in this study admitted that they are untrustworthy. Most married women acknowledged that there is a need to use a condom in marriage. The admission of guilt by male participants and the suspicion of male infidelity by most female participants suggest that there is a need for protection in marriage. Despite this, condom use does not seem to be a usual sexual practice in marriage. This is because condom use is associated with untrustworthiness.

In the current study, most men and women know condom use as a protective tool. Some participants also know condom use as a contraceptive tool. The next section discusses how reproduction is valued and how this affects condom use. The next topic discusses expectations in a relationship that affect sexual safety.

4.1.6. An expectation to procreate affects condom use. Extract 14 was taken from a workshop with adult males and females. A male participant argues that condom use is a difficult sexual practice and that it is not favourable in marriage due to the expectation of reproduction.

Extract 14

285 P : so I am trying to say that when it comes to the needle, eh, if I have a wife even I myself do not
286 : want the needle because ((unclear))
287 P : exactly
288 P : I want to know that I am a man to this person who is my wife. I don't want any needle. So
289 : men themselves do not want the needle ((unclear))
290 P : mm

In Extract 14, a male participant seems to take responsibility for his wife's conception. He mentions that he does not want his wife to use a needle. A needle can possibly mean a certain type of contraceptive that is in a form of an injection or a 'needle' because it is associated with his wish to be seen as a man to his wife (line 288). This might be associated with a need to prove masculinity and virility. His statement suggests that reproduction is gendered. He interprets this as being able to have children (although it is not directly mentioned in the extract).

Extract 15 was taken from an individual interview with a cohabiting female partner who is 35-45 of age. Her statement suggests that procreation is an expectation from her male partner. The female partner admits that her partner rejects her attempts to negotiate condom use.

Extract 15

- 49 P : For instance like now when we meet in X I told him: we have not seen each
50 : other let's use a condom. He'd reply: I don't know about that. I was not raised up to that,
51 : people using plastics
52 I : uh hh () uh.hh
53 P : Even though you were not raised up to that ↑but, he'd say: = what did you see
54 : that you think that we should start using condoms?..
73 P : I was not born into using plastics. I'd say: no, condoms are number one. If you
74 : use a condom you are safe. There's no risk of pregnancy; you remain as you are. He'd say:
75 : no we need children. A Xhosa man will always remain like that...

In Extract 15, the cohabiting female participant expresses her need to use a condom. Her partner's answer suggests that condom use is also not favoured in their relationship as he rejects the idea of the risk non-condom use might bring by saying that there is no risk (line 74). One might reason that her partner considers fertility as more important (line 75). Condom use is an unusual sexual practice to him and he equates a condom to plastic (line 73). The male partner asserts his wish by opposing condom use.

Extract 16 was taken from a focus group discussion of married women aged 46-60 years. This woman's statement suggests that reproduction is expected from a female partner and thought of as a man's responsibility. This woman also seems to associate being a man with the ability to reproduce children.

Extract 16

- 679 P : I think that's how they prove that they are men, that they can have babies.
680 : To be a man you have to have children and there is nothing else.

Condom use is not a common practice in sexual relationships where fertility is a need. There are a variety of factors that affect sexual safety in marriage and in cohabiting relationships. In this study, most women understand that there are sexual risk factors and indicate a need for protection. However, protective sex by using a condom is not a common practice in marriage and in cohabiting relationships. There are various factors affecting a woman's ability to negotiate condom use successfully. The next section will discuss how condom use is negotiated in sexual relationships.

4.2. Male power and women's lack of power affect condom negotiations

This section will present other challenges that are faced by men and women when they communicate about the risk of HIV and STI infection. This includes a discussion of the impact of men's rejection and disapproval of protection as well as women's inability to assert their wishes to protect themselves against infection (e.g. women yielding to male power by accepting non-condom use). These factors also affect communication about the risk of HIV infection in married and cohabiting partners.

4.2.1. Male power and condom negotiation in marriage. This section will focus on analysing the manner in which condom use is negotiated in marriage. Condom use seems to be unsuccessful because sexual decision-making is not equally shared. In a focus group discussion with married women aged 46-60 years, a participant acknowledges that men are powerful and they have a right to insist on sex (see Extract 17).

Extract 17

626 P : Then you suggest that hey man we have been apart for so long I would really like us to
627 : use a condom.
628 : But still, I say that a man is so hard headed,...
630 : He will not listen to you, because he is like no this is my wife and so I have a right
631 : to do whatever I want he does not care about protection

In Extract 17, a married woman expresses the difficulty she faces to protect herself because of her assumption that it's her husband's marital right to have unprotected sex (line 630). These rights seem to entail a right to do whatever he wants to do, such as not listen to his wife (line 630). She comments that he does not care about protection (line 631).

Extract 18 was taken from a workshop with older and married men and women. In this Extract a participant comments that because of a man's power, condoms are 'not usable' (line 1).

Extract 18

1 P : you see (.) no we agree that's how it is, that the reason a condom is not usable it's
2 : because of the things spoken of here, that people who are males are stronger they
3 : defeat a female that's how we don't know how to protect ourselves

She comments that men are stronger (line 2) and that they 'defeat' women (line 3). 'Defeat' in this context likely means that they reject condom use. She says that this means

that they as women therefore do not know how to go about protecting themselves (line 3). In a workshop session with adult men and women, a male participant also refers to men's control of decision-making in sexual activity (Extract 19).

Extract 19

215 P : mm no chief ne, the thing that Sisi .was saying you see, I mean for women I mean that its
216 : not easy for them to be the ones who are insisting on condoms, I mean that issue with using
217 : condom is entirely dependent on men

In Extract 19, a male participant argues that it is not easy (line 216) for women to insist about condom use, and that the decision is 'entirely dependent on men' (line 217). His statement reinforces the notion of men being the decision-makers when it comes to sex, and puts forth the image of men being more powerful.

In an individual interview with a married man between the ages of 26 and 34 years, another male participant admits that he does not favour using condoms in sex as it affects the sensation he experiences (lines 257-258). He comments that men reject condoms (line 271).

Extract 20

254 P : now I mean it will feel like, I mean I won't enjoy what I am doing cause like I am used to doing it a
255 : certain way you see?
256 I : okay
257 P : this is what will result in a situation where one has it on and one will be 'fuck I don't know what I am
258 : doing=
259 I : =yes...
271 P : of which a condom is what us as men we don't want to put on=

In this Extract, he suggests that using a condom would lead to a distancing from feeling 'I don't know what I'm doing' (lines 257-258). He also reflects on the general negative attitude of men about condom use.

In a focus group discussion with married and unmarried men aged 35-45 years, another male participant rejects condom use. In Extract 21 below, he indicates that men are stubborn (line 314) and assert their preference of sex without a condom (line 315).

Extract 21

314 P : I like to emphasise that we as men are hard headed. And you tell her that no man me

315 : as a man I will not use this thing I want skin on skin. And she says no man lets' use this and this and
316 : you tell her no man there's no such I won't do that

Extract 22 was taken from a workshop with older adult men and women. In this extract, a male participant acknowledges that there are differences these days. He feels that the 'times we are living in' (line 145) 'forces' him to use a condom 'put it inside' (line 145).

Extract 22

145 P : uh, in this thing that (unclear) in the times that we are living in we are forced to put it inside,
146 : it's because of the times we are living in. I hear the woman saying where is the condom, and with
147 : red eyes I say that no leave that thing man. I am forcing her now, that we must do this thing
148 : because my blood is hot

In Extract 22, this man comments that women ask to use a condom (line 146), but he explains that because of his passion, he does not want to use a condom. As a result he might have to force her to have sex without a condom (line 147).

Most men and women acknowledge that women initiate, influence, and indicate their concern about safe sex practices. This section illustrated the way men refuse safe sex practices and force their preferences onto women. As can be seen, they also admit that condom negotiation does not succeed and this can lead to non-consensual sex and to sexual violence. This is discussed in more detail below

4.2.2. Male power, abuse of women, and exposure to risks. Women attempt to communicate about the risks they encounter in sex such as HIV and STI infection, but this is not always successful.

In a focus group discussion with married women aged 35-45 years (Extract 23), one of the participants discusses being infected with an STI, and knowing that her partner was unfaithful (line 552). She comments about the way her sexual health was affected.

Extract 23

551 P : like your vagina, it becomes itchy. You see. Then you must know then that huh uh,
552 : there is this something that he was doing on the side
553 P : these STIs
554 : mm
555 : you see. There is this thing that he was doing that
556 P : he has infected you with
557 P : that he has brought to me. There are risks like that

558 P : this HIV and AIDS
 559 P : what is it called again?
 560 P : STIs, yes
 561 I : and so, do married people talk about these things, that there are these things. Are
 562 : these things that you talk about with your partner?
 563 P : I speak about it sometimes
 564 P : you talk about it, but men are
 565 P : hard headed
 566 P : they are hard headed, yes, they won't admit it that he's done it
 567 P : for example, even these condoms it's not something that they like hearing that they
 568 : should use. That they should use condoms

In Extract 23, a married woman shares her experiences about the sexual health-related problems and sees her health in relation to her husband's behaviour. She reflects on her experience of being infected by a STI by her husband through his infidelity (line 552). She comments that she tries to talk to her husband about the risks such as HIV and STI infection, but explains that men are stubborn (lines 564-565) and will not admit to extramarital sex (line 566).

Extract 24 was taken from the focus group with married women aged 26-34 years. Here, a woman describes her emotional response to her husband's infidelity.

Extract 24

416 P : and you know loving a person, and he is whoring around in front of you, going with other girl
 417 : in front of you, and you reckon that no man, you are really feeling bad

In the Extract above, a married woman says that men often have multiple partners (line 416). She comments that she loves her husband, and that it makes her feel bad to know that he has multiple partners (line 417).

In Extract 25, from a focus group discussion of married and unmarried women aged 35-45 years, a female participant comments on an experience of when she communicated about sexual health risks in her relationship.

Extract 25

511 P : and I want to support what XXXX is saying. Most of the time it is the men who see themselves as
 512 : clean, so if you have that thing as a woman you feel bad because you feel that maybe he is going to
 513 : hit you, that 'where did you get this from?'. Maybe at the time he does not have the signs maybe you
 514 : are the one that had the signs first. So, when you tell him about this thing he hits you, 'where are you

515 : getting this thing from because I don't have it'. But this thing showed itself on me and the thing that
 516 : was needed was for him to go and get help so that it does not get worse for him. And he says you
 517 : must tell him where you got it from. But most of the time it is the woman who is accused of
 518 : cheating. And so you keep quiet and endure because you are scared to say. You reckon that you are
 519 : really not feeling what you are doing although you are feeling that something is wrong
 520 I : so you are saying that for women it is not always easy to talk about these things

As can be seen, she comments on what she experienced that prevents communication about sexual health risks. She mentions that she feared violence such as being beaten (line 513) if she raised the fact that she has 'signs' (possibly referring to an STI or to HIV; line 514). She expresses concern for her husband in that he receives treatment so that it does not get worse for him (lines 515-516). Her fear is that if she raises her concerns, she will be blamed. She comments that women are portrayed as unfaithful, who are 'accused of cheating' (lines 517-518), and that men are portrayed as 'clean' (line 512). She therefore keeps quiet (line 518). She suggests that she becomes passive in sex (she 'endures' and that she is not feeling what she is doing; lines 516-519).

In a the focus group of married women aged 35-45 years, a married woman also comments about the difficulty she experiences when it comes to communicating about sexual health risk. In Extract 26, she discusses her experience as possibly resulting from her husband's risky behaviour. She mentions that they should deal with their health together, such as testing (line 118). She also mentions that her husband denies that he has infected her (line 120). She comments that if she tells him she went to the clinic and was diagnosed with something, he would reject her, that he will not want her anymore (line 122).

Extract 26

117 P : maybe you went to the clinic and you find that you've got HIV. Sometimes, you know
 118 : we are married mos, we should go to the clinic and test together. And I know that I have
 119 : had no affair. I will wonder where I got it from, but the thing is that I got it from him. And
 120 : when I tell him he says no. You see, he'll be like no no, no, no. You see, those are things that
 121 : happen in a marriage. And you must tell him that I went to the clinic and this is what I was
 122 : found to have. And he will not want you then. He will be like no man I don't know anything
 123 : about that

Some women in this study commented that sexual health risk communication, HIV disclosure, and treatment are difficult issues to manage in marriage. In the next theme, I discuss male sexual practices. Most men and women commented that there are men that

engage in casual partnerships and extramarital affairs. Multiple partnerships seem to be a known male sexual practice and it is confirmed to be a risky sexual practice.

4.3. Multiple partnerships and women's tolerance of men's infidelity

Most men and women in this study seemed to indicate that the sexual privileges afforded to males differ from those afforded to females. Women seem to tolerate male infidelity without challenging it.

Most male and female participants argued that men have extramarital partners. Male participants categorised their relationships as either a serious relationship (e.g. marriage or cohabiting) or a less serious relationship (e.g. casual partners). Most women admitted that they are exposed to infections such as HIV and sexually transmitted diseases, but that they accept such sexual constraints. Extract 27 is taken from a focus group discussion of married and unmarried men aged 35-45 years. In this Extract, some men admit to engaging in relationships with more than one partner, and they discuss the categories of their relationships and their meaning.

Extract 27

- 53 I : alright. So with the one that you are loving, you are committed to her, what is that called?
- 54 : You know because there is one that you love just because you want to sleep with her? What are
- 55 : words that are used in those instances?
- 56 P : that's my fasty
- 57 P : that's my fasty, when she is the one person that I am with
- 58 : when you really like her...
- 63 P : the one we do not love we usually call her free kick...
- 66 I : that's a ball, right, is there another word that is used to describe someone that you don't love
- 67 P : it's said that you just going round and round
- 68 I : yes just going round. Okay, maybe what are some of things people who are in relationships do?
- 69 : I heard you saying that they kiss each other and they buy themselves nice things
- 70 : and they take each other out. Are there other things that people who are in relationship do?
- 71 P : there is something that you must go and fetch a person so that she can come and sleep here
- 72 : in your house, uh, so that you can have sex.
- 73 P : yes
- 74 P : there is something else also, and that is called commitment you can tell her your
- 75 : problems

In Extract 27 above, male participants engage in a discussion about types of sexual relationships. They mention that one sexual relationship is based on love and commitment

and the second type of a sexual relationship is characterised by a lack of love. Some of the male participants agree that they engage in sexual intercourse with women they relate with just to have sex with them (lines 71-72); these women are called ‘free kicks’ (line 63) and there is lack of love. Their statements suggest that these male participants do not only associate sex with love, but they have sex even with those they do not love.

Multiple partnerships seem to be a known male sexual practice. In a focus group with married and unmarried women aged 35-45 years, they discuss that they are aware that even married men have extramarital partners and that they view this as ‘normal’.

Extract 28

- 8 P : A person, a husband but they have somebody that they are in a relationship with from outside
9 : We can see them, they don’t even need to tell us, we can see that something is going
10 : on in that marriage, maybe you see them with so and so. Especially with us the
11 : younger people, the men (unclear) but even the women they do that. Like maybe they
12 : drink, and when they drink alcohol does things to you mos, and then they see someone
13 : there at the shebeen, even though she is married
14 P : no, I don’t understand the question do you mean that we must speak only about them
15 : men only, because I am a woman the man is doing something but I am doing nothing..
21 P : let me say that it does exist that men do that. Mostly. I have never seen or heard
22 : that a woman was doing that.

In Extract 28, married women discuss extramarital partnerships by men and women. This is a behaviour that is known as they say ‘we can see them’ (line 9), which suggests a communal awareness of multiple partnerships. There seems to be different opinions as some participants mention that married women also have extramarital relationships. Others assert that only men are unfaithful and believe that women are innocent (line 15), as one woman states: “I have never seen or heard that a woman was doing that” (lines 21-22).

Women participating in the focus group of women aged 35-45 years, also commented that men do not hide multiple partnerships, and it is known to happen.

Extract 29

- 36 P : Even here in the bushes XXXX, they have sex, you see. A married person takes a
37 P : person from the shebeen and they have no chance to go and have sex in a proper place and
38 : so they will do it here in the bushes
39 I : ok
40 I : So when they are doing that, what is that called?

41 P : It's called winning
 42 P : It's called being won
 43 P : It has no name because tomorrow they don't even pay attention to each other
 44 : because they were just doing a momentary thing
 45 P : they were cheating (stealing)
 46 P : most of the time, *ubiwano* (stealing)
 47 I : Ok so it's called stealing (laughs). So when that goes on for a long time what is that
 48 : called?
 49 P : It's *isidyolo*
 50 P : *Ukukrexeza*, when a person is married and they have a person from outside of
 51 : marriage
 52 I : So all these words, what is the difference between these words?
 53 P : There is no difference between these words but
 54 P : that word *ukukrexeza* means that you have a lover even though you are married
 55 I : So it's the same like being loose maybe
 56 P : yes
 57 P : It's the same like *ubiwano* because you are stealing this person, because you are
 58 : married and so you are not doing this freely. Others even say that it's *umakwhapeni*. Roll
 59 : on, that's what they say...

In the focus group discussion with women, most participants commented about multiple partnerships and they also referred to it as an act of having a secret partner). They explain that partners who have secret partners are 'stealing' or do not do it freely (lines 45-47 and 57-58). According to the group, this activity has reached a communal awareness. Participants mention that cheating starts in places such as shebeens (lines 36-37). One might therefore associate cheating with drinking, although it is not directly mentioned in the extract. Participants' arguments suggest that such partners are untrustworthy or unfaithful to their partners.

In Extract 30, a male participant agrees that having a secret lover is a risky sexual practice because sexual safety by using a condom is compromised. Extract 30 was taken from a focus group discussion with married men aged 46-60 years. In this Extract, a male participant defines casual sex as an urgent need and his statement suggests that it is a risky sexual behaviour.

Extract 30

629 P : He is telling the truth, that now during the day I meet someone and she says yes to me right
 630 : then, then I must quickly do this before other people see me. Then we do this quickly and I am out

631 : and gone before other people see me, I am done with the deed
 632 P : ((laughter))
 633 I : yes, yes quickly and you're done with it
 634 P : that's how that thing is done
 635 I : and where is the condom that time
 636 P : no, you forget that thing all that is forgotten. If you are doing this thing secretly, and
 637 : maybe you can see that this girl is beautiful that condom will seem too far away

This married male participant describes extramarital sex as 'meeting someone that says yes to me' and feeling that he 'must quickly do this' (i.e. have sexual intercourse with her; lines 629-630). This sexual activity seems to be risky because he admits that there is no time to protect himself by using a condom. Failing to use a condom is expressed by using the words such as 'you forget that thing' (line 636). He also indicates that a condom is not used because it is not always available as 'that condom will seem too far away' (line 637).

Extract 31 was taken from a focus group discussion with married women aged 26-34 years. In this discussion, a married woman seems to accept multiple partnerships and she reasons that men desire sexual satisfaction from more than one partner, as 'a man has never had enough' (line 520). In this Extract, a married woman acknowledges that there is no such thing that a man is only with his wife. She generalises her belief about this male sexual practice and her statement possibly means that men need variety (line 520). According to her, this is a common male sexual practice.

Extract 31

517 I : mm. Okay so what makes a person to have multiple partners?
 518 P : Mostly the men do it.
 519 I : Yes, what makes them do that?
 520 P : A man has never ever had enough, we grew up and that was the thing that was happening
 521 : around us.

In a focus group discussion with married men aged 46-60 years (extract 32), a male participant justifies multiple partnerships. He argues that their behaviour is different from that of females, and that it cannot be criticised. In this Extract, a male participant's statement normalises and destigmatises multiple partnerships as a male sexual practices. He points out that 'us as men cannot be criticised' (line 786). His statement suggests that this risky male sexual behaviour is acceptable for men, but that women are not expected to behave like men.

This possibly means that virility is seen by this male participant as a normal male sexual practice.

Extract 32

- 781 I : so let me hear this properly, you are saying that a woman is not supposed to have this
782 : on her mind, or that this is not something that she should really be doing
783 P : that's what I'm saying
784 I : but the man, that is something that he should be doing all the time? No I want us to put
785 : it exactly as it is
786 P : yes that's what we are saying. Because us as men we cannot be criticised

In a workshop session with adult married and unmarried men and women, most men justified multiple partnerships. In Extract 33, virility is also normalised by a male participant.

Extract 33

- 264 P : Okay I just wanted to touch there Interviewer, to address XXXX's question about what makes
265 : and so it's like and no its clear that this is so and so it's like he's strong so maybe he needs to have
266 : many children scattered in all these places, all around to show that he is like his father so those are
267 : some of the other things that distract us in our brains. So what you tend to think when you meet a
268 : cherry, you think that better-
269 I : What do you call a person like that?
270 P : he is called udlalane
271 I : who?
272 P : udlalane
273 P : dlalane
274 P : dlalane
275 I : okay
276 P : So now you have that thing in your mind now that it's better that I have all my children
277 : scattered around in all these places so that I can be known and then the fact that there is HIV only comes
277 : afterwards.

In Extract 33, a male participant supports the notion of virility (although it is indirectly mentioned), but his statement seems to suggest that it is more valued than condom use. He refers to this sexual practice as being a player (*udlalane*), which is associated with masculinity. The participant's statement suggests that being a player involves 'having many children in all these places' (lines 274-277). This suggests that he does not use a condom, although is not explicitly stated. Secondly, he views this as a way of getting social

recognition; his words are ‘so that I can be known’ (line 277) and it can be recognised that he is strong (line 265).

In a workshop session with adult married men and women men, some male participants discussed men’s inability to practice monogamy and equated this with being ‘*isishumane*’. In Extract 34, practicing monogamy is not favoured by men.

Extract 34

418 P : it won’t be easy to not have someone but you are used to having someone...

421 I : what makes it to be not easy? ...

426 P : It’s to avoid to be called [*isishumane*

427 I : [< no bhuti>.

429 I : you afraid of being called *isishumane*?

As can be seen in the extract above, most male participants discuss the inability to abstain from having a relationship due to the fear of a social label associated with being asexual, referred to as *isishumane* (line 426). According to them, a man that abstains is labelled *isishumane*, and they seem to be concerned about failing to be seen as masculine.

In the current study, multiple partnerships for men seem to be a common practice. The views of most married and unmarried men in this study suggest that they favour it. Most women indicated that this practice affects them. Few women seem to accept it, but despite this, they endure it. Extract 35 was taken from a workshop with adult married and unmarried men and women. Here a married man once again rationalises and normalises multiple partnerships.

Extract 35

430 I : Okay now do people have partners, does that happen?

431 P : Us men, I would like say that a man was never made to have one partner, he quickly gets fed up

432 : with one partner

433 : he’s never satisfied...

440 : when you see a girl walking there in town wearing jeans and your body gets hot and you reckon eish

441 : if I could get her

An adult male participant justifies multiple partnerships saying ‘a man was never made to have one partner’ (line 431). He relates it to a man’s biological needs, that ‘your body gets hot’ as their sexual desires are quickly aroused when they see a girl wearing jeans (‘gets hot’, line 440). He mentions that men in general have an unsatisfied sexual appetite

(line 433), and therefore cannot have only one woman. He supports his statement by saying that a man needs variety, or 'more' women, as he cannot have only one partner (line 432). He uses the words such as 'they quickly get fed up with one partner' (lines 431-432). This behaviour is contrasted with that expected of women. In Extract 36, the male partner's statement suggests that a woman is confined to be in a relationship with one sexual partner and that if she changes a sexual partner she is given names.

Extract 36

713 I : why is that you would rather have this disease than to be left by

714 : you know, by a person who does not want to use a

715 : condom, what makes you do that

716 P : you are scared that you will be called a bitch or *umalalevuka* [meaning sleeping with different men]

717 I : okay so she is saying that they are called names

Extract 36 was taken from a workshop with older people in the community (married and unmarried men and women). This discussion seems to suggest that women tolerate the risk of being infected by diseases. The statement of this male partner seems to suggest that there are different gender expectations. Women are expected to be in a monogamous relationship otherwise they will be labelled as promiscuous (line 716). Most men in this study admitted that they practice multiple partnerships. Most women also know that men engage in casual partnerships. Some women assume that this risky sexual practice has to be tolerated. In the next section, men and women's response to sexual health care will be discussed.

4.4. Men and women's response to sexual health risks

These extracts illustrate that most male and female participants agreed they differ in the way they take care of their health. Men are viewed as negligent as they fail to prevent HIV infection, do not disclose their HIV status, and they also fail to access treatment when they are ill.

In a focus group discussion with men aged 35-45 years, some of the men define the behaviour of men and women as presenting unequal gender practice, characterised by being responsible and a lack of responsibility. Men admitted that women are more responsible regarding condom use.

Extract 37

337 I : so we are agreeing that it's the men who usually take responsibility when it comes to having

38 : sex. Or are we saying that no it's not like that?
 339 P : no, it's the women
 340 P : it's the women, it's the women who take the most responsibility. Because the men they like to
 341 : get drunk, very drunk and he won't hear anything. The woman is the one who is always at home not
 342 : doing anything and she will insist on using the condom

In Extract 37, the male participants agree that women 'take the most responsibility' (line 340) and negotiate condom use ('she will insist on using the condom', line 342). One participant reflected on men's lack of a sense of responsibility regarding safe sex practices when they are drunk (lines 340-341) that 'men, they like to get drunk, very drunk' and they are resistant to condom ('he won't hear anything'; line 342).

In Extract number 38, taken from a workshop with married and unmarried men and women, a female participant expresses her feelings about her health concerns and argues that men fail to take care of their health-related problems and are the cause of the health problems they encounter in the house.

Extract 38

433 P : I am XXXX. I also want to add onto what XXXX is saying. That most of the time it's the women
 434 : who are active about going to test. Because if a woman has a headache she will run to
 435 : the clinic. But a man, it's hard for him even when he is on his death bed and you tell him to go to the
 436 : clinic he will be afraid to go to that clinic, because he is afraid of being pricked at
 437 : the clinic. So now that's going to be worse now because when you go to the clinic you get pricked
 438 : and you see now that you don't even trust him because you as a woman what do you do, you stay at
 439 : home and you do housework but the man will go out to the cows and do his things. On his way there
 440 : maybe there are places where he can drink and he is going to go there and maybe there is a girl
 441 : that is beautiful there and he is going to think that hey she is more beautiful than the wife that I
 442 : have left at home so what must I do now I must go to her and ask her to come with me. So now he
 443 : realizes that's why he is scared is that he is not sure whether he is safe or not because he did
 444 : not protect himself too much. So maybe sometimes he is afraid of infecting the woman
 445 : that is why men do not want to go and test at the clinic more than women. Because women know
 446 : that ultimately their family is their responsibility and that they must protect their children. The man
 447 : has no time for that because he knows that even if I am dead it's the woman who is going to be
 448 : there, she is going to take care of the family, she will make sure that the children eat. Thank you

In Extract 38, a female participant mentions that a woman is active and responsible when it comes to health care as she attends a clinic to test for infection (line 434). She is responsible in the domestic sphere (lines 438-439), family support and care such as taking

care of her husband and protecting their family (lines 445-446), and also advises her husband to attend to his health (lines 435-436). However, he is not willing to take her advice - 'but it's hard for him even when he is on his death bed' (lines 435-436). She mentions that a man engages in risky behaviour such as drinking (line 440), engaging in extramarital relationships (lines 440-442), failing to protect himself from infection (lines 443-444) and is not willing to test for infection (line 445) and that even if he is infected, he fails to take the responsibility for that by hiding the infection. She suggests that this is the reason he does not attend the clinic.

In a focus group discussion with married women aged 46-60 years, these women explain women's vulnerability to infection from their husbands. They argue that it is difficult to protect themselves from such infection by using condoms in marriage (see Extract 39).

Extract 39

539 P : it is usually the women, men do not want to talk about it

540 P : yes and even going to the clinic it is the women

541 I : and even going to the clinic it is still the women

542 P : they don't go

543 P : And even the first person to give advice about condom use is usually the woman that no man (says) lets

544 : use a condom because she sees all these things that are out there, that something is wrong,

545 : whenever I sleep with him I get this thing on me, but he is the one that runs away and does not want

546 : to do it. When a woman has information that is helpful she is willing to share it with her family

547 I : So is there a way that women can protect themselves from this thing? From this transmission?

548 P : yes there is

549 I : what is it

550 P : it's condoms

551 I : it's condoms, but I don't know whether condoms are easy to use I can hear she is saying it as if

552 : it is easy

553 P : yes she is really saying it as if it is easy

554 P : but he will speak

555 P : as if it is something that happens easily

556 P : but they don't want it

557 I : XXXX is saying that they do not want it

558 P : no they do not even want to see it

Most married women comment that they generally take responsibility, for example, by raising discussions about condom use (line 539), attending clinics and attending to health concerns (line 540), as well as by giving advice when they see symptoms of poor health

(lines 543-544). These participants mention that ‘whenever I sleep with him I get this thing on me’ (lines 544-545). Women request condom use, but find it difficult to be listened to, and it is therefore not used (line 556). A woman is also portrayed as responsible for others as well by sharing the information that is helpful with her family (line 546). Men are seen as irresponsible about health care as they do not want to communicate about HIV infection – ‘they don’t want to talk about condom use’ (line 539). They do not want to see it (line 558), and they do not want to go to clinics (line 542). Most women argue that they take responsibility for sexual safety, such as educating their sexual partners about safe sex practices, but that this not an accepted sexual practice.

Extract 40 was taken from a focus group discussion of married women aged 46-60 years. Here a female participant reflects on women’s emotional responses to their husbands. In this Extract, a married woman discusses her emotional response and the impact of her husband’s infidelity on her. She describes it as intolerable to some people and that it has a negative impact on marriage (line 69). She seems to be reluctant to leave her marriage because of her husband’s extramarital affair (line 64). She explains that her husband’s infidelity can affect her status of being a woman (lines 72-73). She is concerned that people will talk about it, that her leaving her husband will be known and reduce her dignity (line 71) and render her worthless (line 73).

Extract 40

- 63 : People leave marriages and it ends up in a divorce because of something that
 64 : started that way. As a wife I leave my marriage because of something that started like that.
 65 : So sometimes it becomes something solid. It depends on a person, some people cannot
 66 : tolerate being cheated on. Sometimes this girl that my husband is cheating on me with lives
 67 : in the same village and they are doing it right in front of me, they are no longer hiding it
 68 I : So what you do then is to leave him?
 69 P : Yes of course, she will not tolerate that, so then she reckons then that’s the end of the
 70 : marriage
 71 P : Another thing is that you will hear rumours. That woman is reducing her dignity of
 72 : being a woman. And you people what not (unclear) that one I left her, her husband
 73 : what not. So now you become worthless and you even leave that marriage, take your
 74 : children and go

Extract 41 was taken from a workshop with men and women. Here a male participant also admits that it is not easy for a woman to leave a relationship. His statement suggests an expectation that women should be in monogamous relationships and endure male behaviour.

Extract 41

676 P : a woman when she's been in a relationship, like she's been in a relationship with me, then I
677 : leave her, and then she's in another relationship with this guy, things are going to be said about her,
678 : like others will say that she's a bitch, so for her, the thing that makes her resort to that is because she
679 : doesn't want her name to end up coming up in that way you see, so she ends up now submitting
680 : herself to (unclear)

In Extract 41, a male participant encourages a woman's tolerance of a man's infidelity. According to him, leaving a relationship and starting a new one affects the woman's social status as she will be labelled as a 'bitch' (line 678). He also acknowledges that women therefore opt to tolerate men or to submit (line 679).

4.5. Summation

The results section began with a presentation of the nature of a relationship such as marriage and cohabiting relationships. Most of the men and women who participated in this study seemed to be aware of HIV prevention strategies such as HIV testing and condom use. These participants admitted that HIV testing is not a usual practice before a sexual relationship starts. Most men and women described marriage and cohabiting relationships as sexual unions with expectations they have to meet such as being trustworthy and being able to reproduce children. Some married women mentioned that when love and commitment developed, condoms are not used. Some women commented that they are overpowered by their male partners because they are often younger than them. Some unemployed women reported that they lack power to insist condom use as they fear to lose financial support and their sexual relationships.

Most women viewed themselves as at risk of being infected by HIV and they seemed to be helpless because their male sexual partners often force their sexual decisions by beating them. Some female partners commented that they are exposed to intimate partner violence and that they become sexually passive. They argued that this affects condom negotiation, condom use, and HIV disclosure. Non-condom use is a common sexual practice in marriage and in cohabiting relationships due to these relationship dynamics.

Most men and women affirm their gender roles and gender expectations. Most men attain the social status of 'being a man' by engaging in risky sexual behaviour with more than one woman. Most men who practice multiple sexual partnerships admitted that they fail to use a condom with their casual partners and that this exposes their stable partners such as

married and cohabiting female partners to HIV infection. The findings of this study also reveal that most men who practice multiple and sexual partnerships fail to attend clinics or they ignore their health care needs when they are ill. Most women in this study seemed to seek to be desired by men and possibly by society by tolerating male risky sexual practices. The HIV epidemic seems to be influenced by these gender expectations. In the next section, I will discuss this notion.

Chapter 5 Discussion

This section discusses the findings presented in the results. This study explored the risk of HIV infection for married and cohabiting partners in a rural Eastern Cape setting. This study aimed to identify challenges faced by married and cohabiting men and women that affect safe sex practices in their sexual relationships. This study sought to identify factors that affect condom use and condom negotiation. It furthermore sought to identify cultural factors that affect safe sex practices in marriage and in cohabiting relationships. In this section, the findings of the study will be presented and the theory of gender and power will be used to understand sexual relationships and risks as discussed by the research participants. The three structures of the theory of gender and power will be used to discuss the research findings.

In the discussion, three dominant themes are presented. The first theme is non-condom use and economic dominance and the first structure of gender and power, namely the sexual division of labour, will be used to discuss it. The influence of men's economic dominance and the manner in which this affects condom use in marriage and in cohabiting relationships will be discussed here. The second theme discusses male sexual dominance and women's vulnerability to HIV infection using the second structure of the theory of gender and power, namely the sexual division of power. The third theme focused on the cultural expectations and sexual practices of men and women and the third structure of the theory of gender and power, namely the structure of cathexis or of social norms and affective attachments, was used to analyse this theme.

5.1. The sexual division of labour: non-condom use and economic dominance

The theory of gender and power stresses that women have a low economic status and that this affects the assertion of condom use (Wingood & DiClemente, 2000). Nyamhanga and Frumence (2014) also argue that women living in poverty are exposed to the risk of HIV infection as they engage in risky sexual behaviours as required by their husbands. Condom use is a desired sexual preference for women in this study. Asserting condom use is more challenging for women who have a low economic status, as their financial dependence on men affects their sexual assertiveness (Tolan, 2005). Their low economic status leads to a lack of sexual autonomy and this means that they cede to men's decision-making in sexual interactions. In the current study, an unemployed married woman was aware of her husband's infidelity and saw a need for protection, but acknowledged that condom negotiation and

condom use are challenging. Condom negotiation for her fails for three reasons. Firstly, she mentioned that her male sexual partner refuses her sexual initiatives. Duffy (2005) argues that the African culture expects men to be responsible for sexual activities. She also argues that a male partner ignores any initiative by a woman about sexual activity. This author also mentioned that when a female partner asserts her sexual ideas, she provokes the male partner and that this can lead to violence. The female research participant cited a second reason, that when she continues proposing condom use, her husband felt provoked and he threatened to leave her. As a result of these verbal threats, she was fearful and withdrew negotiation. Wingood and DiClemente (2000) argue that emotional abuse means exposure to the risk of HIV infection as women who are dominated by fear consent to have unsafe sex. Freeman (2010) argues that when sex occurs under such conditions, it is forced. Forced sex is risky because protection is also affected. Thirdly, the female research participant argued that her husband threatened to leave with his money and said that he would look for sex from extramarital partners. This female participant thus argued that she could not assert condom use during their sexual interactions. She admitted that she fears losing her husband or ceding to other female competitors. The African culture expects married women to be able to keep their sexual partners and to avoid losing them in a world where they compete with extramarital partners (Leclerc-Madlala, 2009).

Another married female participant argued that she relies on her husband's money to support her children and that she therefore cannot afford to lose him. Freeman (2010) argues that economically dependent women cannot have sexual control over their lives as their sexual needs are always determined by their husband's sexual needs. According to the World Bank (2006), gender-based violence emerges in the form of emotional violence and economic violence. Men who threaten their wives therefore control their wives' sexual activities. The World Bank (2006) reasons that men who set a condition about sex, apply punishment such as restricting women's access to finances if this condition is violated. This is referred to as economic violence.

One other married female participant explained that she does the caring work as she has to look after the children. She characterises her work as unpaid. Women's gender role as carers of their children leads to the endurance of risky marriages and tolerance of engaging in risky sex. Hoosen and Collins (2004) argue that women are often aware that their sexual partners expose them to infection, but that they cannot protect themselves from this infection, as they are economically and psychologically dependent on men. Fear of being rejected by a man can be related to a psychological dependence of women on men (Freeman, 2010).

Hoosen and Collins (2004) argue that women who are living in poverty often expose themselves to the risk of HIV infection. In this study, men who were bread winners use verbal threats to their wives to have sex on their own terms. Male power is therefore applied in the form of economic dominance. Hoosen and Collins (2004) argue that when women are threatened, they are unlikely to suggest condom use.

One other HIV risk factor in this structure is that men who reside in rural areas often migrate to other provinces or towns to find work. This is a HIV risk factor that affects married people in this study. A married female participant argued that men work ‘outside’, meaning far from their wives, and they then engage in multiple partnerships. She also mentioned that women are often infected with diseases by their male partners. One woman indicated that there is a need for women to access female condoms. This indicates that she desired to be in control of safe sex practices and to be protected. Hoosen and Collins (2004) also argue that sex with a condom is disliked in marriage and in cohabiting relationships. Women who are in unequal positions of power in relationships are at risk of being infected by diseases because of economic vulnerability such as unemployment and poverty (Wingood & DiClemente, 2000). In this study, most breadwinners accumulate power to dominate their wives. Power imbalance can therefore affect safe sex practices in sexual relationships, as will subsequently be discussed.

5.2. The sexual division of power: male sexual dominance and women’s vulnerability to HIV infection

Connell (1987) argues that men who practice hegemonic masculinity promote gender inequality between men and women and exercise control over women. Jewkes and Morrell (2010) defined hegemonic masculinity as the type of masculinity that supports social ascendancy. Men who support hegemonic masculinity often reject condom negotiation and ignore sexual communication by their female sexual partners (Duffy, 2005). A married female participant commented about the difficulty she encountered when she negotiated condom use as her husband failed to listen to her and he did not want her to talk about condom use. Wingood and DiClemente (2000) argue that steady male partners (which possibly mean married and cohabiting male partners) reject condom use and force their own sexual preference (such as unprotected sex). Previous literature reveals that, in marriage, condom use is difficult because men gain sexual rights once they pay the bride price or the *lobola* (Duffy, 2005). In the current study, a married woman mentioned that married men have marital rights to sex and they demand to have sex on their terms.

Men use this power to assert sexual entitlement (Stern et al., 2016). A female participant argued that male power over women also occurs because some men are older than their female partners. In the current study, the age difference between sexual partners is seen as a cause of power inequities between men and women. A cohabiting female participant raised the importance of using a condom with her boyfriend and tried to advise him that condoms are safe when they engage in sexual intercourse. Her boyfriend refused to take this advice and he referred to a condom as a 'plastic'. In the current study, most female participants attempted to negotiate condom use but they encountered challenges. Firstly, as mentioned earlier, men seemed to fail to listen to the request for safe sex practices. Secondly, they described men as 'hard to convince' or stubborn. Thirdly, they mentioned that men reject condom use. Male resistance to condom use sets up conditions for sexual violence, especially when their power to decide about sexual activities is challenged (Stern et al., 2016). Duffy (2005) reasons that men who have adopted the norms of hegemonic masculinity use physical dominance such as beating to wield power over women. A married female participant mentioned that she was beaten by her husband when she negotiated condom use and when she disclosed her HIV status. The female participant's statement suggests that some sexual encounters are non-consensual and forced. The problem with sexual violence is that women are exposed to sex without a condom.

Most of the women in the study admitted that they cannot control their sexual partners' promiscuous behaviour, and that they also engaged in risky sex with their steady partners without using a condom (Wingood & DiClemente, 2000). Bhagwanjee et al. (2013) argue that men's power over women makes women powerless and victims of being infected by diseases. In this study, a married female participant admitted that she was infected by a sexually transmitted disease. A female participant mentioned that even when she attempted to disclose her HIV status to her husband, he failed to admit that he infected her. Connell and Messerschmidt (2005) argue that a failure to admit when they are guilty illustrates males' sexual dominance over women. In this study, male power was also evident when a male participant failed to admit that he infected his wife. Instead, he accused her of bringing the infection and he became violent when his wife disclosed her HIV status.

Most women indicated that they have sexual needs but that they have to suppress them. They try to negotiate safer sex practices but their male partners often overpower them. In these relationships, there seems to be no sexual consent. Jewkes and Morrell (2012) proposed that there is a need to implement interventions that will seek to empower women to be able to challenge sexual violence.

In the next section, the influence of gender roles and their implications for men and women's sexual relationships will be analysed. The third structure of the theory of gender and power called the structure of cathexis or of social norms and affective attachments will be used to guide this discussion.

5.3. The structure of cathexis or of social norms and affective attachments: cultural expectations and sexual practices

In this section, I discuss how culture guides the manner in which male and female sexuality should occur. I focus on risky male sexual practices and how they are influenced by cultural factors such as multiple partnerships, engagement in unprotected sex, and risky behaviour such as alcohol use and men's failure to attend to health care. The role of culture in relation to femininity will also be discussed and how women's desire to be seen as trustworthy affects condom negotiation. The manner in which the behaviour of women is influenced by culture, such as being monogamous will be discussed. I also discuss the cultural expectations of women including the expectation to prove fertility and risk factors that lead to HIV infection. I then discuss women's tolerance of men's sexual behaviour. Finally, I will discuss men and women's response to their sexual health care needs.

5.3.1. Trust and exposure to the risk of HIV infection. In the structure of cathexis or of social norms and affective attachments, women are expected to be trustworthy (Wingood & DiClemente, 2000). This cultural expectation affects condom negotiation as women fear being seen as untrustworthy, loose and unfeminine (Wingood & DiClemente, 2000). Wingood and DiClemente (2000) argue that women accept that there are inequalities regarding the sexual behaviour of men and women. Women avoid changing sexual relationships as they fear being seen as promiscuous. Most women in the current study indicated their desire to be seen as trustworthy by their partners and emphasised the importance of trust in a sexual relationship. There are male and female participants who indicated that introducing condom use in marriage is a problem as this suggests that you do not trust your partner or that you are untrustworthy. Hoosen and Collins (2004) argue that married people set trust as a standard in their lives to ensure that they feel safe or free from diseases. These authors referred to trust as a 'security' that is used to do away with condom use in marriage, and this also happens in cohabiting relationships. In this study, trust was a dominant feature of a sexual relationship, but some women indicated concerns about their husbands' infidelity and argued that their sexual partners cannot be trusted. A male participant also admitted that he was unfaithful. The meaning of trust in this study seems to

be an assumption that both partners are in a monogamous relationship. This is a HIV risk factor and exposes married women to risk of HIV infection.

Unprotected sex was called ‘natural sex’ by the participants and was an expected practice by married women to meet the sexual needs of their male partners. According to Bhana and Anderson (2013), women view sex as a way of securing a man and love, even if it is risky. Women also respect being in stable relationships, and in this study sex was seen as a way of keeping the relationship strong. Flood (2003) argues that men’s expression of sex is detached from love and that sex and love do not mean the same thing. Male participants in this study defined their sexuality as urgent, and lust-driven, and expected women to be ready for sex when they needed it. This means that when they have sex they are driven by their biological needs and by lust. Men do not abide to the principles of monogamy such as being trustworthy. Most men in this study said that they have casual or extramarital partners. One male participant mentioned that he forgot to use protection by using a condom when he engaged in sex with a casual partner, and that a condom is not always available. Trust guarantees sexual safety when both partners can be mutually trusted or when faithfulness as stated in the HIV prevention strategies is abided by both sexual partners (van Dyk, 2008). The problem is that most male and female participants acknowledged that men seem to be not trustworthy. This means that married and cohabiting women face a risk of being infected by HIV by their male sexual partners.

5.3.2. Fertility, virility, and marriage. Cultural expectations of fertility, virility, and marriage also affect sexual safety. Wingood and DiClemente (2000) argue that family expectations related to marriage also create exposure to risk of HIV infection. Traditional marriage is guided by culture which determines what is culturally expected from woman to qualify for marriage. In the current study, marriage was formed based on qualities in the woman identified by the husband’s family to ensure that she is a ‘suitable girl’. Being a suitable girl for marriage in this study also entails being young and trustworthy. One woman in this study mentioned that she was introduced to marriage by her family at a young age, meaning she was ‘abducted’ to marry an older man. Being abducted also means that the woman’s sexual life is under the control of her husband as marriage also happened without her consent. This also affects the sexual power in marriage.

Wingood and DiClemente (2000) argue that sexuality is controlled by culture and that sex in marriage is meant for conception and for producing children. In this study, procreation was also an expectation of participants in marriage and in cohabiting relationships. According to Peacock et al. (2008) married men and women value fertility and men value virility. A

cohabiting female participant mentioned that her boyfriend does not welcome condom use and expected her to conceive. This suggests that the expected sexual practice in a cohabiting relationship and in marriage is sex without a condom. Mbizvo and Bassett (1996) mention that infertility often clashes with men and women's cultural expectations and can lead to the break up of a marriage.

Some married male participants indicated that they control contraceptive use and condom use. Male participants in the current study indicated a need to be seen as virile. They defined virility as the 'male ability to have children with different women', and this suggests that men think they are proving their virility through engaging in unprotected sex with different women. The desires of men and women to have children stands in opposition to HIV prevention strategies as these strategies require that partners use condoms consistently when engaging in sexual intercourse. The need to prove fertility and virility establishes the conditions for married and cohabiting partners to engage in high risk sex (Eaton et al., 2003). Most married male and female participants in this study indicated that they need to produce children. Some married men mentioned that they monitor their wives' contraceptive use. Contraceptive use seemed to be monitored by both married men and women. This is unlike condom use that seemed to be the responsibility of women (initiating it), but without the power to insist on it being used. The problem is that some men engaged in multiple partnerships and this exposes married women and cohabiting partners to the risk of HIV and STI infection. Multiple partnerships and women's tolerance of this practice will subsequently be discussed.

5.3.3. Multiple partnerships and its effect on HIV prevention. UNAIDS (2016) reveals that male sexual practices such as multiple partnerships and their engagement in unprotected sex are risky sexual practices that cause high HIV infection rates in Sub-Saharan countries and in South Africa. Most male participants in the study acknowledged that they and other men engage in multiple sexual partnerships. The problem is that sexual safety practices such as using a condom seem not to be practiced with these casual partners. A married woman indicated that extramarital relationships seem to be openly practiced. This might be, as Mfecane (2008) argues, that men who engage in this sexual practice seek social recognition and to be seen as real men. According to Mfecane (2008), men who engage in multiple partnerships are trying to avoid being seen as weak men. A weak man in the current study is a man who practices monogamy or is not in a sexual relationship. Being in a monogamous relationship prevents partners from HIV infection when both partners are faithful to one another (van Dyk, 2008). Mfecane (2008) argues that when a man does not

abide by these expectations of masculinity, he is devalued and is viewed as a shoemaker or *isishumane*. In other words, he loses social recognition. Some men admitted that they engage in multiple sexual partnerships and that they do not use condoms with both their casual and steady partners. The problem that faces married and cohabiting women is that they are vulnerable to HIV infection as their male sexual partners engage in risky sexual practices.

Some married women in the current study indicated their concern of being at risk of HIV infection and some of them mentioned that their male sexual partners have already infected them. This risky male sexual practice occurs because most men in this social setting seem to adopt the conservative male cultural norms that promote multiple sexual partnerships (Jewkes & Morrell, 2010). Women who testified to their vulnerability to HIV infection in this study are mostly married women. Women are often expected to submit to male sexual demands (Jewkes & Morrell, 2010). These cultural expectations increase women's vulnerability and can put them at risk of HIV infection. In the following section I discuss tolerance as an expectation among married women and the risk it poses to women.

5.3.4. Tolerance and women's exposure to the risk of HIV infection. Women who reside in rural areas are expected to abide to the cultural beliefs that guide their sexuality such as respect and being obedient (Bongela, 2001). Being obedient means that they cannot question their male partner's sexual behaviour and must instead be respectful by accepting it (Jewkes & Morrell, 2010). In the current study, a married woman understands that men have sexual desires and need to have a 'variety of sex with different sexual partners'. This statement suggests that this sexual behaviour is an accepted male sexual practice or it is possibly accepted by some women perhaps because they cannot convince their male sexual partners to do away with this behaviour.

The structure of cathexis or of social norms and affective attachment encourages women's emotional involvement to love their partners and motivates them to be tolerant of risky male sexual practices (Wingood & DiClemente, 2000). This might be the reason that women in this study do not leave their sexual partners but endure the difficulties they encounter in their sexual relationships. Men in this study referred to a woman that leaves a relationship or changes a sexual partner as a 'loose woman' or a 'bitch'. A few married women also mentioned that when a woman leaves her marriage she becomes worthless. This means that if women are tolerant of their husbands' promiscuous behaviour, they will prevent the loss of social recognition. Marriage seemed to be valued and married women seemed to feel worthy. Reddy and Dunne (2007) argue that women who favour acquiescent femininity are accepting, tolerant, and prefer to be ignorant about their husbands' promiscuity to save

their marriages. This study reveals that some married women are often tolerant of their husbands even when they have been infected by them. One married woman said she was beaten by her husband when she disclosed her HIV status. She also mentioned that she preferred to be silent, that HIV disclosure is affected and it might be difficult to negotiate condom use and seek treatment.

Tolerance among married women is a risky cultural expectation as they cannot prevent HIV infection, they cannot disclose their HIV status, they cannot freely seek treatment, and they cannot leave their marriages. There is a need for more workshops to educate women continuously so that they can find more strategies to deal with these risky and harmful gender beliefs and expectations.

5.3.5. A gendered way of responding to health care. According to Hoosen and Collins (2004), men often lack the responsibility to ensure that safe sex is practiced in marriage. Most male and female participants admitted that women are responsible for healthcare such as practicing safe sex, but it fails to be successfully implemented. They argue that women can only watch their husbands acting recklessly sexually by having extramarital partners, and cannot stop or control them. Some of the female participants also reflected on their experiences that there is no mutual effort to attend to healthcare needs such as attending clinics when they are infected with HIV and AIDS. In the current study, a married woman mentioned that men fail to attend to their health even when they are seriously ill. This experience is supported by Bhagwanjee et al. (2013) and they mentioned that women attend clinics when they are infected but seemed to fail to influence men successfully to attend with them, even when their health deteriorates or when they are infected by diseases. According to these authors, women can only watch them struggle with their health. They refer to this gender position as a spectator position.

In this study, male strength is problematic in two ways. Firstly, most men engage in multiple partnerships. Secondly, men who favour multiple and sexual partnerships are often infected by sexually transmitted infections and they refuse to attend to their healthcare needs. Men's failure to take care of their sexual health is described by Connell and Messerschmidt (2005) as avoiding to be seen as hurt in order to be seen as strong. One might reason that men who adopt this sexual practice seem to value their social status more than their health status. There is a need to increase HIV and AIDS awareness programmes to specifically target men to increase insight about gender norms and their harmful gender beliefs.

5.4. Summation

In this section, the results of the study were discussed in relation to the literature and theory. There are three themes that emerged and they interconnect with one another to provide a better understanding of challenges that lead to the risk of HIV infection in marriage and in cohabiting relationships. In each theme, it is evident that there is a lack of consent in sexual activities facilitated by different mechanisms such as unequal economic power, unequal sexual decision-making power, and unequal cultural and gender role expectations. When these inequalities emerge in sexual relationships, they elevate male power over women. Unequal gender norms among men and women can be seen as the reason for inequities in marriage and in cohabiting relationships. Men's social role as breadwinners does not only lead to economic power, but also allows men to have sexual power over women. Women submit to male power because they hold subordinate positions and this affects their sexual decision-making power.

Next, I discuss how this study attempted to address the research questions. I then provide a brief conclusion, including an overview of the limitations and strengths of this study. Finally, recommendations are made with regards to practical implications and future research.

Chapter 6 Conclusion

According to Dube et al. (2017), HIV infection occurs in marriage and in cohabiting relationships. Shisana et al. (2014) argue that one of the leading causes of HIV infection in married and cohabiting women is that condoms are not used. This study aimed to understand the sexual practices that increase the risk of HIV/AIDS infection in marriage and in cohabitation. This study used data that was collected in a rural setting in the Eastern Cape, South Africa. The main research question was to investigate the challenges men and women are faced with when engaging in safe sex practices in their sexual relationships. The main research question was simplified into three sub-questions stated below.

The first sub-question was aimed at identifying challenges facing married and cohabiting men and women between the ages of 26 and 60 years in engaging in safe sex practices in their sexual relationships. The study revealed that unemployed married women or married women living in poverty cannot take independent decisions about sex, and cannot oppose sex without a condom even if they desire to practice safe sex. Most married women in this study are housewives and this resulted in them being in subordinate positions and losing sexual autonomy and independent sexual decision-making power. Some married men were the breadwinners and they used verbal threats to force their wives to submit to their sexual demands. Sex for many unemployed married women was not consensual but occurred on men's terms because women lacked economic independence.

The second sub-question was aimed at identifying factors that affect condom negotiation and condom use by married and cohabiting men and women between the ages of 26 and 60 years. Male power is indicated in this study as affecting married and cohabiting women. This study revealed that married and cohabiting men took decisions regarding sex and that these decisions were unopposed, and that they furthermore preferred to engage in unprotected sex. HIV prevention by using a condom was a difficult practice for married and cohabiting women. Some men used violence when they were opposed by their wives and this forced women to submit to male sexual choice. Women who were exposed to intimate partner violence sometimes engaged in non-consensual unsafe sex. Sometimes sex in marriage and in cohabitation was non-consensual.

The third sub-question was aimed at identifying cultural factors which influenced safe sex practices for married and cohabiting men and women between the ages of 26 and 60 years. Unequal gender roles in this study affected married and cohabiting participants. There are two cultural expectations which resulted in increased risk of HIV infection. Firstly,

men's strength encouraged them to engage in unhealthy sexual practices. Secondly, the maintenance of a 'good feminine image' such as respect and tolerance by married women resulted in women engaging in unprotected sex. Married women indicated that they want to protect themselves from HIV infection by their husbands, but protection fails because they have internalised this moral conduct such as being sexually ignorant by avoiding to propose safer sex by using a condom. Many married women often accept that men are promiscuous. There are married women who hold on to their expected duties which include the 'spousal duty' of caring for the sick spouse who had infected them and not leaving their husbands.

6.1. Limitations of this study

There were limitations to this study. I worked with secondary data which meant that I could not go to the research site to collect data and I could not probe the participants' comments where there was a lack of clarity. Using secondary data can be difficult with the theoretical approach (i.e. the theory of gender and power) as it was applied after the research had been conducted.

6.2. Strengths of this study

The use of triangulation was a strength in this study as the data provided through the interviews, focus groups, and the mixed focus groups (i.e. workshops) were rich and provided a thick description of the phenomenon under study in detail. The findings from the focus group discussions enabled the female participants to engage in detailed discussions to clarify their perceptions and their shared needs, to express their vulnerability to HIV and STI infection and to share a vision or a need to use condoms. The mixed focus group discussions provided a platform for a dialogue between male and female participants about issues related to HIV infection. Female participants were able to articulate their agency about sexual safety. Focus groups, mixed focus group discussions, and the use of the in-depth interviews provided a rich source of data to address the research questions. The HIV risk factors were explained in detail and this helped the researcher to be familiar with the culture of the research participants, thereby improving the credibility of this study. The research participants provided the background information of the research problem and they were able to talk about the effects of the cultural beliefs on HIV prevention. Future researchers will be able to understand the background information of the problem and this might enhance the transferability of this study. Triangulation also provided an open space and a confidential space for the research participants to articulate their differences about the risk of HIV

infection. This allowed the researcher to understand the ideas and problems faced by both male and female participants. This decreased the potential bias of the researcher and improved the confirmability of this study.

I worked with data that was in two languages, namely *isiXhosa* and English. This was advantageous when it came to interpreting and understanding the participants' responses. It contributed to the credibility of the analysis and interpretation of the data. The theoretical approach I used in the current study is the theory of gender and power, and it was beneficial in this study during data analysis to clarify issues relating to culture that affect HIV prevention. This study has added information to the growing body of literature on HIV prevention.

6.3. Recommendations

6.3.1. Personal level. The researcher recommends that more behavioural change strategies should be focussed on parents and caregivers about boys and girls during the early childhood stage to influence more gender equitable beliefs. This will help to challenge pervasive current individual and cultural beliefs, and to eliminate power imbalances between men and women.

More awareness workshops should be hosted at community level for parents and elders of the community about the negative effects of the gender inequity, and this should be related to the effects of inequity on HIV prevention. Norms that consider women as inferior should be discussed in order to reach solutions and to improve the social status of women. The injustices such as gender-based violence that are influenced by the social norms should be challenged at this level. The importance of HIV prevention strategies such as HIV communication and equal decision-making about condom use should be discussed and more men should be engaged in this discussion.

6.3.2. Policy recommendations. Government should issue policies and laws that will enforce and strengthen women's rights and strict laws should be implemented to sanction people who violate women's rights. Awareness days about gender equality should be set in the calendar to raise awareness about gender-based violence and HIV infection.

6.3.3. Recommendations for future research. The researcher believes that her present study focused on men and women's perception about the risk of HIV infection they face in marriage and in cohabiting relationships. Future research should be conducted to focus on the perception of men and women about power inequality and on gender norms and their effect on HIV prevention.

6.3.4. Intervention recommendations. HIV prevention interventions should focus more on marriage and on cohabiting relationships. HIV prevention programmes should be contextualised within the socio-cultural context and with the assistance of the traditional leaders and the community members. The negative impact of gender norms should be analysed and men should be engaged in these discussions in an attempt to bring more insight about its harmful effects on HIV prevention. Married and cohabiting partners should be encouraged to know their HIV status before relationships commence. More awareness programmes should be conducted to encourage men and women to negotiate condom use before marriage or cohabitation relationships start. Men should be involved in gender equity policy-making so that they can practically influence change in the way of relating in marriage and cohabiting relationships. Gender equity should be included in the school syllabus from the primary school level and to help young girls to develop self-efficacy to challenge gender inequalities and to negotiate safe sex practice successfully. Women's economic empowerment should be strengthened especially in rural areas to encourage economic independence among women. More projects employing women should be funded to uplift the economic status of women.

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Appendix 1A

Letter to the Chief for Permission to Conduct Research (*isiXhosa Version*)

8 December 2011

Nkosi XXXXXXXXX othandekayo,

Ndike ndasebenza e-Ematyholweni ndisenza iinkqubo zophando ezininzi ukusukela ngo 1990. Ngo 2000-2003 senza uphando ngentsholongwane nesifo sikagawulayo,, ulutsha, ezobudlelwane kunye nempilo ekwabelaneni ngesondo. Ndingathanda ukuba sidibane, ukuzo cela imvume yakho yokuba siqhubeke noluphando e-Ematyholweni kuleminyaka embalwa elandelayo. Ingqwalasela yoluphando kukubona ukuba iimpendulo malungelana nesifo sikagawulayo sezatshintsha na e-Ematyholweni. Oluphando lizakujonga ulwazi labantu ngentsholongwane nesifo sikagaqulayo, iingcinga zabantu ngesisifo kunye nokuba bapendula/bayibona kanjani lemeko. Iqela labantu abasebenza koluphando basuka e Yunivesithi yaKwaZulu-Natal, eMgungundlovu (Pietermaritzburg), kunye nabasebenzi, nabafundi abasukae Yunivesithi yaseFort Hare. Oluphando luquka, udliwano-ndlebe kunye nengxoxiswano nolutsha, abazali, amabandla, inkokheli zesintu, iingcibi, abanyangi/izangoma kunye nabasebenzi base kliniki. Oluphando luzoquka/bandakanya iimfundiso/imihlangano apho ulwazi oluqokelelwe kudliwano-ndlebe nakwiingxoxiswano, lizokwandlalwa khona. Lenkqubo yoluphando yenzelwe ukuba abahlali base Ematyholweni babe nesabelo ekuqondeni nasekucalucaleni olulwazi. Kungezeka ukuba ngenxa yokuba sixoxisana sisonke kulenkqubo yophando kunye nakwi ncukacha, utshintsho lungavela emhlanganweni.

Singathanda ukuqhuba oluphando kwiilali ezimbalwa zaseEmatyholweni. Kodwa ngenxa yokuba ixesha esinalo lufutshane, asizukwazi ukuba sisebenze kuzo zonke iilali. Uqokelelo-lwazi loluphando luzokuqala ngonyaka ka 2012 futhi lungaqhubeka kude kuyophela unyaka ka 2013. Iindliwano-ndlebe kunye nengxoxiswano zizoshicilelwa ukwenzela ukuba abaphandi babambe ngononophelo oko abantu abakuthethileyo, bakutolikele kwisingesi. Inkqubo yemfundiso/yomhlangano izoshicilelwa kusetyenziswa i-video camera, kushicilelwe nyanisekileyo oko abantu abakuxoxileyo. Olulwazi luzokubhalwa phantsi lusuka/lusukela kushicilelo lwe-video. Onke amagama abantu abazobe behlomla/bethatha ingxaxheba

kudliwano-dlebe nakwi ngxoxiswano azogcinwa efihlakele azokwaziwa liqela lophando kuphela. Wonke umntu ezoba ehlomla uzonikwa inombolo ukuze izimvo zabo zihlale zifihlakele. Ezi nkcukacha ziqokelelwe kule nkqubo yophando zisosetyenziswa ukubhala amanqaku azokwaziswa/bhengezwa kwi nkonfa ukwenzela ukuba abantu bafunde kumava oluphando. Abanye babafundi nabafundisi-ntsapho abaqhuba oluphando bazokusebenzisa lenkqubo yophando ukufezekisa/ukugqibezela izifundo zabo. Ndingathanda ukuphendula yonke imibuzo mayelana noluphando.

Ozithobileyo,

Dr. Mary van der Riet

Senior Lecturer, School of Psychology

Appendix 1B

Letter to the Chief for Permission to Conduct Research (English Version)

8 December 2011

Dear Nkosi XXXXXXXXXX,

I have worked in *Ematyholweni* with various research projects since 1990. In 2000-2003 we conducted research about HIV/AIDS, youth, relationships and sexual health. I would like to consult with you, and seek your permission to continue the research in *Ematyholweni*, over the next few years. The focus of the research would be on seeing how responses to HIV and AIDS have changed in *Ematyholweni*. It would look at what people know about HIV and AIDS, what they think about it and how they are responding to it. The team of people working on the project are from the University of KwaZulu-Natal, in Pietermaritzburg, and also staff and students from Fort Hare University. The research would involve interviews and focus groups with young people, parents, church groups, traditional leaders, traditional educators, traditional healers, and the clinic staff. It would also involve workshops at which information collected in interviews and focus groups will be presented and discussed. The process of the research project is meant to include the residents of *Ematyholweni* in understanding and analyzing this information. It might happen that because we are all discussing the research process and the information together, changes will come out of the workshop process.

We would like to work in a few villages in *Ematyholweni*. Unfortunately because of time constraints it will not be possible to work in all of the villages. The project data collection would start in 2012, and might continue until the end of 2013. The interviews and focus groups will be recorded so that the researchers can accurately capture what it is that people have said, and translate it into English. The workshop process will be filmed using a video camera, also to accurately record what people discuss. This information will then be transcribed (or written down) from the video recording. The names of all of the people who participate in the interviews and focus groups will be kept confidential and known only by the research team. Each participant will be given a code number so that their views will remain private. The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the

experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

I will be happy to answer any questions that you have about the project.

Yours sincerely,

Dr Mary van der Riet

Senior Lecturer

School of Psychology

Appendix 2A

Interview Questions 18+ Parents and Married People (*isiXhosa Version*)

Process:

Introduction of the research process

Sign consent documents

Obtain permission for audio-recording

Complete demographic information sheet

RELATIONSHIPS

1. Lingakani ixesha seleutshatile?
2. Bendicela undichazele kancinci ukuba nadibana kanjani nomyeni wakho/nonkosikazi wakho?
3. Unabo na abantwana?
 - a. Mingaphi iminyaka yabo?
4. Uyathetha na nabo ngokuthandana nentlobano zesini?
 - a. Waqala nini ukuthetha nabo ngezizinto?
 - b. Bendicela undixelele kancinci ukuba uthini kubo?
 - c. Uyathetha na nabo ngeengozi zentlobano zesini?
 - i. Uthetha ngeziziphi iintlobo zenengozi?
 - ii. Yintoni abanokuyenza bona ngezizingozi?
 - d. Ukuba awuthethi nabo, kutheni ungathethi nabo?
5. Wena wake wanaye Umntu othandana naye?

HEALTH RISKS

6. Njengabantu abatshatile, niyaxoxa na ngengozi zeentlobano zesisni?
 - a. Ukuba kunjalo, zeziphi iingozi enizixoxayo?
 - b. Ngubani owavusa lombandela wezizingozi?
 - c. Kwathiwani kulengxoxo?
 - d. Khona uthsintsho owalibona ngenxayalengxoxo phakathi kwenu?
7. Xa ucinga, kubalulekile ukuba kuthethwe ngokulalana okukhuselekile emthsatweni?
 - a. Xa ucinga, kubalulekile ukuba nizikhusele xanilala emthsatweni wenu?
8. Wakewaxoxa nomkakho/nomyeni wakho ngezifo ezigqithiselwa ngokulala?

- a. Bendicela undichazele kancinci ngalengxoxo?
 - b. Ukuba akunjalo, kutheni?
9. Uyaxoxa ngokukhuleka ngentlobano zesini nomyeni/nomkakho?

CONDOM USE

10. Niyazisebenzisa na iicondom emtshatweni wenu?
- a. Ukuba kunjalo Bendicela undixelel ukuba wazisebenzisa nini, kutheni?
 - b. Niyisebenzisa njalo na icondom?
 - c. Ukuba akunjalonga, kungoba kutheni?
 - d. Uziva kanjani xakufuneka uyofumana icondom? Ngoba?
 - e. Uyfumanaphi icondom, zikhona ingxaki ojamelana nazo xaufuna icondom?
- Bendicela uchaze
11. Zikhona na ezinye iindlela zokuzikusela ungayisebenzisanga icondom? Ndicela undichazele
12. Uyakwazi na ukumcela umyeni wakho/umkakho ukuba manisebenzise icondom ukhululekile?
- a. Uye athini xausenza esisicelo?
 - b. Ungaziva kanjani ukuba umkakho/umnyeni wakho angakucela ukuba nisebenzise icondom?
13. Uyayiphatha na wena icondom? Ngoba?
- a. Ucinga ntoni ngabafazi abaphatha iicondom?
 - b. Ucinga ntoni ngendoda ehamba iphethe icondom?
14. Nathetha na ngokusebenzisa icondom? Bendicela undichazele ukuba kwenzeka ntoni?
15. Ukugqibela kwakho ukulala nomntu wakho, nayisebenzisa na icondom?

HIV QUESTIONS

16. Bendicela undixelele kancinci ngolwazi onalo ngentsholongwane ka gawulayo?
- Please note I do not want to know your status, you do not have to tell me anything about whether you are positive or negative. Andifuni kwazi ukuba upositive na
17. Ukhona umntu owake wathetha naye nge AIDS
- a. Bendicea undichazele
 - b. Ukuba akekho, kutheni engekho?
18. Kikhona na into oralela ukuyazi ngesisifo?
19. Kikhona na Umntu apha e Ematsholweni omaziyo ukuba upositive?

- a. Wazikanjani ukuba upositive lomntu?
- 20. Ukuba Umntu uneHIV okanye iAIDS, kufanele na abazise abanye abantu? Ngoba?
 - a. Ukhona na Umntu omaziyo oHIV positive?
 - b. Baphathwa kanjani abantu abanentsholongwane apha eEmatyholweni?
 - c. Kufuneka itshintshe na lento?

TESTING

- 21. Loluphi ulwazi onalo ngokuhlolwa kwentsholongwane kagawulayo?
 - a. Ucinga ntoni ngayo, yinto entle okanye ayintlanga? Ngoba?
- 22. isimo sakho seHIV uyasazi na? ndicela ungandixeleli ukuba sithini
- 23. Umyeni wakho, umkakho wamhlola na intsholongwane ngaphambilokuba nitshate?
- 24. Wena wake wayihlolelwa iHIV?
 - a. Ukuba kunjalo
 - i. Kwakutheni uzeuye
 - ii. Wawuziva kanjani ngelixeshauyohlolwa?
 - iii. Wahlolwa phi
 - iv. Kwakunjani?
 - v. Selekewaphinda, kangaphi?
 - vi. Ungaphinda futhi uyohlolwa? Ngoba?
 - b. Ukuba zange uphinde, kutheni?
 - i. yintoni ekunofuneka itshintshe ukuze uphinde?
- 25. Ukuba unaye umfazi/inkosikazi, uyasazi na isimo seHIV sakhe?
 - a. ukuba uyasazi, usazi kanjani?
 - b. Ukuba awusazi, kutheni ungasazi?
 - i. Uyafuna na ukusazi?
- 26. Nakenaxoxan nomkakho/nomyeni wakho ngokuyohlolwa?

TREATMENT

- 27. Iyatritwa na iHIV?
 - a. Ukuba kunjalo, kanjani?
 - b. Ukuba akunjalonga, kanjani?
 - c. Ukuba uneHIV uyitrita kanjani?
 - d. Ungayaphi eEmatyholweni xaufuna itritment
- 28. Uyazazi iARVs?

29. Ungazithatha na xakunesidingo sokuba uzithathe? ngoba?

- a. Ungayozithatha phi?
- b. Yintoni enokunqanda ukuba ungazithathi?

GENERAL

30. Yintoni enokwenziwa ngeHIV eEmatyholweni?

31. Yintoni onokuyenza ngeHIV wena apha eEmatyholweni?

Appendix 2B

Interview Questions 18+ Parents and Married People (English Version)

Process:

Introduction of the research process

Sign consent documents

Obtain permission for audio-recording

Complete demographic information sheet

RELATIONSHIPS

1. How long have you been married?
2. Tell me a bit about how you met your husband/wife?
3. Do you have children?
 - a. What are their ages?
4. Do you talk to your children about sex?
 - a. If yes, at what age did you/do you talk to them? Can you tell me briefly what you say?
 - b. Do you talk to them about the risks in sex?
 - i. What kinds of risks?
 - ii. What can they do about these risks
 - c. If no, why do you not talk to them?
5. Have you been in a relationship before?

HEALTH RISKS

6. As married people, have you discussed the risks of sex? Why/why not?
 - a. If yes, what risks have you discussed Who raised the question of the risks?
 - b. What was said in the discussion?
 - c. Did anything change because of the discussion?
7. Do you think it is important to worry about safe sex in your marriage? Why/why not
 - a. Do you think it is important to practice safe sex in your marriage? Why/why not?
8. Have you discussed with your wife/husband how to prevent getting a sexually transmitted infection?

- a. Please tell me briefly about that discussion (why did it come up? What was the worry/concern? Who raised it?) If no, why have you not discussed this?
9. Can you discuss sex freely with your partner? Why, why not?

CONDOM USE

10. Have you ever used a condom in your marriage?
 - a. If yes, can you explain when and why? Do you always use a condom? If no, why not?
 - b. How do you feel about getting a condom? Why? Where would you get a condom? Are there problems with getting condoms? Elaborate
11. Are there other ways of practicing safe sex without using a condom? Please explain.
12. Can you freely suggest using a condom to your husband/wife? Why/why not?
 - a. What would his/her reaction be if you suggested using a condom? How would you feel if your husband/wife suggested using a condom?
13. Do you carry a condom with you? Why/why not?
 - a. What do you think about a woman carrying a condom around with her What do you think about a man carrying a condom around with him
14. The last time you had sex, did you and your husband/wife talk about condom use? Can you tell me what happened?
15. The last time you had sex did you use a condom? Can you tell me what happened?

HIV QUESTIONS

16. Can you tell me briefly what you know about HIV/AIDS (Please note I do not want to know your status, you do not have to tell me anything about whether you are positive or negative).
17. Have you ever talked to anyone about HIV and AIDS?
 - a. If yes, please elaborate?
 - b. If no, why not? What stops you from talking about HIV?
18. Is there anything you would like to know about HIV? Do you know anyone in Ematyholweni who is HIV positive? (please do NOT tell me their names)
 - a. How do you know they are HIV positive?
19. If someone is HIV positive should they tell others? Why/why not
 - a. Do you know of anyone who is HIV positive? How are people who are HIV positive treated in the *Ematyholweni*? Should this change? Why/why not

TESTING

20. What do you know about HIV testing
- a. What do you think about it? Is it a good/bad thing? Why?
21. Do you know your own HIV status? (PLEASE DON'T TELL ME YOUR STATUS, ONLY WHETHER OR NOT YOU KNOW YOUR STATUS) Did you check your husband/wife's HIV status before getting married? Why/why not? Have you ever been for an HIV test?
- a. If yes,
 - i. Why did you go?
 - ii. What did you feel about going for the test? Where did you go?
 - iii. What was it like? Have you been again? How often do you go?
 - iv. Would you go again? Why/why not?
 - b. If no, why have you not gone?
 - i. What would need to change for you to go? (under what conditions would you go for a test?)
22. If you have a husband/wife do you know his or her HIV status?
- a. If yes, how did you find out? (did your partner tell you? Did you go for a test?)
If no, why not?
 - i. Do you want to know?
23. Have you discussed going for a test with your husband/wife? Why/ Why not?

TREATMENT

24. Can HIV be treated?
- a. If yes, how?
 - b. If no, why not?
 - c. If you had HIV, how would you treat it?
 - d. Where would you go in Ematylholweni for treatment?
25. What do you know about anti-retroviral treatment (ARV's)? (What is it, what does it look like, how does it work?)
26. Would you take ARV's if you needed to? Why/why not?
- a. If yes, where would you go to get them?
 - b. If no, what would stop you from taking them?

GENERAL

27. What can be done about HIV and AIDS in the Ematyholweni? What can YOU personally do about HIV and AIDS in Ematyholweni?

Appendix 3A

Interview Questions 18+: Unmarried people who have been in/or are in relationships (isiXhosa Version)

Process:

Introduction of the research process

Sign consent documents

Obtain permission for audio-recording

Complete demographic information sheet

RELATIONSHIPS

- If not in a relationship currently, questions are about what happened in the last relationship
 1. Wakhe wathandana na?
 2. Ukhona Umntu othandana naye ngoku?
 - a. Ngumntu walapha?
 3. Bendicela undixelele kancinci ngobubudlelwane benu?
 - a. Iqale kanjani?
 - b. Uneminyaka emingaphi?
 - c. Lixesha elingakanani?

HEALTH RISKS

- If not in a relationship currently, questions are about what happened in the last relationship
 4. Kobubudlelwane benu niyaxoxa na ngentlobano zesini neengozi ezichaphazela impilo?
 - a. Zeziphi iingozi enizixoxayo?
 - b. Zivuswa ngubani ezingxoxo?
 - c. Nathetha ngantoni kulengxoxo?
 - d. Likhona utshintsho olubonayo ngenxayale ngxoxo?
 5. Kubalulekile na ukuba nizikhathaze ngengozi ezichaphazela impilo kwiintlobano zesini?
 - a. Kubalulekile na ukuba nizikhusele xa nisenza isini?

6. Nakenaxoxa na nomntu wakho ngokuzikhusela kwizifo ezigqithiswa ngesini?
 - a. Ndicela undichazele ngalongxoxo?
7. Ukuba zange nixoxe, kutheni?
 - a. Ungaxoxa ngokuzikhusela ngokukhululekileyo na nomntu wakho? Ngoba?

CONDOM USE

8. Nake nayisebenzisa na icondom?
 - a. Bendicela undichazele?
 - b. Uyisebenzisa njalo na icondom?
 - c. Ukuba hayi, ngoba?
 - d. Uziva kanjani xakufuneka ufemene icondom? Ngoba?
 - e. Ungayifumanaphi icondom xa uyifuna? Zikhona ingxaki ojongana nazo xaufuna icondom?
9. Zikhona na ezinye iindlela zokuzikhusela ungayisebenzisanga icondom xa uzolala nomntu?
10. ngokukhululeka na umntu wakho ukuba makasebenzise icondom?
 - a. Angathini?
 - b. Ungathini wena ukuba umntu wakho angatsho lonto kuwe?
11. Icondom uyayiphatha na kuwe? Ngoba?
 - a. Ucinga ntoni ngabafazi/amantombazane aphatha iicondom?
 - b. Ucinga ntoni ngamadoda/amakhwenkwe aphatha iicondom?
12. Ukugqibela kwakho ukulala nomntu wakho, naxoxa na ngokusebenzisa icondom? Bendicela undichazele ukuba kwenzeka ntoni?
13. Ukugqibela kwakho ukulala nomntu wakho, nayisebenzisa na icondom?

HIV QUESTIONS

14. Bendicela undixelele ulwazi onalo ngeHIV/AIDS?

(Please note I do not want to know your status, you do not have to tell me anything about whether you are positive or negative). Ungandixeleli isimo sakho sentsholongwane, andifuni ukusazi sona
15. Ukhona Umntu owakhe waxoxa naye nge ntsholongwane iHIV ne AIDS?
 - a. Ukuba Ukhona, Bendicela undichazele?
 - b. Ukuba akekho, kutheni, yintoni ekwenza ungathethi ngayo?
16. Ikhona na into ofuna ukuyazi ngeHIV/AIDS?
17. Ukhona na Umntu omaziyo apha eEmatsholweni onentsholongwane kagawulayo?

- a. Wazikanjani ukuba unentsholongwane kagawulayo?
- 18. Kuyafuneka na ukuba axelele abanye abantu na Umntu oneHIV ukuba unayo? Ngoba?
 - a. Unaye na wena umntu omaziyo oneHIV?
 - b. Baphathwa kanjani abantu abane HIV aphe e*Ematyholweni*?
 - c. Kufanele kutshintshe na oku? Ngoba?

TESTING

- 19. Wazintoni ngokuhlolwa kweHIV?
 - a. Yinto entle okanye embi?
- 20. (PLEASE DON'T TELL ME YOUR STATUS, ONLY WHETHER OR NOT YOU KNOW YOUR STATUS) isimo sakho seHIV uyasazi na?
- 21. Umntu wakho wasihlola na isimo sakhe sentsholongwane ngaphambi kokuba nithandane?
- 22. Wakewahlolwa na
 - a. If yes,
 - i. Wasiwa yintoni?
 - ii. Waziva kanjani xa siyakuhlola?
 - iii. Wayaphi?
 - iv. Kwakunjani?
 - v. Wakhe waphinda futhi? Kangaphi?
 - vi. Uyozeuphinde na? Ngoba?
 - b. Ukuba hayi, kutheni ungaphindanga waya khona?
 - i. yintoni ekunofuneka itshintshe ukuze uphinde?
- 23. Ukuba unaye umntu onaye, Ingaba uyasazi na isimo sakhe se HIV?
 - a. Ukuba uyasazi, wasazi kanjani?
 - b. Ukuba akunjalo kutheni?
 - i. Uyafuna na ukusazi?
- 24. Nakenaxoxa na nomkakho/nomyeni wakho ngokuyohlolwa?

TREATMENT

- 25. Iyatritwa na iHIV?
 - a. Ukuba iyatritwa itritwa kanjani?
 - b. Ukuba akunjalonga, kanjani?
 - c. Ukuba uneHIV uyitrita kanjani?

- d. Ungayaphi eEmatyholweni xaufuna itritment?
- 26. Zisebenza kanjani? ziyintoni?
- 27. Ungazithatha na iARVs xakukho isidingo sokuba uzithathe? ngoba?
 - a. Ungazithatha phi?
 - b. intoni enokunqanda ukuba ungazithathi?

GENERAL

- 28. Yintoni enokwenziwa ngeHIV eEmatyholweni?
- 29. Yintoni onokuyenza ngeHIV wena apha eEmatyholweni?

Appendix 3B

Interview Questions 18+: Unmarried people who have been in/or are in relationships (English Version)

Process:

Introduction of the research process

Sign consent documents

Obtain permission for audio-recording

Complete demographic information sheet

RELATIONSHIPS

- If not in a relationship currently, questions are about what happened in the last relationship
 1. Have you been in a relationship before?
 2. Are you in a relationship at the moment? Are you married?
 - a. Is it with someone in the area?
 3. Tell me a bit about the relationship
 - a. How did it start?
 - b. How old is your partner?
 - c. How long has it been going on for? How long have you been married?

HEALTH RISKS

- If not in a relationship currently, questions are about what happened in the last relationship
 4. In your relationship, have you discussed the risks of sex? Why/ why not?
 - a. If yes, what risks have you discussed?
 - b. Who raised the question of the risks?
 - c. What was said in the discussion? Did anything change because of the discussion?
 5. Do you think it is important to worry about safe sex in your kind of relationship?
Why/why not?
 - a. Do you think it is important to practice safe sex in your kind of relationship?
Why/why not?

6. Have you discussed with your partner how to prevent getting a sexually transmitted infection?
 - a. Please tell me briefly about that discussion (why did it come up? What was the worry/concern? Who raised it?)
7. If no, why have you not discussed this?
8. Can you discuss sex freely with your partner? Why, why not?

CONDOM USE

9. Have you ever used a condom in your relationship?
 - a. If yes, can you explain when and why? Do you always use a condom?
 - b. If no, why not?
 - c. How do you feel about getting a condom? Why?
 - d. Where would you get a condom? Are there problems with getting condoms?
Elaborate
10. Are there other ways of practicing safe sex without using a condom? Please explain
11. Can you freely suggest using a condom to your partner? Why/why not?
 - a. What would his/her reaction be if you suggested using a condom
 - b. How would you feel if your partner suggested using a condom
12. Do you carry a condom with you? Why/why not?
 - a. What do you think about a woman carrying a condom around with her what do you think about a man carrying a condom around with him?
13. The last time you had sex, did you and your partner talk about condom use? Can you tell me what happened?
14. The last time you had sex did you use a condom? Can you tell me what happened?

HIV QUESTIONS

15. Can you tell me briefly what you know about HIV/AIDS? (Please note I do not want to know your status, you do not have to tell me anything about whether you are positive or negative).
16. Have you ever talked to anyone about HIV and AIDS?
 - a. If yes, please elaborate? If no, why not? What stops you from talking about HIV?
17. Is there anything you would like to know about HIV? Do you know anyone in *Ematyholweni* who is HIV positive? (please do NOT tell me their names)

- a. How do you know they are HIV positive?
- 18.If someone is HIV positive should they tell others? Why/why not?
 - a. Do you know of anyone who is HIV positive? How are people who are HIV positive treated in Ematyholweni? Should this change? Why/why not?

TESTING

- 19.What do you know about HIV testing?
 - a. What do you think about it? Is it a good/bad thing? Why?
- 20.Do you know your own HIV status? (PLEASE DON'T TELL ME YOUR STATUS, ONLY WHETHER OR NOT YOU KNOW YOUR STATUS)
- 21.Did you check your partner's HIV status before getting into the relationship? Why/why not?
- 22.Have you ever been for an HIV test?
 - a. If yes,
 - i. Why did you go? What did you feel about going for the test ? Where did you go? What was it like? Have you been again? How often do you go?
 - ii. Would you go again? Why/why not?
 - b. If no, why have you not gone?
 - i. What would need to change for you to go? (Under what conditions would you go for a test?)
- 23.If you have a partner do you know his or her HIV status?
 - a. If yes, how did you find out? (Did your partner tell you? Did you go for a test?)
 - b. If no, why not?
 - i. Do you want to know?
- 24.Have you discussed going for a test with your partner? Why/ Why not?

TREATMENT

- 25.Can HIV be treated?
 - a. If yes, how?
 - b. If no, why not?
 - c. If you had HIV, how would you treat it?
 - d. Where would you go in *Ematyholweni* for treatment?

26. What do you know about anti-retroviral treatment (ARV's)? (What is it, what does it look like, how does it work?)
27. Would you take ARV's if you needed to? Why/why not?
- a. If yes, where would you go to get them? If no, what would stop you from taking them?

GENERAL

28. What can be done about HIV and AIDS in the *Ematjholweni*? What can YOU personally do about
29. HIV and AIDS in *Ematjholweni*

Appendix 4A

Information about the research project (*IsiXhosa Version*)

Mhlaliwase *Ematyholweni* othandekayo.

Nisenokwazi ukuba ndakhendenda inkqubo yophando apha *Ematyholweni* ngaphambili. Olophando lwalumayelana nentsholongwane kunye nesifo sikagawulayo, nokuba nina ningabahlali base *Ematyholweni* nicingantoni na ngentsholongwane kunye nesifo sikagawulayo, nokuba nisithatha njani/Nicinga ntoni ngesisifo. Kolophando, sathetha nolutsha, kunyenabazali mayelana nobudlelwane, ukwabelana ngesondo/iintlobano zesini, kunye nobungozi bentsholongwane nesifo sikagawulayo. Kulenqubo yophando, sifuna ukunibonisa ezinye izinto esazifumana kolwaphando futhi sive ukuba nina nicingantoni ngezozinto. Singathanda ukubamba imihlangano, embalwa apho sizothetha ngezinto esazifumana kolwaphando. Seyadlula iminyaka, emva kwalanqubo yophando, mhlawumbi nezinto sezatshintsha *Ematyholweni*. Singathanda ukuqhuba olunye udliwano-ndlebe kunye neengxoxiswano, neenkokheli zesintu, abantu abatsha, abazali, iingcibi, abanyangi, abezenkolo kunye nabasebenzi base kliniki. Kwezodliwano-ndlebe kunye neengxoxiswano, singathanda ukuba nithethe ngobudlelwane, indlela ezikhuselekileyo zesondo, nokubanicingantonina ngentsholongwane nesifo sikagawulayo. Udliwano-ndlebe kunye neengxoxiswano zizokushicilelwa ukwenzela ukuba abaphandi babambenyanisekileyo oko abantu abakutshileyo/abakuthethileyo futhi bakutolikele kwisingesi ukwenzela ukuba bonke abaphandi bakuqonde/bakuve. Emvakokuba sesilubambile udliwano-ndlebe kunye neengxoxiswano, sizothatha iingcombolo/inkcazelo/inkcukacha sizenze imfihlo. Wonke umntu othatha umnxeba uzokunikwa inombolo ukwenzela ukuba igamalakhe lingasetyenziswa. Oku kuchaza ukuba angekwazi ukuba ubani utshontoni kwindliwano-ndlebe neengxoxiswano.

Ezingcombolo/olulwazi, luzokusetyenziswa nakweminye imihlangano, apho sizoxoxa ukuba abantu bathini nangezobudlelwane, kunye nezempilongesondo. Ngalendlela, sithemba ukubona ukuba abantu base *Ematyholweni* bazivakanjani ngalengxaki yentsholongwane nesifo sikagawulayo nokuba bacinga ukubayintoni enokwenziwa ngaso. Le nkqubo yemihlangano izoshicilelwa kusetyenziswa I video camera ukwenzela ukuba kushicilelwe nyanisekileyo oko abantu abakuxoxayo. Ezingcombolo zizokubhalwa phantsi zithathwa kwi

video recorder. UMary Van der Riet, enimaziyo, owakewenza uphando apha *Ematyholweni* ngaphambili, nguye umkhokheli wale nkqubo. Ngoku sengumhlali waKwaZulu-Natal futhi ungumfundisi- ntsapho eyunivesithi yakwaZulu-Natal. Kuzobekukho abafundi abambalwa kunye nabafundisi-ntsapho abaphuma eyunivesithi yakwaZulu-Natal, nabanye abasuka eyunivesithi yase Fort Hare, abancedisa ngophando. Abanye baba bantu bangenza iindleliwano-ndlebe kunye neengxoxiswano, futhi bazobe bekhona kwiimfundiso/kwimihlangano. Sizokubazisa bonke ababantu kuni. Ezinkcukacha ziqokelelwe kulenkqubo yophando zizosetyenziswa ukubhala amanqaku azokwaziswa/bhengezwa kwinkonfa ukwenzela ukuba abantu bafunde kumava oluphando. Abanye babafundi nabafundisi-ntsapho abaqhuba oluphando bazokusebenzisa lenkqubo yophando ukufezekisa/ukugqibezela izifundozabo. Singathanda ukwenza le nkqubo yophando kwiilali ezimbalwa. Kuzokuxhomekeka ukubasinxesha elingakanini na. Uqokelelo lwencukacha luzoqala ngo 2012 futhi kungenzeka ukuba luqhubeka ukufikela ekupheleni kuka 2013. Singathanda ukunimema ukuba nithathe inxaxheba kulenkqubo yophando. Ukubanabantu abaninzi abathatha inxaxheba kuzonceda ukuba kubekho imibono emininzi eyahlukeneyo ngalengxaki. Ukuba unemibuzo, sicela uqhagamshelane no Mary kulenomboro xxx xxxxxxx. Ukhuseleko lwabathathinxaxheba kulenkqubo yophando beselijongwe lavunywa yikomiti yezophando yaseYunivesithi yaKwaZulu Natal. Kodwa ukuba unemibuzo ungathintana no Ms Carol Mitchell kulenombolo xxx xxxxxxx okanye Ms Carol Mitchell, School of Psychology, Private Bag X01 Scottsville, 3201 okanye email: xxxxxxx@xxxxxxx.

Ozithobileyo

Dr Mary van der Riet

Senior Lecturer, Psychology, UKZN

Appendix 4B

Information about the research project (English Version)

Dear resident of *Ematyholweni*

You may know that I have conducted research here in *Ematyholweni* before. That research was about HIV and AIDS and what you as residents of *Ematyholweni* think about HIV and AIDS, and how you respond to HIV and AIDS. In that research we spoke to youth and parents about relationships, about sex, about sexual health, and about the risk of HIV and AIDS.

In this research project we want to show you some of the things that we found in that research, and find out what you think about those findings. We would like to hold a few workshops where we talk about the findings of that research. It has been a number of years since that research project, and perhaps things have changed in *Ematyholweni*. We would therefore also like to conduct more interviews, and focus group discussions with traditional leaders, young people, parents, traditional educators, traditional healers, church members and the clinic staff. In these interviews and focus group discussions we would ask you to talk about relationships, sexual health practices, and what you think about HIV and AIDS.

The interviews and focus groups will be recorded so that the researchers can accurately capture what it is that people have said, and translate it into English, so that all of the researchers can understand it. Once we have held the interviews and focus groups, we will take the information, and make it confidential. Each person who participates will be given a code number, so that his or her name is not used. This means that you will not be able to know who said what in the interviews or focus groups. This information will then be used in another workshop, where we can all discuss what people say about relationships, and sexual health. In this way, we hope to see what people in *Ematyholweni* feel about the problem of HIV and AIDS, and what you feel can be done about it. The workshop process will be filmed using a video camera, also to accurately record what people discuss. This information will then be transcribed (or written down) from the video recording.

Mary van der Riet, who you know has conducted research in *Ematyholweni* before, is the leader of the project. She is now living in KwaZulu-Natal and is a lecturer at the University of KwaZulu-Natal. There will also be a few students and lecturers from the University of KwaZulu-Natal, and some from the University of Fort Hare, who are helping her with the research. Some of these people may do the interviews and focus groups, and they will be at the workshops. We will introduce all of these people to you. The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

We would like to do this research process in a few villages in *Ematyholweni*. It depends on how much time we have. The project data collection would start in 2012, and might continue until the end of 2013. We would like to invite you to participate in the research project. The more people who participate, the more different views we have of the problem. If you have any questions, then please let us know. You can talk to us directly, or you can call Mary on XXX XXXXXXXX. This project has been approved by the Ethics committee of the University of KwaZulu-Natal. If you have any questions about the ethical issues in this project, then you can contact Ms Carol Mitchell on XXX XXXXXXXX, or Ms Carol Mitchell, School of Psychology, University of KwaZulu-Natal, Private Bag X01, Scottsville, Pietermaritzburg, 3201 or email XXXX@XXXXXXXXXX.

Yours faithfully

Dr Mary van der Riet

Senior Lecturer, Psychology, UKZN

Appendix 5A

Consent form for individual interviews (*isiXhosa* Version)

Kulodliwanondlebe sizokubuza imibuzo edibene nokuthandana, intlobano zesini kunye negozi ezidibene neHIV ne AIDS. Sufuna ukwazi kuwe ukuba ucinga ntoni ngezizinto. Udliwanondlebe uzokuthatha iyure enye

Emvakodliwanondlebe nengxoxiswano sizokuthatha iincukacha sizenze imfimfihlo. Uzokinikwa inomoro eyiyikodi ukwenzela ukuba igama lakho lingaveli, kwaye nezinto ozithethile.

Sizosebenzisa ezoncukacha zalodliwanondlebe kwingxoxo nabanye abantu. Sifuna ukuxoxisana ngezinto ezifana nokuthandana nezinto ezichaphazela impilo. Sifuna ukuva ngani ukuba Nicinga ntoni ngezizinto nokuba Nicinga ukuba kungathiwani ngazo

Iincukacha ezivela kwezingxoxo esizozibambha zizokusetyenziswa ekubhaleni amaphepha azobhengezwa kwinkomfi naphambi kwabanye abantu nabaphandi. Abanye abafundi bazosebenzisa lenqubo ukuze bafumane iidigri zabo.

Ukuthabatha inxeba kwakho kulenqubo kuzonceda ukuba sifumane amava ahlukeneg alengxaki yentsholongwane kagawulayo nesifo sikagawulayo.

Ukuba uyavuma ukuba lilunga lalenqubo, kodwa mhawumbe uphinde uzivekungathi awusafuni ukuthabatha inxeba kulenqubo uvumelekile ukuba uziroxise kulenqubo. Ukuba sisinqweno sakho ukuziroxisa sizokuyekisa.

Ukuba unemibuzo ngalenqubo ungatsalela umnxeba ku Dumisa Sofika kule nomboro xxx xxx xxxx okanye u Mary kule nomboro xxx xxx xxxx
Mary van der Riet & Dumisa Sofika

Imvume yokuthabatha inxeba kudliwanondlebe

- Ndiyavuma ukuthabatha inxeba kulenqubo
- Ndilifumene ithuba lokufunda ucwecwe lencukacha zalenqubo futhi ndiyaziqonda

- Ndiyichazelwe intloso yalenqubo. Ndinalo ulwazi lokuba kudingwa ntoni kum futhi ndiyazibophelela ukwenza ezozinto ezicelwe kum.
- Ndiyaqonda ukuba akunyanzelekanga ukuba ndithabathe inxeba kulenqubo, futhi ndingayeka nanini apho ndithande ukuyeka khona.
- Ndiyaqonda ukuba zonke incikacha eziqokelelwe kulenqubo zizogcinakala ziyimfihle
- Ndiyaqonda futhi ukuba ndizogcinakala ndikhuselekile kulenqubo
- Ndiyaqonda ukuba incukacha ezivela kwezingxoxo esizozibambha zizokusetyenziswa ekubhaleni amaphepha azobhengezwa kwinkomfi naphambi kwabanye abantu nabaphandi. Abanye abafundi bazosebenzisa lenqubo ukuze bafumane iidigri zabo. Ndiyaqonda ukuba kuyyonke lenqubo, igama lam lizohlala likhuselekile.
- Ndinazo iincukacha zabaphandi kulenqubo kwaye ndingabatsalela umnxeba nanini ukuze ndicaciselwe ngemibuzo endinayo nangezinto endingaziqondi.

Isityikityo

Date

Appendix 5B

Consent form for individual interviews (English Version)

Dear Participant

In this interview we will ask you some questions about relationships, sexual health and the risk of HIV and AIDS. We would like to find out what your experience is, and what you think about these things.

The interview will take about 1 hour.

Once we have held the interviews and focus groups, we will take the information, and make it confidential. This means that you will be given a code number, so that your name is not used and not linked to the statements that you make. We would then like to use the information we get from all of the interviews and also from the focus groups in workshops with more people. Then we can all discuss what people say about relationships, and sexual health. In this way, we hope to see what people in the *Ematyholweni* feel about the problem of HIV and AIDS, and what you feel can be done about it.

The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

If you participate in the interview, your views will help us to have a different perspective on the problem of HIV and AIDS. If you agree to participate, but then at a later time you feel that you would like to withdraw from the interview, or not participate any more, that is fine. You can say so and we will stop the interview.

If you have any questions, then please let us know. You can talk to us directly, or you can call Dumisa Sofika on xxx xxxxxxxx or Mary on xxx xxxxxxxx

Yours faithfully, Mary van der Riet and Dumisa Sofika

CONSENT TO BE INTERVIEWED

- I agree to participate in this research

- I have had an opportunity to read and understand the information sheet given to me.
- The purpose of the study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate in this study.
- I understand that my participation is voluntary and I know that I may withdraw from the study at any point, without negative consequences.
- I understand that the information collected in this interview will be kept safe
- I understand that my identity will remain confidential
- I understand that the information collected may be used for student studies, for future research, for conference presentations and for journal articles. I understand that in all of this my name will not be mentioned and that my participation in this research will be completely confidential. I understand that no identifying information about me will be published.
- I have the contact details of the researcher should I have any more questions about the research.

Signature of Participant

Date

Appendix 6A

Consent form for audio recording (*isiXhosa* version)

Ucwecwe lemvume yokugopha udliwanondlebe

Ukuze sikuqonde kakuhle, futhi sikukhumbule okuxoxwe apha sifuna ukuteypa ingxoxo yethu nge rekoda. Sizophinde siyimamele lengxoxo kulerekoda sibhale phantsi iincukacha zalengxoxo. Ingxoxo izotolikwa ukuze iviwe ngabanye abaphandi. Ukuqhiba kwethu ukwenza lonto sizokuyicima yonke into ekwi rekoda.

Siyakuthembisa ukuba igama lakho alizukavela kwi rekoda nakwizinto ezibhaliwe ephepheni. Igama lakho sizokuligcina liyimfihlo ngokulinika inomboro.

Uyavuma na ukuba siyiqophe ingxoxo?

Ukuba uyavuma, ndicela ubhale igama lakho apha

_____ umhla ka_____

Appendix 6B

Consent form for audio recording (English version)

Consent to audio record interview/focus group

In order to be able to understand clearly what you have said in this interview/focus group, and to remember it, we would like to record the discussion on this small digital recorder. We will then listen to the recording and write it down (transcribe it). It will also be translated into English. After we have written the information down, we will then delete the recording on the digital recorder.

We assure you that your name will not be linked to the recording or the written information from the recording. We will give you a code name, using numbers, for example Participant 1_Interview 3. Or Focus group 3.

Do you agree that we can record the discussion? If yes, then please sign here

_____ Date _____

Appendix 7A

Focus Group Questions for 18+ (Young people, unmarried, married, parents, older people; *isiXhosa* version)

Process:

Introduction of the research using info sheet

Signing of consent documents

Obtain permission for audio-recording

GET demographic information on SHEET

QUESTIONS ABOUT RELATIONSHIPS

- Use YOUNG If under 30 and unmarried
- Use MARRIED if married participants

1. Ingabe abantu abatsha/abatshatileyo bayajola na apha eEmatyholweni?

- a. Ibizwa ngantoni/kuthiwa yintoni xa besenza lonto? (kuyathandanwa?/yintoni ukujola?)
- b. Ingabe kukhona iindlela ezihlukile zokuthandana? (zeziphi ezikhoyo iindlela zokuthandana apha eEmatyholweni?)
 - i. Bendicela nindichazele ngezizindlela?
 - ii. Ngawaphi amagama asetyenziswayo xakuthethwa ngoluhlobo lokuthandana/abathandana ngalo?

1. Abantu abajolayo zeziphi izinto abazenzayo?

2. Ulutsha luwafumana nini amathuba okudibana? Bendicela nindiphe umzekelo

3. Kuyenzeka na ukuba abantu bathandane nabantu abadala/abancinci kakhulu kunabo?

- a. Nina ngokubona kwenu nithini ngalento? (niyibona iyingxaki, ingeyiyo ingxaki?)

4. Abantu banyanzelekile ukuba babenabantu ngamanyane amaxesha? Ngoba?

5. Ulutsha/abantu abatshatileyo abathandanayo bayazenza intlobano zesini

- a. Bazenzelani intlobano zesini? Ngokubona kwenu, yintoni abafuna ukuyifumana kwintlobano zesini?
- b. Yintoni eyenza abanye abantu bakhethe ukungazenzi intlobano zesini?

RISKS IN SEX

6. Ingaba ikhona imiphumo emibi okanye iingozi ekubeni nentlobano zesini? Yeyiphi lemiphumo emibi?
 - a. Ingaba abantu xa bethandana bayaxoxa ngengozi eziphathelene nokuba neentlobano zesini ?
 - i. Ningandenzela imizekhelo yezingxoxo (Ngubani oyiqalayo lengxoxo, uye athini, kwenzekani emva koko ?)
 - ii. ngubani umntu ovusa umbandela wokuzikhusela kwingozi ezichaphazela impilo kwizithandani?
7. Bazikhusela kanjani abantu abenza iintlobano zesini kwezi ngozi?
 - a. Ukuba bayazikhusela, bazikhusela kanjani (cacisa)?
 - b. Ukuba abazikhuseli, yintoni eyenza ukuba bangazikhuseli?
 - c. Bayathetha na ngengozi nabantu babo?
 - d. Abantu abangomama notata bazikhathaza ngendlela efanayo ngizingozi?
 - e. Kungabe abantu abangomama no tata bathatha inxaxheba yokuzikhusela kwezingozi ngendlela efanayo?
8. Kungabe abantu abasebekunye ixesha elide bayazikhathaza na ngeengozi zentlobano zesini?
 - a. Xa nicinga, kufanele na bazikhathaze ngalonto?
 - b. Kuthetha ntoni xabezikhusela kwintlobano yesini abantu abasebekunye ixesha elide?
9. Bayazisebenzisa na iicondom abantu?
 - a. Ukuba abazisebenzisi, yintoni eyenza ukuba bangazisebenzisi?
 - b. ukuba ziyasetyenziswa iicondoms
 - i. Zisetyenziswa nini?
 - ii. Ngubani ekuba nguye ovusa indaba yecondoms xakuzolalwa? Kutheni ingulomntu?
 - iii. Bazifumana phi ezicondoms?
 - iv. Zeziphi iingxaki ezikhoyo ekufumaneni iicondoms?
10. Bayazisebenzisa na iicondoms abantu abasemtshatweni? Bazisebenzisela ntoni/kutheni bengazisebenzisi?
11. Abantu abasebetshate ixesha elide kufanele bazisebenzise na iicondoms?

12. Nicinga ntoni ngomtu ongumama/ngentombi ephatha iicondom kuyo?
13. Umntu ongutata ophatha icondom kuye nicinga ntoni ngaye?
14. Umntu onaye umntu anaye kuyenzeka ukuba abe nabantu abaninzi ajola nabo?
Kwenziwa yintoni?
 - a. Kuyafana ko mama no tata?
15. Abantu abatshatile kuyenzeka ukuba babenaye abantu babebaninzi?
 - a. Kuyafana na ko mama no tata?
16. Bayathetha na abantu abangomama ngetlobano zesini? Kwenziwa yintoni? Bathetha nobani?
17. Amadoda ayathetha na ngentlobano zesini? Ngoba? Bathetha nobani?

Additional questions for PARENTS

18. Abazali bayathetha nabantwana babo ngentlobano zesini?
 - a. Bathetha nabo xasebe neminyaka emingaphi?
 - i. Bendicela nindixelele kancinci ukuba kuthethwa ngantoni?
 - b. Ukuba akunjalongo kwenziwa yintoni?

HIV QUESTIONS

19. Bendicela nindixelele kancinci ngolwazi eninalo ngeHIV/AIDS?
NB I do not want to know about your status so you do not need to tell me if you are positive or negative. Andifuni kukwazi ukuba umntu upositive okanye negative na
 - a. Yintoni iHIV/AIDS?
 - b. Ifumaneka kanjani iHIV/AIDS?
 - c. Uyabonakala na umntu oneHIV/AIDS? Ubonakala njani?
 - d. Xanicinga iyanyangeka iAIDS? Bendicela nindichazele.
 - e. Ukhona umntu owake wathetha naye ngeAIDS?
 - i. Kwakungubani lomntu?/ngubani umntu ongathetha naye ngeAIDS
 - ii. Nathetha ngantoni? Yintoni eningayixoxa nalomntu?
 - iii. Ukuba akheko umntu ongathetha naye kutheni kunjalo?
 - f. Loluphi ulwazi onothanda ukubanalo ngeHIV/AIDS?
20. Ukhona umntu omaziyo oneHIV/AIDS? Bakhona na abantu abaneHIV/AIDS apha eEmatjholweni?
 - a. Nazi kanjani ukuba bapositive?

- b. Uzivanjani xa uphambi kwalomntu?
 - c. Abantu abanengculaza baphathwa kanjani apha eEmatyholweni?
 - d. Xanicinga kufanele itshintshe lento? Ngoba?
21. Ukuba abantu bapositive, kukhona abantu ababaxelelayo? Ngoba?
- a. Kunyanzelekile na baxecele abanye abantu? Ngoba?
22. Abahlali balapha eEmatyholwenibayayixilongelwa na iHIV/AIDS?
- a. Bazixilongela ntoni?
 - b. Baxilongelwa phi?
 - c. Yintoni ebavimba ukuba bangayi kuyoxilongwa?
 - d. Yintoni ekunofuneka ukuba itshintshe ukuze abantu bazise ukuyoxilongwa?
23. Bayaxoxa na abantu abathandanayo ngokuzixilongela iHIV/AIDS?
- a. Ngoba?
 - b. Zeziphi izinto abazixoxayo ngokuxilongwa?
24. abantu abathandanayo bayacebisana ukuba mabasazi isimo seHIV/AIDS sabo?
- a. Ukuba ewe, ngoba?
 - b. Ukuba hayi, ngoba?
25. Ingaba amadoda nabafazi bayaya na ukuyoxilongelwa iHIV/AIDS?
26. Yeyiphi intlobo yetreatment ekhoyo eyenzelwe abantu abapositive ?
- a. Ithathwa phi le treatment?
 - b. zikhona na iipilisi ozaziyo, wazintoni ngazo (zinjani, zithathwa phi, ziyimalini?).
 - c. Isebenza kanjani/isetyenziswa kanjani?
 - d. Loluphi ulwazi eninalo nge ARVs?
 - e. Abantu bayazitya na iARVs xebefanele bazitye?
 - f. Bayenza kanjani, bayaphi?
 - g. Ukuba abazityi, banqandwa yintoni ukuba bangazityi?
 - h. Xanicinga kunyanzelekile ukuba bayifumane itreatment abantu abapositive

Iphelile imibuzo ebesifuna ukuyibuza kuni. Ikhona imibuzo enifuna ukuyibuza na kuthi ngezizinto ebesizixoxa? Enkosi ngothatha umnxeba kule focus group.

Appendix 7B

Focus Group Questions for 18+ (Young people, unmarried, married, parents, older people; English version)

Process:

Introduction of the research using info sheet

Signing of consent documents

Obtain permission for audio-recording

GET demographic information on SHEET

QUESTIONS ABOUT RELATIONSHIPS

- Use YOUNG If under 30 and unmarried
 - Use MARRIED if married participants
2. Do (young/married) people in *Ematyholweni* have boyfriends or girlfriends
 - a. What is it called when they do this? (is it dating?/what is dating) Are there different ways of having a boyfriend or a girlfriend? (What kinds of relationships do young/married people in the *Ematyholweni* engage in
 - i. Can you describe them?
 - ii. What words do they use to describe these relationships?
 3. What kinds of activity do boyfriends and girlfriends engage in? When do young people in *Ematyholweni* have a chance to meet? Can you give examples? Do people sometimes have relationships with people who are much older/younger than them?
 - a. What do you think about this? (Is this a problem? Why/why not?)
 4. Are people sometimes forced to have relationships? Why? Do young/married people in relationships have sex?
 - a. Why do they have sex? What do you think they want from sex? If they don't have sex, why not?

RISKS IN SEX

5. Are there risks in having sex? What are these risks?
 - a. Do people in relationships discuss the risks in sex?

- i. Can you give me an example of this discussion? (who started it, what was said, what happened after the discussion?) Who usually raises the issue of health risks in relationships?
- 6. How do people having sex protect themselves from these risks?
 - a. If they protect themselves, can you explain how they do it ? If they don't do anything, why not? Do they discuss the risks with their partners? Do men and women worry about for these risks in the same way? Do men and women take responsibility for these risks in the same way?
- 7. Do you think people in long term relationships are concerned with the risks in sex?
 - a. Do you think they should be concerned?
 - b. What does safe sex mean for a couple who has been going out for a long time?
- 8. Do people use condoms?
 - a. If they don't use condoms, why not? If they use condoms:
 - i. When do condoms get used? Who raises the issue of using a condom? Why this person?
 - ii. Where do they get them from? What are problems with getting condoms?
- 9. Do people in marriages use condoms? Why/Why not? Should married couples, or couples in long-term relationships use condoms? Why? Why not? What do you think if a woman carries a condom with her?
- 10. What do you think if a man carries a condom with him? Do people in relationships have more than one partner? Why
 - a. Is this the same for men and women? Why?
- 11. Do married people have more than one partner? Why?
 - a. Is this the same for men and women? Why?
- 12. Do women talk about sex? Why, why not? Who do they talk to?
- 13. Do men talk about sex? Why, why not? Who do they talk to?

14. Additional questions for PARENTS

- c. Do parents talk to their children about sex? If yes, at what age does this happen?
 - i. Can you tell me briefly what is said?
- d. If no, why not?

15. HIV QUESTIONS

- a. Can you tell me briefly what you know about HIV/AIDS? *NB I do not want to know about your status so you do not need to tell me if you are positive or*

negative. What is HIV/AIDS? How do people get HIV/AIDS Can you tell if someone has HIV/AIDS? How? Do you think AIDS is curable? Please elaborate. Have you ever talked to anyone about HIV/AIDS?

iv. If yes, whom did you talk to?

v. What did you talk about?

vi. If no, why not? What prevents you from talking about HIV and AIDS?

b. What would you like to know about HIV and AIDS?

16. Do you know of anyone who has HIV/AIDS? /Are there HIV positive people in *Ematyholweni*?

e. How do you know that they are HIV positive?

f. How do you feel around that person?

g. How are people who are HIV positive treated in the *Ematyholweni*?

h. Do you think this should change? Why/why not?

17. If people are HIV positive, do they tell others? Why/why not?

b. Should they tell others? Why/why not?

18. Do people in the *Ematyholweni* get themselves tested for HIV?

e. If yes, why do they go?

f. If yes, where do they go?

g. If no, what prevents people from going?

h. What would need to change for people to go for testing?

19. Do people in relationships have discussions about HIV testing?

c. If no why not?

d. If yes, what kinds of things are discussed?

20. Do people in relationships encourage each other to know their HIV status?

c. If yes, why?

d. If no, why not?

21. Do men and women go for testing?

22. What types of treatments are there for HIV positive people?

i. Where do they go for that treatment?

j. If there is medication, what do you know about it? (where do you get it, what does it look like, how much does it cost?)

- k.** If there is medication, how does it work?
- l.** What do you know about anti-retroviral treatment (ARV's).
- m.** Do people take ARVs' if they need to?
- n.** How do they do this? Where do they go?
- o.** If they don't take them, what stops them from taking them?
- p.** Do you think that people should get treatment for HIV?

That is all the questions we wanted to ask you. Do you have any questions about the research process, or about what we have been discussing? Thank you for participating in this focus group.

Appendix 8A

Consent form for Focus Groups (*isiXhosa* Version)

Ucwecwe lemvume yengxoxiswano

Kulengxoxiswano sifuna ukukubuza imibuzo ngobudlelwane bokuthandana, iintlobano zesini nentsholongwane nesifo sikagawulayo. Sifuna ukuva ukuba ucinga ntoni ngezizinto.

Ingxoxiswano izothatha ixesha elingangeyure ezimbini.

Emvakodliwanondlebe nengxoxiswano sizokuthatha iincukacha sizenze imfimfihlo.

Uzokinikwa inomoro eyiyikodi ukwenzela ukuba igama lakho lingaveli, kwaye nezinto ozithethile. Njengane lunga leliqela labantu abakulengxoxiswano, sizokucela ukuba usayine incwadi eyisibophelelo semfihlo. Ukusayina kwakho eliphepha kuthetha ukuba awuzukuzithetha izinto esizixoxe kweligumbi, okanye ezithethwe ngabanye abantu ngaphandle kwalamagumbi, kwabanye abantu. Kodwa, asinasiqiniseko sokuba abantu abazukuzithetha ezizinto ngaphandle kwalamagumbi. Sicela nilumke ukuba igenzeka lento. Mhlawumbi endaweni yokuba uchaze izinto ngawe, ungenza umzekelo ngezinto ezenziwa ngabanye abantu. Emvakoko, sifuna ukusebenzisa ezincukacha eziqokelelwe kulenqubo kwezinye ingxoxiswano, phambi kwabanye abantu. Kwezongxoxiswano kulapho esingathetha khona, sive ukuba abanye abantu bacinga ntoni ngezizinto, nokuba bacinga ntoni ngeHIV neAIDS nokuba ingathiwani.

Iincukacha eziqokelelwe kulenqubo zizosetyenziswa ngabafundi ukubhala amaphepa wabo we research, nokufumana iidigri zabo, futhi zizokubhengezwa kwiikomfa phambi kwabanye abantu ukubazisa ngalenqubo yoluphando. Ukuba uthabatha umnxeba kulengxoxiswano esiyibambayo, amava wakho azosinceda ukuba sibenemibono emininzi ngalinxaki yeHIV ne AIDS. Ukuba uyavuma ukuba lilunga lalenqubo, kodwa mlawumbe emvakwexesha uphinde uzive ufuna ukuroxisa inxeba yakho kulomba, kulungile. Kufuneka ukhululeke usixelele, sizokuroxisa.

Ukuba unemibuzo ofuna ukuyibuza ungatsalela umnxeba kuMary kule nomboro xxx xxx
xxxx

Mary van der Riet

Ucwecwe lwemvume yokuthabatha inxeba kwingxoxiswano

- Ndiyavuma ukuthabatha inxeba kulenqubo
- Ndilifumene ithuba lokufunda ucwecwe lencukacha zalenqubo futhi ndiyaziqonda
- Ndiyichazelwe intloso yalenqubo. Ndinalo ulwazi lokuba kudingwa ntoni kum futhi ndiyazibophelela ukwenza ezozinto ezicelwe kum.
- Ndiyaqonda ukuba akunyanzelekanga ukuba ndithabathe inxeba kulenqubo, futhi ndingayeka nanini apho ndithande ukuyeka khona.
- Ndiyaqonda ukuba zonke incikacha eziqokelelwe kulenqubo zizogcinakala ziyimfihle
- Ndiyaqonda futhi ukuba ndizogcinakala ndikhuselekile kulenqubo
- Ndiyaqonda ukuba incukacha ezivela kwezingxoxo esizozibambha zizokusetyenziswa ekubhaleni amaphepha azobhengezwa kwinkomfi naphambi kwabanye abantu nabaphandi. Abanye abafundi bazosebenzisa lenqubo ukuze bafumane iidigri zabo. Ndiyaqonda ukuba kuyyonke lenqubo, igama lam lizohlala likhuselekile.
- Ndinazo iincukacha zabaphandi kulenqubo kwaye ndingabatsalela umnxeba nanini ukuze ndicaciselwe ngemibuzo endinayo nangezinto endingaziqondi.

Signature of Participant

Date

Appendix 8B

Consent form for Focus Groups (English Version)

Dear Participant

In this focus group we will ask you some questions about relationships, sexual health and the risk of HIV and AIDS. We would like to find out what your experience is, and what you think about these things. The focus group discussion will take about 90 minutes.

Once we have held the focus groups, we will take the information, and make it confidential. This means that all of you who participate in the discussion will be given a code number, so that your name is not used and not linked to the statements that you make.

As a member of this group we will also ask you to sign a confidentiality pledge. This means that you will not tell other people outside of this discussion in this room what was said by other group participants. This will help all of you to feel that you can speak more freely. We would then like to use the information we get from all of the focus groups and also the interviews in workshops with more people. Then we can all discuss what people say about relationships, and sexual health. In this way, we hope to see what people in the *Ematylholweni* feel about the problem of HIV and AIDS, and what you feel can be done about it. The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

If you participate in the focus group, your views will help us to have a different perspective on the problem of HIV and AIDS. If you agree to participate, but then later you feel that you would like to withdraw from the interview, or not participate any more, that is fine. You can say so and we will stop the interview.

If you have any questions, then please let us know. You can talk to us directly, or you can call Mary on xxx xxx xxxx

Yours faithfully
Mary van der Riet

CONSENT TO BE INTERVIEWED

- I agree to participate in this research
- I have had an opportunity to read and understand the information sheet given to me.
- The purpose of the study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate in this study.
- I understand that my participation is voluntary and I know that I may withdraw from the study at any point, without negative consequences.
- I understand that the information collected in this interview will be kept safe
- I understand that my identity will remain confidential
- I understand that the information collected may be used for student studies, for future research, for conference presentations and for journal articles. I understand that in all of this my name will not be mentioned and that my participation in this research will be completely confidential. I understand that no identifying information about me will be published.
- I have the contact details of the researcher should I have any more questions about the research.

Signature of Participant

Date

Appendix 9A

Confidentiality pledge (*isiXhosa* version)

Isibophelelo sokugcina ingxoxiswano iyimfihlo

Njengelunga labantu abakulengxoxiswano, ndiyathembisa ukuba andizukithetha ngaphandle kwalamagumbi izinto esizixoxe namhlanje. Andizukuzithetha namntu izinto esizixoxe apha. Izinto ezithethwe ngabanye abantu zizohlala ziyimfihlo.

Igama _____ Date: _____

Appendix 9B

Confidentiality pledge (English version)

Confidentiality pledge

As a member of this Focus Group, I promise not to repeat what was discussed in this focus group with any person outside of the focus group. This means that I will not tell anyone what was said in this group. By doing this I am promising to keep the comments made by the other focus group members confidential.

Signed _____ Date: _____

Appendix 10

Verbatim Transcription Conversion

	(.)	Just noticeable pause
	(.3), (2.6)	Examples of timed pauses
	↑word, ↓word	Onset of noticeable pitch rise or fall (<i>can be difficult to use reliably</i>)
A:	word [word	Square brackets aligned across adjacent lines denote the start of overlapping talk. Some transcribers also use "]" brackets to show where the overlap stops
B:	[word	
	.hh, hh	in-breath (note the preceding fullstop) and out-breath respectively.
	wo(h)rd	(h) is a try at showing that the word has "laughter" bubbling within it
	wor-	A dash shows a sharp cut-off
	wo:rd	Colons show that the speaker has stretched the preceding sound.
	(words)	A guess at what might have been said if unclear
	()	Unclear talk. Some transcribers like to represent each syllable of unclear talk with a dash
A:	word=	The equals sign shows that there is no discernible pause between two speakers' turns or, if put between two sounds within a single speaker's turn, shows that they run together
B:	=word	
	<u>word</u> , WORD	Underlined sounds are louder, capitals louder

	still
°word°	material between "degree signs" is quiet
>word word<	Inwards arrows show faster speech, outward
<word word>	slower
→	Analyst's signal of a significant line
((sniff))	Transcriber's effort at representing something hard, or impossible, to write phonetically

Figure 1. Verbatim transcription conversion. Retrieved from:

<http://homepages.lboro.ac/~ssca1/notation.htm>

Appendix 11

Ethical approval for the broader study



UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Research Office, Govan Mbeki Centre
Westville Campus
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DURBAN, 4000
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Ximbap@ukzn.ac.za

8 November 2011

Dr M van der Riet (24839)
School of Psychology

Dear Dr van der Riet

PROTOCOL REFERENCE NUMBER: HSS/0695/011
PROJECT TITLE: Activity theory and behavior change

FULL APPROVAL NOTIFICATION – COMMITTEE REVIEWED PROTOCOL

This letter serves to notify you that your application in connection with the above was reviewed by the Humanities & Social Sciences Research Ethics Committee, has now been granted **Full Approval** following your responses to queries previously raised:

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. **PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.**

Best wishes for the successful completion of your research protocol

Yours faithfully

A handwritten signature in black ink, appearing to read 'S. Collings', written over a dotted line.

.....
Professor Steven Collings (Chair)
Humanities & Social Sciences Research Ethics Committee

Appendix 12

Ethical approval for the current study



03 September 2015

Mrs NV Qabaka-Dyabooi 215060689
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Mrs Qabaka-Dyabooi

Protocol reference number: HSS/1229/015M linked to HSS/0695/011
Project title: Management of HIV risk by men and women in long-term relationships in a rural area Eastern Cape setting.

Expedited Approval – Class Application

In response to your application dated 27 August 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)

/px

cc Supervisor: Dr Mary van der Riet
cc Academic Leader Research: Professor J Steyn
cc School Administrator: Ms N Ndlovu

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

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Website: www.ukzn.ac.za



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Appendix 13

Extract Codes

Table 3

Extract Codes: 1 - 30

Extract Number	Extract Code
1	20120612-35-45-F-DZ-Z-E
2	20120618_35-45_FG_F_DS_OJ_R(1)
3	20120519_CL1_E_TS_DS(2)
4	20130526_CL_Parents
5	20130526_CL_Parents
6	20120613_35-45_F_OJ_S
7	20120519_CL1_E_TS_DS(2)
8	20120616_46-60_FG_F_OJ_DZ_Z
9	20120616_46-60_FG_F_OJ_DZ_Z
10	20120519_CL1_E_TS_DS(2)
11	20120511_46-60_M_DS_S
12	20120613_35-45_F_OJ_S
13	20120519_CL1_E_TS_DS(2)
14	20120825_CL2_MvdR_DS_M(1)
15	20120617_35-45_F_OJ_S_(E)
16	20120616_46-60_FG_F_OJ_DZ_Z_(1)
17	20120616_46-60_FG_F_OJ_DZ_Z_(1)
18	20120526_CL_Parents
19	20120519_CL1_E_TS_DS(2)
20	20120509_26-34_M_DS_R
21	20120620_35-45_FG_M_DZ_Y(1)
22	20120825_CL2_MvdR_DS_M(1)
23	20120618_35-34_FG_F_DS_OJ_R
24	20120510_26-34_FG_F_DS_T
25	20120616_46-60_FG_F_OJ_DZ_Z
26	20120618_35-45_FG_F_DS_OJ_R
27	20120620_35-45_FG_M_DZ_Y(1)
28	20120618_35-45_FG_F_DS_OJ_R
29	20120618_35-45_FG_F_DS_OJ_R
30	20120617_46-60_FG_M_DZ_S

Table 4

Extract Codes: 31 - 41

Extract Number	Extract Code
31	20120510_26-34_FG_F_DS_T
32	20120617_46-60_FG_M_DZ_S
33	20120519_CL1_E_TS_DS(2)
34	20120519_CL1_E_TS_DS(2)
35	20120620_35-45_FG_M_DZ_Y(1)
36	20120519_CL1_E_TS_DS(2)
37	20120620_35-45_FG_M_DZ_Y(1)
38	20120825_CL2_MvdR_DS_M(1)
39	20120616_46-60_FG_F_OJ_DZ_Z
40	20120618_35-45_FG_F_DS_OJ_R
41	20120519_CL1_E_TS_DS(2)