THE USE OF LOVE MEDICINE AMONG BLACK AFRICANS IN KWAZULU-NATAL AND RISKS OF HIV TRANSMISSION TO BOTH MEN AND WOMEN IN SOUTH AFRICA

A Thesis Submitted To the School Of Nursing in the Faculty of Health Sciences: University Of KwaZulu-Natal
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Date: April 2010

DECLARATION

I declare that the the use of love medicine among black Africans in KwaZulu-Natal and risks of HIV transmission to both men and women in South Africa. All resources and materials that I have used or quoted have been indicated and acknowledged by means of references.

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Signature ..... April 2010

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Signature ..... April 2010

DEDICATION

This dissertation is dedicated to my niece, Ntombifuthi Mhlongo, who got sick and died while I was in the USA studying. It is also dedicated to all the other young women who have died and left their children to be taken care of by other people. We can reduce morbidity and mortality, especially of young people, by paying more attention to the socio-cultural issues faced by women such as their desperation to have partners or husbands and their need to meet socio - economic factors.

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  He gave me strength and courage to conduct the study and even in the unsafe areas He protected me.

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physical and psychological effect on the recipient. These effects are viewed as some form of power by the users, which is used to manipulate the recipient. The names given to the products tend to be associated with the motive behind their use. It was clear that the use of love medicine requires fluid exchange and, therefore, condoms are purposely avoided during the practice in order to ensure the transfer of the product used. The users are influenced by a broader social context and motivated by various issues in their sexual relationships.

In conclusion the findings showed that love medicine as a practice has the potential of contributing to the HIV infection. The users live in past where they have experienced or observed what it like not to have male partner; in the present where they compete for partners and the fear of the future without a partner becomes more scary. Because of cultural constructed sexuality women do all they possible can to enhance sexual pleasure in order to have and keep their partners. Use of love medicine becomes an immediate constant solution. The loss of a partner to another woman is perceived as being more urgent than the need to prevent HIV or AIDS. Therefore there is need to visit the love medicine in the era of HIV pandemic.

Campbell (1996) raised a concern regarding health promotion approaches and HIV and AIDS prevention programmes in that they focus on individual change. The programmes are based on the assumption that individuals will respond to the messages given to them and take action because they have personal control over their health. Campbell's concern is that these programmes are not relevant to all women because not all women have full control in the issues of sexuality and negotiating safe sex. According to Campbell (1996), health promotion programmes should take socio-cultural context and gender power into consideration in order to be effective. In line with this view, Mane and Aggleton (2001) stated that HIV-related risks are often highest in situations where women are socialized to please men and defer to male authority.

Ten years ago Kun (1998) and Meyer-Weitz, Reddy, Weijts, Van den Borne and Kok, (1998) called for qualitative studies to assess and demonstrate whether existing cultural practices increased the HIV risk among both men and women. Nshindano and Maharaj (2008) have also expressed the need to examine cultural norms and practices as the number of HIV infections increases. According to Raj, Amaro and Reed (2001), far more research is needed in this area as they maintain that certain cultural practices do indeed increase the risk of HIV. I, the researcher in this particular study, in agreement with the above, argue that research should include common cultural practices that might cause resistance to certain behavioural changes promoted by HIV and AIDS prevention programmes. One such practice that is culturally imbedded among the African people is the use of substances which will be referred to as love

medicine in this particular study. Cocks and Mollar (2002) reported that there is a paucity of research in this area.

The term 'love medicine' is a direct translation from the Zulu *umuthi wentando,* or more simply, just *intando.* I am aware that *intando* is a specific Zulu term, but in this study its English translation is used to encompass all the medicines that are used to enhance love or sexual relationships. These include a variety of substances used for numerous reasons such as attracting a new partner, being loved or being more appreciated by a partner. Brown and Brown (2000) and Baleta (1998) refer to it as medicine that is used to enhance the sexual relationship of partners. A variety of love medicines are available ranging from the traditional to the more modern packaged kind (Scorgie, Kunene, Smit, Manzini, Chersich , and Preston-Whyte, 2009). Although both men and women purchase these medicines with the aim of improving sexual relationships or enhancing sexual pleasure, the practice generally seems to be more common among women. The use of love medicine has been practiced in South Africa for a long time, but there is little reference to it in literature, compared to other sexual issues.

Most black South Africans are aware of the different medicines, practices and procedures available and they know where to go or whom to contact to obtain the 'right' medicine. There are traditional healers or herbalists known as 'helping women' who provide love medicine for a fee and can be found along the streets and buildings of the city centres. In addition to this, there are shops where a variety of modern substances can be bought to enhance sexual pleasure and strengthen relationships. Love medicine is such a part of everyday conversation

that if a male partner appears to be taking good care of his female partner and sharing her tasks, a statement like "she gave him love medicine (*wamdlisa intando*)" is commonly passed. According to Scorgie (2003), present-day sexual practices and norms in South Africa have been powerfully shaped by the relatively long history of mission Christianity, which laid the 'templates' for a conservative moral discourse on all matters of sexual practices. This is aggravated by the vast socio-cultural dislocations brought by industrialisation and migrant labour in the first half of the twentieth century (Scorgie 2003). Christianity prompted profound shifts in indigenous practices and institutions intended to regulate courtship and sexuality (Delius and Glaser, 2002 and Scorgie, 2003). As a result, people do not talk openly about sexual relationships or traditional practices because these are not acceptable in the existing form of Christianity. It is for this reason that the use of love medicine, a cultural sexual practice, remains an 'open secret' meaning that although people know it happens, they prefer not to talk about it.

Meyer-Weitz, Reddy, Weijts, Van den Borne, and Kok, (1998), explained that complex socio-cultural factors shape sexual relationships, marriage and morality related behaviours. Culture, gender and ethnicity are factors that can shape an individual's life (Paplau, et al, 1999). These factors converge to shape a social structure, which in turn influences the behaviour and psychological functioning of an individual or community and thus shapes their experiences. Paplau, Venigas, Taylor, (1999) further explained that it is out of these experiences that people keep on creating meanings which direct their behaviour and practices there-after. Paplau, et al

(1999) suggested that these be investigated if they pose challenges to behaviour change interventions.

According to Kavanaugh and Kennedy (1992), culture is a collection of beliefs, values and behaviours shared by a group of people. It based on prevalent constraints within a group that are common to that community. It is consensual, neither inert nor inalterable (Schrefer, 1994), but continuously renovated to meet the transformations that are happening in the environment (Escobar, 1995). Every social grouping in the world has specific norms, traditions, cultural practices and beliefs that make them different from other groups. Some of these practices, according to Square (2009), are beneficial to all members, while others are harmful to a specific group. They are taught within families and passed from one generation to another and consolidated within generations by peers or other community members (Runganga, Pitts and McMaster, 1992; Braunstein and van de Wijgert, 2003). Superficial aspects of culture may change easily, but basic cultural values and beliefs change slowly and may provide the bases for strong resistance to change. LeCompte and Schensul (1999:49), therefore, describe culture as an abstract constructed as people interact with each other and participate in shared activities. Cultural practices thus need to be considered when conceptualizing, designing, organizing and developing HIV education programmes and assessing their outcomes (Raj, et al, 2001).

According to Parker, Herdt and Carballo, (1991), culture shapes an individual's sexuality. Sexuality, the quality or state of being sexual and identification with behaviours and norms distinct to a particular biological sex, is a socially and culturally constructed phenomenon

(Young 1994). According to Alksnis, Desmarais and Wood, (1996) and Simon and Gagnon (1987), sexual scripts are developed which guide and regulate sexual practices. Simon and Gagnon described these as types of schemes that are influential in assisting individuals to organize their ideas of appropriate sexual experiences. These influence an individual's behaviour, evaluate their sexual "beingness' and impact on how they are perceived and evaluated by others (Simon and Gagnon 1987). It is because of these scripts that people are able to differentiate between what they consider to be good or bad sexual behaviour. These authors explained the script as being used as a measure of central tendency (Simon and Gagnon 1986)

A person's sexuality is also connected to and expressed through other cultural domains such as initiation rites, religion or marriage. These domains outline the objects of sexual desire, appropriate relationships between the individuals involved in a relationship and the time and place for sexual activity, without taking into consideration the feelings of the people involved (Hynie, Lydon, Cote and Wiener, 1998). This results in the acceptance of cultural practices in spite of not everyone being happy about them. It is therefore important to establish and understand the underlying particularities of a sexual culture because sexual behaviour is not just a biological or physiological phenomenon, but rather an experience that is culturally informed and shaped by social processes (Parker, Herdt and Carballo, 1991).

Gender categories function within cultures to establish classification of privileges and entitlement where men often seem to have the advantage (Acker 1991). In most societies,

gender determines how and what men and women are expected to know about sexual matters and how to behave as sexual beings. Women are often socialized to please men and defer to male authority while men are portrayed as the breadwinners, giving them more power and better status. The high cultural value placed on pleasing a partner may encourage women to take risks that could expose them to HIV infections. While status does have an influence on power, women, in their own way, still manage to control or manipulate their environment while negotiating and adjusting to changing times.

Different ethnic groups have diverse concepts of gender roles. Even after all the efforts to improve gender equality in the traditional black communities in South Africa, men play a dominant role and women are expected to be submissive and unquestioning of their partners' behaviour. Women are expected to remain virgins until marriage while men's multiple sexual partnerships, on the other hand, are not only tolerated but sometimes even encouraged (Varga, 1997; Weiss; Whelan and Gupta, 2000; Wood and Jewkes, 2001). Polygamy and concubinage are also still accepted as normal cultural practices in some of the African traditions, even in modern life (Mokhobo, 1989; Preston-Whyte and Zondi, 1989). Some of these gender norms predispose both men and women to high risk sexual behaviour.

Social, economic, ethnic and political factors also have a great influence on an individual's behaviour. Lower economic power adds to women's vulnerability. In South Africa, in particular, discrimination, inequities, inequalities and violence are some of the legacies of the infamous South African apartheid regime of the past. This is most evident in black areas where

the majority of women are unemployed and poverty is at its highest level. As a result, women wishing to control their own sexual activities in order to reduce the risk of HIV, find that social and economic factors, including violence, place risk reduction out of their control (Rogers, 2000; Turshin, 1991).

According to Jackson (2000), socialization, individual and family morality, personal choice and decisions regarding risk-taking behaviour determine patterns of sexual behavior. Risky elements include among others, gender inequalities, power relations, socio-economic status, family structure and cultural values and norms as well as personal factors such as age, gender, class, education, socio economic status and culture (Gentry, Elifison and Sterk, 2005; Singer, Roger and Corcoran, 1987). These include the high value placed on the need to be loved or be part of a sexual relationship.

1.2 Rationale for the study

In spite of HIV awareness and the availability of free condoms in South Africa, the rate of HIV infection seems to be increasing, especially in KwaZulu-Natal. According to findings of the study conducted by Kunene, Scorgie, Manzini, Smit, Preston-Whyte, Beksinska,(2005), one of the reasons people use love medicine in its various forms was to please a partner in bed. Users wanted to be loved, appreciated or be economically cared for by their partners. This study highlighted the fact that unprotected vaginal sexual intercourse is considered the best conduit for love medicine in no matter what form it has been taken. This raised concerns about the potential risks to both men and women using such medicines. In the battle against the HIV and

AIDS pandemic, these research findings of Kunene *at al.* highlighted the need to explore the use of the substances which are referred to in this study as love medicine.

In the study conducted by Kunene *et al.* 2005, I was intrigued by the practices and procedures described by participants as they depicted various activities carried out in order to be loved, to enhance their sexual relationship and/or to please a partner. In some cases, certain practices were even performed to prevent male abuse. I came to realize that there was more to the issue of love medicine than vaginal practices. The other source of interest was to investigate further the practices influenced by gender issues embedded in the community in which I live. I was born in one of the districts where the study has been conducted, I worked in one of them for almost ten years, conduducted various research in all the four for almost five years.

A study has shown that about 200 animal species and about 550 species of plants are actively traded in KwaZulu-Natal alone for the mixing of different traditional medicines, including love medicine (Mander, Ntuli, Diederichs and Mavundla 2007). The fear that some of the species might face extinction has been a cause of concern for the government and those who are working with environment preservation (Mander, Ntuli, Diederichs and Mavundla 2007; Botha, Witkowiski and Shackleton 2004). None of these studies, however, have looked into the effects that these traditional medicines may have on human beings, especially those used as love medicine.

Most of the programmes aimed at reducing HIV concentrate on prostitution and casual sex. Hunter (2002), Kaufman and Stavrou (2002) and Le Clerc-Madlala (2001) have raised concerns that as well as prostitution, materialistic based sexual relationships are fuelling the spread of the HIV pandemic in South Africa. These include multiple relationships, interpreted as serial monogamy and concurrent relationships (Manhart, Aral, Holmes and Foxman 2002). The latter has been identified as the more risky in that the spread of sexually transmitted infection is more rapid (Kelly, Barowski, Flocke and Keen 2003). On the same note, there are some stable relationships that may also have implications in the spread of HIV as indicated by (Turshen 1991).

1.3 Problem statement

In spite of HIV awareness initiatives, targeted HIV and AIDS intervention programmes and also the availability of free condoms in the country, the rate of HIV infection seem to be on the increase, especially in KwaZulu-Natal. Suggestions were made a decade ago to investigate whether socio-cultural practices, especially those of gender, as well as traditional beliefs and practices, posed challenges in the form of resistance to the behaviour changes promoted by HIV prevention interventions (Kun 1998; Meyer-Weitz, et al. (1998). The work by Ortiz-Torres, Serrano-Garcia and Torres-Burgos (2000) revealed that one of the crucial challenges faced by researchers and interventionists in the HIV ands AIDS prevention field is how to promote change in cases where social norms and normative beliefs exist in specific cultural contexts where these norms and beliefs promote HIV and AIDS risk-related behaviours. Campbell (1996)

recommended research in a social context to establish how men differ from women in their perceptions of risk, interpretations of AIDS prevention information and determinants of risk factors. Parker, Easton and Klein (2001) recommended research that could move beyond the limited success of traditional behavioural interventions and explicitly attempt to achieve broader social and structural change. In line with these recommendations, Goal 3 of the Millennium Development Goals (MDGs) refers to the promotion of gender equality and empowerment of women as a response to HIV. King, Lifshay, Nakayiwa, Kantuntu, Lindkvist, Bunnell (2008) suggest that this may be achieved through interventions which are based on scientific evidence which has focused on understanding motivations, beliefs and perceptions with regard to HIV risk.

Most of the studies in South Africa have focused on traditional medicines in the treatment of physical disorders (Ngubane 1977). In the study conducted by Cocks and Moller in the Eastern Cape, about a third of the participants used traditional medicines to enhance their wellbeing. They used the medicines as a protection from evil spirits, for luck and for blood cleansing. Some of the participants provided evidence that these medicines could help in restoring lost love or bringing about good fortune with the opposite sex (Cocks and Dold, 2000). The use of love medicine in a sexual context was never the focus of the investigation (Cocks and Møller (2002).

Very little has been researched about medicines used in the name of love or in love relations yet this is a known phenomenon among the African community. Matters of motives, however,

for such practices and the social, cultural and historical meanings attributed to them by those who engage in them, have not been documented. Furthermore, there is limited literature, if any, on the possible health risks, especially that of HIV, associated with the use of love medicine. This particular research, therefore, is intended to explore the use of love medicine, taking into consideration the broader social context within which the use of love medicine is practiced. It will be approached from a gender perspective in order to establish how the use of love medicines may contribute to the risk of HIV transmission to both men and women.

1.4 Significance of the study

This study endeavours to bring together cultural practices, to view them in their social context and to attempt to understand them. It also endeavours to draw conclusions from the perceptions of the users, which is significant in this era of HIV. This is not only important for the community itself, but also for the health care workers, particularly the nurses, who are often not viewed as community members, but who are likely to be affected by the cultural practices of the community in which they work. Nurses are usually the primary contact for a community member seeking health care, but seldom, if ever, are the customs involving the use of love medicine discussed with them. This study endeavours to shed some light on the possible reasons why sexually transmitted infections, such as HIV, seem to be on the increase in spite of all the awareness campaigns. The study findings may also encourage the health care practitioners to take into consideration the social context of the community in which they work and where the awareness programmes are being implemented.

This study uses theories that are commonly used in other disciplines such as education and gender studies and can equally be applied to nursing. According to Munhall (2007), working alongside other disciplines enriches the understanding of nurses and broadens their possibilities by incorporating the many facets of being human. Therefore, while this study is done as a nursing dissertation, it aims to address other facets in the profession and could be included in nursing science literature to broaden the understanding of a community and its customs.

Most studies regarding the use of substances in relation to sex focus on vaginal drying, tightening or douching and other related treatments, and on the potential clinical consequences for women and their partners (Dallabetta, Mioti, Chipangwi, Liomba, Canner and Saaah, 1995; Beksinska, Rees, Kleinschmit and MacIntayre, 1999; Brown and Brown, 2000). I am not aware of any studies which focus on the actual use of love medicine or on the social context in which these practices occur.

The purpose of this study, therefore, was an attempt to fill the above gaps in the current literature. This study was designed to investigate the practice of love medicine and the experiences of people who make use of love medicines within their communities in the selected areas, with the aim of developing an intervention relevant and specific to them. This will enable programme managers to access appropriate information when planning their

programmes and may have an effect in the management of the pandemic (Barnette and Whiteside 2006: 345). It may also encourage the people who plan HIV intervention programmes to develop messages and make use of media that is relevant to the specific community as they target the audience in an understandable, responsive way using a culturally acceptable action plan.

The use of love medicine includes the smearing and drying of the vagina as well as the use of insertions. These practices may contribute towards the complex web of biological, economic and cultural factors that increase the risk of HIV infection and other sexually transmitted infections in women (STIs). Researchers have speculated on the effect of personal or cultural preferences regarding lubrication during sexual intercourse (Green, 2000; Bagnol, 2003). Health promotion and disease prevention initiatives will be more effective if these interrelated elements are taken into account. This study intended to contribute to an awareness of the possible or potential risk posed by the use of love medicine in this era of HIV. It is hoped that the findings may create an awareness among health workers such as midwives and primary health care nurses and that knowledge pertaining to the use of love medicine may assist them in the management of their patients and make them more responsive to the social-cultural aspects of HIV prevention. The findings of this research may be useful in the development of educational messages which promote the usage of barrier methods such as condoms and microbicides.

Gender roles, which traditionally value masculinity as more powerful, may be accepted, challenged, modified or rejected as individuals develop and shape their own gender identities (Kistner, 2003). According to Mann and Maitra (1992:34), it is important to understand the control women have over their sexual lives and their mechanisms of exercising this control when dealing with HIV and AIDS. This study focused on the use of love medicine in its social context and attempted to reconcile its gender issues. It also attempted to illuminate the lived experience of both men and women in the selected study areas and present recommendations from the perspective of the participants themselves. The study hoped to provide literature compiled by Black women which might start a dialogue on the practice of love medicine and assist the development of further research into this phenomenon.

1.5 Aim of the study

The aim of this study is to explore the use of love medicine among black Africans in KwaZulu-Natal, to understand the motives related to the use of such practices and to establish whether the use of love medicines may contribute to risks for HIV transmission to men and women.

1.5.1 Study Objectives

The study objectives were as follows:

1. To describe the broader social context in which these love medicines are used among blacks including culture, economy, the gender system and religion
2. To establish how dissemination of information on the practice and various kinds of medicine occurs

3. To identify and document the love medicines used in the four districts of KwaZulu-Natal; (see the attached map of KZN)

4. To understand the motives, intentions, perceptions and experiences (beneficial and detrimental) of individual men and women who use love medicines in KwaZulu-Natal

5. To identify the perceived risks involved in the use of love medicine to both men and women

6. To explore possible interventions, as suggested by participants, which might reduce the risk of HIV infection, if there is any, that is associated with the practice

1.6 Research questions

The study was specifically designed to address the following research questions:

1. What factors influence the utilization of such medicines? The broader social context, such as gender, economy, culture, historical setting, religion, and medical setting will be considered.

2. How is information on the use of love medicines disseminated from one user to another, from one generation to another and from the provider to the user?

3. What kind of love medicines are found in the various communities studied?

4. What motivates men and women to use these medicines?

5. What perceived implications do these practices have on the lives of men and women and their sexual health?

6. What are the possible risks of HIV infection associated with the use of love medicine?

7. What interventions can be recommended by the participants for reducing the risk, if any, of HIV transmission as a result of using love medicines?

1.7 Operational definition

This section presents the key terms that are used in the study. These terms could have different meanings in other contexts, but they are defined and explained in this section to ensure that consumers and researchers have a common understanding of each term as used in this study. The terms are:- Use of love medicine, matters of motives and risk of HIV infection.

1.7.1 Use of love medicine

Love medicine is the English translation of a Zulu term *umuthi wothando* or, in short, *intando* which is a term commonly used in the daily life as part of the local language in Kwa-Zulu Natal. The English definition has been broadened for the purpose of this study.

The concept 'use of love medicines' refers to the utilization of any substance perceived or described by a user which has an effect on being loved or cared for by a sexual partner or the effect of increasing one's ability to please a partner. It includes the use of medicine to enhance love during courtship and to increase a man's sexual interest and/or vigor. It also includes the use of those medicines which are perceived as protecting a woman from competitors and helping to keep her partner faithful to herself. I will focus on two categories of love medicines:

a)Traditional-simple medicines which are referred to in Zulu as *imithi yentando* or *intando.* These consist of animal products, minerals and parts of plants (green leaves, bark, roots, stems, bulb, fruits, flowers and seeds) which may be used in their green, fresh form or dried, preserved and ground into powder (Ngubane, 1977).

b) Modern love medicines which could be any substance which is marketed in western packaging and is available in the shops. These may include water as well as plants and are sometimes referred to as herbal medicines or minerals substances. Modern love medicines, in this study, are mainly substances purchased from shops which are perceived by users as foods or drugs that arouse sexual instinct, induce love desire and increase pleasure and performance. These may include prescribed aphrodisiacs. There are two main types of aphrodisiacs:

a) psycho-physiological stimulants which can be visual, tactile, olfactory or aural preparations

b) consumable preparations including certain foods, alcoholic drinks, drugs and love potions

Both modern and traditional substances used may have an aphrodisiac effect.

1.7.2 Motives

"Motives" refers to a need or drive that makes individuals engage in a specific action. It is normally referred to as an energizing factor that compels an individual to act, behave or perform a certain behavior. Motives range from environmental or ecological influences to perceptions, memories, cognitive development, emotions, explanatory style, or personality

Vroom (1964) explains that for a particular behaviour to take place three factors need to be in place and a low value in one will result in a low value of the rest. The individual has to perceive a probability of success, there must be a connection between success and reward and a value (valence) must be attached to the goal. According to this theory, all variables must be strongly present in order for motivation and resulting behaviour to take place. In this study the users of love medicine are motivated by the need to have an opposite partner, secure a relationship or control or manipulate the situation to his or her advantage. The user must have seen or heard that love medicine works and also believe in the use of traditional therapy and its mystical or supernatural power. An example of this supernatural power is to believe that by applying love medicine on a cut, it will get into the blood system and have an effect on the intended partner. Another example is that if a woman puts this kind of medicine in her mouth and talks to someone from a distance, that person will feel the effect and respond accordingly.

1.7.3 Risk of acquiring HIV infection

In order for an individual to get infected by Human Immunodeficiency Virus, it is critical that HIV contaminated body fluid comes into direct contact with the target site. According to Fan, Conner and Valareal (2007:127), sexual practices which present the highest risk are where blood, semen, or cervical or vaginal secretions from a person who is infected with HIV comes into contact with the mucosal membrane of another person.

The only two possible ways of reducing the HIV and AIDS epidemic are avoiding the risk or reducing the exposure to the risk. Abstinence from sexual contact is clearly a way to avoid the

risk, but as an alternative, exposure to risk could be reduced by placing a barrier between potential sources of infection. Fan et al (2007) recommend that individuals need to think about this before engaging in sexual activities. Socio-cultural dimensions need to be taken into consideration when programmes are planned because every individual belongs to some form of socio-cultural dimension. In this study, risk of acquiring HIV means:

a) intentionally participating in risky sexual encounters;

b) knowingly engaging in a relationship with someone who has other sexual partners;

c) remaining in a sexual relationship which has multiple sexual partners and perceiving this as normal competition

d) engaging in multiple relationships to achieve secondary gains such as material or financial gain, the raising of status or making a partner jealous.

e) It also involves all the sexual practices involving unsafe sex.

Unsafe sex in this study specifically refers to sexual behavior resulting in blood, semen or vaginal secretion being passed from one body to another. The use of love medicine adds to the risks by making it easy for the Human Immunodeficiency Virus to enter through the skin by performing cuttings (*ukugcaba*) where the medicine is applied or by using love medicine to dry the mucosa with the aim of improving sexual pleasure.

an overview of the design and elucidates the target population. It specifies the sample, the sampling techniques and the criteria for their selection. It also explains the methods used in the collection of data, the procedures followed, the ethics, which included entry into the community, and how confidentiality was maintained during data collection. It explains how the data has been managed and analyzed. The last part of the chapter presents specific information regarding the reliability and validity of the study.

Chapter five

This chapter presents the findings of the study, divided into two main sections. The first section is about sample realization. The second section discusses the study results which is further divided into six subsection:- conceptualization of the term love medicine, the broader social context, kinds of medicine used, matters of motive, classification of love medicine according to possible risk to HIV infection and the risk of HIV infection. The perceptions of HIV risk by participants as well as HIV risk possibility based on data analysis is presented in this sub-section. The latter is presented in a table describing each kind of love medicine showing kind of medicine used, reason for use, intention or purpose hoped to be achieved and the possible risk to HIV infection. The last sub-section presents data on possible intervention for the perceived risks from the point of view of the participants.

Chapter six

This chapter presents the discussion, interpretation of the findings, recommendations, summary of the study and the conclusion. It is divided into a number of sections where the

finding are discussed and interpreted and this is compared to the existing literature. It opens by presenting love medicine as a phenomenon. This is followed by a presentation on the users of love medicine, how the users are socialized and how the products are marketed. The next section discusses the broader social context influencing the use of love medicine and this is followed by the different kinds of love medicine and matters of motive for use of such products. The next section is about the health risk associated with the use of love medicine and is followed by the implications of using love medicine. The recommendation section is based on the all the above discussion and is followed by a summary, conclusion and limitations of the study.

Recently feminist thinking shifted towards considering the complexity and interrelated forms of social commonality or differences and, thus, not regarding all women as being homogenous (Archer 2004; Reneger and Soward, 2003). This brought with it the establishment of Black Feminism (Judith and Thorne 1985, Collins 1989; Collins 1987). Even at this stage, however, black women living in rural areas have not been taken into account, included or represented in discussions with the aim of understanding their lived experiences.

As a black woman from a rural area, I will be the first to acknowledge that there are some similarities between American black women and the black women of South Africa. One of these highlighted by Collins, (1990), is how many black women have struggled, trying to be mother to everyone while her partner or husband is neither working nor earning a wage to provide for the family. This author argues that this burden is far from being natural or universal and is embedded only in race and class formation.This study followed the principles of the feminists' research as recommended by Kelly, Burton and Regan (1994 32- 41) which are as follows:

Firstly, the feminist approach acts as a reminder for the need for commitment in taking seriously the experiences of women and the women's perspective is placed in the centre of the discussion by actually saying, "What about women?" as its underlying theme rather than as a comparison to man (Warren 1997)

Secondly, feminist research recommends qualitative methods as an endeavour to see the world from the distinctive aspect of women in their social world. In this study a feminist approach has been used because it provides a system of ideas about human life that involves women participants who are knowledgeable and active with regard to the use of love medicine. The qualitative approach provided an opportunity to investigate the context as well as the real experiences of the women as opposed to making them simply agree or disagree with what the researcher has hypothesized. The feminist researchers do realize, however, that there are times when quantitative research may be required (Jayaratne and Stewart 1991).

Thirdly, the overarching goal of feminist research is to concentrate on women's lived experiences in a respectful manner that legitimizes women's voices as a source of knowledge (Campbell and Wasco 2000). Although the study was about the use of love medicine, the focus was on the women themselves and what motivated them to use love medicine, their experiences before and after use as well as the perceived possible health risk of such practices in their lives as women.

The fourth principle is to gather information that would bring about social change. According to Maguire (1987), feminism is the belief that women universally face some form of oppression or exploitation. Therefore feminists have a commitment to uncover and understand what causes and sustains oppression, in all its forms. It is also a commitment to work individually and collectively in everyday life to end all forms of oppression (Maguire, 1987:79). Change can only be achieved by asking or enabling women to tell their personal experiences, by providing them

with a platform to do this, by listening and conceptualizing their personal realities and by trying to understand.

The fifth principle is that both the researcher and the participants openly recognized their positions. Because I came from the big city and was a woman researcher studying at Ph.D level, I was aware that some participants might perceive me as being superior and this, I wanted to avoid. Most participants, however, appeared to perceive this research as a way of being recognized as being more knowledgeable than many people of higher education. As a result, they were more than willing to show me, a researcher, how little I know about what actually happens in the field of sexual relationships and the use of love medicine. During the research, for example, when women started asking questions on how I would react, I would make it clear that this was not about me, but that I was there to listen to what they did or how they felt. This motivated the participants and made them feel important and consequently they made an effort to give even more information. The women appreciated the fact that they were not judged in any way, but rather given the chance to justify their deeds, giving them the courage to discuss some of their actions which were either cruel or not very safe, like casting a spell on another woman or using medicine prepared with body dirt.

This study was an endeavour to see the world from the distinctive point of women in their social structure. Denzin and Lincoln (2005) maintains that research involves power and that the traditional methods used for conducting social research has silenced many marginalized and oppressed groups of the society by making them passive objects of inquiry. The major

distinction of feminist research from traditional research is that it rejects hierarchical power relations (Maynard (1994); Fonow and Cook (1991) and empowers women who are usually oppressed (Fonow, Cook 1991; Campbell and Wasco 2000). Although the focus of the research was on and for the women, I am aware that women are generally understood in comparison with men and, for this reason men were also included in the study as part of the population. This was also done to remove sexist bias (Harding, 1987).

2. 1. 3 Guiding Theories

Theories provide an explanation of the conceptual framework on perceptions or assumptions of how the world operates (Creswell 1997). It provides the list of concepts that need to be taken into consideration when conducting the study. In this study the main concepts that have been taken into considerations are as follows: meanings, language, power, sexuality. Therefore the constructivism and post-structuralism theories have been selected because they explain these concepts while fitting in well with the naturalism paradigm and the feminist approach to life.

2.1.3.1 Constructivism theory

Constructivism, although not confined to education only, represents a paradigm shift from education based on behaviorism to learning based on cognitive theory (von Glasersfeld 1998 and Fosnot, 1996:26). Constructivist theorists argue that knowledge cannot exist

independently of the knower because human beings constantly construct their own knowledge and skills (Guba and Lincoln, 1994). There is no real reality and no single truth but multiple truths that are socially constructed (Campbell and Wasco 2000). Human subjects are the constructors of their meanings (Rogers, 1991:32). They do this by connecting what is expected of them with their experiences and communicate this among themselves.

Knowledge, therefore, is something that belongs to both the individual and the community (von Glesersfeld, 1998). Constructivism, therefore, fits naturally with the naturalist paradigm because it looks at the realities and constructs meaning to the practice of love medicine. Fosnot, (1996) Eisner, (1991) and Erikson, (1993) caution, however, that like learners, individuals try to explain things they do not understand. Therefore the knowledge constructed and meanings given can be speculative, incomplete and sometimes contradictory. Some things that were assumed to be the 'truth' become challenged in the light of new discoveries. This was taken seriously when conducting the research and while participants were not judged in any way, it was questionable how much speculation was actually regarded as truth.

Social Constructivism theory provides a useful framework for understanding the process through which particular forms of knowledge are related to gender and sexual practices, including the use of love medicine. This theory helped in explaining how individual providers or users learn the traditions of using love medicine and how new love medicines are created and modified from time to time in accordance with new meanings being allocated to experiences and cultural expectations.

2.1.3.2 Post structuralism theory – Feminist

I realise that the feminist post-structuralism theory generally applies to a range of theoretical positions developed from the work of, among others, two pilosophers; Derrida and Foucault, a psychoanalyst; Lacan, and a linguist; Saussure (Jones, 1998; Sarup, 1993). According to Michael and Peters (2001), post-structuralism cannot be reduced to assumptions, methods, theory or even schools. These authors describe it as a movement. This movement followed the structuralism theory and therefore much of the discussion indicates a position taken contrary to some of the assumptions of the earlier theory. Amongst other concepts post-structuralism is marked by a rejection of totalizing, essentialist and foundationalist concepts. The rejection of these three goes well with feminist approach which guided the assumptions for this study.

Totalizing concepts is rejected by post structuralism for its inability to view life from different perspectives or broader social concepts. By totalizing, one looks at all phenomena under one explanatory concept. For example, things are what they are because it is the will of God. If one applied this approach to the black women involved in this study, it would follow that "it's God's will" for women to be oppressed and for men to have privileges of multiple sexual relationships and thus, no need to advocate for change.

Essential concepts suggest that there is a reality which exists beneath or beyond language, and that it is waiting to be discovered. According to post-structuralism theory this cannot be accepted because post-structuralism specifically argues that identity and meanings are rooted

in language. This result in meaning being always provisional and shifting and identity not fixed (Wendt and Boylan, 2008; Jackson, 2004; Howe, 1994; Sands and Nuccio, 1992).

The foundationalist concept was rejected as it suggests that signifying systems are stable and an unproblematic representation of the world which is isomorphic with human thoughts and there is no otherness. This earlier theory partly conceptualises ways in which gender categories and identities are constituted (Beasley, 1999) and, thus, makes it hard for people to challenge the systems.

Post structuralism argues that the production of discourse, the way we know our world through language, is controlled, selected, organized and distributed by a certain number of procedures.

This theory argues that because the signs or symbols used in language are based on what people know or are socialized into, they have an effect on behaviour. For example people can easily be persuaded to buy into an idea or product if it forms part of their language base. Language used does not hide the truth but makes up a temporary face (Velebeyoglu, 1999). This is evident in the way advertisements are displayed to persuade people to believe that the product is good for them.

Post structuralism theory applied to this research project refers to the language used with regard to power and sexuality. Specific language has been used for generations and some

people, over the years, have been socialized into believing that men are of more value than women, that a woman needs to have a male partner and that a certain race or class might be better than another. Consequently, in some cases, women have become subservient to males and need a partner to feel of value.

This use of language as part of the post structuralism theory will assist in guiding the study to explore how the products are marketed using meanings that are understood by participants. These meanings given cannot be reduced to one and the same through translation or be believed as reality (Velibayoglu, 1999 and Jones 1998). Because I believe that each individual has a meaning for each event occurring in his or her life, I consider this theory appropriate for this study. The post structuralism theory will assist in an attempt to understand the different meanings associated with the use of love medicines as the individual's intentions, perceptions and experiences are explored from their own points of view.

Foucault argues that power is present in everyone and that every individual is thoroughly "laced with crisscrossing patterns of power". He also asserts that power in relationships is not something that is given once and for all, but that it can be modified. He states that power helps to illuminate social functioning and is thus shaping and constantly reshaping participants as it brings them into action (Schuld, 2004). Each object has its own distinct capacity for action. He argues that where there is power, resistance is always possible and, as a result, person A is never sure of achieving a result from person B. It is only after removing the resistance that power becomes unilateral and one sided (Patton, 2003). This part of Foucault's theory will be

explored as to how power is modified and how it illuminates social functioning and thus shapes and reshapes participants by bringing them into action.

Foucault's notion of power is better understood as a 'mechanism for life' that includes strategies of self-development that both constrain and enable the one with the power (Lacombe, 1996). He described power as being omnipresent and that it runs through all relationships and interactions. According to Foucault it is not that people have power, but rather that power is technique or action which individual can engage in. It is for this reason that he argues that power is not private but can be personal, cannot be possessed, but can be exercised (Healy 2005). He therefore concluded that although power changes its configuration it is already there. It takes a form of a matrix (Gerrie 2003) and emerges through the activity of "immediate everyday life". Therefore power is, according to Foucault, linked to interactive relations (Schuld, 2004).

Foucault's notion of power will assist in exploring the mechanisms of life that exist as strategies of self development that constrain or enable an individual to get what he or she needs or wants. An example of this is how women give pleasure to men in order to benefit indirectly, while the men, themselves, are of the opinion that they are deserving of this sexual pleasure. Foucault (1980) concludes that we should focus less on determining who has the power, but more on the media through which the power is generated and transmitted in its endless cycle. I am of the opinion that women who feel marginalized and compromised and not in a position to tell their partner that they do not want to compete for his love, are more likely to turn to the

use love medicine with the perceptions that it gives them a feeling of power in dealing with the situation. Love medicine, then, is used not as a rule, but rather as a way of dealing with a situation by which a form of power is exerted over another individual in the hope of maintaining a functioning relationship.

Foucault argues further that gender identities are not fixed by biology or culture, but are partly forged through the language or discourses which are used to describe individuals (Foucault, 1979) and the things they do or perform. This (forging through language) then becomes a constant site of the struggle for power. Legality and morality are used to maintain the status quo and these produce conflicts for the individuals involved. According to Butler (1990), certain performances become so indoctrinated and habitual that they are taken for granted and it falsely appears as though gender is something we have which determines our behaviour

Foucault asserts that the understanding of sexuality is repressed as a construct of power in the form of a new kind of sexual knowledge about correct practices. What needs to be done is to focus on trying to comprehend the complexity of the social matrix which gives a particular understanding of sexuality and its force. Foucault (1980) points out that sexuality follows the development of consumerism which is dependent on developments of production and marketing.

In this study, the researcher has applied the Feminist, Post-structuralist theory while digging up, piecing together and examining an extremely complex, but also always fragmentary, array

of components which both men and women use to enhance their sexual relationships and how these actions and activities are taught and transferred from one generation to the other. In addition, elements of post-structuralism theory have been applied in order to explain how social norms, beliefs and values regulate sexual behavior and how sexual practices, including the use of love medicines, are interpreted. The researcher has endeavoured to extrapolate from these social constructs some insight into the beliefs of those who use love medicine. The researcher postulates that the data collected from this research can be a useful tool for analyzing what is going on among the population where the study has been conducted.

In conclusion the study has been influenced by both personal and professional experiences. The argument was based on the feminist approach, guided by the naturalist paradigm and using both the constructivist and post-structuralist theories to investigate, analyze and interpret the complex and highly sensitive issue regarding the use of love medicine.

3.1.1 Traditional healing and traditional medicine

In order to understand traditional healing and traditional medicine one needs to understand the worldview of the people who use it. It is only by understanding the culture and the history of the people that one can appreciate their perceptions with regard to illness, disease and misfortune and how these are explained and managed by those people performing the healing practices. Some of the foundation literature was written many years ago. While my main focus is going to be on the Zulu nation in KwaZulu-Natal, I would like to clarify that traditional healing is not limited to this population, but found throughout Southern Africa and indeed, the world. Although the practice of traditional medicine is world wide, customs and applications vary from place to place with each country using its own vocabulary.

Countries such as Asia and Latin America use traditional medicine to help meet some of their primary health care needs and other nationalities documented include Arab, Hindu, Greek, Roman as well as Chinese and others in the Far East (Zanolari, 2003). The use of traditional medicine is gaining popularity even in highly industrialized countries such as the United States of America, where complementary medicine is used (United Nations 2003). World Health organization reported (2003) gave figures of use of traditional medicine in countries such as America, Australia Canada as being above 40 percent.

3.1.2 Traditional healing

Traditional healing is defined by the World Health Organization (2002) as the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. De Andrade and Ross (2005) support this definition and add that some cultures also use a special rope and water as part of their traditional healing.

The terms traditional medicine, indigenous medicine or folk medicine describe the knowledge systems which have developed over centuries within various societies before the era of modern medicine. When traditional healing is referred to as indigenous healing, it invokes the African conception of cosmology (Xaba, 2002). Madomombe (2006), in support of this, explains that traditional healing is linked to a belief system that remains integral to the lives of Africans. Traditional healers do not use medicines from factories or laboratories, but get their ingredients directly from nature in the form of herbs, plants, bushes, grasses, trees and even certain rocks (Vilakazi, 2006).

In South Africa, different people use different words when referring to this form of healing. Examples of these include: *umuthi* or *amakhambi esintu, amamyeza, dihlare,* depending on the language used (Hammond Took, 1989*)*. *Umuthi*, according to Ashforth (2005), is a substance that is fabricated by an 'expert' who possesses secret knowledge drawn from the

within the African context and these practices should not be viewed from the perspective of Born again Christians. Where African Christians might include *iziwasho* and traditional spiritual healers in a religious ceremony which requires slaughtering an animal as a tribute to the ancestors in order for misfortune to be removed, this would be considered a demonic engagement for so called 'Born again Christians' (Ashforth, 2005).

A unique aspect of traditional healing is that it deals with the individual in totality while taking into consideration the disease and its symptoms. Jäger (2005) describes this holistic view of patients as a strength which is lacking in western medicine. Good health is conceptualized within a broader frame as particular attention is paid to the person, not to the illness (Hewson, 1998). There is also an indivisible unity of the body and mind which enters into a harmonious relationship within the universe and among the group (Ndege 2001). This harmonious relationship is the combination of biological, religious, social and magical factors. As a result, according to Straker (1994), the supernatural world is as relevant in the diagnosis of illness as the natural world. One often finds that the main causes of illness are perceived as having magical, mystical or animalistic forces (Ngubane, 1977; Ashforth, 2005; Siddley, 2004). Not all diseases are considered in this light, however. Ngubane (1977) indicated that there are times when a disease might be considered simply a disease such as influenza, measles or chicken pox, and one can take treatment without consulting a traditional healer. This is supported by Gumede (1990).

Traditional healing uses the approach that illness, disease and misfortune are of social origin and have social, rather than biological causes. While this might be true with other forms of medicine, most social causes (Vilakazi, 2006; Green, 1992; Green, Zokwe, and Dupree, 1995) in this form of therapy include dealing with the cause, being in harmony with ancestors or people that you live with or are within your network (Craffert, 1997 and Ngubane, 1977). Thus, the therapy should include dealing with the cause, and restore harmony within personal and social relationships and with one's ancestors (Burhmann, 1986; Craffert, 1997 and Ngubane, 1992). Burhmann, (1986) suggests, however, that there is more to a sense of well- being than being in harmony with the spirits and the people around you, and that one needs the positive affirmation of being appreciated and liked and involved in a love relationship. The absence of such affirmation brings about insecurity concerns and the need for traditional healing.

In the worldview of a person likely to make use of traditional medicine, conditions such as illness, disease or misfortune as well as not being on good terms with or being left by one's sexual partner, could be caused by four possible attributes which are a Supreme Being, ancestors, witches, and pollution (De Wet, 1998; Hammond Took, 1989). Traditional therapy goes beyond taking treatment for that particular problem and may include things like a ceremony, the slaughter of a certain animal, the cleansing of the person by using herbs from within and the provision of something to protect that person from further attacks. The latter does not necessarily mean immunity (Ngubane, 1977). Different traditional healers use different techniques and individuals may be given different forms of healing by the same traditional healer. While many different techniques are used, not all of them are for an

immediate healing process, but rather steps towards it and a way in which the life of the individual is able to be re-connected (Ngubane, 1977).

Traditional healers profess cures beyond things that can be conceived or proven, even by science. For example, a traditional healer can claim to be able to protect your house from burglars, protect one from being hijacked, return one's long lost partner, keep one's husband faithful, make one pass an examination or protect one from being caught when committing crime. All these could be listed in an advertisement for any one particular traditional healer (Ashforth, 2005).

A study conducted in KwaZulu-Natal indicates that almost three quarters of the people who go to traditional healers were treated for sexually transmitted diseases, one fifth were treated to reverse bad luck and six percent were treated for a spell (*izichitho*) that was cast on them (Peltzer, Mnqundaniso and Petros, 2006). Their study did not use the opportunity to find out about well being and love as stand alone variables. With reference to those treated for a sexually transmitted disease, *ilumbo* was mentioned and explained as a disease where a man prepares *ilumbo* on his wife like a trap. This is done so that if the wife has sex with someone other than the husband, that man, not the husband, will get this disease. This according to this study was the second highest sexually transmitted infection mentioned (Peltzer, et al 2006). *Ilumbo* is what was referred to in the cosmology of traditional healing as an example of protection or doing something to harm another person who has relationship with one's partner, using traditional medicine. This has been reported as a possible action of a jealous

husband or an action of a woman in multiple relationships. Similar findings have been reported by a number of authors (Meyer-Weitz, Reddy, Weijts, Van den Borne, Kok, 1998; Scott and Mercer, 1994; Green, 1992) Gumede (1990) explains there are particular individuals who provide services for people who want to cast a spell (*isichitho*) on someone else using traditional medicine, a practice which is regarded as witchcraft. Ashforth (2005) supports the researcher's belief that sometimes traditional healers perform acts that can be perceived as witchcraft. This is when the traditional healer has identified the source of a misfortune and gives the customer traditional medicine to make sure that the same misfortune is returned to the one who sent it (Ashforth, 2005).

3.1.3 Profile of those who use traditional medicine

World Health Organization traditional report (2003) estimated that about 80% of the population in Africa uses traditional medicines for their primary health care. In South Africa, about 75%, that is 33 million people, consult with traditional healers either before or after going to qualified doctors (Gilbert and Walker, 2002). These figures are even higher than those estimated by (Mander, Quin and Mander 1997), who quoted a figure of 27 million users in South Africa, of whom 6 million were in KwaZulu-Natal and 2 million in Durban alone.

There are several large markets of traditional medicine in South Africa. Mander (1998) conducted a study in the largest market of such medicine which is situated in Durban. This market is similar to the Faraday Market in Johannesburg (Mander, et al 1997). Because this

research was confined to the marketplace and did not include consumers in the street, it is possible that the number of people using traditional medicine might have been underestimated.

The findings of this research indicated that most of the users are Blacks and that they represent a wide range of the socio-economic spectrum Mander *et al* (1997). The patients of the traditional healers range between 15 to above 66 years of age. Most users (36.5%) fall in the 26 to 34 year old bracket, followed by 32.7% being between 15 to 25 years old. More than half (52.9%) of the users in this study were female. Over 60% had at least some from of secondary education and 8.7% had a diploma or degree level of education. Almost all (96%) of the users had a Christian affiliation with more than a quarter being Zionist (Mander *et al.,* 1997). This is not surprising because one of the reasons why the Zionist Church was established was to synchronize traditional practice into the Pentecostal elements (Thorpe, 1982).

It became clear that the use of traditional medicine is not confined to those with lower earnings as even professionals and managers use this kind of medicine. The users dwelling places ranged from shacks to big houses, including flats and four roomed houses. More than three quarters of the users indicated that they would continue using traditional medicine even if the price was increased (Mander *et al.,* 1997). Similar findings have been reported by Cocks and Møller (2002) from their Eastern Cape study.

There are other varieties of traditional medicines available within the country which are being packaged and sold over the counter. Example of these include Dutch and Afrikaans traditional medicine which are packaged by the Lenon company for various applications, multi-coloured salts called *itshe labelungu* which are used as a body wash to elicit fortune and also locally packaged Eastern remedies originating from India, Japan and China (Cocks and Dold, 2000).

3.1.4 Providers of traditional healing

In South Africa there are two main categories of traditional healers. The first are the traditional doctors (*inyangas)* who are mainly men with an extensive knowledge of curative herbs. The second category are diviners which include *isangoma and umthandazi* (the faith/ spiritual healers). *Isangoma* are usually women with the ability to make a diagnosis by using guidance from the ancestors through divination (Ngubane, 1977). *Umthandazi* are either men or women, usually from the Zionist church. Faith healers (*umthandazi*) also make use the spirits, but in addition to the ancestors they call on Christian spirits such as Jesus, Maria (mother of Jesus) as well as God (Fako, Linn and Brown 2000). These healers use the power of prayer and may lay hands on the sick person or may use a special rope to pray (Kale 1995). Similar categories have been reported in other parts of Africa such as Zaire, Zambia and Mozambique (Ndulo, Faxelid and Krantz, 2001)

3.1.5 Methods used for traditional diagnosis and management of the client

Different methods used by traditional healers to come to a diagnosis and their comprehensive or holistic plans of management have been identified. Their methods include divinatory throwing of bones, talking to the ancestors, praying, using water, sensing that the patient's blood is dirty, using the bible, using the special rope, looking at the affected parts, feeling the patient's pain and knowing what is wrong, talking to the patient's relatives and listening to the patient's complaints (De Andrade and Ross 2005).

Methods of treatment and the administration of medicines, which have been documented by Kale (1995), include drinking infusions (*ophizwayo*), steam inhalation (*ukugquma*), snuff (*ukubhema ngekhala*), licking (*ukukhotha)*, implantation under skin or rubbing into an actively bleeding cut (*ukugcaba/chaza/izinhlanga*), enema (*ukuchatha*), bath/wash (*geza*), poulties (*owokuthoba*) purging /emetics (*ukuphalalza*) and internal cleansing (*izimbiza*). Others methods include water being sprinkled (*ukuchela*) or spurted from the mouth (*ukukhafula*) (Ngubane, 1977). Similar findings were reported by Cocks and Møller (2002).

Use of traditional medicine is also very varied. Traditional medicines can enter the body through the lungs by breathing in burnt medicines (*isikhafulo*), by mouth through food (*idliso*), through contact as well as sexual intercourse. Other documented methods of activating the powers of traditional medicines include applying it on clothes or any form of material,

smearing or placing it in or near the targeted person's bed or throwing it on the area next to the targeted person (Ashforth, 2005).

Given the fact that ill-heath or misfortune is not believed to be accidental, some of the healing methods include protection and strengthening the resistance of the individual as well as other family members so that ill-health or misfortune may not have an effect (Ngubane, 1977). This might involve planting certain plants in particular places or around the house (Cocks and Møller, 2000), performing ceremonies or wearing a totemic object on the neck, arm or waist (Hewson, 1998).

In addition to traditional healers, there are people who sell these forms of medicines who are referred to as herbalists. Some herbalists gather their traditional medicine and sell it directly to the traditional healers or individual users. Others gather their medicine and sell to vendors or shops who resell this kind of medicine to the traditional healers or individual people. As a result, there is a fast growing market for traditional medicine found on the pavements, along the main streets and in certain shops in the towns and cities. Some of the trading is done in places where pensions or government grants are received and the people who sell traditional medicine in these places are referred to as pension vendors (Botha, Witkowski and Shackleton, 2004).

3.1.6 Training of traditional healers and related practices and prices

Traditional people normally receive several months or even years of special training which includes strict discipline (Fako, et al 2000). According to LaGuerre (1987), the knowledge pertaining to this form of healing is transmitted to the individuals in the form of dreams, by their families, by the society or community and by teaching each other. The study conducted in KwaZulu-Natal indicates that more than half of the traditional healers had training lasting more than a year (Peltzer, *et a.l* 2006).

Often the treatment is not written down anywhere. A person is given the necessary treatment or someone collects it with verbal instructions on how to use it and the details regarding ceremonies or other procedures that might need to go with the healing. The more effective the treatment of that particular traditional healer is perceived to be, the more people will choose to consult him or her (Devisch, 1993). LaGuerre, (1987) supporting this, indicated that there are three factors that legitimize the healer: - the subjective reality of the healer; the objective reality based on his/her successful cures; and the belief systems of the community which impact on the first two. He further explained that there are people that will always adhere to this type of healing. He divided them into three groups:- those born and socialized in it who would be permanent believers, temporary believers who turn to it because of some personal crisis and those who now and again use some form of or specific aspects of traditional healing.

The mixing of these medicines, the varying dosages and frequencies are kept secret by the traditional healers (Kale, 1995). There are concerns that these may carry dangers of pharmacopoeia and also that no efficacy studies have been done on these medicines (Kale, 1995). An appeal has been made by Jäger (2005) to the Universities to conduct research into these kinds of medicines. Vilakazi (2005), on the other hand, proposed to the President that a project be undertaken to test some of the traditional medicines which have shown to have had positive effects on patients with HIV or AIDS. He argues that the use of these medicines should not be put on hold, because they have what is called "walking evidence" (Vilakazi, 2006), meaning there are patients who have shown improvement and managed to go back to work after being treated by traditional healers. He further states that traditional medicine is the greatest gift of humankind that was otherwise destroyed by first Arabs and later by Europeans.

Kofi-Tsekpo (2004) highlighted the need for quality control of traditional healing. In South Africa, Shabalala-Msimang, the Minister of Health (2004-2008), is very much in favour of this kind of medicine. She was quoted recommending it even for people who were HIV positive. Traditional healing in all its forms has been illegal in South Africa under the provision of the Witchcraft Suppression Act of 1957 which was last amended in 1970 (Ashforth, 2004). Despite this and the challenges of apartheid, this form of healing has survived. One of the reasons for this is that it is not simply a manner of healing, but that both users and providers are rooted in the beliefs of the traditional cosmology on which traditional healers are trained (Fako *at al*, 2000).

The price of a pack or kit could reach up to R30, but the average price was about R6.91 (Cocks and Møller, 2002). This cost is far less than consulting a medical doctor or buying western medicine from a chemist. Kale (1995), however, argues that the price of traditional medicines is not cheap. The main reason for this is the cure is never final there is always some aspect that may need attention involving more money. The healer may suggest a feast for the hungry ancestors who are taking care of an individual and a goat or a cow may need to be slaughtered in order to reinforce protection and enhance well-being. Such procedures can cost thousands of rand and substantially increase the expenses of using traditional medicine (Ashford, 2004).

3.1.7 Traditional healing as a form of income generation

Traditional healing has become a form of income generation. Mander *et al* (1997) and Mckean and Mander (2007) have estimated that between R2.5 and R2.9 billion per year, as income, is generated by medical products and product trade in South Africa. McKenzie (2008), estimates that Durban alone trades such medicine to the value of R173 million per annum. Traditional healing also provides employment for those who assist the traditional healers to grind, package and supply their medicine and some households are solely dependent on this income. It is clear that the practice of traditional medicine has become such an income generator that it exploits those who use it by not informing them about the possible risks that might be involved with its use. Prescribing love medicine to those who want to be loved and recommending direct contact in its application is likely to encourage unsafe sex practices and this, we know, increases the exposure to the risk of acquiring HIV infection.

Studies showed that in KwaZulu-Natal alone, about 200 animal species, including parts of rhino, snakes, crocodiles and lizards, and about 550 species of plants are actively traded (Mander et al 2007). Traditional healers mix these ingredients in a variety of different ways to make their medicines. While this generates an income for the traders, the fear that some of the species might face extinction has been a cause for concern for the government and those working with environment preservation (Mander, et al 2007 and Botha, Witkowiski and Shackleton 2004). Møller and Dold (2000) have called on the government to find ways of controlling this market, especially for those medicines that could have side effects. While Vilakazi (2005) calls traditional medicine the gift of humankind, he also mentions that the great challenge is how to separate genuine traditional healers from false exploiters.

Typical market in the street of Durban (Mander, 1999)

3.2. Literature review on the use of love medicine

Love medicine is a direct translation of the Zulu *umuthi wentando* which in plural in known as *imithi yentando* (Scorgie, Kunene, Smit, Manzini, Chersich, and Preston-Whyte, 2009). This is simply called *intando* in isiZulu. This is a widely known term describing traditional medicines which are used to enhance love relationships. In this context, however, the term includes medicines which are used to enhance or maintain wellbeing with the intention of attracting the opposite sex as well as to enhance an existing sexual relationship and to ensure that a partner becomes more loving and caring.

Because of modernization, some of the love medicines have been influenced by other cultures from different parts of the world. The researcher has established that there are both traditional and modern types of love medicine and that some traditional medicines have been packaged in the modern way (Cock and Møller, 2002). For the sake of this study, all those love medicines which have been packaged in the western or modern way, will be regarded as modern medicine.

While there are a number of studies which have been published regarding the use of love medicine within Africa, little is known about the wide variety of practices which are carried out to ensure feelings of wellbeing, being loved and being cared for or appreciated by a sexual partner. The main focus of most studies have been with reference to the drying or tightening of the vagina for sexual pleasure and most of these were biological or clinical in approach

(Runganga Pitts, and McMaster 1992; Kilmarx Limpakarnjarnarat, Supawitkul, et al 1998; Kun, 1998; Morar, Ramjee and Karim, 1998; Brown, Ayowa and Brown, 1992, Brown, Ayowa and Brown, 1993 and Braunstein and Van de Wijgert, 2003). I suggest that this limits the perceived use of love medicine as a means of merely increasing physical sexual pleasure when, in fact, the users have broader reasons for using the medicines and performing various rituals and practices. These reasons can only be explored by behavioural studies, as suggested by Brown and Brown, (2000).

This study is not limited to factors enhancing sexual pleasure, but since most of the literature has used this approach, the main review focuses on practices, products, changes, and effects of the practices. It will also present the literature that has been documented regarding an association between the practices and the risk of acquiring STI and HIV infections. The first section will be on intra-vaginal practices which will be followed by practices carried out to specifically arouse sexual desire or pleasure.

Brown and Brown (2000), indicate that intra-vaginal practices are widespread and that some are beneficial to the users while others could be harmful. Interest in these practices started as early as 1988, and many papers have been published. Since then, most of them have been retrospective studies, which make it hard to give conclusive evidence as the information is based on the participants' ability to remember (Brown and Brown, 2000). Observational studies have also been conducted where an individual would be observed before and after

inserting the product or be followed up for a number of days after inserting the product (Kilmarx *et al*, 1998; Brown et al, 1992 and Brown et al, 1993).

The characteristics of people who use love medicine vary from country to country. In South Africa, they have been described as mostly young women who have little education and low socio-economic status Beksinska et al 1999). In Bakino Faso and Senegal, the women are more likely to be married (Scholes, Daling, Stergachis, Weiss, Wang and Grayston 1993; Kim, Funkhouser, Simpson, Brown and Merchant, 2003). The study conducted in Zimbabwe showed that even professionals use traditional medicines and perform procedures to enhance sexual pleasure (Runganga et al 1992). In some developed countries douching was still being practiced (Foxman, Aral and Holmes 1998).

3.2.1 The practices or procedure using love medicine

According to Kunene and Scorgie (2005), a variety of medicines was used to enhance sexual pleasure and usually presented in the form of a kit. The user was expected to follow a course which may take up to a week. The practices ranged from bathing in, douching, ingesting, inhaling, smelling, touching or drinking concoctions or special porridges. The application of absorbent to be removed just before sex and the application of solid substances either with a cloth or a finger for certain periods have also been reported. Other practices which have been reported from other countries include the insertion of self prescribed suppositories. Other authors who have written on this topic are Runganga, et, 1992, Brown et al, 1992 Brown,

Brown and Ayowa, 1993; Dallabetta, et al 1995; Sandala, Lurie, Sunkutu , Chani , Hudes, Hearst 1995; Rungang, 1995; Baleta, 1998; Civic and Wilson, 1996; Brown and Brown, 2000). These studies were about vaginal practices or ways of enhancing sexual pleasure as opposed to using a love potion.

3.2.2 Products used for love medicine

Some products are derived from herbs and others from the leaves, bark and roots of African trees or plants (Brown and Brown, 1999; Morar and Karim, 1998; Beksinska, *et al*, 1999; Brown and Brown, 2000; Braunstein and van de Wijgert 2002). Some are converted to tablets or powders that can be dissolved for drinking or are ingested with food. Mineral products such as alum have been reported to be used to achieve the effect of making sex pleasurable. Human parts or excreta or secretions as well as animal parts have been reported to be used for similar effects (Civic and Wilson, 1992; Runganga, *et al* 1992; Beleta, 1998)

3.2.3 Reasons for the use of love medicine

The primary reason why people make use of love medicine appears to be the desire to bring about biological changes within the vagina to enhance sexual pleasure. There are also secondary underlying reasons, however, which are socially motivated and related to socialization, culture and traditional belief systems.

In the first case, people perform these practices with the aim of effecting physical changes in the body for a variety of reasons. Some use the medicines to cause contraction of the vagina, others to reduce vaginal secretions with the intention of drying the vagina and others to increase the warmth of the vagina, all, however with the intention of enhancing arousal in the woman and sexual excitement for both partners, (Runganga, *et al*, 1992, Brown Ayowa and Brown, 1993). Kilmarx's et al (1998) study on commercial sex workers indicated that this is done to improve the sexual pleasure of their male clients. The study by Ray, Gumbo and Mbizvo (1996) confirmed that men sometimes pause in their lovemaking to allow women to dry themselves, in the belief it is less pleasurable to have sex when a women is wet.

In the second case, and more important to this study, people seem to perform these practices for psychological reasons. These include the hope of being more loved or appreciated by a partner, a desire to increase sexual responses and the wish to achieve 'love potion' effects (Civic and Wilson. 1996). Women further hope to maintain their husbands' fidelity, to provide sexual satisfaction, to increase sexual compatibility with their partner as well as to improve relationships (Runganga, *et al*, 1992). According to the participants from the study by Brown et al. (1993), those who have started making use of these products have to continue using them in the belief that should they stop, their partners would think that they had had sex with someone else.

3.2.4 Health implications to the user or partner associated with practices of using love medicine

Studies conducted in the early nineties showed a relationship between the frequency of douching and reproductive tract infections and pelvic inflammatory disease (Scholes; et al, 1993; Halperin, 1999; Rajamanoharan, Low, Jones, and Pozniak,1999, Fonck, Kaul, Keli, Bwayo, Ngugi, Moses, and Termmerman 2001, Holzman; Leventhal; Qiu, Jones and Wang 2001; Ness; Hillier; Richter, 2003). Researchers suggested that some of the practices performed in the use of love medicine might be harmful. Links between dry sex practices and potential HIV infection have been documented as being uncertain. The reason for this according to Hira, Mangrola, and Mwale, (1990), is that some of the studies were either too small or they did not plan to test the hypothesis. Some of the participants using vaginal practices to enhance sexual pleasure did, however, report that they experienced physical trauma during sexual intercourse Hellman and Desmond-Helman, Nsubuga, Baingi-Baing, Mbidde and Tager, (1991). Irritations of the vaginal and cervical mucosa which may facilitate the transmission of pathogens of sexually transmitted infections, including HIV, have been documented by Brown and Brown (1992). This correlated with HIV seropositivity (Brown, Brown and Ayowa, 1993).

Some studies merely observed the vaginal changes by examining women over a period of days to check for changes in the vaginal wall or cervix. Other studies went further, taking both introital and high swabs of blood in order to assess a possible association between using the medicines and the causative organisms of ulcers or chancroids and also to establish the odds

ratio of becoming infected or getting ulceration (Kreiss; Coombs; Plummer Holmes, Nikora, Cameron, Ngugi, Ndinya-Achola and Corey, 1989; Hira et al 1990).

Findings show that the insertion of leaves into the vagina often resulted in some form of inflammation, fine petechiae (red dots), streaking on the cervix and vaginal wall and blotchy red demarcated lesions which could last lasted from 24 hours up to six days, depending on the product used. Morar et al (1998) believes that these products are likely to interfere with the vaginal secretions and membrane and may results in trauma. When only water and cloths were used to dry the vagina, were no lesions observed.

Researchers have raised the concern that all the vaginal practices, since they interfere with the vaginal fluid, may predispose women to HIV infection (Brown et al, 1993). They have also speculated that inflammation of the sexual organs of either partner or the presence of open sores and wounds, especially if these are combined with the use of inserts or cuts, possibly make both partners more susceptible to infection. (Brown & Brown, 1993; Sandala et al 1995; Dallabetta et al, 1995; Kun 1998; Baleta, 1998; and Myer, Kuhn , Stein , Wright and Denny 2005).

Kilmarx et al (1998) reported that, from his study in which exfoliation of the vagina was being observed, there was an increase in genital HIV-1 RNA shedding in women who were using suppositories It follows that if one partner has cuts and the other one has shedding, then the risk of infection is likely to be increased. An increase in sexual transmission infection was

reported by Beksinska et al (1999). Another concern raised is that users may mask existing sexually transmitted infections by douching or by inserting a form of love medicine and this may further predispose them to the risk of acquiring HIV infections (Beleta 1998; Kim, Funkhouser, Simpson, Brown, and Merchant, 2003).

Brown and Brown (2000) states that it is difficult to do a cohort study on such practices because there could be too many confounding factors such as the change of practices, the change of products or even the change of a partner. More recent studies have shown a stronger association between the use of vaginal practice with the aim of enhancing pleasure and sexually transmitted infection Meyer, et al (2004). McClelland; Lavrey; Hassen; Mandaliya; Ndiya-Achola; Beaten (2006), conducted a ten year cohort study on the correlation between intravaginal washing and an increased risk of acquiring HIV-1. Although there were other confounding factors, the results showed that there was almost a three fold increased risk of seroconversion among those who were using intravaginal washing.

A study conducted by Civic and Wilson (1996), stated that there is common belief that the magic of love medicine is likely not to work if a condom is used. According to Steiner, Piedrahita, Joanis, Lucinda and Spruyt, (1994), condom breakages were associated with the use of inserted substances and there was no reports of replacing them. The participants indicated that the usual response of one of the partners to such a breakage was, "You just continue." Sparrow and Levill (1994) did not find any association between the use of drying agents and condom breakage or slippage.

Participants reported fears that the insertion of substances into the vagina is likely to cause cancer or infections. They believed that no matter how careful one could be, something always gets left inside (Brown et al, 1993). It appeared that participants are aware of the possible risks attached to the use of love medicine. A fear based on fact it seems, because, in the comparative study conducted by van de Wijgert (1997), it was shown that women performing these practices were more likely to have an abnormal Papanicolaou test result and also that lactobacilli were less frequently detected in the vaginal flora of frequent users of intravaginal medication.

3.2.5 Aphrodisiacs as specific form of love medicine

Some medicines have been reputed to have aphrodisiac properties and have been used throughout history (Waddell, Jons and Lane, 1980 and Zanolari 2003). Aphrodisiacs are defined as substances that enhance and or increase sexual pleasure or arouse sexual desire or libido (Rosen, Ashton 1993).These have been used with the purpose of increasing the desire and drive associated with the sexual instinct (Hermandez, Hostettmann, Hesse, Guilet and Marstone, 2003). According to Zanolari (2003), in the Roman Tradition such aphrodisiacs were associated with moral laxity.

Aphrodisiacs come in the form of food, drink, drugs or even devices. Many of these originated from the ancient belief that the symbolic appearance or shape of the medicine has an impact on its powers. Rhinoceros horns, for example, have been used extensively by men to enhance their sex drive based purely on the association between their shape and that of an erect penis.

It is ironic to note, however, that the chemical analysis of powdered horn extracts reveals only polypeptides, sugars, phosphorus, ethanolamine and free amino acids (Inagaki and Oida, 1970). Although there are many aphrodisiacs on the market, there is little scientific evidence that they actually work.

Aphrodisiacs of plant origin include the bark of the West African tree *Corynanthe yohimbe*, which is regarded as a tonic that enhances sexual power and virility. It contains a substance called *indole* alkaloid *yohimbine*, which has long been used as a sexual stimulant for domestic animals and, more recently, to treat impotence in men (Morales et al, 1986, Morales, Marshall, Surridge, Fenemore 1987 and Sonda, Mazo and Chancellor 1990). Although the evidence is far from conclusive, results from clinical trials have shown that *yohimbine* has a positive effect on sexual desire and performance in some men. Sexual desire is often described as sexual appetite. Zanolari (2003) states that the increase of the appetite is not essentially associated with an equivalent increase in the capacity to satisfy that sexual desire which raises concerns as to what the person should do if the desire is not satisfied.

There are a number of experimental studies that have been done on animals such as rats, which showed that some of the roots of plants used as a sexual stimulant and aphrodisiac, do have the intended effect (Thakur and Dixit, 2007). The results showed the effect of the aphrodisiac increased the male rat's attraction to the female by 2.5 fold, which was significant. The number of sexual bouts also increased. The mount intromission and post latency was significantly reduced and there was a reduction in the physical exhaustion of the experimental

group (Thakur and Dixit, 2007). Similar findings have also been documented (Zamblé, Martin-nizard, Sahpaz, Hennebelle, Bordet, Duriez, Brunet, Bailleul 2008, Park, Lee, Shi, Bang and Lee 2006, Kamtchouing, Mbongue, Dimo, Watcho, Jasta and Sokeng, 2002, Ranasooriya and Dharmasiri 2000, Kenjale, Shah and Sathay 2008). All these studies were done on male animal species.

3.2.6 Implications of aphrodisiacs

A study conducted by Rawstone, Digiusto, Worth and Zeblotska (2007), has indicated that people who use aphrodisiacs are more likely to engage in risky sex related behaviour than non users. This risky behaviour includes looking for sex in three or more venues, engaging in sex marathons, participating in group sex as well as making use of other aphrodisiacs. Similar results have been reported by Urbina and Jones (2004). While there is inconclusive evidence as to whether the use of love medicine increases the risk of HIV infection, I argue that the use of aphrodisiacs and the associated behaviour patterns are not in accordance with the prevention strategies put in place to reduce the risk of contracting HIV.

In summary, we cannot keep on denying the fact that there are people who use love medicines and perform certain practices in order to enhance sexual pleasure and studies have shown a correlation between some of these practices and sexually transmitted infection. Some researches have raised concern that such practices are likely to mask the signs of sexual infections. Many of the users, themselves, seem to be aware of the risks involved, but continue to perform love medicine practices in a variety of ways. The study conducted in Durban

showed that at least three quarters of the black population were estimated to be using traditional medicine. The profile of the users included different age groups as well as different socio-economic status.

Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. Although there is limited data on this in most countries, there is evidence that shows the use of love medicine, although it might be called different names, is commonly practiced in certain groups and cultures. Like all customs, these are influenced or related to the specific community in which they live. Some cultures perceive women's bodies as being contaminated or impure which in turn influences the women's perception of their own bodies and sexuality, the men's perceptions of the women's bodies and sexuality and their resulting sexual behaviour. Like all other value and cultural norms, these customs are passed from one generation to another by older female relatives and reinforced within generations by peers or other women in the communities (Runganga, Pitts and McMaster 1992; Braunstein and van de Wijgert 2003).

This study was intended to examine the cultural factors which might exist in the study district and further to explore the motives underlying certain behavioural practices. This study is not suggesting that people who use love medicine should be examined or tested for HIV. I argue that there are strategies that individuals need to develop or practices that need to be changed in order to reduce the risk of HIV. Firstly, it would make sense to avoid exposure to the risk of

acquiring HIV completely and if that's not an option, then to reduce the risk of exposure as much as possible. I argue, therefore, that people who make use of love medicine tend to ignore both options and do just the opposite. This is based on the fact that love medicines have an aphrodisiac effect which increases the appetite for sex without necessarily increasing the capacity to be satisfied. Based on the study findings in this section, I suggest that individuals who have increased their sexual appetites by aphrodisiacs are more likely to participate in sexual activities and by making use of intra-vaginal love medicine applications are less likely to use condoms, resulting in unsafe sex practices. In addition, the point raised by a researcher, that inflammation lesions and shedding of the vaginal mucosa during these activities is even more likely to increase the risk of HIV infection.

According to Maguire (1987:79), feminism is a belief that women universally face some form of oppression or exploitation. Therefore, feminists have a commitment to uncover and understand what causes and sustains oppression, in all its forms. It is also a commitment to work individually and collectively in everyday life to end all forms of oppression (Maguire, 1987:79). Therefore the **fourth principle** was to gather information that would bring about social change. In this study, the researcher worked with the women, themselves, to identify the situations and the challenges that they are facing and to allow them to give recommendation for possible intervention. The intention of the researcher is to utilize the results to advocate the improvement in the condition of these women, especially in the study sites.

The fifth principle is that both the researcher and the participants openly recognized their positions. I was aware that, although I grew up in the some of the areas I studied and was a woman, the participants might perceive me as having power because I came from the 'big city' and was studying at Ph.D level and I wanted to avoid this. Most participants, however, appeared to perceive this research as a way of being recognized as being more knowledgeable than people with a higher level of education. As a result, they were more than willing to show me, a researcher, how little I knew about what is happening in the field of sexual relationships and the use of love medicine. During the research, for example, women would start asking questions on what I would do. I made it clear that this was not about me, but I was there to listen to what they did or how they felt. This motivated the participants and made them feel important and, consequently, they made an effort to give even more information. Some of the actions they described were not very safe or had a cruelty aspect to others, like using medicine

prepared with human faeces or casting a spell on someone and they appreciated the fact that they were not judged, but rather given a chance to justify their actions.

In summary, a qualitative design using a feminist approach was identified as the design most suitable for this study, but was used only as a guide in the collection of data because qualitative applies to processes and meanings which are not vigorously examined, unlike the use of love medicine (Bryman and Teevan, 2005). This is a broad approach to the study of social phenomena and drew from multiple methods to respect the humanity of participants while focusing on the context.

4.2 Research approach

Ethnography was used in this study for its ability to investigate people's behaviour in everyday contexts, rather than under experimental conditions (Munhall 2007). This design is a flexible, responsive and iterative form of research which carries specific focus questions about social and cultural practices of everyday life from the perspective of the women being studied, with the aim of gaining understanding of their real world (Hesse-Biber and Leavy 2007). It is known for its ability to give shape to new constructs or paradigms, and new variables, for further empirical testing in the field or through other traditional ways such as quantitative studies. It has the ability to generate new analytic insights by engaging in interactive, team exploration of often subtle arenas of human difference and similarity (Genzuk, 2003).

There are two main approaches to ethnography (Halloway and Wheel, 2002). A descriptive ethnographic study centers on the description of culture whereas critical ethnography involves the study of macro-social factors such as power and control and examines common sense assumptions and hidden agendas in this arena. This study adopted a critical ethnographic approach.

A researcher using an ethnography design should 'live with and live like' those who are being studied, usually for a year or more (Hammersley, 1990:1). I felt justified in doing the study since I was born and bred in one of the districts and had interacted, on a daily basis, with most of the community members of three of the districts while attending school and later working as a nurse. Furthermore, I have conducted several other research studies in these selected districts over a period of more than five years.

As a design, ethnography is not very different from the approach that is normally used in everyday life to make sense of our surroundings. Unlike experimental or social surveys, ethnography is less specialized and less technically sophisticated (Genzuk 2003). Hammersley (1990:7) indicated that ethnography principles can be summarized under the three headings of naturalism, understanding and discovery:

Naturalism is the view that the aim of social research is to capture the character of naturally occurring human behavior, and that this can only be achieved by first-hand contact with the behaviour in its natural setting. As a researcher, I was intrigued by the social interactions which

took place in daily life and by the meanings expressed by community members as they referred to their interactions in their sexual lives. Therefore, I decided to take the research to the natural setting as opposed to laboratories (Marshal and Rossman 2006) and used the qualitative research approach (Lincoln and Guba 1985). As a result, the study is conducted in a natural setting which exists independently of the research process. As the researcher, I minimized, as much as possible, my effect on the behaviour of the people being studied. The aim of this was to increase the chances that what was discovered in the setting could be generalized to other similar settings that have not yet been researched. Finally, the notion of naturalism implies that social events and processes are explained in terms of their relationship to the context in which they occur (Hammersley, 1990).

Understanding as a principle of ethnography means taking into consideration that the population being studied has a pattern of behaviour that differs from that of physical objects or animals. They do not have fixed ways of responding to stimuli, but are involved in the interpretation of stimuli and construct their own meanings which are socially negotiated as they respond to the situation with which they are faced. As a result, the freely constructed character of human actions and institutions is emphasized as opposed to the causality in the social world (Hammersley, 1990: 8).

Discovery as another feature of ethnographic thinking means that the research process is an endeavor to discover meaning as opposed to limiting the research to the testing of certain explicit hypotheses or making deductions(Genzuk 2003). Ethnography argues that when

approaching the phenomena with hypotheses one may fail to discover the actual nature of those particular phenomena. Therefore, the study guide used has been sharpened and modified as the process of data collection continued (Hammersley, 1990).

4.3 Study setting and population

In ethnographic studies, research settings should assist the researcher in yielding rich data (Holloway and Wheeler, 2002). While this study was conducted in areas where there are many women, I am aware that their status as women does not necessarily mean they are all the same. There are those who find it easy to make themselves heard or visible by demanding their rights in some way or the other. I acknowledge that inequalities and inequities also occur among women and they may differ according to class, race, age, religion and ethnicity. This is even more so in South Africa. In this study, the black population living in four districts that have been prioritized by the President as nodal points within KwaZulu-Natal province has been identified as ideal for this investigation. These districts are Ugu, uMzinyathi, uMkhanyakude and Zululand (See the attached Map - Appendix 1).

These districts together have a population of 2.5 million people, or 26.9% of the total population of the province (Statistics SA 2003). There is a slightly higher percentage of females living in these districts (54.1%), as compared with the province as a whole (53.2%). According to Statistics SA (2001), 63% of the population in these nodal areas was younger than 24 years old.

The four nodal point areas are predominantly rural and characterized by a high rate of unemployment (54%). According to Statistics SA (2001), the majority of households had no access to piped water (68%) or waterborne toilet facilities (76%). Poverty has been found to play a major role in the sexual behaviour of the community which may result in predisposing its members to the risk of HIV infection (Green, Pool, Harrison, Hart, Wilkinson, Nyanzi, Whitworth, 2001; WHO 2000).

The application of a feminist approach will assist in taking a clear position by not allowing relativity. Although the focus is on women, particularly the black women who live in the selected areas, it does not totally cancel out the opposite sex. The feminist approach specifies that the renderings of a gender category or identity make sense only in relation to characteristics constructed as "gendered other". This implies that women's experiences and perspectives cannot be understood unless in relation to men's experiences which exist as stereotypical opposites (Pattman, 2006). Therefore men have also have been selected to be part of the target group for the study. I believe that only by linking the experiences of men and women, their situations and circumstances in relation to each other and their reasons for using love medicine can one attempt to understand their reality or their world. Being responsive to the needs of the community would help greatly in the design of interventions or programmes aimed at the reduction of HIV related behaviour.

4. 4 Sample and sampling technique

Holloway and Wheel (2002) assert that ethnographers use purposive or criterion-based sampling in that they adopt specific criteria for selecting informants. According to these authors, the key informants are those participants whose knowledge of a setting and phenomena under study is intimate and long standing. The sampling was a non-probability purposive sample which was later followed by snowballing. Informants in qualitative research are selected because of some characteristic which is popular (Patton 2001). According to Patton (1990), purposive sampling is based on the assumption that the investigator wants to discover, understand and gain insights, and therefore must select a sample from which the most can be gained.

I am aware that the non probability method of sampling cannot ensure that every element available is fairly represented in the sample selected. This study was unique and sensitive, thus the need to identify people who knew the subject and were willing to talk about it was more important than representation. The other reason for using this type of sample was that the data to be collected was the lived experiences of those who had knowledge on the practice of using love medicine as well as those who had used such practices themselves (Munhall (2007: 530). Therefore purposive sampling was done where certain people with identified criteria were approached. If they agreed, they were interviewed or invited to join a focus group discussion.

The three different sets of samples utilized were as follows:- key informant participants, focus group discussion participants and in-depth interviewees. Different recruitment techniques were applied for the different samples. The districts are widely spread throughout the province (see the map attached). As person who has lived and worked in most of these districts, I already had an established network of field workers. These field workers have been trained in community entry, recruiting and the collection of data. I worked with them in identifying potential participants, inviting and recruiting them, finding suitable venues and preparing for focus group discussions. Because of confidentiality and the sensitivity of the practice, the researcher could not obtain information on who knew about love medicine before the study had commenced. Therefore a snowball form of sampling followed, whereby participants themselves identified more people who were willing to participate in the study.

Snowball sampling is used when a population listing is unavailable and cannot be compiled (Henry 1990). This type of sample relies on previously identified members to identify other members of the population. Initially, the cases of interest were identified by people who are regarded as information-rich. These were the community leaders, people who knew about the community in general or those who knew about the use of love medicine and thus likely to know about the providers or users of love medicine. One community member was identified as an initial participant. After speaking to that person, she or he was asked to identify others that had information on love medicine within the study population. The sample grew like a snowball as newly identified members identified others. While both key informants and some of the in-depth interviewees were sampled this way, others were identified from the focus

group discussions. This snowball method was found to be ideal for the hard-to-establish population of both providers and users of love medicine.

Focus group participants were sampled differently. The characteristics of age and sex were used to determine the participants' eligibility to participate in the group and this was followed by quota sampling (Munhall 2007) where eligible community members who were willing to participate were recruited by the trained field workers for focus group discussions. These potential participants were invited to join a focus group discussion at a specific venue at a specific time. On the day of the discussion, screening was done using the set criteria and only those who met the criteria were admitted.

4.4.1. Selection criteria

The study was planned to focus on those individuals who were members of the community, who were either regarded as being knowledgeable about the community or likely to be well informed about the use of love medicine and the people who use it. As in all purposive samples, the criteria for selection were clearly explained. It was decided that there would be representation of all the four districts, including both men and women of different age groups. Criteria for selection in order to participate in the study were set as follows:

a) A person must have spent more than five years in the district;

b) A participant had to be between the ages of 18 and 60 years old.

c) The sex of the individual determined which focus group discussion he or she would be invited to join in each of districts since these were planned to be either all male or all female discussion groups.

4.5 Method of data collection

According to the ethnographic approach, field work is a disciplined mode of inquiry that engages in the ethnography of firsthand information in data collection over an extended period of time. This kind of approach produces a narrative that offers insight into and understanding of human social life. It aims to understand culture from the native point of view (Munhall 2007). Data is gathered from a range of sources, but observation and/or relatively informal conversations are usually the main ones (Burman, 2006, Bryman and Teevan 2005 and Denzin and Lincoln, 1998). In order to avoid the possibility of bias that is inherent in the interpretation by the observer, Bryman and Teevan (2005) suggest that interviews and focus group discussion forms of data collection should be used for data collection. It is for this reason that, although I had observed these communities while living amongst them and conducting other studies with them, I had to have what is regarded as formal data collection by using these methods of qualitative data collection. This was conducted from December 2007 to May 2008.

These qualitative methods of data collection were utilized to facilitate an inquiry of sensitive issues such as sexual behaviour, sexual practices and gender related issues which might be a

reason for using love medicine. The reason for utilizing different methods was to broaden the perspective and provide as much evidence as possible to increase the credibility of the study for decision makers such as policy makers and programme managers (Ulin, Robinson, Tolley and Mcneill 2002). Each method of data collection was designed in such a way that it gave a different level or angle to the study. This approach also suited the sensitivity attached to the issue of sexuality and the purpose of getting as much data as possible by using a number of methods as recommended by Spradely (1979), Lofland and Lofland (1995) and Denzin and Lincoln (1994). Using different methods of data collection was to assist in drawing conclusions from the synthesis of all the different groups (Hilton 2002).

The study used a thematic guide to elicit the cognitive structures guiding the participants' worldview (Marshal and Rossman 2006). This approach was useful in eliciting the meanings participants attached to events and behaviour as well as generating the typology of cultural classification ideas. The interviews and discussions were rich in descriptive narrative and highlighted by nuances of culture. As a researcher, I was able to obtain first hand information as I observed participants being interviewed and being engaged in discussions in their own familiar setting.

I am aware that these forms of data collection have been criticized for the possibility that the researchers might impose their own values to the phrasing of questions or interpretation of data (Marshal and Rossman 2006). Therefore, different samples at different sites were involved, using different tools to study the same phenomena.

There was a tool guide for each of the three samples, that is, for key informants, focus group discussions and in-depth interviews. These three tool guides (see appendix 3) were developed based on a previous study conducted by the World Health Organization which researched similar gender sexuality and vaginal practices. These tools were expanded to encompass the entire practice of using love medicine and were translated into Zulu and then back into English to maintain uniformity of question asking and to avoid misinterpretation.

As an interviewer, I had to be well conversant with the aims, objectives and questions of the study in order to listen and take notes, while at the same applying good research practices during interviews and focus group discussions. This role had to be practiced before going into the field (Marshal and Rossman 2006). Although I worked with experienced field workers who assisted in recruiting, organizing of the venues and note taking, they had to be trained with regard to these particular study objectives and re-orientated on the ethical issues of confidentiality and a non-judgmental approach. This was extremely important as the study was dealing with the sensitive issues of sexual behaviour and the use of *umuthi wentando,* which in some cases can be perceived as witchcraft.

4.6 Data collection

The collection data was not structured and that is why there was no detailed plan or order that was followed in the way it was collected from key informant interviews, focus group discussions and in-depth interviews. The common order of data collection was to start with the

key informants, followed by focus group discussions and, later, the in-depth interviews. In practice, this meant that not all the key informants were interviewed before moving on to the next group. The reason for this was that some of the key informants, especially the traditional healers, were identified by the focus group discussion members. Some of the in-depth interviewees were identified while the researcher was sitting with them, waiting for a key informant such as a traditional healer. Therefore the sequence of data collection varied.

4.6.1. Process of data collection

The process of data collection varied according to the type of sample. The detailed presentation of what happened in each sample is presented under each subsection, namely: Key informant, focus group discussion and in-depth interview subsections. The overall procedures followed during interviews and discussions are presented in this section.

Data collection took place in school classrooms and in houses, where the field workers had negotiated with community members to provide a venue for a focus group discussion. In the houses that were utilized, either the family members were not around or it was owned by one of the participants. In some cases, where privacy in the house proved to be a challenge, the in-depth discussion took place in a car in an attempt to make the venue as natural and neutral as possible (Ulin et al 2002). All the interviews and discussions were conducted in the language most preferred by the participants, which was Zulu. In some cases, participants tended to mix Zulu and English during an interview or discussion.

care workers, traditional healers or medicine herbalists. All the interviews were conducted by the same person with the help of a note taker unless the interviewee was not comfortable with the second person in which case I would interview and take notes while the interview was digitally recorded.

The key informants were expected to assist the researcher in understanding how gender issues might relate to sexuality and the use of love medicine. It was assumed that they would be able to assist in explaining the cultural norms that govern relationships and sexual behaviour and give information on where love medicines can be obtained and how this information was passed from one person to the other and transferred from one generation to the next (Mack, Woodsong, Macqueen, Guest and Namey, 2005). It was hoped that the key informants would guide the researcher in identifying the providers as well as the users of love medicines and highlight the link between love medicine and the health of the community. With this in mind, some of the key informants had to be health care workers who had experience of working within the communities. A wide range of health care workers from the different districts were interviewed, including people in charge of the health service, primary health care nurses, HIV and AIDS counsellors as well as community health care workers.

I was also aware that some of the key informants might be reluctant to appear ignorant and that sometimes they would give the information that they thought one would like to hear, rather than the truth. Therefore, this data was verified from other sources, such as the focus group discussions, in-depth interviews as well as other key informants. As an example, some of

traditional healers denied certain practices, such as including human dirt in their potions or not giving love medicine unless the individual was married or the husband was not supporting his wife financially. Most of them denied giving love medicine to unmarried women in the fear that they might target married men, thus causing problems for the wives. This was dismissed by focus group discussions and in-depth interviews who said that traditional healers do not even ask if you are married as long as you pay for the product. Contradictions and new ideas were raised and added to the guide as new themes and these were discussed with other participants until consensus was reached (Ulin, et al 2002). Sometimes these were only prevalent in one the particular area.

Most of the key informants shared information freely, with the exception of the traditional healers. Several things were noted about traditional healers. Some of them took a long time to be convinced that I was conducting research. Some were not comfortable about talking because of earlier negative experiences and I had to explain that I would not be taking the names of plants or animals they used for making love medicine. One traditional healer asked, after giving information, what I did exactly, showing that she still had certain doubts.

They were also concerned about confidentiality as some of their practices were not entirely ethical. Some were aware of the association between sexually transmitted infections and the use of love medicine while others felt that the use of love medicine could have a negative effect on family lives, particularly if used by unmarried women aiming at married men, which was not uncommon. Therefore, they denied giving love medicine to such women. Focus group

were made up of the same sex with an age gap of no more than ten years. In that particular group, the health care workers wanted to include one male who was working with them so the homogeneity in this group was based on the job they are doing. They were all working with the prevention and management of HIV within a health facility. Although this was a deviation from the set criteria, it brought richness to the data collected. The female participants were asking the male for clarity on male related practices and visa versa. Two people conducted each interview or focus group discussion with one person leading the discussion and the other taking notes and checking on the digital tape.

The focus group discussions provided a very detailed and explicit account of social and cultural sexual practices which included the use of love medicine. In spite of both the researcher and note-taker sharing the same culture as the participants, there were times when the information was not familiar to them and a certain amount of probing had to be done. This was regarded as new information which needed further validation and was thus brought up for discussion in the other groups.

Participants were eager to participate in the focus group discussions and in one of the districts we had to send some away because there were too many for the group. Most of the time, they seemed to find the topic exciting and tended to volunteer their own personal information or show how much they knew about the current practices in the use of love medicine. Sometimes it became a challenge to control a group where participants had so much information. In some cases, the women would share their experiences openly as if they wanted to be recognized as

being informative and up to date with what was happening in sexual relationships. This was more pronounced among the young people. In older groups, however, participants were quick to volunteer their sufferings and their reasons for using love medicine rather than explaining what procedure or type of medicine was used. Some of the information became too personal so I had to take decisions to minimize the risk of recognition at the expense of some detailed data, and remind the participants about the rules of the focus group discussion Bergen (1993).

In some cases, participants offered information or made statements that sounded strange. Even before I tried to follow up on the issue, other members would correct the statement using phrases like *"you are lying"* or *"that is your opinion but this is what I know...."* Some would support or disagree. In most interviews, it was hard to let one finish before others gave their own views, added to or finished another participant's sentence. There was a lot of laughter and sometimes they would all talk at the same time. As a result, the researcher had to keep on saying, *'One person at a time,'* to maintain some kind of order.

The researcher and the note-taker were both female. In the past, I have conducted interviews with males and found them very willing to share information. This time, however, the note taker was young and attractive and there is a possibility that this could have affected the data. Some of the males openly suggested that they wanted to finish the session so that they could talk to the note-taker.

4.6.2.3 In-depth interviews

Face to face, in-depth interviews were conducted with individual men and women from the community. The aim here was to extract each individual's perspective on the use of love medicine. The opinions of the individual users were specifically elicited to share personal feelings, experiences, meanings and the social context in which love medicine is being used (Mack, et al 2005). Particular attention was given to social circumstances, love relationships, beliefs and practices as well as the gender issues related to the use of love medicine.

In-depth interview participants were selected on the basis of having been identified by a key informant as being potential or possible users of love medicine or having been observed to be more knowledgeable than others during focus group discussions. Some of them, although they had been identified as users, denied this, while revealing an in-depth knowledge of the practice. They were then classified as key informants in that they had extensive knowledge of the practice although they denied making use of it. In such cases, it was important to continue with the interview to avoid making it obvious that the researcher was pre-informed about their behaviour. It was easy to hide pre information as all the in-depth participants were approached with the same questions of whether they knew someone who used love medicine to enhance sexual relations or whether they had used any of these medicines themselves. This made it easier for the individual to disclose whether they had used such practices before being interviewed further.

4.7 Ethical consideration

A proposal was written in preparation for an application for ethics approval. Guides were developed and revised for the collection of data from the key informants, focus group discussions and in-depth interviews. Consent forms and information sheets were developed. All these documents were sent to the ethics committee for approval. This was obtained from the University of KwaZulu-Natal Ethics Committee in November 2007.

It is always important to get support from the key figures. This research was a follow up study on a gender and sexuality investigation, so the co-operation from key figures had already been obtained while conducting the main study. The field workers and some of the liaison personnel were the same people who had been used in the original study. A liaison person from each district assisted in continuing the process of data collection. Based on their knowledge of the areas, they identified the initial potential key informants, the areas where the data collections could take place and also gave guidance on how to enter each community considering the different politics and cultural practices of each area.

Information sheets with detailed information of the study were made available to those participants who were able to read. This information was also given verbally by the interviewer to all participants to ensure that they were well informed about the study. The autonomy of participants was stressed and those who agreed to participate in the study were asked to sign a

written consent. Those who could not write were asked to make a thumb print on the consent document.

The basic ethical considerations of respect, participants' autonomy, beneficence and justice were adhered to in the study. Protection of confidentiality and anonymity was observed in that the participants were given identity numbers and pseudonyms during the discussions or interviews. The source of information regarding those participants who were identified by others was never divulged. At the beginning of an interview, each participant was asked if he or she knew someone who had used love medicine or whether they had used it themselves. By following this procedure, it was not obvious to a potential participant, who denied being a user, that they had been identified as such by others. Thus, confidentiality was provided to all participants.

4.8 Compensation

Participants were not paid for taking part in the study although members attending the focus group discussions were given a compensation fee since most of them had to pay for transport to get to the venues. Accordingly, an amount of R20.00 was given to each member of the focus group discussions. Refreshments were provided since many of the participants had travelled some distance and, in some cases, had to wait for other transport to take them home.

4.9 Data management

Preparation for data management was commenced even before going into the field. A proper plan for downloading the tapes and for the storage of hard copies was arranged and only the researcher was able to access the information. Identity numbers in the form of a coding system were developed. Each document was clearly marked as either key informant (KII-number), focus group discussion (FGD-number) or in-depth (IDI-number) to avoid the mixing up of data. These documents were later coded with numbers only. The first number represented the district, the second number the kind of interview and the third number the name of the participant or the focus group discussion. In addition to these, the focus group discussions had an additional number to represent the individual participants.

Almost all participants were able to sign the consent form which divulged their real names. These forms were kept separate from the data, to avoid any links between the participants and the tapes or hand written notes. Only the study researcher had access to the consent signed forms as form pf ensuring confidentiality.

The debriefing of data collected was done on the same day after each focus group discussion or interview. The tapes were listened to in relation to the notes while experiences were still fresh. This immediacy enabled the further development of questions and assisted in identifying views or leads to be followed or points that needed more clarification or verification.

Transcription of both tapes and notes was done in a private and secure place. The transcribers were given a short course on good ethical practices so that they could adhere to the ethic of keeping the data confidential. The recordings were transcribed verbatim and some of the tapes will be presented as representations of what took place. Notes of observations were added to the transcribed data immediately after data collection.

Zulu was the language of choice for most of the participants. Therefore, transcripts were transcribed in Zulu and later translated to English in preparation for analysis. The note-taker and I are fluent in both languages which enabled us to countercheck the scripts after translation. The names of the participants and the names of the towns were removed from the transcripts and identity numbers were given to ensure confidentiality and anonymity.

As a researcher who shares the same culture as the participants and who has conducted a similar study on vaginal practices, it was possible that I might draw from the previous study and conclude some of the responses. I avoided this, however, by asking for clarity from the participants. I followed the recommendations of Strauss and Corbin (1998), where I tried to let the data talk to me as during data analysis.

4.10 Data analysis

The initial stages of data analysis of open coding took place concurrently with the process of data collection and continued on an ongoing basis. It was anticipated that key informants,

focus group discussions and in-depth interviews would result in large quantities of narrative data. Therefore, preparations to handle this on a daily basis were done from the beginning of the study. The focus was to be as true to the phenomena being studied as possible, concentrating on the research method (Hycner, 1999).

According to Bryman and Burgess (1999), even the transcripts from the tape recordings might not be able to capture the emotional context. Notes were added to the transcript to cater for this. This included intonation of voices, pauses and other emotional expressions such as laughter. Analysis included critically examining data collected, coding, identifying emerging issues, summarizing and synthesizing the data with reference to the added notes on emotions. Further questions were designed in case certain issues needed further investigation. More interviews and further probing for specific topics were pursued. Follow up on the themes, questions and issues that emerged from the data were done. Assessment of both the quality and quantity of collected data was done on an ongoing basis to identify information categories and thematic patterns that recur. Notes were jotted down while reviewing the data and to record the range of the responses to questions posed by the researcher. Recurrent themes and emerging issues were also jotted down. Convergence, divergence and inconsistence between data from different sources were noted. If necessary, further qualitative data collection was done.

The first part of analysis was delineating unit meaning. This was done by getting immersed in data which involved devoting a lot of time to repeatedly reading data, going over every word,

phrase, sentence, paragraph and noting the added non-verbal communication that was jotted down during data collection (Burnard, 1991). At this stage, the aim was to get the essence of the meaning before addressing the research questions mainly in an attempt to understand the data and to note any ambiguity. It was very important to check possible ambiguities as the data collection was in Zulu and the transcripts translated into English. Words and sentences had to be examined and some words had to be left in Zulu because they lost their meaning in translation. This was done as the researcher was familiarizing herself with the data and trying to gain an overview of the issues depth and diversity of the data. The process of data analysis led to further collection of data, through the asking of questions which were triggered by information collected from informants. This assisted in getting further insight into the phenomenon under study, i.e. 'the use of love medicine'.

The next step was delineating meanings relevant to the research questions (Hycner, 1999). At this stage the version of analysis was descriptive and heavily based on the research question to see if all the questions were answered. This was also started during data collection where the analytic tool was used as described by Strauss and Corbin (2008). This was applied from the first scripts where whatever was missing or not clear was re-highlighted in the guide and asked in the following interview. It was found, however, that usually those questions which had not been answered were because of a lack of knowledge in the participants. The questions were used to probe further and develop provisional answers whereby the processing of abstraction and conceptualization was commenced.

Categorizing of concepts was done by extracting concepts from the raw data (Burnard 1991). These were then developed in terms of their properties and dimensions using NViVo. The categories were refined and became more responsive to the emerging and analytic themes (Strauss and Corbin 2008). This was followed by looking for conceptualization from the refined categories which encapsulated and represented diversity of expressive attitude, circumstances, different districts and different areas within the districts. Comparisons were constantly made. Incidents from all the lists of all the districts and all the participants were compared. Similar incidents were grouped together under descriptive concepts. A colleague was invited to generate category systems independently without having seen the researchers list, as recommended by Burnard (1991). The two lists were discussed with two more colleagues and adjusted to enhance the validity of the categorizing method and to avoid researcher's biases.

The various meanings of words were checked and if one word had several meanings they were also checked. The 'Flip flop technique', where concepts would be turned upside down to obtain a different perspective on the phrase, was applied to some of the categories. For example, it was necessary to establish whether phrases like, 'he has to pay' or 'he has to bring the little that he has' were common in all the districts. This was to check if there could be meanings that one might be missing. The 'waving of a flag' technique was also applied where an issue would be raised that sounded exaggerated such as where the participants would say everyone is using love medicine, *"if there is anyone who says is not using she will be lying...."* as recommended by Strauss and Corbin (2008).

The clustering unit of relevant meaning was done to determine if any of the units of relevant data could be grouped together. Judgment about meaning, relevance and the importance of issues and their implicit connection between ideas was done at this stage. Logic intuitive thinking was applied in designing and refining a thematic framework of presenting the data. The researcher had to be satisfied that the research questions had been addressed. All the clusters were examined to asses the meaning and the essence of each. This was done by going back and forth between the identified clusters.

All the data relevant to each category was identified and examined by using a process called constant comparison, in which each item is checked or compared with the rest of the data to establish analytical categories. This requires a coherent and systematic approach. The key point about this process is that it is inclusive and categories are added to reflect as many of the nuances in the data as possible, rather than reducing the data to a few numerical codes (Pope, Ziebland and Mays, 2006).

4.11 Academic rigor

Although I used the feminist approach to explore, understand and discover information about the use of love medicine, it was important to ensure the fundamental criterion of qualitative, trustworthy research is maintained, as suggested by Lincoln and Guba (1985). It is for these reasons that credibility, dependability transferability and confirmibilty were the criteria

considered for determining the reliability and validity of this study (Lincoln and Guba, 1985; Harmmesley, 1987,).

4.11.1 Credibility

Credibility is the extent to which the data, data analysis and conclusions are believable and trustworthy. It includes understanding of the context and confidence in the truth of the findings. There must be consistency in terms of explanation, and enough narrative data which is sufficiently rich to support the findings (Ulin et al 2002). It is for this reason that all the steps and procedures applied in this research have been clearly documented. A selection of criteria was developed to target people of a certain age or sex, but also to ensure that only people who had been in the area for more than five years were interviewed. Multiple data sources have been used which included various districts, urban and rural, different social levels, different age and sex groups and different techniques. It was assumed that although different methods and different samples were used, the findings would converge and grant a greater credibility to the research.

In addition, contextual, dialogic and reflexive validity have been applied to this study (Denzin and Lincoln 2005, 467). Relating and assessing the contextual developments have been identified as prerequisites for doing a good quality study of this kind (Denzin, and Lincoln 2005). Contextual validity applies because the study was to be conducted within rural areas where there are more women and it's the women who are perceived as custodians of cultural

practice. It is believed that practices are likely to differ in the different districts of the province. Therefore, prolonged and persistent field work was conducted in different districts with different samples using different tool guides (Hilton 2002). The venues for data collection were made to be as natural and neutral as possible (Ulin et al 2002).

Dialogic validity was also applied. The researcher assesses the internal universe of the participants objectively through rigorous use of methods such as observation, interviews and discussions. This process is referred to as methodological triangulation where multiple methods of data collection are used to study the same phenomena (Denzin, and Lincoln 2000: 391). In this case, the research has been more interactive because the researcher was known to many of the participants and had already observed a number of the activities and life style of the community through previous research in these areas. In order to avoid suggestions or presumptions during data collection or analysis, low inference descriptors were used.

The last validity applied is self reflective. Self reflective awareness of mediation is one of the criteria for valid research (Denzin, and Lincoln 2005: 467). According to Davies (2004), feminist and post-structuralist researcher's experiences are not separable from the data and nor should they be. But it is important to identify how to place that experience within the study. It is also necessary to monitor and acknowledge how ones own beliefs and values affect the process and quality of data collection and analysis (Morse and Richard 2002). Supporting this, Fook (2002), further explained that one needs to appreciate how oneself might influence the study by looking at one's own background, embodiment, personalities and perspectives and at how

these intermingle in the context of one's work as a researcher. From a feminist perspective, I had to take time to look at my own position of power and how that might influence my interpretation of participant's perceptions, views and meanings. I made a conscious effort to explain clearly my personal experiences throughout the study process as a document this study. This is a form of bracketing that researchers do so that the reader can make his or her own judgements about my positional stands on the study.

According to Cooper and Burnett (2006) self reflectivity is a way of enhancing quality for qualitative research. It is about considering the nature of representation and being sensitive to the contextual feature in which the information is presented while one continues to get more information from the participants. I had to share some extracts of conversation from other districts or other interviews giving interviewer's assumptions or position about the issue of love medicine practices. This contributed to openness in the research process by completely acknowledging my role of the researcher.

While I am aware that sharing the same culture with the participants could cause biases, I used statements such as, 'the recording person or the peer reviewing the data might not understand', and asked the participant to explain further. The reason for this was that some participants felt I should have known most of what they were talking about. I found this the easiest way to ask for clarification or sometimes I paraphrased what had been said to ensure that I understood.

In some cases, emotional reactions were displayed and statements such as 'you appear to be excited about this product', allowed the participants to clarify if perceived feelings were accurate. Some of the scripts show how I had to assure the participants that their moral standard would be maintained and make it clear that, although issues might be sensitive, there would be no judgments and the study was not about what was wrong or what was right. In that way I followed both constructivism and post structural theories.

4.11.2 Confirmability

This may not be easy since the study will be using the feminist paradigm, but the research has to document all possible biases. As indicated earlier, I did not go into the field with a blank mind as I had already conducted a similar study in an urban area although the focus was much narrower. I had already conducted similar work and had already done some of the literature review, which is what inspired me to conduct this form of study in the first place.

As suggested by participants, I had to change my dress code and make it clear that I was not from the Department of Health, factors which might have hindered discussions. The report has been seen by the original population who has endorsed the data as accurate. The data has been discussed with some colleagues who are experts in feminist and nursing research to see if they agree with what has been said in the report and to clear misconceptions (Lincoln and Guba 1985). This check also covers interpretative validity while doing confirmability.

4.11.3 Dependability

In qualitative research one does not expect to get the same result even if using the same tools. The correct procedure was followed, the research questions were made clear and logically connected to the research purpose and the design will be explained clearly. One interviewer collected all the data to ensure uniformity in asking and probing for more detailed information. Different note takers were used at different sites, but they were all experienced. At the end of each session, both the researcher and the note-taker compared their notes while having debriefing and identification of issues to be taken further in preparation for the next session.

The study followed triangulation of data by using different methods, tools and techniques during data collection to ensure dependability. Parallels were made across data sources where there was inconsistency or contradiction, which assisted the investigator to understand better the beliefs and behaviours of the participants with regard to their sexual behaviour and sexual practices which include the use of love medicine and the gender issues related to this. These were interpreted in relation to constructivism theory in that there is no single truth and that knowledge belongs to the individual and the community (von Glaserfield 1998). It also followed the naturalist paradigm that reality is multiple and subjective (Polit 2001)

4.11.4 Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to another context or setting (Guba and Lincoln 1989). This cannot be guaranteed, but following the document procedure of this research in similar communities and even in other sites, the possibility of getting the same results is very high.The study was not designed, however, with the aim of generalizing, but to access unique information in the four nodal areas of the province in order to understand the context in which love medicine is being practiced. The areas are mainly rural, but there are some towns from whichI got the urban sample. Consequently, the sample was selected from both rural and urban areas to represent view points and experiences of those specific populations and to reflect key issues in the research problem. The main aim is to produce data that is conceptually, even though not statistically, representative of people in their specific contexts. The researcher will account for contextual factors and I believe that as researcher I have enough experience to accomplish this.

In summary, formal qualitative data collection has been collected in four nodal districts from December 2007 until May 2008, using an ethnographic approach. The reason why this is described as a formal process is because an observational part had been going on while conducting other studies within these districts to ensure that data collected is contextual and bias is avoided from the observation of these communities. While the sample included men, the focus has been on the women, their lived experiences and their reasons for using love medicine. Participants have been given the opportunity to direct and guide the research while

the research used a developed guide to focus the on the practice of love medicine in these four districts.

CHAPTER FIVE

Results

Introduction

This chapter is divided into two sections. The first section presents sample realization. This is followed by the presentation of research findings. The findings sections include the love medicine phenomenon, the broader social context within which the use of love medicine is practiced, the risk of HIV infection and possible intervention as recommended by the participants.

5.1 Sample realization

A total of 148 participants were involved in the study. The ages of the participants ranged between 18-60 years old (Table 1 below). Of the 148 participants, ten were married and the remaining 138 were either separated, divorced or had never been married. Two of participants said they were not Christians. Most of the participants had high school education. Out of every ten, two had some form of tertiary education such as teaching or nursing. Fewer than ten of them were still at school and 15 were studying at tertiary level. Some of the community members interviewed were not employed although most of them had completed matric and some of them had some form of tertiary education. Those who were employed ranged from domestic or factory workers to teachers, health care provides and supervisors. Six were self employed working as traditional healers or vendors.

An effort was made to include people with similar characteristics from all the districts in the various samples. These included same age group, traditional healers and health care providers. A snowball technique of sample selection was used. In the beginning, a total of 19 participants were interviewed as key informants, these having been identified in the initial stages by the research team members. The number of key informants increased as certain people were identified by the users as being providers of love medicine, someone they had introduced to the practice or someone with whom they had shared some of their love medicine. Some of these denied being users and therefore could not be interviewed as in-depth participants. Others were keen to give information or show off their knowledge about the practice so agreed to participate as key informants. Key informants provided in-depth information with regard to the use of love medicine.

A total of 16 homogenous focus groups were conducted. Each group, except the health care workers, consisted of six to 12 members of a similar age and gender. In the group made up of health care workers, the homogeneity was based on the fact they worked in the same field and they were of similar age group. Within each district participants were grouped according to certain characteristics. Five focus group discussions were held with participants aged between 18 and 24, with one group being all male. Seven focus group discussions were held with participants aged 25-34. Of these, one was a male group and another comprised of health care workers. In each of the four districts, a focus group discussion was held with participants aged 35 years and older. Males and older women were not easy to recruit and it proved a challenge to bring them all together at the same time and keep them all until the discussion was finished.

A total of twenty in-depth interviews were conducted. These were the people that were identified either by researchers during focus group discussion or other participants. All of these, on their own admissions, were involved with the use of love medicine.

Table 1: Number of Participants/district as distributed by tool

Type		Number of Participants				
		Ugu	**Umzinyathi**	**Umkhanyakude**	**Zululand**	**Total**
FGD	18-24	6	8	12	8 +6 (m)	41 (5groups)
	25-34	6 X2	8 +6	7 (HCW) +6 (m)	7	45 (7groups)
	35+	6	6	6	6	24 (4groups)
Sub Total		**24**	**28**	**31**	**26**	**109 (16groups)**
KII		5	5	4	5	**19**
IDI		5	6	4	5	**20**
Total		**34**	**39**	**39**	**36**	**148**

KII= Key informant interview
IDI= Indepth interviews
FGD= focus group discussion
HCW= health care workers
M= male focus group

5.2 Research results

This section covers the finding as constructed from the deductive and inductive analysis of data based on observations during ethnographic work with the community members in all the four study areas as well as a combination of interviews and discussions. The purpose of this study was to explore the use love medicines among black Africans in KwaZulu-Natal, to

understand the motives related to the use of such practices and to assess whether or not the use of love medicine may contribute to the risk of HIV transmission to both men and women.

The direct quotes used in this study are presented in these numbers as oppose to using people's name in case there is someone staying in a particular district with the same name. In order to ensure confidentiality numbers have been used. The first number represents the district, the second number represents the kind of sample and the third number represents the individual. For an example, 112 means, reading from the right, second key informant from the district coded as number one. Number 233 means the third in-depth participant from the district coded as number two. The focus group had an additional number which represents the individual. For example 321.1 would the participant number 1 from the first group of of the focus group of the district coded as number three. The findings are presented in the following sequence:

1. The love medicine phenomenon
2. The broader social context of the setting in which love medicine is used
3. Matters of motives which place pressure on women to use love medicine,
4. Kinds of medicines used
5. Classification of love medicine according to possible risk to HIV infection
6. Potential risk of acquiring HIV infection
7. Possible intervention

5.2.1 The love medicine phenomenon

A number of subcategories emerged with regard to the love medicine phenomenon. These included: (a) conceptualisation of the term love medicine; (b) routes used to administer love medicine; (c) who are the users of love medicine?

5.2.1.1 Conceptualization of the term 'love medicine'

Love medicine, in this study, emerged as a well known phenomenon among the communities where the study was conducted. Participants had varying ideas when it came to describing the practice of love medicine. They all, however, agreed that love medicine, which is *intando*- a noun constructed from *umuthi wothando* in local language, is a term given to all products used to establish or enhance love or a sexual relationship, to attract a new partner, as a stimulant to arouse or induce feelings of sexual desire (libido enhancer) and/or to improve sexual performance. They were all in agreement that this form of medicine results in greater sexual performance and promotes extreme sexual pleasure and arousal.

Key informants explained the term *intando*;

***112**: The practice of using certain products to enhance relationship, by both men and women, is common in this area. The people here are still very traditional and most of them use muthi.*

***113**: Love medicine is something that was there even in our ancient times I mean people used to have polygamy and you will find that one woman is getting more attention than others and people will be quick to say aha! She has fed him umdlisile-*(has given him love medicine*). ... all these* (referring to products that are inserted or applied on the contact points*) are called*

intando (love medicine). .... *The notion is that he will love you more... He finds it hard to control himself (always wants more of his partner).*

***112**: Use of certain products to enhance relationship is common in this area. The practice is by both men and women.*

***422.7**: Women use iwoza woza (name of the love medicine) to ensure that every man who sleeps with them leaves to tell the tale. Men also rub some ointment on their penis to prevent it from loosing erection.*

***422.2:** ... after using these things you become very attractive and all men come to you.*

Data obtained through discussions also reflected that the conceptualization of the term love medicine seems to have changed over time. In the past, love medicine was medicine that was mixed with a partner's food, a practice which was called *'ukumdlisa intando'*. Now, love medicine is used in different ways. Some come in the form of sweets, powders, pills, concoctions or even dried fruit and are consumed by the user themselves. Others are inserted vaginally and, in some cases, are applied to actively bleeding skin cuts which are made on the contact points such as the clitoris

***131:** the word ' intando', in the past, referred to the medicine used in food. ... But things have changed there are so many methods used these days.... nowadays even the one that people insert vaginally is called intando, but originally when people spoke of intando they meant the one that is added in the male partner's food".*

***113**: This is common in this area, I mean use of intando as they call it. .....They also use other things that they get from ochayile (street vendors) some of them are for insertion into the vagina or even for ukugcaba (applying love medicine on the actively bleeding cut). ....*

The findings in this study further revealed that some love medicines are named according to their desired effect. Examples of these include *'delunina'* which means the love medicine that makes a man forsake all other women including his mother and focus on the user, *'bhekaminangedwa'* which refers to the love medicine that makes the man or partner focus on the user only, 'i*sibambelelo*' which means the medicine that makes a partner hold onto to you and *'owemali'* which means the love medicine that will inspire a partner to give the user money. These kinds of love medicine are commonly used by women according to the informants;

***121.12**: ...Not only his mother, delunina is for him to leave other women that were there before me as well as his mother and focus on me... The other ones (women) are old now I am new so is his mother....*

Talking about love medicine known as *bhekaminangedwa* and *owemali* she said

***224.6**: If your man is going out with another woman, he won't feel her, and even if he has money he can only think of giving it to you. And he will always be on top of you wanting more (sex) all the time.*

Data obtained from the life histories of informants revealed that they believe that love medicine has a powerful effect on the mind and that the recipients of love medicine will actually leave all other women or men and focus on the user.

***122.3** If she does not love me, I will go to the herbalist or may be ask the traditional healer to make her izipoliyane (she will find herself running and crying all the way to my home on her own). ... The minute she reaches my home I will make her lick umuthi and make incisions on her skin and apply umuthi while it is still bleeding to strengthen the relationship.*

122.1 *They (women) ask for love portion or something that will make one always think about them and forget other relationships one have.*

413: *These work…. love medicine…, anything that she wants I would give her. Even if I am married I would not take care of my wife anymore, but give everything to her. I would be aware maybe that she is not giving me much but she is only taking my money. The minute she sees that I do not have money she will leave me.*

431: *He does not go anywhere no, he stays here, drinks his beer get drunk and give kids money to go and buy meat, the kids would end up not buying it because he gives them money many times when he is drunk. So what kids do they give it to me. I tell you he would give me money all day long. Till it is finished in his pockets….*

Men also used love medicine to have control over women and to ensure that the woman does not engage in relationships with other men as stated in these extracts;

122.2 *She won't sleep with another person, but I can sleep with other girls*

Men also indicated that love medicine is used by both partners as a way of reducing risk and ensuring that they don't engage in sex with other partners. They do this in order to protect each other.

122.2 *She will also do that so that both of us do not have sex with other people. We are just looking out for each other. We will then be AIDS free.*

5.2.1.2 Routes to administer love medicine

Further analysis of data revealed that a number of routes are used to administer love medicine. These routes include ingesting love medicine orally, putting it under the tongue (sublingually), massaging or applying it on the skin, rubbing it into fresh bleeding skin incisions (*ukugcaba*),

inserting it directly into the vagina, licking medicine from fingers from a hot potsherd (*ukuncinda*) and inhaling it via facial saunas *(gquma*).

***113**: ... includes muthi for steaming, purging, cleansing so that people love you even more so for your partner. They also use other things that they get from ochayile (*street vendor*) some of them are for insertion and even for ukugcaba* (applying substance on actively bleeding skin cut).

***121.10:** He'll be living with another one some place else, you want him to come back to you, while you steam you talk and ask that you want him to be separated with the other woman. You must say that I need you here, before the end of this day I want you here with me.*

***R00:** (they all talk) isimonyo (is some form of muthi, usually, oily in nature which is applied on the face so that people like you); isigqabo (love medicine applied on the eyebrows); cutting and applying love medicine on the fresh bleeding site (ukugcaba) and also one to insert here, inside (pointing at the vagina).*

***121.10:** ... they must be using pills because there are pills that are available from the shops, so it means that they are using them to make themselves hot. ... and sweet as well from Chinese shops*

Some participants shared stories that the traditional healer (*inyanga*) introduced love medicine into women's vaginas by engaging in sex with them. They then instructed the women not to have a bath before sleeping with their partners.

***431: ...** her husband was abusing her so much.... They (inyanga and the woman) went to the nearby forest. On arrival in the forest the man (inyanga) instructed her to kneel down .... He took the black substance smeared it all over ...On the thing (pointing on the pubic area).*
***I:** You mean on his penis.*

431: *(Agreed, using her head and continued with the discussion) She said he smeared it again on her and he penetrated her. ... When he was finished he said, get dress... your husband will never give you any trouble. From now on he is going to build you a big house and he will love you to bits. ...till now her husband is crazy about her.*

5.2.1.3 Who are the users?

Data obtained through life histories reflected that love medicine is used by all categories of people; men, women, young girls and boys, married and un-married, educated and non-educated, the rich and the poor, religious and non-religious people, as well as health workers. The extracts below are in support of this statement.

113*: All types of people do use umuthi wentando. They may not use the same types but they all at some stage do something to enhance relationship. Both men and women of all ages as long as they have partners they want to impress each other, educated or not, poor or rich when it comes to love they are the same.*

113*: You will find that a professional nurse who knows all about health and claiming to be a Christian changes completely. Say here is matron who is married to a teacher she ends up using these things. People do not plan to do this. You will find that her husband suddenly has relationship with a girl that is not even as educated say like one working at Spar (Retail shop).*

122.3: *Those who are not educated*

122.5: *the educated too. It is the same even educated people do use it*

124.4*: Men use love medicine.... Some of it they apply it on their hands when approaching a woman that they want to has relationship with. The minute they touch her she will be like a*

toffee (kind of melting sweet) *and agree to the man easily. Some put it in the belts on their arms some have it in a cloth around their hips. There are so many of these things that men also do.*

221.1: *... women use 'ugazi' so that they can be loved by their men. It's massage oil that they smear on their chests and private parts to make them hot and nice.*

I: *If I can summarize you are giving me a clear picture that both men and women are using these medicines and there are chances that if you are not married you more likely to use love medicines because you want.....*
122.3: *(finishing her sentence) your things to be right*

In summary, love medicine is the direct English translation of the local language term *umuthi wethando,* which is sometimes called *intando* - a noun derived from this. In the past, this medicine was used by women who were in polygamous or multiple relationships. They used to put this form of traditional medicine into their male partners' food. They believed this practice would make their partner love them more than any of the other women. As time has rogressed, however, various other kinds of substances have been introduced and these are believed to produce multiple effects such as making a man leave others, love the user more, conform to demands and be generous with money. These newer substances can be applied in a variety of ways from merely touching the target like *isibambelelo*, applied to actively bleeding cuts or inserting into the vagina.

All these are done with the hope of gaining attention and enhancing a sexual relationship. Some of these products are given names according to their desired effect or what is hoped

they might achieve. While some of these concoctions are perceived as being traditional medicine, there are also others available which are packaged in the western form and sold as modern medicine from certain chemists. The practice of using love medicine seems to be known by most of the community members where the study was conducted.

5.2.2. Broader social context of the setting where love medicine is used

Data collected through the discussions revealed that there are existing conditions, situations or challenges that seem to influence the practice of using love medicine. These are referred to in this study as the broader social context. A number of sub-categories emerged under this category. These subcategories included socio-cultural factors, socio-economic factors, gender related issues, multiple sexual relationships and individual beliefs and norms. According to data, these factors seemed to influence individuals or contribute to the use of love medicine. These factors are discussed separately although they occur concurrently most of the time. Figure one represents the schematic drawing of the broader social context of the setting where love medicine is used as revealed by data.

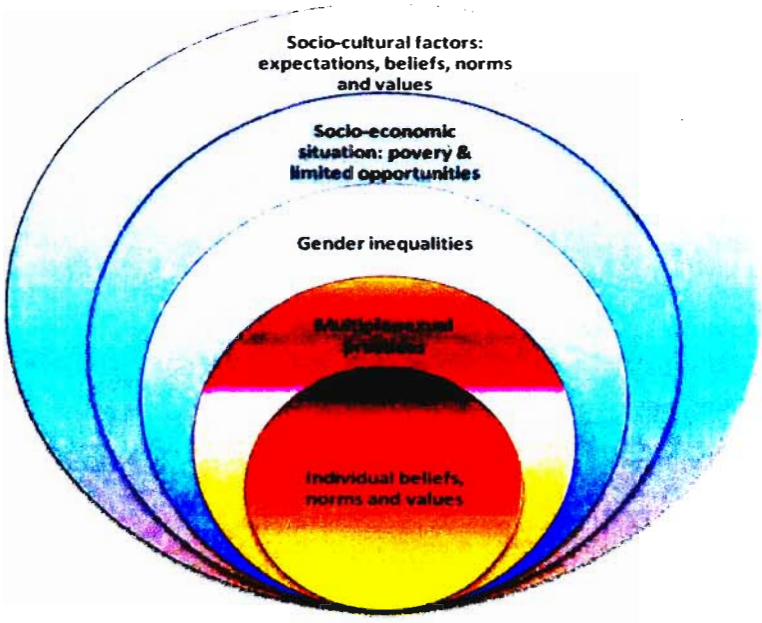

Figure 1: Broader social context influencing the use of love medicine

5.2.2.1 Socio-cultural factors

A number of sub-themes emerged under the socio-cultural theme. These included a forced relationship or marriage (*ukuthwala kwezintombi*), building a homestead (*ukuvusa umuzi kababa*), polygamy *(isithembu*), early engagement in sexual debut (*ukuqoma* symbolizing *ubuntombi)* and the socialization of young men to a culture of having more than one partner (*ubusoka*).

Data collected from all focus groups revealed that *ukuthwala kwezintombi* (forced relationship or marriage) is a culture that is still practiced for a number of reasons. According to the participants, when a man wants a girl (in most cases, a girl that is still a virgin) to make his wife, this man, without even proposing to the girl, would arrange for people to go and take her by

force to his house. They then force her to drink a special traditional love medicine that will make her start developing feelings of love for this man.

413: *"For example in the past if a girl that you wanted refused to have a relationship with you, you as a man could invite at least three other guys to help you. They would go to that girl, grab a hold of her and force her to drink muthi (love medicine). One would hold her hands the other one the head and the final one would open her mouth and force her to swallow that muthi. By the time she gets to her house wow! She would be loving that man. ….She was literally held and forced (ibanjwa idunyelwa). It was known that ufuna ukwakha umuzi (the man wants to build a homestead). She would not even tell her family that she has been grabbed by a number of men who forced her to drink umuthi. They were not really doing a bad thing they were just assisting the man to build a homestead you know. All they wanted was for that muthi to go beyond the teeth. It would be done!... It would be effective there-after (meaning the maiden would love the man after that)"*

122.3: *She has already come on her own so she is going to lick because the ways are different of building a relationship. The minute she reaches my house I'll make her lick muthi and give her incision with umuthi to strengthen the relationship and make sure she never thinks about anyone but me. Then I'm finished about her*

Building a homestead

One of the strong socio-cultural expectations that emerged from this study was the culture of building a homestead (*ukwakha umuzi kababa*). According to the life histories, getting married and building a homestead were found to be highly valued. Among these communities it is more important to have a husband than just a partner as it is a form of security. It emerged from the data that young girls invest their future in relationships with the hope of getting married and having a husbands of their own who will provide for them. According to the participants, their

culture puts pressure on both men and women to get married and expand the clan. Failure to do this results in an individual being given a bad name or viewed as a failure in life. This may sound like the story of *amabhinca (word used to referred to those who dress in a traditional way usually uneducatedand)* , but for most women in these nodal districts, regardless of their level of education, the importance attached to having a male partner has not changed. Their values and beliefs are still rooted in their culture and the time-honoured traditional practices of building a homestead with a man and expanding the clan. Often, in the case of single people, someone close to them such as a friend or peer, may start suggesting that she or he gets love medicine in order to be attractive to the opposite sex. As a result of this pressure, a woman finds herself entering into a relationship with a married man or a man with multiple partners with the hope that he will marry her. There is no guarantee, however, that the partner will love her enough to marry her and consequently, many turn to the use of love medicine as a possible answer to make it happen, to make him love her more, make him marry her or make him only have her in his mind. Regardless of the level of education, the emphasis on having a male partner has not changed as the community norms and values regarding marriage and building the homestead are deep-rooted in the old traditional beliefs.

413. *It was known that ufuna ukwakha umuzi (the man wants to build a homestead). She would not even tell her family that she has been grabbed by a number of men who forced her to drink umuthi. They were not really doing a bad thing they were just assisting the man to build a homestead you know. All they wanted was for that muthi to go beyond the teeth. It would be done!... It would be effective there-after (meaning the maiden would love the man after that)"*

The problem is trying to get someone to marry you. All your age group women are married and you also want to be married. You want to wear gold on your finger (all talking at the same time

making it difficult to make out what they are saying) You are going to use all these things that have been mentioned, love medicine such as peaches and the sweets so that you are adorable and appreciated enough by your man to marry you.

***323.6**: No way marriage is required because even the one that you love should eventually think about marrying you. You cannot just have love relationship that is not getting anywhere for years and years while he continue to give you money. He would prefer that you get closer to him and thus marry you*

***I:** Is having a husband that that important?*
***323.4** Yes he is important who want to be called uzenda-zamshiya [1](they all get married and left her single)*

Some of the participants felt that even for those working, the values attached to having a partner, getting married and building a homestead are made to be such important factors that even educated people end up compromising and using love medicine to achieve this

***122**: Yes it the working ones that are more desperate for being cared for and loved by their partners. I am saying this because I know that from my experience I want a man that is going to give me full attention. Having said that it does not mean that I am scarred of the competition but if I realize that the competition is too much then I have no choice but to stand (meaning start using umuthi).*

Discussions revealed that for a man to keep all the women needed to build a homestead, he would use love medicine. The informants indicated that, even after marriage, a man had the responsibility of ensuring that none of the women in his homestead were fighting so he would give them all the same medicine.

[1] Zendazamshiya is like an insult used for women who "failed" to get married. This is one of the words that are used to make women feel bad if they are not married. Note there is not one for man in the same position

relationship. Yes, you supposed to be happy and say "here come another wife". This is still happening in this community. A woman will do ululate but make sure she remains the most loved one by using love medicine

A man with many wives sometimes resorts to using love medicine to ensure that the wives present themselves as a unified peaceful family, especially in public places. These men refer to their wives as their children, as stated in these extracts;

413: (He smiled) *At that time umuthi was even used to mould your own kids so that they would be good and would not hate each other. A man would be married to four or five wives and they would not fight nor would you hear them talking badly to each other. It was known in the community that this inyanga has umuthi for moulding the kids. As a man your wives are also your kids you want to make sure there is peace in the family. You want to unite all your wives and kids so that there is peace in the family.*

When asked about the implications of being in a polygamous relationship, some participants indicated that it forced them to resort to the use of love medicine. According to the participants, women whose husbands are having extra-marital affairs which may lead *to isithembu* are sometimes introduced to the use of love medicine by their friends.

431: *My husband loved having extramarital relationships (*emphasizing*). Other women then advised me to use such medicine. She took me to someone who then gave me medicine called intando. This person gave me this medicine with the instruction that I should make small incisions and apply it on both eyebrows (pointing at the eyebrows)*

One of the participants stated that although it is a painful experience, it is better for women to know their competitors.

***332**: I am not satisfied by the love I get from my husband. Man should not have more than one woman. But men are never satisfied with one woman. I therefore allow him to show me the woman he has, so that I know who I am competing with. It is more dangerous if he has secret lovers, I rather work on facts than suspicions.*

The jealousy experienced by women in polygamous relationships made them turn to love medicine as a way in which to win the hearts of their husbands. In these circumstances, women search for the most effective medicine, sometimes even going into competition with the other wives as to who is using the strongest medicine. The women boast about the effectiveness of their medicine and how they go out of their way to obtain it.

***232**: She knows we are rivals (sihlezi sibhekene). She is also doing something but awumbiwa ndawonye (*meaning muthi differ in strength*) who ever get the strongest get to win. As it is she has not been in JHB (*where the husband is*) and I do not want her to go there. If I can hear that she is likely to go there I will go out of my way to stop that. To be honest with you, I do not wish any good thing to happen to her. I do not want her to have a beautiful house; I do not want her to get any good thing every good thing should be mine.*

Engaging in sexual debut (Ukuqoma symbolizing ubuntombi)

Participants indicated that a young girl engaging in a relationship with a male partner is highly regarded by some of the community as it symbolizes that the girl is now a mature woman. This is a common practice among people that are referred to as *amabhinca.* The girl publicly declares that she is in a relationship by sending a white flag *(indwangu emhlophe)* to the boyfriend's family. If she is still at school, she is expected to stop once she has made her declaration. She has to wait with the hope that one day her boyfriend will be able pay *lobola* to

however, this well respected culture of *ubusoka*, which was characterized by not engaging in penetrative sex to respect women, has changed and men take advantage of the cultural norms and sleep with many of these women as stated in this extract;

***323.3**: Being isoka was happening even in the olden days but it was different. These days amasoka are using girls and they say that in the olden days it was not like this.*

They say that in the olden days man loved and respected woman they were not rushing for sex the way they do now. If they did, they did not engage in penetrative sex (babesoma). These days, you have relationship with a man today, the following day he wants to have sex with you.

Another participant confirmed this and said;

***323.1:** In the olden days it was known that a man has girlfriends here and there but they were competing on being humble and try to show that they will be the best wife. These days it is not like that one will start using umuthi so that he will love her more. These days it is all about sex nothing but sex...*

Data sources revealed another rationale for engaging in concurrent relationships. Men who were ready to get married had several relationships in order to have a better understanding of the women they were involved with so as to identify the woman who would meet their requirements. According to the participants, during this courtship process, a man normally looks for a woman who is able to endure hardships, who can persevere when things are not going well and who can humble herself and submit to her husband-to-be.

***323.1:** ... a man used to have girlfriends all over and they had to behave themselves as they were in competition and the man was looking for certain qualities from them.*

324.1: ... *They were competing on being humble and trying to show that they will be the best wife.*

323.6*: He also has one that he has planned to marry that he loves more among us. Is it not that we are always competing we are two or three in the competition, there is one that he will marry and leave the rest of us.*

Highlighting the downside of this culture of *ubusoka,* the process of searching for a suitable wife, participants explained that things have changed and that nowadays an unmarried man continues to sleep with all the women he is involved with, even after he (*isoka)* has selected his wife to be. Athough *ubusoka* is an acceptable practice in the communities where the study was conducted, it made women feel vulnerable and fear that their realtionshipship might end , as stated in the extract below;

323.1*: ... these days women do not humble themselves and wait for isoka who is likely to leave her they just use love medicine because she is realising that he is leaving her she does not want him to leave her.*

Confirming this one of the participants said

323.4*. ... it is men who are making woman to use umuthi, if only man could stay with one woman till you decide to take the relationship to the next level it would not be like this. It is man that are making women to do these things*

Responding to another one who was saying it is women who make them do this by taking their partners. Screaming she said

323.1:No! *it is man that make us do all these things... because you find that you start fighting over small thing ... you find that it not just that there is problem but the is another woman in the picture. The problem is that you love him. Then you will not want to be left behind you will start running for muthi (love medicine)*

Some participants stated that women are changing with the times and not allowing this culture of exersicing *ubusoka* to get them down. Now they are making use of love medicine to speed up the process. According to the participants, this culture of waiting for a man to choose the best girlfriend no longer applies as the choice is now in the hands of the women. They say the girls trick the men by using love medicine and the one with the most powerful love medicine wins.

322.4. ... These days, it is no longer like that, the girls are using umuthi (love medicine) so that he will love her more. The one with a more effective love medicine wins and he takes her to be his wife. Unfortunately this medicine wears off.

Data also revealed that there is still a general belief in the traditional role of love medicine as a therapy. Part of this includes using substances in order to enhance relationships, including sexual relationships. Therefore, any perceived negative change in a relationship warrants a visit to a traditional therapist. Some of the participants stated that they had grown up observing their elders, such as older brothers and sisters using traditional love medicines. Therefore, it became a norm that, when one began courting *(ukuqoma)*, one needed to start practicing traditional therapy which included the use of love medicine.

The data showed that, in some cases, even individuals who are not from families who practice traditional therapy are likely to be influenced by their peers to use love medicine. When faced

with perceived challenges such as the lack of a proposal or being abused by a partner, friends or peers introduce them to traditional therapy mainly in the form of love medicine. In some cases, the friends or peers even allow them the use of their homes to perform the practices. Sometimes, it is the traditional healers, themselves, who initiate people into the practice of love medicine. It was explained that traditional healers make it easy for the person to become socialized into the practice and accommodate them by introducing less demanding procedures such as putting love medicine in water for bathing or washing the face.

***232**: My mother was a Christian and I am ibhinca. Like all Christians[2], she wanted me to go to school but I chose to be ibhinca. Mina ngangiqhephulela ngiveza ithanga* (meaning she used to wear attire that identifies her as such and she took pride in what she did). *Ngaba intombi... (*I did not engage in sex before marriage*)*

***234:** In my times when you are intombi you were to take time before engaging in sexual relationship (wawushelwa), I did not see that happening with the Christians so I wanted to experience that , and I wanted to tell my parents when it was time for be to engage in a sexual relationship. I did not see that with Christian girls instead they have many boyfrineds*

5.2.2.2 Socio-economic factors

Subcategories that emerged under socio-economic factors promoting the use of love medicine included poverty, unemployment and the high social mobility from rural to urban areas. These subcategories emerged as being linked. Data showed that these factors are even more

[2] Christianity in this case is not used as religion but as group of people that do not wear traditional clothes. It may happen that one does not even believe in God, but in this community if one wears western clothes that person is regarded as a Christian.

challenging for young people, especially for the girls who drop out of school for different reasons including those who leave because they are preparing to get married. The following are some of theqoutes:

2.1.3: *Unfortunately there are no job opportunities in rural areas. Men have to go to the cities to look for employment so as to support their families.*

2.3.6: *Men are forced to go and look for work in the city leaving their wives behind. Some have more than one and they have to support all of them. A lot happens while they are in the cities.*

It emerged from the data sources that in spite of the high social mobility between rural areas and the big cities, close links are maintained with rural family members. It is not uncommon for a male to have more than one wife and or girlfriend in the city and those who work there still tend to visit the rural areas once a month or so, for at least a weekend. This, according to the findings, poses certain challenges for all the partners that are involved in the relationship. When he visits for a weekend, he cannot possibly see all the women he is involved with. Those who he has neglected blame themselves for not being able to give him enough pleasure to ensure that he wishes to be with them the whole time. They also believe that the woman he chooses to be with has done something to make him prefer her to any other woman. The chosen one then becomes a target for the use of negative love medicine as those who have been neglected cast spells on her in an attempt to get their partner's attention.

214: *In our places as Blacks particularly in KZN you find that man has about five to six girlfriends and a married man has four to five wives. Most men stay in the big city, leaving all these people behind in the rural areas. When he comes for weekend he will not even cover them all, let alone satisfying them.... Women start competing and using love medicine.*

It also became evident from the data that limited job opportunities and poverty in the districts caused women to engage in prostitution and target men who are able to meet their financial needs. These women make use of love medicine to attract men who can provide them with material things and money. It emerged from the data that there is a belief that men will do anything for women who give good sexual pleasure so it follows that love medicine, which is used to enhance sexual pleasure, will result in the gain of materialistic things and status. This was supported during the discussions as participants explained which men were being targeted:

***323.4**: People that are in senior positions in the big companies, yes people like that ...*

***422.6:** This is a business now. People are all benefiting from sexual activities. If you have the rich one you need to keep him by whatever means. Yes there should be one for money and the one that you are working on so that he marries me. The car should come from them, there will be one to buy me a car too....If you use umuthi well he will buy you a car*

Data obtained from informants also revealed that the women who engaged in relationships with men for material gain often found themselves in situations where they had more than one partner. These male partners were targeted for different needs so that they could get the best from each. Therefore, such women could end up being involved with several men

***313**: Some woman may have two or more boyfriends and then others, (not serious boyfriend) will be those who are giving material things in their lives. Like one will give you money and one will provide you with transport, you know when you need a transport you must call him. But some will have boyfriends that are not working, not studying just staying at home as additional- Ughunta waselokishini* (someone who does nothing except drink liquor and eat food*). I really could not understand that one, I really could not ...*

(they both laughed)

422.2: *Say there is one who has beautiful car you want to be in that car, there is one who is working in parliament who has money you want that too. It is not common to get someone who has everything then you want all what each one of them has. Then you end up having more than two partners. So you are going to put them all together so that you get the best from each*

Data further revealed that in some cases the women also have one man who they regard as their real partner. These women try to hide the fact that they have had sex with someone else and use love medicine to restore the vaginal muscle to what they regard as 'the normal or right state.' In other words, they believe they need love medicine in order to be 'put right' what they are doing as they perceive this kind of love medicine of having the ability to return their private parts to a virgin state.

123.2: *...Yes alum tightens and doesn't feel like she has had someone else before, I saw her with my own eyes at work. She washed this thing (*pointing at the private part*) with it when she was about to go to him. ...hiding that she was with someone else, it really tightens the muscles. Then he will find it closed tightly like this...(* putting her hands together as sign of being closed*) Tshitshi phaqa (*meaning it become a virgin like state*).*

Participants explained that should a man who has been successful or earning a good salary get retrenched or lose his status for whatever reason, he will most likely be abandoned by several of his sexual partners.

321.3*: if the person loses his job ...You must leave him and find another one. You must leave that person because if you do not leave him, where are you going to get money, clothes and some other staff.*

It became clear from the data that men who were unemployed were not primary targets when it came to the use of love medicine

***323.5**: You cannot use umuthi for the hobo (poor), the one that is going to ask you to give him money... No you cannot do that, no you cannot do that even if you love him....*

***323.6**: You can love him but you cannot use umuthi the way you would do to the one who has money. Love medicine is used to someone who is who has good education and working in the right places ....like teachers and police (others adding other professions)*

5.2.2.3 Gender related issues

Data showed that there are clear gender roles for both men and women. The role of the men in sexual relationships is to provide for the women and their families while the women are expected to please the men. Pleasing a man includes giving him sexual pleasure and the discussions revealed that women regard this as the key to having and keeping a man. It is this sexual satisfaction that encourages him to pay *lobola* and eventually marry the woman. The socialization is so strong that if a man leaves a woman, she feels that she failed to please him and that is why he has left. In some cases, the woman who has taken the partner would openly say this and taunts the wife by suggesting that she finds something to make her hot if she wants her husband to return to her. One participant explained what could happen when a wife asks the girlfriend to stop having a relationship with her husband:

***113**: ...You know this can be so bad that sometime the matron or professional nurse will call and say can you please borrow me my husband. The girl will give it back to her and say as he is here*

with me I have not finish with him, you will have to wait. She will even ask her why don't she ask him why he left her in the first place, she is cold she better find something to warm herself up. The professional nurse will be pushed to do even more things to make her hot.

The perception of men being providers was so strong that even if a man was not working, women felt that he is still obliged to give her what little he had. This included school boyfriends, some of whom were from the poor families. In some cases, sex is perceived as compulsory in a relationship. If a girl refuses to have sex with her boyfriend she is perceived as not being in love with him. This is what a nineteen year old young man said when he was asked how he felt about receiving a gift from his girlfriend rather than sex.

223: *No, gifts are supposed to be from men, men are supposed to provide financially and give gifts and women are supposed to provide sex and give men what they want....*

All the women, including schoolgirls, agreed that all they needed to do to get materialistic things from men was to have sex with them. This is what one of the participants in the under 25 year old focus group said:

***223.6**: After having sex with him, he starts giving you money and doing almost everything for you.*

The women felt justified in expecting a male partner to give them material things or other support. They felt that men are obliged to give their sexual partners something because that is their role and it proves that they care. If a man does not come up to expectations the woman might start using love medicine to ensure that she gets what she believes is due to her.

***223.1**: He started it.., he is the one who told me that he loves me, so he must show it by giving me something. Uthando isikweledu* (direct translation - love is debt*). School children for instance ask their partners to buy them matric dance stuff, cell phones and airtime and if he can provide that, then you know he is caring.*

Supporting this, a focus group discussion participant who was still at school, said

***223.6**: If you tell him that you are going for trip, he should offer to assist without being asked, then that guy is caring. Even if he is unemployed the little that he has he must put it on the table.*

This becomes a cycle where a man gives money and the woman feels obliged to give sex or the man giving money feel entitled to have sex. Participants explained that one can get money without having sex, but the amount will be less if sex not involved.

***422.4:** There is no way she cannot have sex with them. Men, if they are going to give you anything (uma ezoshaya iphakethe nje) you have to have sex with them these days*

According to the data, men openly believe that if a woman uses his money, she must give him sex in return. This is what one of the focus group discussion participants said:

***422.1: ....** 'consume money and consume the vagina'* (meaning that a if woman uses a man's money the man wants sex in return) *that is what they say. (They all laughed)*

Women were of the opinion that every sexual encounter should feel 'special and different' so that the man would continue to give material things. In order to spice up their sexual encounters, women once again turn to the application of love medicine.

***223**.1 Because if he gets the best spiced he will always want you back, so he will do everything to keep you ,even if it means buying expensive gifts or giving more money.*

Commenting about the gifts and money given by men this participant said

***223.6**: After enjoying such sex with you..... it is appreciation he should appreciate the kind of sex you give him, he will keep coming back.*

5.2.2.4 Multiple sexual practices

Data revealed that multiple relationships were common in almost all the districts. This practice is not only acceptable, but also promoted so that men can have a wide choice in selecting the woman or women that he feels suitable for building his homestead. In almost all the communities, family members openly celebrate an unmarried man having many girlfriends. In one of the districts, where the maiden still brings white clothes or a flag, even the married males celebrate the new love affair. The first wife or other wives are expected to participate in the celebration of accepting a new girlfriend. If they don't, they open themselves to being questioned on whether they are jealous or insecure. Therefore, the wife or wives ululate in jubilation that their husband has won another maiden's heart. However, this does not mean that they are happy with the situation, they simply do not have the power to control or question their partner's behaviour. Many of these women resort to the silent power of love medicine to deal with the situation. The following extracts are in support of the above description;

***214:** Yes that is one of the traditional practice, you are suppose to ululate sometimes you are the only one in the house in the early morning hours so you will be jumping and ululating in jubilation. ... Yes, you supposed to be happy and say "here comes another wife". This is still*

happening in this community. A woman will ululate but make sure she remains the most loved one by using love medicine.

A woman in polygamous marriage described the hostility between the other wife and her, said:

***232**: Sihlezi sibhekene (we are adversary) she is also doing something but awumbiwa ndawonye (meaning the love medicine used differs in strength) who ever get the strongest get to win.... Tobe honest with you, I do not wish any good thing to happen to her. I do not want her to have a beautiful house; I do not want her to get any good thing every good thing should be mine.*

The women explained that they are constantly aware of possible or continuous competition. Some felt that it was better to know who the competitor was. They would then be able to direct a spell on her so that the partner would leave her. They would also use love medicine themselves to ensure that the partner would love them better than his new love and return home.

***332**. Rather I allow him to show me the woman that he has so that I know who I am competing with. It is more dangerous if he has secret lovers, I rather work on facts than suspicions....*

Some felt that it was a painful experience to have their partner in a relationship with another woman. They viewed her as a rival and said they preferred not to know who she was.

***323.7**: What I am saying is that it will be better if a male partner, if he decides to have another woman, that he should not do it in front of you. It is the most painful thing to see. I think it is better if you hear from other people*

The discussions revealed that women also had multiple relationships for various reasons. One reason given was they felt insecure because of the competition. Another reason was the need to get married and expand the clan. Participants explained that some of them use love medicine in order to attract more men. In addition to socio-economic reasons described above, various other reasons were given for multiple relationships. The women explained that they needed options so that if one man left or did not continue with the relationship, there would be another already in place as an alternative. Other participants explained that this practice also gave them a wider choice in cases where they might receive more than one marriage proposal. They felt their biggest challenge was having to give sexual pleasure to many men and believed they had to rely on love medicine to stay dry, tight and hot each time.

According to the findings, women find themselves in a situation where they want to be loved, have status as well as material possessions in order to fit in with their peers and their society as a whole. Most of the women in these districts are unemployed and perceive men as having better privileges. They look for partners who are able to meet these needs and it is common for women to have more than one partner. They give each partner a different title and explained that they assign the names according to what the men provide. This practice results in partners being called ATM machines, ministers or misters of what they provide e.g. Minister of Finance, Transport, Security and so on.

311: *Ok, there are many things, but it is because everyone wants to be loved. And some want to get married, but those young women want money. You will hear them saying they have got*

minister...Minister of Finance and Minister of Transport... they say when they need a transport they must call him the transport one and if they need money, they must get it from that person.

This participant explaining this in another district she said

422.4:... *You are going to have Mister Finance who is going to give you money, Mister Transport if you want to go somewhere he fetches you and if you want to go to parties there is one for that.*

Two different groups emerged among the women who are having multiple sexual relationships. In one group, women have one main partner who she is passionately in love with and other men she has sex with are regarded as providers. The one that she loves is referred to as a straight or "*ungqo*" the direct translation of which means "the real one". In some cases, the loved one is of no materialistic benefit and sometimes he is not even employed. In such cases the woman collects from the "others" who she refers to as ATM, Minister of Finance or Minister of Transport, depending on what he provides. She then uses the money to finance her life with her loved one or buys airtime to call him. This group of women use love medicine to attract men as well as to ensure that they continue to provide for their needs. They use these men as long as they are getting something, but as soon as the men stop providing they abandon them, while continuing with what they call a "straight partner".

Another group of women, however, had multiple relationships in order to try a number of partners to see if they were "good enough". Participants explained that women also want to have the chance to experience a variety of sexual partners. They have sex with various men to

test if they good enough for the commitment of marriage, should they be asked. This is what one of the participants said about testing;

322.4: *Habe! you want to know who is powerful you do not want to tie yourself with the weak thing...*

322.5: *...how will I know if they are powerful enough? You guys (talking to the interviewers) better get a cure because we are not going to stop, no one is going to stop tasting. Is it not that men are also tasting,... women also wants to have a taste. People do not tell how each person taste like so one has to do it for herself...*

This group made use of love medicine to increase their sexual desire and to assist the men in matching them during the sexual encounter. They believe the medicine works if the partner enjoys the encounter and comes back frequently for more. This gives them hope that the relationship will go to the next level.

5.2.2.5. Individual beliefs and norms

According to the findings individual beliefs and values play a major role in the use of love medicine. These beliefs are mainly influenced by individual socialization, social networks, experience in sexual relationships as well as the previous use of love medicine. They include beliefs about traditional therapy, which includes the use of love medicine, and can be influenced by socialization within a family which uses traditional therapy as part of family practice or life style. Individuals with such beliefs tend to explain diseases and negative changes or experiences as being due to being bewitched or not being in harmony with the

universe. As a result, such people tend to approach the traditional healers or use traditional medicine even for sexual relationships.

***231**: Ok, I steam and purge to cleanse…. (laughing) yes …cleansing so that I am right. Not to have isigcagcwa (unluckiness)… I grew up with it really I have never bothered to look at it as not part of my life practices. It just something I just do when I feel like I doing it.*

***231**: …my grand father is inyanga. But use of umuthi is part of family practice. My grand father knows these things*

***133**: He used to beat me because his other girlfriend had used umuthi…. I went for izinhlanga (application of love medicine on bleeding cuts) …Yes, after that I went to him on the same day, since you have to go there while it is still wet. After that we did not fight, everything was alright.*

It emerged from the data that some of the participants who use love medicine identified themselves as Christians. People with such religious beliefs do not normally believe in such practices, but according to the findings of this study, women find themselves being forced to take some kind of action, even if it is in conflict with their religion, in order to keep her man. Friends or peers introduce them to the practice of using love medicine as a way of attracting a man, keeping him or taking the love relationship to the next level. Some of them explained that they were literally dragged to traditional healers by those who felt that they needed to use love medicine which was sometimes the case when friends became aware of an abusive partner or one not giving financial support.

123.3: *... you cannot sit and say that God will see, just because you are a Christian. He (God) will forget you one day -you need to do something for your self (meaning you need to get love medicine).*

Participants estimated that between eight or nine out of ten people use love medicine in some form. A participant in one of the groups even said that *"if they are saying they are not using anything they are not telling the truth."*

Several patterns of use emerged during interaction with the participants. There are those presented as using love medicine constantly as part of their life style. Another group got introduced due to circumstances which exposed them to experiences which have been described as driving forces for turning to the use of love medicine. Among this group some of them use love medicine intermittently when the circumstances arises, like being left by partner for another woman or being abused. Others tried the medicine, but not seeing any positive outcomes or results, they abandoned the practice completely.

Some started in their teens as they prepared themselves for courtship and then continued with the practice. Others started immediately after beginning relationships to prevent their partners from getting other women. There were also those who started using love medicine when their partners had found someone else or when they realized that they were about to lose a partner. All these different applications of love medicine demonstrate its diversity.

5.2.3 Kinds of love medicine

According to data sources in this study, love medicines are mainly derived from plants, animal fat or animal parts, human dirt and body fluids, water and mineral products. Special criteria are used when selecting these plants or animals. They have to possess a certain shape or appearance, behave in a certain manner or be observed as having a special power to attract people in the ways of love. The behaviour of certain animals has been observed, particularly those that are more sexually active in the belief that, as a source of love medicine, users will have a higher chance of achieving the same effect. Consequently, such animals are used for love medicine for both men and women in the belief that they will both want and enjoy sex. Other species, such as certain birds, are used for their tendency to fly as couples. The users hope that love medicine mixed with parts of that bird as an ingredient will result in couples assuming the desired behaviour of always walking or staying together. All species are observed as a potential source of love medicine whether they are water or land animals or even birds. This is what a provider said:

131: *... there are those (products) that they get from the animals, they extract animal fat to make love medicine. They take those animals or birds, like doves, which love each other, so they use these animal oils/fat so that people who have used them as love medicine will love each other the way those animals do. ...It could be water or land animal sometimes they mix them (both land and water animal)*

It also emerged from the data that sometimes only certain organs from an animal are used. The female elephant genitalia were referred to as an example of a particular organ being used for this purpose. Some women believe that by using this organ as an ingredient in love medicine, it would change her own genitalia to resemble that of an elephant, thus making her more sexually attractive to her partner. The participants stated that love medicine mixed with this organ has the effect of tightening the vagina, which is one of the desired effects among those who make use of love medicine.

131: *"This animal (the elephant), its vagina is different from other animal's vaginas that is why those who make love medicine use it. ...they also hope that the vagina will become tight.*

The combination of these two animals, elephant and impala, will result in one making you enthusiastic about sex and this one will keep it swollen and tight. It makes the man (her partner) to see her vagina as something different and he finds it hard to control himself always wants more of her (female partner).

Some plants were described as loving trees or as plants that are loved by many people. Some trees have thorns which users believe, if used in love medicine, will make their partners cling to them like thorns. This is what one of the providers and users said about one of the plants used.

131: *... they use loving trees, mainly from the bushes/forests but there are some that they get at home when one is making intando. They use those beautiful trees that we all love and adore. The notion is that your partner will adore you even more. If you want to make intando that is what you use. They look at those trees that are green during certain seasons so that the love will always grow and be rejuvenated in that season. ... As love dies down, as soon as this grass starts to be green love starts growing again.*

Talking about the thorny plant used she said

131: *.... there is something called isinama (direct translation- attaches on/ sticks on) which they add on it. This thing has fine thorns and it attaches itself and clings on the people as they walk along it. You can imagine this in the muthi mixed with animal fat/oil and you are suppose to apply it on the vagina which so sensitive. Its circles and attaches itself around the trees. That is why you use it because you want him to love and cling on you and not think about anyone else but you.*

Some of the grasses and plants are used because of their network-like shapes. Traditional healers often use grass that is always green, whatever the season. There is a belief that those who use love medicine mixed with this grass will be assured of love that will never fade or die.

... this particular grass they use is always green irrespective of the season so your love will stay like that in any season.

Some informants did indicate, however, that the extracts from some of these plants and trees may have a negative effect such as causing skin irritation.

In summary, there are different kinds of love medicine and these are derived from different plant or animal species. They are selected because certain behaviour or characteristics have been observed. They are usually provided in their raw form as animal parts or fat or the roots, bark or stems of plants which have been ground into small pieces or powder form. These are then given to the user with verbal instruction on how to use them. In some cases, the users are instructed to obtain body fluids such as saliva or blood to complete the form of love medicine required. Sometimes they are required to perform certain acts to obtain the fluids that can be painful and humiliating. Certain love medicines necessitate cutting oneself to obtain the blood or squeezing a sanitary pad for menstrual blood to mix with the medicine. The fact that people

do actually carry out these rituals show that they have strong motives for using love medicine and a firm belief that it does achieve the desired effects.

5.2.4 Matters of Motive

Data showed that these communities had drives or needs that propelled them to use love medicines. These are referred to, in this study, as matters of motives. There are various reasons accounting for matters of motive and these often compel the individual to change the kind of medicine used from time to time. The name of the love medicine tends to be associated with the motive behind its use. Participants indicated that people get trapped in a cycle of using love medicine and that, once one starts with the practice, there is a tendency to continue, thus making it a continuous cycle. Data revealed that in most cases, a stronger or different medicine had to be used to take the love relationship to a higher level. Sometimes users just repeat using medicines they have used before or, if something unexpected happens, such as a partner becoming involved with someone else, they use something stronger. While some of the love medicines presented here (Figure 2) can be used by both men and women, the focus is on women and, for simplicity, only one path is illustrated.

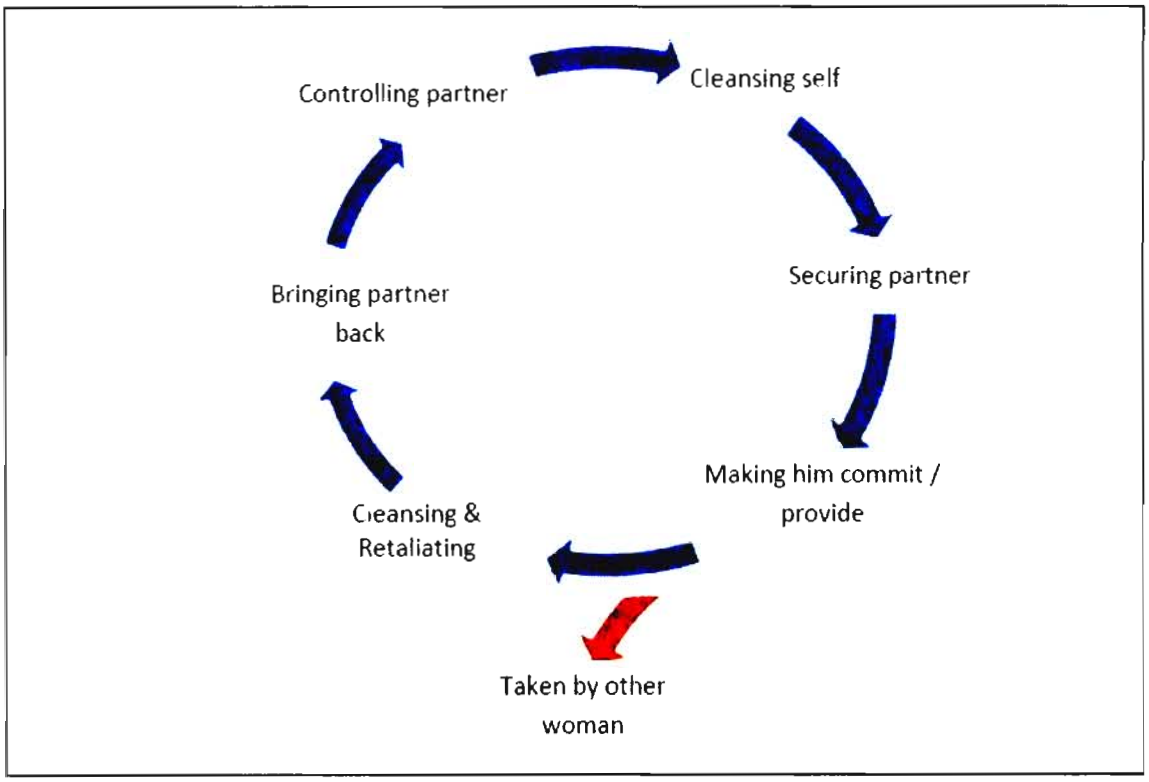

Figure 2: Love medicine cycle matters of motives and the kinds of medicine used

5.2.4.1 Cleansing oneself

Cleansing commonly marks the beginning or initiation to the use of love medicine with the opposite sex in mind. The motive for the first level of cleansing is described as the need to attract as many of the opposite sex to you as possible. At the teenage stage, both girls and boys start discussing the need to prepare themselves for courtship with other young people of their age. One of the participants described this as "*sharpening themselves for ukuqoma*" meaning preparing for the start of a realtionship. They want to have what is called *ugazi* (charisma). The following extracts represent some of what the people said during data collection.

131: *You start by using a cleansing medicine so as to be appealing to the opposite sex. …. The more you do this the more you become more adorable. You start purging and steaming…*

The man described it as

233*…preparing a young man so that they have as many women loving them as they want.*

Another reason teenagers perform cleansing rituals is because they are conscious of their excessive facial oils which is termed *isidina.* While this is usually explained as acne due to hormonal changes, in some areas people interpret this condition in relation to traditional therapy. One of the participants explained *isidina* as a motive for using love medicine because the local people get very concerned when one has the condition and believe it results in what is referred to as *isinyama* in the local language meaning bad luck.

421.6: *Yes, if a person has this (talking about isidina) on the face, it remains whitish like pus; it makes that person not to be liked. People will be sort of disgusted by merely looking at her/his face and she will have isinyam in everythingshe does…. It is not nice to look at one's face when one has isidina. So that person needs cleansing. Only steaming and purging can help that person.*

Even people who are in relationship or already married sometimes use a cleansing form of love medicine because they believe that they have lost their magnetism. Their partners apparently stop giving support, ignore them or become negative and criticizing all the time. In some instances they even beat the women for no reason. When this happens, a woman believes that she has lost her partner even although he is physically there. Explaining what such an individual needs to do, one of the participants said

422.5: *Eee…You start with the red one for cleansing regardless of whether you are removing a spell or you want you charisma (ugazi), dignity... such things... If possible you avoid contact with your partner when using the red medicine until you start the white one*

After cleansing, a person is given another medicine depending on the next level of the cycle and the motive that drove him or her to consult the provider. Most of the women in this study felt that men are unpredictable and their continual involvement in multiple relationships makes the women feel insecure.

5.2.4.2 Securing the relationship

Once an individual has used the cleansing medication successfully and has managed to get a partner, she or he uses a different love medicine to secure the relationship with that partner. One of the participants described why she used this medicine:

221: *When you have used love medicine to secure your relations, all he does is look after this (pointing at her private part). No he will not want you to be out of his sight in case someone else touches that part. Ha! Ha! (laughing)... Because he is scared that you might give this to other people he does not trust anyone.*

223: *To secure my relationship, I use love medicine that will tighten my vagina. Having loose fitting and wet vagina is associated with infidelity and men do not want to share their women. Therefore women do their best to be tight, dry and hot which they believe will help them secure the relationship. …. women want to secure their loves"*

While some start using love medicines as soon as they get a partner, others only do so when there are perceptions or evidence of negative changes in the relationship. This includes being

aware that there is someone who is having a relationship with ones partner. In these districts women compete openly for a male partner irrespective of his marital status. According to this participant, one of the reasons why one uses love medicine is to ensure that one doesn't lose a partner to another woman.

***234**: It starts with two people having a relationship with one man, that is the beginning of all this. One starts performing practices that will make her successful and make the other one fail... That is where it starts. She will start using medicines. The most important is to get the one to make her to be loved more and the one to make her competitor not loved. .... This is not something that is happening or done in this area only it is done everywhere.... Yes it is done everywhere else most of the time now... girls are doing it now.*

Different participants commented on how they started using love medicine to secure their position in their relationship. Explaining how she started using love medicine one participant said:

***232**: I had a relationship with my husband and she came in a year later. After that my husband who was my boyfriend then changed. I went to a traditional healer, ngabhunkula (I took it very seriously). This woman (referring to a traditional healer) told me that this second wife who was a girl friend then had done something to my boyfriend, I started steaming and purging. After that this traditional healer made applied love medicine on the razer blade made incisions with to make sure that nothing affects me in future.*

In some cases the motive for using love medicine to secure a relationship was based on a comment made by the male partner or even a perceived reaction. Whether these comments or reactions were positive or negative, women felt that they needed to either reinforce the positive reaction or change the negative by using love medicine.

432: *Ok I fell in love with this man. He had many girls loved him, and he said those girlfriends are right and I am not "right" (Meaning they were dry, tight and hot). I did not want to leave him or him to leave me although I knew he loved too many women. I had noticed that I was always wet and not enjoying him, and he told me that I am cold. Yes, when I realized that those girlfriends were doing something clever, I asked the traditional healer, who told me that they using traditional love medicine (umuthi) and then I started using love medicines.*

5.2.4.3 Make him provide or commit

The next step in the cycle after securing the relationship was to take the relationship to the next level. This would either make him commit to marriage or provide financial or material things while preparing for lobola. Because these motives were not easy to separate, in some cases the same love medicine was used for both. Both married and unmarried women used love medicine to ensure that their men provided for them. The main motive for married women to start such love medicine was because of the tendency of married men to forget about their families and use all their money on the new sexual partner or partners.

431: *Like my husband, he was working in the (naming the city) and he loved women. The problem was that the minute he had those multiple relationship he tended to forget completely about his family or coming back home. Yes I was worried about the fact that he was forgetting to come home and he would not even give me money when he had his affairs. Other women then advised me to use the medicine.*

It emerged from the data that not all users of love medicine wanted their partners to marry them. In some cases, the women themselves admitted to having multiple relationships with

the aim of getting a little bit from each man while having someone else that they loved passionately. Nevertheless, getting a male to commit to building the homestead and providing for his family was the main reason for using love medicine. It was noted that women will do whatever it takes to ensure that they are the most appealing candidate for a proposal. The following participant explained why women use love medicine with the hope of getting a man to marry her.

3.2.3 *The problem is trying to get someone to marry you. All your age group women are married and you also want to be married. You want to wear gold on your finger (all talking at the same time making it difficult to make out what they are saying) You are going to use all this things that have been mentioned, love medicine such as peaches and the sweets (*names given to love medicines that are used for enhancing sexual pleasure*) so that you are adorable and appreciated enough by your man to marry you.*

223.2*: Sometimes you find that he is your baby's father you do not want him to leave you for other woman so it is important that you have isihambelelo so that he does not go anywhere and he provides for you and your child.*

Data also revealed that sometimes married men promise women, especially young girls, that they will marry them. Some of these women fall in love with the married men and fall pregnant with the hope that they will soon be married to their partners. They only discover later that those were false promises.

234*: Yes I knew that he was married, at the time when we started with the relationship he did not say that he will give me the baby and then leave me, he said he wants us to end being a beautiful thing. Then that is where it should go. Hey I am going to stand up. I am going get love*

medicine very soon. I will stand up for big things not just simple things. The big thing will be to cast a spell on her (wife) first. I want to end their relationship and get love medicine for my man.

It was common among women to blame other women if the partner does not fulfill her wishes as indicated in the script above. As a result, any woman that is involved with her partner is perceived as a barrier and she will try by all means to remove her so that she can have her partner to herself. Therefore she may cast a spell on the other woman with the hope that her partner will leave her (that other women) and be able to fulfill his promises. In some cases the spell is perceived as manifesting itself in a form of vaginal that makes a woman wet and loose or penile discharge for a man. Some felt that the spell can even be in the air. This participant explained what happens if a spell has been cast:

422.6: *The man will complain of the fecal matter that smells in the room. You will wash and spray perfume, but he will continue to complain. You will try to do everything to make sure that the house is clean maybe even change the linen daily in the bedroom but nothing will work. He may even say you are not bathing, you stink. Then you will realize that you need to do something....*

The participants explained that such circumstances sometimes limit the choices of an individual. Even if a woman does not want to use love medicine, she is forced to start engaging in the practice because she has a spell on her.

***323.5**: Sometimes even if you do not want to use muthi and you just tell yourself that I am not going to do anything, your competitor will not only use umuthi for her partner but she will also put spells on you. Then you will start having very bad pimples lice and so on....*

***323.3**: No it is not only pimples that they can do they, can also make you smell very bad like fecal matter at the same time you will not even smell that yourself.*

It emerged from the data that having a spell put on one not only results in the possibility of being physically or emotionally left by a partner, but there is also the perception that the same spell can have a negative effect in all spheres of a person's life including relationships at work or with other community members. Therefore, this itself becomes a motive for the use of love medicine irrespective of whether the person wants her partner back or not, as it is just as important to be liked and accepted by other people. This is how one participant presented this:

***323.5**:... even other people will not like you anymore and they may be disgusted by you. Even if your partner desires to be with you, when he looks at you,... he may just beat you even if you have not done anything wrong.*

5.2.4.4. Cleansing and retaliating

Participants explained that it is important to cleanse oneself and remove the spell. This is achieved by using different medicines at the same time, one to send the spell back to whoever sent it in the first place and another to make the user more desirable. If this works, the partner starts getting disgusted by the woman who originally cast the spell and this makes it easy for the next step of returning him to his partner to take place.

Your competitors may use a medicine that will make your husband see you unattractive. Sometimes you develop even pimples and you have oily skin. You are forced to see a traditional healer who will give you a cleansing medicine and isimonyo for later. Isimonyo makes you

adorable to your partner and other people. Thereafter traditional healer gives you one for securing your partner

5.2.4.5 Returning the partner

If the woman is still interested in resuming the relationship, after cleansing and removing the spell she would start using love medicine for returning her partner to her. This stage has several steps. The first step to be performed is to use the love medicine which is referred to *isikhafulo* (calling him). This is how a participant described what happened after mixing the substances as instructed by the provider

422.5: *...Took a gulp and spit it while calling his name and telling him that I wanted him back. It only took me three days after doing it I got a phone call. He asked me to come and visit him. I said why all of sudden .... He insisted that I come and visit him. The girlfriend that he had was in his place he told her to leave...*

The women believe that this is the most critical part and the product used should be effective enough to make him make the necessary moves. If it does not work it will be a problem because the next step, the medicine for sexual enhancement, can only be used after he has arrived home. If he does arrive, one has to apply *isibambelelo* so that when hugging and kissing, he gets the first dose of love medicine. One of the participants who had been given three different types of love medicine to use for this said she could not get to the other steps because her partner did not respond to the first one. This is how she put it:

234: *They say isikhafulo (1) is for calling him to come to you. .... I was told that if you use it he comes to you immediately. I did not see that happening. So I could not continue because you drink that one (2) (referring to the one for enhancing sexual pleasure) when you know he is coming, you need to call him first before you use the one for drinking. Isibambelelo (3) you apply it on the points of contact including your hand and your private part, they say if you meet him, then it works...*

This same participant explained what she finally did to restore her partner and ensure that he would not leave her again for other women.

431: *She also gave me another one that I had to scrape my nails with the razor so that that I can get them in powdery form. Mix that with umuthi that she gave me as well as the blood that came out from the incisions I made on the eyebrows I had to put that in his food for him to eat. She (traditional healer) said things were going to be ok. Yes he came back and stayed in the house.*

5.2.4.6 Controlling the relationship

The next step, as presented by the participants, is to take control of the relationship by controlling the partner by using various forms of love medicines. The motives for women to use these kinds of love medicine range from being exposed to abuse by the current or previous partner, being neglected or experiencing challenges in the relationship such as where the partner, married or unmarried, is involved in multiple relationships.

422.3: *Multiple sexual relationships is one form of violence because by the time he leaves you in the house you are emotionally abused, you are always worried and thinking about it. Sometimes he is not even giving you money, say you have kids you will just see his pay slip but you will never know what he does with the money. All women do these things because of all the abuse that they are exposed to by man.*

In many cases where women are using this kind of love medicine, they become so much in control that the situation gets reversed. The women openly or publicly shout at their partners. They humiliate them by expecting them to do all the household chores which are normally done by women. The participants explained that in such cases, the men are unlikely to retaliate, but rather conform or oblige to any demand made by the women who has used such controlling love medicine. This is part of the discussion

***324.1**: No I wanted to talk about the one that is use when you are talking to your boyfriend. You put it in your mouth and slightly gnaw it. ...After gnawing it you then remove it as you kiss him the minute he tastes that first saliva after removing the umuthi he will just listen to whatever you say and conform to your instructions. Anything that you say or want, he will do it.*

According to the participants, the person who has used such medicine does not need to be around her partner to make him do whatever she wants. They referred to this as controlling him at a distance. Some of the participants described this as remote controlling. This one explained:

***324.3**: yes there are some women who use love medicine as remote control for their partners. I am saying this because when you use this you want him to listen and do as you say. You tend to drive him or as they call it 'pull him by his nose'. He becomes isithithi (*closest translation, puppet*) He listens and agrees with everything you say (they are all in agreement). He becomes fearful of his wife and trembles when he sees her or even when he thinks of her.*

Confirming this a male participant said

413: *These work.... love medicine..., anything that she wants I would give her. Even if I was married I would not take care of my wife anymore but give everything to her. I would be aware maybe that she is not giving me much but she is only taking my money. The minute she sees that I do not have money she would leave me.*

One of the participants explained how the love medicine she had used changed her partner's behaviour.

431: *...Now that I am using the love medicine I tell you he gives me money all day long till it is finished... Yes ! Yes ! it is because of my thing that I gave him. He stopped having girlfriends and stayed here. He has now got his pension and he is staying at home. I am the one who is collecting his work pension*

It became evident from the discussions that participants believed there was a risk associated with a woman being in control of her male partner. Some of them felt that women who use this kind of love medicine are likely to cheat on their partners or have multiple relationships.

321.2*: Women that use love medicine cheat a lot. Because you will see that the partner who has been given umuthi will be like conforming to everything and lack that manhood. He becomes isindandanda nje- a person that conforms to all the instruction, rules and regulation from a woman. That is not what a man is supposed to be*

423.6: *Yes, there are really quite a number of women who use love medicine and have multiple relationship*

5.2.5 Classification of love medicines

All the different medicines presented in the section above were analyzed further. The main criteria for this was to establish whether there was an exchange of body fluids during the procedure or whether it necessitated engaging in unsafe sex. Several points were explored in order to determine these factors and these included the kind of love medicine itself, what it entails, the procedure undertaken when using it, reasons for using such love medicine, common intentions given for using that particular variety of love medicine, age of initiating the practice, the nature of the product itself, the procedure and site where it is performed, the person performing the procedure, the effect of the substance used and whether a condom can be used during application. Based on these points the kind of practice was identified as either low or high risk.

5.2. 5.1 The low risk love medicines

The low risk love medicines were identified as those medicines which have minimal interference in the body of an individual and do not expose the user to the exchange of bodily fluids. Medicines that were used for purging, steaming, bathing or washing the body were regarded as less risky. This includes the use of water that has been prayed over which is regarded as holy water. Other low risk love medicines are those used to cast a spell, or those put under the tongue by the user. In this case, the user simply calls the name of her partner with this medicine under her tongue and that will do the trick.

234: *They say isikhafulo is for calling him to come to you. .... I was told that if you use it he comes to you immediately.*

Other medicines are chewed by the users and while chewing it they have to kiss the partner and exchange saliva. Once the partner tastes the woman saliva she has full control of that man. There is a tendency to assume that if one has used love medicine on the partner he is not likely to have other women. Safe sexual practice does not often become a discussion for such couples

***324.1**: No I wanted to talk about the one that is used when you are talking to your boyfriend. You put it in your mouth and slightly chew it. By the time he is kissing you then he is going to be affected by your saliva. Yes whilst you are just talking and relaxing... After chewing it you then remove it as you kiss him the minute he tastes that first saliva after removing the umuthi he will just listen to whatever you say and conform to your instructions. Anything that you say or want, he will do it.*

In some cases the practice itself may be low risk, but the consequences may lead or expose the user to risky behaviour such as multiple sexual relationships. This participant explained how she ended up being given attention by many man.

***422.5:** they pray for the water and give it to you to wash, isiwasho is even stronger than umuthi. There is Mr Ziyalo (simulated name for the spiritual healers) ...what he does is pray and give you water to wash. The spell, no matter what kind, goes back to the owner. I tell you there was time when not a single man was saying a thing to me after I was left by my baby's father... I took water and went to Mr Ziyalo (naming him again). I followed the instructions within four days I saw the results...(meaning she got more men interested to her)*

5.2. 5.2 The high risk love medicines

The high risk medicines include those where small skin cuts have to be made which cause bleeding. The traditional healer applies the love medicine to the incision while it is fresh and still bleeding. This results in body fluids becoming mixed with love medicine. There are other risks attached to this process. The traditional healer may use a razor that has not been sterilized and his unprotected hands might not be entirely clean as he makes the incisions and applies the love medicine to the bleeding cuts, thus putting both parties at risk. For the medication to work the user has to have sex with her partner while the incision (which may be in the clitoris) is still fresh and it is believed that the use of condoms will cause a barrier to the effectiveness of the medication.

232: *After that this traditional healer made incisions with a razer blade to make sure that nothing affects me in future.*

Sometimes the traditional healer applies the love medicine to his own penis and introduces it into a woman's vagina through unprotected sexual intercourse. He then advises her to go and sleep with her partner immediately, before having a bath. Other love medicines are merely applied inside the vagina, but for them to work the woman has to engage in sex with her partner without the protection of a condom.

232: *You apply the love medicine inside the vagina. This one makes him go mad with excitement,*

***221.6**: While using umuthi there is no way sex with condom can be done..... You rather tell people to stop using umuthi than tell them to use condom.*

***313**: ... my friend had to have sex with this Inyanga that was a foreigner without a condom.*

***431:** ... her husband was abusing her so much. Inyanga took her to the forest and instructed her to lie down. The Inyanga said "do not be surprised", he took the black substance smeared it down there (pointing on the pubic area) and then penetrated her without even explaining. When he was finished he said, get dress, your husband will never give you trouble again. From now on he is going to build you a big house and he will love to bits. Indeed the husband's behaviour changed*

Some of the love medicine that is applied inside the vagina dries up the normal vaginal discharge and the woman engages in dry sex which results in excoriation of the vagina.

***232** There are those that dry you up, I mean making you not to be wet. A man should not swim in your excessive vaginal discharge but must find you dry.*

The love medicine which take the form of simple bathing, steaming, purging and drinking may be regarded as safe if the users take the precautions of having safe sex. The other kinds of love medicine, however, that include inserting substances into the vagina or applying substances to actively bleeding cuts have more serious implications because they involve the exchange of fluids. These put both the user and the traditional healer or who ever is cutting at risk. In addition, the fact that direct contact and fluid exchange is needed for love medicine to be transferred exposes not only the user, but also the partner to the all the risks that go with unprotected sex.

5.2.6. Risk of HIV infection

This section is divided in two parts. The first part presents the perceptions of the participants with regard to the potential risk of acquiring HIV infections. This is followed by an assessment of the possible risk to HIV based on a number of points that are usually included in a discussion of HIV prevention.

5.2.6.1 Perception of HIV infection risk by participants

Most of the participants were concerned about the possibility of exposing themselves to the risk of HIV, but they made it clear that they felt the punishment or pain of embarrassment of not having a male partner or husband, or the failure to keep him was greater than the fear of the possibility of acquiring HIV. They believe that it is much more important to secure and protect a relationship than to worry about acquiring HIV infection. It also became evident that these community members felt they had more pressing and urgent needs which ranged from financial needs to the societal expectations of having a partner. Women were more open about these needs.

221.2: *I don't think so....(they agree).... They don't think about it at all. They are busy thinking of what they want at that moment in time, they think of the now and not the future, they don't care what the future holds for them.*

What did emerge from the discussions was that there is an existing tension between protecting a sexual relationship and acquiring HIV infection. The most striking data was that women were prepared to put their lives at risk as long as they could get a man to be their husband. This

appears to be influenced by the strong social need to get married. Participants were determined not to be left behind. They explained that if a woman remains unmarried when her age group is already married, she becomes stigmatized and named *zenda-zamshiya,* which in translation means 'all got married and left her behind'.

422.6: *I cannot afford to lose a husband (she is not married but she is hoping that if she has sex without a condom the partners she has will marry her therefore she is looking at him as husband to be) because I am trying to prevent HIV. I rather give him without a condom. He (husband) is important. Who wants to be called uzenda-zamshiya (they all get married and left her single)?*

A woman's desperation to secure a husband becomes greater as her age increases irrespective of whether she is working, even in a professional capacity. As a result, women use more and more love medicine in order to attract and secure a relationship. The participants admitted that there is the possibility of getting HIV infection, but the fear of being left on their own is greater than the fear of having HIV. They further explained that they were not going to stop using love medicine.

422.2: *... we grew up with the belief that life is about having a man when you reach a certain stage I have to have a husband even if I am working I can afford everything but my life is not complete unless I have a husband. As results we end up grabbing here and there, trying to find "Mr Right". It is for this reason then that we end up getting STI's because we have unsafe sex and not use condom while using all these substances (referring to love medicines)....*

Because it is necessary for an exchange of fluids to take place for love medicine to be effective, participants explained that it was not possible to use a condom as the two do not work

together. They made it clear that they had no intention of using condoms and would continue avoiding them.

***221.6**: ...We all know that condom is for prevention of fluids contamination from one person to the other, so how do you change that concept. How do you say it is selective? No matter what one has used, is supposed to get through to him. Then condom by its nature is not meant for that. Therefore condom can only be used when muthi is not there.*

Some felt that the price for getting and usingthe substance is too high, this include money paid and procedures used for the practice. Therefore they wanted to make sure that there is good transfer

***232**: No, you need to make sure that there is direct contact with the intended person. So you can not use condom because condom forms a barrier. You do not want anything that is going to delay the process. You want him to get it straight. Remember there are other things that you apply/insert into you vagina. So they all need to get to him. You cannot pay for all these only to use a condom to prevent it from being effective.*

Participants felt that as much as community members live in the three dimensions of present, past and future, the importance of getting a person now in order to be married is more important than any thing which may happen in the future. The painful experiences of being rejected by a partner in the past remains indelible in their minds and this makes it hard for them to think about changing their beliefs and practices in an attempt to prevent AIDS, something that might only happen in the distant future. This participant had been left by her fiancé a few months before this discussion

***422.2:** Let me tell you this, I have learnt my lesson, I do not want to be the one who is left, never again, the next person that has the potential of being a husband I will scrape and feed him*

(meaning she will use love medicine). So the use of love medicines is not going to stop and condoms are not going to be used. Unless you do it they are going to take him,.... use all means to keep him otherwise you are going to loose him, awumbiwa ndawonye (the one with the strong one wins).

Some of them believe that everyone has HIV and everyone is going to die of it. Therefore, they see or express no need to prevent the spread of HIV infection.

422.4: *People believe that there is no-one who does not have it and there is no-one who is not going to die we all have HIV so why worry...*

Data revealed that some of the community members are aware that they are going to die and that this could be due to HIV or AIDS. But, given the socio-economic situation and lack of job opportunities they portray little hope for a better future. They feel that they will not be able to change their situation to make their lives better than what it is until they die. Some of them even blame the previous government for putting the virus in the food. Sometimes having AIDS, as bad and scary as it may be, is perceived as beneficial in that those who have been diagnosed as being HIV positive get a government grant. One woman said this with tears in her eyes and her voice stayed in my mind:

422.6: *Sisi Busi (referring to the interviewer) this makes no sense, say we all go to the clinic to test maybe out of all of us here only one will be negative "so what is the point of using a condom". It is all the same. Anyway there is a grant to console those who are HIV positive. Sisi Busi we all have it we do not even need to test, we all have this HIV. At least there is lot of money in the HIV grant let us use the government money. Wow! We are all going to die anyway at least let us get the grant whilst we can.*

Confirming that some people perceive some benefit in having HIV, she continued:

422.3: *At least if you have HIV you get a little bit of money (uyaholahola). We are trying to get money by all means ....*

In addition to this perceived benefit, those who had some knowledge of HIV and AIDS explained that general ignorance and myths about how it is transmitted further contributed to the reasons why many people made little effort to try and prevent becoming infected by the virus.

221.7: *Some people don't care about HIV or AIDS who say that they won't be the first ones it kills (they agree)...they say that everyone has it, even the food we eat has the virus. They say that the Whites put it on our food.*

In summary, participants were aware of the possibility of spreading the HIV infection when using love medicine, especially when it involved unsafe sex. However, they felt that there are other issues that influence them to compromise their health. These include the need to have a partner, experiences of having been rejected, lack of job opportunities and the availability of a government grant.

In addition to this, it emerged from the findings that there are myths and misconceptions regarding the transmission of HIV which are aggravated by the cultural beliefs associated with traditional therapy. As a result, blaming someone else or others for HIV or AIDS related deaths was as common as blaming someone else for a relationship that was not working. Some people did not believe in the reality of HIV and denied ever having buried any relative or family member who had died of the disease, claiming rather, that they had been bewitched.

5.2.6.2 HIV infection risk based on the practice presentation

Sexual behavior has been identified as the main driver of the HIV pandemic in South Africa. The data from this study revealed possibilities or potential risks that are associated with the use of love medicine. Most of the procedures would not be harmful if precautions were taken during sexual activities. Unfortunately, however, the practice itself has the inherent belief that there should be body fluid exchange and skin to skin contact. Sexual intercourse is the preferred mode of applying love medicine and, because of the very nature of the practice, it is the sexual act itself that is used as a measure to asses whether the love medicine has indeed been effective.

It usually follows that the more the couples have sex after using love medicine, the more they want it. The data revealed that an increase in the number of sexual sessions per night as well as the more times a man visits with a desire to be together are some of the measures used to assess the effectiveness of love medicine. This is how one of the users described how they measure whether love medicine is working or not:

333 *I can say they may have sex once for that night because the boyfriend did not enjoy from the beginning. If you have repeated sex it means he enjoyed it. Yes it means it went well (laughing).*

If there have been more frequent sessions during the night, according to some of the participants, that means that the love medicine worked.

131: *You can tell that at that time (during sex) mmhh!.. you feel it yourself .... And you can see him that on that day that he cannot let go, he clings on to you. I tell you, your partner will*

refuse to let go if you have used it. He literally refuses to be away from you. He does not get enough of you ... he wants to be with you all over. He follows you where ever you are. He becomes so jealous as if someone touches you and takes whatever you gave him. As a result he wants you to be always close to him. That is exactly what you wanted that he must love you alone and even more and that is what intando (love medicine) is all about.

A variety of different types of love medicine have been presented above (section 5.2.4). Several points were explored and further analysis was done to determine the possibility of the risk of HIV infection. These points, (Table 2), include the kind of love medicine itself, what it entails, procedure undertaken when using a specific love medicine, reasons for using such love medicine, age of initiating the practice, sexual relationship at the time of use, nature of the product itself, procedure and the site where it is performed, the person performing the procedure, effect of the substance used and whether a condom can be used during application or not.

[NOTE WELL: While most of the love medicine is used by both men and women this table focuses on women.]

The main criteria examined were whether there was a possibility of the exchange of body fluid during the procedure and whether it involved the requirement of engaging in unsafe sex. Based on these points, the different aspects of practicing the use of love medicine were identified as low or high risk.

Practices in the category of low risk include mainly those that have been presented as cleansing and cleansing with retaliation. It is important to note, however, that these low- risk practices mark a beginning. Because of the traditional beliefs of the users, the chances are high that in time they will progress to the other practices, which will put them at risk. This is particularly the case when it comes to cleansing with retaliation because the individual is already scared that she might lose a partner which is her reason for using the medicine. Such users are likely to compromise anything, including their lives, in order to get their partner back. Therefore the women will not even suggest using a condom. One of the participants confirmed that she would rather have HIV than be left alone

***422.2**: ...If he comes back and wants it (sex) without a condom so be it ... use all means to keep him otherwise you are going to loose him again,*

In addition to the intention to transfer love medicine through fluid exchange, women also believe that men enjoy sex more without a condom and are prepared to give them that pleasure.

***422.2:** Some women have this perception that if he gives you money and takes you out then he is fine. So why do you have to be concerned, why can't I prove to him that I love him too? I do*

Confirming the issue of trust as reason for not using a condom this participant said:

***422.1:** It shows that you love him and you trust him with your life, you see.*

The use of love medicine, thus, not only increases the risk of contracting HIV by not using a condom, but also increases exposure by a higher frequency of encounters.

Table 2 : Summary of kinds of medicine used and the potential risk to HIV infection

Category of practice	Reason for use	Intended goal/ purpose	Health risk
Cleansing **Procedures** Purging Steaming Bathing/washing **Users** Used by both men and women	Preparation for courtship Attract attention from opposite sex Excessive secretions on the face Loss of dignity/ charisma from one's partner Pimples that are perceived to be from being bewitched Need to attract opposite sex Cleansing with the purpose of making one attractive Positive effect on one's appearance	Be more loved and desired by opposite partner Become appealing to everyone Make one's skin attractive. Make more people attracted to one Clear pimples Get natural beauty Get charisma / (*isthinzi*- dignity) Remove spell. It appears to be the beginning of any use of love medicine provided by traditional healer	**Procedure** –not much risk associated with HIV except that the medicine for purging could have an effect on the metabolism. But no literature has been sought on this. **Practice –Low risk** Attract more of the opposite sex Beginning of the use of love medicine Lead to sexual engagement Can start as early as 14 years Later in life, used when there is evidence of multiple relationship User is often aware of, or engaged in, multiple relationship
Securing the relationship **Procedure** Apply love medicine on contact points of the body Make cuts and apply love medicine. Apply, smear on, or insert, the genital Lick it (put it on the hand and lick it Drink (with water or milk/ milk products)	Mainly used to prepare the genitalia for or in order influence the opposite sexual partner Has an effect on the vagina Preventing the partners from having other women Sheer jealousy Suspicion that partner has other women Ensuring that even if he has other women, he believes that there is no one like you. Make him loves you more	Improve sexual pleasure, enhance love relationship. Hot Dry Tight Making partner struggle confuse him, make one the best sexual partner. make him feel you. provide sexual pleasure for your partner	**Procedure** - sometimes small cutting & application of love medicine is done even on the clitoris Individual has to have sex while the cutting are still fresh Body fluids are mixed with love medicine Insertion of drying agents The used love medicine has to be transferred without a condom including the licked or love medicines which have been drunk **Practice- High risk** Condom is purposely avoided to ensure transfer of the love medicine Commonly used where there is suspicion or evidence of multiple partners The user intends to win the partner from other sexual partners Users tend to have multiple relationships and use this to conceal infidelity or so that they can perform equally with all of them

User Mostly by women and some men			Increases sexual desire and Increases the sexual exposure Could lead to bruising as partner struggles during penetration due to drying agents applied
Make partner commit or provide **Procedure** Cast a spell to the one that is perceived as the strong contender Do all above procedures Put love medicine under the tongue before calling or talking to him **User** Mainly women	Protect one's territory Make partner commit to the relationship Make him take the relationship to the next level Make him give you money or gifts as form of provision Even if he has other women make him feel you as being the best	Remove the other contender Get married, build the homestead Get financial support Make him listen and do what you want Make him show that he appreciate you, by doing "things" for you	**Procedure** – sometimes small cutting and application of love medicine is done even on the clitoris Individual has to have sex while the cutting is still fresh Condom is purposely avoided to ensure transfer of the love medicine Body fluids are mixed with love medicine Insertion of drying agents The used love medicine has to be transferred without a condom **Practice – High risk** The used love medicine has to be transferred without a condom The user intends to win the partner from other sexual partners Increases sexual desire and increases the sexual exposure The users are also likely to be having multiple partners providing different needs for each
Cleansing and retaliating Procedures Purging Steaming Bathing/washing Cast spell to other contender **User** Mainly women who believe that a spell has been cast on them	Loss of dignity/ charisma from ones partner Pimples that are perceived to be from being bewitched Appearance of pubic lice Informed by traditional healer that a spell has been cast Return the spell to the sender Has an effect on one's appearance	Return one's dignity Regains ones charisma Clear pimples Get natural beauty Remove spell. It appear to open the opportunities for the next steps to return the partner	**Procedure** –This cleanser differs from the first one in that there is additional equipment used and the individual has to call a name as she purges. **Practice - low risk** Partner is known to be having an affair with someone else Pubic lice explained as a spell as oppose to sexual transmitted infection – sign of multiple relationship Efforts are being made to return him There is an urgency to get the next step which is having sex so that the partner gets love medicine through sexual contact No plans are made for HIV prevention

Returning the lost partner **Procedure** Khafula Cleanse Make cuts on the contact points Apply love medicine on the hands **User** Mostly by women and some men	Make him/her leave the other contender for you Make oneself attractive and desirable Prepare oneself for sexual pleasure	Make the person dream about you Prepare for improved sexual pleasure as soon as the partner comes back or find an opportunity to have sex with him	**Procedure -** sometimes small cutting application of love medicine is done even on the clitoris Individual has to have sex while the cutting are still fresh Condom is purposely avoided to ensure transfer of the love medicine Body fluids are mixed with love medicine **Practice –High risk** More of opposite sex gets attracted Used when there is evidence of multiple relationship No testing for HIV on return There is urgency to transfer the rest of the love medicine sexually This means purposely avoiding condom use Pubic lice being interpreted as spell and thus not treated accordingly
Controlling the partner Put love medicine in his food Do any procedure on securing relationship using more than what is normally used **User** Mostly by women Users have experienced loss of partner Tend to be verbally abusive to the partner Tend to be demanding	To avoid previous experience either with the same partner Ensure that the partner does not have other women Keep him under constant fear of what can happen if you find out that he is talking to other women	Control the partner in absentia Control his finances Seclude him from his social network Keep him busy and make him jealous. make one the best sexual partner. make him feel you. provide sexual pleasure for your partner	**Procedure** – sometimes body fluids and human products are mixed with love medicine to be added in the partner's food Small cutting application of love medicine is done on the points of contact including clitoris In some cases the male traditional healers use their own penis to transfer the love medicine to the women who then has to transfer to the partner Individual has to have sex while the cutting are still fresh Condom is purposely avoided to ensure transfer of the love medicine Insertion of drying agent may cause bruising during partner's struggle to penetrate **Practice - High risk** Gives false hope that the male partner does not have other partners Possibility of acquiring HIV is not likely to be considered

5.2.7 Possible interventions as suggested by participants

One of the objectives of the study was to investigate possible interventions that might reduce the spread of HIV. These were addressed during the interviews or discussions that identified love medicine as contributing to the risk of acquiring HIV infection. Therefore, all the proposed interventions are based on the issues that came up from the each interview or discussion. In most of the cases, however, participants felt that there was nothing that could be done, either to stop people from using love medicine, or reduce the pandemic of HIV and AIDS.

Participants felt that people are not going to stop using love medicine. They did, however, suggest that, with help, it was possible to continue with the practice more safely. They suggested that those developing strategies to reduce the spread of HIV infection should do so in collaboration with the traditional healers, who are so trusted by the community,

***231**: I will say if people use that medicine, they must make sure that they use condom in order to stop the spread of HIV. Yes people are saying if you are using a condom, the medicine will not work, they are saying that, but to stop being infected with those unknown disease, you must use a condom. Or rather stop using umuthi and use only a condom. So I was thinking that we must speak to izinyanga and to recommend that they need to advise people that use umuthi use to it with condom as this diseases is spreading too much in our province. I think people believe them (izinyanga) so if we convince the izinyanga to do the job I think more people will listen to them.*

Other ideas put forward as possible interventions included the creation of job opportunities in the rural areas as well as other social activities such as sport or any other form of entertainment. Participants felt that if there were more activities available, especially for

young people, they would have less time to think about and invent ways of attracting the opposite sex.

Another important factor that emerged from the data was people blaming someone else for the spread of HIV as opposed to each person taking responsibility to make a difference. Most of the time men were identified as the main cause of people using love medicine, because of their multiple sexual practices. It was felt, therefore, that intervention could only be possible if the men changed their sexual behaviour and started focusing on only one woman at a time.

Open communication between partners was another possible intervention suggested by some of the participants. They explained that sometimes, when a man was aware that one of his girlfriends had died of what he suspected to be AIDS, he would try to protect his wife, by avoiding sexual contact or try to introduce a condom without telling her the reason why. Women, however, interpreted the situation differently. Most women assumed that if her partner is no longer having sex with her, it is either because she was not hot, dry or tight enough for him or because another woman, who is involved with her partner, has cast a spell on her. She usually reacts by using love medicine and demanding sex without a condom to treat what she perceives to be the problem. If a woman stops having sex with her husband in an attempt to protect him, he, on the other hand would conclude that she is having an affair and thus preserving herself for the other man.

In both cases, the partner who is trying to protect the other ends up giving in and having sex without a condom. Most of the participants, at the end of the discussions, suggested that a cure for HIV must be found because they could not imagine people stopping the practice of the love medicine or having safe sexual practices.

In summary, the use love medicine is a well known practice. The figure below summerises the the findings It has its history imbedded in traditional culture and is associated with building a homestead. Men, in the olden days, used love medicine to make their polygamous wives and their children live happily together. Women also used the practice in order to get more attention from *isoka* or husband who had multiple sexual relationships. The use of love medicine is evolving with time. The marketing is expanding and the providers are introducing more and more substances all the time. There are now love medicines that can be used while talking on the phone and these are presented as sweets or referred to as tea. This seems to be a marketing strategy to entice even more users. The names used seem to give the impression that the product is guaranteed to give the desired effect. It is interesting to note that in spite of education and civilization, people still believe in the use of love medicine. Whether this is because the providers are good at makerting their products according to the beliefs of the community remains a question that cannot be answered by this study. However, more people are getting involved in the business of selling or providing love medicine in whatever form.

Girls, as young as 14 years old, start to use love medicine in preparation for courtship and boys, a little later, at about 16. This is dependant on socio-cultural factors, socioeconomic, gender issues and an individual values and believes on traditional therapy. In most the cases the study showed that the practice is associated with multiple sexual relationships. Users believed that almost everybody uses love medicine and therefore fear that unless they do the same they might lose their partner to a competitor who is using such medicine. The practice is often associated with no condoms used.

CHAPTER 6

Discussion and Interpretation of findings, Recommendations and Conclusion

Introduction

This chapter is divided into a number of sections where the finding are discussed and interpreted and this is compared to the existing literature. It opens by presenting love medicine as a phenomenon where the researcher explains what love medicine is, how it has evolved with time, the various names of such products and the duality, - having both positive and negative effect, of this medicine is discussed. This is followed by a presentation on the users of love medicine, how the users are socialized and how the products are marketed. The next section is about the broader social context influencing the use of love medicine which is followed by kinds of love medicine and matters of motive for use of such products. This next section is about the health risks associated with the use of love medicine and is followed by a discussion of various implications of using love medicine. Based on all the above discussions, the recommendation section is presented which is followed by a summary and the conclusion and the limitation.

6.1 The love medicine phenomenon

In the context of this study love medicine is known as *umuthi wentando* in the local language and refers to medicine that is used to attract a new partner, to establish or enhance an existing sexual relationship, as a stimulant to arouse or induce feelings of sexual desire (libido enhancer) and/or to improve sexual performance and the quality of sex as stated in Scorgie, et, al (2009); Brown and Brown (2000); Balela (1998). According to the findings in this study,

some of the products used as love medicine were presented as having an effect of tightening the vagina, making it dry and hot. Others were presented as having the ability to alter the appearance, shape or appeal of women's genitals and increase the sensation to the man during sexual intercourse as stated in Andel, de Korte, Koopmans, Behari-Ramdas, Ruysschaert, (2007); Scorgie, et al, (2009). Andel, et al (2008) however, reported that some of these have a negative effect. They can make women feel uncomfortable and experience pain and bruising during sexual intercourse from product mixed with thorny plants, but endure because they want to satisfy their partner.

Research findings revealed that love medicine is used by both men and women to keep the partner. It gives the partner some form of power over the partner of the opposite sex. Love medicine enables the user to manipulate the partner to do whatever they desire. The women who are regarded culturally as less powerful obtain power through the use of love medicine and they are able to control their men. This is in line with Foucault's (1979) statement that power is everywhere. According to Foucault, every individual is surrounded by different patterns of power to be discovered and used. The shift in power from men to women as a result of the use of love medicine is in line with the statement by Foucault that power in relationships is not something that is given once and for all, but it can be modified and it constantly reshapes participants as it brings them into action. Men in this particular study also used love medicine as a form of power to manipulate women, especially those who were difficult to convince. They used love medicine to force these women, especially young women, to marry them.

The findings reflected that love medicine may be used in a positive manner to reduce the risk to STIs. Some partners according to the findings from this study voluntarily submit to the power of love medicine by agreeing as a couple to use love medicine on each other. This is done as a way of protecting themselves against relationships related risk. Such agreement between partners is described by Rhodes and Cusick (2000) as a critical effort to manage risk related to having concurrent sexual relationship. According to Rhodes and Cusick (2000), the couple adopt this approach in the relationship as a form of protection against the risk of contracting STI's, including HIV. Rhodes and Cusick (2000) further stated that managing risk in a relationship is critical and efforts to protect intimacy and relationships from risk are applauded in areas which are characterized by threat and insecurity.

The understanding of the love medicine phenomenon seems to have changed over time. Initially, love medicine was the traditional medicine that women put into their partners' food in the belief that it would make him love the user more than any other woman. Data sources revealed that the practice of love medicine changed over time and included purging, steaming, topical application, cleansing of the body and incisions on genital areas, including the clitoris and pubic area. It also reflected that as time progressed, various different kinds of substances were used and the methods of administration were adapted accordingly to include sublingual substances, vaginal insertions, and potions to be applied on actively bleeding incisions. Most of these routes used to administer love medicine have been reported in other studies that have explored the use of traditional medicine (Cocks and Møller 2002; Kale, 1995). The paradigm shift in the understanding and practice of love medicine subscribes to the view by post structuralism that identity and meaning are not fixed, but is always

provisional and shifting, as stated in Wendt and Boylan (2008); Jackson, (2004). This means love medicine has a temporal face that changes with time, as stated in Velebeyoglu (1999).

Most of the products used as love medicine emerged as given names according to the desired effect; *'delunina', 'bhekamina ngedwa', 'owemali', 'isibambelelo'*. While some forms of love medicine are perceived as having physical effects such as tightening the vagina or enlargement of the penis and stimulants to men, other forms emerged as having a psychological effect. For example love medicine known as *owemali (*for money*)* makes men give their partners all the money they have. The love medicine administered by men to young women to force them to love or marry them makes these women lose their minds and run to the user's house and accept the proposal to be this man's girlfriend or wife. The physical and psychological effect of love medicine was reported by Civic and Wilson (1996) in the study they conducted in Zimbabwe, a study that was exploring dry sex.

Further analysis of findings reflected that love medicine comes in two forms. One form is positive and is used to make one feel more loved or appreciated by a partner. The other type is more negative and is referred to as spells. These are cast on others who might be perceived as a threat to a happy relationship. Therefore, a woman who has challenges in her sexual relationship might believe that it is because of another woman who also has a relationship with her partner. One of them will cast a spell resulting in *isidina* or *isinyama,* excessive oiliness or white pimples on the face. It is believed that the man will feel disgusted when looking at these manifestations and he will leave her for the one who has cast the spell. It came up in this study that nearly every-one, particularly women, who is in a good, stable and

happy sexual relationship, is perceived as using some form of love medicine and/or performing some traditional therapy.

The study revealed that a love medicine spell can also manifest itself in the form of a vaginal discharge. This is usually the act of either a jealous partner or the new girlfriend. A male version of this type of spell would result in a penile discharge being inflicted on whoever tries to have sex with his female partner. This is believed to be some form of protection used by a jealous male so that his partner does not engage in sex with other men. It followed that the participants in this study viewed penile or vaginal discharges as the results of a spell rather than sexually transmitted infections. These findings showed a high level of ignorance regarding STIs, especially vaginal and penile discharges. This ignorance regarding vaginal and penile discharges as infections was also documented by Meyer-Weitz, Reddy, Weijts, van den Borne, Kok, (1998); Scott and Mercer, (1994). Peltzer, Mnqundaniso and Petros, (2006) reported that vaginal or penile discharge referred to as *ilumbo* was the second highest form of sexually transmitted disease reported in their study.

6.2 Users of love medicine

Love medicine, in this particular study, was reported to be used by everyone, irrespective of the age, gender, religion, level of education, social class and economic status. With respect to age, the younger groups of women (from age 18- 34 years) appeared to be the most informed about love medicine and it was established that they were also the main users. They knew what was currently available in the market and what to ask for. The younger group of women

described one of the medicines as 'cell phone medicine' whereby the user simply phones her partner and speaks to him with love medicine under her tongue. It is believed that the effect of this medicine will make the partner give money to the user and this was found to be commonly used by young girls. Young girls and young boys all made use of various medicines for cleansing, purging, steaming and bathing to make themselves attractive to the opposite sex. The findings in this study revealed that some of the younger people do not only use love medicine to make them attractive to opposite sex, they also engage early in unsafe sexual practices.

All the participants, except two who claimed to be Christians, indicated that they were aware of the use of love medicine or making use of it themselves. Although these two claimed that they did not use love medicine, other informants reported that Christians often do use it, but do so privately. These findings regarding Christians not using love medicine were contradictory to the findings in the Mander, Quin and Manders' (1977) study where almost all users of traditional medicine had some kind of Christian affiliation. In Mander, et al's study, almost all of the participants admitted or implied that they had tried or were still using traditional medicine. Ashforth (2005) pointed out that commonly, Christians are expected not to associate themselves with traditional healers or traditional therapy of any sort including the use of love medicines. This author argued that Christians commonly view use of any kind of *umuthi* as demonic. Therefore those who do engage in this practice tend to hide the fact or keep it as private as possible by going to places where they will not be recognized.

Hewson (1998), in defense of those African Christians who do use traditional medicine, stated that God and the Spirit should be interpreted within the African context where God assist men in his endeavor to make life work. Findings in this study showed that when it comes to sexual relationships, women find it hard to sit or pray and wait for God to make things happen for them, as also stated by Jarama, Belgrave, Bradford, Young and Honnold, (2007). Women in this study explained that their major fear was losing their partner to another woman believed to be using love medicine. In support of why they used love medicine, they stated that God had given them brains so that they could do something to prevent this or get their husbands back. They even stated that, *"God assists those who assist themselves."* In order to have and keep a partner, women in this particular study relied on the magic and power of love medicine. Literature shows that this is a commonly used statement by women in such situations as it is not unique to the districts where the study was conducted. Women in the studies by Scorgie, et al (2009); Cocks and Dold (2000); Cocks and Møller (2002); Civic and Wilson (1996) and Runganga, Pitts and McMaster (1992) also pointed that that God assist those who help themselves. He wants you to make a move and then will help you.

Regarding class and status, discourses reflected that all people, irrespective of their class or status, used love medicine. What came out clearly was that professionals and those with good status, just like Christians, were not openly making use of these practices. They utilized the services of traditional healers who were far away from their homes where they will not be recognized to keep it a secret and they consulted them at night. Similar findings have been stated in Ashforth (2005).

6. 3 Socialization, providers and marketing of love medicine

Data revealed that there was a difference between men and women in the way in which they were socialized to the culture of using love medicine. Women from the community socialized one another on how to prevent a male partner from being taken by another woman, how to make him commit to the relationship and how to make him provide financially. Women tend to perform the procedures in private hoping that no-one notices, especially their parents and partners. As a result, mothers and sisters rarely introduce their daughters or sisters to the practice of love medicine. This study showed that girls are introduced to the use of love medicine by friends, peers and close relatives such as cousins and aunts. Their mothers and sisters have no involvement in the socialization of girls to the use of love medicine. In line with these findings Runganga et al (1992); Braunstein and van de Wijgert (2003), stated that some cultural and traditional practices, like other values, are taught by peers or other community members.

Men, on the other hand, either observe their elder brothers openly performing the procedures or the brother actively introduces them to the practice. It was one way of socializing boys to manhood. What was also noted in this study is that men could ask female partners to prepare their love medicine, while women tended to hide and use the love medicine without being noticed. This makes one wonder why men use love medicine openly and women practice this secretly. This may be associated with norms and values related to what is regarded as acceptable behaviours for men and women and issues of power which allows men to view themselves as in control of women from an early age.

According to this study the providers of love medicine were among the people who play a major role in introducing new products and making the users believe that certain products are better than the other products in the market. Ashforth (2005) pointed out that persuasive language is used to promote the love medicine products and the public is bombarded with adverts of substances that can be used to enhance sexual relationships (Copy of the pamphlets attached appendix 2). Pamphlets are handed to passers-by irrespective of age or any other characteristic. Ashforth (2005); Cocks and Dold (2000) reported that in these pamphlets the products are listed for the public and sometimes prices are included.

Marketing strategies are used to introduce participants to love medicine. It emerged from data sources that many of the products are advertised in colloquial language according to their desired effect. Such examples are, *'it will make him think of you only'* , *'bring your lover back',* and *'Get you to marry that love of your life'* (see the attached pamphlets which were obtained from the informants). Velebeyoglu, (1999) argued that the use of such language makes people feel that this is what they need. Bayles and Bujra (2000), supporting this, indicates that language is used to place value on sexuality and sexual behaviour because all the products are presented as 'enhancing sexual pleasure.' Phrases like *'walala wasala',* meaning you snooze you loose (if you do not do something you are going to be left behind), are used to encourage women to use love medicine to enhance sexual pleasure in order to keep their partner. Authors such as Bayles and Bujra (2000) argue that persuasive language used plays a major role in exposing people to the risk of contracting HIV.

Traditional healers and some of the faith healers also play a major role in the marketing of love medicine as they are highly respected members of the communities. As a sign of respect, they are called by names such as *umama,* (mother), *ubaba* (father) *umuntu (the person) or obonayo* (the one that can see). All these titles denote the authority traditional and faith healers have over the people who are using love medicine and other related traditional therapy. As a result of their position of authority, it is easy for them to introduce the idea of using love medicine or promote a new product of love medicine to their clients during a consultation. More importantly, traditional healers and faith healers emerged as the first line of contact at a community level when people were having health problems. In Peltzer, et, al,(2006) it was reported that about 36% of those who had visited a health clinic in the past 12 months had first been to the traditional healer. This is an indication that traditional healers have an influence and are respected in the communities.

The providers of love medicine in this particular study were not different from the providers of traditional medicine as documented in studies by Ashforth (2005); Bagnol (2003); Cock and Dold (2000) and Mander *et al,* (1997). The providers included trained traditional healers, faith healers, street vendors and pharmacies. Some of the venders had gained their information by being experienced users themselves and who had started mixing and selling for other women. Others were buying the products from chemists and selling at an increased price to other women. They market their merchandise in public places where women come to collect children grants, along the streets and even in the public toilets. In addition to these vendors, an emerging form of franchise has been reported where the providers tend to employ people

to sell the packaged products and this practice seems to be mushrooming throughout the province.

Further analysis of the findings related to marketing of love medicine revealed what was pointed out by Foucault (1980). Foucault (1980) pointed out that sexuality of fulfillment follows the development of consumerism. He explained that in such cases new development takes place to satisfy the demands of the consumer and is perceived as having the possibility of fulfilling or satisfying his or her needs. The one perceived as having the best products possess the power to control the consumer. It emerged from the findings that there are two distinctive tiers of sexual consumerism related to the use of the love medicine. The first tier is where the providers of love medicine develop the product and market it for both men and women who are the potential consumers of such products. Marketing of love medicine is done in such a way that it is up to the consumer to create his or her own meaning and there after decide whether to buy the idea or not. The truth is not hidden, but the focus is on what one can achieve. As a result, not much is said about the possible risk of acquiring HIV or hastening the chances of getting AIDS by increasing exposure to unsafe sex. The meanings are rooted in the language and they are always provisional and shifting to suite the consumers' needs as explained by Wendt and Boylan, (2008); Jackson, (2004); Howe, (1994); Sands and Nuccio, (1992).

The second tier is that men are the consumers, traditional healers and women themselves are the producers and the products are bodies of the women. These are put on display and language is used that does not hide the truth, but construes it so the women feel justified in

having unsafe sex in order for the love medicine to be transferred to the intended target thereby achieving the desired effect of getting a man who will love, care and provide for them. Unsafe sex is literally promoted in the belief that the medicine will not work if used in conjunction with a condom. Therefore based on expectations, experiences and the immediate needs, women tend to focus on the potential benefit of using love medicine. They tend to create new meaning that after using the products, the men will focus on them and that they will always come back even if they do go astray.

It emerged from this study that the participants were becoming concerned about the increasing number of providers. They felt that some of the products were not genuine, but that the women were so desperate to have and keep their partners that they used them anyway. Some of the users were too ignorant to tell whether a product was genuine or phony. More importantly, the users find themselves trapped in situations where they keep trying other products because some of the products are not assisting in achieving the desired effects. Suggestions were therefore made that the government should do something to control the market. This concern was also raised by authors such as Vilakazi (2005); De Wet (1998). This may, however, be a challenge to those who are involved in the practice of love medicine, as this may have an impact on the income or may threaten jobs for those who are just suppliers, as also alluded to by Mckean and Mander (1999) and Mander (1997).

The findings also reflected that the natural resources which are utilized for making love medicine or other traditional therapy are at threat and fear of extinction for some of the species has been a cause for concern for the government and those who are working with

environment preservation. McKean and Mander (2007); Mander, Ntuli, Diedericks and Mavundla (2007); Botha, Witkowiski and Shackleton (2004) also pointed this out. Curbing the use of love medicine may have negative implications to the survival of a number of people, especially the manufacturers, the suppliers and the users. Therefore this issue must be treated with caution and health professionals and other relevant stake holders need to come up with suggestions that will not have a negative impact to this particular group of people.

6.4. The broader social context leading to the use of love medicine

According to Ashford (2005), the broader social context has an influence on the social vulnerability of both men and women as some of the norms and values are socially constructed. Subcategories that emerged under the broader social context included socio-cultural factors, socio-economic factors, gender related issues, multiple sexual relationships and individual beliefs and norms. These factors are presented together because they are intricate and intertwined thus making it hard to discuss one without bringing the other to the discussion. Factors that emerged under the socio-cultural domain included building a homestead (*ukuvusa umuzi kababa*), forced relationship or marriage (*ukuthwala kwezintombi*), polygamy (*isithembu)*, early engagement in sexual debut (*ukuqoma symbolizing ubuntombi*), and socialization of young men to a culture of having more than one partner (*ubusoka*).

Regarding building a homestead, the findings reflected that getting married and building the homestead was one of the most highly valued norms and expectations of both men and

women to continue family heritage as stated in Chong and Kvansky (2005). Marriage seemed to be highly valued according to the culture in these communities and as an end to all. The findings revealed that a man should have a wife, or even more than one, in order to build a homestead. These men commonly used love medicine to control their wives so that they do not question their behaviour. Men's power to control women in this study was demonstrated by having as many wives as they preferred under the pretense of building a homestead. A woman, on the other hand, had to get married so as to assist man in building his father's homestead (*ukhakha umuzi kayise*[3]). Because of the value attached to building a homestead, women felt the need to be married or stay married even if the husband gets married to more women or has extramarital relationships. In view of this vulnerability of women to men, Mane and Angleton (2001) pointed out that cultural expectations shaping women's behavior sometimes exposes them to risky situations and emotional abuse.

Women in this study indicated that they were expected to support their husbands when they introduced a new wife into the family otherwise they were regarded as being jealous. Furthermore, women indicated that, because of cultural expectations, they fear that they would be punished by both families (their own family and their in-laws) if they refused to engage in sex with husbands even if he has been unfaithful. This reflects that although it might compromise the health of the women, infidelity by men was not only socially acceptable, but even encouraged in some of these communities. In line with the findings in

[3] Ukhwakha umuzi kababa (kayise) is analogue used as reason why a man should have wive, the more wives he has the bigger the homestead and the more the head of the family is respected in the community. Therefore the each son cannot claim ownership but is sort of looking after it. One often here men saying not in my father homestead when in actual fact he is the one who has literally build it.

this study, Campbell (1997) stated that some rigid traditional beliefs and practices continue to place women at risk and discourage men to engage in safe sex.

The study findings revealed that attracting a partner and getting married was critical to both men and women. To be in a love relationship emerged as a place where people hope to find security and a place where women get some identity. Rhodes and Cusick (2000) pointed out that in such relationships women secure identity in a world of uncertainty. Men give women some status and identity. The drive to have a male partner drove women in this particular study to extremes such as getting a male partner through using love medicine. This belief of having a male partner made women vulnerable to men and they accepted to be with a man who has other partners.

The findings showed that these communities place such a high value on sexual love relationships that the women appear to make it their life investment. Some stop going to school and make it public that they have made the decision to be with a particular man. They expect the romantic love relationship to continue until they get married and then even after marriage. Margulis and Sagan (1991,) on the other hand, argue that romantic love relationships almost inevitably fade over time, and normally the longest time for seeing one's love as being perfect usually lasts from as little as one month to several years. In this particular study, however, it came up that as a result of traditional beliefs, any experience or perception of fading love is not regarded as normal, but rather as a misfortune. Someone is identified as having done something to damage or affect the relationship negatively, as also documented before by Ashforth (2005); Bateman (2004); Siddley (2004) and Ngubane (1977).

A culturally unexpected behaviour in a rural area came up in this study in that women too engaged in multiple relationships with the aim of trying several men for sexual virility and sexual satisfaction. In all these multiple sexual relationships individuals use love medicine to keep themselves hot, dry and tight as a way of enhancing sexual pleasure. The use of love medicine is done with the belief that it will make a partner or other partners not to feel that she was with someone else. The use of certain products to improve sexual pleasure has been reported before (Kim, Funkhouser, Simpson, Brown, and Merchant (2003); Kilmarx et al (1998); Scholes, Daling, Stergachis, Weiss, Wang and Grayston (1993); Brown, Ayowa and Brown, (1993); Runganga *et al* (1992).

The cultural expectation that men and women must attract an opposite partner at a certain stage in their lives came up very strongly in this study. The findings showed that if men or women fail to attract opposite partners they are labeled negatively. They are called names such as *'isahluleki'* (failure), *'uzenda ziyamshiya'* (peers are all married and you are still single) or *'isishimane'* (male that fails to attract women). Women who were married, but who had to separate with their partners and go back home were called *'umabuya emendweni'* (the one who has returned from marriage) . This term has the connotation of failure to fulfill one's role as a woman in society. To avoid being called such names, both women and men felt compelled to start using love medicine so as to attract or get a partner, or to sustain their marriages by keeping their partners. Some of the women, even if they do not like it, end up having to share one man to avoid the being labeled as *"uzenda zamshiya"* or *"umabuya emendweni"*. They stayed in the relationship with the hope of being the second or even third wife or that the partner might leave the wife or wives for her. In such cases, women would do

anything to get a 'ring on the finger' as they call it. This included resorting to love medicine which they believe has the ability to make the partner love them more and also separate him from his other girlfriends or wives.

According to the findings of this study, women who are married also work hard to keep their partner or husband and also make use of love medicine. In such a situation, all women, married or not married are confronted by a conflicting situation, marriage, love or safe sex. In relation to making the marriage work or focusing on health safety, Rosenthal, Gifford and Moore (1998) pointed out that these are competing discourses and unfortunately marriage or relationship safety seems more important than safe health or safe sex. Rosenthal et al, further revealed that the search for safety conceptualized in terms of health represents for many men and women a risk of losing the possibility of love or marriage, which is what also emerged from this study. In Rosenthal et al's study safe was not equated to condom use but to a secured sexual relationship.

The findings in this study also revealed that there are socially constructed expectations, norms and appropriate male and female behaviours and characteristic behaviors and roles shared within the community which make men and women vulnerable. These gender norms and values differentiate men from women and define the ways they interact with each other as stated in Chong and Kvasny (2005). In the context of this study, men emerged as expected to be providers and women as expected to please men in a number of ways including sexually and taking care of them unconditionally. This culture is instilled at a very early age. These two gender roles seemed to dominate the sexually related behaviour in the districts researched.

Men provide for the women and the family and women please the men. It was, however, noted that these roles provide a higher power status for the men while reducing that of women to simply becoming providers of sexual pleasure and providers for the physical needs of men. This was expressed repeatedly by the participants who felt that women were vulnerable to male authority and power. Acker (1991), documented that in some societies men are socialized as providers and women are socialized to please men and defer to male authority as they are regarded as providers or breadwinners. Hunter, (2006) pointed out that the socialization is so strong that even in cases where the man does not work he is still expected to provide for his family.

According to this study, women have to stay in marriages which are not conducive to happiness or health because of the gender expectations and power inequalities. Chong and Kvasny (2005) asserted that such form of behaviour resulting from unequal power reflects covert kind of abuse of women. These authors further explain that an unequal power balance in gender relations translates into unequal sexual interaction, thus making those with less power vulnerable to some form of abuse. The male pleasure, according to gender-related expectations, supersedes female pleasure with men having greater control in the issues associated with sex. Gender-related expectations create an environment where risk is acceptable or even encouraged as women are expected to succumb to male domination and power. Vercoe, (1997) alluded to the fact that the perception that men have more privileges, place both men and women at risk of acquiring HIV. Chong and Kvnasy (2005) further pointed out that imbalanced power between women and men in gender relations

curtail women's sexual autonomy and expand male freedom thereby increasing both gender risks and vulnerability to the HIV epidemic.

The power given to men to engage in multiple sexual relationships in the name of culture made women vulnerable to a number of health risks such as sexually transmitted infections and HIV. Mane and Aggleton (2001) warns that vulnerability of women stems from socio-cultural factors, which makes it critical to establish these factors in addressing health risks. Mane and Aggleton (2001) further pointed out that cultural and societal expectations create an environment where risk is acceptable and even encouraged, as was observed in this particular study. Manliness, in the context of this study, was characterized by having multiple partners. The men engaging in risky behaviours were labeled as real men by names such as *'amadoda oqobo'* (real men) or *'isoka lamanyala'* (direct translation- dirt womanizer). Although these labels might sound very masculine, the men are, in fact, exposing their partners and themselves to the risk of HIV by engaging in sex without any protection as it emerged from this study. This is line with what was pointed out by Campbell (1995) that traditional beliefs about masculinity discourage safer sex and women as well as men continue to be at risk. Mane and Angleton (2001), reported an important observation that gender norms and cultural expectations shaping women's vulnerability also places men at risk because they are also at risk of contracting and spreading HIV.

The findings in this study showed that women in these particular communities measure their value of womanhood as having a man in their lives. They develop a dependency on men and perceive that having a man gives them a certain form of status and security. It emerged from

the study findings that such women avoid anything that may lead to rejection or separation from their partner. This shows that women see themselves as incomplete without a male partner. Mane and Aggleton (2001) also argue that inequality in gender relations is not something that is created by men only, but that both men and women construct gender relations together. Because of the socialization aspects of this particular culture, women are regarded as minors and dependent on men. They are also expected to understand that a man can have as many women as he wants and that every time he introduces a new girlfriend they are supposed to rejoice with him. This practice of multiple partners provides a captive group of sexual partners bound by possible sexual contact to one person. This person, usually a man, while continuing his normal sexual activities within the group, is free to go out at any time and bring more women into the circle without being questioned, This is in line with what has been presented by Mokhobo, (1989); Preston-Whyte, Zondi, (1989), on how multiple relationships and polygamy is not only accepted, but promoted. The point that women are expected to be passive yet suffering inside, forces them to find ways of being passive yet in control. The findings showed that no effort is made to check the HIV status of any person at any stage in such situations. On the contrary, there is a rush to give him enhanced sexual pleasure with the aid of love medicine, and for this to work it is necessary that body fluids are exchanged.

The findings revealed that although women seek power from love medicine, they expose themselves to the risk of contracting HIV. In the process of trying to get their partners back, they feel that the risk they take by not using a condom is preferable to the punishment of losing a partner. They also feel that after spending a lot of money on the love medicine they

cannot compromise and use a barrier which might reduce the effect of fluid contact during intercourse and thus reduce the chances of the medicine being effective. Bird and Harvey (2001) suggest that culturally determined gender norms prescribe appropriate sexual behaviour that influences the risk of HIV infection. Rosenthal, Gifford and Moore (1998), research revealed that there are competing discourses around safe sex and safe love. In their study, safe sex was not equated to using a condom. Participants regarded unprotected sex as a strategy for maximizing the sexual encounter to result in a longer term relationship. The participants in this particular study, just like in Rosenthal, et al's (1998), did not conceptualize a safety risk in terms of 'health', but rather in terms of losing love. Unprotected sex after using love medicine is regarded as special, as an extension of intimacy with the potential to bring about a desired effect. It may lead to love, marriage or financial security.

Regarding the socio-economic factors, the four districts where the study was conducted are mainly rural. The community members seemed to be marginalized as compared to urban setting with very limited job opportunities, high unemployment and minimal, if any, development. This was pointed out by Karim and Karim (2005), who maintained that resources in rural areas are generally not sufficient to meet the needs of the community. In most rural districts, men and some of the women migrate to the big cities to get better education and job opportunities. Karim and Karim (2005), and Barnett and Whiteside (2006), describe this situation where migrant workers move between urban and rural areas as being perfect for the sexual transmission of infection as there is a tendency for such migrant workers to have relationships in both urban and rural areas. According to Lurrie et al. (1997), although improved transport has facilitated the frequent movement between the rural and

urban areas, there has been little change in sexual practices. The study by Preston-White et al (2000) highlighted that migration and population movement is a risk to unsafe sexual practices. The findings in this study showed that sharing a man with a woman in urban areas leads to competition where women, especially those in rural areas, resort to using love medicine as a weapon to gain control over their partners. The findings showed that in the rural areas being researched, it is a common practice to make use of love medicine in order to sustain a relationship with a partner who is a migrant worker.

Women emerged as also affected by lack of employment opportunities in rural areas leaving them economically vulnerable. Most women in the study were vulnerable due to the lack of economic alternatives. Most of them were financially dependent on male partners or government social grants. Data revealed that women in these communities resorted to causal sex as a means to generate income. In the study by Susser and Stein (2000), women expressed that poverty made prostitutes out of them because they used men for financial gain, not love. Sex emerged as being a weapon for economic survival and men provided for those women who met their sexual needs so it follows that women use love medicine to entice men and give them the power to manipulate them. In line with this, Prolifroni and Welch (1999) reported that giving men sexual pleasure resulted in them yielding or circumscribing to the demands of the opposite sex.

The study findings further revealed that women abused the power they obtained through the use of love medicine by engaging in multiple and concurrent sexual relationships to generate more money to meet their materialistic needs. The focus was on the now and not the

consequences in the long term. It is hard to separate this behaviour from prostitution since the engagement in sex is for financial gain. Turshen (1991:113) explained that prostitution is common where there is migration, poverty, low living standards and lack of opportunities. He also argued that there is a blurred line between infidelity and prostitution.

The findings showed that two groups were distinguished within the communities where the study was conducted. One group was perceived as being made up of those who have what others do not have and the second group as being those who need or desire what the other group has. The first group included professionals such as teachers, police, managers or people in high positions, usually married. Leclerc-Madlala, (2003) described the men within this group as having the three "Cs" which stands for car, cell phone and credit cards. The second group was mostly women, usually young and sometimes still at school. Findings revealed that these young women tend to target the first group in order to get what they want. It has already been documented that woman sometimes have sexual relationships for secondary gain including basic survival or subsistence needs (Hunter, (2002); Leclerc-Madlala, (2003); Luke, (2003) and Dunkle, Jewkes, Nduna, Jama, Levinskweyiya and Koss, (2007)).

The issue of sexual relationships between those who have and have not, was debated among the participants and two parallel arguments came out of this debate. The first argument was the community accusing the men. They were presented as richer, older and driving flashy cars, trying to attract young girls who are sometimes as young as their daughters. In most cases, these girls are unemployed or from poor families. Not only is there inequality of age, sex and class, but also by virtue of being unequal in terms of power, such women are already

compromised and therefore condom negotiation becomes a challenge. This has been documented before (Bayles and Bujra (2000)). These authors have further argued that the challenge is that the poorer, not only lacking access to opportunities and other services, are already compromised by their lack of information. The mere request of a condom may be perceived as a risk that may lead to conflict, loss of partner or even anger resulting in abuse. This has also been documented by (Wingwood and DiClement, (1998)).

Such older men were presented as being corrupt and always enticing young girls by giving them material things and taking them to hotels for sex, usually leaving them before midnight to be with their wives physically while they are mentally still with the young girls.. Women who have had this experiences explained that they were aware of changes in their relationship such as fighting with their husbands, being "beaten for no reason" or the husband not taking any suggestions from his wife. They explained that these circumstances caused a loss of dignity (*ukulahlekelwa isithunzi*) to the wife. Therefore, to regain their husbands and their dignity, these women would start using love medicine.

Others in the community argued the young girls were at fault because they deliberately target rich men, even if they are married. These girls go to the extent of saying, *"I want that wife out of that house; she does not deserve all that what her husband is doing for her."* Some of them justified their actions by saying that they knew that the men were married, but it was not a problem because they were in love. They made it clear that they were willing to compete with the wives and seemed fully aware that the wives or other woman would fight using love medicine. They also believed, however, the local saying *"awumbiwa ndawonye"* meaning

"only the one with the strong love medicine will win". Like all other cases where love medicine is used, the use of a condom is purposely avoided to enable the love medicine to be transferred to the target partner.

This study is unique in that findings showed that both the wives and the young girls suspect or are aware that the partner has other sexual relationships and they regard this as 'normal' competition. The wives use love medicine hoping that the husband will focus on her and not go for other women. They also hope that even if he does leaves, he will realize that the best is with her. On the other hand, the young girls use love medicine so that the partner gets more sexual pleasure and, thus, ensure that he will provide her with material things or even leave his wife to be with her. While using love medicine, according to the findings, there has to be fluid exchange and even if one wants to use a condom, one cannot do so when love medicine is being used. It is this partly this intention of fluid exchange during transfer of medicine that makes the use of love medicine a challenge to the prevention methods of HIV.

The study also showed that, in many cases, married men left their wives for the financially desperate young women who attracted them by using love medicine. These young women reported that they only wanted someone to provide for their financial needs and if the man in question began struggling financially, they dumped him. In these cases, the wives had to accept their husbands appreciate his coming back without them having been tested for HIV. Chong and Kvansy (2000) linked this unquestioning and unassertive behaviour in women from China to the desire to be faithful and committed lovers to their husbands as valued in their communities. In such communities, according to Chong and Kvansy, self-worth and social

acceptability of women comes exclusively from having a male partner and continuing to be a faithful wife and mother to this man's children as was also noted in this particular study.

In this study, it came out that women who are rejected by their partners or husbands resort to drastic decisions which increase the risk even further. For example, some forms of love medicine are introduced vaginally by the traditional healer engaging in sexual intercourse with the women. They are then instructed not to bath until after engaging in sexual intercourse with their husband or partner putting pressure on the women had come up with ways of sleeping with their husbands or partners immediately after having had sex with the *inyanga* (traditional healer). If *inyanga* practices this he is likely to be infected and then continue to infect other women who then infect their partners. Because of common multiple relationship the spread of HIV will even be faster.

As a result of gender related issues, data revealed that the role played by women in these communities has the possibility of reducing them to mere sexual entities while giving men all the power. But these women believe they can manipulate this power through the use of love medicine and gain control. They believe that by enhancing sexual pleasure they can make men conform to their requests and therefore use love medicine to ensure that their partner gets the best sexual pleasure. This practice has the potential to make women compete in the provision of sexual pleasure while men, in turn, are reduced to the status of consumers of the sexually prepared women.

This study findings revealed that some married women, as a result of pressure from their marriages, also engage in extra marital relationships. The rationale they give is that they need emotional support of a man when their biological needs are not met by their partners or husbands. The findings revealed that women who had been left by their partners needed someone else to spend time with and referred to such partners as "shoulders to cry on". Some married women have extra marital affairs because they are abused by their partners and some, who were not married but hoping to be, indicated that having multiple relationships keeps their options open explaining that if one partner does not propose, another one will. They justified their actions by pointing out that men tend to have many girlfriends and end up taking one.

It emerged from the findings that the cultural norms also affected men in that the more they provide, the more they become targets for women, who go out of their way to separate them from their wives and families so that they can win the so called providing man. Men confirmed that the effect of the love medicine can be very strong. Sometimes a man who is under the influence of love medicine may realize that he is neglecting his family and that such behaviour is not right, but his desire for sexual pleasure tends to be so strong that he will end up spending everything he has with this newly found lover.

Another factor which emerged from the study was the expectations regarding the men's sexual performance. According to the findings, if a man does not have many sex session every night, it is interpreted that he does not have the required virility. Women explained that they try several men sexually to see how 'powerful' they are in their virility and that they prefer to

commit to marriage to someone who is sexually 'powerful'. Being powerful is explained as being able to satisfy their sexual partner and do this as many times as possible per night. Therefore, if a man is unable to keep a woman, he is likely to feel that he is not powerful enough. This, according to the findings, results in men using love medicine in order to meet the expectations. According to the traditional healers, this type of love medicine is mixed with animals that are always following their female partner and are often highly sexually active. There has not been literature accessed to support or dispute this.

This study is also unique in that the findings provide details of what women actually do with the hope of having and keeping the partner. These include the use of different kinds of love medicine such cleansing, making him provide, returning him when he has been taken by someone else and even controlling his sexual behaviour. Such women, according to the participants, are desperate to transfer the applied or inserted love medicine to secure the relationship or to get material things. Therefore the thought of taking precautions is considered to be delaying the possibility of achieving the desired effect which could be getting finance, getting the man to buy material things or just getting him back.

6.5. Kinds of medicines used

The findings in this study reveal that there are various kinds of love medicines available. Some of these are traditional love medicines which were mainly derived from plants, animal fat or parts and some minerals such as limestone and water. This was not different from what

has been presented before (Brown and Brown, (2000); Morar, Ramjee, Karim and Karim, (1998); Beksinska, Rees, Kleinschmidt and McIntyre, (1999); Brown and Brown, (2000); Braunstein and van de Wijgert (2002)). Most of these are referred to as traditional medicine in that they are used in their original form from nature (Vilakazi (2006). At times, human products or excreta are added into these products, as was reflected in this study. Studies conducted by Civic and Wilson, (1992); Runganga et al (1992); Baleta, (1998) have alluded to the use of human parts or excreta or secretions and animal parts as part of traditional therapy. Like all traditional medicine described before (Ashforth 2005) three main categories of focus have been identified:- cleansing , securing or strengthening and protecting the person from evil forces.

It emerged from the data that products used particularly for traditional love medicine were based on the observation of certain features of plants and animals including their behaviour, shape, or even how people might be attracted towards a certain species. The users hoped that love medicine, mixed with that chosen species as an ingredient, will assist couples to assume the observed behaviour and always walk or stay together.

In addition, love medicine is also available in modern packaging. Participants explained that sometimes products might be identified as love medicine, but they were not originally intended to be used as such. These include bath salts which are described as enhancing sexual pleasure, but are used more as a means of securing a partner.

6.6. Matters of motives for the use of love medicine

Matters of motive are the issues that drive or motivate individuals to behave in a particular way or perform a certain behavior such as engaging in the use of love medicine. Franken (1994), argued that motivation can become the arousal and direction, and can also maintain persistence of the behaviour such as practicing love medicine. Kleinginna and Kleinginna, (1981) described motivation as the internal state or condition that is sometimes referred to as desire, need or what the individual wants. These authors explain that this energizes and directs goal oriented behaviour (Kleinginna and Kleinginna, 1981). Motives are energizing factors that compel an individual to act in certain way (Huitt, 2001). Cultural constructions of sexuality in these communities seems to be the most energizing factors that drive and directing individuals to use love medicine.

6. 6.1. Cleansing self

According to the findings of this study, scripts of norms and standards have been developed in these communities. These scripts not only create a sexual identity and direct sexual behaviour, but are underlying prescriptions for sexual behaviour that is used to evaluate the sexual "beingness' of the individual as reported by Alksnis, Desmarais and Wood, (1996); Simon and Gagnon (1987). According to Longmore, (1998), messaging for sexual behaviour is based on such scripts as the cultural context changes. As an example, the message in this study is that one has to be appealing and attractive to opposite sex and is referred to in the local language as having *ugazi*. This applies to both men and women. According to this

particular study, the changes in the skin such as pimples which are normally associated with hormonal changes are interpreted in relation to traditional therapy belief. This is associated with the possibility of making an individual disgusting to other people and not in with the "spirits". This serves as an arousal, pointing the person in the direction of using love medicine. Those close to the affected person may start suggesting and motivating the use of cleansing medicine *(isigezo)* as a way of regaining *'ugazi*, as reported in Scorgie, et al (2009). This is in line with what has been described as a way of being in harmony with the spirits and the people around the individual (Burhmann, 1986; Ngubane, 1977).

The procedures for using the cleansing kind of love medicine include purging steaming and bathing/washing and these same procedures have been documented by (Cocks and Møller 2002; Kale 1995). Cleansing as a practice does not seem to pose any risk to the acquisition of HIV infection, but it does, however, mark the beginning of the practice of using love medicine. This simple practice of cleansing should be treated with caution as it can be the first step of many into the practice of love medicine. The findings indicated that as more of the opposite sex become attracted it becomes hard to say 'no' to most of them and even harder if they come with material things when one has nothing. Such users were portrayed as having a multiple relations because of these reasons.

6.6.2. Securing the relationship

Love medicines that are used to secure a relationship or make a partner provide or commit are discussed together because the motives as well as the products tend to be similar, the

only difference being what the individual desires at a particular moment. For example, those who are new in a relationship wish to secure the relationship and those who have been in a relationship for sometime wish for a proposal of marriage. Some participants explained that they wanted partners to provide material goods or finance. Except for the latter, where additional love medicine is added to food, it emerged that all the substances are used with the aim of enhancing sexual pleasure.

Data showed that one of the motives to use love medicine is the social sexual construct about a good man and good woman. Young (1994) has alluded to this and explains that the quality or state of being sexual and identification with behaviours and norms distinct to a particular biological sex, is a socially and culturally constructed phenomenon. Alksnis et al, (1996); Simon and Gagnon (1987) argued that there are sexual scripts developed that guide and regulate sexual practices. In particular in this community such script presents a good man and good woman. The community strive to be that good man or good women and love medicine is used to achieve these. Further sexual meanings are developed in the course of social interaction and exposure to sexual messaging that takes place within the changing cultural and social context (Longmore, 1998).

A good man is a man who has more than one partner, *'isoka'*. This word has the connotation that he can have as many women as he wants and be able to keep all of them. This is in line with what Leclerc-Madlala (2002), describes as meanings behind the multiple sexual partnerships in the efforts to secure the status of being *'isoka'*. Hunter (2005), described *'isoka'* as man that is successful with women. This brings about competition, insecurity and

fear among the women who are sharing one man. In order to secure the relationship women use love medicine which they believe will make men perceive them as good women.

It also emerged that there is a notion of what the community considers a good women. Amongst other things, she has only one male partner and is referred to as *intombi* (girlfriend or wife). *'Intombi'* in particular, has to be tight or keep oneself *'tshitshi phaqa'(*closed) denoting a virgin state and some present this as being *'ugcwel'(*full) and wait for her *'isoka'* as sign that she will make a good wife. She is supposed to be dry, hot and tight. Participants explained that, *"the man should not just fall inside- angagaladeli nje, he must struggle."* It is interesting to note that, according to the participants, this expectation is the same irrespective of the number of children a woman might have. This is in line with the finding of the study done in other parts of the same province by Scorgie et al, (2009). Friction and sensation during sexual contact seemed to be the most energizing factor for use of love medicine in order to be perceived a good woman. Similar results have been presented by Brown and Brown (2000) who argued that this was one of the common desires for those who use traditional medicine even in other countries. The study conducted in Zimbabwe showed that men also indicated that there is no sexual pleasure when having sex with a women perceived not to be dry, (Ray, Gumbo and Mbizvo (1996). The study by these authors indicated that sometimes a man would ask a woman to dry herself. Therefore, women work hard to ensure that they remain dry by inserting or applying what is termed here as love medicine.

Women in these communities believe that if a partner perceives a woman as dry, tight and hot he is likely to focus on her. Similar finding have been reported in studies conducted in other countries (Runganga et al, 1992, Brown, Ayowa and Brown, 1993). In almost all cases the role of love medicine is to enhance sexual pleasure. Kilmarx et al's (1998), study showed that commercial sex workers used similar practices to enhance sexual pleasure for their customers. In this study, most users practiced the use of love medicine as a way of securing a relationship, making him commit or provide and in some cases to take control of the relationship as presented in the cycle (Figure 2). The study by Civic and Wilson (1996) has shown that those who use love potions hope to be loved and appreciated more by their partners and this concurs with the findings of this study.

There appears to be a 'sexual script' for to both married and unmarried women. One 'script' is that a loose fitting or wet vagina is associated with infidelity. This is not different from cultural scripts described by Hynie, Lydon, Cote and Wiener, (1998); Stephen and Phillips, (2005). It was interesting to note that even if a woman has a number of children, she is expected to be like *'intombi phaqa'* (virgin like) and various products are used to achieve this 'virginal state' with the hope that she will be able to keep her partner.

The study illustrated that there are sexual constructed meanings attached to a partner's behaviour during sexual acts. These are interpreted as being positive or negative. For example, if "*he stays on top* (meaning he has sex) *the whole night or wants more the more he get*" is interpreted as partner enjoying the sexual pleasure given. If he had it only once, it means "*it did not go well*" (meaning he did not enjoy it). The second case scenario tended to

motivate the individual use a different love medicine while the first meant that the love medicine had been effective and therefore more of that type would be used. These act as motives that drive and direct individuals (Simon and Gagnon 1987) to use the various love medicines available, depending on the perceptions of the partner's behaviour or comments. This does not only expose the individual to the risk but increases the risk of repeated exposure for both partners.

6.6.3 Make him provide or commit

There is a perception that if a man really enjoys a sexual encounter that has been spiced with love medicine, he is likely to do anything for his partner in order to get more as often as possible. This gives a woman the power to be in control of the relationship and thus make her partner provide or commit to be with her all the time. The study conducted by Runganga et al (1992), gave similar findings that the practice of insertions or application of substances to the vaginal area to provide sexual satisfaction is used maintain the husband's fidelity. This study highlighted the perception that even if a man is married, he is likely to forsake all others, including his wife, children and his mother to be with the woman that has used an effective love medicine. As a result, this kind of love medicine is sometimes referred to as *'udelunina'* (forsaking even ones own mother for the sake of such sexual pleasure).

Findings showed, that in some cases, users were aware that if a partner had had a taste of enhanced sexual pleasure, he tended to give material things. Participants explained that some women took advantage of this and used even more love medicine to get more material things

or more attention from her partner. Others were depicted as using this kind of love medicine on a number of men, ending up with multiple partners, to get the various material benefits they desired. Rawstone, Digiusto, Worth and Zablotska (2007); Urbina and Jones (2004), have indicated that users of such love medicine are more likely to engage in risky behaviour than non users. It emerged from the findings that some of the risks included the itchiness which is perceived by users as an aphrodisiac effect. If such love medicine has been used and the target partner fails to come, such individual is described or perceived as being likely to find the substitute from the 'alternative' or the so called 'shoulder to cry on' partner which is a form of multiple sexual partners.

Procedures for using love medicine for securing relationships and making a partner provide or commit range from applying or inserting love medicine in the vagina to *'ukugcaba'* which is applying love medicine on actively bleeding small cuts. This has been documented by other researchers (Cock and Møller 2002; Kale 1995). The cuts are done on the points of contacts, sometimes even on the clitoris. In the latter case, the sexual contact has to take place while these are still fresh to ensure the transfer of love medicine. Most women are fully aware that their partners are involved in multiple relationships, but because the intention to make him commit, provide or even to return is so strong they are willing to compromise their lives and engage in unsafe sex in order to ensure that the love medicine will be effective.

6.6.4. Cleansing and retaliating

A woman who has lost her partner becomes motivated to use love medicine, in some cases, for the first time. This kind of love medicine clearly demonstrates the traditional healing approach as described by Vilakazi, (2006); Green, (1992); Green *et al.*, (1995). The individual who has lost, or perceives that she is losing, her partner views this as a misfortune that has a social cause or causes. Therefore, in order to get her partner back, she makes use of a traditional therapy. This tends to follow a number of stages until the individual is not only having a good sexual relationship, but is also in harmony with the spirits and people around her (Craffert, 1997; Burhmann, 1986; Ngubane, 1977. Depending on the distance the individual needs to travel to consult a traditional healer or provider, she may be given a complete kit with various types of products for the different stages of the therapy process or otherwise, if close by, several visits are done to complete the process with each visit involving costs that range from R20 to R500 for a complete kit.

It emerged from the finding that, in these cases, women generally used cleansing and retaliating kinds of love medicine. They tended to believe that the women who had taken their partners had started by casting a spell on them to cause an outbreak of pimples, pubic lice or vaginal discharge which would have the effect of causing disgust in the men. This is referred to as *isidina (*disgust*), isinyama* (bad luck in everything*)* or even *'ilumbo'* ,which is believed to be a spell cast by contenders or another woman who wants the partner. Similar findings have been documented by Peltzer, et al, (2006). These authors explained this as an act by a jealous husband or an action of another woman in multiple relationships. The former

is explained as way of guarding against those who may want to have sex with the wife or girlfriend and the latter as way of trying to separate couples. Similar findings have been reported by a number of authors (Meyer-Weitz et al, 1998; Scott and Mercer, 1994; Green, 1992).

The individual will not only cleanse to remove the pimples, pubic lice or vaginal discharge presented by the spell, but will also use another kind of love medicine with the hope of returning the spell to the sender. This is their way of dealing with the social cause. Vilakazi, (2006); Green, (1992); Green *et al.*, (1995) have argued that in traditional healing, the individual does not only treat the disease, but also deals with the cause. Ashforth, (2005); Gumede, (1990) argued that by casting spells, the traditional healers are performing acts of witchcraft. In this study, this was presented as retaliating to what is perceived as magical, mystical and animistic forces as described by Ashforth, (2005); Bateman, (2004); Siddley, (2004); Ngubane, (1977).

6.6.5. Returning the partner

The effective use of the cleansing and retaliation form of love medicine is expected to make the partner start returning to the woman who he left. This kind of love kit is called 'returning lost partner' or similar words are used (see appendix 2). This process is hastened by what is called *'isikhafulo'* which is perceived as a way of calling him back and telling him to leave the other woman using the magic of traditional therapy. Ngubane, (1977) has alluded to such

practice. The first part, *'isikhafulo',* is the most critical part and the product used should be effective enough to make him start thinking positive thoughts about returning.

This is followed by using *'isibambelele'.* Women are aware that sex might not occur when the couples meet after such a separation. Therefore, *'isibambelelo'* is love medicine that can be applied on the points of possible contact such as hands and clothes in the belief that when one touches the partner, the love medicine will be transferred. Ashforth, (2005) has alluded to this form of traditional medicine and described hugging and kissing as similar practices of transferring the medicine. Once this first dose of love medicine has been used, the user proceeds with the next step.

This step is to secure the relationship. It involves preparing for a sexual encounter and substances are applied or inserted into the vagina or cuts are made as explained in securing relationship above. In this case, every positive effect observed after the use of the medicine becomes the motive which energizes the user to get the next kind of love medicine until the relationship is secured again. The provider and the peers or friends guide the women on which steps to follow.

6.6.6 Controlling the relationship

In the midst of all the environmental conditions, beliefs and values prevalent in these districts, love medicine becomes a way that women use to negotiate and challenge gender inequality in their relationships. While the sexual script in these districts expect women to

find and keep a male partner, to get married and to build and maintain the homestead, they do not have any tools to do all this. Most of them rely on men who, even when they are employed, sometimes end up neglecting or even abusing their wives and families. In order to prevent or protect them from emotional, physical, psychological or even financial abuse, women use love medicine that has been described as having a controlling effect on her partner.

It emerged from the data that women who use this kind of love medicine have usually been involved in a challenging relationship. These include the physical or psychological loss of a partner or abuse by the partner who openly has multiple sexual relationships, neglects the family or uses all his finances to entice, entertain or finance his girlfriends. Some of the women confirmed to have used such medicine. They were either married as described above or women who had babies with such men using the medicine in the hope of inducing marriage. The common factor that was highlighted by the study, however, was that these women would do anything to ensure that their partners stop their bad behaviour and focus on building the homestead.

Many of the love medicines used in these cases necessitated the mixing of certain body fluids or secretions into the love medicine and putting it in food. Uses of human excreta and body secretions have been reported in other studies (Civic and Wilson, 1992; Runganga et al, 1992; Baleta, 1998). Those who had actually used this kind of medicine presented a picture of being in control of their partner and some indicated that he may even become too conforming as a

result and do just anything he is asked to. It follows then, that any man who appears to be helping his partner, is perceived by others as one who has eaten this kind of love medicine.

The study findings indicated that, in some of these cases, the roles become reversed and the men take over the household chores while the women instruct them on what to do in the house and publicly shout at them. The participants explained that these men may become embarrassed, but will not fight or leave such a woman. Instead, they strive to become better in order to avoid the embarrassment or arguments and thus, become obliging to all the demands made on them. Even if they do engage in other relationships, they will make sure that news of it never reaches their partners' ears.

Data revealed that such men usually become fearful of their female partners. As a result, it is assumed that he will not do anything that she does not want and, therefore, he is considered 'sexually safe' and faithful. Because the general assumption that the type of love medicine used in these cases is classified as low risk and that such a partner will not engage in a relationship with anyone else, the use of condoms among such couples does not even become part of the discussion.

It emerged from the findings that one of the motives why women attempt to gain control over their partner by using love medicine is with the hope that he will not be taken by other women. Their main concern is that men who have been taken by other women tend to come back infected with HIV or even already having an AIDS related condition. The women expressed concern that, due to traditional practices and gender inequalities, the wives are

forced to take back the returning husband, especially if he is ill. Ndinda, Uzodike Chimbwede and Pool (2007) argued that this is because among African societies marriage is not just between two people, but between families.

In an attempt to avoid this happening the women, usually wives, become pro-active and use love medicine to keep their partners or get them back before they lose all they have and before they get ill. There was no evidence, however, from the findings, that the returned partner is tested before assuming his role in the sexual relationship. What was highlighted by the findings was that the women prepare themselves and when the time comes for the partner to return, they hurry to transfer the love medicine sexually without using a condom, thereby providing him with sexual pleasure so that he will not leave again. There was no literature to support or argue against this.

6.7 Health risks associated with the use of love medicine

Critical analysis of findings revealed a number of health risks associated with the use of love medicine. According to the findings in this study, some forms of love medicine products are used to dry the vagina. Researchers have indicated before that some of the practices which are similar to use of love medicine interfere with the mucosa resulting in excoriation and bruising and thus facilitates the entry of pathogens (Scholes, Daling, Stergachis, Weiss, Wangand and Grayston 1993; Halperin 1999; Fonck, Kaul, Keli, Bwayo, Ngugi, Moses, and Termmerman 2001; M Holzman, Leventhal, Qiu et al 2001; Ness, Hillier, Richter, 2003).

Civic,and Wilson (1996) indicated that men are aroused by warmth from the vagina and they want a tight vagina that will make them feel warm. Although this did not come out clearly in this study, Andel, et al (2008) warned that dry sex damages the epithelium of the vagina and causes lacerations, inflammation and the suppression of the vaginal natural bacteria. This, according to these authors, increases the likelihood of getting sexually transmitted infections including HIV. Mane and Aggleton (2001) pointed out that women are biologically vulnerable, especially their vaginas. The membrane covering the vagina is very fragile and tears easily. In Chong and Kvasny (2005,) it is stated that the membrane of a vagina is permeable and because HIV is more concentrated in semen, it increases the risk to HIV. This health risk is also reported by Scorgie et, al (2009) and Civic and Wilson (1996).

The risk of HIV as a result of using love medicine is compounded by rejecting the protection of a condom and this came out repeatedly in this particular study. According to the findings there should be exchange of body fluid and skin to skin contact for the medicine to work. Informants in the research done by Andel et, al's (2008), expressed that medicine used for dry sex is incompatible with condom use. The study by Civic and Wilson (1996) showed that the plants used in making this kind of love medicine makes the body hot and breaks the condom. Scientific research has shown that there is possibility of condom breakage under any circumstance. Therefore this possibility is likely to increase if love medicine is used. The participants verbalized this. This reflects that engaging in unprotected sex was an acceptable risk in these communities, as also stated in Rhodes and Cusick, (2000). According to Malow, Stein, McMahon, Dévieux, Rosenberg and Jean-Gilles (2009), condom use regrettably remains one of the main indicators of risk reduction, as behavior intention to use a condom is

associated with the adoption of protective behaviour. It emerged in this study, that even if the individual is aware of the need to use a condom or has been using a condom constantly, one has to avoid condoms when love medicine is being used. After experiencing such pleasure, according to the findings, it becomes almost impossible to go back to using a condom even if one is aware of the risk. Jarama et al., (2007) describe this as disconnection between knowledge of HIV and actual behaviour.

It emerged that all the participants using love medicine are aware of the implications of not using a condom. Some of them feared that they might already have the HIV infection and some of them have lost hope. This is the opposite of what has been presented before based on belief that "it will not happened to me" documented by Holland, Ramamzanoglu, Sharpe and Thomson (1992). The participants in this study have gone beyond the risk denial which has been documented by Snyder (1997), and this seems to play a role in preventing them from going for HIV testing. Some have even diagnosed themselves and others, or assumed that everyone is infected without any proper testing. To them, the risk of losing their partner seems more challenging and immediate and, as a result, outweighs the relative risk to their own health as alluded to by Cusick and Rhodes (2000).

Engaging in unprotected sex during the process of administering love medicine places both men women in danger. They are further endangered by the traditional healers, who sometimes introduce the love medicine by engaging in unprotected sexual intercourse themselves with the women. The use of love medicine, in these cases, places the women,

their husbands, the girlfriends, the traditional healers as well as any others who might be involved in the multiple relationships at risk of sexually transmitted infections such as HIV.

Incisions on the genital area for the purpose of administering love medicine emerged as another risk. The cleanliness of the razor used to make skin incisions is not guaranteed and may be a source of infection. The medicine has to be applied by the traditional healer, in some instances using his bare hands. With no gloves to protect the traditional healer, he /she, is at risk of being contaminated by fresh blood from the incision especially if he/she has any cuts on his/her hands.

It emerged from the data that these community members, particularly the women, are aware that HIV is a deadly disease. The three dimensions of past, present and future, however, affect the way they perceive the disease (Karim and Karim 2005). To them, HIV and AIDS seem to be part of the far future and some even hope that by that time they discover that they are infected a cure would have been discovered. Their past experiences and the present are more real to them and thus make it hard for the women in these communities to ignore.

The past includes the painful experiences of being rejected by a partner for another woman and being told by her that *"you are cold find something to make yourself hot."* It also includes the fear of being labeled *'zendazamshiya or mabuyemendweni'*(a failure). While both terms literally mean that one has failed to meet expectations, the first means a failure to get a man and make him commit to marriage and the second a failure to secure the marriage. In some cases, women find such names so traumatic that they feel compelled to get their partner back

or prevent him leaving again. Such individuals tend to be so absorbed in the past that the future becomes uncertain and sometimes hard to imagine without the male partner. Because of this, sexual relationships become more important than potential health risks as suggested by the study findings of Cusick and Rhodes (2000.)

Another factor which emerged was that while some of the community members were concerned that they might be HIV positive, they consoled themselves by the fact that they would get getting a government grant. Although they are aware that the grant is actually R800, they tended to round it off to R1000, which they felt is 'a lot of money' and a good contribution to people who are poor or unemployed. They explained that keeping their man, even if it meant getting HIV, would not be so bad because the government would assist. This implies that HIV and AIDS is a disease that has some form of benefits. Some even expressed that family members were benefiting from the grant while looking after an HIV positive person. They saw the grant as a form of income and made statements such as, *"at least one gets paid a thousand."*

6.8 Implications of love medicine

This section looks at the repercussion of using love medicine based on the findings of this study. The following are some of the negative health implications to the users of love medicine:

- Sexual practices associated with love medicine
- Addiction to the use of love medicine,

- Procedure of administration and the products
- Yardstick for measuring the effect of love medicine
- Love medicine as part of traditional therapy
- Love relationships and family destabilization

Sexual practices and decision making

The use of love medicines, especially those that are believed to enhance sexual pleasure, is likely to work against the prevention of HIV. Firstly, after experiencing sexual pleasure where love medicine has been used without condoms, the couples are unlikely to go back to sex with a condom. Secondly, condoms tend to reflect both infidelity and lack of trust, the former being one of the reasons why love medicine is used in the first place in an attempt to hide multiple relationships. The issue of trust is line with the findings of Bayles and Bujra (2000), who explained that where the issue of trust is threatened, it becomes hard to negotiate condom use.

Women in these communities are in constant competition and live in fear of losing their partners. They have perceptions that if their partner has experienced pleasure, he is likely to come back for more, thus creating trust and an even stronger emotional bond. Therefore, giving him enhanced sexual pleasure and avoiding a condom becomes the way of expressing love and trust. In this study, it emerged that women are showing their partners that they trust them with their lives because they perceive that being intimate is very important for the person who is providing. As Bond and Dover (1997), have indicated the use of a condom removes this element of trust. Supporting this, Doyal and Anderson, 2005 argued that making

use of a condom introduces the idea of multiple partnerships and shatters any illusions of being exclusive. Scott and Freeman (1995: 163), in their book, have suggested that one of the challenges is to translate anxiety about HIV and AIDS into rational dialogue because it calls trust and intimacy into question. Supporting this Rhodes and Cusich (2000), argued that expression of love and intimacy tends to play a major role in decision making when it comes to the risk of HIV.

It emerged from the study findings that some love medicines are perceived as having an aphrodisiac effect which increases the libido without necessarily increasing the capacity to be satisfied. Participants explained that if their partner had not arrived after having used such love medicine, women found themselves looking for a substitute. Based on the fact that they are unlikely to use a condom, unsafe sex is likely to be practiced exposing all concerned to the risk of acquiring HIV infection.

Addiction to the use of love medicine

An important factor that emerged from the study is that participants agreed that once they had been initiated into the use of love medicine, it becomes almost impossible to have sexual relationships without using one of the products. This was similar to findings documented by Brown et al. (1993). Women became hooked and explained that once they had started using such products to enhance sexual pleasure they lost confidence in themselves. They tend to try various products on the market with the hope that a new one will be better than the one previously used. This, in itself, has financial implication and, in some cases, users ended up having multiple partners purely to get money to buy more love medicine.

Procedure of administration and the products of love medicine

Cleansing, returning the partner and retaliating procedures can be classified as low risk, but the challenge is that woman using such love medicine is already compromised with sexually transmitted infections such as pubic lice and evident discharge. She is aware that her partner has been taken by someone else, but is nevertheless in a hurry to get him back and ensure that he gets the necessary sexual pleasure to stop him from going back to the other woman. Therefore, even if these women are aware that either they or their partner might be HIV positive, the pain and humiliation they have experienced make it hard to even suggest a condom. The risk of HIV becomes minimized and the focus is placed on getting the partner back. This supports findings presented in the studies by Brown et al,(1993) and Warwick et al (1987) that assumption that awareness of the risk and negotiation skills are not reliable, but the interplay between broader social context and rationalization of the risk plays a major role in the HIV pandemic. The desperation of the women and the amount of money they spend on love medicine makes it hard for them rationalize their health and the risk of acquiring HIV.

The love medicines used for securing relationships, making partners commit and controlling partners require application, insertion and sometimes even applying the medicine to bleeding cuts. These have been identified as high risk love medicines which expose users to the risk of acquiring HIV because they all provide entry for the virus in the form of bruises, open wounds and the exchange of body fluids such as blood and semen. The situation becomes even more risky in the event of multiple relationships, which are often the case. When these kinds of love medicine have been used, condoms are purposely avoided, even by those who usually do

use them. Data revealed that it is highly unlikely that the couple will go back to using a condom after experiencing such sexual pleasure.

Yardstick for measuring effect of love medicine

According to the findings, one of the yardsticks to measure whether the love medicine has been effective is that the partner desires sexual contact more often and should *"be on top of you all the time, should not let go or refuse to do so."* To ensure maximum pleasure, the women should be dry, hot and tight and willing to have unprotected sex so they resort to love medicine. Findings revealed that some of the products, even if one simply touches them, can cause itching and bruising. It follows, therefore, that inflammation, lesions and shedding of the vaginal mucosa are likely to occur. This may increase the risk of HIV infection among those who use love medicine that is applied or inserted vaginally. Traumas of the capillary vessels during sexual contact, even under normal circumstances, have been documented by (Alcena 1994: 77). This author argues that such instances provide a perfect media environment for the entry of the HIV virus.

Love medicine as part of traditional therapy

Love medicine follows the traditional therapy convictions, as explained earlier, that diseases and misfortune are not perceived as incidental. Therefore any sickness or misfortune is explained in accordance with traditional healing and the real "cause" is sought. This is in line with what has been documented by various authors who state that the social causes for the disease are sought by those who believe in traditional healing (Vilakazi, 2006; Green, 1992; Green et al, 1995). Instead of dealing medically with a symptom of disease such as a discharge

or pubic lice, the affected person starts by identifying possible opponents and focuses energy on returning the spell and getting the partner back. The women become desperate to seal the relationship by giving their partners love medicine and initiating a process of unsafe sex where the use of a condom is purposely avoided. There is no evidence that either of the couples test for HIV before engaging sexually when the partners return.

In some cases, the individuals do seek treatment for the discharge, but consult traditional healers who treat the condition with traditional medicine to dry the vagina. Previous studies conducted in the same province indicated that this is a common practice (Peltzer et al, 2006). This, in itself, can make it hard to treat a sexually transmitted infection even if the person does eventually go for medical treatment. By the time the person gets examined there will be no obvious discharge and, because their use of love medicine has not been taken into account, they might not receive the appropriate treatment.

Love relationships and family destabilization

It emerged from the findings that the use of love medicine often results in instability in love relationships. The situation becomes even more challenging when married men leave their wives and children to be with the women who give them sexual pleasure. Sometime, the male partner does not physically leave the house, but distances himself from his wife and children or become abusive towards them. According some of the traditional healers, one of the reasons why they are unwilling to give love medicine to unmarried women was because the women use it to target married men which results in the breakdown of marriages and causes suffering for both the wives and children. Some of the female users, especially older

ones, gave this as a reason for starting the practice of using love medicine. They explained that their children would go hungry for days while they knew that their partners could afford to take care of their families. One of the male traditional healers, who was against the use of love medicine, explained that the only time he gave this kind of love medicine was when a wife said the husband was not supporting her financially.

These are various implications that came out of this study relating to the different stakeholders and enlightening information on the use of love medicine and the associated risks of acquiring HIV infection. It is for this reason that various recommendations targeting various stakeholders were developed.

6.9 Recommendations

The recommendation is based on the data analysis as well as direct suggestions given by the participants as possible interventions which might reduce the risk of HIV infection

6.9.1 Recommendation for future research

The study opens opportunities for both qualitative and quantitative research. There is a need to investigate the in-depth use of love medicine among the women and men especially in the districts where this study was conducted. The need to explore the association between the use of love medicine and the risk of acquiring HIV in more systematic studies is suggested. Investigations on the risk associated with marketing with special attention given to the

pamplets given to the public without even considering the age or sexuality knowledge of those who are given such pamphlet.

There is need to find interventions that will enable the users to break away from the chain of using love medicine once one has started (addiction) as form of step down process. Other studies that can be done include chemical analysis of the composition of substance used for love medicine. This will provide more accurate information on drying and heating effect of products used. Also it will give insight on the possibility of condom breaking when love medicine is used.

This study was conducted in the district areas that are mainly rural and most of the women were unemployed while the male partners tended to migrate to the cities. It would be interesting to conduct similar research in an urban area to assess whether there are similar practices and if so, compare the motives. Such a study could take the form of a comparative study between urban and rural practices.

The findings also highlighted the fact that patterns in the use of love medicine change over time and therefore there is a need for ongoing research into the use of love medicine and the implications associated to HIV prevention and management.

A collaborative research that uses a participatory approach is recommended to explore how gender-related, socio-cultural and economic conditions leading to the use of love medicine can be changed to fight the spread of HIV. This research may also include establishing types of

health promotion messages that are culturally sensitive and which takes into consideration the gender-related issues and socio-economic and cultural factors. A research that uses a participatory research approach has a potential to develop a sense of ownership from the community members and sustainability of such programmes.

Preference for dry sex and tight vagina came up repeatedly in this study. This means there is a need for research that will aim at establishing interventions that may lead to dry sex, but minimize the risk of HIV and strategies that might work to change the mindset of women regarding dry sex. There is also a need to explore how condoms can be improved in such that they provide that special tingling sensation that will make users prefer them more.

Researchers and community health nurses could collaborate and develop materials in the form of brochures or booklets using simple language to educate the public about love medicine and how its use contributes to the spread of HIV. They may get funding from the health and other related department or non-govermental organizations with an interest in prevention and management of HIV and AIDS. These groups should get input from the community members and make communities take a leading role in the development and distribution of this material to get their buy in. The funding for this project should have some capacity building component for training volunteers that can educate people about use love of medicine and the possibility of health risk. The volunteers should be given a stipend or incentives. They should work hand in hand with the Community Health Nurses or Primary Health Care nurses. In South Africa midwives are part of both categories.

6.9.2 Recommendations for health care service providers

The study showed that nurses, who are the first contact with the community members, need to be aware of the possibility that love medicine has been used. Factors such as the broader social context of use and matters of motives should be highlighted so that the nurses will be able to take these into consideration. They should be sensitive to the fact that some women are afraid to be tested for HIV because they are fully aware that they have been practicing unsafe sexual practices as well as the fact that are involved with partners who have multiple sexual relationships. Nurses should understand the circumstances why women use love medicine and why they purposely avoid using condoms. It is therefore recommended that health care workers be fully informed about the broader social context of the areas in which they work to give them the opportunity to counsel their patients about the potential risks of acquiring HIV when engaging in love medicine practices. The HIV prevention message should take these into consideration.

Primary and community health care nurses should conduct a social mapping exercise to identify community-based organizations which are involved in HIV prevention and management and collaborate with them for their HIV and AIDS programmes to be more effective. Collaborating will open avenues to tap into other resources available in the communities and share the expertise in the fight against HIV,

Study findings demonstrated that community members believe in traditional therapy which is often a contradiction to medical management and can delay or disrupt the seeking of

appropriate treatment. It is important that health education programmes should be given within the communities which highlight the need to seek medical treatment without delay even if one is using traditional therapy. During consultation process at the health facility especially for patients that come for gnaecological problems the question of whether a patient has been using love medicine should be included. This will enable the health care providers such as nurses to be able to discuss these issues sensitively in order to reach a correct diagnosis.

It emerged from the findings of the study that peer education is taking place within the community regarding cultural constructed sexuality in which the community includes use of love medicine in some cases. The challenge, however, is that the information being passed from one to the other is not always accurate. For example, excessive oily skin due to normal physiological changes is regarded as a spell that warrants traditional therapy rather than a normal condition. Therefore, there is a need for the young people in these communities to receive some form of sex education where they can be taught about the normal hormonal changes that will take place in their bodies and this can be done through the existing structures within the communities.

The curriculum for training nurses in sexually transmitted infection should take the broader social context into consideration. There is need to integrate information from anthropology and social science can help in preparing health promotion and prevention messages. Nurses should be updated on the possibilities of the risk of sexually transmteed infections including HIV infections that are associated with use love medicina and other traditional practices.

6.9.3 Recommendations for planners of HIV prevention and management programme

The findings demonstrate that existing risk reduction techniques are generally ineffective in the lives of low–income black women whose risks are increased as a result of their circumstances. Both social and economic circumstances place these women in the nodal districts in a different position from other risk groups. Therefore their risks to HIV infection differ from other community members and these need to be taken into consideration when developing strategies and prevention messages for HIV and AIDS pandemics. Therefore, interventions need to be relevant and applicable to each specific community. This can be achieved by allowing the target community to define their own realities within the context of high–risk environments and behaviours while being assisted to address the controlling images created in the society.

Traditional healers, as the recognised first line of contact in the communities should work in collaboration with health professionals especially the community or public health nurses. They should undergo some preparation in diagnosing sexually transmitted infections, especially vaginal and penile discharges as community members view these as effects of negative love medicine. They should learn how to diagnose and refer appropriately and timeously. The University of KwaZulu-Natal Nelson Mandela Medical School is working with traditional healers from the province, and it is suggested that the training programmes should include management of sexually transmitted diseases at a community level.

6.9.4 Recommendation for gender advocacy group

The fact that multiple sexual relationships for men are acceptable within the culture in these districts should be considered when developing prevention programmes. This needs to be put on the table for the community to visit their own reality and deal with their own biases. There is evidence that gender related and cultural constructed sexual behaviour factors need to be given special attention. Therefore, there is need for an agency for such gender activities in the nodal districts. Such an agency could argue for the empowerment of black women in particular and work towards a change of their current oppressive conditions. This has been used for the black American women as an attempt to fight against HIV (Guy–Sheftall, 1995). Women need to be empowered so that they are economically independent from men. Employment opportunities should to be created for women in rural areas. The government is currently placing greater emphasis on agriculture and farming as more funds can be generated through farming. There is need to build the self esteem of women to such an extent that they no longer view themselves as having a value only if they are in a relationship with a man.

Beliefs and sexual communication in these districts need to be given special attention. Women are raised with the belief that they are there to be the providers of sexual pleasure for men. This devalues female sexuality and pressurises women to an early sexual debut. Women find it difficult to abstain from sex because it is part of their culture to be perceived by men as providers of sexual pleasure and this is compounded by the availability of love medicine. Advocacy groups need to develop workshops for defining love relationships,

especially for young people. Women need to have workshop where they will learn about who they are, what makes a woman a woman as well as empowerment strategies.

While the government has raised concerns with regard to the possible extinction of certain natural resources because they are used in traditional medicine, little attention, if any, has been given to the possible extinction of certain communities who might get HIV infections as a result of using the medicine itself. It is recommended that steps should be taken to protect the users while controlling the market of traditional healing. There is a need for advocacy work to protect community members from the pamphlets that are distributed and also from the love medicine that is sold from public areas such as pavements and public toilets. The community and the government should give special attention to the pamphlets to ensure that while the providers market their products the community is protected from information that promotes unsafe sex and that such pamphlets are not distributed to inappropriate age groups.

6.9.5 Recommendation on microbicides which are friendly to women's needs

Condoms have been criticised in the study because of their nature of being a barrier. This is a challenge for those who are using love medicine where fluid exchange has to take place and there is the belief that the magic may not work if condoms are used. This is in line with the study findings of Civic and Wilson (1996). Other researchers have raised the issue of condoms being described as a sign of emotional distance or detachment (Rhodes and Cusick 2000). Therefore, microbicides which come in various forms such as rings, lubricants or even tablets

are being developed to prevent HIV and could be one of the solutions. If microbicides are made with the desires of the intended users in mind, such as enhancing sexual pleasure while reducing the risk of HIV infection, maybe they would be more acceptable. It is therefore suggested that those who are manufacturing microbicides take the findings of this study into consideration and develop a product which has the ability to make the women dry while at least keeping them hot it might prove useful in communities such as these.

6.9.6 Recommendation for collaboration with the love medicine providers

It emerged from the study that the providers, especially the traditional healers, play a major role in influencing the use of love medicine without a condom. Also, they are not only trusted by the communities, but given the status of authority. When talking about traditional healers people use phrases like, *'mother', 'father' or 'the one who can see beyond'* Therefore, it is recommended that programme managers work together with the providers and traditional healers so they can be guided in the types of love medicine they supply to their customers. New products are constantly being introduced to the market and, therefore, it is important that the programme planners work alongside the providers and traditional healers to develop strategies and plans to devise safer ways of using such love medicine. This could include promoting a medicine which could be used in conjunction with a condom or making use of love medicines that are less invasive or those that have been classified as low risk. Traditional healers could be encouraged to look at safer routes of administering love medicine, for example, bathing, steaming or applying it sublingually and avoid those practices regarded as high risk such as those which are administered vaginally.

6.9.7 Recommendation on messages

The study has shown that messages for HIV prevention do not take into consideration the social context under which sexual practices take place. Sometimes the messages contradict or challenge norms and cultural expectations and make the individual feel isolated as opposed to being part of a social community. An example of this would be advising HIV positive women, who have no power in the relationship, to introduce the use of condoms in order to avoid further infection. Information such as this should go with some form of empowerment, especially in areas such as these where being left or leaving ones husband is viewed as a form of failure.

In this study it was clear that even if one has a disease, it is often blamed on a certain individual known or unknown. This person is perceived to be driven by jealousy or intending to destroy the relationship for his or her benefit. It is recommended that programme planners should take cultural practices and norms and values and other contextual factors into consideration when developing messages.

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The study showed that people have lost hope of having a future and they believe that they are all going to die of AIDS. Therefore, they want to enjoy the government grants, which they perceive as being of benefit to those who have no job opportunities. It is recommended that the messages about HIV and AIDS prevention should be persuasive and emphasise the benefits of not getting infected by HIV as opposed to short negative messages such as 'AIDS kills'. The messages should be broader to include the interests of the family or concern for

others as opposed to preserving oneself. This would be more relevant in such community where the need to marry, have a family and build the homestead is of such importance.

The health education programmes targeting young people should include the developmental needs of young people as most of them engage in the practice of love medicine while their bodies are not yet fully developed to cope with risks associated with the practice. These programmes should include the physical and psychological development of young people, their hormonal changes and imbalances in relation to issues of sexuality and also the vulnerability of women who are not empowered to stand their ground regarding safer sex. In this study, education as the key to life messages should be emphasized as this has an influence on the economic vulnerability of women later on in life.

Young men should be socialised to be responsible man who are practicing safe sex as early as possible to protect themselves and those they enter into relationships with. Such programmes should be led by men and key figures in communities because they are regarded by young boys as role models. Respect for women should be instilled as early as possible in young boys. Older men should also be involved in women empowerment programmes so as to be role models to young men in the support of women.

6.11 Summary

The HIV and AIDS epidemic is having a severe impact worldwide. According to Loewenson and Whiteside (2001), it is reversing the hard-won development gains in life expectancy and

health, as well as in economic and social development. Reviewed literature clearly reflects that culture and gender are some of the most crucial factors contributing to vulnerability to HIV and the impact of HIV and AIDS. A decade ago a number of authors (Kun,1998; Meyer-Weitz et al; 1998) called for research that will use a qualitative approach in studying existing culktural practices and their contribution in increasing the HIV risk among both women and men. The call has been made by more researcher to look into cultural and traditional practices if they are not contributing to HIV infection (Nshindano and Maharaj; 2008; Raj, Amaro and Reed, 2001). Authors such as Cock and Møller (2002) highlighted the use of love medicine as one of area that needs special attention. This study therefore is aimed at exploring the use of love medicine among black Africans in KwaZulu-Natal with the intention of understanding the motives related to the use of such practices and whether or not the use of love medicines contributes to risks for HIV transmission to men and women. This study adopted a social constructivist and feminist approach, and qualitative ethnographic design in order to explore the phenomenon of love medicine in-depth. Informants included both men and women but the women's voice was illuminated as literature indicates that in most HIV related discourses and research studies, the women's voice is often overshadowed by the male voice.

The findings have demonstrated the broader existing setting that influences the use of love medicine as well as the matters that motivate and energizes the practices. Within these particular communities there are expectations and gender roles. Men are expected to provide financial security and material things while women are expected to give pleasure in exchange. These expectations lay a foundation for trading sex for material things and women

become compromised in the process. Women are expected to have a male partner as a form of security and this makes them determined to do anything to have and to keep a man, even if it means compromising their own lives. They make use of a variety of love medicines to enhance sexual pleasure in order to achieve this. Like all other values and cultural norms and practices, these are passed on one generation to another by family members and within generations by peers or other women in the communities. Persuasive language is used to market love medicine which seems to promote the practice further. More providers are joining the market while more users are getting hooked. There is no corresponding acknowledgement or recognition of the potential risk that goes with the practice.

The findings of this study have shown that while community members are aware and, in some cases, concerned about getting HIV infection they are still prepared to indulge in unsafe sex. They are prepared to pay a high for love medicines, both financially and physically. They sometimes experience pain and bleeding during cutting and application of love medicine and some of the products applied cause itchiness which can lead to bruising. Some participants indicated that even if they had been in the practice of using condoms, they purposely avoided them when using love medicine.

In most cases, the informants suspect or are aware that their partner has multiple relationships. Most of them regard this as competition and continue to stay in the relationship and turn to love medicine products as a solution. Others believe that if they use love medicine they have no competitors and therefore find no reason to be concerned about the possibility of any sexually transmitted infections including HIV. They believe that their

partner is focused only on them because of '*ubhekaminangedwa*', the love medicine believed to achieve this. Some use '*udelunina*' in the belief their partners will forsake all others, including their mothers and focus on them alone. It was of interest that others were aware of the possibility of the man having other women, even other sexual partners, but he will know that the best is with her. Even in such cases, condoms were not used because the women want to give the best possible pleasure. This was perceived to be when love medicine has been inserted and a condom not used.

The study showed that in cases where a woman is deserted by her partner, a social cause is identified. This is often perceived to be due to a spell that has been cast by another woman. The deserted woman tends to retaliate and uses love medicine to get her partner back. While discussing all the steps involved in returning her partner, there was no reference to HIV testing. The findings confirm that the women using these love medicines seem to be in a hurry to get them transferred and deliberately have sex without a condom.

The study also showed that, in some cases women themselves, are involved in multiple sexual practices. These women use love medicine with the hope that it will help to hide the fact that they are having sex with various men. Such women were described as using love medicine to make their vaginas resemble that of vanity state , tight and dry and this is based on the belief that loose, wet vaginas denote infidelity. Therefore, to protect themselves from being accused of infidelity, they use various love medicines.

The study findings have indicated that some of the love medicine practices do contribute to the possible risk of acquiring HIV infection. Others have been identified as low risk practices, but they mark the beginning of the use of love medicine. The challenge is that while some of the love medicines are not likely to expose the users to risk, they are usually combined with others which enhance sexual pleasure as a means of sealing the relationship or showing appreciation and trust. In such cases, even if the so called '*owemali*' or 'cellphone medicine', which is normally put under the tongue or applied on the hand, was used to make the partner provide material things, a condom would be avoided during sex. In some cases, unprotected sex is perceived as an act of trust in one's partner. Even in seemingly low risk cases where love medicine has been put in the partner's food, there is the danger that, if it works, he will stop having other relationships and therefore the use of condoms or the risk of HIV infection does become part of such a couple's discussion.

In addition to this, there are other negative implications of using love medicine such the probable addiction to the practice. Some of the procedures of administration are likely to expose one to risk. These include insertions of products that can cause an increase in friction of the dried vaginal canal. Frequent and prolonged sexual engagements which are used as a measure for the effectiveness of the products can lead to a rapid increase in the viral load, the disruption of love relationships and families as well as a financial implication due to cost of love medicine.

6.12 Conclusion

The aim of this study is to explore the use of love medicine among black Africans in KwaZulu-Natal, to understand the motives related to the use of such practices and to establish whether the use of love medicines may contribute to risks for HIV transmission to men and women. The findings have given insight on the availability of various substances used and the practice of love medicine, the implications of use of love medicines to individual health as well as family life.

In conclusion, there is a very wide gap between the value of giving pleasure with the aim of getting some form of perceived or constructed security and the prevention or control of the HIV pandemic. The use of love medicine appears to be in total contrast to the measures recommended by HIV awareness programmes to try and contain the disease. The use of persuasive language to market love medicine is another factor promoting unsafe sex. More providers are joining the market while more users are getting hooked and there is no acknowledgement or recognition of the potential risk that goes with the practice. Broader social context plays a major role in the use of love medicine and gender roles and community expectations seem to put pressure on the community members. This includes pressures that one should have a partner and the challenge of being judged if deserted by that partner. In many cases women compromise their safety or even sacrifice their lives with the hope of securing a relationship. Appropriate specific interventions are urgently needed to deal with both the social context of the communities as well as the use of love medicine that is

mushrooming in these districts. Communities have suggested possible inter and number of recommendations have been made.

6. 13 Limitations of the study

Only black African men and women participated in the study because it was designed to assess the use of love medicine among this group. However, it does not necessarily mean that only black people use love medicine. Although men were involved in the study, the focus was on women. The study adopted a feminist approach because the intention was to give women a voice. This may be interpreted as a weakness, but the study had a specific purpose which I believe, as a researcher, has been achieved.

Some people might argue that the study cannot be generalized, especially because it was done in districts that are mainly rural. The reason for selecting such districts was that they have been identified as having a slightly higher number of women. In most cases, these women are unemployed and they rarely get a chance to have their views documented. Therefore, while the selection of the areas for the study may be a limitation, the study gave these women the opportunity to talk to the researcher, a person who come from their area, shares their culture, has done work in all the selected districts and has taken time to observe their behaviour while conducting an ethnographic study. This was useful since the purpose was to get in-depth information and provide women with a platform that is safe for them to tell their story. The fact that the participants came from the same background as the researcher as well as the homogeneity of the sample strengthens the chances of getting

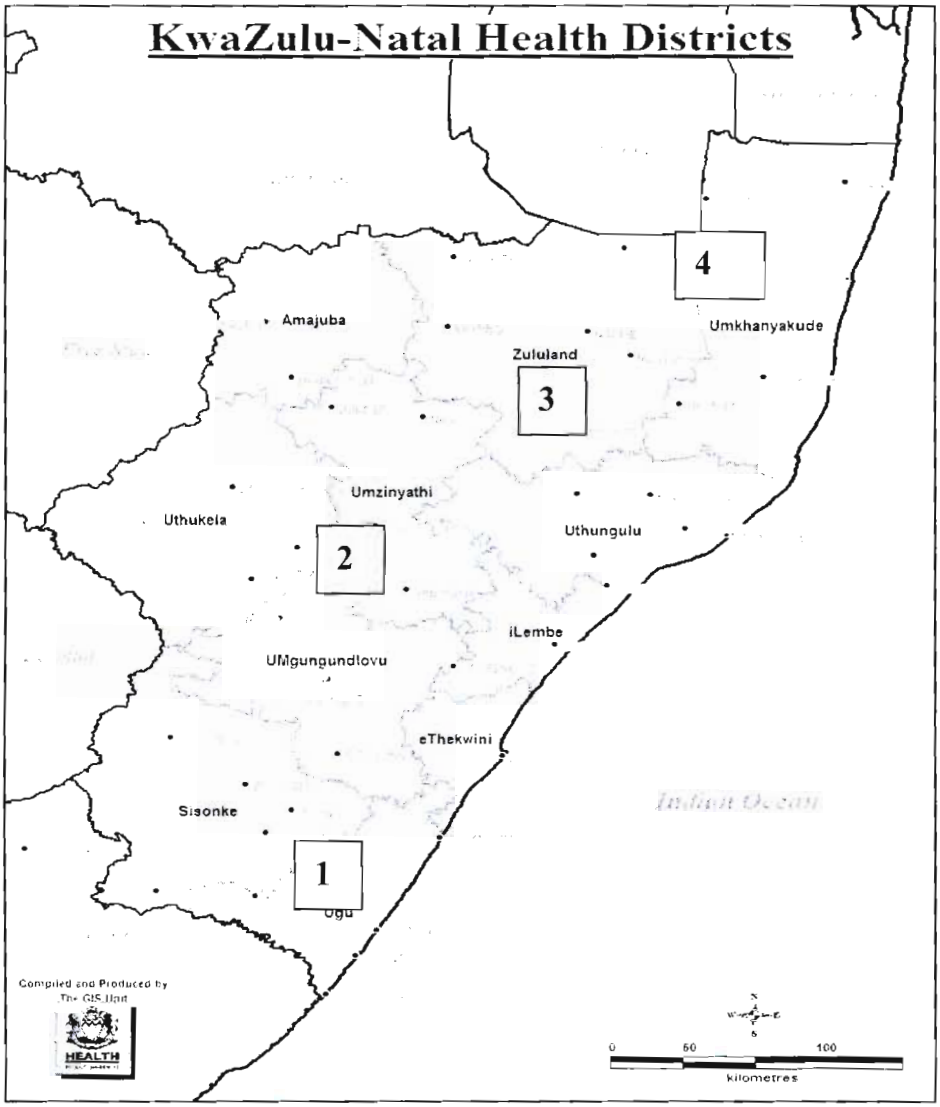
comprehensive information from the various districts. This information can be used to plan specific programmes for this marginalized group of women.

Sexual relations and sexual practices have behavioural aspects. Some of these are socially acceptable and some are not. Therefore, discussions pertaining to sexual relations or sexual practices are regarded as personal and sometime as sensitive issues. This is even more so during this era of HIV and AIDS. Therefore, it was anticipated that it would not be easy to get the kind of sample required to talk about love medicine and other sexual related practices. A snowball method was identified as ideal for this kind of study, especially for interviews. It was anticipated that some of the participants may wish to keep some of their practices private. However, the researcher has worked with such issues before and she used her experience to be sensitive while guiding the participants in discussion. This enabled them to talk freely and openly about their sexual practices including the use of love medicine. Some of the participants denied using love medicine in spite of being identified as users by others who knew them. The researcher managed to get as much information while interviewing the participants as key informant as during the in-depth interviews.

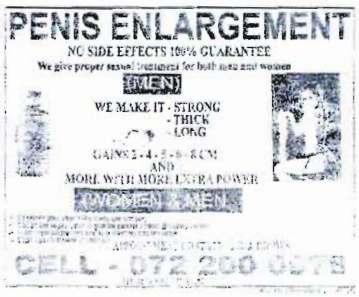
The snowball kind of sample could be viewed as a limitation that can results in biases. It is possible that the people interviewed reported that almost everyone is using love medicine because they were using love medicine themselves or they network with such people. However, the study was designed to get in-depth information on the use of love medicine and because this topic is not something that can be openly discussed the researcher had to rely on participants to identify the providers and the users.

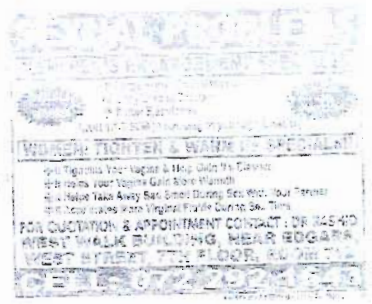
The other possible limitation is that the researcher, although being a female, did both male and female interviews and the field workers assisting her were females. Some people my percieve this as limitation. However, the researcher has, in the past, successfully conducted equally sensitive studies involving males.

Apendixes 1: Map Of KwaZulu-Natal showing the four districts where the study was conducted



Appendix 2: Samples of pamphlet that are handed to public along the pavement and at the road traffic area.





Appendix 3 Letter requesting permission and permissions granted to conduct the study sent to various municipalities

18 January 2007

Attention: Municipal Manager
Ulundi/ Municipality
Ulundi

20 February 2007

Attention: Municipal Manager
Jozini Municipality
Umkhanyakude

18 January 2007

Attention: Municipal Manager
Ulundi Municipality
Ulundi

20 April 2007

Attention: Municipal Manager
Nqutu Municipality
Umzinyathi

Dear Sir
Re: Permission to conduct gender, sexuality and vaginal practice

I am writing this letter to request permission to conduct the a research within your local municipality/or to come and present the project people such as local leaders if necessary.

The project is funded partly by World Health organization and partly by Ford Foundation as part of PhD studies as explained in the meeting. The main part which is the survey will be conducted in all the district and the detailed study focusing on sexual practices will be conducted in the four nodal district of KwaZulu-Natal (Umzinyathi,Ugu, Zululand and Umkhanyakude).

The purpose of survey is to learn more about the different vaginal practices performed by women to increase sexual pleasure or enhance their reproductive health or both. The purpose of the follow up study will be to learn more about what people do to enhance sexual relationship including sexual pleasure. The first one will be conducted on women only while the follow -up detailed study will include both men and women

Ethical approval for the survey has been obtained from the Wits University Ethics committee and the follow up study ethical approval will be obtained from the University of KwaZulu-Natal as part of the requirement for PhD research.

Your assistance will be highly appreciated

Yours faithfully

Busisiwe Kunene

.....
Programme Director

20 April 2007

Attention: Municipal Manager
Nqutu Municipality
Umzinyathi

Dear Sir
Re: Permission to conduct gender, sexuality and vaginal practice

Following a project presentation at the Umzinyathi District Offices in, it was resolved that we can liaise with local municipalities to explain the project.

The project is funded partly by World Health organization and partly by Ford Foundation as part of PhD studies as explained in the meeting. The main part which is the survey will be conducted in all the district and the detailed study focusing on sexual practices will be conducted in the four nodal district of KwaZulu-Natal (Umzinyathi,Ugu, Zululand and Umkhanyakude).

The purpose of survey is to learn more about the different vaginal practices performed by women to increase sexual pleasure or enhance their reproductive health or both. The purpose of the follow up study will be to learn more about what people do to enhance sexual relationship including sexual pleasure. The first one will be conducted on women only while the follow –up detailed study will include both men and women.

Ethical approval for the survey has been obtained from the Wits University Ethics committee and the follow up study ethical approval will be obtained from the University of KwaZulu-Natal as part of the requirement for PhD research.

I am writing this letter to request your assistance in the following:

- Permission to conduct research within your local municipality/or to come and present the project to other people such as local leaders if necessary.
- Informing relevant department managers and or other local leaders and authorities about proposed researches.
- If possible identify a person that can assist to enter in various communities

Your assistance will be highly appreciated

Yours faithfully

Busisiwe Kunene
.....
Programme Director

NQUTHU MUNICIPALITY
UMASIPALA WASE NQUTHU
Private Bag X5521, NQUTHU, 3135
Tel: +27(0) 34 271 6100, Fax: +27(0) 34 2716 111

07 May 2007

RHRU Durban Office
3 Floor West ridge Medical Centre
95 Jan Smut Highway
Mayville
4091

Attention: Busisiwe Kunene / Ntsiki Manzini

Dear Madam

Re: Research Sexuality and vaginal practices and HIVAIDS

Following our telephonic conservation and the presentation you made on your visit, you are kindly informed that you are allowed to do research on gender, sexuality and vaginal practices at Ngudulwane and Hlathi Dam. As discussed that will be followed by detailed data collection on sexuality practices for Busisiwe Kunene's PhD work that will include other Umzinyathi areas.

The name of the person who will be assisting you is Mrs. P. K. Mkhonza her cell number is 072 215 4105.

Hope the above is in order.

Yours faithfully

MJ LUVUNO
MUNICIPAL MANAGER

To: Ms Busisiwe / Sindi

RHRU

FROM: CLLR I ZIKHALI

DATE: 12 APRIL 2007

SUBJECT: RE- PERMISSION TO DO THE RESEARCH

This letter serves to give RHRU the permission to do genders, sexuality and vaginal practice the research quantitative that will be followed by qualitative data collection on sexuality which is part of PhD work at Ward 12 under Jozini Municipality Jurisdiction.

Thank You

CLLR H.T ZIKHALI
WARD COUNCILLOR
0829024505

JHAMILA CLINIC PHONE NO: 0355791004

UMASIPALA WASOLUNDI

Private Bag X17
Ulundi
3838

" The City of Heritage "

ULUNDI MUNICIPALITY

Tel: 035 - 874 5100
Fax: 035 - 870 0598
E-mail: ceotc@mweb.co.za

REPRODUCTIVE HEALTH & HIV RESEARCH UNIT
PO BOX 38884
POINT
DURBAN
4009

REF:6/21/2
ENQ:MH Mtshali
DATE: March26, 2007

GENDER AND SEXUALITY SURVEY AND THE REQUEST TO UNDERTAKE A SURVEY.

The abovementioned subject refers to your letter dated 18 January 2007 and we are pleased to advise that ULUNDI MUNICIPALITY has no objection to your application. to carry the gender and sexuality research as well as the details study on sexuality which is part of PhD study to be done at ULUNDI MUNICIPALITY area.

For further information and assistance regarding your survey work please refer to our, Mr MH Mtshali Telephone number: 035-87451 06 Fax number 0354701575.

Thank you,

N.V. ZULU.
ACTING MUNICIPAL MANAGER.

Attention: Sindi

031 261 8868

UMZUMBE MUNICIPALITY
UMASIPALA WASEMZUMBE

P O BOX 561
HIBBERDENE
4220

TEL: 039-6849180
FAX: 039-6849960
E-mail:umzumbe@venturenet.co.za

Ward 7 Councillor

ATTTENTION: Mr Dlamini

LETTER OF CONFIRMATRION

Umzumbe Municipality hereby confirms that Reproductive Health and HIV Unit is doing the research on vaginal practices that will be followed by sexuality practices. They have introduced and reported the study to Umzumbe Municipality.

This letter serves to confirm the above information. Kindly assist Busisiwe Kunene and Sindile Dube

Yours Faithfully

Disco Khuzwayo
IDP MANAGER

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za

27 NOVEMBER 2007

MS. MB KUNENE (971166939)
SCHOOL OF NURSING

Dear. Ms. Kunene

ETHICAL CLEARANCE: "THE USE OF LOVE MEDICINE AMONG BLACK AFRICANS IN KWAZULU-NATAL AND THE RISK OF HIV TRANSMISSION FOR BOTH MEN AND WOMEN IN SOUTH AFRICA"

I wish to confirm that ethical clearance has been granted for the above project, subject to:

1. The title of the project being changed to **"The use of love medicine among Black Africans in kwaZulu-Natal and the risk of HIV Transmission for both men and women in South Africa"**
2. **Contextualization of the study (what the study is about) e.g. degree, UKZN, etc. being included on the informed consent document**

This approval is granted provisionally and the final clearance for this project will be given once the above conditions have been met. Your Ethical Clearance Number is HSS/0621/07

Kindly forward your response to the undersigned as soon as possible

Yours faithfully

.....
MS. PHUMELELE XIMBA

cc. Post-Graduate Studies
cc. Supervisor (Prof. O Adejumo)

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: sshrec@ukzn.ac.za

UNIVERSITY OF
KWAZULU-NATAL

14 JANUARY 2010

MS. MB KUNENE (971166939)
SCHOOL OF NURSING

Dear Ms. Kunene

PROTOCOL REFERENCE NUMBER: HSS/0621/07D
PROJECT TITLE: "WHERE TO FROM IQMS: USE OF LOVE MEDICINE AMONG BLACK AFRICANS IN KWAZULU-NATAL AND THE RISK FOR HIV TRANSMISSION TO BOTH MEN AND WOMEN IN SOUTH AFRICA"

FULL APPROVAL NOTIFICAITON – COMMITTEE REVIEWED PROTOCOL

This letter serves to notify you that your application in connection with the above was reviewed by the Social Sciences & Humanities Research Ethics Committee in 2006, has now been granted full approval following your responses to queries previously addressed:

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study 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

.....

PROF. S COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Prof. O Adejumo)
cc. Ms. C Dhanraj

Reference list

Acker, J. (1991). Race, gender and leadership. London: Routledge.

Alcena, V. (1994). Aids the expanding epidemic – Multicultural overview. New York Alcend Medical Communication Inc.

Alksnis, C., Desmarais, S., and Wood, E. (1996). Gender difference in scripts for different types of dates. Sex Roles. 34, 499–509.

Andel, T., de Korte, S., Koopmans, D., Behari-Ramdas, J. and Ruysschaert, S. (2008). Dry sex in Surimane. Journal of Ethnopharmacology, 116, 84-88.

Archer, L. (2004). Re theorizing "difference"in feminist research. Women's Studies International Forum 27 (5-6) 459-473.

Armstrong N. and Murphy E. (2008). Weaving meaning? An exploration of the interpaly between lay and professional understanding of cervical cancer risk. Social Science and Medicine 67(7) 1074-1082.

Ashforth, A. (2005). Muthi, medicine and witchcraft: Regulating 'African Science' in post - Apartheid South Africa? Social Dynamics 31:2: 211-242.

Bagnol, B. (2003). Identities and sexual attraction: Female adolescent rituals in Northern Mozambique and in the Mozambique. Paper presented at Sex and Secrecy. Johannesburg, South Africa.

Baleta, A. (1998). Concern voiced over "dry sex" practices in South Africa. The Lancet, October 17, 352 (9136):1292.

Baleta, A. (1989). South Africa to bring traditional healers into mainstream medicine. The Lancet, 355 (9127): 554.

Barnette, T. and Whiteside, A. (2006) Aids in the twenty first century. Disease and Globalisation. Great Britain: Palgrave Macmillan.

Bateman, C. (2004). Healers 'get real' about tackling AIDS. South African Medical Journal, 94 (2), 74-75.

Bayles, C. and Bujra, J. (2000). AIDS, Sexuality and Gender in Africa: The Struggle Continues. London: UCL Press.

Beasley, C. (1999). What is feminism: An introduction to feminist theory. Thousand Oaks, CA : Sage .

Beksinska, M., Rees, H., Kleinschmit, I. and MacIntayre, J. (1999). The practice and prevalence of dry sex among men and women in South Africa: a risk factor for sexually transmitted infections? Sexually Transmitted Infection 75:178-180.

Bergen, R.K. (1993). Interviewing survivors of marital rape. In: C.M. Renzetti and R.M. Lee, Editors, Researching Sensitive Topics, Sage, London.

Bird, S.T. and Harvey, S.M. (2001). No glove no love Cultural belief of African American women regarding influencing strategies for condom use. International Quarterly of Community Health Education, 20, 237 - 251

Bond, V. and Dover, P. (1997). "Men, women and the trouble with condoms: problems associated with condom use by migrant workers in rural Zambia" Health Transition Review, Supplement to Vol. 7: 377-391.

Botha, J., Witkowski, E.T.F. and Shackleton, C.M. (2004). Market profiles and trade in medicinal plants in the Lowveld, South Africa. Environmental Conservation 31 (1): 38-46.

Braunstein, S. and Van de Wijgert, J. (2003). Cultural Norms and Behavior Regarding Vaginal Lubrication During Sex: Implications for the Acceptability of Vaginal Microbicides for the Prevention of HIV/STI; Population Council, New York.

Brown, J. E., and Brown, R. C. (2000). Traditional intravaginal practices and the heterosexual transmission of disease: a review. Sexually Transmitted Diseases: 27(4): 183-187.

Brown, J. E., Ayowa, O.B. and Brown R. C. (1993). Dry and tight: sexual practices and potential AIDS risk in Zaire. Social Science Med 1993; 37:989-994.

Brown, R.C., Brown, J.E. and Ayowa, O.B. (1993). The use and physical effects of intravaginal substances in Zairian women. Sexually Transmitted Diseases, March-April, 20(2):96-9.

Brown, R.C., Brown, J.E. and Ayowa, O.B. (1992). Vaginal douching; sexually transmitted infections 82(2) 210-214

Brown, R.C., Brown, J.B. and Ayowa, O.B. (1992). Vaginal inflammation in Africa (letter). New England Journal of Medicine 327:572

Bryman, A. (1996) Zulu meidicine and medicine men. Cape Town: Struik.

Bryman, A. and Burgess, R.B. (1999). Qualitative analysis: Thousand Oaks: Sage Publications.

Bryman, A. and Teevan, J. (2005). Social Research methods: Canadian edition Oxford University Press.

Bührmann, M.V. (1986). Living in two worlds: Communication between a white healer and her black counterparts. Wilmette, Ill: Chiron.

Burman, A. (2006). Mix method, Volume iii. Thousand Oaks, CA : Sage

Burnard, P. (1991). A method of analyzing interview transcripts in qualitative research. Nurse Education Today. 11: 461-466.

Butler, J. (1990). Gender trouble. Feminism and the subversion of identity. United State of America: Taylor Francis publisher Inc.

Campbell, R. and Wasco, S.M. (2000). Feminist approaches to social science: epistemological and methodological tenets. American Journal of Community Psychology; 28 (6): 773 – 791.

Campbell, T. (1997). Technology, multimedia, and qualitative research in education. Journal of Research on Computing in Education, 30(9), 122-133.

Carton, B., Laband J. and Sithole J. (2008). Zulu identities: Being Zulu, past and present Columbia. C Hurst and Company Publishers Ltd.

Chong, J. and Kvasny, L. (2005). Social construction of gender and sexuality in online HIV/AIDS discourses in China: A feminist critical discourse analysis. Intercultural Communication Studies, 16 (3), 53-65

Civic, D. and Wilson, D. (1996). Dry sex in Zimbabwe and implications for condom use. Social Science Medical Journal, 42: 91-98.

Civic, D. and Wilson, D. (1992). Dry sex in Zimbabwe and implications to condom use. Sexual transmitted infection. 68: 245-248.

Cocks, M., and Dold, A. (2000). The role of African chemist in the health care system of the Eastern Cape Province of South Africa. Social Science and Medicine 51: 1505- 1515.

Cocks, M., and Møller, V. (2002). Use of indigenous and indigenised medicines to enhance personal well being: South Africa Social Science and Medicine 54: 387-397.

Collins, P.H. (1990). Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. New York : Routledge.

Collins, P. H. (1989). The social construction of Black feminist thought. Signs, 14: 745–773.

Collins, P. H. (1987). Black feminist thought: Knowledge, consciousness, and the politics of empowerment. New York: Routledge.

Cook, J. A., and Fonow, M.M. (1990). Knowledge and women's interests: Issues of epistemology and methodology in feminist sociological research. In J. M. Nielsen (Ed.), Feminist research methods: Exemplary readings in the social sciences. Boulder, CO: Westview Press.

Cooper, N., and S. Burnett. (2006). 'Using Discourse Reflexivity to Enhance the qualitative research process: An example from accounts of teenage Conception', Qualitative Social Work 5(1): 111–29.

Craffert, P.F. (1997). Opposing world-veiw. The bodyguards between traditional and biomedical health care practices. 5th African Journal of Ethnology 20: 1-9.

Creswell, J.W. (1997). Qualitative inquiry and research design; Choosing among five traditions. United State of America :Sage

Cusick, L. and Rhodes, T. (2000). Sustaining sexually safety relationships: HIV positive people and their sexual partners. Culture, Health and Sexuality, 2, (4): 473-478.

Dallabetta, A.G., Miotti, P.G., Chiphangwi, J.D., Liomba, G., Canner, J.K., and Saah, A.J. (1995). Traditional vaginal agents: use and association with HIV infection in Malawian women. AIDS, 9: 293-297.

Davies, B. (2004). Introduction: Poststructuralist Lines of Flight in Australia, International Journal of Qualitative Studies in Education 17(1): 3–9.

Davies, D., and Dodd, J. (2002). Qualitative research and the question of rigor. Qualitative Health research, 12(2): 279-289.

De Andrade, V., and Ross, E. (2005). Beliefs and practices of Black South African traditional healers regarding healing impairment. International Journal of audiology 44: 489-499

Delius, P., and Glaser, C. (2002). Sexual socialization in South Africa: a historical perspective. African Studies. [Special Issue: AIDS in Context] 61 (1): 27-54.

Denzin, N.K., and Lincoln, Y.S. (2008). Landscape of research qualitative research. Thousand Oaks, CA : Sage.

Denzin, N. and Lincoln Y.S. (2005). Qualitative Research. Third edition. Thousand Oaks, CA: Sage Publication.

Denzin, N.K. and Lincoln, Y.S. (2000). Introduction: the discipline and practice of qualitative research", (Eds),Handbook of Qualitative Research, Sage, London.

Denzin, N. K., and Lincoln, Y. S. Eds. (1998). The landscape of qualitative research: Theories and issues. Thousand Oaks: Sage Publications.

Denzin N.K, and Lincoln Y.S. (1994). Handbook of qualitative research. Thousand Oaks, CA: Sage.

Department of Health. South Africa Demographic Health Survey. (1998). Full Report. Pretoria.

Department of Health (2006). National HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa. Pretoria: Department of Health.

Des Jarlais, D.C., Friedman, S.R., Choopanya, K., Vanichseni, S., and Ward,T.P. (1992). International epidemiology of HIV and AIDS among injecting drug users. AIDS 6: 1053-1068.

Devisch, R. (1993). Weaving the treads of life: the Khita gyn-eco-logical healing cuilt among Yaka United State of America: Chicago Press.

De Wet, T. (1998). Doepra after dark. Protective for infants in Soweto in South Africa. Anthropology Dissertation (unpublished).

Doyal L. and Anderson J. (2005)'My fear is to fall in love again ...' How HIV-positive African women survive in London. Social Science Medical Journal, 60: 1729-1738.

Duma, S. E., (2006) Women's journey of recovery from sexual assault trauma: A grounded theory. Unpublished Doctoral theses submitted at University of Cape Town.

Dunkle, K.L., Jewkes, R.K., Nduna, M., Jama, P.N., Levin, J.B., Sikweyiya, Y. and Koss, M.P. (2007). Transactional sex and economic exchange with partners among young South African men in the rural Eastern Cape: prevalence, predictors, and associations with gender-based violence. Social Science and Medicine 65(6): 1235- 1248.

Dworkin, S. L. (2005). Who is epidemiologically fathomable in the HIV/AIDS epidemic? Gender, sexuality, and intersectionality in public health. Culture, Health and Sexuality: 7 (6) : 615 – 623.

Eisner, E. W. (1991). The enlightened eye: Qualitative inquiry and the enhancement of educational practice. New York, NY: Macmillan Publishing Company.

Erikson, E. (1993). Childhood and society. New York: W. W. Norton & Company.

Escobar, A. (1995). Encountering development: The making and unmaking of third world. Princeton, NJ: Princeton University Press.

Fako, T.T., Linn, J.G. and Brown, B.E. (2000). Transferring health technology to South Africa: The importance of traditional African culture. Journal of technology transfer 25, 299-305.

Fan, Y. F., Conner, R. F., and Villareal, L.P. (2007). AIDS science and society. Boston: Jones and Bartlet publisers.

Fonck, K., Kaul, R., Keli, R., Bwayo, E., Ngugi, E., Moses, S., and Termmerman, M. (2001) Sexually transmitted infections and vaginal douching in a population of female sex workers in Nairobi , Kenya. Sexual transmission infection 77(4) 271-275.

Fonow, M. M. and Cook, J. A. (1991). Back to the future: A look at the second wave of feminist epistemology and methodology. In M. M. Fonow and J. A. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 1–15). Bloomington: Indiana University Press.

Fook, J. (2002). Social Work Critical Theory and Practice. London: Sage.

Fosnot, C.T. (2005), Constructivism: Theory, perspective and practice (2nd edition), New York: Teachers College Press.

Fosnot, C.T. (1996), Constructivism: A psychological theory of learning. In Fostnot (Ed), Constructivism: Theory, perspective and practice (pp 8-33), New York: Teachers College Press.

Foucault, M. (1983). "Afterword: The Subject and Power." In Michel Foucault: Beyond Structuralism and Hermeneutics. 2nd ed. Edited by Hubert Dreyfus and Paul Rabinow. Chicago: University of Chicago Press,

Foucault, M. (1980). Power / Knowledge: Selected Interviews and Other Writings 1972-1977. Edited by Colin Gordon. New York: Pantheon.

Foucault, M. (1979). The History of Sexuality: Vol 1 An Introduction. London: Allen Lane.

Foucault, M. (1978). The History of Sexuality. New York. Vintage book.

Fox, S. (2003). Gender based violence and HIV and AIDS in South Africa: Organizational responses Department of Health South Africa.

Foxman, B., Aral, S.O. and Holmes, K. (1998). Interrelationships among douching practices, risky sexual practices, and history of self-reported sexually transmitted diseases in an urban population. Sexually Transmitted Diseases: 25(2):90-99.

Franken, R.E. (1994). Human motivation (3rd edition) Pacific Grove Califonia: Brooks/ Cole Pub Co.

Friedman, S.R. and Des Jarlais, D.C. (1991). HIV among drug injectors: The epidemic and the response. AIDS Care, 3 : 239-250.

Gage, A. (1995). Women's socioeconomic position and contraceptive behaviour in Togo. Stud Family Planning, 26 (5):264–77.

Gentry Q. M., Elifson K. and Sterk C. (2005). AIDS Education and Prevention, 17(3), 238 -252.

Genzuk, M. (2003). A sythesis of ethnographic research. Center for Multilingual, Multicultural Research: University of Southern California.

Gerrie, J. W. 2003. Was Foucault a Philosopher of Technology? Techné: Journal of the society in Philosophy and technology, 7 (2) 14 -26.

Gilbert, L. and Walker, L. (2000). Treading the path of least resistance: HIV/AIDS and social inequalities-a South African case study. Social Science Medicine Journal, 54: 1093–110.

Green E. (2000). Traditional healers and AIDS in Uganda. The journal of Alternative and Complimentary Medicine, 6: 1-2.

Green, G., Pool, R., Harrison, S., Hart, G.J., Wilkinson, J., Nyanzi, S. and Whitworth, J.A.M. (2001). "Female control of sexuality: Illusion or Reality? Use of vaginal Products in South West Uganda," Social Science Medicine, 52 (4): 585-98.

Green, E.C. (1999). Engaging indigenous African healers in the prevention of AIDS and STDs. In Hahn R. A., (ed). Anthropology in public health (pp 63-83) New York Oxford University Press.

Green, E.C., Zokwe, B. and Dupree, J.D. (1995). The experience of an AIDS prevention program focused on South African traditional healers. Social Science and Medicine, 40 (4): 503-515.

Green, E.C. (1992). Sexually transmitted diseases, ethno-medicine and health policy in Africa. Social Science and Medicine, 35(2): 121-130.

Guba, E. G. and Lincoln, Y. S. (1994). Fourth generation evaluation. Newbury Park Califonia: Sage.

Guba, E. G. and Lincoln, Y. S. (1989). Fourth generation evaluation. Newbury Park. Sage publications.

Gumede, W. (2005). *Thabo Mbeki and the Battle for the Soul of the ANC*, Zebra Press, Cape Town.

Gumede, M. (1990). Traditional Healers: A Medical Practitioner's Perspective. Johannesburg: Skotaville.

Gupta, G.R. (2000). Gender sexuality and HIV / AIDS: The what, why and how. SIECUS Report, 29 (5): 6-12.

Gupta, G.R.,; Weiss, E. and Whelan, D. (1995). Male-female inequalities result in submission to high-risk sex in many societies. Special report: women and HIV. AIDS Analysis Africa. 5(4):8-9.

Gupta, G.R., Weiss, E. (1993). Women's lives and sex: implications for AIDS prevention. Culture Medical Psychiatry , *17:399-412.*

Halloway, I. and Wheeler, S. (2002). Qualitative Research in Nursing. Oxford: Blackwell Publishing Company.

Halperin, D.T. (1999). Dry sex practices and HIV infection in the Dominican Republic and Haiti. Sexual Transmitted Infections. 75 (6): 445-446.

Hammersley, M. (1990). Reading Ethnographic Research: A critical Guide. London: Longman.

Hammersley, M. (1989). Some notes on the terms of validity and reliability. British Educational Research Journal, 13(1): 73-81.

Hammond-Took, D. (1989). Rituals and medicines: Indigenous healing in South Africa. Johannesburg:

Hammond-Tooke, W. D. (1970). Urbanization and the meaning of misfortune. Africa, 40 (1): 25-38.

Harding, S. (1987). Feminism and methodology. Bloomington: Indiana University Press.

Healy, K. (2005). Social Work Theories in Context: Creating Frameworks for Practice. Basingstoke: Palgrave.

Healy, M. and Perry, C. (2000). Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. Qualitative Market Research, 3(3), 118-126.

Hellman, N.S., Desmond-Helman, S., Nsubang, P.S. J., Bainganan-Baing, G., Mbidde, E.K. and Tager, I.B (1991). Genital trauma during sex is a risk factors for HIV infection in Uganda. VII International Confernce on AIDS /II STD World Congress.

Henderson, P. (2004). The vertiginous body and social metamorphosis in a context of HIV/AIDS.

Henry, G.T. (1990). Practical Sampling Applied Social Research Method Volume 21. London: Sage Publishers

Hesse-Beber, S.N. and Leavy, P.L. (2007). Feminist research practice. Califonia Thousands Oaks: Sage Publishers.

Hewson, M. G. (1998). Traditional Healers in Southern Africa. Annals of Internal Medicine 128:
1029-1034.

Hilber, A. M., Chersich, M. F., van de Wijgert, J. H., Rees, H. and Temmerman, M. (2007). Vaginal practices, microbicides and HIV: what do we need to know? Sex Transm Infect 83(7): 505-508.

Hiton, A. (2002). Should qualitative and quantitaive studies be triangulated? International cancer news: 14 (2) 8.

Hirst, M. (2005). Dreams and medicine The perpective of Xhosa Diviners and Novices in the Eastern Cape, South Africa. Indo-Pacific Journal of Phenomenology , 5:25-47.

Hira, S.K., Mangrola, U.G. and Mwale, C. (1990). Apparent vertical transmission of human immunodeficiency virus type 1 by breast-feeding in Zambia. Journal of Pediatrics. Sept;117(3): 421–424.

Hoepfl, M. C. (1997). Choosing qualitative research: A primer for technology education researchers. Journal of Technology Education, 9(1), 47-63.

Holland, J., Ramazanoglu, C., Sharpe, S. and Thomson, R. (1992). Pleasure, pressure and power: some contradictions of gendered sexuality. Sociological Review, 40: 645-674.

Holzman, C., Leventhal, J.M., Qiu, H., Jones, N.J. and Wang, J. (2001). Factors linked to bacterial vaginosis in non pregnant women. American Journal of Public health, 91: 1666-1670.

Howe, D. (1994). 'Modernity, Post-modernity and Social Work', *British Journal of Social Work* 24: 513–32.

Huberman, A.M. and Miles, M.B. (2002). The qualitative research Companion. London: Sage publishers

Huitt, W. (2001). Motivation to learn: An overview. Educational Psychology Interactive. Valdosta, GA: Valdosta State University. Retrieved July 2007, from http://chiron.valdosta.edu/whuitt/col/motivation/motivate.html

Hunter, M. (2002). The materiality of everyday sex: Thinking beyond 'prostitution', African Studies: 61 (1) 99–120.

Hunt, C.W. (1989). Migration of labor and sexually transmitted disease: AIDS in Africa. Journal of health and social behaviour: 30: 353- 373.

Hycner, R. H. (1999). Some guidelines for the phenomenological analysis of interview data. In Bryman A. and. Burgess R.G (Eds.), *Qualitative research* (Vol. 3, pp. 143-164). London: Sage Publishers

Hynie, M., Lydon, J.E., Cote S., and Wiene, S.R. (1998). Relational sexual scripts and women's condom use: The importance of internalizing norms. The Journal of Sex research 35: 370-380.

Inagakin, I., and Oida, N, (1970) On the constituents of rhinoceros horn (I) Nagoya Shiritu Dai-gaku Yakugakbu Kenkyu Nempo 18: 57-66.

Islam, M.W., Tariq, M., Ageel, A.M., Al-Said, M.S., and Al-Yhya, A.M. (1991). Effect of heamatodes on sexual behaviour of male rats. Journal of Ethnopharmacology 23, 1-2: 67-72.

Jackson, H. (2000). AIDS in Africa continent in crisis. SAfAIDS. Harare Zimbabwe: Avondale.

Jackson, A. (2004). 'Performativity Identified', Qualitative Inquiry 10 (5): 673–90.

Jäger, A. K. (2005). Is traditional medicine better off 25 years later? Journal of Ethnopharmacology 100: 3-4.

Janzen, M. 1992. Ngoma: Discourses of healing in Central and Southern Africa, Barkeley: University of Califonia Press.

Jarama, S. L., Belgrave F. Z., Bradford, J., Young, M. and Honnold, J.A (2007). Family, cultural and gender role aspects in the context of HIV risk among African American women of unidentified HIV Status: An Exploratory Qualitative Study. AIDS Care, 19(3): 307-17.

Jayaratne E.T., and Stewart A. J. (1991). Quantitative and qualitative methods in the social sciences. Current feminist issues and practical strategies in Fonow and Cook 1991. Beyond methodology 85 - 113 Indiana: Indiana University press.

Jenkins S.R. (2000) Introduction to the special Issue: Defining gender, relationships, and power. Sex Roles, 42, 7-8

Joesoef, M.R., Sumampouw, H. and Linnan, M *et al.* (1996). Douching and sexually transmitted diseases in pregnant women in Surabaya, Indonesia. American Journal of Obstetrics and Gynecology. 174 (1):115–119.

Johnson, B. R. (1997). Examining the validity structure of qualitative research. Education, 118(3): 282-292.

Jones, D.J (1998). "Post-structuralism" at:http://www.roga.demon.co.uk/frames.htm access April 2006

Judith, S. and Thorne (1985). The missing feminist revolution in sociology. Social Problems 32 (4): 301-316.

Kale, R. (1995). South African Health: Traditional healers in South Africa: a parallel health. Biomedical Journal; 310:1182-1185.

Kamtchouing, P., Mbongue G.Y.F., Dimo, T., Watcho, P., Jasta, H.B. and Sokeng, S.D. (2002). The effect of Aframamomum malegueta and Piper guineense on sexual behaviour of male rats Behavioural Pharm [short report] 13(3): 243-247.

Karim, S.S. and Karim, Q. (2005). HIV in South Africa, Cape Town: Cambridge University Press.

Karim, Q.A., Karim, S.S. and Soldan, K. *et al*. Reducing the risk of HIV infection among South African sex workers: socioeconomic and gender barriers. American Journal Public Health 1995;85:1521–5.

Karim, S.S., Ziqubu-Page,T.T.and Arendse, R. (1994). Bridging the gap: Potential health care partnership between African traditional healers and biomedical personnel in South Africa. South African Medical Journal: 84(5): 250-3.

Karim, A.Q. (2001). Barriers to preventing human immunodeficiency virus in women: experiences from KwaZulu-Natal, South Africa Journal of America Medical Womens' Association. 56(4): 193-6

Kaufman, C.E., and Stavrou, S.E. (2002). "Bus fare, please": the economics of sex and gifts among adolescents in urban South Africa, Policy Research Division Working Paper. New York: Population Council, No. 166.

Kavanaugh, K.H., and Kennedy, P.H. (1992). Promoting cultural diversity. Califonia: Sage publishers

Kelly, S., Barowski, E., Flocke, S. and Keen, K. (2003). The role of sequential and concurrent sexual relationship in the risk of sexual transmitted diseases among the adolescents. Journal of Adolescent Health, 32(4): 296-305.

Kelly L., Burton, S., and Regan L. (1994). 'Researching Women's Lives or Studying Women's Oppression? Reflections on what Constitutes Feminist Research' in Mary Maynard and J. Purvis (editors) *Researching Women's Lives from a Feminist Perspective.* London: Taylor and Francis.

Kenjale, R., Shah, R., and Sathaye, S. (2008). The effect of chlorophytum bovilial on sexual behaviour and sperm count on male rats. Phytother Res. 22(6): 796-801.

Kilmarx, P.H., Limpakarnjarnarat, K., and Supawitkul, S. *et al* (1998). Mucosal disruption due to use of widely distributed commercial vaginal product: potential to facilitate HIV transmission. AIDS: 12(7): 767-773.

Kim, O.H., Funkhouser, E., Simpson, T., Brown, P., and Merchant, J. (2003). Early Onset of vaginal douching is associated with false beliefs and high-risk behavior. Sexually Transmitted Diseases: 30(9) :689-693.

King, R., Lifshay, J., Nakayiwa, Kantuntu, S., Lindkvist, D., and Bunnell R. (2009). The virus stops with me: HIV-infected Ugandian motivation in preventing HIV transmission. Social Science and Medicine 68: 749-759.

Kirk, J., and Miller, M. L. (1986). Reliability and validity in qualitative research. Beverly Hills: Sage Publications.

Kistner, U. (2003). Gender based violence and HIV /AIDS in South Africa: Literature Reiew. CADRE/ Department of Health.

Kleinginna, P. Jr., and Kleinginna, A. (1981). A categorized list of motivation definitions, with suggestions for a consensual definition. Motivation and Emotion, 5: 263-291.

Kofi-Tskpo. (2004). Institutionalisation of African traditional medicines in the health care system in Africa: African Journal of health Science 11(1-2) i-ii.

Kreiss, J.K., Coombs, *R.,* Plummer, F., Holmes, K.K., Nikora B., Cameron W., Ngugi E., Ndinya-Achola J.O., and Corey, L. (1989) Isolation of human immunodeficiency virus from genital ulcer in Nairobi prostitutes. Journal of infectious diseases 19, (2):403- 407.

Kun, K. (1998). Vaginal drying agents and HIV transmission. Family Planning Perspective, 24(2): 93-94.

Kunene, B., Scorgie, F., Manzini, N., Smit, J., Preston-Whyte, E. and Beksinska, M. (2005) Matters and motives for vaginal *practices in* KwaZulu-Natal, South Africa. Paper presented at the Sexology Conference in Canada, 10 - 15 July, 2005.

Lacombe, D. (1996). "Reforming Foucault: a critique of the social control thesis", The British Journal of Sociology", 47 (2): 332-352

Laguerre, M.S. (1987). Afro-Caribean folk medicine South Hadley, M.A: Bergin and Garvey.

Lambert, H. and Wood, K. (2003). Dirty bodies, clean talk? Sexuality, health and communication in India and Africa. 4th International Conference of the International Association for the Study of Sexuality, Culture and Society (IASSCS) on Sex and Secrecy, University of the Witwatersrand, Johannesburg, June 2003.

Leclerc-Madlala, S. (2001). Demonising women in the era of AIDS: on the relationship between cultural constructions of both HIV AND AIDS and femininity. Society in transition 32(1): 38-46.

Leclerc-Madlala, S. (2002). On the virgin cleansing myth: gendered bodies, AIDS and ethnomedicine. African Journal of AIDS Research, 1: 87-95.

Leclerc-Madlala, S. (2003). Transactional Sex and the Pursuit of Modernity. Social Dynamics 29(2): 213-233.

LeCompte, M. D. and Schensul, J. J. (1999). Designing and conducting ethnographic research: Ethnographers toolkit (vol 1). Califonia: Altamira Press.

Lincoln, Y. S., and Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage Publishers.

Lofland, J., and Lofland, L. H. (1995). Analyzing social settings, 3rd ed. Belmont,: Wadsworth.

Loewenson, R. and Whiteside, A. (2001). HIV/AIDS: Implications for poverty reduction, United Nations Development Programme policy paper, UNDP.

Longmore, M. A. (1998). Symbolic interactionism and the study of sexuality. Journal of Sex Research, 35: 44–58.

Luke, N. (2003). Age and economic asymmetries in sexual relationships of adolescentgirls in sub-Sahara Africa, Studies in Family Planning 34 (2): 67-86.

Lurie, P., Hinzen, P., Lowe, R.A., (2004) HIV beyond epidemiology: USA Blackwell Publishers

Lurie, M. , Harrisona, A., Wilkinsona D. and Karima, S.A. (1997). Circular migration and sexual networking in rural KwaZulu/Natal: implications for the spread of HIV and other sexually transmitted diseases. Health Transition Review, 3 (7): 17-27.

Lyye, J. (2004). Some post-structural assumption. Brock University: Department of English available:http://www.brocku.ca/english/courses/4F70/poststruct.html.access: 2006 February.

Mabin, A. (1990). Limits of Urban Transition Models in Understanding South African Urbanisation. Development Southern Africa, 7: 311- 322.

Mack, N., Woodsong, C., MacQueen, K.M., Guest, G. and Namey, E. (2005). Qualitative research methods: A data collector's field guide. North Caroline: Family Health International.

Madamombe, I. 2006. "Traditional Healers Boost Primary Health Care: Reaching Patients Missed by Modern Medicine." Africa Renewal, 21:10-11,

Maguire, Patricia. (1987). Doing participatory research: a feminist approach. Amherst, MA: Center for International Education, School of Education, University of Massachusetts.

Malow, R.M. Stein, J.A. McMahon, R.C., Dévieux, J.G., Rosenberg, R., and Jean-Gilles, M. (2009). Effects of a culturally adapted HIV prevention intervention in Haitian youth. Journal of Association of Nurses AIDS Care. 20(2):110-121

Mathison, S. (1988). Why triangulate? Educational Researcher, 17(2): 13-17.

Maman, S., Mbwambo, J. K. and Hogan, N.M.,*et al.* (2002). "HIV-positive women report more lifetimepartner violence: findings from a voluntary counselling and testing clinic in Dares Salaam, Tanzania." American Journal of Public Health, 92(8): 1331-1337.

Mane, P., and Aggleton, P. (2001). Gender and HIV/AIDS: What do men have to do with it? Current Sociology, 49, 23, 23-37.

Mann, P., and Maitra, A. S. (1992). AIDS prevention. The socio cultural context in India. Bombay: Tata institute Social Science.

Mander, M., Ntuli, L., Diericchs, N. and Mavundla, K. (2008). Economic of traditional medicine trade in South Africa (unpublished report).

Mander, M., Ntuli, L., Diedericks, N. and Mavundla, K. (2007). South Africa's medicines Industry. Pretoria: Department of Trade and Industry.

Mander, M. and Ntuli, L. (2006). Emerging trends in medical plant trade in Durban. Ethekwini municipality, unpublished.

Mander, M. (1998). Marketing of Indigenous Medicinal Plants in South Africa: A Case Study in Kwazulu-Natal. Food and Agriculture Organization, Rome.

Mander, J., Quin, N. and Mander, M. (1997). Trade in wild life medicines in South Africa. Traffic East/Southern Africa. (unpublished report).

Mane, P. and Aggleton, P. (2001). Gender and HIV/AIDS: What do men do about it? Current Sociology, 49, (6): 23-37.

Manhart, E., Aral,S., Holmes,K. and Foxman, B. (2002). Sex partner concurrency. Sexual Transmitted Diseases 29(3) 133-143.

Marshal, C. and Rossman, G.B. (2006). 4th edition Designing Qualitative Research. Thousand Oaks, CA: Sage.

Maynard, M. (1994). Methods, practice and epistemology: the debate about feminism and research. In: M. Maynard and J. Purvis, Editors, Researching Women's Lives from a Feminist Perspective., London: Taylor and Francis Ltd

Maxwell, J. A. (1992). Understanding and validity in qualitative research. Harvard Educational Review, 62(3): 279-300.

McClelland, R.S., Lavrey, L., Hassen, W.M., Mandaliya, K.; Ndiya-Achola, J.C., and Beaten, J.M. (2006). Vaginal washing and increased risk of HIV-1 accquisition among African women: A prospective study. Epidemiology and Social: Concise communincation: 20(2): 269-273.

Mckean, S. and Mander, J. (1999). Case study: traditional medicine and the vultures. Economics of the traditional medicine in South Africa. Food and Agriculture Organization, Forest product Division. http//www.ceroi.net/reports /Durban/issues/Terenstri/muthi.htm. (access August 2008).

Mckean, S. and Mander, M. (2007). Traditional medicine and vulture trade: case study: South African Health review 197-199. Sabinet.

McKenzie, M. (2008). Promoting the indigenous natural products industry: The role of local Government. www.cpwild.co.za accessed (2008).

Myer, L., Kuhn, L., Stein, Z., Wright, T C. and Denny, L. (2005). Intravaginal practices, bacterial vaginosis and women's susceptibility to HIV infection: epidemiological evidence and biological mechanism. The Lancet infectious diseases 5 (12) 786-794.

Meyer, L., Denny, L., De Souza, M., Baron, M.A., Wright, T. C. and Jr, Kuhn L . (2004). Intravaginal practices, HIV and other sexually transmitted diseases among South African Women. Intra-vaginal Practices, HIV, and Other STDs, 31(3): 174-179.

Meyer-Weitz, A., Reddy, P., Weijts, W., van den Borne B. and Kok, G. (1998). The socio-cultural contexts of sexually transmitted diseases in South Africa: Implications for health education programmes. AIDS CARE, 10, (1): 39-55

Michael, A. and Peters, L. (2001). Poststruralism, Marxism, and Neoliberationism: Between Theory and Politics. London Rowman and Littlefield.

Miles, M. B., and Huberman, A. M. (1994). Qualitative data analysis, 2nd ed. Newbury Park, Cal.: Sage.

Mokhobo, D. (1989). AIDS in Africa. Nursing RSA/Verpleging , 4(3): 20- 22.

Monnig, H.O. (1997). The Pedi. Pretoria: Van Schalk.

Morales, A., Marshall, P., Surridge, D.H.C., and Fenemore, J. (1987). Double blind trial of Yohimbi in the treatment of psychogenic impotence. The Lancet 330, 8556: 421-423.

Morar, N. S., Ramjee, G., Karim, A., and Karim, S. S. (1998). Vaginal insertion and douching practices among sex workers at truck stops in KwaZulu-Natal. South African Medical Journal 88(4): 470.

Morse, J. and L. Richards. (2002). Read Me First – for a Users' Guide to Qualitative Methods. London: Sage.

Munhall, P.L. (1989). Qualitative design: Advance design in nursing research. Boston: Jones and Bartlet Publishers.

Munhall, P.L. (2007). 4th edition Nursing Research a qualitative perspective. Boston: Jones and Bartlet Publishers.

Myer, L., Denny, L., De Souza, M., Wright, T.C. and Kuhn, L. (2006). Distinguishing and emporal association between women's intravaginal practices and risk of Human Immunological Virus infection: Prospective study of South African women: American journal of Epidimiology 163(6): 552-560.

Myer, L., Kuhn L., Stein Z. A., Wright T. C. and Jr., Denny, L. (2005). Intravaginal practices, bacterial vaginosis, and women's susceptibility to HIV infection: epidemiological evidence and biological mechanisms. The Lancet Infectious Diseases 5(12): 786-94.

Ndege, G.O. (2001), Health, State, and Society in Kenya: Faces of Contact and Change. Rochester: University of Rochester Press.

Ndinda, C., Uzodike, U. O., Chimbwede, C. and Pool, R. (2007). Gender relations in the context of HIV /AIDS in the rural areas of South Africa. AIDS Care, August 2007; 844-849.

Ndulo, J., Fexel, E. and Krantz, I. (2001). Traditional healers in Zambia and their care for patients with urethral/vaginal discharge. The Journal of Alternative and Complementary Medicine, 7: 529 -536.

Ness, R.B., Hillier, S.L. and Richter, H.E. (2003). Why Women douche and why they may or may not stop. Sexually Transmitted Diseases. 30(1): 71-74.

Ngubane, H. (1992). Social basis of healing and healing in Africa. Berkeley: University of California Press.

Ngubane, H. (1981). Clinical Practice and Organization of Indigenous Healers in South Africa. Social Science and Medicine 15(3): 361-366.

Ngubane, H. (1977). Body and Mind in Zulu Medicine. London: Academic Press.

Nshindano, C. and Maharaj, P. (2008). Reasons for multiple sexual relationships: perspectives of young people in Zambia. African Journal of AIDS Research 7(1): 37-44.

O' Reily, K. (2005). Ethnographic methods New York: Routledge Taylor Francis group.

O'Sulluvan L.F., Hoffman S., Harrison A. and Dolezal C. (2006). Men multiple sexual partners and young adults' sexual relationships: understanding the role of gender in study of risk. Journal of Urban Health: Bulletin of New York Academy of Medicine 83 (4): 695-707.

Ortiz-Torres, B., Serrano-Garcia, I. and Torres- Burgos, N. (2000). Subverting culture : Promoting HIV/AIDS prevention among Puerto Rican and Dominican Women. American Journal of Community Pyschology, 28, (6): 859.

Paplau, L.A., Venigas, R.C.and Taylor, P.l. (1999). Gender, culture and ethnicity: Current research about women and men CA: Mayfield Publishing.

Park, S.W., Lee, C.H., Shin, D. H. and Lee, S.M. (2006), Effect of SAI, a herbal formulation on sexual behaviour and penile erection. Biological Pharmacology bulleting 29 (7): 1383-1386.

Parker, R., Herdt, G., and Carballo, M. (1991) Sexual Culture, HIV Transmission and AIDS research. The Journal of Sex Research. 28(1): 77-98.

Parker, R.G., Easton, D. and Klein, C.H. (2001). Structural barriers and facilitators in HIV prevention: a review of international research. AIDS, 14: S22-S32.

Pattman, R. (2006). " Making pupils the resources and promoting gender equality in HIV/AIDS education". Journal of Education.

Pattman, R., (2005). Boys and girls should not be too close: Sexuality, the identities of African boys and girls and HIV education. Sexualities, 8: 497-516.

Patton, P. (2003). Foucault and subject of power part II. Ethics and the subject of politics. Edited by Moss J. Thousand Oaks, CA: Sage.

Patton, M. Q. (2002). Qualitative evaluation and research methods (3rd Edition.). Thousand Oaks, CA: Sage Publications, Inc.

Patton, M.Q. (2001). Qualitative Research and Evaluation Methods (2nd Edition). Thousand Oaks, CA: Sage Publications.

Patton, M.Q. (1990). Qualitative evaluation and research methods. SAGE Publications. Newbury Park London: New Delhi.

Peltzer, K., Mnqundaniso, N. and Petros, G., (2006). HIV/ AIDS /TB knowledge, beliefs and practices of traditional healers in KwaZulu-Natal South Africa. AIDS care August 2006: 18(6): 608-613.

Pettifor, A.E., Measham, D.M., Rees, H. and Padian. N.S. (2004). Sexual Power and HIV risk. Emerging Infectious Diseases 10(11): 1996-204.

Pope, C., Ziebland, S. and Mays, N., (2000). Qualitative research in health care: Analysing qualitative data. Biomedical Journal; 320(7227): 114–116.

Polifroni, E.C. and Welch, M. (1999). Perspective of philosophy of science in nursing: An historical and contemporary anthropology. Lippincott: Philaldelphia.

Polit, D.F. and Beck, C. T. (2008). Nursing research generating and assessing evidence for nursing practice. Baltimore: Walter Kluwer.

Polit, D.F. and Beck, C.T. (2005). Essentials of nursing research: Methods appraisal and utilization. Philadelphia: Lippincott: Philaldelphia.

Polit D.F. (2001). Essentials of nursing research: Methods appraisal and utilization. Philadelphia: Lippincott: Philaldelphia.

Polit, D.F. and Hungler, B.P. (1991). Nursing research: principles and methods. 4th edit. Philadelphia: J.B. Lippincott Company.

Prestine-Whyte, E.M. (2003). Context of vulnerability: Sex, secrecy and HIV/ AIDS. African Journal of AIDS research: 2(2): 85-90.

Prestine-Whyte, E., Varga, C., Oosthuizen,H., Roberts, R. and Blose, F. (2000). Survival Sex and HIV/ AIDS in an African City. In Parker, R., Barbos, R.M., Aggletone P. Framing the sexual Subject: The politics of Gender, Sexuality and Power: Berkerley, CA: University of California Press.

Preston-Whyte, E. and Zondi, M. (1989). To control their own reproduction: the agenda of black teenage mothers in Durban. Agenda, 47- 68.

Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S.L., and Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. AIDS Care, 14:789–800.

Quinn, T.C. (1996). Association of sexually transmitted diseases and infection with the human immunodeficiency virus: biological cofactors and markers of behavioural interventions. International Journal of STD and AIDS, 7 Supplement 2:17-24.

Rajamanoharan, S., Low, N., Jones, S.B. and Pozniak AL. (1999). Bacterial vaginosis, ethnicity, and the use of genital cleaning agents: a case control study. Sex Transmitted Diseases 26 (7): 404–409.

Raj, A., Amaro, H. and Reed, E. (2001). Culturally tailoring HIV/AIDS prevention programmes: Why, When and How. Handbook of Cultural Health Pyschology. Academic Press: Boston.

Ramjee, G., Gouws, E., Andrews, A., Myer, L. and Weber, A. (2001). The Acceptability of a vaginal Microbicide among South African Men. International Family Planning Perspectives. 27 (4): 164-170.

Ramjee, G., Morar, N. S., Braunstein, S., Friedland, B., Jones, H. and van de Wijgert, J. (2007). Acceptability of Carraguard, a candidate microbicide and methyl cellulose placebo vaginal gels among HIV-positive women and men in Durban, South Africa. AIDS Resistance Therapy 4: 20.

Ranasooriya, W.D. and Dharmasiri, M.G. (2000). The effect of terminalia catappa seeds on sexual behaviour and fertility male rats. Asian J Andro Sep; 2: 123-219.

Ravenstein, E.G. (1985). The Laws of migration: Journal of Royal Statistical Society.

Rawstorne, P., Diguisto, E., Worth, H. and Zablotska, I. (2007). Association between Crystal Methamphetamine use and potentially unsafe sexual activity among gay men in Australia. Arch Sex behaviour 36: 646 – 654.

Ray, S., Gumbo, N., and Mbizvo, M. (1996). Local voices: What some Harare men say about preparation for sex. Reproductive Health Matters, No 7: 63-73.

Renegar, V. R. and Sowards, S. K. (2003). Liberal irony, rhetoric, and feminist thought: A unifying third wave feminist philosophy. Philosophy and Rhetoric, 36, 330 -352.

Rhodes, T. and Cusick, L. (2000). Love and intimacy in relationship risk management: HIV positive people and their sexual partners. Sociology of Health and Illness, 22, (1), 1-26.

Rhodes, T. and Cusick, L. (2000). Sustainable sexual safety in relationships: HIV positive people and their sexual partners . Culture of Health and Sexuality 2, (4): 473 – 487.

Richter, M. (2003). Traditional Medicines and Traditional Healers in South Africa.Discussion paper prepared for the Treatment Action Campaign and AIDS Law Project.

Rogers, E. M. (2000). Journal of Health and communication: Interpersonal Perspective 5, 1-28.

Rogers, W.S. (1991). "Anthropology and sociological approaches." In Explaining health and illness: An exploration of diversity.

Rosens, R.C., and Ashton, A. (1993). Prosexual drug: empirical status of the new aphrodisiac. Archive of Sexual Behaviour 22: 521- 544.

Rosenthal, D., Gifford, S. and More, S. (1998). Safe sex or safe love: Comparing discourses. AIDS Care, 10, (1), 35-47.

Rubin, G. (1990). Thinking sex: notes for a radical theory of the politics of sexuality. In Pleasure and danger: Exploring female sexuality. London: Pandora Press.

Runganga, A.O., and Kasule J. (1995). The vaginal use of herbs/substances: an HIV transmission facilitatory factor. AIDS Care,7(5): 639-45.

Runganga, A., Pitts, M., and McMaster J. (1992) . The use of herbal and other agents to enhance sexual experience, Social Science Medicine, 35(8): 1037-1042.

Sandala, L., Lurie, P., Sunkutu, M.R., Chani, E,M., Hudes, E.S. and Hearst, N. (1995). Dry sex and HIV infection among women attending a sexually transmitted diseases clinic in Lusaka, Zambia. AIDS. Jul. 9(1): 61-68.

Sandala, L., Lurie, P., Sunkutu, M. R., Chani, E. M., Hudes, E. S., and Hearst, N. (1995) 'Dry sex' and HIV infection among women attending a sexually transmitted diseases clinic in Lusaka, Zambia. AIDS 9, (1) 79 : S61-S68.

Sands, R. and Nuccio, K. (1992). 'Postmodern Feminist Theory and Social Work', Social

Sarup, M. (1993). "Post-structuralism and Postmodernism", London UK :Harvester.

Schoepf, B.G. (1991). Ethical, methodological and political issues of AIDS research in Central Africa. Social Science and Medicine, 33, 749 – 763.

Schoepf, B. (1992) . AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire, Medical Anthropology: 14: 225-242.

Scholes, D., Daling, J., Stergachis, A., Weiss, N.S., Wang, S. and Grayston, T. (1993). Vagina Douching as a risk factor for acute pelvic inflammatory disease Obstetrics and Gynecology 1993;81:601-606.

Scholes, D., Stergachis, A., Ichikawa, LE., Heidrich, F.E., Holmes, K.K. and Stamm, W.E. (1998). Vaginal douching as a risk factor for cervical Chlamydia trachomatis infection. Obstet Gynecol; 91: 993-997.

Schoofs, M., AIDS: the agony of Africa. (1999). Part 5: Death and the second sex. How women's powerlessness spreads HIV. Village Voice. Dec 7,44 (48): 67-8,71,73.

Schrefer, S. (1994) Culture and nursing Care: a pocket guide. St Francis: UCSF Nursing Press.

Schuld J. (2004). Foucualt and Augustine: Reconsidering the power of love. Jouranl of the American Academy of Religion, 72 (4): 1070-1072.

Scorgie, F. (2003). Mobilising 'tradition' in the post-apartheid era: amasiko, AIDS and cultural rights in KwaZulu Natal, South Africa. Unpublished PhD Dissertation: University of Cambridge.

Scorgie, F., Kunene, B., Smit, J.A., Manzini, N., Chersich, M.F. and Preston-Whyte, E. M. (2009). In search of sexual pleasure and fidelity: vaginal practices in KwaZulu-Natal, South Africa. Culture Health and Sexuality 11: 3, 267 -283.

Scott, S., and Freeman, R. (1995). 'Prevention as a problem of modernity: the example of HIV and AIDS' in J. Gabe (ed.) 'Medicine, Health and Risk: Sociological Perspectives' Oxford: Blackwell.

Schuld, J.J. (2003). Dynamics frigidity and analysis of power and love Foucault and Augustine. Reconsidering power of love, Norte Dame Indiana, USA: University of Norte Press.

Scott, S.J., and Mercer, M.A. (1994). Understanding cultural obstacles to HIV/AIDS prevention in Africa. AIDS Education and Prevention , 6(1): 81-89.

Seale, C. (1999). Quality in qualitative research. Qualitative Inquiry, 5(4): 465-478.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. Management Decision, 39(7): 551-555

Seal. D.W., Ehrhardt A.A. (2003) Musculinity and urban men: Percieved scripts for courtship, romantic, and sexual interactions with women. Cultural health Sexuality, 5: 295-319.

Sherif, C. W. (1987). Bias in psychology. In S. Harding (Ed.), Feminism and methodology 37–56. Bloomington: Indiana University Press.

Siddley P. (2004). South Africa to regulate healers. Boimedical Journal, 329: 758-765.

Sidinga *et al* (eds) 1995. Traditional medicine in Africa. Kenya: Nairobi East Africa educational Publishers.

Simon, W. and Gagnon, J. H. (1987). A sexual scripts approach. In J. H. Greer and W. T. O'Donohue (Eds.), Theories of human sexuality (pp. 363–383). New York: Plenum.

Simon, W. and Gagnon, J. H. (1986). Sexual scripts: Permanence and change. Archive of Sexual Behaviour 15(2) 97-120.

Singer, E., Rogers, T. F. and Corcoran, M., (1987). The polls: Report; AIDS. Public opinion quarterly, 51, 580-595.

Smit, J., McFadyen, L., Zuma, K. and Preston-Whyte, E. (2002). Vaginal wetness: an underestimated problem experienced by progesterone injectable contraceptive users in South Africa, Social Science and Medicine, 55:1151-1522.

Sonda, L. P., Mazo, R., Chancellor, M.B. (1990). The role of yohimbi for treatment of erectile impotence. Journal of sex and marital therapy 16(1) 15 -21.

Sparrow, M.J. and Lavill, K. (1994). Breakages and slippage g condoms in family planning clients. Contraception; 50: 117- 129).

Spradely, J. P. (1979). Ethnographic interview. New York: Holt, Rinihart and Winston.

Stacey, J, and Thorne, B. (1985). "The Missing Feminist Revolution in Sociology." Social Problems 32: 301–16.

Stanley, L., and Wise, S. (1990). 'Method, Methodology and Epistemology in Feminist Research Processes' in Stanley, L. (editor) Feminist Praxis: Research Theory and Epistemology. London: Routledge Kegan Paul.

Statistics South Africa Editors Inc., South Africa. (2001-2002). South Africa at Glance

Statistics South Africa. (2003). The people of South Africa Population Census: Primary tables; KwaZulu-Natal. Pretoria, South Africa: (www.statssa.gov.za).

Steiner, M., Piedrahita, C., Joanis, C., Lucinda, G. and Spruyt, A. (1994). Condom breakage and slippage rate among participants in eight countries. International Family Planning Persperspective, 20 (2): 55-58.

Stephen, P. and Phillips, L. (2005). Integrating Black feminist thought into conceptual frameworks of African American adolescent women's sexual scripting processes. Sexualities Evolution and gender: 7(1): 37–55.

Stine, G.J. (2008). AIDS update. University of Florida; New York: McGrew Hill Companies.

Straker, G. (1994). Integrating African and Western healing practices in South Africa. American Journal of Psychothererapy. 48(3): 455-67.

Strauss, A. and Corbin, J. (2008). Basics of qualitative research: Techniques service organizational researche methods United Kingdom. Sage.

Strauss,A. and Corbin J. (1998). (2nd edition). Basics of qualitative research techniques and procedure. Thousand Oaks London: Sage publication.

Susser, I. and Stein, Z. (2000). Culture, sexuality and women's agency in the prevention of HIV/AIDS in Southern Africa. American Journal of Public Health, 90 (7): 1042-1048.

Squire, C. (2009). The social context of birth TJI Digital Padstow, London: Cornwall,.

Synder, C.R. (1997). Unique invlnarability: a classroom demonstration in estimating personal mortality. Tackling of psychology, 24, 197-199

Swaans, K., Broerse, J., van Diepen, I., Solomon, M., Gibson, D. and Bunders, J. (2008). Understanding diversity in the impact and response among HIV /AIDS –affected household: The case of uMsinga, South Africa.

Thakur, M. and Dixit, V.K. (2007). Aphrodisaic activity of dactylorhiz hatagirea (D Don) Soo in male albino rats: Evidence Based Complimentary and Alternative Medicine, 4 (Supplement 1): 29 -31.

Thorne, S. (2000). Data analysis in qualitative research: Evidence-based nursing, 3: 68-70.

Thornton, R. (2002). Flows of 'sexual substance' and representation of the body in South Africa. Seminar Paper presented at Wits Institute for Social and Economic Research (WISER), University of the Witwatersrand, Johannesburg, March 2002.

Thorpe, M. (1982). Psycho-diagnostic in the Xhosa-Zionist church. MA Theses, Rhodes University , Grahamstown (unpublished).

Turshen, M. (1991). Women and Africa. Trenton New Jersey: Africa World Press

Ulin, P.R., Robinson, E.T., Tolley, E.E. and Mcneill, E.T. (2002) Qualitative method: A Field Guide for Applied Research in Sexual and Reproductive Health. Durham, NC: Family Health International.

UNAIDS.2008 Report on the Global HIV/AIDS Epidemic. Geneva, Switzerland: UNAIDS, http://data.unaids.org/pub/EPISlides/2008/2008_epiupdate_en.pdf

United Nations. (2003). United Nations World Heath Organization Fact sheet no. 134, revised May, 2003 - Traditional Medicine.

Urbina, A. and Jones, K. (2004). Crystal methamphetamine, its analogues and HIV infection: Medical and psychiatric aspects of a new epidemic. Clinical Infectious Diseases 38, 890 – 894.

Utomo, I. (2003). Vaginal drying and cleansing in the South East Asia: Notes for future Research – A presentation to the Asia Pacific Conference on Sexual and Reproductive Health.

Van de Wijgert, J.H.H.M. (1997). Unpublished. The effect of douching, wiping, and inserting herbs inside the vagina on the vaginal and cervical mucosa, on the vaginal flora, and on the transmission of Human Immunodeficiency Virus and other sexually transmitted diseases in women in Zimbabwe (dissertation). Berkeley: University of California at Berkeley.

Van de Wijgert, J.H.H.M., Khumalo-Sakutukwa, G.N. and Coggins, C. *et al.* (1999). Men's attitudes toward vaginal microbicides and microbicide trials in Zimbabwe. International Family Planning Perspectives. 25(1): 15-20.

Van de Wijgert, J.H.H.M., Mason, P.R., Gwanzura, L., Mbizvo, M.T., Chirenje, Z.M., Iliff, V., Shiboski, S. and Padian, N.S. (2000). Intravaginal practices, vaginal Flora disturbances, and acquisition of sexually transmitted diseases in Zimbabwean Women. The Journal of Infectious Diseases, 181: 587 – 94.

Varga, C. (1997). Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu-Natal South Africa. Health Transit Review: 7 (3): 45–67.

Varcoe C (1997). Untying our hands. The social context of nursing relation to violence against women. Unpublished Doctoral Dissertation Vancouver University of British Columbia

Velibeyoglu, K. (1999). Post-structuralismand Foucault. Retrieved September 7, 2005, from. http://www.angelfire.com/ar/corei/foucault.html.

Velebeyoglu, K. (1999). Poststructuralism and Foucault, available at: Post-structuralism and Foucault.htm Ph.D. candidate at Izmir Institute of Technology, February.

Vercoe, C. (1997). Untying our hands: The social Context of nursing in relation to violence against women. Unpublished Doctoral Dissertation submitted to Vancouver BC University of British Columbia.

Vilakazi, H. (2006). 'Conception and Terms of Reference of "The Presidential Project on African Traditional Medicine". Unpublished but widely circulated paper.

Vilakazi, H. (2006). The coming revolution in modern medical science: dreaded diseases and African traditional medicine –a proposal presented to the President of RSA.

Vilakazi, H. (2005). African traditional medicine. Presentation at Medunsa: 2 February.

Von Glasersfeld, E. (1998). Why constructivism must be radical. In Larochelle M, Bednarz N, Garrison J. Constructivism and education 22-28. Cambridge: Cambrigde University.

Waddell, T.G., Jones, H., and Lane, K.A. (1980). Legendary chemical aphrodisiacs. Journal of Chemical Education 57(5): 341-342.

Wainer, H., and Braun, H. I. (1988). Test validity. Hilldale, NJ: Lawrence Earlbaum Associates. Nahid Golafshani 606.

Walby, S. (1994). Towards a theory of patriarchy. In the Polity Reader in Gender Studies. OxfordBlackwell publishers, 1994: 22-28.

Warren, K.J. (1997). "On Taking Empirical Data Seriously." In Ecofeminism: Women, Culture, Nature, Bloomington: Indiana University Press.

Weiss, E., Whelan, D. and Gupta, G. (2000). Gender, sexuality and HIV: making a difference in the lives of young women in developing countries. Sexual and Relationship Therapy.;15: 233–245.

Welz, T., Hosegood, V., Jaffar, S., Batzing-Feigenbaum, J., Herbst, K., and Newell, M. (2007). Continued very high prevalence of HIV infection in rural KwaZulu-Natal, South Africa: a population-based longitudinal study. Epidemiology and Social: AIDS, 21(11): 1467-1472.

Wendt, S., and Boylan, J. (2008). Feminist social work research engaging with post structural ideas International. Social Work, 51(5): 599–609.

Willaim, S.A. (1990). Some implications of women theory. New York: Meridian Press.

Willis, J. W. (2007). Foundations of qualitative research interpretive and critical approaches. Thousand Oaks, CA: Sage.

Wilton, T. (1997). Engendering AIDS: Deconstructing sex. Text and epidemic. London: Sage Publication

Wingwood, G.M., and DiClement R.J. (1998). Partner influences and gender related factors associated with noncondom use among young adult African American women. American journal of community Psychology, 26: 29-53.

Winter, G. (2000). A comparative discussion of the notion of validity in qualitative and quantitative research. The Qualitative Report, 4(3&4). Retrieved August 2008, from http://www.nova.edu/ssss/QR/QR4-3/winter.html.

Witchcraft Suppression Act (No. 3 of 1957, as amended by Act No. 50 of 1970).

Wood, K. and Jewkes, R. (2001). "Dangerous' love: reflections on violence in sexual relationship of young people in Umtata". Pietermaritzburg: University of Natal Press.

Wood, K. (2003). Questioning sex in a South African township. Paper presented at the Association of Social Anthropologists Decennial Conference on 'Anthropology and Science', Manchester.

Woodsong, C. (2004). Covert Use of Topical Microbicides: Implications for Acceptability and Use. Perspectives on Sexual and Reproductive Health. 36(3) : 127-131.

Woodward, K. (1997). "Introduction." in Identity and Difference, ed. Kathryn Woodward, pp. 1-8. London: SAGE Publisher.

World Health Organization (WHO). 2002. Women and HIV/AIDS, fact sheet number 242. Geneva: WHO

World Health Organization (WHO). (2003). Traditional medicine: Report by secretariat Fifty six World health Assembly. http://www.who.int/mediacentr/factsheet/fs134/en/ Accessed June 2006.

Wyatt, G. E., Myers, H.F., Williams, J., Kitchen, C.R., Loeb, T., and Carmona, J.V. (2002). Does history of trauma contribute to HIV risk for women of colour? Implication for prevention and policy. American journal of Public Health, 92: 660-665.

Xaba, T. (2002). The transformation of indigenous medical practice in South Africa. Bodies and Policies: Healing ritual and democratic South Africa. Les Cahiers l'IFAS no 2 Johannesburg: IFAS.

Yakubu, M.T., Akanji, M.A. and Oladji, A.T. (2005) Aphrodisiac potential of aqueous extract of Fogdogia agrestis (Schweinf.Ex Hiern)s male albino rats. Asian Jandrol 7 (4): 399-404.

Young, J. (1994). Anthropological research on patterns of sexual behavior in Sub-Saharan Africa: implications for HIV/AIDS interventions. Journal of the Steward Anthropological Society, 22(1):1-12.

Zamblé A., Martin-nizard, F., Sahpaz, S., Hennebelle, T., Bordet, S., Duriez, P., Brunet, C., Bailleul F. (2008).Vasoactivity, antioxidant and aphrodisiac properties of Caesalpinia benthamiana roots. Journal of Ethnopharmacology 116, 1: 28-29,

Zanolori B. (2003). Natural aphrodisiac. Studies of commercially-available herbal recipes, and phytochemical investigation of Erythroxylum vacciniifoluim Mart. (Eryhroxylaceae) from Brazil. Doctorate theses, University of Lausanne.