UNIVERSITY OF KWAZULU-NATAL

SEXUAL PRACTICES OF MARRIED WOMEN IN RURAL KWAZULU-NATAL: IMPLICATIONS FOR WOMEN'S VULNERABILITY TO HIV/AIDS EPIDEMIC

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A thesis submitted in the fulfillment of the requirements of the Masters degree

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DECLARATION

I, Thembeka Mary-Pia Mngomezulu declare that this is my own work, entitled "Sexual practices of married women in rural KwaZulu-Natal: Implications for the women's vulnerability to HIV/AIDS epidemic". This work has not been submitted for any degree examination purposes before. All resources referred to in this text have been acknowledged by means of references.

Thembeka Mary-Pia Mngomezulu

Signature:---------- **Date:** 04 March 2009

Supervisors

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(Dr. B.P. Ncama)

---------- **Date:** 04 March 2009

(Mrs. S.J. Majeke)

DEDICATION

TO ALL PREVIOUSLY DISADVANTAGED MARRIED WOMEN OF SOUTH AFRICA WHO DESPITE ALL ODDS, CONTINUE TO BE GOOD WIVES AND MOTHERS

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ABSTRACT

Purpose: To explore sexual practices of married women, which make them vulnerable to HIV infection in a rural setting, and the implications such practices have for the HIV/AIDS epidemic.

Methodology: An ethnographic approach was used to explore the phenomenon of, which was sexual practices of married women, both ancient and contemporary. Unstructured interviews and focus group discussions were undertaken. The researcher applied the principle of theoretical saturation and a total of fifty participants were included in the study. All the interviews were taped and transcribed. Data analysis was done manually by the researcher, using themes and sub-themes.

Findings: Married women engage in short term sexual relationships with secret lovers which are either concurrent or frequent while their husbands are away on migrant labour. A number of factors that cause women to engage in such risky sexual practices were identified. Some of these factors included scarcity of men due to migration and economical resources, the fact that women cannot negotiate safe sex due to gender and cultural factors; limited knowledge of infections particularly HIV/AIDS, life skills including their sexual rights and how to exercises these rights, and economic skills. Recommendations included the designing of an intervention program to sensitise and empower women on factors that make them vulnerable to HIV infection.

Conclusions: Married women in the rural KwaZulu-Natal indulge in multiple concurrent or successive extramarital partnerships in the absence of their migrant men. These sexual practices place them in a vulnerable position to get HIV infection as they engage in risky sexual behavior without condom use. They also have fear of being rejected by their secret lovers and their own husbands because of women's economic dependency on men.

ACRONYMS

HIV	Human Immune Deficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
ACDIS	Africa Centre Demographic Information System
DSA	Demographic Surveillance Area
TB	Tuberculosis
STI	Sexually Transmitted Infections
VA	Verbal Autopsy
UNAIDS	The Joint United Nations Programme on HIV/AIDS Services
SAFAIDS	Southern Africa AIDS Information and Dissemination Services
KIT	Royal Tropical Institute
WHO	World Health Organisation

GLOSSARY OF TERMS

Induna:	The headman.
Inceku/izinceku:	This is the right hand man/men to *Inkosi.*
Inkosi:	This is the highest figure of authority in the tribal authority in the rural communities.
Isidikiselo:	The name given to a married woman's accepted secret sexual partner while the husband is working in the cities.
Isiziba:	The deep end of the river. This is usually where under water animals live.
Ishende:	The name given to a married woman's unacceptable secret partner occurring whether the husband is away or not.
Isoka:	This is generally a name given to a man who has many women lovers. In the Zulu custom it is a symbol of manhood and is acceptable.
Isifebe:	A women who has more than one sexual partner.
Ubufebe:	This is an act of engaging in more than one sexual partner. The term is normally used in the case of a woman. But to a man having many women including married women, the term 'isoka lamanyala' is used.
Umsebenzi:	Refers to any ritual which involves slaughtering of any animal ranging from a cattle down to a chicken and it involves appeasing of ancestor spirits.
Shembe:	The Nazareth Church named after its founder Mr. Isaiah Shembe.
Ebuhleni; Ekuphakameni; Enhlangakazi; EJudiya:	'Sacred' places where the members of the Shembe religion meet for conventions.

Ivezandlebe:	A child born by a married woman from i*shende.*
I bhodwe:	The husband.
Ilobolo:	The brides' wealth paid in the form of cows or money by a groom to the bride's parents as a prerequisite to marry the woman
Inyumba:	Sterile woman
Masikhanda:	A man or woman singing and playing traditional songs on a guitar.
Umakhwapheni/uqedisizungu:	Modern name for a secret lover of a married woman.
Ubhodl'endlini:	Same as *ishende* but this is only used to alert the *ishende* that the husband has arrived.
Amadaka/amalongwe:	Also refers to *ishende* because it is believed that such relationships originated when the woman went to collect wood to make fire.
Ukukipita:	Culturally unacceptable cohabiting that occurs Without marriage or the brides' wealth being paid.
Isithembu:	Polygamous marriage.
Ukungenwa:	Widow inheritance.
Umabuyemendweni:	Offensive name give to a woman who has left her marriage or divorced, meaning that she is a failure.

Phrases

Ubuhle bendoda 'zinkomo:	The beauty the man is only recognized through his ability to pay *lobola* for a woman.
Ithuna lentombazana lisemzini:	In the Zulu culture there is no divorce. A married woman can never comes back home.

	she remains in her marriage until she dies.
Ungabheki emuva:	This is an instruction to a woman on her wedding day telling her to never to return home once married.

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CHAPTER 1: INTRODUCTION

1.1 Background of the study

The latest global statistics report that more than 40, 3 million people are now living with the human immunodeficiency virus (HIV). Close to 5 million people were newly infected in 2005 (UNAIDS/WHO, 2005: 2). According to UNAIDS (2005: 5) approximately 2.3 million people died of HIV in 2003 and almost half of the people living with HIV/AIDS are women in the reproductive age group. The rates are high along major highways, borders, in trading centres and in the urban areas. This excessive loss of human life poses a number of questions about sub-Saharan Africa. Though the epidemic has developed later in this region than elsewhere in the world, Sub-Saharan Africa has the highest infection rate. Approximately 25. 8 million people in this region are living with HIV. This means that two thirds of all people living with HIV are in Sub-Saharan Africa and 77% percent of these are women. To date 2.4 million people have died of HIV related illnesses in Sub-Saharan Africa with 3. 2 million more becoming infected with HIV every year (UNAIDS/WHO, 2005:2).

HIV/AIDS is having a grave impact on the social and economic development of most of the countries affected by the epidemic. Eighty percent (80%) of the world's AIDS deaths are occurring in Sub-Saharan Africa. This region has suffered the worst impact of the global AIDS epidemic (Caldwell, Caldwell and Pieteris, 1998: 140).

Among the countries in Sub-Saharan Africa, HIV statistics continue to climb most rapidly in South Africa, as this country has more people living with HIV/AIDS than any other country world wide. AEGIS (2005:2) shows that of 47 million South Africans, 5.3 million were believed to be infected with HIV in 2003 and by 2005 this figure had increased to 6.3 million.

The incidence of AIDS is higher in poorer provinces like KwaZulu-Natal, as the HIV epidemic in KZN preceded that of other provinces in South Africa by 2 to 3 years. Of the 4.7 million South Africans estimated to be HIV positive in 2000, 36% were from KwaZulu-Natal. This province has the highest prevalence rate in the country, compared to the national rate of 20.5% (S. A. Department of Health, 2005: 5). Projections show that the impact on the demographic structure in South African population is going to be hard hitting. As the population is going to be reduced its structure is going to change drastically. According to this report the population may not reach 50 million by the year 2020 (AEGIS, 2005: 5).

In 2000 a study done in one of the Mkhanyakude Sub-Districts in a rural area in Northern KwaZulu-Natal showed that 66% of all deaths in the age group 15-44 were attributed to AIDS. Of these, 72% were females and 61% were males (Camlin, Gareme, Moultrie, 2002: 7). Verbal autopsy results from data collected in the Demographic Surveillance Area of Africa Centre for Health and Population Studies in 2000 show that AIDS, with or without TB, is the largest single cause of adult death (48%). Mortality due to AIDS is higher for women than men,

accounting for 52% of all females and only 44% of all male deaths. In comparison to men, AIDS mortality was higher among women up to 30 years of age, but higher in men than in women above this age. The risk of dying from AIDS peaks for women at ages 25-39 yrs and for men at 30 to 44 years. HIV positive individuals are 3 and 7 times more likely to die of TB and malaria than HIV negative individuals. It is postulated that adult mortality in rural KwaZulu-Natal will rise more rapidly in the coming years unless effective treatment interventions are introduced (Hosegood, Timaeus, and Vanneste, 2002: 664). For instance in 2005 in Hlabisa sub-district, according to Livesley (2005:2), 35,000 of the 220,000 residents were HIV infected and 5,000 needed treatment immediately.

The above statistics show that two decades after its discovery in 1981, HIV/AIDS is still ravaging the world. What is clear is that attempts to stop HIV/AIDS have achieved very little. Health 24 News Report 2000-2005(2005: 1), a health website, indicates that in South Africa there are certain socio-cultural factors that have been identified as responsible for the rapid spread of the disease. These are:

- gender inequality and male dominance
- political transition and the legacy of apartheid
- stigma and discrimination
- poverty
- the sex work industry, lack of knowledge
- misconceptions about HIV/AIDS

- and cultural beliefs and practices (Health 24 News Report 2000- 2005 (2005: 2).

To these, Aggleton and Mane (2001: 23) add gender relations, oppression, racism, social exclusion and migration as core factors in the spread of HIV/AIDS. In their study on gender and AIDS done in Sub-Saharan Africa, Aggleton and Mane (2001: 23), demonstrated that AIDS is a gendered epidemic. They stated that gender is one of the most crucial factors contributing to the vulnerability of women to HIV infection and the impact of HIV/AIDS. Among the ideas they raised is "women's inability to negotiate sex, let alone safer sex" (Aggleton and Mane, 2001: 26).

Migration

Several studies have been carried out to add to the existing body of knowledge. For instance, another factor that has exacerbated the spread, of and caused increased vulnerability of some ethnic groups to HIV, is the state of capitalist penetration, which led to a breakdown of the material base in the rural life causing young men to migrate to towns to seek work (Gafos, 2004: 15). Elements of the apartheid regime such as migrant labour, the homelands system, the Group Areas Act and forced removals, contributed to the widespread poverty, gender inequality, social instability and unsafe sexual practices that now influence the spread of HIV/AIDS (24Health News Report HIV/AIDS 2000-2005, 2005:2).

According to Health 24 News Report 2000-2005 (2005: 2) the rapid increase of the spread of HIV/AIDS in South Africa can largely be attributed to the high levels of inter and intra national population movement invoked by the expansive migration labour system developed during apartheid as mentioned above. The historical transformation of social relationships as a result of the migrant labour system, and the resultant impact on Sexually Transmitted Infections (STIs) and HIV have been well documented. In a qualitative study of gold miners in Gauteng, Campbell (1997: 280) concluded that the construction of masculine identities in that setting, rendered miners particularly vulnerable to HIV because of their involvement in unprotected sexual activities.

The role of circular migration in the diffusion of HIV between regions, and urban and rural settings, has also been well established by Gafos (2004: 14). She postulated that by the time HIV reached South Africa in the 1980s, the migrant labour system had already constructed a social environment that was conducive to its transmission, and a national and international network facilitated its dissemination across the country (Hosegood and Solarsh, 2001: 20). From the above findings it is therefore easy to deduce that the labour supply areas of South Africa such as KwaZulu-Natal, experience the highest burden of disease. It is important at this point to proceed with a discussion of migration as it provides the vehicle for the virus making migrants and their households more vulnerable to HIV.

Lurie, Harrison, Wilkinson, and Karim (1997:19) in their study on migration and its implications for HIV and other Sexually Transmitted Infections in the Hlabisa Sub-district in KwaZulu-Natal, hypothesized that men who were mobile were at risk of contracting HIV infection, as they were more likely to have additional sexual partners (than non-migrants). This is in agreement with Health 24 News Report 2000-2005 (2005:2) which stated that some of these men worked as mine workers and like other migrant men who lived in single-sexed hostels were involved in unsafe male-to-male sex and in the engagement of sex workers, practices that are rife in such settings. When they contracted the disease they carried it back home and infected their wives.

In another study which Lurie et al, (2000: 443-7) conducted in Hlabisa, it was discovered that married women were infected with HIV while their migrant husbands were found to be HIV negative. This raised the question of how the married women became infected. Lurie et al, (2000: 443) did not probe the dynamics
of such rural patterns in order to discover, how else women might be infected except by their regular partners?

This study seeks to find out about married women's sexual practices and the implications these sexual practices have on the HIV/AIDS epidemic. Aggleton and Mane (2001: 27) have pointed out that factors like gender relations, oppression, racism and social exclusion are core factors in the spread of HIV/AIDS.

Mobility is also more complex than the simplistic picture portrayed in the literature and media. More women are now also involved in labour migration. Hunter (2001b: 1 & 2) investigated many women who were labour migrants themselves in his study done at Mandeni, KwaZulu-Natal. He confirmed that women who are unmarried also engage in different kinds of relationships, which are regular or casual in kind. His study however, did not focus on married women.

Both Lurie (2000: 25) and Hunter (2001b:1 & 2) in their studies raised questions about the sexual practices of married women whose husbands were migrant labourers. This study will attempt to find answers to such questions.

Cultural practices and marriage

South Africa is a multicultural and multiracial country, having different and heterogeneous social groups. In the province of KwaZulu Natal, the majority of people is of Zulu ethnicity. The family as a social unit is very important in the Zulu culture. It is through the family that the socialization of Zulu cultural norms and values is done. These norms and values are internalized and perpetuated from generation to generation. In order that the family can exert this influence, there should be marriage between a man and a woman. Marriage continues to be considered as playing a major role in the construction of man and woman linkages (Griffiths, 1997:14). Socialization of both men and women from a young age is towards marriage. Marriage is the climax of any girl's sexual life.

Culturally a man needs to pay his future in-laws *lobolo* (bride prize) for marriage to occur. *Lobolo* is costly because payment of at least 11 cows is needed. Men

are therefore expected to leave home to seek employment far from home in order to be able to pay the *lobolo.* The *lobolo* cultural practice has never changed despite increasing levels of unemployment, wages that do not increase for those who are employed and the increasing costs of cattle.

On the basis of the cultural norms, marriage is hoped to play a protective role for both the man and the woman in a partnership. They are protected against STIs and HIV infection, as they are expected to be faithful to one sexual partner. Though this may be what is hoped for, it is gender biased in that it is culturally acceptable that a man can have other partners. A man with many girlfriends is called *"isoka lamanyala"* denoting a dirty practice (Hunter, 2003a: 13). On the other hand the woman is not expected to have other relationships besides her husband. However this was not always the case as while the men were away from home women used to have *"isidikiselo"* or *"ishende"* meaning a private lover for a married woman (Hunter, 2003a:15). This study has explored whether these practices still exist and the findings are discussed in the last chapter.

Marriages in rural KwaZulu-Natal may be either monogamous or polygamous and either civil or customary under South Africa Law. All of these forms are recognized as legal by both the South African Law and Customary Law. In this study, marriage includes what has been explained above and also include women living together with their partners, where there had been negotiations between the two families and part of or full *ilobolo* has been paid and consensus

reached that they can stay together as a married couple. This phenomenon and its concept will be discussed in more detail in the next chapter.

There is a decline in marriages in the Demographic Surveillance Area of Africa Centre. This change is shown in a study done by Hosegood and Preston-Whyte, (2002:5), which indicated the continuing decline of marriage by establishing that by age group 45-49, 37% of women and 42% of men had never married. The proportion of unmarried women and men who were in a regular partnership was 38.9% for women and 40.1% for men (Hosegood and Preston-Whyte, 2002: 20). This means that there was an increase in the number of non-marital relationships where partners were co-habiting without legal union. This study seeks to explore such factors by focusing on what types of sexual relationships and practices women are becoming involved in, as these relationships may contribute to the escalation of the HIV/AIDS epidemic. Building on the extensive qualitative data on migration that the Africa Centre collects, the proposed study will interrogate and draw links between two main areas of investigation: a) the dynamics of marriage including the plight of married women in their relationships, b) patterns of their relationships including their sexual practices and their vulnerability to HIV/AIDS.

Gender Relations

South Africa is characterized by a patriarchal system which favours male dominance and female subordination. This system is rife in the Zulu ethnic group in KwaZulu-Natal. Socio-cultural norms that create power imbalances in favour of

men are accepted in most cases by men and women alike and have grave implications for women's health and development (Health 24 News Report, 2000-2005: 5). Poverty and gender power imbalances undermine the success of carefully planned behaviour change programme designed to address the problem of HIV/AIDS (Parker, 2001: 168). Previous studies, such as those conducted by Marks (2002), Hunter (2003b) and Campbell (1997), to mention but a few, have paid little attention to the consequences of the disease on the family and the far-reaching effects that poverty and gender have in perpetuating gender inequalities. Research focusing on gender roles and their impact at household level is not common.

Looking at the degree to which women are able to live under stereotypical gender roles and unequal power relationships between them and men, could mean that "women are less likely to control how, when and where sex takes place" (UNAIDS, 1999:106). It is believed that women are bound by culture and tradition, which in this case perpetuates gender inequality between them and men, placing both at risk of contracting HIV (Hunter, 2002: 14). This study therefore attempts to place the spread of HIV/AIDS in its historical and social context with different sexual relationships, gender and AIDS as points of departure. It seeks to explore which risky sexual practices may expose married women to HIV/AIDS. Women have no say in sexual matters such as negotiation for the use of a condom during sexual intercourse. They are therefore vulnerable to STIs and HIV/AIDS because of their biological make up and socio-cultural

factors. Another contributing factor is that women are economically disadvantaged as society expects them to be housewives. They also have limited access to resources within the family such as land and livestock, which reduces women's self reliance and makes them dependant and more vulnerable to HIV infection.

1.2 Motivation of the study

I am a nurse working at the Africa Centre on Health and Population Studies in the Hlabisa District of KwaZulu-Natal Province. For 3 years I have worked as a Verbal Autopsy Research Nurse. My job involved visiting households where there had been a death as identified by the Africa Centre Demographic Information System. Through in-depth interviews, informants provided information in a chronological order about the circumstances around the time of death in order to lead to a diagnosis of the diseased.

Preliminary data extracted from ACDIS Verbal Autopsy report attributed 40% of deaths in women aged 15 to 59 years and 33% of those in men of the same age to HIV alone and 22% of those in men to HIV and TB. (Hosegood, Tmaeus and Vanneste, 2002: 16). Studies where there are ACDIS sites, however, show that deaths attributed to HIV through Verbal Autopsies are underestimated.

Based on my experience at the research centre, it would seem that although women empowerment programmes exist, they are not targeted at peri-urban and rural women because of the political attitudes that prevail and the kind of physical

setting in which the women live. In these areas any organization introducing a programme has to be affiliated with the ruling organization, which complicates entry into the rural and peri-urban communities. Women in informal settlements are also neglected, as they are usually not organized because of various social factors. As a result, women in both rural and informal settlements thus remain deprived of development initiatives. Seeing this amongst women, I felt that they needed to develop life skills that would empower them to counteract their vulnerability to HIV/AIDS epidemic. This could be done through situational analysis and cultural and gender awareness which would alert women to the impact these factors have on sexual reproductive health which renders them vulnerable to HIV infection.

1.3 Statement of the problem

It is more than two decades since the first AIDS cases were reported in South Africa, but the AIDS epidemic continues to escalate despite many AIDS awareness interventions. There is a belief that marriage reduces one's susceptibility to HIV infection but evidence has shown that migrant men and some women engage in extramarital relationships and become infected with STIs and HIV. Lurie et al. (2003: 816) found that non- migrant women were HIV positive while their male migrant partners were HIV negative. Studies in this area are limited and there is a need to know more about women's sexual practices while their partners are away and consequently their vulnerability to HIV infection. This explores the sexual practices of married women during their husbands'

absence and what strategies could be adopted to reduce their vulnerability to HIV/AIDS.

1.4 Purpose of the study

The study seeks to explore sexual practices of married women whose husbands work in other cities as migrant workers, how such sexual practices influence women's vulnerability to HIV infection and to design a programme that would empower women with life skills on sexual practices to make them less vulnerable to HIV infection.

1.5 Objectives of the study

The objectives of the study were to:

1) explore the sexual practices that married women with migrant husbands engage in,
2) explore factors that perpetuate the kinds of sexual practices married women with migrant husbands engage in,
3) explore women's vulnerability to HIV infection, and
4) design a prevention programme that would inform and sensitize married women about sexual practices that influence their vulnerability to HIV infection.

1.6 Significance of the study

As discussed in the earlier sections of this chapter, a number of socio-cultural

factors influence the spread of HIV/AIDS. These factors such as sexual negotiation, affect sexual bahaviour and decision-making. Interventions therefore need to focus on socio-cultural determinants of high risk sexual practices and pay attention to why risky behaviour is frequently engaged in despite people's awareness of its negative health consequence (Varga 1997: 28).

There is limited knowledge about the attitudes of rural women as they have not been investigated and reported on in South Africa. This study focuses on factors that influence the sexual behaviour of married women and it is hoped that the findings of the study will enlarge the body of scientific knowledge and shed new light on the unexplored field of the social aspects of human behaviour linked with HIV/AIDS.

1.7 The study area

The study area covers 1,430km² of the Hlabisa District in the Northern part of KwaZulu-Natal Province in South Africa. This area is known as Mpukunyoni in the Mkhanyakude sub-district (Refer to Map in appendix B). It is situated about 250 km north of Durban. The area is characterized by rural decentralized homesteads under the traditional authority and a peri-urban township with formal and informal settlements under the municipal authority.

The population-based study was done in the Africa Centre Demographic Surveillance Area in the Hlabisa Sub-district, KwaZulu-Natal, South Africa. ACDIS covers an area of 345 square km, which is a portion in the sub-district.

The population of more than 90,000 persons resident within ACDIS is largely rural although approximately 10,000 live in the urban township area of KwaMsane. The population is badly affected by unemployment, making them very poor. The area is popularly known as Mpukunyoni Area, which stretches from the Umfolozi River in the South; N2 National Road from Durban to Phongola in the East; the Umfolozi Game Reserve in the West and the Nyalazi River in the North. The whole sub-district has a population of 213,000 in an area of 1,430km².

Statistics used as the background of this study were obtained from the data sets contained in the ACDIS namely: Demographic information obtained through the Verbal Autopsy study, Household Socio-Economic Survey (HSE), Sero-prevalence survey and other studies carried out on the site.

The migration study conducted in the ACDIS shows that in comparison to men, women more often engage in transactional and casual sex (Hunter 2001b: 6). These factors may influence the spread of AIDS epidemic. The sexual activities of rural women have been given little attention in literature. Women have been presumed to have no sexual desires. Their sexual desires are constrained and determined by social factors external to them, which are usually cultural issues. It is imperative, at this point, to bring to attention the objectives and the research question of the study. The main aim is to explore the sexual practices that married women engage in that make them vulnerable to being infected with HIV/ AIDS. The study will therefore attempt to place the spread of HIV/AIDS in its historical and social context in terms of different sexual relationships, gender and

AIDS as points of departure. Further to this, the study seeks to explore which risky sexual practices may expose married women to HIV/AIDS.

1.8 Definition of terms

For the purpose of this study ten crucial terms were identified and their meanings are explained here.

Culture

Culture, as discussed by Goosen and Klugman (1996: 32), refers to a way of life and implies that at any given point in time, people's lives are governed by norms, beliefs and values. Culture differs from society to society and is fluid and changes over time. The process of socialization, which occurs through the family, church and school, maintains culture. It is internalized by individuals and so runs from generation to generation. Non-compliance with norms and values of a particular culture is sanctioned by the community structures. Gender is embedded in culture so that cultural stereotypes prevail.

Femininity

This implies submissiveness or adaptation to male power. For women it includes such characteristics as being emotional, kind, caring and accepting male sexual behaviour. It also includes non-assertiveness in reaction to sexual advances by a man. According to Trigiani, in certain cultures, a woman cannot negotiate alternate sexual practices like safer sex (Trigiani, 1998: 8).

Gender

This term refers to socially constructed role expectations of men and women from childhood through the process of socialization (Lont, 1995: 80). Gender differs from sex in that it is social and culturally constructed rather than being biological or natural or differentiated by the sexual organs of a particular individual (De Bruyn, 1998: 2). Gender attributes and characteristics vary from society to society. Through gender role socialization both sexes learn which behaviours and attributes are socially sanctioned. In most societies, being a man or a woman means not only having different biological characteristics, but also involves different expectations about the appearance, qualities, behaviour and work opportunities of a male or female (Lont, 1995: 80).

Marriage

This term can be defined as a legal or customary union or contract made between a man and a woman who engage in the relationship of being husband and wife. It could have variations like legally recognized conjugal relationship between man and woman accepted as marriage with mutual responsibility of both parties to care for each other and rear children born to them (Preston-Whyte, 1993: 63).

In this study, marriage will include what has been explained above and also women living with their partners where negotiations between the two families or *ilobolo* has been paid or there is consensus that they live together as a married couple. In this study the term marriage will also refer to men and

women who are living together as recognized by religious and customary law.

Masculinity

Masculinity varies from culture to culture and from time to time. Masculinity implies physical and emotional strength and the acceptance of multiple partners (Trigiani, 1998: 6).

Sexual practices,

In this study, sexual practices imply different kinds of sexual relationships in which people are involved such as :

- *Regular sexual practice* is a long-term sexual relationship. In this study this Includes cases where marriage has been delayed due to parents' expectations of payment of bride-wealth by the man.
- *Transactional sexual practices,* as Doyal (1995: 79) explains, imply that women may have long-term 'sugar daddies', who may give them money in return for sexual favours. Some girls use this money to funding their education. Such exchange of gifts or money usually occurs in a gender context where men have access to and control of resources and are in a position to give women these in exchange for sex. It is usually a practice involving older men and younger women (Ntozi, 1997: 148).

- *Casual sexual practices,* according to Hunter (2001b: 6), range from once off or by chance to shallow or superficial sexual encounters with no intention of marriage in the future. These could be intermittent or occur for a short period of time for example less than a year. Men and women involved in this kind of relationship may simultaneously have regular partners known or not known to their families.

Vulnerability

This refers to the state of being prone or susceptible to an adverse situation (Flaskerud and Winslow, 1998: 69). In this study, it refers to women's susceptibility to HIV infection.

1.9 Outline of the chapters

In Chapter 1 the research questions of concern have been introduced, as provided in the study objectives. The chapter provides the context of the study through an account of the different studies carried out world-wide, in Africa and in South Africa as well as KwaZulu-Natal on the same or similar topics. Chapter 2 reviews the current status of HIV/AIDS, its impact, factors influencing it, the theoretical framework guiding the study, and sexual practices of married women and their vulnerability to HIV/AIDS. The research methodology employed in this study is reviewed in Chapter 3, and relates to how purposive sampling was done and the steps which were followed to collect data. Chapter 4 provides a discussion of the results from both the interviews of married women and key informants. This also includes results from focus group discussions and field notes.

From the discussion of results of the study, the researcher designed an intervention programme that is relevant to the rural married women. According to Varga (1997: 48), interventions should focus on "socio-cultural determinants of high risk sexual practices and pay attention to why risky behaviour is frequently continued despite population awareness of its negative health consequences"

(Varga 1997: 28). Chapter 5 will discuss the intervention designed according to the study objectives. It is worth noting, however, that this intervention was only designed but not tested. Among the recommendations made in the last chapter, it is suggested that the intervention should be tested before it is used. The concluding chapters: Chapter 6 summarizes the findings and also refers back to the theories introduced in Chapter 2. It concludes with recommendations, study limitations and areas for future research.

1.10 Conclusion

The chapter has clearly revealed the escalation of the AIDS epidemic despite interventions and other efforts to combat it. It was made clear that women are the most affected group due to several factors that make them vulnerable to HIV infection. The main factors are migration, cultural factors and gender relations. The chapter gave account of evidence of migrant men infecting their wives and a change of trend where non-migrant women are becoming HIV infected while their migrant husbands are HIV negative. According to the chapter the study will look at which sexual practices make women vulnerable to HIV/AIDS.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter reviews the current status of the magnitude of HIV/AIDS, and the effects of HIV/AIDS on individuals and families. The chapter also reviews factors influencing HIV/AIDS and theoretical frameworks that look at the vulnerability of women to HIV/AIDS. Key gaps in knowledge were identified. A literature search was carried out on published literature which was identified using Medline electronic databases. Hard copies were accessed through the University of KwaZulu-Natal library and published articles were also used.

In addition, relevant studies that have examined the interplay of demographic factors and the social dynamics of culture, gender, marriage and migration in relation to vulnerability to HIV/AIDS epidemic were examined.

Magnitude of the problem

UNAIDS/WHO (2005: 1) announced that about 55 million Africans are expected to die of AIDS by 2020, many of them at a much younger age than they would have. Infection, morbidity, disability and mortality are dominant among sexually active and productive people between the ages of 14 and 49 years. The prevalence rate varies but increasing in all parts of Africa except in Uganda where a decline of 7% was recorded in 2003 and 2005 reports state that Angola had the lowest rate in Southern Africa (UNAIDS/WHO, 2005: 27; 24). Two thirds of all people living with HIV in Sub-Saharan Africa translates to 66,7% of women,

which makes Southern Africa the epicentre of the global AIDS epidemic (UNAIDS/WHO, 2005: 2). The same report further shows that Sub-Saharan Africa has the highest prevalence of Sexually Transmitted Infections. For instance 25.8% of pregnant women in the ante-natal clinics in the region are infected, showing an increase of almost 1 million more than in 2003. This amounts to 3.9 million who were newly infected with HIV in 2005.

At the end of 2005 about 4.7 million South Africans between the ages of 15 and 49 years were estimated to be living with the HIV/AIDS and 360, 000 children and adults had died of AIDS. South Africa has the highest number of people living with HIV both in Sub-Saharan Africa and globally. The latest statistics show that the prevalence in KwaZulu-Natal has reached 40%, the highest level to date (UNAIDS/WHO, 2005: 7). In addition to the high rate of mortality associated with AIDS, the health, socio-economic and development consequences of HIV/AIDS for individuals, families, communities, nations affected throughout the whole world, are enormous with grave impacts on all aspects of life. HIV prevalence among pregnant women in South Africa has been reported by the Department of Health (2004) to range between 28.5% and 30,5%. Of these statistics, KwaZulu-Natal has the highest prevalence, of up to 40% (UNAIDS/WHO, 2005: 7).

Impact of HIV/AIDS

Millions of people have become impoverished as a result of HIV/AIDS. For instance, while children have lost parents, parents have also lost their children

and their property. At community level, civil servants like teachers, health workers, and government leaders have been lost. The business sector has lost business leaders, nations have lost their investments in decades of human resource development. As a result, societies have lost untold potential contributions to social, economic, political, cultural development and spiritual life (Aggleton and Mane, 2001: 24).

Floyd, Reid, Wilkinson, and Gilks, (1999: 18) in their study conducted in Hlabisa, show the impact of the HIV/AIDS epidemic on existing health care services in the Hlabisa Sub-district. According to this study, admission numbers at Hlabisa hospital from 1991 to 1998 rose from 6562 to 11, 872, an increase of 81%. This was attributed to the growth in tuberculosis cases on the African continent which is closely linked to the increasing number of HIV infected people who are at a much higher risk of acquiring the disease (Kempkes, 1999: 26).

Ford and Hosegood (2003: 14) studied many children in rural South Africa who had been forced to move as a consequence of the impact of the AIDS epidemic in Southern Africa. Migration can be identified as one of the coping strategies to mitigate the impact of adverse events such as the death of adult household members. It was also found that 1,528 (5%) of children had migrated in or out of a household in the Demographic Surveillance Area (DSA). In addition to this, a further 5% (447) of households experienced an AIDS death in 2000. In this study, 245 households dissolved, of which 17 (7%) were households where the person who died from AIDS was the head of household (Ford and Hosegood, 2003:15).

Migration is not limited to children. Evidence in the Hlabisa area shows that, circular male migration is the norm. Sixty two percent of Grade 7 children had fathers who were migrant labourers. Fifty percent of kraals had one male migrant and another 30% of kraals had two or more male migrants. About one third of kraals had a female migrant, and a further 15% had more than one female migrant (Lurie et al., 1997: 18).

From local demographic data Ford and Hosegood (2003: 2) showed that households headed by women due to widowhood or in the absence of marriage are much more likely to migrate, dissolve or experience an adult AIDS death than households headed by men.

An area characterized by such high levels of migration renders migrant workers particularly vulnerable to HIV owing to the living conditions they are exposed to while away from their families (Campbell, 1997: 273; UNAIDS/WHO, 2005: 26).

2.2 Factors influencing the spread of HIV/AIDS

2.2.1 Culture and gender in marriage

Gender is either biologically or socially defined. In this study gender is that which society makes out of the biological sex differences. Boys and girls are brought up differently. They are socialized to perform different roles in accordance with the norms, attitudes, practices and expectations of their cultures. Unlike roles that are biologically determined however, gender roles are taught and learned, they

are the result of deliberate socialization and are therefore changeable (Trigiani, 1998: 53).

This means that society ascribes roles to either females or males. In a patriarchal society there is unequal status between the sexes, with males assuming a higher status and authority over females, resulting in the subordination of women and male domination. Such gender relations revolve around power and start from the family as a unit of the social system and are articulated through the broader social arena in which power relations are perpetuated (Van Zoonen, 1991: 82). According to Kabeer (1994: 55), gender relations stem from the ensemble of social relationships through which the female species becomes domesticated.

The social structure reproduces, reinforces and maintains a dominant ideology that supports male supremacy through the mass media, culture, religion, education, politics, capitalist and economic systems.

According to feminist theory, the position of women is such that they are prejudiced and discriminated against in several ways. Discrimination of women is a broad and worldwide phenomenon. In addition, gender and social class are often a cross-cutting dimension whereby women tend to have less status in patriarchal societies. While men have access to power and other resources, women face discrimination due to both their gender and their social class position (Van Marle, 1997: 3).

Women are not only subservient to men, but women from a lower social class are also subservient to women of middle or higher class. There is the additional problem of race or skin colour, where in many instances black women work for a white woman '*missus*', as domestic workers and are in an inferior position. "Whatever the case, a woman has to engage with privilege: male privilege, race privilege, class privilege, heterosexual privilege" (Van Marle, 1997: 3). Women in society have not only been kept subordinated, but have often suffered abuse, in the form of domestic violence.

There are very strong cultural practices that are gendered in most African societies, particularly among the Zulu ethnic group. Cultural bias is strengthened by the existence of traditional structures and norms governing women. Here male domination as against female subordination is still strongly practiced and sanctioned. Cultural norms and social expectations create an environment where risk is acceptable and even encouraged for real men (Aggleton and Mane, 2001: 25). Such cultural practices are more strongly evidenced in rural areas than in urban areas.

2.2.2. Socialization

Shared norms and expectations within society about appropriate female and male behaviour characteristics and roles are common denominators across cultures and are intensified in African cultures, particularly that of the AmaZulu. In the process of socialization, norms and values of a particular society are passed

from generation to generation. These are taught from early childhood so that members of that society internalize them. Experience shows that when girls are assertive and aggressive they are said to be behaving like boys while boys who become emotional and cry are said to be acting like girls. These attitudes shape adult behaviour. The agents of socialization are the family, churches and schools. During the socialization process gender is also taught and internalized so that it becomes part of the individual's culture (Alsop, Fitzsimmons, Lennon and Minks, 2002: 5).

Therefore, where male dominance or patriarchy is accepted as the norm, gender embedded in culture causes sex role stereotypes. Non-compliance with the normative sex role stereotypes is not sanctioned by the community structures and what is taught in the communities is reflected in all other social systems. This is the norm in the Zulu culture and has an effect on sexual behaviour, which may lead to increased vulnerability of both sexes to HIV infection (Health 24 News Report, 2000-2005 (2005: 5).

2.2.3 Masculinity

Culture teaches both girls and boys at a very young age about femininity and masculinity respectively. Masculinity prescribes that boys and men should be strong, forceful, display power, should have more than one sexual partner and take the leadership role in a relationship. Gender norms and dominant cultural expectations which cause women's vulnerability also influence men's behaviour.

The belief system underlying men's behaviour forms the basis of risk associated with such accepted and socially rewarded male behaviour (Aggleton and Mane, 2001: 25). Girls and women should be passive, show respect and be submissive to their sexual partners i.e. not question their partners' decisions (Trigiani, 1998: 58).

Like women, men also tend to act as society expects them to. They portray themselves as strong, both physically and emotionally. This is manifested in the way they treat their sexual partners. Masculinity is also demonstrated in the number of women or girlfriends a man has, and whether he is involved in habits described as manly, for example, smoking or drinking of alcohol. These practices place them at a health risk. Due to their lack of power, women find themselves in a vulnerable position where they cannot negotiate and make decisions regarding when and whether sex should take place (Uche, 1994: 12; Aggleton and Mane, 2001: 26; Ford and Hosegood, 2003: 26).

Lately, this understanding of masculinity has been questioned as women gain more autonomy with the ability to earn a wage outside the home. Women may try to escape marriage as it often makes them vulnerable to the demands and oppression of the spouse (Moore, 1994: 140). Apart from this, due to reduced income, the men's role as heads of households and breadwinners has become a precarious one. They have found themselves in a situation between the culture they expound and the discontent and powerlessness they feel as a result of their

subordinate economic status. This results in men's authority becoming under threat and, most importantly, also threatens their identity and sense of self-esteem (Kandiyoti, 1998: 276). Owing to low employment rates, men lose part of their self esteem and their masculinity is at stake, as manhood depends on the ability to fend for their families. As a result, when a man wants to build his self-esteem he drinks and seeks comfort from other women, which further exposes both men and women to HIV infection (Campbell, 1997: 277).

2.2.4 Gender Based Violence

Gender based violence is derived from the perspective of inequalities in power between men and women where men have the power over women (De Bryun, 1998: 14). Men tend to resort to violent behaviours of various forms ranging from psychological abuse such as threatening to remove the women from the home, extreme jealousy, and verbal assault, which mounts to physical, sexual and emotional abuse. Oppression or discrimination is also a form of violence against women. Though the ideology of gender discrimination is sanctioned by law in South Africa (where people are regarded as equal before the law), this policy is not practiced as structures such as the media, continue to reinforce it.

2.2.5 Mass Media

The mass media has been criticized by feminists "for reinforcing, reproducing and maintaining the dominant ideology of patriarchy" (Van Zoonen 1991: 118).

Patriarchy, has condemned women to sex-stereotyping roles, encouraging their subordination and male supremacy.

According to the feminists, the media-created woman is:

- a wife, mother, housekeeper for a man
- frequently a sex object used to sell products to men
- a person trying to be beautiful for a man
- portrayed as less than a man
- in the 1920's were restricted to stereotyped positions, weak, vulnerable, dependent and submissive (Tuchman, Daniels and Benet, 1978: 47).

2.2.6 Poverty

Poverty causes sex to become a transactional process (Caldwell; Orubuloye; Anarfi, Awusabo-Asare and Ntozi, 2002: 140-141). These findings may be true when the status of some women is considered. For instance, the majority of women in rural areas, have low levels of education and cannot earn their own income and so suffer from lack of access to sustainable livelihoods. These women are dependent on their husbands for income. Husbands sometimes do not give their wives enough money to cater for both themselves and their children. This is a factor which contributes to the conditions in which HIV transmission occurs. For instance, women may engage in sex with extramarital partners for money and in the process become infected with HIV. Poverty should thus be seen as a "part of the dynamic social processes" (Cohen, 2006: 1).

2.2.7 Migration

Mobile populations, where men and women are isolated from traditional, cultural and social networks and find themselves in new conditions, will engage in sexual behaviours with adverse consequences in terms of HIV infection (Cohen, 2006: 3). The study on migration done by Ford and Hosegood (2003: 15), shows that it is apparent that migrancy undermines the stability of family life and also leads to tensions in family relationships. Marks (2002: 25) agrees with Lurie (1997: 18) that migration has grave implications for public health control as the process of continuous movement of large numbers of people spreads a variety of communicable diseases as well as HIV/AIDS.

To substantiate this assertion, a study to empower sex workers to use condoms to prevent the spread of HIV in West Bengal, showed that a significant proportion of new infections was occurring in women who were infected by their migrant husbands who in turn had been infected by sex workers (UNAIDS/WHO, 2005:34; Lurie, 1997: 17)

2.3 Marriage and cohabiting

2.3.1 Marriage

Marriage is nearly universal in African countries with only a few older men of more than 40 years having never been married. The majority (97%), for instance, in Kinshasa) of marriages are acknowledged as legal or formal in comparison to informal marriages i.e. those not recognized under the law (Magnani, Betrand,

Makani and McDonald 1995: 19). Marriage is still a very important institution among black South Africans either as nuclear or extended families. It is acknowledged that other forms of marriage may assume different structures depending on families and households. South Africa has not been immune to changes in the proportion of women who do and do not marry. Since the second World War, there has been a steady increase in the percentage of women between the ages of 30-34 years who choose not to marry (Preston-Whyte, 2002: 65). Marriage provides an environment in which to bear and rear children. It is one type of partnership that provides a major reference point for assessing other forms of relationships, as relationships, whatever their nature, according to Griffiths 1997: 61) develop in the shadow of marriage.

The Demographic and Health Survey conducted by Hosegood and Sorlash (2001: 30), showed that marriage as an institution is not universal in South Africa. According to the survey 48% of women of reproductive age had never been married or are not currently living with their sexual partners. Preston-Whyte, (1993: 69) reported that between one sixth and one fifth of women aged 30 to 49 are married to a man who has more than one wife and about 11 percent of women aged 45 to 49 have never been married.

To be socially recognized, marriage should involve linkages of both the man's and the woman's families to be socially recognized. This involves, in some societies, culturally laid down norms and values pertaining to a particular culture.

For instance, in the Zulu culture there should be formal negotiations initiated through established networks involving both families. According to Griffiths (1997:14) these linkages are invested with symbolic attributes. These attributes are gendered, in marriage networks, which, when constructed through men, are characterized as hostile and assertive but when done through women, are nurturing, supportive and non-aggressive sets of relations which operate in the private domain (Griffiths, 1997: 57).

Besides marriage negotiations between the families, marriage should also be registered in official churches with Home Affairs. Most people did not go to these institutions to get married for several reasons including political and economic concerns. They used customary marriages instead where a tribal 'police' performed the wedding. The union was later registered at the Home Affairs Department to be recognized in civil law. The Customary Marriages Act number 120 of 1998 recognizes marriages previously called 'traditional marriages', and as a result, now in both monogamous and polygamous marriages the older wife is recognized. The incidence of marriage is affected by factors such as the prevalence of widowhood, divorce and polygamy. Such incidents usually determine the number of times a person marries.

Marriage as a form of protection from STIs and HIV infection is questionable. To Aggleton and Mane (2001: 28) monogamy does not protect women from infection because of the sexual behaviour of their male partners, who have unprotected

sex with other partners. According to Aggleton and Mane (2001: 20) cultural norms and other expectations create an environment where risk is acceptable, and in some cases even encouraged for real men.

In historical terms, in most societies sexual relations were discouraged before marriage. Rarely would you find a woman bearing a child before marriage. Marriage occurred early. But due to societal changes in the cost of living, marriage was delayed till lovers had enough money to start their own families. Lately, due to this delay and other factors more young people engage in pre-marital sex resulting in the birth of illegitimate children. Today the family and community generally accept the situation of an unmarried mother (Modo, 2000: 449), more so than in previous generations where it was considered to be scandalous.

A study conducted in Malawi contends that marriage is considered very highly desirable. The divorced and the widowed mostly remarry. Reasons for remarrying in Malawi are largely based on the gendered division of labour in which men engage in the provision of financial support to the family. Women needed someone on whom to depend for economic subsistence and they reached an age where their sexual desires made it advantageous to have a regular partner to look after all their needs (FAO, UNFPA and Government of Malawi, 1998: 50). This means that even in the era of AIDS the unmarried will nonetheless seek sexual partners and thereby place themselves at risk of

infection. Parents who urge their adult children to marry sooner rather than later in order to avoid AIDS echo this concern (Ntozi, Nakaabi, and Yovani, 1997: 26).

Economic pressures may impose strain on marriages or may cause individuals to want to escape from traditional family life. More dissolutions or divorces have occurred in rural than in urban areas probably because unions in rural areas are not as rigidly contractual as in urban areas. Their dissolution is therefore much easier. A study done in Nigeria showed that some of the causes of dissolution of marriages are divorce, separation, death from several causes (the majority of which are AIDS related), no love, constant quarrels, unfaithfulness, changed residence, family disputes, changed minds and financial problems (Ntozi, 1997: 30).

The assumption is that most people will choose to marry at least once in their lifetime (Wells, 1983: 9). Marriage has an old oppressive sex role stereotype that prescribed what a man and a woman could do in a marriage. For instance, women have to cook, render care to their husbands and families, bear children and according to Wells (1983:52), "cater for their husbands' every whim, with no life or identity of their own". Wells further proposes that today more women have learned to choose a lifestyle on the basis of new stereotypes. They have become independent career women who relate to men in the same way as men relate to women.

2.3.2 Cohabiting

Education has affected the marriage tradition, as many unmarried educated girls are unwilling to marry. They may choose to cohabit which, according to Hosegood and Preston-Whyte (2002: 9), is a deliberate decision taken by some men and women for various reasons such as loneliness. According to him, this also occurs among the divorced women when their boyfriends lure them to move from maternal homes and stay with them.

Today, couples have a longing to live together and decide when to get married. Marriage usually takes place if their living together works. Some just want to stay together because they feel lonely while others do so because they do ot have other plans (Wells 1983: 52). Cohabiting of this kind occurs more frequently in peri-urban and urban areas and is different from what this study concentrated on. Parents may not approve of their child's lifestyle and according to Wells (1983:53), there is not the equal cohesion that exists with a married couple because there is still the feeling of 'mine' and 'yours' rather than the concept of 'ours'. This result to insecurities and in the long run such insecurities tend to weaken the desire to get married. "This change in the relationship can lead to a tug-of-war that is draining and demoralizing, as the one who wants to marry adopts strategies to persuade the other" (Wells, 1983: 53). This causes pain and may drive them further apart. Thus they might feel it would be easier to separate if things did not work out (Preston-Whyte and Hosegood, 2002: 10).

In cases of cohabiting that is traditionally organized, however, it will not be easy for the parties to split because, as in a marriage, when there is misunderstanding between the parties, both families intervene. In a rural KwaZulu-Natal ethnic group, cohabiting is negotiated between the man's and the woman's families. Part of the *lobolo* is paid as guarantee that the couple will eventually get married and it is agreed by both parties for them to live together as a married couple usually with the man's family. Before this is negotiated, a couple would have taken a long time dating and doing other kinds of sex play but refraining from sexual intercourse until marriage. In cases of cohabiting that is traditionally organized, a woman does not verbalize her feelings because she would have undergone similar 'marriage counselling' from older women in the family when she left home.

In all these cases of cohabiting, it is not easy for the parties to split. When there is a misunderstanding between the partners, both families intervene. Families hold a meeting and communally try to solve the problem. When the woman's family is not satisfied with the outcome of the meeting, they might take their daughter back home 'until the rest of the *lobolo* is paid and an official marriage has occurred. Usually she takes her younger children with her, but the older children remain with their father, though they may visit their mother. The partners see each now only when the man visits the woman and the younger children in her home. This usually puts pressure on the couple to get married sooner.

2.4 HIV/AIDS and marriage

In most societies women have less access to education, training and resources than men. Men are more likely to control sexual interactions and decision-making. Men are involved in reproductive decision-making in societies characterized by an unequal balance of power so that they may influence their partner's sexuality (Tallis, 2000: 38). Women cannot be solely blamed for their reproductive health, as men are also involved in decision-making.

In many societies risky sexual behaviour is a driving force behind the spread of HIV and other STIs. The World Health Organisation conducted a survey on the sexual behaviour of men and women between in ages of 15-49 years in 18 countries. Men reported having 5 to 7 partners in the previous year in Sri-Lanka, Guinea Bissau and Rio-de Janeiro. This behaviour places men and their partners at risk of HIV infection and other STIs, with women being more susceptible than men.

While working in the Verbal Autopsy Research project conducted in the Africa Center Demographic Surveillance Area, I came across situations in which, when the woman cohabiting with a man dies she is soon replaced by another one. The new woman becomes a major informant during verbal autopsy visits to the households about the circumstances of death of the deceased wife, who might have died only a few months earlier. Even if all the signs and symptoms show that the cause of death was AIDS, the new wife seems to be unaware of the fact.

This is a common occurrence, making these new wives vulnerable to infection and not having the knowledge to protect themselves.

Tallis in Agenda (2000: 39) cites studies that were done by Karim et al. in 1991 in KwaZulu-Natal aimed at assessing the power of women to lower the risk of HIV infection. These studies showed that half of women felt that they had no right either to insist that their partners use condoms or to refuse sex. They were unable to question their men about other sexual partners or insist on monogamy or the use of condoms or to tell them to go for a blood test (Tallis, 2000: 39).

Poverty and their powerlessness lead many women to disregard their own risk and engage in unsafe sex practices. Even in countries such as South Africa, where gender equality is entrenched in the Constitution, in reality women's lives in their home relationships and in broader society are far from equal. According to Tallis (Agenda, 2000: 70), inequality in analyzing the position and status of women in relation to the position of men makes it obvious that women and men do not enjoy equal status or rights. Inequality is linked to HIV/AIDS. Freedom of expression has little impact on women who have been denied education, are illiterate or are silenced in other ways. Gender inequalities also affect the possibilities of prevention of, and access to appropriate materials, information and resources, equality of care received and survival chances.

2.5 Gender and Health

There is growing evidence that medical research has become a gender activity. For example, research topics and methods that used data analysis generally reflected a male perspective. Common problems for example, incontinence, dysmenorrhoea and osteoporosis, which cause considerable stress to women have received little attention as they are not central to women's productive roles. The failure to reduce high mortality rates from breast cancer shows that there has not been enough research in this area. Further studies conducted by the Women's Health Project show that gender bias is also seen in the design of a wide range of studies. For instance, where a disease affected both women and men, many researchers have ignored the possible differences between the sexes in diagnostic indicators, symptoms, prognosis and in the relative effectiveness of different treatments as identified in HIV/AIDS research. As an example Coronary Heart Disease (CHD) continues to be seen as a male disease and this is reflected in a number of ways in research design, yet CHD is the single most important cause of death for post- menopausal women (Klugman, 1997a: 34).

Klugman (1997b: 37) further looks at gender differences and access to health and shows a feminist argument that the normal process of pregnancy and childbearing has been taken away from women themselves. This means that women have no say to the process of pregnancy and childbearing. Many doctors treat depressed women with a pill, without identifying the underlying cause such as domestic violence or living conditions. Medical attention for poor women who

cannot afford it is lacking, as they find themselves without treatment compared with men in the same social group. In most poor countries, the lack of access to health care is mostly felt by women. This is so because men have access to and control over money, and decision-making powers. It is difficult for women to pay for medical care or transportation costs as facilities are usually far away (Klugman, 1997b: 37).

Doyal (1995: 18) agrees with Klugman that research has selectively ignored many biological differences between the sexes and as such the understanding of women is partial and erroneous. He further reports that to correct the situation we need to move beyond the biological boundaries in order to understand the complex relationships between women's health and the quality of their daily lives.

It is worth mentioning that women might not seek medical help if their illness happens during harvest time, so that their complaint is ignored and the illness becomes worse. Emphasis is put on the reproductive health of women during their childbearing years so that at the adolescence and menopausal stages they are neglected. It is at these stages when they mainly suffer mental breakdown. There is no medical care at the most crucial periods of their lives.

2.6 Sexual practices of married women

The question is what do married women do when their husbands are away or they themselves as career women are at work away from their partners? Lurie et

al., (2003: 816), in his migration study in the Hlabisa District and Carltonville, reported evidence of sexual contact by respondents with a person other than their regular partner in the previous year. Lurie showed that use of condoms, although low, was significantly higher among non-migrant women than among migrant women. Migrant women are thus at higher risk of HIV infection than non-migrant women. Prevalence of HIV and other STIs was more than 37.1% among migrant women. (Lurie et al., 2003: 815). Therefore, as much as migrant men and migrant women are at a significantly higher risk of HIV infection than non-migrant women, circular migration increases the risk of HIV infection for non-migrant women as it does for non-migrant men.

Other forms of relationships, whatever their nature, develop in the shadow of marriage (Griffiths, 1997: 61). The older a woman becomes, the more chance there is of a relationship breaking down and the more difficult it becomes to find another partner. Older women find themselves competing with younger women and the situation is often exacerbated by the lack of available men.

In contemporary society men still leave their homes to seek work in urban areas away from their homes and families. They leave girlfriends behind in the hope that they would soon come back with the required bride-wealth to get married. Such regular separations are usually prolonged. Men and women thus usually engage in different sexual relationships, one of which is casual sex. According to a study done in Mandini, KwaZulu-Natal by Hunter (2001b: 6), casual sex can be

discussed in the context of transactional sex where sexual intercourse is exchanged for gifts and sex. This is a factor for the rapid spread of AIDS, but is not the form of prostitution similar to that occurring to migrant labourers on transport routes (Lurie et al., 1997: 122). This form of transactional sex usually involves young girls and older men who are employed and financially well off.

Similar studies, which support the hypothesis of Lurie et al.'s (1997:123) assertion that migration increases the risk of HIV infection were conducted in Uganda in 1995, Senegal in 1993, Zimbabwe in 1990 and South Africa in 1992 (Lurie et al., 1997: 123). All the above studies contend that men infect their sexual partners when they return home. This thinking is also supported by Kark (1949: 78) in a study conducted in Centocow in KwaZulu-Natal Midlands where he found that even though women whose husbands were migrants had extramarital relationships they did not get infected in their relations but got infected from their husbands.

These studies do not explain the infection in those women who live with their non-migrant husbands or how those involved in regular relationships are exposed or become vulnerable to HIV infection (Lurie et al., 1997:123).These studies only highlight that as men migrate away to urban areas to seek work, they acquire relationships, which place their women at home at risk of HIV infection. On the other hand, a study of mineworkers and their partners found that in 40% of relationships where only one person was found to be HIV positive, it was in fact

the woman who had stayed at home and not her mining partner who was infected (Lurie et al., 2003: 816). Could this mean that women of migrant men still engage in other sexual practices while their husbands are away? If so, what has happened to the extramarital relationships now that causes women to get infected from their extramarital partners instead of getting infected by their migrant husbands? This study aims, therefore, to investigate evidence of the sexual practices of married women and why women are getting infected from their extramarital relationships.

A study done in the Dominican Republic in 1995 on workers in sugar cane fields showed that women had more than one lifetime partner. This has not been investigated in KwaZulu-Natal. Risk factors such as a large number of lifetime partners and extra marital relationships, which are known to increase the risk of HIV infection were more common among migrant women in the Dominican Republic (Lurie et al., 2003: 817). According to Lurie et al. (2003: 824), their study is similar to the one done in Senegal in 1993 as it also showed a higher prevalence of HIV infection among men who had worked in another African country than among men who had never travelled.

A study done in Nigeria in 1992 demonstrated that having extramarital sex partners is not restricted to men only. It showed that married women also have such relations involving multiple or casual partners. It also showed that two out of five married women had had sexual relations with the lover in the previous two

weeks (Isiugo-Abanibe, 1994:120). This could mean that it is not always the man who infects his marriage partner, but women also do. Studies on married women's extramarital sexual relations have not been done in KwaZulu-Natal.

Isiugo-Abanihe's study (1994: 112) conducted in Nigeria reveals that there is a very high level of sexual networking among married people. Eight percent (8%) of men and 7% women did not give a thought to AIDS when they chose sexual partners outside their marriage. The results of the study show that about 46% of men and 54% of women claimed they had had sexual intercourse with people other than their partners since their marriage. The issue of extramarital sexual relations of married women needs to be explored in South Africa and thus this study will focus on extramarital relations in rural KwaZulu-Natal, in the Mpukunyoni area.

Though there are few such studies in Sub Saharan Africa, Modo (2000:446) contends that there was evidence of *Nyatsi*, (which are names given to extra marital sexual partners of married women) habits of women in Lesotho where a woman had a boyfriend while married to an absent mineworker. When they were caught, their men divorced them on grounds of adultery. Some married women broke up other people's homes as they snatched men from their women. This kind of sexual behaviour is comparable to the *'isidikiselo'* practice in KwaZulu-Natal, South Africa. Women of migrant men were abandoned by their male partners, as the men formed new relationships in the cities. Even if these sexual practices were common in both Lesotho or KwaZulu this kind of behaviour was

not culturally accepted as some men ended up killing their wives or sending them back to their homes (Modo, 2000: 448). Both *Inyatsi* and *isidikiselo* sexual practices resulted in the emergence of '*amavezandlebe*' which is a name given to children born to married woman out of wedlock.

2.7 Married women's vulnerability to HIV/AIDS

In comparison to men, women are more susceptible to HIV infection for various reasons. Biologically, women have a delicate membrane on the vagina, which is easily injured during intercourse. The vaginal skin has folds, escalating chances of infection. In comparison, men have a less delicate area under the foreskin, placing them at a lesser chance of contracting infection (De Bryun, 1998:10).

During sexual intercourse gender related vulnerability occurs when male sexual needs are acknowledged because, according to De Bryun (1998: 12) "Everything is centered around the pleasure of the man". This is confirmed by the fact that herbalists sell herbs that cause dryness in the vagina for the male's pleasure. In some cultures, there are some practices which have been identified as contributing to contracting HIV infection. For instance both men and women in the African culture like dry and tight vaginas because they believe that this increases pleasure for the man during sexual intercourse (Leclerc-Madlala, 2002:10). As far as health is concerned this practice causes inflammatory lesions of the vagina and cervix because some products cause extreme dryness that could foster epithelial trauma during coitus, both for the woman and her sexual

partner. Thus dryness and tightening may increase vulnerability and risk of HIV infection to both men and women (De Bryun, 1998:18).

Socio-demographic factors also add to the problem of vulnerability to HIV infection in terms of access to health services. Economic factors cause women to need a basic income to fend for their families. Some of the needs include shelter and food, and these expenses may deter women from embarking on protective health behaviours. Often their men leave and do not give them money to cater for these needs. Poverty and the need for survival; gender and the inability to negotiate specific and relational issue, drug related behaviour, multiple partners, beliefs that condoms are embarrassing and female condoms are not freely available and costly all cause women to have no control over sexual relations (De Bryun, 1998:18).

Even if women could negotiate condom use, it is culturally expected by the family and husband that the wife should bear a child sometime, as they are married. Even if a man has multiple sexual partners, due to his need have a child the condom use is temporally stopped in order to have a child. As mentioned above, the Zulu ethnic group culturally expects married people to have children, which is a cultural expectation that further aggravates women's susceptibility to HIV/AIDS, as women cannot challenge their culture.

Experience shows that in some cultures the gender issue of masculinity condones male involvement in multiple sexual partnerships and aggression. Lately, women also become involved in such practices but women are stigmatized so they do it privately while male involvement is accepted. Cultural practices may thus aggravate the physiological vulnerability of women. Violence against women is one other social factor that makes women vulnerable to HIV infection in the form of marriage rape and incest. Violence against women is sometimes condoned in society as media portray women as sex objects and victims of abuse (Lont, 1995:15). Violence against women is further aggravated by the ability of men to exercise violence, desert or chase their wives away. Because of such male behaviour, which is accepted, women are placed in a vulnerable situation to HIV infection. "Sexual violence is an outlet for power and anger; it is also an expression of masculinity that depends on the submission of women" (Mager, 1999:24).

Mass media plans programmes that are in accordance with the societal values. Though these programmes are usually gender biased, the planners are not aware of this bias as it is taken for granted that they should happen that way. For instance, women are portrayed as sex objects and as housewives so they are trivialized and become vulnerable to sexual abuse (Tuchman, Daniels and Benet, 1978: 28).

Myths and misconceptions also play a role in that they cause people to deny the relevance of AIDS in their lives. People who believe in witchcraft do not attribute disease to viruses but believe that an enemy deliberately caused the disease. My experience in working in the Verbal Autopsy project shows that people believe that diseases like TB, AIDS and others, are due to the consumption of a poisonous herb or witchcraft. Myths have also resulted in sexual violence in the form of rapes. Men have raped young girls in the belief that sleeping with a virgin cleanses them of the HIV infection (Leclerc-Madlala, 2002: 15).

As well as misconceptions, women lack information and so have a poor understanding of their own bodies and the mechanisms of HIV/AIDS transmission. Gender issue causes men to be exposed to the media in the form of radio and newspapers but women hear about current events very late. One woman in Senegal said: "I don't need condoms because I'm not a prostitute" (De Bryun, 1998:16). Different to the reason why this woman is not using condoms, is the inability to use condoms because women in other communities cannot negotiate condom use with their husbands.

Women are also susceptible to infection as primary care givers. For instance, AIDS patients are not hospitalized for a long time but are discharged and continue to be ill at home. As primary caregivers, women are expected to take care of them, which brings them into direct contact with the patients' body fluids. This is a health risk practice when it is done in ignorance of how HIV is

transmitted. Women usually give care without protecting themselves by wearing gloves which can result to them becoming infected with HIV.

A study done in the United States of America in 1996 showed that when women comprise an increasingly large number of AIDS cases (De Bryun, 1998: 16). According to this study, the incidence of women with AIDS in 1996 was more than 3.6 times greater than it had been 10 years earlier in the USA. Most of these infections were, however, attributed to heterosexual transmission where women indulged in unprotected sex. Condom use depends on attitudes, beliefs, self-efficacy and the partner (De Bryun, 1998: 16). This means that even if female condoms were available, their widespread use is doubtful as men are still the decision-makers because of the power they possess in a relationship.

Structural factors place women at risk. For instance, while male condoms are freely available, their use depends on male acceptance. Female condoms are not freely available and where these are available they are expensive and are unaffordable. These condoms could give women a certain amount of control and power in a relationship, as they are inserted prior to sexual contact and cover a large part of the vagina with minimal chances of breaking. (De Bryun, 1998: 20).

There are reports indicating that married life is not always pleasant, resulting in women engaging in extramarital relationships. For instance, a study done by Isiugo-Abanihe (1994) looked at extramarital relationships among men and women and their perceptions of HIV/AIDS. The results of his study claim that the

more educated people were, the more they sought outside relationships. This was demonstrated in both sexes. Another factor that was discovered was the lack of emotional bonding between men and women, which resulted in low sexual satisfaction. This, in turn resulted in sexual satisfaction being sought outside the marital home (Isiugo-Abanihe, 1994: 119). These studies were done in Nigeria and elsewhere but no such studies have been done or documented in South Africa, KwaZulu-Natal.

The above literature review supports the fact that HIV/AIDS is still a global problem as it is escalating, and has grave impact to families, communities, and all sectors. It also shows that women are more vulnerable to HIV infection revealed by the larger numbers of infected women in comparison to men. The literature also displays factors that cause women's vulnerability. However, gaps in studies conducted support the significance of the study. For instance Lurie at al (2000: 443) strengthened the need to investigate the findings that women were found HIV positive while their migrant partners were negative.

2.8 Theories and theoretical framework that guide the study

The study is guided by the feminist theory (Ritzer, 1992) and the Theory of Vulnerable Populations (Flaskerud & Winslow, 1998). At the end of the chapter there is an illustration of framework and the construct guiding the study based on the mentioned theories.

2.8.1 Feminist Theory

There are various types of feminist theories and this study will be mainly guided by the Theory of Dependency Feminism which contends that there is inequality between men and women, with men assuming superior positions and women in subordinate positions (Ritzer, 1992:43). Their existence involves power relations, which are skewed towards men. Men have access and control over resources with women having none. This causes women's dependency on men and may affect female decision-making on their sexual behaviour and therefore cause them to be vulnerable to HIV/AIDS.

Ritzer (1992: 44) contends that the ***Feminist theory*** seeks to provide a system of ideas about human life that features women as understood from a woman-centred perspective. The theory takes into account the situation and experiences of women in society. According to him, feminism seeks to treat women as subjects in their own right in the investigative process. It also sees the social world from the point of view of women (Ritzer, 1992: 44).

Ritzer further postulates that everywhere women have always been subordinated. Subordination dates back to the 1600s (one may argue that it dates back to the Bible times) and has been seen to increase. Feminist movements in Western countries started in the 1780s to protest against male oppression. Such protests were neglected by the sociologists the majority of whom were men. It was only in the 1960s that female and male sociologists

addressed feminist concerns as a discipline. From then gender concerns have been put up as a theory to consider women issues. Feminist theories place gender as a platform for women to voice their concerns (Ritzer, 1992: 447). Since 1994 the South African Constitution has advocated gender equality for everyone and it discourages any form of discrimination.

Assumptions of the feminist theory are:

- Women's social situation is different from men's.
- Women's situation is unequal to men's.
- This means that women's situation is that of an oppressed group and men are seen as oppressors in a male constructed patriarchal system (Ritzer, 1992: 44).

Theories of gender differences postulate that from infancy to old age there is a difference between men's and women's basic values, sex identity, sex fantasies and therefore a difference in looking at things generally. Boys and girls relate differently to each other and men and women relate differently to their male and female offspring. For example, women relate differently to their boys or girls. Boys play differently from girls. Women also relate differently to each other because of their identities and the way they are socialized. From childhood the overall life experience of females differs from that of males (Van Zoonen, 1991: 20).

The institutional explanation and other explanations hold that differences in the household division of labour (chores), mothering and care giving are rooted in socialization that occurs from childhood within family and social institutions like the polity and economy. Politically men and women are differently situated in society resulting in gender inequality. Women get fewer material resources, less social status, less power and fewer opportunities than men. Such social inequality between the two sexes places women in a dependent position. Women's economic dependency on men causes them to be submissive to male sexual advancement with no ability to negotiate or make sexual decisions (Ritzer, 1992: 462).

The South African government has moved to change such situations by introducing the Bill of Rights that enshrines the rights of all people as a corner stone of democracy, (Republic of South Africa Constitution Act 108 of 1996). In the Constitution everyone is equal before the law. This gives women reproductive rights and considers them as having a say on any matters related to their sexual life. These constitutional rights seem to exist only in theory as they have never been implemented at grassroots level. The plight of women in rural KwaZulu-Natal is still more or less as Ritzer (1992: 46) hypothesized.

Further to this, Feminist Theories outline various types of feminism such as ***Dependency Feminism*** (Please refer to Figure in this chapter (2) in page 60). This theory stipulates that the situation of women is due to contradictions

between social classes and contradiction between sexes. When the metropolitan centres allowed relations with capitalist and neglected the areas on the peripheries (rural areas), exploitative relations were created (Ritzer, 1992: 462). This change set up a difference between women's roles in two regions. That is, in the metro women enjoyed advantaged positions as they were given greater opportunities to enter the capitalist world. On the other hand the disadvantaged women in the rural areas experienced no economic advancement, which led to general pauperization (extreme poverty) and marginalization in which women suffered disproportionately (Kabeer 1994:47). As a result, women particularly those in the rural areas, depend on men for economic support. Social dynamics such as gender and culture also prescribe that women cannot make decisions on sexual matters. They are marginalized, subordinated, discriminated and stigmatized.

Women's dependency on men has been changing. More women have been migrating to the cities and towns to get employment. The Africa Center Demographic Information System data (ACDIS) show that there are more women migrating than men. This autonomy still does not give women power in relation to sexual matters with their sexual partners. Women still suffer gender oppression in their relationships, which make them vulnerable to HIV infection whether they are in the rural areas or urban areas to which they have migrated (Hunter, 2002:101). This situation is aggravated by traditional and cultural postulations that a woman's place is in the home and in the kitchen. She is expected to refer to her

husband in all matters relating to the world outside home. The world beyond the home was portrayed as wild and hostile and keeping the woman in the safety of her home was to protect her. She was thus socialized to be protected by her husband and to remain in the confines of her home. In return, women were to obey their husbands and cater for their needs and wishes. Thus women have been always portrayed as male sex objects. This trivialized women. In this way women suffer exclusion from the public sphere, giving them an inferior status within society and causing a dependent situation both in the family and in society (Kabeer 1994: 45).

In explanation of gender equality between women and men and women's dependency on men, **Socialist feminism** contends that human beings are defined by gender, race, ethnicity, age, sexuality and nationality.

Postmodernist theory agrees with the feminist theory that gender shapes both the material and the symbolic worlds and intersects with race and ethnicity. It also influences the structural forces of the economy, social and political discourses. However, this theory contends that the situation could be changed as it is not fixed but dynamic (Kabeer, 1994: 40). It further asserts that meanings occur in a wide context involving the above forces and discourses but changes could be made through the process of negotiation (Trigiani, 1998:8).

The Feminist theory forms the context in which this study was conducted. Feminists argue that gender inequalities that exist in society where women are accorded an inferior status perpetuate the vulnerability of women. This increases women's relative risk or susceptibility to adverse health outcomes (Ritzer, 1992: 44). Feminist theory also advocates women's rights and challenges women's oppression and subordination.

As mentioned above, the Feminist theory and the Conceptual Model of Vulnerable Populations will be used in order to place women in context as they are the vulnerable population in this regard.

2.8.2 Conceptual Model of Vulnerable Populations

It was mentioned in the introductory statement that the feminist theories form the basis of the study, thus the following discussion should be understood in that context. The theoretical framework has been adapted from the Conceptual Model of Vulnerable Populations' health related research by Flaskerud and Winslow (Flaskerud and Winslow, 1998: 68). In terms of this model (Refer to Figure1 in page 60 of this chapter), Flaskerud and Winslow (1998:69) refer to the definition of vulnerable populations as social groups who have an increased relative risk of, or susceptibility to adverse health outcomes, evidenced by increased comparative morbidity, premature mortality, and diminished quality of life. They view the fundamental causes of increased susceptibility to disease as low socio-economic status and lack of environmental resources. Groups recognized as

vulnerable are the poor, those in subordination, marginalized and denied human rights, to mention but a few.

Behaviour does not occur in a vacuum but occurs in a socio-cultural context, which is affected by culture and gender discourses. In this study adverse health outcomes relate to women's vulnerability to HIV/AIDS. Women lack the power, opportunity, ability and skills to make and implement decisions that impact on their own health (Tallis and Welbourn, 2002: 9).

The status of women in the context of the Conceptual Model of Vulnerable Populations will best be understood using the following headings:

2.8.2.1 Resource availability

The Model postulates that though there is widespread information regarding HIV/AIDS, rural women may not find it easy to access this information because of lack of technology and their own illiteracy. Information also does not always target rural women in relation to their specific needs and concerns, particularly those pertaining to sexual issues. Rural women also lack the skills necessary to negotiate for safer sex, which is a factor that is also strongly identified by the Feminist Theory above. These women do not have access to health care and quality care because of the low income in the family, poverty, no medical aid and distance from the health services. They have poor socio-economic and environmental resources.

2.8.2.2 Relative risk

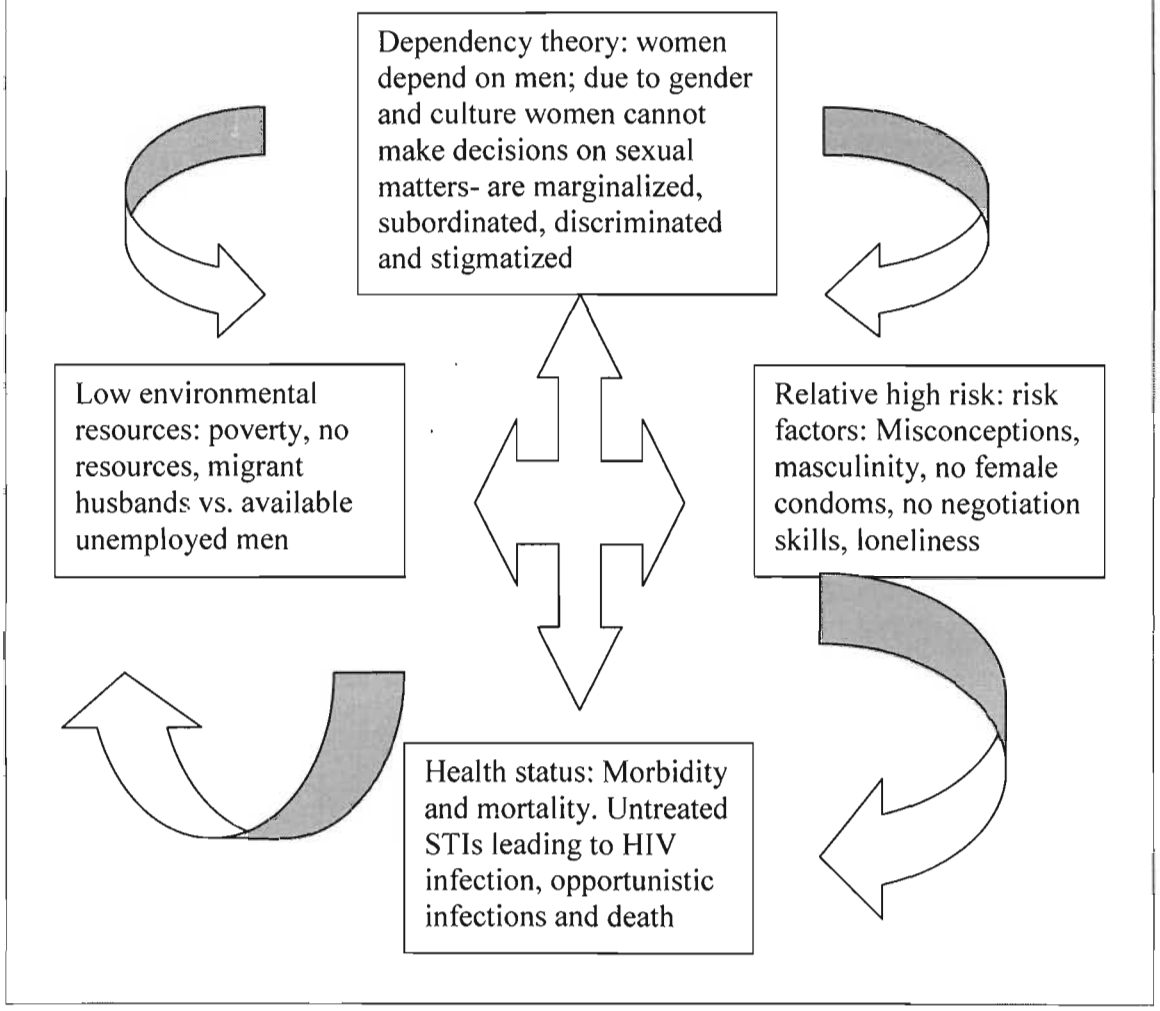
Relative risk is viewed from the perspective of exposure to risk factors where low socio-economic and environmental resources increase the risk factors among vulnerable population groups who experience the lack of resources. Risk factors are social beliefs, systems about phenomena like masculinity in the form of sexual abuse and violence.

2.8.2.3 Morbidity and Mortality

Unprotected sexual practices resulting in sexual diseases are associated with poverty, ethnicity, and gender. Preventive measures are less frequently used by women who are poor, less educated and unemployed. The women's health status is jeopardized as exposure to risk factors is related to increased morbidity and premature mortality. Women are also exposed to gender based violence, and abused women tend to engage in unprotected sex leading to other morbidities like STIs, HIV and Hepatitis B Virus. Association between diseases and low socio-economic environmental resources, has been found (Flaskerud and Winslow, 1998: 4).

The following diagram (Figure 2:1) represents the theoretical framework guiding the study which includes the Feminist Theory and the Theory of Vulnerable Populations (Ritzer 1992; Flaskerud and Winslow, 1998).

Figure2.1: Framework and Construct guiding the study: Feminist Theory & the Conceptual Model of Vulnerable Populations adapted from Flaskerud & Winslow (1998).



2.8.3 Application of the Feminist Theory and the Model of Vulnerable Populations in the study

The interplay between the two theories will give a concise picture of the plight of women and will also give factors that may cause women vulnerability to HIV infection. For instance, the theory of Dependency Feminism gives a vivid illustration of inequality between men and women, with men assuming superior positions and women in subordinate positions. There is involvement of power relations, which are skewed towards men giving men more access to and control over resources with women having less. The misappropriation of resources results to women remaining dependent on men. This affects female decision-making on their sexual matters therefore causing their vulnerability to HIV/AIDS.

According to the Model of Vulnerable Populations the above plight of women, as per Feminist Theory, is confounded by the inherent lack of resources. Such a situation may place women at risk, as they may engage in risky sexual behaviour in order to also have access to resources. Because of their subordinate position, women may not treat their infections, which may in turn aggravate morbidity and progress to mortality. Both the Feminist Theory and the Model of Vulnerable Populations best give a picture of how women may be placed in a vulnerable position to contact HIV infection. These factors provide firm grounds on which to base the study.

3. Conclusion

The chapter has given an elaborate account of the magnitude of how women become vulnerable to HIV infection. Theories grounding the study have examined the vulnerability of women to HIV/AIDS and how the epidemic impacts on the population, the DSA being a point of reference. Social dynamics such as culture, gender (marriage, socialization and masculinity), gender based violence, poverty, and migration were mentioned as key issues that aggravate the vulnerability of women to HIV infection.

The study may not only answer the question of what sexual practices of wives of migrant men engage in while their husbands are away, but it is envisaged that it may also answer the question of how migrant men's wives tested HIV positive while their husbands were not HIV infected. According to the chapter, the study will be conducted within the parameter of both the Feminist Theory and the Theory of Vulnerable Populations (Ritzer: 1992; Flaskerud and Winslow: 1998).

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter illustrates the research approach and design the study adopted and gives reasons for its selection. The research design and approach includes explanation of the study population, sampling method, sample size, recruitment of the study participants, how data was collected and analysed. It also provides a brief discussion on ethical considerations, on constraints and limitations of the study.

In the study the chapter also reviews concepts like credibility, bracketing, triangulation and transferability as these are frequently used in a qualitative study. In addition, a brief outline of how literature reviewed in the previous chapter formed basis for designing of the intervention (that would empower women), is provided in the explanation of each module.

Self reflexivity

In qualitative research, particularly in ethnography; the researcher may seek cultural description based on first hand experience of a group of people he or she seeks to study. This, the researcher may execute by conducting in-depth interviews and by even staying in the field to take notes on people's behaviour. (Van Maamen, 995: 1). Interaction with people in their settings may affect the researcher's behaviour towards the situation or individuals she is meant to study.

Self-reflexivity, an act of awareness of the self; the feelings and the impact they may have on her research work, is crucial to exercise. One way of engaging in

self-reflexivity is to provide answers as to why the researcher is interested in the research topic she has chosen. To this, Nagata (2005: 15) cites Joyce Fletcher, that the self-reflexive exercise articulates the "the story behind the story". Engaging in self reflexivity in this manner may enable the researcher to reach depths of her research; identify her biases; and be able to attend and shift them so that they do not confound with her work (Nagata, 2005: 15)

With regard to self-reflexivity I resided in the community to be studied. I had also worked in this community for over 5 years, and therefore had developed a strong relationship with the community. I also had a chance to observe overt behaviour and so developed interest in the topic of the study. The above mentioned exercise of self reflexivity was done and reference is made to section 1.2 in Chapter 1.

Complementary to self reflexivity is the fact that many ethnographers do not believe that understanding requires that they become full members of the group(s) being studied. These researchers believe the ethnographer must try to be both an outsider and an insider, staying on the margins of the group both socially and intellectually. The ethnographer must also try to see familiar settings as "anthropologically strange", as they would be seen by someone from another society. This process is known as the Martian perspective (Genzuk, 1999:9)

For the study, I conducted interviews and focus group discussions and listened to conversations. Field notes on the subject of sexual practices were made at

every opportunity that presented itself on the subject of sexual practices. I used non-participant observation. Data was collected between December 2005 and May 2006, which was a period of 8 months.

3.2 Research approach and design

This study is descriptive in nature. It is a qualitative study, using Ethnographic design. Ethnography is a type of qualitative enquiry that involves the description and interpretation of cultural behaviour (Polit and Hungler, 1999: 245). This study used ethnographic methodology since it aimed at studying the cultural practices of married women whose partners were away. The emic perspective refers to the way members of a culture view their world, and this has been referred to as the insider's view. This study focused on the emic view, which is the local language, concepts or means of expression that are used by the members of the group under study, to name and characterize their experiences.

A quantitative approach was not seen as suitable for this study "as it would not have allowed the emic perspective of participants to be studied" (Polit and Hungler, 1999: 245). Quantitative research is mainly guided by the researcher's preconceived ideas. The researcher's reason for choosing ethnographic approach is that ethnography allows for "understanding of people on their terms and within their context instead of applying theory which could be discriminative"

3.3 Study population

The rural population in the Demographic Surveillance Area (DSA) of Africa

Centre for Health and Population Studies, the Hlabisa sub-district is situated in the southern part of Mkhanyakude District Municipality, and was chosen as the study population. The DSA is situated about 250 km north of Durban. The area is characterized by rural decentralized homesteads under traditional authority, and a peri-urban township with formal and informal settlements under the municipal authority.

This population is generally a black community and in 2001 the socio-economic status of the area was described as follows:

Thirty eight percent (38%) of the households in the DSA had access to piped water, either in their dwellings (8%), in their yards (15%) or at a public tap (15%). Boreholes provide a safe alternative in 13% of households. A large proportion (42%) of households had no access to clean water as most relied on water from a flowing river or a stream and 7% had to use stagnant water, with all the resultant hazards.

Half of all households in the DSA reported using a pit latrine. A small fraction (4%) of these, had a ventilation-improved (VIP) pit latrine and the rest the (46%) used ordinary pit latrines. Thirty nine percent of households in the DSA reported that they had no toilet facilities and the rest had a waterborne sewerage system (these respondents lived in the township). Half of all DSA households had electricity.

As far as education is concerned, the average 20 year old had completed over 7 years of schooling; 40 year olds 4 years of schooling, and 60 year olds only 2

years of schooling. Thirty eight percent (38%) of the population aged 15 to 65 reported that they were currently employed. Twenty five percent (25 %) were unemployed and the remaining 37% were not economically active. Thirty six percent (36%) of all children under the age of 7 have had some contact with the child support grant system, and between 80 and 90 per cent of children aged 1- 6 years who had contact with the system had been receiving grants since 2002. Households rely on both informal and formal money borrowing for consumption and financial risk management. Households are often excluded from, or have limited access to, savings and borrowing mechanisms (Zambuko and Mturi, 2003:46-76). The study population comprised only women from the local community. It comprised married and unmarried women from the ages of 20 to 90.

3.4 Sampling, selection and identification of study participants

A sampling frame was used which was the pool of potential population in the Africa Center Demographic Information System (ACDIS) on migration data (This data was solely for homesteads in which there was a man who was away on migrant labour). Systematic sampling was used by selecting every 5^{th} homestead from the pool giving a total of 10 homesteads selected for the study.

Selection for In-depth interviews

Fifteen (15) women were selected for in-depth interviews. These comprised five (5) unemployed married women of migrant labourers, five (5) key informants of elderly women and five (5) employed women of unemployed men selected.

Selection of unemployed married women of migrant labourers

From the 10 homesteads selected from the pool two (2) unemployed women of migrant men were selected from 2 homesteads. The additional three (3) women were selected through snowballing, where respondents pointed out others who met the selection criteria. A total of 5 unemployed women of migrant men were selected.

Selection of key informants

Purposive sampling was done to select five (5) key informants from the remaining eight (8) homesteads. This second group selected for the in-depth interviews was defined as elderly female community members who had been married to migrant men for many years. They had grown up children who were migrant workers themselves. These key informants were selected because they were in a position to have a good knowledge and experience of the life of a wife of a migrant husband. They were also living with the daughters-in-laws in order to give an account of their daughters-in-laws' life styles. The 5 key informants were widows older than 55 years of age.

Selection of employed women of migrant labourers

The third group of women participants comprised three (3) employed women selected by purposive sampling. Further two (2) women were selected by snowballing. In all 5 in-depth interviews were conducted

Selection for focus group discussions

Participants for the focus group discussions (FGDs) were different from participants for in-depth interviews. Thirty eight (38) women were selected for FGDs and five (5) FGDs were conducted. Participants were distributed to five FGDs as follows: FGD 1 had 5 participants; FGD 2 had 7 participants; FGD 3 had 7 participants; FGD 4 had 10 participants; FGD 5 had 9 participants.

One of the FGDs was conducted with a group of young unmarried women, which I selected from a group of trainee fieldworkers. Four (4) other focus group discussions were conducted with women from other households in the DSA. Among these four, one constituted of married and unmarried women. Some of the married women in this focus group were not married to migrant men. This was done in order to get a general experience of what other women felt with regard to vulnerability of women to HIV infection in general and vulnerability of women of migrant men in particular.

Other FGDs were conducted with the study participants who had been identified by the Community Health Workers CHWs. Participants identified by these CHWs also identified other participants whose husbands were migrants through snowballing. This kind of sampling used to identify women of migrant men to form focus groups was done until saturation was reached. Elected participants for FGDs included married and unmarried women aged between 20 and 55 years.

Process of data collection

Data collection started with in-depth interviews of the key informants to get an idea of what happened when they were still women of migrant men. The interviews consisted mainly of the history of what happened to them when they still had their husbands working away from home, compared to what they saw happening with the younger wives of migrant men. The next step was to conduct a focus group discussion with unmarried women to assess what they knew or had seen married women of the day do while their husbands were away. This data would give me a picture of what other people conceived as sexual behaviour of the old and the young women who were married to migrant men. It would also refute or support what the women of migrant men conceived of what constituted their own sexual behaviour. Over and above, this data would help provide the area of focus when actually interviewing the women of migrant men.

After interviewing the old women, three (3) in-depth interviews were conducted with unemployed married women, in order to get a picture of what sexual practices married women engaged in while their husbands were away. Data obtained from the first focus group discussions and the first interviews formed the platform for the interviews and focus group discussions that were still to be carried out with other groups of women. These interviews and the focus group discussions were also used to verify what women in the first interviews had said.

After the interviews of the key informants and the 3 focus group discussions, the interviews for married women and 2 focus group discussions were conducted

interchangeably, i.e. 3 interviews, a focus group discussion, 2 interviews and the last focus group discussions. The reason for following the process of data collection using focus group discussions and interviews interchangeably was to verify data already obtained. Verification of data would ensure consistency and quality of data collected. Data collection would be according to my own sense of what data still needed to be obtained.

The smallest focus group discussion had 5 participants and the largest focus group discussion comprised 10 participants. All participants were selected based on their informed consent. Preliminary information of how to introduce the study was given to the CHW. On the day of the focus group discussion, full information was given to the participants to obtain informed consent. The information consisted of explaining about the purpose of the study as obtained on the Information Sheet (Refer to appendix C).

Selection of participants for the focus group discussions was also guided by socio-demographic factors in terms of age, employment/unemployment, migration, marital status, and education level. This information was used by both the researcher and the CHWs in the selection process.

Sample size

In qualitative research, rather than being predefined, the sample size is determined by data saturation, meaning that the sample size is considered

sufficiently large when no new data is obtained (Kempkes, 1999: 18). For instance, before the actual process of data collection started, it was anticipated that more interviews with married women and fewer interviews with key informants would be enough to give the required data. At the end, however, 5 interviews with the unemployed wives of migrant labourers, 5 interviews with key informants and 5 interviews with the employed migrant women were conducted to provide satisfactory data according to my discretion. In addition to the 15 in-depth interviews and 5 focus group discussions were also conducted.

3.5 Data collection method

Demographic characteristics

Demographic characteristics of participants were collected. This information served to provide individual attributes that were needed in data analysis. Fifteen (15) interviews and 5 focus group discussions (FGD) were conducted. The demographic information of the participants is illustrated below:

Table 3.1: Description of participants

Ages in years	Number	Identification	Education	Occupation
55 to 90	5	Key informants comprising widows whose husbands were *once migrants during their* lifetime, with whom in-depth interviews were conducted.	Grade 0 to 6	Pensioners, with one non-pensioner selling 'love *medicines' to women having* problems with their husbands
20 to 55	5	Unemployed wives of migrant men whose husbands were still alive and on migrant labour, with whom in-depth interviews were conducted	Grade 4 to 10	Majority were housewives. One had a sewing machine and was selling clothes at pension pay points. Another one was making grass sleeping mats

30 to 50	5	Employed wives of men who are unemployed with whom in-depth interviews were conducted.	Grade 5 to 10	Three (3) domestic workers, 1 self employed and 1 general assistant in a hospital.
30 to 50	5	FGD 1: Wives of migrant men.	Grade 7 to 10	Five (5) housewives and unemployed women.
30 to 49	7	FGD 2: Wives of migrant men	Grade 4 to 8	Six (6) housewives and one (1) Community Health Worker.
31 to 44	7	FGD 3: Wives of migrant men	Grade 8 to 12	All seven (7) involved in income generating projects like craft and sewing.
25 to 40	10	FGD 4: Mixed group of married and unmarried women.	Grade 6 to 10	A few involved in craft and some in gardening. The unmarried women are not involved in any project
20 to 30	9	FGD 5: Unmarried women	Grade 12 +	All nine (9) trainee research fieldworkers.

In-depth interviews

In-depth interviews were conducted with married women whose husbands were working away from home as well as with women who were working away from their homes while their husbands were non-migrants. This included unmarried women living with their regular partners in a cohabitation relationship with the family regarding them as legal wives.

In-depth interviews were also conducted with old women above the age of 55 years who served as key informants. Women of this age group were selected because of the experiences which they had had when they were young married wives whose husbands were migrants. These older women were in a good position to compare their activities as young women when their husbands were away with the behaviour of contemporary women in a similar position. Thus they

would give a historical picture of sexual behaviour patterns and personal histories. Interviews were tape-recorded while the scribe took notes.

In practice in-depth interviews that are unstructured generate more individual data as they accord the researcher more flexibility to adapt to the individual participant. Interviews in this study were conducted in an informal way so that the participants were able to introduce more issues which had not been anticipated by the researcher. In-depth interviews also ensure a high level of confidentiality. In this study, the interview guide was based on the issues related to the objectives of the study and this guide was used during the interviews (Refer to appendix D as based on the study objectives in section 1.3).

Focus Group Discussions

Focus group discussions were conducted with the study participants who had been identified by the Community Health Workers. Participants identified by these workers also identified other participants whose husbands were migrants.

Five focus group discussions were conducted. These discussions were semi-structured, focusing on migration and changing relationship patterns. Topics covered included the prevalence of different kinds of relationships and the historical emergence of sexual relations, which married women engaged in while their husbands were away. Data on sexual relations was to date back about hundred years ago, as older women told of what they had heard happening in generations before them. Factors perpetuating the presence of these

relationships, access to environmental resources (human, economic and material resources) and the effects these resources had on sexual relationships, informed part of the interviews. The influence of cultural, gender and social factors on the emergence of such relationships, women's rights issues, knowledge of HIV/AIDS, risk factors and implications they have on the progression of the epidemic were also discussed. In the case of the focus group discussions, discussions were conducted using the interview guide based on the basic issues of the study and the initial findings of interviews with other participants and the key informants (Refer to appendices E and F as based on the study objectives in 1.3).

3.6 Research assistant

Recruitment

As a researcher for the study, I recruited one Research Assistant (RA) to work with. This was done because the sample was too large for a Master's Degree and in view that this is a qualitative study I needed assistance. Her role was limited to logistics for conducting the interviews and FGDs. For example organing of venues, equipment, and transport).

The criteria for the recruitment of the RA was the ability to speak the local language and also be fluent in English. There was no need to train the RA as she was previously involved in similar work and therefore familiar with the logistic process in the research environment.

3.7 The participants' portfolio

The women interviewed were of 3 different categories, namely: wives of long-term migrant men who worked either in Johannesburg, Durban or Empangeni, who came home sometimes at the month end or on alternate months, or on Easter and Christmas holidays. Another category was wives of short-term migrant men, who visited home at weekends and month ends. The third category was elderly women of more than 55yrs of age who were either mothers of migrant men, or had their husbands working in Johannesburg or elsewhere during their married life.

Two of the focus group discussions comprised a mixture of 18 both married and unmarried women. Of these, eleven (11) women were married and the remaining seven (7) were unmarried. This mixture deviated a little from the planned sample, which stipulated that only married wives of migrant men would participate. This deviation was because it was perceived that married women could be biased while unmarried women could give an objective account of what was happening in the married women's sexual lives.

There was a great deal of cooperation from the participants. They were enthusiastic to talk about their own experiences and about what was happening around them. The older women were particularly happy to narrate what had happened in their times, when they were young and what was happening now. These older women obviously felt that the young generation of wives was immoral. The young generation attributed this immorality to several causes like

the food they ate, loneliness, poverty and other causes as will be discussed in Chapter 4.

The younger women, wives of migrant men, were equally enthusiastic to tell stories about their miserable lives. There was no difficulty in obtaining the information the researcher wanted.

3.8 Data collection strategies

The researcher tape-recorded both the in-depth interviews and the focus group discussions, while also scribing some notes. (For interview guide please refer to appendix E). Confidentiality was maintained during interview sessions as I ensured the participants. They gave written consent for participation in in-depth interviews. Anonymity was also ensured as no document would be traced back to them.

3.8.1 The interview process.

The interviews were carried out with the participants in their own settings. This was usually in their hut, where privacy was maintained by asking the participants to have a private place away from the rest of the family members. The researcher politely explained that the questions to be asked were confidential and that she needed privacy with the participant. This was not a problem because normally whenever Africa Centre fieldworkers pay a visit, the community members show respect and provide the privacy needed.

Participants were generally participative and gave valuable information. Some however were a bit uncomfortable and did not want to give information. The majority, however, were very happy to be the part of the study. During the interviews, the interviewer could see that participants were giving information with the hope that they would get assistance in the form of an intervention to help them out of their desperate situations. Perhaps this was particularly so because in the introduction of all interviews it was mentioned that interviews would contribute to an attempt to design an intervention. Throughout the interview, the researcher had to guard against exaggerated or biased data.

With the participants in the focus group discussions, the researcher was assisted by peer leaders, as people who had "walked in the shoes" of the targeted group (Fluskerud and Winslow, 1998:75). The 'peer leaders' referred to were two Community Health Workers (CHW) from two different *izigodi* (meaning the area wards). CHWs normally have the profile of the community in which they work. They were therefore in a good position to communicate to female participants and campaign amongst them for the focus groups. Their role was to identify homesteads that had migrant men in their wards and bring together women to form focus groups. Each CHW was told that the criteria for the selection should be wives of migrant men not older than 55yrs of age. They were told about the grouping of these women and were able to organize them accordingly for interviews. The selected women met in a central area which was the Africa Centre offices.

During the FGDs the issue of confidentiality was also addressed as the participants were assured that there would be no disclosure to people unrelated to the study. Instead of real names pseudo-names were used during the FGD sessions. The sampling method using snowballing meant that the issue of anonymity would not be addressed as the members knew each other from the community. This was also due to the presence of the peer leaders.

Money was provided for transport and lunch was bought for them. They were not, however, made aware of this offer prior to the meetings. During both interviews and focus group discussions, the researcher created an atmosphere of mutual sharing and established a rapport with participants. The researcher was also a good listener who showed empathy when participants answered the questions earnestly and showed their heartfelt experiences. This she showed by reflecting, summarizing, paraphrasing and listening attentively. In this way she moved with the flow of the interviews, using verbal and non-verbal communication. Her empathy assisted participants to offer more information until the researcher felt that data saturation had been reached.

During both the interviews and the focus group discussions, the participants laughed and giggled as they were sometimes embarrassed. They also shed tears of sadness, dismay and anger. Others sometimes stared into space because of resigned feelings and desperation. At the end of the interviews, the researcher would ease the atmosphere by talking about the situation in a general manner over lunch. It was not unusual that during these debriefing sessions

more information would be revealed by the participants, owing to a more relaxed atmosphere. During lunch everyone would be at ease, as participants would "regain their composure" before going home. (See appendix E and F for an example of an interview and a focus group discussion respectively).

3.8.2 Alternatives to direct questions for interviews

Vignettes

As the study used qualitative methods, vignettes were used across normative responses to ground the discussions in concrete cases rather than abstract views (Green and Thorogood, 2004:99). These vignettes consisted of summary descriptions, such as an unemployed married woman who had had an affair, a woman who had divorced her husband and gained custody of her children, and others as will be discussed in Chapter 4.

Vignettes were used to prompt discussions around the problem in question and to find out the kind of solution that was appropriate (Green and Thorogood, 2004:99). Critical incidents were also used, for instance, to find out which group of women indulged in promiscuous behaviors: between employed women working away from home and unemployed women staying at home.

Field notes

Patton (1990: 287) postulates that "to capture a holistic view, the researcher should stay alert to what happens during informal conversations...no break for the dedicated fieldworker!" Though the researcher was not doing participant

observations, she kept a notepad in her bag so that each time any conversation or situation related to the study occurred, she was able to record it.

3.9 Trustworthiness

In qualitative research it is sometimes difficult to determine ultimate trustworthiness. To assess the truth value of qualitative findings the following criteria were used.

3.9.1 Credibility

Qualitative researchers recommend that for the credibility of the researcher to be ensured, the person undertaking the research should undergo a process of training to learn how to conduct interviews. This training should also include the researcher's experience, track record status and presentation of the researcher.

The researcher had enough experience in interviewing to attempt a study of this nature as her work for the past four years had involved doing Verbal Autopsy Interviews. Before this she was involved in training of Primary Health Care Nurses on interview techniques. Recently she had been a Training Manager for over 3 years, involved in training fieldworkers on how to collect data, using sensitive questions about sexual behaviour and sexual activities.

To accommodate other elements of credibility, I collected data using rigorous methods such as qualitative methods of enquiry, a purposeful sampling clarifying to the participants the nature of the research, conducting in-depth interviews herself, careful use of data captured using tapes to uncover areas of ambiguity

and uncertainty, and verifying the findings with (some) participants to ensure that they were the true reflection of their experiences. This checking was done to yield high quality data and was systematically analyzed with attention to issues of credibility.

3.9.2 Bracketing

According to Patton (1990: 111), to bracket is to suspend own beliefs in reality in order to study the reality of everyday life as experienced by the people in the setting being studied, as they are trying to make sense of their world.

Before the beginning of research, ethnographers typically take time out to review personal biases and the experiences that may interfere with their ability to listen and observe. Ethnographers must establish internal emotional boundaries to separate personal experience from interactions with the host culture (Polit and Hungler, 1999: 248).

Field and Morse (1995: 88) recommend that, in the process of bracketing, a researcher must examine and declare any underlying values and assumptions about the phenomena under study. The researcher undertook some bracketing before embarking on this study. Ethnographic bracketing texts appear in various forms e.g. "short stories, poems, fiction novels, photographic essays, personal essays, journals...and social science prose" (Patton, 1990: 87). It is through these texts, that emotions and self-consciousness are featured. Firstly the

researcher considered her own preconceived ideas about the phenomenon under study and attempted to put them aside. Thus the researcher bracketed off by use off her own devastating experience so it could not overflow into her study. This she did by drawing the following poem, which explicitly pictures the experiences and preconceptions on the topic under study:

I am a Woman of the new Millennium

I am a woman, the unprivileged; he is a man, privileged and powerful

He claims he loves me but he tames me submissive

I have nothing to claim he has everything to claim

Because I am a woman, and he is a man

I don't look him in the eye because he is a man

I don't question his whereabouts, he is a man

I don't go anywhere with him because I am a woman

I don't have feelings and I therefore make no qualms

Because I am a woman, and he is a man

I came to him with nothing, I thus have nothing

Even the body I have is his, and I have no say

If he sleeps away I neither ask nor raise a complaint

He does what he likes because he is but a man, and I am a woman

When I wake up at 4 am and sleep at 10 pm

When I fetch water, wood and make fire

When I cook, wash and go to the fields

When I feed chickens, pigs and bear children' it is all but nothing

Because I am a woman, and he is a man

I am tired. I am fed up and am angry

I have rights, have choices but have no power

I have feelings, I am human but unhappy

I have had enough am fed up and will take no more

Because I am a woman of the new millennium

(Compiled by me)

3.9.3 Triangulation

According to Patton (1990: 147), triangulation is a methodological approach making use of more than one "data source and analytical perspective to increase the accuracy and credibility of findings". In the context of qualitative studies, this concept refers to comparing and cross-checking the consistency of information derived at different times and by different means (Patton, 1990: 558). It is used to test for consistency in findings across different kinds of data to offer opportunities of deeper insight into the relationship between inquiry, approach and the phenomenon under study.

In this study triangulation was used to cross check information elicited from interviews and Focus Group Discussions. Means used in the study included different types of purposeful sampling (choosing of interview participants, a FGD of unmarried women, and snowballing) and the use of different methods of data

collection. This process also included comparing what participants said in public in the focus group discussions, and what participants said in private in the in-depth interviews.

The participants said the same things consistently. These views were also seen from different perspectives, that is, the perspective of younger married women and elderly married women. Even the field notes taken of what people talked about confirmed what had already been said by participants. In addition to interviews and focus group discussions, story telling and field notes were used to identify patterns of occurrences and commonality of incidents.

3.9.4 Transferability

Transferability can be described as the process of applying the results of research in one situation to other similar situations. This means that if there are enough similarities between the two situations inference that the results of the research would be the same or similar in the other situation is made.

Transferability is also explained as referring "to the degree of congruence between the context in which research was conducted and the new context in which research is to be conducted" (Barnes, J. Conrad, K., Demmont-Heinrich, C., Graziano, M., Kolawinski, D., Neufeld, J., Zamora, J. and Palmquist, M. 2005: 3). Therefore, if the context in which research was done is similar to the context in which a similar research is to be done, the same methods become applicable.

This process is followed because qualitative data are firmly rooted in specific context.

It would be feasible to apply lessons learned in the context of this study to similar contexts in other studies, as the researcher has provided enough description of the research context, characteristics of the study, nature of the participants' interactions with the researcher and the physical environment. She also used components of the conceptual model, that is demographic characteristics of the participants that make them fit to a definition of vulnerable populations (Flaskerud and Winslow 1998:). Consequently, a 'thick' meaning, a rich and thorough description of the research setting or context and of the processes and transactions observed during the enquiry was done. The inclusion of a theoretical framework guiding the study enabled the researcher to determine if the study is transferable to other settings, which it is (Reference is made to Chapter 2 above, on The Feminist Theory and The Conceptual Model of Vulnerable Populations).

For the purpose of both bracketing and transferability, it is crucial to mention that participants for the focus group discussions (FGDs) were different from participants for in-depth interviews. [Thirty eight (38) women were selected for FGDs and five (5) FGDs were conducted. Participants were distributed to five FGDs as follows: FGD 1 had 5 participants; FGD 2 had 7 participants; FGD 3 had 7 participants; FGD 4 had 10 participants; FGD 5 had 9 participants].

3.10 Pilot study

A preliminary study was conducted. One focus group discussion and two in-depth interviews were conducted during the pilot testing to explore the feasibility of the study, to develop the interview guide further and to check that it was understandable and elicited the required kind of information. The data obtained from the pilot study was included in the study since qualitative researchers argue that every source of data is important and should not be separated from the study.

3.11 Translation

Interviews were conducted in the local language, thus instruments for data collection were translated from English into the local language of the participants. Experts in research do this to ensure that information is not distorted and to minimize errors that arise with verbal interpretation by interviewers (Scotts, Coulibaly and Verall, 1988: 59). Data was then translated back into English and compared with the English original version of the questions. Data was taped and transcribed. It was then back translated into English.

3.12 Data management (handling/storage)

The taped data and the notes captured during data collection were labelled, using Africa Centre Bounded Structure Identification numbers. These are the unique numbers allocated by the computer for every homestead mapped when it joins the Demographic Surveillance Study. The names of the household members were not attached to the data collected. Taped data was entered into

the computer through use of a digital voice editor program. Transcribing was then done within 48 hours of data collection, for accuracy and correctness. Data in hard copies were kept under lock and key to prevent access by unauthorized persons.

Transcription of data

The researcher was actively involved in transcribing the taped interviews into text. The researcher had to proofread the text by playing back the tapes. This gave the researcher a chance to further familiarize herself with the narratives. All verbal and non-verbal cues were elicited from the narratives.

3.13 Data analysis

Analysis was done to provide information to meet the objectives of the study. The researcher read through all the interviews and made notes in the margins and the data was then organized into topics and files. From the data themes or patterns were identified. Several readings were made in order to develop a coding scheme. Eventually the researcher came up with experiential themes and their sub-themes where data with common as well as unique themes and patterns were organized. This helped her to capture and code the stories of the research participants in a standardized framework to describe what was collected during fieldwork. No computer programs were used to analyze data collected, but data analysis was done manually by the researcher, using the themes and sub-themes.

3.14 Ethical considerations

Permission was first sought from the Africa Center Directorate to do the study in the Demographic Surveillance Area of Africa Centre for Health and Population Studies. This was on condition that Africa Center Ethics Committee accepted the proposal. Research was only done when ethical clearance was obtained. The Africa Centre Ethics committee accepted that the study could be done in its Demographic Surveillance Area. Permission was also sought from the University of Natal Ethics Committee after submission of the study proposal. Finally, informed consent was obtained from community members from the selected households after the informed statement was read to each of them. (Refer to appendix C for the information sheet).

The importance of anonymity and strict confidentiality was emphasized because of myths and secrecy surrounding HIV/AIDS and the fear of stigmatization. Joining the study was voluntary, and the participants were free to terminate their involvement if and when they wished or could skip questions that they felt were too sensitive. The researcher conducted interviews herself and because of her experience she was sensitive to the feelings of the participants and did not push too hard or over-probe the subjects.

To ensure that confidentiality was maintained, each participant interviewed had her own code number. Interviews were recorded digitally. When transferred on to a computer these numbers were password protected. Backup files were also password protected by a barcode number only, which was labeled 'transcripts'.

Confidentiality was ensured since, in order to ascertain the name of the interviewee, the interview number had to match with the codebook and both items were kept in separate secure places.

Africa Centre had already been conducting various studies in the area so there was low risk of stigma associated with visits from the Centre researchers. Only the researcher had access to the information given by participants and did not disclose it to anyone who was not concerned with the research. Any alleged breach of confidentiality was to be investigated. The researcher established rapport at the beginning of the interviews and the focus group discussions, and discussed the issue of secrecy and confidentiality with participants. Interviews were conducted in rooms with adequate privacy, which allowed minimal interruptions.

3.15 Constraints and limitations

An important constraint on the study was the limited time available for the actual field study and data analysis and report writing. This made it impossible for the researcher to present the findings of the analysis to all the participants in order to verify if these correctly reflected their perceptions and experiences. One key informant and two married women were contacted for this purpose, and they gave the verification that the findings reflected their views. Verification endorsed the credibility of the findings.

Sexual behaviour in most societies has been a very sensitive topic to talk about as it involves probing into the most private space of the inner self. For this reason

very relevant and appropriate approaches needed to be applied, in order not to violate people's personal space. In Zulu culture, talking about sex is taboo, particularly to strangers and more so to the opposite sex. It should therefore be expected that in such a culture, some degree of resistance might be experienced This may lead to participants not giving actual information about their feelings and experiences as they might feel it is against their norms and thus unacceptable.

To counteract this, researchers who were familiar with the local culture and language were involved in the study. This was so particularly because of the sensitivity of sexual language used by local people, which needed well informed researchers. Moreover, when giving information the participants would tend to talk in the third person even if the issue pertains to them.

A limited number of respondents would possibly decrease the representativeness of the study but would not affect the validity of the study and would not be generalizable to the rest of in population, owing to the sampling method used and by the limited size of the sample. The findings of the study do, however, provide an indication of trends and could inform further research, meaning that the sampling method used in this study could be transferred to other similar population groups (transferability). Limitations of the findings of the study will be discussed in Chapter 5.

3.16 Experiences in carrying out research in the field/ Africa Centre.

The researcher encountered a few difficulties in carrying out the Focus Group

Choice of which life skills should be included in the intervention was not a dilemma as the participants displayed their needs in terms of life skills training.

3.17.4 The content of the intervention

The intervention has six (6) modules namely: (1) anatomy of the female genitalia. (2) HIV/AIDS awareness. (3) Gender and Health. (4) Women's reproductive rights. (5) Communication and assertiveness skills, and (6) Economic skills development.

Development of the modules was based on the above-mentioned 'HIV/AIDS education and life skills programme' (Van Dyk, 2005: 147). However, this was also strongly supported by findings of the study as mentioned in the above section. For instance, excerpts derived from the participants during interviews and focus group discussions, are relevantly cited in each module for the purpose of substantiation for choosing it. In this regard, reference is made to Chapter 4. Such training, it is believed, will enable women to apply these skills in different situations thereby reducing their risk of HIV infection (Boler, and Aggleton 2005: 1). The choice of teaching methods and their explanation is described in the modules.

3.17.1 The Designed Intervention

With reference to the previous chapters, reports on HIV infection revealed that more females were infected than men. This was attributed to various factors, some of which are discussed in Chapter 4. These include the socio-cultural

dynamics of the patriarchal system embedded in the culture, particularly in the Zulu ethnic group. This system is inherent in the people's belief system so that it shapes their behaviour. Such behaviour places them in a vulnerable position to become infected with HIV.

Together with the already mentioned factors, there are also socio-economic and political factors that aggravate the situation. These factors are unemployment, the political history of South Africa, poverty, unemployment and migration. Even more importantly, programmes that aim to change people's behaviour need to be informed by an understanding of the way in which such behaviours are shaped by socially negotiated identities within particular social context-issues that are central to the current research (Camlin, Graeme and Moultrie, 2002:276).

To understand the situation of women and therefore develop a strategy to help them, a study of this nature had to be conducted to give a baseline or situational analysis of the problem, its causes and how to combat it. From the beginning of data collection, focus group discussions and in-depth interviews formed the basis of the intervention, by providing adequate input to the formulation of the intervention programme. Probing provided data on how the programme would be formulated, what its content would be in order to be successful, how it could be conducted and by whom.

3.17.2 Implications for Health Interventions

Working within a Vulnerable Groups Framework in the context of Feminist Dependency Theory, attention was given to the way social identities are forged, and the challenges of the socio-cultural context that makes women living with migrant workers particularly vulnerable to HIV infection. In particular, attention was paid to the role played by components of the framework (availability/unavailability of resources, risk factors, health status, morbidity and mortality in the woman's plight as a vulnerable group.

The Conceptual Model for Vulnerable Populations research and practice postulates that peer education by members of targeted group should develop and maintain any health programme (Flaskerud and Winslow, 1998: 16). The intervention derived from this study will be used on other community programmes that aim to sensitize communities to socio-cultural factors that impinge negatively on them and to empower vulnerable populations to protect themselves from HIV infection through capacity building life skills. Those wanting to use the intervention must be aware that it has never been tested. Thus it needs modification according to the group with which it will be used.

The intervention was developed based on the study findings as discussed in Chapter 4, and is shaped by the theoretical themes tabulated in the same chapter.

3.17.3 Purpose

The intervention aims to develop awareness among women in sexual

"...He only had liver damage, he was not infected. I am not infected because... we had a period of four years not sleeping together".

These statements show lack of understanding of the length of period HIV lie dormant before progressing to AIDS. The expression also shows women's ignorance of co-morbidity, as the wife believed that death of her husband was only due to liver problem. Based on this a decision was made that women need in-depth education on HIV/AIDS epidemic.

3.17.4.3 Module 3: Gender and Health

Society expects males and females to behave in a certain way. It prescribes how they should behave, which results in women being subservient to men. As a result women, have no decision-making powers in sexual matters. This, with the idea of masculinity which allows more than one partner for men, makes women vulnerable to get HIV infection from their male partners. This makes HIV/AIDS both a social issue and a health issue. One of the participants during the focus group discussion said, *"She becomes just like a sister to her own husband and the younger wives call her "mama" The husband does not visit her anymore. That is why the older women have 'amashende' (extra-marital partners)".*

The topics in this module include the explanation of gender as a concept, gender equality, gender equity, gender roles, sex role stereotypes and how these are reinforced. The modules on the anatomy of female genitalia will compliment this

module so that a better understanding of how females easily get infected with sexually transmitted infections in comparison to men can be provided. The above information and exercises provided in the module and discussions in other modules will help women understand the gender and health link (HIV/AIDS-gender link) and therefore empower them to protect themselves from risky sexual behaviour.

Over and above the content of these discussions, the module will help women understand their situation and so accord them knowledge of how to cope with their situation so that they do not become victims of sexual exploitation by their sexual partners. Interviewed on participant said, *"...When married educated and employed women see this (exploitation), they say that they will never get married because emzini kuyahlushekwa (women are ill-treated in marriage)"* Mothers-in-law were pointed out as part of agents that perpetuate the married younger women's situation.

3.17.4.4 Module 4: Women's Reproductive Rights

In the Bill of Rights, the South African Constitution recognizes women's rights as basic human rights. Though women know that they have rights, they do not know exactly what these rights are. Even if they have a glimpse of what these are, they are not able to exercise them. The module will provide women with knowledge about their rights and will also empower them to exercise these rights.

Regarding this, one of the participants said, *"Your only right is to be a wife; to be able to stay with him. When he did not come back home he was obviously with a girlfriend, so what?"*

In the study younger women showed that they knew that they had rights, but also showed that they had no voice and were expected to be submissive to their husbands. Knowing and exercising their one's rights is part of the concept of life skills. It assumes that having access to the resources and power, people may be able to change their lives (Boler andAggleton, 2005). Thus educating women on their reproductive rights and how to exercise them will empower them with knowledge and skills they need.

3.17.4.5 Module 5: Life Skills Development (Communication and Assertiveness Skills)

It has been highlighted above that women lack the skills to communicate with their sexual partners in sex-related matters. They are not assertive enough to negotiate safer sex with men. As illustrated in Chapter 4, the study showed that women cannot communicate sexual matters directly with their husbands. They usually communicated through their mothers-in-law. It was decided that developing a module that would incapacitate women on sexual negotiation and communication skills will enable them to discuss sexually related problems. In turn this skill could empower then to avoid becoming infected with STIs and HIV.

3.17.4.6: Module 6: Economic skills development

From the study, poverty emerged as one of the factors that drive women to engage in extra-marital relationships. Boler and Aggleton (2005: 9) contend that if one of the goals is to reduce poverty, or gender inequalities, then using the HIV platform is a useful tool. This corresponds with one of the strategies pointed out by participants that, what will enable them to become economically independent (so that they do not engage in practices that make them vulnerable to contacting HIV infection), would be development of economic skills. It is necessary to empower married women, so that they do not depend entirely on their husbands. They need training in economic skills. This need was substantiated by the following excerpt from the participants, *"We are engaged in economic projects…but this ends nowhere as we buy food with the income"*.

Although women engage in income generating projects, these are just enough for subsistence and so they remain poor and economically dependent on men. This module will help address the economic problem by providing necessary skills.

The facilitator is required to arrange for a specialist in economic development to come and address the participants and educate them on how to start their own small businesses, how to raise funds and how to enter into the labour market. It is only when women have acquired these skills that they will be able to make

their own decisions regarding sexual matters and be able to fight against being infected by men with HIV/AIDS.

3.17.5 Method of teaching

Women are social beings who "live in a complex web of social and cultural interactions, which frame their decisions and actions" (Boler and Aggleton, 2005:7). This means that there is a need to take local context into account as behaviour change is influenced by combination of factors including the interaction with others. This ideology strengthens the notion of the study that life skills training and AIDS education is provided to a group of women as their self identity occurs in a collectivity; within a family or community (Boler and Aggleton, 2005:7).

These two authors further contend that, in order to conduct life skills training, participatory methods of teaching are more relevant, as they would make participants responsive, raising questions rather than providing clear cut answers. They would also be challenged to find new ways of relating to one another and to their situations (Boler and Aggleton (2005:4). Based on this evidence, the researcher selected the participatory teaching methods to be used for training on the intervention - HIV/ AIDS education and life skills training (Van Dyk, 2005: 156).

Following are the participatory teaching methods to be used:

- Open discussions
- Exercises

- Group work
- Case studies
- Role plays
- Story telling and songs

3.17.6 Teaching medium

There was no specific indication that women who are highly educated, and professional are not affected by the socio-cultural, political and economic factors revealed in this study. It is therefore assumed that they are also affected by same factors. The intervention can thus be used with all classes of women from the local Zulu ethnic group. This will mean that the Zulu language can be used to conduct workshops. The use of Zulu will depend on the group preference of the media.

3.17.7 Monitoring progress

The use of the intervention tool can be evaluated by use of group discussions with the facilitators and participants. The effectiveness of the training can be assessed through interviews with course participants and the evaluation tool issued to the participants at the end of each session. Where the participants are illiterate, a round of verbal expressions will be used, with the facilitator posing relevant questions and probes.

3.18 Conclusion

The chapter gave an elaborate picture of the methodology adopted in data collection for the study. Data collection was done over a period of 8 months; from December 2005 to May 2006. This is a qualitative study, descriptive in nature

and of an ethnographic design to study the cultural practices of married wives of husbands in migrant labour. The study was conducted in Northern KwaZulu-Natal in the DSA of Africa Centre for Health and Population Studies. Systematic sampling was used by selecting every 5th homestead from the pool of homesteads in the ACDS. Fifteen in-depth interviews were conducted with 5 unemployed married women, 5 employed women and 5 key informants over the age of 55 who were selected for their personal experiences as wives/widows of migrant men and their observations of the younger generation of women married to migrant men. Five focus group discussions were conducted one of which comprised a group of unmarried women in order to give an objective account the sexual practices of married women while their husbands are away. Data was tape recorded, transcribed and translated before storage. Vignettes and field notes were also used as methods of data collection and means of triangulation to ensure accuracy of data obtained.

Based on the data collected, an intervention would be developed, as one of the study objectives. The intervention aimed to empower women with life skills to protect themselves from the vulnerable situation they are placed in by their partners.

CHAPTER 4: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents how data analysis and interpretation of findings was done using ethnographic approach. Analysis involved attaching of meanings and significance to the analysed findings as they emanated from analysis of data collected through interviews, focus group discussions and field notes. The chapter will also cover the method of data analysis used, and excerpts elicited by the participants during interviews and FGDs.

Process of data analysis

In ethnographic research, "the analysis process involves consideration of words, tone, context, non-verbal cues, internal consistency, frequency, extensiveness, intensity, and specificity of responses" (Krueger, 1994: 6). This refers to narrative analysis where meanings are attached to experiences with participants giving their own interpretations and explanations of events (Aikinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland L., 2001).

Findings of this study are looked at in a historical context, comparing trends of what happened in previous generations with what is happening nowadays. For instance, the practices that married women used to engage in and are currently engaged in and the reasons for these changes will be uncovered. Acceptance of these practices is discussed and the implications of these have on women's

health status in general and the spread of STIs including HIV and AIDS in particular.

Results regarding factors perpetuating married women's engagement in such practices are also presented, and the risks they bring. Together with these an outline of married women's awareness of the consequences of these practices is made. This data will provide an understanding of the strategies that women think should be implemented to prevent their vulnerability to the infections.

As a researcher, I was actively involved in transcribing the taped interviews into text, I proof read the text by playing back the tapes, which gave me a chance to familiarize myself with the narratives. As the study adopted an ethnographic approach, data analysis meant that the focal point would be "identification of descriptive patterns, and looking for relationships and linkages among descriptive dimensions" (Krueger, 1994: 6).

Such patterns were categorized into experiential themes for each participant as identified in each interview and the FGD. Experiential themes were further sub-categorized into sub-themes and were used in analysis. The said experiential themes and sub-themes are displayed in Table 4.1 below.

The data collected was not much and did not need a soft-ware program to categorize it. No Microsoft program was used to analyze data collected, but data analysis was done manually.

Table 4.1 Themes and sub-themes	
Experiential Themes	**Sub-themes**
4.2.1 Sexual Practices of Married Women	• Historical emergence of these relations and their types ➢ Olden days *isidikiselo* relations, its emergence, acceptability and duration ➢ Present day extra marital relationships, *ishende*, its emergence, acceptability and duration ➢ Polygamy and cohabitation
4.2.2 Factors that encourage women to engage in these practices	• Dependency Theory (Marginalization, subordination, discrimination and stigmatization. • Socialization (gender, culture and religion) • Lack of sexual satisfaction
4.2.3 Resource availability: societal and environmental resources.	• Economic status (Income job, poverty) • Support system • Migrant men as a scarce resource for their wives remaining at home • Education knowledge and power • Access to health care and resources

Experiential themes	Sub-themes
Relative risk: High risk factors	• Migration • Alcohol abuse and health problems • Unsafe sex • Cultural practices • Feelings of helplessness or powerlessness • Significant others
Knowledge about the epidemic	• Transmission, signs and symptoms of AIDS • Prevention and beliefs/myths
Human rights	• Situation of a married woman
Health status: morbidity and mortality	• Unprotected sex leading to HIV infection

4.2 Presentation of results

As mentioned in the above section, detailed description and in-depth quotations elicited by the participants were captured, as they constitute essential qualities of qualitative accounts. In the presentation they have been included to allow readers to understand fully the research setting and the thoughts of the participants as they presented them in the narratives.

4.2.1 Experiential Theme: Sexual practices that married women engage in: historical emergence of these relationships and their types

4.2.1.1 Sub-theme: Olden days Isidikiselo, its emergence, acceptability and duration.

Extramarital relationships and relationships outside monogamous marriages are not new. The phenomenon has always existed. A key informant aged 60 years confirmed that married women in her generation did engage in extra marital relations. She also narrated a vignette she heard of such relations:

> *"Decades ago when the izinceku of a certain Inkosi were seen with the younger wives they were killed. In fact both the woman and inceku suspected to be her private sexual partner were killed. They were then thrown into the Inyalazi River, which had crocodiles. One day when one of the Inkosi's wives was suspected to have been out at night pretending to have diarrhoea, the izinceku were called to take her to the river. She suddenly stabbed one of them to death before they threw her into the river alive where she was eaten by the crocodiles.*
>
> *That was my grandfather's* (the inkosi) *prison - isiziba* (deep end of the river). *Recently the family has done a ritual to bring all of the spirits of women who were thrown into the river back home. It is said that those women are crying in the river"*

The narrative in the above passage as expressed by the older participant confirms the existence of *isidikiselo* relationships in the olden days and the feelings that prevailed towards them.

In olden days in rural KwaZulu-Natal, women's extra marital relations were indirectly called the top or lid (*isidikiselo*). The term was explained by the older

women who were key informants, in the interviews. According to them, the *ibhodwe*, the pot, was the primary man who paid *ilobolo* for the woman and *isidikiselo,* the lid (top), was the other man who was an extramarital partner of the woman. *Isidikiselo* occurred when the wife could not conceive a child despite treatment from traditional healers and Western doctors, or when, "*a woman married a man who was not a man – a man who had a problem with his manhood",* referring to the man who could not beget children or who was sterile. Further discussion of *isidikiselo* relations revealed that the women infidelity also occurred when the man had gone to the cities for a long time without paying a visit, *ebhungukile.*

Explanations given by both participants and key informants show that *isidikiselo* also played a role in keeping a woman in the husband's family for the continued existence of the family name. This kind of relationship was arranged by the family, particularly by the mother-in-law. The brother or the cousin of the husband or any man of choice of the family had to sleep with her to prove her fertility. This was a secret, as only few family members knew the arrangement. This relationship had to start when the husband was back from work so that should the wife conceive, the delivery of a baby would correspond to the husband's visit. On the other hand, if the baby was conceived in the absence of the husband she would go to Johannesburg where the husband was working and sleep with him so that it would look, as if the baby belonged to him while it belonged to *isidikiselo.*

When a woman was infertile, she was isolated and given names like *inyumba.* The naming occurred after all means to treat her had failed. She was sent to her own home for treatment and if she still could not bear children, another woman who could bear children was taken for a wife.

The study participants also reported that the husband was not made aware of these arrangements, even his wife could not tell him. This was done so that the woman would not leave because she was having a child, an old traditional belief that children hold the marriage together. Children born from such relationships belonged to the husband. This was a secret of the few in the family, as the rest of the family was not to know about it. Such extramarital relationships usually continued even after the first child was born so that sometimes more children were born from the same men, usually *isidikiselo*. This is best narrated in the following song from a popular M*asikanda,* a person singing traditional music:

> *"This child looks differently from the rest of the 7 children whose is it?" asked the man hitting the wife.*
> *"This child is yours, father," answered the wife* (in respect wives call their husbands father)
> *The husband hit her even harder "Who is the father of this child?" The woman seeing that she would die finally said," All the 7 children are not yours, father, but this is the only child that is yours"*

According to this song the last-born child was the only child that the husband had fathered as he had been away for many years in Johannesburg and only came home during Easter and Christmas holidays. He finally came back to retire, but it is just a song because there is no way that the husband could not know that

children born while he was away were not his. When both the key informants and the participants were asked about this, both groups knew the story and said that, seeing that the woman was pregnant the in-laws would send her to her husband so that they would sleep together. The man would then not be able to say the child was not his as they had slept together. The husband was then able to father this one child because he was finally staying with his wife, as the rest belonged to *isidikiselo.*

The *isidikiselo* relations operated in an ambiguous moral space. Though a woman was married and was expected to remain faithful, her husband's absence meant that her sexual and monetary needs were not met, which could result in her leaving the marriage. Arrangements of *isidikiselo* relations were seen as congruent with maintaining the integrity of *umuzi* (husband's home). It was acceptable as the husband was called *ibhodwe* and an arranged partner *isidikiselo.* The key informants supported this:

> *"Even before our times it was known that if a woman did not get sexual intercourse she would leave. But there was an arrangement made with the husband's brother (isidikiselo) for him to sleep with her. This was known to the family but was kept a secret from the husband. Even children born from the relationship would look like other family members. When the husband became suspicious of a child the older people would say "This child looks like a great grandmother who had already died when you were not yet born." The husband would be convinced. Children from this relationship were accepted and even thought of themselves as belonging to ibhodwe" (*meaning the husband*).*

In summary, the informants confirmed the existence of married women's extramarital relationships in the days when their own husbands worked away from homes. Most of the participants both married and unmarried admitted to

having heard about the olden days' existence of *isidikiselo* relationships. The difference between the two generations is that in the previous generation, it was accepted and was aimed at maintaining family integrity and for the continuity of family existence if the man could not father a child. For these reasons, extramarital relations were therefore arranged by the elder women in the family and were therefore accepted.

4.2.1.2 Present day extramarital relationships, ishende: emergence, acceptability and duration

I*sidikiselo* is no longer a common practice in KwaZulu-Natal. Instead women today engage in *ishende* relations. In focus group discussions, different participants also admitted that there is the existence of extramarital relationships. Participants restated the *isidikiselo* relations as they had heard about them and made remarks as follows:

- "Isidikiselo is an original practice", originated from the Zulu customs.
- "Ishende linqunu" not acceptable, not respectable.

One of the narratives from a married woman in one focus group discussion that showed relations of what married women do today, went as follows:

"Not long ago a married woman was caught sleeping with a married man. A certain man in the community knew about what was going on. He had a garden in the forest and he told the woman's husband about the relationship. The man asked for the husband's cellular phone number to phone him if he saw the wife and her lover in their usual place. The man called the husband who came and caught them. The ishende ran away. The husband was not working that day but the woman was not aware. At night the husband came back and hit his wife. He broke her leg and she was crying for help so loud that the man from the neighbourhood came to her rescue. This couple is old and their children are old too. One of

their children is a teacher. These people have electricity but the woman always goes out to fetch wood so that she gets a chance to meet ishende"

The narrative shows that infidelity amongst women is not confined to urban areas as is the belief or to women whose husbands are away from home but even women who live with their husbands engage in extramarital relations. The study is interested in the question: what sexual practices do married women engage in while their migrant men are away? The two vignettes have provided a picture of what happened in the olden days and what is happening today.

The participants said that though *ishende* relations were practised in the days of *isidikiselo,* it was not acceptable and therefore was not common. According to them *ishende* relationship with a stranger was kept secret from the family, and known only by the woman. A married woman with *ishende* was called *isifebe* (a loose woman with no morals). Married women had one *ishende* at a time because the aim was purely to satisfy her sexual needs. This relationship took a long time to develop. Even if the relationship was revealed and known to other people in the family or community, the couple did not end the relationship. Should the husband hear about this, the woman would be sent back to her home to come back with a cow for as penalty if her husband forgave her. Unlike a woman having *ishende,* the woman would receive no support from the family when caught, while a woman with *isidikiselo* was supported. The family members would sit down in a meeting and would jointly blame the man for going away for a long time as the cause of the problem as narrated by a key informant below:

"He was told that the fault was his for going away for a long time without visiting the wife and that she got tired of waiting. Some women cannot wait for their husbands for long. Unlike me I waited for him for the whole year. Other women were even laughing at me. He came back home, apologized and we continued with life".

When both the key informants and the younger married women participants related what happens in the extramarital relationships, they said a woman in *ishende* relationship met with her *ishende* away from home when she pretended to be fetching wood or water. *Ishende* would also be called *amadaka*. *Amadaka* or *amalongwe* is dry cow dung, which was used for making fire instead of wood where the latter was scarce. Women used to fetch *amadaka , like wood,* to make fire, and so meet with the *ishende.* Sometimes *ishende* would come and sleep in the home of this woman but as a traditional method of conveying messages the woman would sing aloud outside when she knew that the *ishende* was waiting until it was dark to enter the house. One of the key informants related to one of the kind of songs women sang to warn their *amashende* of the husband's presents:

"Ungezi, ungezi ukhon' umaqondana. Ungezi,ukhon' ubhodlendlini" (Do not come, do not come, the husband is there. The man is in the house).

I*shende* would be listening while the woman sang outside and would know that he should not pay the woman a visit as her husband is present. The singing did not alert the husband because this was a common song that could be sung by anyone in the community.

Some women changed *amashende* (plural for *ishende*). According to the participants, the only women who changed *amashende* were those who drank alcohol but otherwise *ishende* was a long time partner. The name *ishende* today is gradually disappearing. Instead *ishende* is called by different modern names, which make it comparatively less offensive. These names are: roll-on, private/secret, *umakhwapheni, uqedisizungu,* clutch bag etc.

The pattern of *ishende* relations as described by the participants shows that women are either changing partners regularly or have concurrent partners. They say this is so because women also steal the partners of their friends. When the participants were asked about the motive of the *ishende* relationship some said: *"The motive for ishende relation is ubufebe"* (promiscuity, looseness with no morals). One of the employed participants gave the following narrative to support the statement:

> *"There's this woman who fell in love with her friend's husband. They both, this woman and her friend's husband, divorced their marriage partners and got married".*

Recently it seems that sexual satisfaction has emerged as a factor among women. This is evidenced by their involvement with younger men who are believed to be more sexually active. These women will lure younger men with money and gifts. Many answers the participants gave, showed that *ishende* is no longer a secret. The participants said "*women do not hide ishende anymore*". They also verbalized that women even leave husbands for other men. Married women fall for very young boys for sexual satisfaction and give them money, their

cars to drive and pay school fees for them. Examples given by younger unmarried women are:

> *"A school teacher gave her car to a school boy with whom she was in love. The boy knocked down some children with the car but they didn't die. The teacher's husband left her"*
>
> *"One boy who is in love with another married woman has been hit by some boys who were sent by the husband. The same woman is paying for another boy's fees in the University. This one is also a teacher"*

The participants gave elaborate accounts of the consequences of *isidikiselo* and *ishende* relations. They mentioned unwanted pregnancies as one of the consequences and that a child that is born out of an *ishende* relation is called *ivezandlebe,* "let's see the ears show us the ears" This is an offensive name given by the husband's family to a child born out of wedlock and it marginalizes children born from this type of relationship. The participants explained that the name means that features like the ears were examined to confirm resemblance to *ibhodwe* as a father. If the signs did not correspond it was realized that the child was not of the family. In the case of *isidikiselo*, when the husband was suspicious, the grandmothers would say that the child looks like a great grandfather that the man himself has never seen. But in the case of *ishende*, they will expose the child by calling him *ivezandlebe.*

Laughing, the participants said that a woman would get support from her mother in law, when a child was fathered by a man who was not a family member, when the grandmother in the family knew and approved of the relationship. When the child was crying uncontrollably the grandmother would call the child's mother

aside and would tell her to take the child out and call it by its real clan name. Indeed the woman would do that and come back with the child no longer crying.

Further consequences of such relations, according to the participants, included marriages that ended in separations and divorces. Sometimes women are sent back to their parents to fetch a cow to cleanse the husband's ancestral home. Otherwise a woman could be sent back to her home permanently or after negotiation with the family, a site may be allocated to her just outside the homestead and a home for her and her children would be built. The worst response would be physical assault on the wife by a husband or even homicide. Though participants mentioned this as a consequence, they agreed that it was very rare for a man to kill his wife because of an *ishende* relationship. Despite these consequences, participants said that women still continue with *ishende* relationships. That is why key informants said that women today do not care about losing their marriages because:

> *"They are men themselves, they even wear trousers like men*
>
> *The president* (of South Africa) *gave them rights to do what they please*
>
> *It is the kind of food they eat today which makes them sexually active*
>
> *It is a fashion because when you talk sense to them they say "kwakukuqala lapho".*
>
> (Gone are the days things were done like that)

Some participants who were young wives of migrant men in the past said that women engaged in *ishende* relations because of:

- *Poverty, as men do not send money to their wives*
- *Loneliness*

- *Low morals or promiscuity*
- *Have no conscience*
- *Peer pressure, as they influence each other*
- *They want to level the score with their husbands, as they suspect that the husbands have other partners*
- *The man is impotent*
- *The upbringing from childhood*
- *Women who drink alcohol*
- *Uncontrollable sexual feelings*
- *Sexual dissatisfaction*
- *Women having no freedom of expression for their feelings - oppressed women*
- *Husbands drinking a lot of alcohol*
- *Ubufebe-nje* (just looseness)

As mentioned on the previous page, it was rare for a man to kill his wife because she had an extramarital sexual partner. Recently, killing of women is emerging. Men do not only kill their wives but they also kill their children and themselves. Field notes revealed that a similar occurrence happened a couple of years ago in the Africa Centre Demographic Surveillance Area (DSA). The narrative unfolds as follows:

> *"A very old man, a pensioner, left his wife for a young woman who was an induna's daughter. They had a child and the man had paid ilobolo as he wanted to marry this young woman. The induna seemed reluctant to marry them. One day the man invited the woman to his home where he killed the child and the mother by cutting their throats during the night. In the morning he went to Mtubatuba town and bought weed eradicating fluid which is highly poisonous. He drank the mixture whereupon they were all found dead with the empty container of poison at a later period".*

Among the people who were talking, no one seemed to know exactly why the man did this. Such situations were not mentioned by any of the participants. The media has shown that it is becoming common for a man to kill her partner. One

such report that made headlines in the Ilanga Newspaper of 5 to 7 August 2005, is about a man who killed his wife and a child (Refer appendix A).

The researcher also asked what constituted *amashende* for the wives of migrant men in this rural area. Participants reported that these may be boys, because women who engage in these practices say their husbands are becoming less sexually active. When this was questioned, the participants added clearly that this was so because men had relations with other women and came home too tired to satisfy their wives. One of the participants supported this by asserting that husbands are usually older than their wives and so tire sooner. The list they gave went from taxi drivers, teachers, traditional authorities, Ministers of Religion to an ordinary unemployed man as constituting *amashende* for the wives of migrant men.

The *ishende* relationship is not only confined to women whose husbands are migrant workers but is also practised by women who have husbands who work locally and who sleep at home every day as was mentioned in the opening participants' vignettes. In the field notes is the example of one woman talking with the others about what is happening in their area.

> *"A woman has ishende who comes home every day when the man is at work and stays with the woman the whole day. The ishende is known even to the neighbours as they do this is broad daylight when children are at school and the man is at work".*

When the participants were asked about the meeting places for the married women and their *amashende*, they said that though some still meet in the

husband's home, fetching wood, *amadaka* or water that was mostly done in the olden days by those women who indulged in those practices are no longer common meeting places. Today women meet with *amashende* at Mtubatuba town, at a local guesthouse or are taken by taxi drivers to their own homes and are brought back. One participant blamed cell phones for making it easy for these relationships to continue.

The sub-theme showed the 2 different kinds of sexual relationships that existed in the olden days: the arranged and acceptable one to the family and the one arranged by the woman herself and kept a secret from the family. The latter known as *ishende* relationship remained for a long time and continued even when the family discovered it. Between the 2 kinds, the arranged kind of a relationship does not exist anymore but the *ishende* relation still exists. The difference in the 2 eras is that the olden *ishende* relations took place over a long time and there was one sexual partner at a time. Such sexual relations today either constitute several partners which occur frequently and concurrently. This practice was disapproved of by the key informants, the unmarried women and some married women. Among the participants, those who did not disapprove presented several reasons for why it is happening while the disapproving ones mentioned the main reason as being promiscuity and low morale.

This sub-theme clearly shows that in the new era, for a married woman to engage in extramarital relations, is so unacceptable that even when the woman

gets pregnant she does not get support from the family. Even her children do not inherit the husband's name but are insulted and called obscene names. The key informants and some unmarried women were against this practice but married women seemed to give support to the practice and even gave several reasons why women engage in such practices. The practice of married women having extramarital relations is not only confined to women whose husbands are migrant men, it is also practiced by married women who stay with their husbands on daily basis.

4.2.1.3 Emergence of polygamy and cohabiting

From the interviews it was evident that payment of *ilobolo* of 11 cows (Each cow normally costs from R2500 upwards) takes many years of saving and payment. Thus arrangement are made that the two, a man and a woman, may live together before *ilobolo* is fully paid. After negotiations with the woman's family, she comes to the man's home. In this way she becomes a wife to the man and his family recognizes her though the actual ceremony has not yet been performed. The word *ukukipita, (*cohabiting) does not apply in this case, if they have gone through all the stages as shown in the operational definition of marriage in Chapter 1. *Ukukipita* occurs when a man and a woman decide to stay together without the involvement or consent of parents from both sides.

The participants pointed out that the cohabiting that migrant men do in the cities is different from what is done in the rural areas. They said that there are girls

from traditional areas who are now in the cities and who meet migrant men from the rural areas. These men usually prefer these women from rural areas as the men believe that compared to the prostitutes the men meet in the cities, the rural girls are still well behaved. They thus fall for these women and cohabit with them. Such girls do not like to be treated like prostitutes as they are not prostitutes. On the contrary, they want these men to pay at least a bit of *ilobolo* and then the same process is followed like in those cases where the marriage is postponed and regulated cohabiting occurs in the rural home. The difference is that these women continue to stay in the city with the men as long as the man is working. While staying with these men in the city, they claim that they are "City wives". At the end they become known to the 'rural wives' and friendship develops between them.

This occurs when wives from the rural area visit their husbands in the city. Occasionally, the town wife will leave them to sleep in the bedroom and she will sleep in the lounge. One participant who is a wife of a migrant man, however, gave a different view of what was happening in her own marriage life.

> *"He does not come home but he is just working here at Empangeni. He has this woman he is staying with. I am not allowed to visit him either. He only comes at Easter and Christmas time. The other woman is having him all the time".*

This is a different aspect of the emergence of polygamy. According to one of the key informants, polygamy should be negotiated between the two people in the marrieage. She illustrates this in the following statement:

"The rule is that if the wife does not like isithembu (meaning polygamy), the husband should not continue with it. Even today isithembu is supposed to be the practice".

Participants who are younger wives of migrant men disagreed with her opinion saying that in reality this does not happen. They said that men just take a woman for a wife without acknowledging the wife's opinion. They even said that in polygamous marriages, love for the older wife diminishes.

"She becomes just like a sister to her own husband and the younger wives call her "mama" The husband does not visit her anymore. That is why the older women have amashende".

Younger married women participants concluded that such a woman is discriminated against because of her age, which also encourages superseded wives to engage in *amashende* practices. Field notes showed that taking a second wife is not confined to men taking wives from the cities. From the field notes a woman, 57 years old and a teacher narrated a story of what she had witnessed from her female colleague.

"There was this woman who had a sister older than her who came over to stay with her and her husband. After a while it became obvious that her sister was in love with her husband and that they were having sexual intercourse behind the wife's back. The married woman decided to leave the husband with her sister and went away to build her own home. She is now living there alone as her children are grown up".

According to the narrative, the woman who left her home was a teacher and was economically independent. Discussions about this with one focus group discussion of younger wives and a couple of key informants showed that this is an old practice which started long ago. Participants revealed that when a married woman could not have children or was ill, her younger sister would be sent by the

parents to assist the married sister. According to the narrative sometimes both sisters would end up being wives of the same man. Further to this, experience shows that today even the babysitter or a maid ends up living with the husband and the wife either continues to stay or leaves them.

4.2.2 Experiential Theme: Factors that encourage women to engage in these practices

4.2.2.1 Sub-theme: Dependency Theory (marginalization, subordination, discrimination and stigmatization)

In previous generations in the Zulu culture it was a disgrace for a married woman to work. It reflected badly on the husband and portrayed him as a failure who could not support his family. Therefore you would find that an illiterate, traditional woman did not work. Nowadays, women work when they have a career or profession. When they do not have these they usually work as domestic workers for more educated women. The study participants complained that their migrant men do not send them enough money to support them and their children. They said that they could not make ends meet and so suffer poverty, as they are not career women. Being uneducated and having no means to be self-reliant forces women to depend on their husbands for financial support. They also complained that some of the men who send money home send it through the mother-in-law, making them (the wives) discriminated against and therefore subordinated.

When asked how long mothers-in-law continue to be an integral part of their married son's life, the participants said that the son's wife is free to enjoy her marriage only when these two women no longer share the kitchen. This refers to when the son's wife has been culturally assigned to cook alone for her children and husband in her own kitchen. This explanation of the young married woman shows very limited autonomy of women in marriage as they are still treated like children by their mothers-in-law.

The participants complained that since there are more pre-marital pregnancies with men not maintaining the illegitimate children, the mother-in-law would support the daughters' children with the son's money because their mothers are unemployed. On the other hand, the son's children only get very little support from their father's money. The woman cannot raise a complaint against this, as daughters-in-law are usually perceived as not liking the husband's mother. This showed how discriminated, marginalized and subordinated married women are in their marriages. One participant expressed herself disappointedly as follows:

> *"Sometimes my mother-in-law would phone my husband and he will then phone me and say, "Give mother so much money". She would not talk to me first, which shows that there are things that they discuss without involving me. When unmarried educated and employed women see this they say that they will never get married because' emzini kuyahlushekwa"* (women are ill-treated in marriage).

In the above discussions on dependency theory factors showing how women were marginalized, discriminated against and subordinated were highlighted. Firstly, in this rural area it is still not fully accepted that married women who have

no career (as most of them are not well educated) are not free to leave their homes to work. Some cultural practices like *lobolo* and the relationship between the wife and the in-laws perpetuate the marginalization of women resulting in their discrimination and dependency on men both economically and sexually. They remain subservient and subordinated to their husbands who refuse condom use.

4.2.2.2 Sub-theme: Socialization (Gender, culture and religion)

Gender, culture and religion are the agents of socialization where beliefs, norms and values of a particular culture are taught at a very young age so that they are internalized and maintained in a society. In Section 4.2.2.1 above, the participants showed submissiveness to their husbands. When asked how this practice came about they said that women's subordination to men and their submissive state is attributable to their socialization where women were taught that they should be submissive to their husbands. They pointed out the special arrangement that, when a girl gets married, older women in the family would sit down with her and give the following 'counselling':

> *"Never answer back, do what ever he says, do not question him, what has he taken away with him that he will not bring back?"* (Meaning that the penis that he has gone away with to other women, will be returned);
> and statements like these:
> *"Ungabheki emuva* (never return home)
> *Ithuna lentombazane lisemzini"* (a girl's grave is in her marriage/a married woman stays in her marriage until death).

Participants were also aware that culture allows men to have several women while women are supposed to have only one man. They said that this is also

perpetuated from childhood socialization where boys are called *amasoka* and according to them this continues throughout manhood. Participants said that it is through having multiple partners before marriage that men are encouraged to engage in polygamous marriages. "*They can't stay with one woman*" as one participant verbalized. Participants were aware that it is unacceptable and a disgrace for women to engage in the same practices.

The issue of virginity testing was mentioned as the way key informants were brought up in their days. This was during the era of the *amaqhikiza* (older girls who looked after and taught the younger girls acceptable womanly behaviour) who saw to it that the younger girls were brought up according to the accepted norms and values so that they would get married without having children first or having not lost their virginity. Some religions seem to perpetuate or encourage polygamy, as the one of the key informants expressed:

(**I**: Interviewer; **P**: Participant)

> *I: But your husband has two wives.*
>
> *P: No, we are three.*
>
> *I: But why did he have 3 wives if he was a churchgoer?*
>
> *P: Yes he was. You know we belong to Shembe Church. They even take 10 wives.*
>
> *I: But how did you meet because you said you were staying at Dukuduku and he was here?*
>
> *P: I have said that we met at the church. You have heard about conventions that occur at KwaNhlangakazi, at Judea, at Ekuphakameni and at EBuhleni?* (The interviewer agreed). *We met in those places. Then we got engaged in church. He then paid ilobolo at my home. You know, they finish paying ilobolo within a short time. In the following convention we got married and then came back home to make a ceremony.*
>
> *I: So, are you the older wife?*

P: No I am the second wife. The others are still alive. The one I come after and the one who came after me.

The above narration clearly illustrates how culture works hand in hand with religion in the process of socialization. Culture and religion are both the agents of gender where girls are expected to strictly adhere to preserving their virginity while men are not expected to behave the same. As shown in the earlier sections, participants were aware that girls marry men much older than they are, which can later have an effect on their sexual activity. When considering meeting the sexual needs of a married woman if her husband has 3 wives but comes home for only one weekend, therein lies the explanation why participants complained of men being unable to satisfy all these wives sexually. This will drive them to engage in *amashende* relations. Perturbed, this key informant said,

"Christianity says you are one – united in marriage, but the Zulu culture says that a married woman is nothing. Even if a man sleeps out or goes and comes back with another woman, he wakes you up to make a bed and food for the other woman so that they can sleep".

One younger married participant admitted having just heard that there were *amaqhikiza* but had not seen them in her time. She said that in the place of *amaqhikiza* was her older sister. *"I think those with no elder sisters are taught by their mothers."* However, she stated that her mother was not able to say anything to her concerning sexuality education. She just spoke superficially and did not talk deeply. She and her siblings feared their mother. They were not able to ask her anything. It was her sister to whom they were able to talk about sex. The

participant shared the kind of talks they had with their sister in the following illustration:

> *"...Like sexual behaviour, when you are a girl and how to behave when you have fallen in love with a man. That you must not discuss sexual intercourse with him before he sees your parents and starts to pay ilobolo. That's what happened to me. I started to have sex with him only when he had already paid ilobolo at home".*

There is however a shift of trend here. When *amaqhikiza* and the church played a major role in shaping young girls' behaviour, the young girls were not supposed to be involved in sexual intercourse before marriage. The trend has changed in modern society when the female siblings took the place of *amaqhikiza* and the church. Sexual intercourse seemed permissible as long as *ilobolo* had been paid.

> *"It depends on the kind of home you were brought up in. If you had good conduct when you were young, you would not be involved in such behaviour. Bad behaviour happens because women today go out of their homes to seek men. This starts when they are still girls. They follow men. It's no longer a man only who takes the initiative. We used to see a boy/man walking up and down outside there wanting to see a girl but it's a girl today who knocks at the door and say "I want to see Siphiwe"* (the boy). *This tells me that if a girl from another homestead could do this, even my own girl could do the same".*

When the participants were asked what could be done to address this situation they seemed unable to come up with a strategy. In fact they seemed unable to control their own children, as is seen in the following passage:

(I: Interviewer; P: Participant)

> *P: I don't know what should be done because even if you tell the children they don't want to hear what you're saying.*
> *I: In other words children do not listen?*
> *P: They don't listen.*
> *I: But there's nothing that can't be stopped. What could be done?*
> *P: I don't know because when a person is grown up they make their own decisions even if you warn them they don't stop.*

Being able to pay *ilobolo* gives a man in the community status. Hence there is a saying: *"ubuhle bendonda 'zinkomo"* (a man's beauty is in his ability to pay *ilobolo).* No matter how brilliant or attractive he is, if he is not able to pay *ilobolo* he is just useless. To be able to pay *ilobolo* gives him the pride of being a real man amongst other men and also gives him power over the woman's sexual life. He does not expect a woman to deny him his sexual rights, which is to sleep with him under any circumstances. Referring to condom use one participant said:

(I: Interviewer; P: Participant)

> *Men say, "You don't trust me. I can't start using it now. Since I was born I have never used them" or "You have another man" or "I paid ilobolo so you can't tell me to use a condom".*
> *I: What do you do then?*
> *P: You prove him wrong by letting him sleep with you.*
> *I: But you can refuse when you are in polygamy because he took the other wife because he loves you less*
> *P: She can't refuse as she also needs the very thing that brings the disease* (penis). *Moreover you have to bear children.*

The above sub-theme showed how gender, culture and religion intertwine as agents of socialization to perpetuate women's submissiveness to men. In different eras there had been structures set in place to reinforce this and also work at each life passage. At each initiation passage, women are taught to respect men. *Ilobolo* was still mentioned in this sub-theme as also causing women submissiveness to men. This results in men feeling that they own their women and accuse them of infidelity when trying to negotiate condom use. In this way women succumb to having unprotected sex to prove their trustworthiness in their relationships.

4.2.2.3 Sub-theme: Lack of sexual satisfaction

Another factor that was mentioned as contributing to women of migrant men engaging in extramarital relationships in the absence of their husbands was their lack of sexual satisfaction. This was stated as usually occurring despite the fact that some migrant men visit their wives occasionally.

> *"They arrive home on Saturday morning and go back to work on Sunday afternoon with taxis to Johannesburg. As soon as he comes he'll go to the neighbours where there is isiZulu beer, umsebenzi, traditional rituals or a wedding. He'll come back in the evening brought by his friends unable even to walkl due to drunkenness. The first thing he'll want is sleep. He'll sleep the whole night or, with luck he'll wake up in the morning and have sex once. The woman doesn't even enjoy it because she is cross with him, and in the afternoon he takes a taxi back to work. He'll come back at the end of the month or after 2 months".*

Other married women participants in a focus group discussion pointed out unanimously that because of their husbands' involvement in alcohol abuse, the woman would thus have *ishende* for sexual satisfaction. For the same reason of sexual frustration men refuse to use condoms with their wives even while having other sexual partners thus engaging in unsafe sexual practices. To this one of the participants said:

> *A man would say to his wife "You have another man, that's why you want us to use a condom" then the wife wants to prove him wrong and has sex without a condom.*

A problem of men not wanting to use protection was also expressed by unmarried focus group participants as it happens with their own boyfriends. All younger participants said that they were aware that men make such accusations deliberately to make women submissive and force them to agree to sleep with

them without protection, which is an issue of gender power relations. They also admitted that women are not empowered enough to refuse their husbands' sexual advances and that men also know this weakness. When asked if it is *ilobolo* that causes this mentality, the participants complained that married women are subordinated as they are not allowed to express opinions on sexual matters nor do they have power to make decisions on these. They said that they could not refuse to have sex without a condom even if a man is known to have other sexual partners. The participants also agreed that i*lobolo* plays a major role in this as is narrated below.

> *"We cannot say anything in this regard as the man paid ilobolo. The family members of both the woman and the man exert pressure on the woman because the man will gather his family and report the matter. They will tend to be against the woman in the name of ilobolo that was paid for her".*

On the other hand, one key informant did not accept this as true. She said, "No one says anything about *ilobolo* because it is just the exchange of gifts" This was said in such a way that it was obvious that this old woman was just saying it for self-protection.

Another factor that causes women to engage in extramarital relationships was expressed by the participants as follows:

> *"Ubufebe-nje.* (Downright promiscuity or low morals*). Some women are just promiscuous. Others do it because of having no conscience of what is wrong."*

The sub-theme showed how in some cases, the lack of sexual satisfaction drives women of migrant men to have other sexual partners in the absence of their

migrant husbands. Migrant men rarely come home from work to visit their wives and if they do they do not satisfy their wives' sexual desires due to alcohol abuse and involvement with other women. This was a factor that was identified by the participants as contributing to their vulnerability to HIV infection, because when they do have sexual intercourse with their husbands, they do so without protection.

4.2.3 Experiential theme: Resource availability: societal and environmental resources.

4.2.3.1 Sub-theme: Economic status (ownership of property, jobs and poverty)

Participants showed that married women do not have an income because they are not employed. Some members of one focus group mentioned that they were engaged in projects only for subsistence but not for commercial purposes. They reported that they did not have markets and resources though one of them mentioned that they were part of a group of 5 who shared one sewing machine which belonged to one of them. With no market to sell their products, they had to use the little money they made to survive and ended up not having money for raw materials. Other means of survival for the married women participants were expressed as follows;

> *"We are engaged in projects like beadwork, basket weaving, catering, sewing, and using only one machine, selling airtime and gardening. But this ends nowhere as we buy food with the income".*

This income was not enough for them and so the women started getting involved in *amashende* relations for additional income. They also said that involvement in *amashende* relationships is aggravated by their lack of ownership of property. For instance, even during a marriage proposal a man asks a woman to come and build *umuzi kababa*, the father's homestead. As the natural heir, the homestead automatically becomes his, despite the fact that they both built it. Thus participants verbalized their despair, *"What can I do? Where else can I go?"* Seemingly women cannot even go back to their own homes as those homes belong to their brothers as heirs. About this issue, one participant said, *"My brother's wife will not like me coming home"* Participants further expressed that instead of leaving the relationship the woman would have other men as a means to make ends meet. Unmarried participants also agreed with the existence of friction between the wives and the sisters of husbands.

In the sub-theme discussion how scarce resources results in the inability of women to have a voice in their marriages or to escape unhappy marriages. Women are unemployed and therefore have no income. Though engaging in economic generating projects, these are just enough for subsistence and so they remain poor and economically dependent on men. Women do not own land or property either in their biological homes and their marriages. Despite this unhappiness in their marriages they cannot leave as their family homes are owned by their brothers.

taxi industry. Taxis provide the resources required by women, for example, love, satisfaction and financial support. Men have also become a scarce resource due to polygamous marriages.

The sub-theme shows that while migrant husbands are a scarce resource due to migrant labour and polygamy, non-migrant men are available and the wives of migrant men fall for them. Married women engage in such extramarital relations for sexual satisfaction, love and financial support. Sex between them occurs without condom use.

4.2.3.3 Sub-theme: Education, knowledge and power

While knowledge is generally seen as power and is therefore an important resource, lack of knowledge is normally seen as detrimental to a relationship. For instance, one married participant who suffers from asthma expressed her powerlessness owing to the lack of knowledge by both her husband and herself, as follows:

> *"He chased me away from Johannesburg. Before this diagnosis we did not know that I had asthma but I had this one attack and the doctor said it was Asthma. My husband said I should go back home and I should never visit him in Johannesburg again because I could die".*

The lack of relevant knowledge of diseases, in particular, that asthma is no longer fatal if treated, was the reason why this man chased away his wife. If this woman had medical aid and could access adequate treatment, she would not have been chased away but would have sought better treatment and continued

living with her husband in Johannesburg. Most of the companies today provide medical aid only for their workers not their families. Marginalization of women who are already marginalized is seen through all walks of life. This participant said that her husband had no medical aid. She was still feeling angry and disappointed about being chased away as she said:

> *"There was no consultation no negotiation; not even involvement in the decision making. I was just told that I'd never visit again".*

From the interviews men also seemed to lack knowledge about the physiology of women. Participants verbalized that their husbands do not satisfy them sexually. They also said that they do not know what to do because they have low education and so do not know how to intervene. They seem to have lost hope as they felt they will never cease to be victims of oppression from their husbands. The women were able to recognize that they have no power over men. Some did however express that they knew that they had sexual rights. Recognition of sexual rights was also mentioned by the key informants, but all women did not know how to exercise these rights. They said:

> *"Women know their rights as married women but the issue of rights contradicts with custom and culture. A married woman is guided by the family values as long as she wants to stay in a marriage"*

Participants also did not know how much their husbands earned. This caused them to accept any amount of money that their husbands gave them. Further probing revealed that they did not have the ability to question and did not know the kind of marriage they were in. Even if they knew that they married in community of property they could not claim a 50% share in the husband's

income. It was apparent that their husbands did not send their wives enough money. Further discussions of the situation showed that the husband's attitude emanates from the notion that women are minors and should accept what their husbands give them. Their husbands are figures of authority, as they even call them *"baba"*, father. When asked why they were doing this, some of them laughed and others said *"It is culture, it shows our respect for them"*.

The sub-theme shows that men do not understand their wives' sexual feelings enough to accord them sexual satisfaction. Amongst married couples relations are based on power which is skewed towards men so that women are not involved in the decision-making process. Women do not even know their husbands' salaries nor the kind of marriages they entered into. Women have considerable knowledge of their human rights however they do not know, how to exercise them. On the other hand, family values and cultural norms take precedence over human rights. Thus women cannot exercise their rights.

4.2.3.4 Sub-theme: Access to health care and resources

Both married and unmarried participants were disturbed by and complained that the health services offer only male condoms and that these have always been readily available and could be obtained free of charge from any health centre. Participants contend that female condoms are not available. They said that these are only obtainable from the pharmacists and are expensive.

Participants particularly became more serious when saying that there are no places available for men to talk about their problems. Some participants agreed with each other about this as expressed: "*I feel that our husbands have problems that they are faced with, which they cannot even share with us as their wives. We ask you to come up with a programme where men would be given a chance to express themselves one on one*". A desperate married participant said:

> *"It could be helpful if you could come to our homes when the men are there during the December holidays so that they can express their problems and we could all sit and talk about them".*

Participants also maintained that there is a lack of support in the communities particularly in the family. This applies to both males and females, although men are more supported by the family, which intervenes on behalf of the male when his wife does not agree to sleep with him. The family gives support to the man because he has paid *ilobolo* for his wife. A shift from the traditional stereotype thinking to a more reasoning and modernized one is seen in the following statement from a woman who divorced her husband. Though she did not get support from her mother-in-law, the community seemed to give her support.

> *P: He used to stay with another woman at home when I was away at work. He was also working but could not support the family. So I decided to divorce him.*
>
> *I: This means that you are the one who applied for the divorce?*
>
> *P: Yes I did, and also got custody of the children.*
>
> *I: What did the people say as this is the rural area? You know how it is like about divorce and you said you applied for it?*
>
> *P: Generally people are against divorce. But people who knew that I was suffering in the relationship, people who saw that when I was away he stayed with this woman sympathized with me. They are the ones who reported everything that used to happen while I was away.*

In the sub-theme married women expressed their concern about the lack of female condoms at health sites. These are only available at the pharmacies and are expensive. Men seem to have sexually related problems which they are not comfortable sharing with their sexual partners. Both married and unmarried women expressed the need for projects and health services that target men so that they could express their problems. The lack of support systems in the community and family was also identified, but the families tend to give support to men when their marriages are in trouble. This exerts some pressure on women to remain submissive to men. Even then women are starting to gain some power taking an example of a woman who divorced her husband despite the lack of support from her family.

4.2.4. Experiential Theme: Relative risk-high risk factors.

4.2.4.1 Sub-theme: Migration

All participants mentioned migration as the most crucial factor, which leads to married women having extra marital partners. Other factors that perpetuate the situation included issues like women being unable to live with their husbands at their workplace. One married participant in a focus group discussion expressed the problem as follows:

> *I: What you are saying is that your husband took you to Johannesburg, brought you here in the rural areas, left you at home and continued to stay in Johannesburg* (laughter from the group).
>
> *P: Yes, and I understand the situation. If there were jobs in the area, say at Mtubatuba, he would be living with his family here. Also if there was a room to live with him where he is working in Johannesburg we would be living together as a family. But now that is impossible.*

I: Impossible?

P: Besides we will never have a home if we can go and live with him. It is a norm that a woman should look after the home.

I: Which is more important, a relationship or a home?

P: (Not answering the question), *The home will be destroyed. I am also considering the children's life. I grew up in the urban area and I have seen that in comparison, children growing from the rural areas are brought up well* (well behaved). *I like children to be like what they are now, as they are comparatively well behaved*

Males stay away for some time before coming to visit their wives probably because they have to save their wages as they are usually unskilled and are poorly paid. Participants also agreed that currently migrant men visit more regularly than in previous generations. Here *isidikiselo* was a substitute until the husband came back home while today that provision is no longer viable. Women engage in *amashende* relations as mentioned above.

In the sub-theme on migration, all participants agreed that the cause of married women's infidelity lies with the migration system, which forces men to leave their rural homes to work in the cities. The majority of men's city residential places do not allow women to stay with their families forcing them to stay apart. Even though in some cases there is daily transport to and from the workplace and the rural homes, because of their low wages men cannot afford to visit home regularly. It was also evident that women were reluctant to stay in the cities with their children because of the immoral effects of city life on their children.

4.2.4.2 Sub-theme: Alcohol abuse and health problems

Participants agreed that alcohol abuse is also another factor that disturbs sexual encounters between husbands and their wives because, when the husbands are paying their wives a visit, the men socialize and pay less attention to their wives. According to the participants, this is another factor driving women to engage in other sexual relations.

Premature ejaculation, as reported by participants, could be one of the factors that exacerbate risk of infection. Men having this problem usually do not get treatment but the condition continues, resulting in poor sexual relationships that could result in women having other relationships.

A man (mentioned earlier) who drinks too much alcohol on his visit to his wife is not different from other men referred to by the participants. According to this, men, employed or unemployed, are always away from home for a good part of the day. They are usually drinking alcohol in the neighbourhood while women are involved in daily household chores. Owing to poverty and low wages, the men drink home-made types of alcohol. One married participant, when the group was asked for the recipe for the commonly used type of alcohol, mentioned that:

> *"Battery fluid is added to the alcohol for a more intoxicating effect which is most liked by the consumers".*

This was a widely known 'recipe' as others admitted. Though they also admitted that nobody knows about the effects of these alcoholic beverages on the human

body, participants attribute male sexual failure to too much consumption of these illegal types of alcohol.

The sub-theme further illustrates how alcohol abuse affects men's sexual performance resulting in a lack of sexual satisfaction in women. Men ingest the illegal home brewed kinds of alcohol which cause premature ejaculation during sexual intercourse. When migrant men visit their wives at home, they abuse alcohol to the extent that they are unable to engage in satisfactory sexual performance. These factors drive women to engage in extramarital relationships and so become vulnerable to infections.

4.2.4.3 Sub-theme: Unsafe sex

Both married and unmarried participants made accusations regarding the sexual behaviour of both males and females. They said that both males and females have *amashende* these days they both lack self-control, unlike before, when *ashende* relations were primarily the practice of males. According to them, this can be attributed to the need for sexual satisfaction particularly for females and the old cultural sexual autonomy among males. Such lack of self-control in both men and women occurs in situations where neither of the parties use condoms. This occurs even when men have untreated STIs, which could be the entry point for infections like HIV. One married and employed participant, who had a husband with an STI, however, used this condition to force her husband to use a condom.

(I: Interviewer; P: Participant)

P: My husband is now having umhlume (STI).
I: Umhlume? Is it from this woman?
P: Yes.
I: How does he feel about it?
P: He feels bad. I refused sleeping with him until he went to the clinic and came back with condoms.
I: So you are using condoms?
P: Yes.

Despite two decades of the AIDS epidemic and the issue of free condoms, participants reported the existence of misconceptions and beliefs about condoms. Agreeing with each other on this, they said:

> *"Men influence each other. They say that when condoms are placed in the sun, worms are visible inside them. In this regard they say condoms are the ones causing the AIDS virus".*

According to participants this leads to men taking the condoms off before ejaculating with the belief that it is when one ejaculates inside the condom that they get the virus that is inside the condoms. One of the alarmed married participants expressing this, said:

> *"Taking the condom out just before ejaculation, is as good as not wearing it from the beginning of the sexual activity".*

In the sub-theme on unsafe sex, all participants agreed that both males and females lack control of their sexual feelings. They even indulge in sexual intercourse without using condoms. The only time when married women are able to force their husbands to use condoms is when husbands have revealed thet they have a STI. Having unprotected sex is further promoted by a misconception that condoms have worms inside them and that if a man ejaculates inside the condom, he would become infected with HIV. Married women said that this leads

to men either refusing to use condoms or taking them off before ejaculating and continuing with sexual intercourse.

4.2.4.4 Sub-theme: Cultural practices

Ukungenwa, meaning widow inheritance, as a traditional practice has been mentioned several times by the participants as another factor that leads to the spread of HIV infection. They showed their concern over getting infected by their husbands because the husbands take the wives of their dead brothers. This they do despite the cause of death of the brother and the participants fear that they could get HIV infection through this practice. One of the married participants in a focus group discussion said:

> *"Instead of this practice coming to an end, it is becoming more widely used as even unmarried women, once they have a child or children from a man who has died, fall victim to being inherited by relatives of the dead boyfriend".*

To explain the inheritance of unmarried women, unmarried participants during interviews and focus group discussions agreed that this practice really happens these days. When asked what causes this they said it is because girls want to marry and also because marriage has become scarce so girls are desperate for the opportunity to get marriage. This practice occurs when an unmarried woman is having a child of the man who subsequently dies. The live brother himself married or not, takes her to be his wife.

The practice of 'woman' inheritance occurs whether or not *ilobolo* has been paid. If the girl has a child of the man who died and *ilobolo* has been paid, she would

be inherited. The field notes, however, revealed a different view of what causes the emergence of this new trend of woman inheritance as is expressed by a married participant below:

> *"If the girl had a child who is an heir to the dead father's financial assets, the live brother would inherit the girl. This occurs even if no lobolo had been paid for the girl"*

This woman was confident that this practice had financial implications. When participants were asked why unmarried women agree to this inheritance even if they were not married to the dead man, they said:

> *"It is because marriage is scarce these days. Men are not employed and so have no money to pay for ilobolo. On the other hand every woman wants to get married"*

One of the cultural practices mentioned by both married and unmarried participants was masculinity. They said that men are *amasoka, m*eaning real men who should have several sexual partners to prove their masculinity. Referring to the issue of masculinity, they made the following comments:

> *"Men cannot control themselves"* and *"Men cannot stay without women".*

The participants said that according to their upbringing, Zulu men should have more than one sexual partner. This, the participants felt, makes women vulnerable to contracting infections from their husbands because they continue with their submissiveness and therefore accept the *amasoka* practice as a given. Unlike the situation when a woman refuses having sexual intercourse with her husband because he has an STI, women have nothing else against their husbands and about their misbehaviour even if their husbands have other women as it is culturally accepted that a man may have other sexual partners. Thus, these cultural practices hinder women from becoming assertive and refusing unprotected sex.

In summary of the sub-theme, widow inheritance, a cultural practice which had started to fade is again becoming popular. It has taken a different angle as it

does not only occur to married women. Unmarried women for which *ilobolo* has been paid and girls with children from the dead brother are inherited by the surviving brother. Women seem to appreciate being inherited because they are aware that marriage has become scarce and that marriage is a cultural need. This practice seems to have financial implications as it mostly occurs where the dead has left some money for the woman or for the child. Both married and unmarried participants are concerned about the HIV infection as widow inheritance occurs despite the cause of death.

4.2.4.5 Sub-theme: Feelings of helplessness or powerlessness

All forms of dependency on men were evident when participants in both the focus group discussions and in the interviews showed resigned feelings about their situation, which it seemed no one could help to change. This was evident in the different utterances the participants expressed.

To some, marriage seemed like a 'no-return' journey in which they are trapped and no one is able to do anything about. This is evident when one participant said, *"It's better to get an infection from your husband than from outside"* She explained this statement by saying that even God and the people would see that she was not the guilty party and would appreciate her innocence. The married participants also showed that their inferiority to their husbands would not allow them to say anything against what their husbands said. Their 'husbands' word is their command' which was expressed as follows:

> *"I can't say no to my husband. If you get an infection from your husband, your conscience will be free since you are not the one who brought the virus to the relationship".*

Expressions like this seemed to reveal how much participants were looking down upon themselves. They also seemed to see themselves as deserving the treatment they were getting from their husbands, as one participant said, *"I am a dish to sell. If I have been disappointed in my marriage, so be it"* They seemed to see themselves trapped, with their future bleak when they said, *"Where will I go since I do not have parents any more?"*

The study participants were not sufficiently educated to be able to earn a reasonable living. One of them even said, *"I am unemployed where will I go?"* There was also evidence that there had always been a war between similar sexes, where sisters-in-law and their brothers' wives were always fighting, in one of the married participants saying: *"I have brothers, their wives will not like if I go back home"*.

Zulu culture has always condemned women who did not get married or who came back from their marriages, by calling them offensive names. According to the participants, women who came back were and are still called *"umabuyemendweni", meaning* returned from marriage or a failure. One of the participants said, *"I am forced to tolerate whatever, I am forced to"*

In this sub-theme women see themselves as being unable to change or escape from their unhappy marriages. They thus chose to stay with their husbands as they do not have the strength or skills to correct their situations. This make them

feel their situation is a given and that they deserve such treatment as married women. This is aggravated by their lack of economic independence. They cannot even go back to their homes as they are married. In this way they feel helpless powerless and trapped in their situation.

4.2.4.6 Sub-theme: Significant others

It was not only the feeling of helplessness that troubled the participants but also the feeling of being trapped. Even if they wanted to leave such relationships because they felt that they would like to have better relationships as they were still sexually active, they would still say the following:

> *"You cannot leave the marriage in order to be able to give advice to your children with a free conscience. What would your children say when you get AIDS as they would have seen you having other partners and know that you got the infection because of your promiscuous behaviour?"*

Rather than getting infected by a sexual partner who treated them better than their husbands (because they believe that they can get HIV infection from any man), they preferred to stay in unhappy marriages because of their children. Participants made this choice out of the belief that when children need customs to be carried out they would need their father or their blood relatives from the father's side. Should the man and a woman separate or divorce there would be a problem to find someone to do the customs for them. It is believed that this could result in misfortune or even death.

When a woman leaves her marriage for another man she is not well accepted by the families, either hers or that of the husband nor by the community. A woman who has left her marriage is labelled a failure and called offensive names of infidelity. Therefore, no one would like to associate themselves with 'such a woman'. The case was cited of the woman who divorced her husband and got custody of the children had not been involved in promiscuous behaviour. This means that she had not disgraced both families and the community. Any family member would be willing to assist in doing customs for her children. The divorced man himself comes when asked, to carry out customs for his children. Decisions regarding whether to leave a marriage or not are made after considering the following, as one married participant said:

> *"You should put children first. When you take haphazard decisions, children will have problems with the customs"* (rituals).

According to her it is not only children, but also the woman's parents who must be considered. The women made their parents proud of them by getting married and *ilobolo* was paid for them. By not leaving the husband, even if he places the woman in a risky situation, shows her submissiveness to her husband in a marriage.

> *"I want my children to listen when I tell them that it's a bad practice to have more than one boyfriend and not to disappear without their whereabouts being known. You see, you cannot tell a child anything while you are not straight in your ways. You'll visit your aunt, a cousin, something like that, meanwhile you are not visiting them but you are visiting a boyfriend. When you get ill the child will be the one who says "Ma is having such a disease"* (implying AIDS). *"They will see what you have because they know this thing"* (AIDS).

According to what this participant said, in practice when a woman gets infected the suspicion that she was infected by her husband is not generally accepted. The family usually accuses the woman of becoming infected from extramarital relationships even if she does not have them. This unfair situation convinces women not to move to better relationships even if it means getting infected from their husbands.

In this sub-theme married women felt trapped in their unhappy marriages because they could not deceive their children and relatives by leaving their unhappy situations. This would result in rejection from their families and lose respect from their children. Besides, when children needed their family for customs and rituals there would not be anyone to do this if she left her husband. In this situation they feel it is better to get infected by their abusive husbands than to leave for more caring men.

4.2.5 Experiential theme: Knowledge about AIDS epidemic

4.2.5.1 Sub-theme: Transmission, symptoms and signs of AIDS

Participants seemed to know about how AIDS is transmitted from person to person. When the researcher asked the participant who had divorced her husband if she had another partner she said that she had decided not to have another partner after all the problems her husband had caused her and she added,

(I: Interviewer; P: Participant)

P: "Besides I don't want to get AIDS"

I: But how do you know if the husband did not infect you as he was having other partners?

P: He only had liver damage he was not infected. I also know that I am not infected because when he died I had already left him 2 years before the divorce. So we had a period of 4 years not sleeping together.

Another employed married participant also gave an account of a woman who had left her husband for another man whose wife had died. When this *ishende* died later, she went back to her own husband and the family asked him to take her back. The participant was asked about the cause of death of this man and replied that people said he had AIDS and that the woman could have been infected because she had also had sexual partners other than her husband. The same participant further said that perhaps this woman had many partners because she thinks AIDS will go away. When another married participant was asked about the topic, she gave this account:

(I: Interviewer; P: Participant)

I: Do you think women of migrant men are more at risk than those of non-migrant men?

P: They are equally in danger of getting AIDS either as migrant men's wives with the husband staying away from home or as non-migrant men's wives with their husbands staying with them if the man or the wife is having ishende.

Though the full blown AIDS stage is only reached after a long time of suffering from several illnesses, some participants know that there is a difference between HIV opportunistic infections related to HIV and AIDS. To support this statement during the interview one participant said:

"By the time you get ill people will associate your previous behaviour when you were well and the signs of the illness that you are suffering from and they will know that you have AIDS"

Experience with the local community has shown that people have seen people suffering and even dying from AIDS. Thus in all focus group discussions when the participants were asked what they knew about AIDS, their spontaneous responses were,

> *"It is this disease which has finished people"* (expressed in different phrases).

In traditional Zulu culture, when there is unfamiliar illness, people tend to attribute the cause to witchcraft. This also happens in the case of AIDS as was shown when one participant said:

> *"Some do not disclose. You just see by the signs they have. Even if they say it is witchcraft, the signs are obvious. We have seen our relatives and children dying from this disease"*

All the participants also seemed to know that transmission occurs mainly through sexual intercourse between people who are infected and those who are not. This was evident in statements like the following:

> *"Men fall for local widows because they have money, despite the fact that they could be infected with AIDS from their husbands...if they behave like this the disease will attack them".*

It was clear that in this rural area there are women who have more than one sexual partner. Participants said of this, *"They'll get AIDS as they do not know their new partners' behaviour well"* To confirm their knowledge of heterosexual transmission, participants were not biased in their answers as they said:

> *"Both partners can come with the virus in a relationship and if they behave like this they will get AIDS".*

The participants seemed aware that married people have an obligation towards their partners so that even if married women engage in other relations, it is not as easy as they would be if out of wedlock. In an interview, the participant who divorced her husband responded in the following manner:

(I: Interviewer; P: Participant)

> *I: You are not very old to be on your own. In fact you look younger than your age. Why don't you have another partner?*
> *P:* (Laughing) *I decided to have no other man after all the problems I had with my husband.*
> *I: Hm.*
> *P: Besides I do not want to get AIDS.*

One of the focus group participants also agreed with the same idea when she said, *"When you divorce, you both feel free to have other partners. That is when AIDS spreads"* The oldest key informant shared with us her experiences while still a young married woman in the following extract:

> *"When the husband came home with a girlfriend in our days, the wife slept in the kitchen leaving the husband and his girlfriend to sleep in her hut. Today wives either fight or leave the husband who does this. They seek jobs away from home and have other men. Men have failed to treat women well. That is why homes have fewer young married women today".*

When this participant was asked why is it so easy to do that today she said that cell phones are a menace:

"They phone each other and make appointments to meet and infect each other with this disease".

When a migrant woman who works as a maid was interviewed, she admitted having seen people with AIDS where she works. She said about one of her fellow maids who was among those who were suspected of having AIDS: *"One of them*

became very thin and went back home with many illnesses". Further probing to capture if she thought that the woman with many illnesses had AIDS, with a far away look she said, *"Who hasn't got it? You can never be sure that you do not have it".*

Participants also knew that one can find out if a person has AIDS by having a blood test. This could be because of sensitization from Africa Centre which has an HIV Surveillance study that tests women between 15 to 49 years old and men between age 15 and 55. The blood tests are done during home visits in the community and eligible participants are tested in their homes. They are referred to the Counselling Centres existing in their areas for blood results. Vertical Transmission Study (VTS) and the Microbicide Study also test their participants. The people from this Demographic Surveillance Area have considerable knowledge of the disease. One of the study participants in an interview said:

> *"I joined the Microbicide Study, did a test and have the results slip, which I showed to my husband. Everyone knows about AIDS".*

In this sub-theme all participants showed considerable knowledge about AIDS: that transmission is from person to person mainly through sexual intercourse. They verbalized that both male and females, irrespective of whether they are migrants, wives of migrant men or not are all at risk if they are not well behaved. This made them feel that rather than leaving their unhappy marriages, was better to get infected by their husbands than by new partners who would treat them with care but who could infect them. In addition to this, they admitted that witchcraft

was still often blamed for any unknown disease but signs of AIDS are distinctive and cannot be mistaken with witchcraft. They know that confirmation of HIV infection is by means of HIV test. Their knowledge comes mainly from the media and sensitization from the local population health studies namely: Population Based Testing and Counselling study, Vertical Transmission Study and Microbicide Study. All of the participants (besides key informants) were part of one or all of these programmes.

4.2.5.2 Sub-theme: Prevention and beliefs/myths

When the participants were asked what could be done to help women avoid getting infected with AIDS, they said that women should be taught about AIDS and condoms and how to use them. They also mentioned that, as much as they knew about AIDS (as they have seen people dying from AIDS), they still needed to be taught more about it.

Participants also displayed knowledge of how AIDS should be prevented as they mentioned condoms as the device for prevention:

> *"Condoms are easy to use but men do not want them" "When you mention condoms to men, they say you do not trust them"*

(This was expressed in a second person probably to make the topic less sensitive)

According to what the participants said, their husbands seem to believe that when women initiate the use of condoms it is because women have other

partners with whom they sleep without using condoms. Men also do this out of jealousy as one participant said, *"That I was suggesting use of condoms meant that I had a man who told me to use condoms with my husband."*

This discussion shows that participants know how to prevent HIV infection mentioning condoms as means of protection. They stated, however, that they still need more teaching on AIDS and how to use condoms. They also pointed out that attitudes towards condom use is a problem as men accuse women who suggest condom of covering up their infidelity wit other men.

4.2.6 Experiential theme: Human rights issues

4.2.6.1 Sub-theme: The situation of a married woman

During the interviews and the focus group discussions participants verbalized their dissatisfaction about the way they were treated in their marriages. They expressed their concern at having no voice as married women. They had to abide by what was happening in their relationships even if they were not happy. The key informants seemed to have adapted to the situation as one of them shared what happened when she was still young.

> *"We did not have rights in our times. If you suspected that something was not going well in your relationship you did not become a magistrate* (make conclusions) *and do what you liked because you thought it's your right".*

When she was probed she admitted that they just kept quiet as *ilobolo* had been paid for them. Whether or not her husband came back home she did not question him. *"What more would you want than to be a married woman?"*

When asked if they were not supposed to express their feelings, as they were married, another key informant said:

(I: Interviewer; P: Participant)

> *P: Your only right is to be a wife, to be able to stay with him. When he did not come back home he was obviously with a girlfriend, so what?*
> *I: What did you do in that case?*
> *P: What is your problem? What has he taken away with him that he won't come back with? Today when a man takes this direction, a woman takes the other.*

Much as these key informants felt that they had no rights in their marriages, which made them submissive to the rules of their households, they expressed their dissatisfaction with the rights that the South African Constitution has given to women. One of them pointed out that the law had become lax and that is why women do as they please, that is, they have become loose because they say they have rights. This contradicted what they felt when they were younger women, which was obvious envy that today's women have rights

On the other hand, the younger participants agreed that they had rights but also showed that they were not able to exercise them. They said they could not question their husbands if they were given little money, though they happened to know that their husbands were paid far more. They also showed unhappiness when they admitted that mothers- in- law had rights over their sons, and their sons' property as shown in the previous sections that mothers-in-law are in control.

One of the participants, aged 42 years old, a younger wife in a polygamous marriage, said that in the Zulu tradition it is a shame for a woman to visit a husband in the city when he has not invited her. She confessed that nowadays women do visit their husbands even if they are not invited. She also gave the explanation that, *"This starts when they are still girls. Today it is girls who visit men".*

The very same participant said that she had no problem about communicating with her husband about sexual matters as expressed in the following passage:

> *"Even when I am having a drop (meaning an STI), as we are two in a polygamous marriage, I inform him. I should inform him because he is the one who will tell me where I should go for treatment: to the doctor, traditional healer or the clinic. We do not hide anything from each other we even bathe together".*

Similarly, two other participants said that they communicated freely with their husbands about sexual matters. The demographics of these participants are that one is a Community Health Worker and the other is a participant in the Microbicide Study of Africa Centre. Their greater knowledge might enable these women to discuss sexual matters with their husbands.

The situation of married women is such that their marriages are unhappy because of the way their husbands treat them. They have no voice. Key informants expect the younger married women to be submissive like they were when they were still young married women. They even blame the South African constitutional human rights as causing married women to expect freedom that results in their promiscuity. On the other hand young married women have an

awareness of their rights but are unable to exercise them due to the culture and socialization which prevent them. It also showed that, more educated women who participated in the local population studies and women who experienced an STI in the relationship could communicate more easily on sexual matters with their husbands.

4.2.7 Experiential Theme: Health status (Morbidity and mortality)

4.2.7.1 Sub-theme: Unprotected sex leading to HIV infection

As mentioned in the above presentation of findings of this study, all the sub-themes discussed seem to contribute to married women's vulnerability to HIV infection, development of the AIDS stage and finally dying. Women engage in risky sexual behaviour without the use of condoms. They do not treat their STIs which then become an entry point to the HIV infection. This, together with a lack of knowledge of the disease's progression, causes people to ignore treating the STIs early and also going for HIV tests. Consequently their health status deteriorates quickly and opportunistic infections develop into AIDS. They therefore die quickly from AIDS.

The health status of women is a pathetic one when one examines the circumstances associated with handling illnesses which hasten morbidity leading to mortality. The above sub-themes clearly boiled down to women's involvement in unprotected sexual intercourse. This often leads to STIs which are rarely treated, developing into HIV infection. Opportunistic infections are also not

treated on time, leading to disease progressing to AIDS and death follows more quickly.

4.3 Conclusion

The chapter gave an elaborate account of the sexual practices of the wives of migrant men. This was best discussed in comparison with the previous generation's married women as they acted as the key informants in the study. Mixing married and unmarried women in the focus group discussions encouraged more involvement in the discussions. All the different groups that were organized gave good data that showed the actual behaviour of married women whose husbands are migrants. Tabulating data into themes and sub-themes was appropriate for illustrations, of the discussions and as such discussions of the findings will be done in the following chapter. Discussions in this chapter will provide the source of information to design the intervention as one of the study objectives.

As mentioned at the beginning of the chapter that data analysis would be through "identification of descriptive patterns, and looking for relationships and linkages among descriptive dimensions" (Hungler, 1994: 6), experiential themes sub-themes on interviews and focus group discussions facilitated analysis. Now that these processes are completed the researcher will present her interpretations of the findings and make conclusions in the next chapter.

CHAPTER 5: SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS OF THE STUDY

5.1 Introduction

Working within the framework of Dependency Theory and The Conceptual Model of Vulnerable Populations, attention has been given to the subordinated position of women, as a vulnerable group, and how gender and cultural factors impinge on their health status, making them vulnerable to the HIV/AIDS epidemic. Conclusions that emerged are in line with the study objectives and the questions guiding the study.

This chapter will look at recommendations of what would, could or should be done in order to address women's vulnerability to HIV/ AIDS. Conclusions of this chapter in particular and of the study in general, will be made.

At the end of the chapter there will be a brief outline of some ideas to design an intervention that would sensitize and empower women to address the problems that make them vulnerable to HIV/AIDS. Finally this chapter will present the conclusions drawn from the findings. Recommendations will be made with regard to the outcomes of the study. Limitations of the research and suggestions for further research will conclude the chapter.

5.2 Summary of the findings

The aim of the study was to explore the sexual practices that married women engage in while their migrant husbands are away, in order to identify the factors that encourage married women to engage in these sexual practices, and to determine women's vulnerability to HIV infection. The purpose was to design a prevention programme that would inform married women of and sensitize them to factors that make them vulnerable to HIV/AIDS.

A qualitative study using an ethnographic approach was conducted. Participants were rural women from the age of 20. In-depth interviews with 15 female participants and 5 focus group discussions were conducted and field notes were also taken.

The theory used to guide the study was the Conceptual Model of Vulnerable Populations, as described by Flaskerud and Winslow (1998), and the Dependency Theory (Ritzer, 1992). Results were organized into various themes and sub-themes and were discussed as follows:

- Historical emergence of the married women's sexual practices and their types
- factors perpetuating women's engagement in these practices
- resource availability, societal and economical resources
- high risk behaviour; knowledge about HIV/AIDS and access to health care
- human rights (including sexual and reproductive rights)

- health status: morbidity and mortality and strategies to design an intervention that would sensitize and empower women to address the problems that make them vulnerable to HI/AIDS

5.2.1 The historical emergence of the sexual practices of married women and their types

Findings show that women of migrant workers are involved in extramarital relations with other men while their husbands are away working in the cities and towns. This practice is synonymous with *inyatsi* relations in Lesotho, as discovered by Modo (2000:446) in her study of the relations of women while their husbands were working in the gold mines.

The difference between previous generations' *isidikiselo/ishende,* (names given to secret lovers of married women) relations and *ishende* relations today, is that, in the olden days, *ishende* lasted a long time but today such relations are of short duration, frequent and sometimes concurrent. A shift of trend is seen as in the past such practices were very secret while today they are done openly. In this era of the AIDS epidemic, such practices could be the way female partners infect their migrant husbands. The findings of this study are similar to findings of studies conducted by Hunter (2002: 17) at Mandeni, KwaZulu-Natal and Silberschmidt (2001:2). Such findings shed light on Lurie's findings of women being HIV infected while their migrant husbands are uninfected (Lurie, Zuma, Gouws and Williams, 2003: 20). In Nigeria similar findings that women engage in

casual sexual relations with men other than their husbands were discovered by Isiugo-Abanihe (1994: 112).

The men who constitute *amashende (*plural of *ishende),* for the married women are available men in the community namely: ministers of religion, unemployed men, teachers, traditional community leaders, taxi drivers and even youth at school. These findings show a change of trend where married women are being sugar mummies (meaning that older women fall for very young men) to the young men. Usually young women are supported by men, as was outlined in a study conducted among women in Nigeria by Ntozi (1997: 145).

This study shows how the social dynamics of culture and gender play a major role in making women submissive to their male partners. Unlike the report in the study undertaken by Modo (2000: 446) in Lesotho, where men used to assault or even kill their wives who had other partners, this extreme response was not evident in KwaZulu-Natal. Incidents of men killing their spouses and children, however, are becoming more commonly reported in the local media (Sibiya, 2005:1). Gender based violence of this nature exerts fear on women, making them more submissive to men and this submission causes women to engage in unprotected sexual behaviour especially with their husbands.

5.2.2 Factors that encourage married women to engage in other sexual practices.

Among the array of factors that encourage women to engage in extramarital relationships is, resource availability (or unavailability), which could either be environmental or societal in nature, was mentioned. In the study area, there is a lack of employment which means poverty for women as there is no money for themselves and their children. Inadequate knowledge regarding women's rights, disease etiology and prognosis, were also mentioned. These women are also uneducated, which renders them unemployable, so they lack economic skills and access to resources that are available, for instance, family land and livestock. They also lack access to information and support and therefore cannot be self-reliant. They are dependent on their men for support. The unavailability of social resources such as their husbands not being available when they are needed causes married women to engage in sexual relations with available men locally, making these women vulnerable to HIV infection.

Health services, though present in the community, are not gender friendly. For instance, female condoms are not available at the clinics. Only male condoms are readily available, which is a dilemma for women as they cannot initiate condom use with their male partners. There are no male clinics which specifically address male issues. This means that the focus of health services has been on the women's reproductive health issues completely ignoring men's reproductive needs, resulting in the discrimination of men in this regard. For instance, men

sometimes experience sexual problems and owing to their upbringing in a patriarchal system which prescribes that men should be 'warriors', they cannot discuss their sexual failure, particularly with female nurses.

Cultural practices also play a role in placing women in a vulnerable position to contract the HIV/AIDS. For instance, widow inheritance, a practice that had been seen as diminishing in the community, is now being revived. Widow inheritance occurs disregarding the cause of death of the inherited woman's husband when she is married off to his brother. The focus group discussions and the field notes showed a new trend of widow inheritance in KwaZulu-Natal. This is not only confined to married wives of dead brothers but the brother of a dead boyfriend will inherit the girlfriend if she has had children with the dead brother. This practice occurs more often when the dead brother has left an inheritance to the child or to both the child and the mother, in which cases widow inheritance has financial implications.

Poverty and lack of employment cause this trend in inheritance. As marriage is a need identified by the participants of this study, girls whose boyfriends had died could not refuse the opportunity to marry their brothers, they had to agree to be inherited. The findings of a study conducted in Malawi among married women supported the assertion that marriage is a need among women, as it showed that even divorced women re-married (FAO, UNFPA and Government of Malawi, 1998: 120). Such findings make the complexity of culture, marriage and sexual

behaviour a little more clearly. Obviously both men and women are placed in a vulnerable position to contract the HIV infection

From childhood women are socialized differently from men, resulting in women remaining a marginalized group, which is discriminated against, is submissive and stigmatized. This condition is reinforced by the cultural practice of *ilobolo,* bride's price, which is a norm and the 'marriage counseling' provided by older women before the girl's wedding. These cultural practices, together with the dependency theory keep women dependent on men. This further drives women to engage in sexual practices with men other than their husbands for support. This results in women engaging in high risk behaviour.

5.2.3 High risk behaviour

As mentioned above, to be involved in high risk behaviour is another factor that causes married women to become infected with HIV. Because of their submissive position in society, women cannot take control of their sexual lives and therefore cannot negotiate use of protection with their sexual partners during sexual intercourse. Women submit to having unprotected sex because of the fear of being abandoned by their sexual partners if they insist on condom use. This could cause the loss of any financial support they do receive. This dependence occurs despite the partner's being known to have other women because their culture still encourages multiple partners for men. A study conducted among women by Karim in 1991 (Tallis, 2000: 39) in KwaZulu-Natal shows that even if

women know that their husbands are cheating, their wives will not insist on condom use.

It seemed generally known by the participants, which men do not want to use condoms during sexual intercourse. But this study also discovered that some women do not want to use condoms either. Similar findings were also discovered in Senegal, in a study conducted among women (De Bruyn 1998: 16).

Another risky behaviour is alcohol abuse. This study discovered that men engage in alcohol abuse, which could mean that they engage in unprotected sexual intercourse with other women in their drunken state. These men then come back to their wives and demand sexual intercourse without protection. Alcohol consumption also results in men experiencing early ejaculation and sometimes impotence, thus depriving women of sexual satisfaction. This frustration drives women to engage in risky sexual behaviour with other men in an attempt to satisfy their sexual needs.

Polygamous marriages are declining as a general practice. Where polygamy is strong in rural KwaZulu-Natal it is perpetuated by the Nazareth Church (*Shembe*), which is very active in maintaining cultural practices. A shift of trend in polygamy has been discovered by this study. Mistresses of migrant men in the cities have always been there, but lately these women demand to be made successive wives. When migrant men are no longer employed, they take these

mistresses back to their families and marry them. This practice is similar to Hunter's (2001a:20) findings in his study on masculinity. The chance of a wife eventually having her husband to herself is destroyed and the problem of unsatisfactory sexual relations, which has been there for years, is not solved. Thus the woman will still engage in extramarital sexual relations even if her husband has returned.

5.2.4 Knowledge about HIV/AIDS and access to health care

Women's knowledge about the epidemic is acquired from the radio, clinics, community research projects like Population Testing and Counseling, Microbicide Study, Vertical Transmission Study, Prevention of Mother to Child Transmission (PMTCT) Study and the Hlabisa Anti-retroviral Therapy (intervention) Programme carried out by Africa Centre for Health and Population studies in the area. Women have also had personal experience of the epidemic as they have seen, cared for, and buried people who have died from AIDS, some of whom were relatives.

Though women have considerable knowledge about the epidemic, misconceptions around HIV/AIDS still confuse them. Adequate knowledge is still needed in the community. For instance there is a misconception amongst the men that condoms have worms which cause people who use them to contract the HIV infection. This is the latest misconception that is still rife in this community. Such a belief could be influenced by the notion that ejaculation should be done inside the women. Setel (1996: 1172) conducted a study among

young people in Northern Kilimanjaro, East Africa from 1991 to 1993, and discovered that many women and men believed the very purpose of having sex was to ejaculate into a woman and for her to receive a man's sperm. In Setel's study, using a condom was felt to be dirtying oneself. Though this notion has not been, investigated in this study, it could influence attitudes in the use of condoms among both men and women.

5.2.5 Human rights (including sexual and reproductive rights)

Feminist theories that women have fewer rights than men still hold true with rural Zulu women (Van Zoonen, 1991: 20; Ritzer, 1992: 44). This study shows that while the Zulu culture accepts that rural KwaZulu-Natal black women should be treated like children and that culturally they have no rights, the Government of South Africa, Bill of Rights (Constitution of South Africa ACT 108 of 1996) stipulates that all humans are equal before the law and have the right to freedom of expression and to other rights. Some women are aware of such rights but cannot exercise them owing to the gender relations embedded in their society. For instance women cannot exercise rights to refuse unprotected sex and to have sexual intercourse only when they want to. This means that the women's knowledge of their rights does not help them avoid HIV infection from their sexual partners.

There is no question of wanting or not wanting to engage in sexual intercourse because when husbands or any sexual partner wants to have sex with a woman,

even without the use of protection, women cannot refuse. Though older women blame the South African Government for married women's misbehaviour, the Government has given rights to women. The older women support fully women's rights to negotiate safer sex with their sexual partners instead of contracting HIV and dying, leaving orphans with the grandmothers. Mothers-in-law are resourceful agents of change if the wives of their sons fear to communicate with their husbands on sexual matters pertaining to sex protection.

Regarding sexual communication between married women and their husbands, a shift has been seen where sexual communication has become easier and women more assertive. This particularly occurs when women are employed, in a polygamous marriage, are participants in Africa Centre Studies, when they have discovered that their partners have sexual relations with other women and when they know that their husbands have STIs. Women's ability to communicate verbally (and even refusal of unprotected sex) on sexual matters occurs even if women are conscious of their husbands' 'right' to ejaculate inside them and where they are bound to be submissive.

What seems liberating to previously gender-constrained women is affected by the cunningness of men. When women refuse to have sex with their partners without protection, men make accusations that they are refusing because they have other men. In order to prove their sexual partners wrong, women succumb to having unprotected sex with them.

Zulu culture requires women to call their husbands *"baba"*, meaning father, which reinforces the man's dominance in the relationship. However the shift from the inability to the ability of women to communicate on sexual matters, as discussed above shows that some women are able to refuse to have unprotected sex with their husbands. Some Zulu cultural men have become caregivers. They look after their children while their wives become migrant labourers as domestic workers. This shows that culture is not static and that the ties of patriarchy are loosening. Such changes mean an improvement in the oppressive state of women and mean that when empowered enough, women can actually take a firm stand and refuse to have unprotected sexual intercourse.

It is not only individuals that show changes from being conservative towards being liberated, but even the community shows some shift in what they believe about women. For instance, the community gives moral support to married women who are emotionally and sexually abused by their husbands, by informing the wife about any sexual misbehaviour of the husband and by giving support when the wife eventually decides to divorce the husband. Though this kind of community support against men's infidelity was reported by only one woman, if used adequately, community mobilization could be facilitated even for sex-related issues.

A woman's personality also plays a role in her decision-making abilities. Because women are not expected to go back to their families after marriage, they develop

feelings of helplessness and of being trapped in their marriages. Another personal issue is that they feel they have to sacrifice their lives because of the children. Women feel they should be role models to the children and should also not disgrace their families by leaving the marriage no matter what their conditions are. All these rights-related factors further exacerbate women's vulnerability to HIV infection.

The study undertaken by Hosegood and Solarsh (2001:15) about marriages in the DSA, shows that the number of marriages has declined. According to the participants in this study, the decline may be due, among other factors to the unhappiness experienced by women in their marriages. Women may decide not to marry at all to avoid the abuse they would experience if they were married. This shows that the cultural and intrinsic need to marry is changing so that women are able to exercise their right of choice. Given enough knowledge and skills, women can choose with whom, how and when to engage in sexual practices.

5.2.6 Health status: Morbidity and mortality

The discussions based on the findings of this study in the above sections give a clear picture of how women are made vulnerable to contracting the HIV infection. Their vulnerability has an impact on how they treat their illnesses. For instance, evidence shows that women do not treat STIs until they are advanced (Flaskerud

and Winslow, 1998: 68). These infections provide entry points to the HIV infection, which progresses quickly to AIDS and then death.

Co-morbidity refers to illnesses that are not directly caused by the primary illness, in this case, HIV infection. They occur because of compromised immune systems, which make women susceptible to any infection, such as meningitis, tuberculosis or others. The co-morbidity worsens the condition caused by HIV infection as the illnesses are not understood by uneducated rural women. The health status of married women in the rural KwaZulu-Natal is thus greatly affected by lack of understanding of HIV/AIDS as an epidemic in its own right.

5.2.7Strategies for designing an intervention

The participants provided a list of information that should be included when designing an intervention that would sensitize and empower women. Teaching people about AIDS and how to use condoms was mentioned. As much as they knew about HIV/AIDS (as they have seen people dying from AIDS), they still need to be taught about it. The following were pointed out for inclusion in the intervention.

- Making female condoms available
- Life skills training on sex negotiation, communication, assertiveness, advocacy and lobbying, self-esteem building, economic skills and provision of markets
- Human and reproductive rights and how to exercise them

- Creation of support groups
- Gender awareness and discarding out-of-date cultural practices e.g. that a woman cannot question her partner's infidelity
- A men's programme e.g. counseling and provision of referral systems
- Awareness of high risk factors
- Addressing misconceptions.

5.3 Conclusion on the findings

This chapter gave a detailed picture of the plight of women married to migrant men in a rural setting in KwaZulu-Natal. That married women of migrant workers engage with other sexual partners in the absence of their husbands was shown not to be a new practice. In the past women did engage in such relations but these were mostly arranged, and those not arranged were not accepted by the family and the community. Today women engage in these relations without any fear, an act which may increase their vulnerability to HIV/AIDS.

The study also exposed the factors that cause women to engage in such practices. Economic factors form the basis of all the other factors that cause women to engage in these risky sexual practices. Discussion on how high risk behaviour impacted on the health status of women terms of disease morbidity and mortality was made. It is evident that women are vulnerable to contracting HIV from both their husbands and their secret lovers.

Recommendations and strategies to design an intervention were made and laid out in the following sections. An intervention targeting a specific audience, like these women, was deduced from the findings and the ideas of the study participants (Refer to appendix G).

5.4 Recommendations

- Women's plight cannot be divorced from the context in which it originates. Addressing these women's issues and empowering them must be done in context, considering all the factors involved. This proposed approach is also based on the notion that behaviour does not occur in a vacuum but in interaction with other people and the environment. Instead of expecting one stakeholder to address the situation, a multi-sectoral approach should be adopted in order to address the situation in a holistic manner.

  Like Setel (1996:1176), I agree that factors such as social stratification, gender relations, and direct experiences with the disease, the whole belief system and behaviour that play a role in the women's situation must be addressed in further discussions of the context and meaning of the epidemic.

- Although the study was carried out in a rural area in KwaZulu-Natal, the issues of married women having secret lovers other than their husbands has wider implications. For the empowerment of women initiatives to succeed, they cannot be given only to individuals but must be available to

all the women in a community. The environment should provide support for the development of women. For instance, women stricken by poverty should make use of indigenous available and accessible environmental resources like grass, wood and soil. Women cannot do this as individuals but as groups within a community. Mobilization of women by traditional structures, for instance, may help women to engage in income generating projects and become economically independent instead of being dependent on their male partners (whether husbands or secret lovers) for income.

Income generation projects also occupy women and keep them busy, thereby preventing them from engaging in negative activities. They also have no time for boredom, loneliness and feelings of worthlessness. Such projects will give women a sense of purpose and therefore empower them to become self reliant.

Involvement in such projects depends on the knowledge and skills the women have. Even if women do have access to information and services, experience shows that female dependence on males cannot be completely eradicated.

- Women empowerment initiatives should include making women aware of their rights as women. They will become empowered to exercise the right

to refuse sexual intercourse without protection. Women empowerment should, however, be balanced with efforts to deal with men's increasing feelings of insecurity and marginalization. The traditional structures can play a major role in this regard by encouraging Community Based Organisations within the community, which would reduce instead of perpetuate gender discriminatory cultural practices. *Izinduna,* the Kraal Heads, could bring men together to change their attitudes towards sex-stereotyping roles in order to mitigate the impact of such gender practices on sexual behavior.

- Widow inheritance is one of the cultural practices that perpetuate the escalation of the HIV/AIDS epidemic. Traditional structures could also help eradicate such practices when the people have adequate knowledge of how HIV is transmitted.

- As an integral part of the community, religion could also play a major role in the mobilization of all segments of the community. Ministers of religion and other authorities in the church could set up groups of their members to impart awareness of gender role stereotypes, HIV/AIDS or any topic of interest according to the needs of their congregation. This openness could ease the tension that exists between the sexes and could allow people to talk more freely about sexual matters, diseases and so facilitate good communication between men and women. If such debates occur within the

church, discussions of this nature could continue even at home where married couples could engage freely in discussions related to their sexual health. HIV/AIDS would no longer be an issue and the stigma of the disease would gradually disappear.

- As elsewhere in the world, reproductive health issues, like HIV/AIDS and people's behaviour, are at the forefront of public health discussions. In the 2nd PACT HIV/AIDS Conference in Cape Town, South Africa (2006) sexual behavior was regarded as a major challenge that contributed to the rise of HIV/AIDS statistics. Stakeholders were urged to promote behaviour change in both females and males, old and young.

- The health services should provide adequate information regarding high risk factors women are exposed to. Health providers should also teach women how to live positively by eating nutritious foods and engaging in low risk behaviour. The focus of health provision has been on women's reproductive health so that there are women's clinics and doctors that specialize in women's conditions. This approach is biased and discriminates against men. Men's clinics and doctors should also be provided for men, as men sometimes encounter reproductive health problems that render them impotent. Having such clinics would help men to feel relaxed talking about their sexual problems not only to health workers but also then to their female sexual partners.

While the health service provides education on healthy nutrition, the Department of Agriculture may provide education to women on how to grow healthy food. The Department could also provide resources like seeds of different nutritious foods so that they do not plant maize only (staple food), but also vegetables to keep them healthy. Equipment and markets at which the women's excess agricultural products could be sold could also be provided. These efforts would keep women healthy so that the progression of HIV into AIDS stage and mortality would be delayed. As women do not have money to purchase such food they should be told what to plant and the kind of animals to stock for healthy food.

The Local Economic Development (LED) programme of the Department of Social Development promotes initiatives to encourage development. These initiatives could include the mobilization of rural women into associations or cooperatives, so that they do not only produce for their household's consumption but also for economic gain. The Department could also establish Non-governmental Organizations providing both life and economic skills to the communities so that women are encouraged to start different income generating projects. In such co-operatives some of the community members could be tending vegetable gardens, while others are engaged in making craft items for sale.

Clubbing together has worked in the past and would help unemployed rural women to engage in bulk buying of their raw material as well as food and seeds. Women could combine to hire taxis every month to assist them to find markets for their excess products. Working together like this could increase co-operation, openness and mutual confidence among the community. Both men and women need economic empowerment so that both genders are able to work together and see themselves as allies instead of competitors.

The South African Government has introduced a structural intervention in housing that has changed men-only hostels into family hostels where the families are allowed to live together. Though this has been a slow process, it has started working. Cultural beliefs that marginalize a woman who leaves a rural home to live with her husband in the city may make women reluctant to live in the hostels. This reluctance may be coupled with negative perceptions that parents have of the impact that urban life could have on the upbringing of their children. To avoid these perceptions, the development could be brought to the rural areas, where factories could be built within the rural communities, thus keeping families united, minimizing the vulnerability of women, and creating an interdependent functioning community.

Many women in the rural areas of KwaZulu-Natal are illiterate, which adds to their marginalized state further, causing them to be more vulnerable than educated women with careers. Providing these women with basic education on top of the factors mentioned above, could empower them to become self-reliant. The Department of Education could provide programmes on adult education from which women could receive the writing and reading skills necessary to write their own proposals and business plans in their own language.

The South African Government has constructive policies on the implementation of programmes and projects to address various issues and meet the needs of the South African people. In the context of urban bias that prevails, these programmes are usually implemented in the urban areas among people who can make ends meet. People in the rural areas are usually left out and the gap between those who are employed and the very poor enlarges. It is recommended that the policy makers see to it that all policies, programmes and projects reach even the remotest areas of the rural communities. Women in the rural areas are aware of the existence of such policies, programmes and projects but they have never filtered down to the rural areas.

5.5 Areas for future research

In terms of the vulnerability of married women to HIV/AIDS, because their husbands are migrant labourers, this study indicates that more studies of this nature need to be conducted in order to reach an understanding of the complex reasons that lie behind this behaviour and to explore the possibility of effecting changes in both the mindset and human behaviour. More research in this area is the challenge for social scientists (Marks, 2002: 18).

Further research that would engage men's issues is recommended if the country is to fight the escalation of the epidemic. Women alone cannot fight the epidemic as their relationship with men involves power relations within an array of belief systems and other factors.

It is also apparent that much more demographic and anthropological research is needed in order to improve the understanding of the trends in HIV epidemic. Conducting this study is in line with what Hosegood and Preston-Whyte recommended that "any studies that look at HIV/AIDS epidemic in contemporary marriage and partnership in KwaZulu-Natal and other parts of Southern Africa, must take full cognizance of the social and cultural as well as gender factors that underlie them"(Hosegood and Preston-Whyte, 2002:22).

More studies in this regard would give more light on what influences such behaviour and probably from such studies more inclusive interventions could be designed for all groups and categories of men and women.

5.6 Limitations of the study

It is true that documentation of studies on the sexual behaviour of married women in KwaZulu-Natal is very limited. Although this study succeeded in investigating the issues of women's reproductive health and their sexual behaviour, it has not explored the situation of married men. This could affect the future implementation of plans and interventions. Similar studies on men would have given more understanding of the male world (particularly within Zulu ethnicity), which remains obscure because of the patriarchal system that prescribes gender roles for both men and women. Among the array of gender role expectations are men's marginalized attitudes, that they should not express their feelings and problems. Including men in this study would have led to designing an intervention that would also provide men with skills that would empower them to avoid exposing themselves to infection as a result of socio-cultural factors.

The intervention, however, has not been tested and interventionists wanting to use it may need to test it before use. The designed intervention is attached as appendix G of this report.

5.7 Conclusion

The aim of the study was to explore the sexual practices of wives of migrant labourers while their husbands are away and the implications such sexual practices have on women's vulnerability to the HIV and AIDS epidemic. As one of the objectives of this study, the findings contributed to the development of an

intervention that would empower women to address some of the factors that make married women vulnerable to HIV/AIDS (Silberschmidt, 2001:667).

While there is clear evidence that women engage in sexual relations in the absence of their husbands which has grave implications for their vulnerability to the HIV/AIDS epidemic, theoretically there is a need to revise the generally accepted stereotypes of male domination and female subordination and factors at their roots. This does not mean that all women are submissive and passive victims of culture. There have been changes in trends, though such change is slow, showing that culture is not static. To speed up the process of change, there is therefore an urgent need for a national intervention programme that would sensitize both women and men to their vulnerable position, to how their vulnerability is influenced by socio-cultural and economic factors, to the seriousness of the epidemic and then empower them to engage actively in efforts to control the escalation of the epidemic.

An example of such interventions has been designed based on the factors surrounding the position of women. It is hoped that the designed intervention addresses the problems identified in this study.

6. REFERENCES

1. AEGIS AFP News Report, 2005. *HIV/AIDS a Major Health issue in the Western Province*. Available: http//www.AEGIS.com. [Accessed: February 2005]
2. Aggleton, P. Mane, P. 2001. *Gender and HIV/AIDS: What do men have to do with it?* London: Blackwell Publishers LTD.
3. Aikinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland L., 2001. Handbook of Ethnography: Narrative analysis in Ethnography.
4. Alsop, R. Fitzsimmons A., Lennon K. and Minsky R., 2002. *Theorizing Gender*: Blacvkwell Publishers LTD Oxford. United Kingdom.
5. Barnes, J. Conrad, K., Demmont-Heinrich, C., Graziano, M., Kolawinski, D., Neufeld, J., Zamora, J. and Palmquist, M. 2005). [Accessed: http://writing.clostate.edu/guides/gentrans, 2009/02/19.
6. Boler, T. and Aggleton P., 2005. *Life skills education for HIV prevention: a critical analysis*. London, Save the Children and Action Aid International.
7. Caldwell, C.J. E., Orubuloye, I. O., Anafi, J. K., Awusabo-Asare, K. and Ntozi, P. M. Orubuloye, Anarfi, Awusabo-Asare & Ntozi, 2002. *The African Aids epidemic (Reflections on Research Programme)*. Journal of population Research, 19 (2), pp 173-190.
8. Caldwell, J. Caldwell, B. Pieteris, I., 1998. *Construction of adolescent in changing world: Implications for sexuality, reproduction and marriage*: Nisena.
9. Camlin, C., Gareme, M., Moultrie, T.A., 2002. *Fertility trend and pattern in a rural area of South Africa in the Context of HIV/AIDS.* London: Centre for Population Studies.

10. Campbell, C., 1997. *Migrancy, Masculine Identities and AIDS: The Psychological context of HIV transmission on the South African gold mines*. London: London School of Economic and political Science.

11. Cohen, D. 2006. *Poverty and HIV/AIDS in Sub-Saharan Africa.* Issues Paper No. 27 Available from: http://www.undp.org/hiv/publications/issues/english/issue27e.html. [Accessed: 12 July: 2006].

12. *Constitution of the Republic of South Africa 1996, Act 108 0f 1996.* Pretoria: Government Printers.

13. De Bruyn, M., 1998. *Facing the challenges of gender based response.* Amstedam: KITS/SAFAIDS

14. Doyal, L., 1995. *What makes women sick: Gender and Political Economy of Health.* McMillan Press LTD. London.

15. FAO, UNFPA and Government of Malawi, 1998. *Transcripts of Focus Group Discussions*: North, Center, and South Malawi.

16. Field, J. and Morse, P., 1995. *Nursing Research: The application of qualitative approaches, 2nd edition*. Canada: University Alberta.

17. Flaskerud, J., and Winslow, B. 1998. *Conceptual model research and practice. Conceptualising Vulnerable Populations Health Related Researc*h. Volume 47 (2), pp 69-78

18. Floyd, Reid, Wilkinson, D. Gilks 1999. Admission trends in a rural South African Hospiital during the early tears of the HIV epidemic. Volume 282 (11) pp.1087.

19. Ford, K. and Hosegood, V., 2003. *The impact of HIV/AIDS on children's living arrangements and migration in South Africa.* Mtubatuba: Africa Centre for Health and Population Studies.

20. Gafos, M., 2004. *The association between migration and HIV in the Umkhanyakude District of KwaZulu-Natal, South Africa.* Mtubatuba: Africa Centre for Health and Population Studies.

21. Genzuk, M., 1999. A synthesis of ethnographic research. Los Angele: University of Southern California.

22. Goosen, M. and Klugman, B., 1996. The South African women's health book. Cape Town: Oxford University Press.

23. Green, J. and Thorogood, N., 2004. *Qualitative methods for health research.* London: SAGE Publications.

24. Griffiths A.O., 1997. *In the Shadow of Marriage: Gender and Justice in an African Community.* University of Chicago Press LTD. London.

25. Health 24 News Report 2000-2005 (2005). *Women's Vulnerability to HIV Infection.* Medical Diseases Centre. www.Health24.com. [Accessed: 21 July 2006].

26. Hoosegood, V. and Sorlash, G., 2001. *Population, mobility and household dynamics in rural South Africa: implications for demographic and health research.* Mtubatuba: Africa Centre for health and Population studies.

27. Hoosegood, V., Timaeus, I. And Vanneste A., 2002 *Levels and Causes of Adult Mortality in rural South Africa,* Mtubatuba, Africa Center for Health and Population Studies, Population Studies Working Group Papers.

28. Hosegood, V. and Preston-Whyte, E., 2002. *Marriage and partnership patterns in rural KwaZulu-Natal.* South Africa. Session 33. Social consequences of AIDS PAA: Atlanta.

29. Hunter, M., 2001a. *Masculinities and multiple sexual partners in KwaZulu-Natal: The making and unmaking of isoka*. Department of Geography. Berkeley. University of California

30. Hunter, M., 2001b. *Materiality of everyday sex: subsistence and cell phones in Mandeni*. Berkeley: University of California.

31. Isiugo-Abanihe, U.C., 1994. *Extramarital relations and perceptions of HIV/AIDS in Nigeria*. University of Ibadan. Nigeria.

32. Kabeer, N., 1994. *Reversed Realities: Gender Hierarchies in Development thought*. London: Verso.

33. Kandiyoti, D., 1998. *Bargaining with patriarchy. Gender and Society* 2 (3), pp. 274-290.

34. Kark, S. L., 1949. *The social pathology of syphilis in Africana.* South African Medical Journal 23, pp 77-84.

35. Kempkes, W., 1999. *Community Perceptions and Practices Regarding the Provision of care for People Living with HIV/AIDS, Chronic illnesses or Disability in Rural South Africa*. London: University of Liverpool, School of Tropical Medicine., 1999

36. Klugman, B., 1997. *Sexual Rights in Southern Africa: Beijing Discourse or a Strategic Necessity?* Health and Human Rights. South Africa.

37. Krueger, A.R., 1994. Focus Groups: A practical guide for Applied Research, Thosand Oaks, CA: SAGE Publications.

38. Leclerc-Madlala, S., 2002. *On the virgin cleansing myth: gender bodies, AIDS and Ethnomedicine*, African journal of AIDS research Vol.1, pp 87-97.

39. Livesly, N., 2005. *ART roll-out in Hlabisa sub-district. Africa Centre for Health and Population Studies*. Mtubatuba: Africa Centre for Health and Population Studies.

40. Lont, C., 1995 *Women and Media: Content/Careers/Criticism.* Wadsworth Publishing Company. USA.

41. Lurie, M. Harrison, A. Karim, S.A. Wilkinson, D., 1997. *Circular migration and sexual networking in rural KwaZulu-Natal: implications for the spread of HIV and other sexually transmitted diseases.*

42. Lurie, M., 2000. *Migration and AIDS in Southern Africa: a review. The Southern Journal of science*, 1996, pp 343-347.

43. Lurie, M., Zuma, K. Gouws, E. and Wilkinson, D., 1997. *Circular migration and sexual networking in rural KwaZulu-Natal: implications for the spread of HIV and other sexually transmitted diseases.* Hlabisa: Medical Research Council.

44. Lurie, M., Zuma, K. Gouws, E. and Williams, D., 2003. *Risk factors for HIV infection among women in Carltonville,* South Africa: Migration demography and sexually transmitted diseases. Durban: Biostatistics Unit, Medical Research Council.

45. Mager, A., 1999. *Gender and the Making of a South African Bantustan: A Social History of the Ciskei*, Portsmouth: Hienemann.

46. Magnani, R.J. Betrand, J, T., Makani, B. and McDonald S.W., 1995. *Men Marriage and Fatherhood in Kinshasa, Zaire.* Tulane University, Los Angeles.

47. Marks, S., 2002. An epidemic waiting to happen? The spread of HIV/AIDS in South Africa in social and historical perspective.

48. Modo, L. V., 2000. *Migrant culture and changing face of family structure in Lesotho.S.A.*

49. Moore, H., 1994. *Household in a South African Bantustan*: A Comment. London.

50. Nagata, A.L., 2005. *Promoting self reflexivity in intercultural education.* University of Rikkyo. Journal of Intercultural Communication Number 8 page: 1 to 167.

51. Ntozi, P. Nakaabi, I. and Yovani, A., 1997. *Fertility levels and trends in the face of the AIDS epidemic in Uganda.* Health transition review, Supplement to volume 7, pp 145-155

52. Ntozi, P.M., 1997. *Fertility Level and Trends in the Face of the Aids Epidemic in Uganda.* Health Transition Review, Supplement to Volume 7.

53. Ntozi, P.M., 1997. *Widowhood, Remarriage and Migration During the HIV/AIDS Epidemic in Uganda.* Health Transition Review, Supplement to Volume 7.

54. Patton, M.Q., 1990. *Qualitative Research and Evaluation Method.* United States of America: SAGE Publication.

55. Polit, D. and Hungler, B., 1999. *Research Principles and Methods.* Pliladelphia: Lipton Company.

56. Preston W., 1993. *Women Who Are Not Married: Fertility, Illegitimacy; and the Nature of Household and Domestic Groups Among Single African Women in University of Natal*; Durban.

57. Preston-Whyte, E. and Hosegood, V., 2002. *Changing marriage and cohabitation patterns in rural Natal South Africa.* Georgia: Population Association of Africa.

58. Preston-Whyte, E., 2002. *Partnerships for HIV/AIDS research in KwaZulu-Natal.* Durban: University of KwaZulu-Natal.

59. Ritzer, G., 1992. Sociological Theory. 2nd edition. McGraw - Hill.

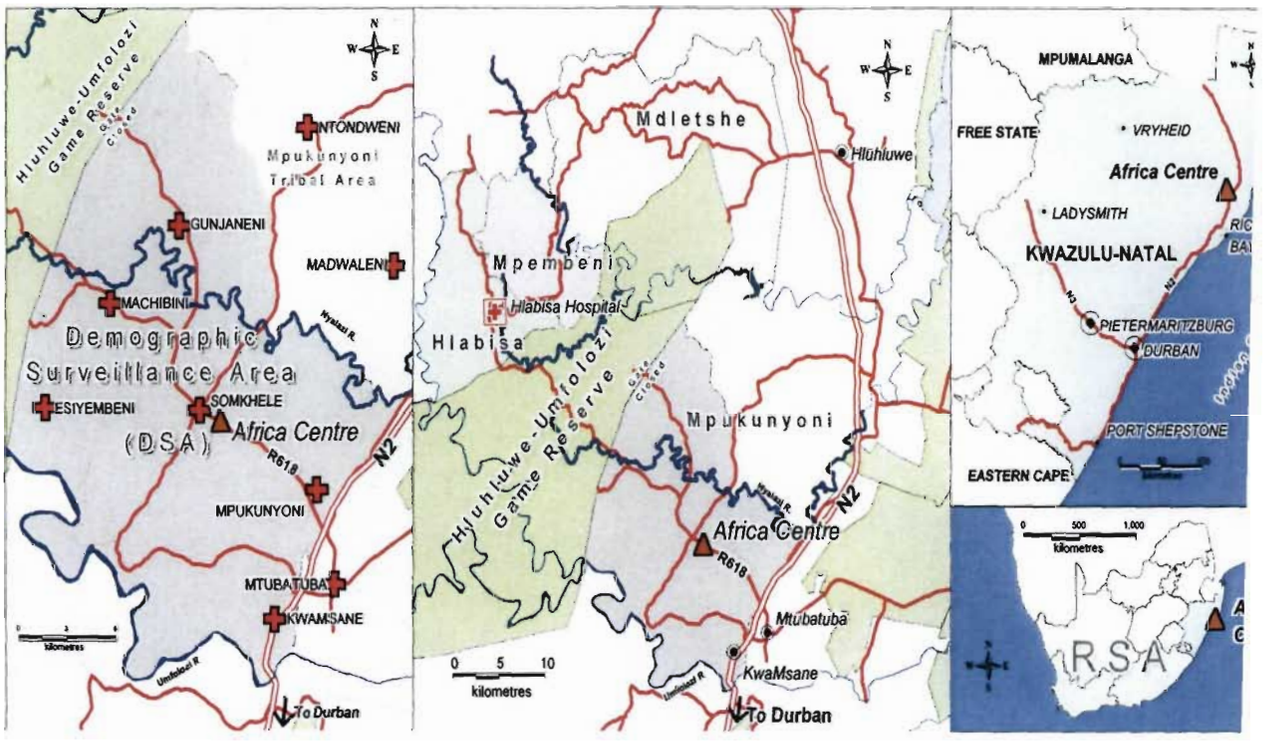
60. SAFAIDS. DeBruyn, M., 1993. *Facing the Challenges of HIV/AIDS: A gender Based response.* Amsterdam Netherlands.

61. Scotts, C. Coulibaly, S. and Verall, J., 1998. *Verbatim questionnaires versus field translation or schedules: an experimental study. International Statistical review.* Volume 56 (3), pp 259-278.

62. *Second (2nd) PACT HIV/AIDS Conference 2006.* Cape Town.

63. Setel, P., 1996. *AIDS as a paradox of manhood and development in Kilimanjaro, Tanzania.* National Centre Epidemiology and Population Health Transition Centre. Canberra: The Australian National University.

APPENDIX A: THE MAP OF THE DEMOGRAPHIC SURVEILLANCE AREA OF AFRICA CENTRE FOR HEALTH AND POPULATION STUDIES AT MPUKUNYONI TRIBAL AREA IN HLABISA SUB-DISTRICT, NORTHERN KWAZULU-NATAL PROVINCE, SOUTH AFRICA.



APPENDIX B: NEWSPAPER CUTTING

15 August 2005: Ilanga Newspaper

Ubulale intombi nengane walala nabo

NOMFUMDO ZUNGU

SISHAQISE omakhelwane isezo sendoda okuthiwa inqumeqhoqhoqho umasihlalisane wo maqede yajikela indodakazi abo enezinyanga eziyisithupha layo yayinquma uqhoqhoqho, cwathi lapho isiqedile yabe isiingenela engutsheni yalala nàso sengathi akonakele lutho.

Lesi sigameko kuthiwa senzeke ezakhiweni zakwa S eMlazi ezaziwa ngokuthi yiseZimeleni. Kuthiwa le ndoda (eligodliwe gama layo ngoba ibingakaveli enkantolo ukubuzwa ukuthi iyaivuma noma iyaliphika yini icaa), inqumise okwembuzi uNksz Sandile Madlala (26) kanye nendodakazi yabo uMbali phakathi kwamabili belele.

Lesi senzo esishiye omakhelwane besathukile, kuthiwa kusolakala ukuthi lo mlisa usigile ngoMsombuluko ebusuku njengoba kuthiwe omakhelwane baze babona sekusile ngoLwesibili ukuthi kukhona okushaya amanzi kumakhelwane wabo njengoba kuthiwe emva kokuba lo mlisa esenze le nto ubephuma engena endlini kubonakala ukuthi kukhona okungahambi kahle kuyena.

Kuthiwa kuthe ngesikhathi esalele lo mlisa umphakathi waphuthuma emaphoyiseni ukuyobika lo mhlola kodwa okuthe efika itshe labe selome inhlama eseshaye wachitha.

Okhulumela amaphoyisa aseMlazi uKapt. Khephu Ndlovu utshele ILANGA ukuthi lesi sigameko sokubulawa kwalona wesifazane nengane yakhe, sibonakale ngesikhathi omunye womakhelwane ezithela phezu kwethantala legazi ebeligobhoza ngomnyango wabe esengena ngaphakathi ngenhloso yokuyobheka ukuthi ngabe konakelephi, igazi elingaka liphumaphi.

Eqhuba, uthe kuthiwa umakhelwane uzithele phezu kwezidumbu ezimbili zilele embhedeni kodwa lona wesilisa osolwa ngalesi gameko eseshaye wachitha kanti ubegcinwe esazunywe wubuthongo.

APPENDIX D:

APPROVAL TO CONDUCT A STUDY IN THE DEMOGRAPHIC SURVEILLANCE AREA OF AFRICA CENTRE FOR HEALTH AND POPULATION STUDIES

AREA OF INTEREST: Sexual behaviour of wives of migrant men

NAME OF RESEARCHER: Thembeka M. Mngomezulu

TITLE OF STUDY: "Sexual Practices of married women in a rural KwaZulu-Natal: Implications for women's vulnerability for HIV/AIDS epidemic"

DATE APPROVED: 1 August 2003

Rationale for the Study

Thembeka Mngomezulu, a professional nurse based at the Africa Center and a Masters student at the University of Natal is well known in the community through her activities at the Africa Center. She will conduct her study with a sample of 20-30 household members of households that have experienced a migration event reported through the current surveillance visits in Africa Centre Demographic Information System.

The researcher will conduct approximately 20 – 30 semi-structured interviews with informants focusing on migration and changing sexual patterns. Written consent will be gained through the form attached to the information script elaborating on the process of the study.

Mrs Mngomezulu will use the primary data for her Masters degree; she is conducting in the Dept. of Nursing, University of Natal, examining the connections between migration, marital status and sexual behaviour patterns amongst women in rural KwaZulu-Natal. The data collected from this project will form the basis of her Masters Degree.

APPROVED BY: Prof A.J. Herbst (Project Leader: Demographic Surveillance System)

APPPENDIC: E

UNIVERSITY OF
KWAZULU-NATAL

ST NO: 202523698

10 November 2004

Ms T Mngomezulu
C/o School of Nursing
MTB
UKZN

Dear Ms Mngomezulu

RE: RESEARCH PROPOSAL

I am writing to advise you that your Research Proposal was approved at the Faculty of CADD Board Meeting held on 1 November 2004 .

Usually once your Research Proposal is accepted you are required to change your Provisional registration to a Full registration. As this has been accepted only at the end of this semester you are advised to change this for the beginning of the new semester 2005.

Yours sincerely

.....
E A Nobin (Ms)
Post Graduate Admissions Officer
Community and Development Disciplines

Mngomezulu prop acc let

Faculty of Community & Development Disciplines

Postal Address: Durban 4041, South Africa

hone: +27 (0)31 260 3139 **Facsimile:** +27 (0)31 260 2458 **Email:** khanyid@ukzn.ac.za **Website:** www.ukzn.ac.za

ding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

THE SOUTH AFRICAN CENTRE FOR EVIDENCE BASED NURSING & MIDWIFERY

THE JOANNA BRIGGS INSTITUTE

UNIVERSITY OF KWAZULU-NATAL

RESEARCH ETHICS COMMITTEE

Student: THEMBEKA MNGOMEZULU

Research Title: SEXUAL PRACTICES OF ~~UNMA~~ MARRIED WOMEN IN A RURAL DISTRICT OF KWAZULU-NATAL & IMPLICATIONS ~~FOR~~ ~~THEIR~~ WOMEN'S VULNERABILITY TO HIV/AIDS

A. The proposal meets the professional code of ethics of the Researcher:

(YES) NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: _____ Date: 23 September 2004

Signature of Supervisor: _____ Date: 23 September 2004

Signature of Head of School: _____ Date: 29/Sept 2004

Signature of Chairperson of the Committee: _____ Date: 8 Oct 2004
(Professor P Erasmus)

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

lephone: +27 (0)31 260 2499 **Facsimile:** +27 (0)31 260 1543 **Email:** **Website:** www.ukzn.ac.za

unding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

APPENDIX F: INFORMATION SHEET

(a) Information Sheet for verbal consent to be administered by fieldworkers

The information that you have provided us with today shows that a migration event has recently taken place in your household. The Africa Center is conducting a study of migration in Hlabisa and would like to ask for the permission of your household to be considered for a further visit to discuss migration in more details. We are particularly interested in the way that migration can affect relationship patterns in KwaZulu-Natal.

If you agree to this request, there is a possibility that two researchers may return in the next month to ask some further questions concerning migration. The households that we select to re-visit will depend on a variety of factors, so it is possible that even after agreeing your household may not experience a visit. However, if a visit does take place, we should make it clear that the person/people from your household whom we approach will not be obliged to agree to be interviewed by researchers and will be asked to sign a form to show that they have agreed to participate in the study. Persons/people selected to participate can withdraw even after signing the form without giving any reasons and this act will not be held against you or your family.

(For the fieldworker – please tick one box)

- The household agrees to the first interview. Yes ☐ No ☐
- The household **does not** agree to the first interview. Yes ☐

Participant's signature.....Date.....

Researcher's signature.....Date.....

(b) Information Sheet to be administered by the researcher to the participants:

1. Background:

We are worried about the rise of the AIDS epidemic and we want to design strategies to help combat this rise. Evidence shows that women are more vulnerable to HIV infection than men. We have come to you to get some information regarding this and at the end of our discussion the information you give us will help us design an intervention that will help women in particular not to get infected by men. Previous research has shown that historically women have been infected with STIs by their male partners, who are on migrant labour. A recent study, however, has shown that these findings are not absolute.

2. Questions it raises:

This raises some questions like these: where did these women get the infection? Could it be that they engage in other sexual practices and get infected while their husbands are away? If so what encourages them to engage in the relationships, which make them vulnerable to HIV/AIDS? What mechanisms could we use to combat/help women not to engage in sexual practices that make them vulnerable to HIV/AIDS? This is just to give you an overview of what information we need from you. Otherwise questions will depend on the flow of our discussion.

3. Benefits of the study

The findings of the study will help in the designing of the intervention program, which will help in sensitizing and empowering of women in factors that make them vulnerable to HIV infection. We hope that through the intervention women will be able to make intelligent choices in engaging in sexual behaviours. We also believe that life skills and also economic skills that women will be trained on using the intervention programme will help them to be self-reliant and able to make decisions in sexual matters. Hopefully this kind of intervention will reduce HIV/AIDS prevalence.

4. Risk of the study

There is no risk involved in being part of the study. The questions asked during the interview may, however, be sensitive as the topic involves sexuality issues.

5. Rights of the participant

As a study participant, you have the following rights:

- A right not to join the study
- A right to withdraw from being part of the study at anytime
- A right not to answer any question you are uncomfortable with
- A right to have clear information regarding the study before you decide to join.
- A right not to be penalized even if you refused to be part of this study.

6. Confidentiality

All information you are telling us will be kept confidential. This means that no person unrelated to the study will know about any of our discussion. Your name will not be written in any of the documents. What we discussed will be kept under lock and key and only concerned people will be given this information. Though interviews will be kept for later reference no one will be able to trace the information back to you and anything you want to ask me will be kept confidential. With your permission I'll use the tape to record our conversation and the scribe will jot down the answers while we talk.

We may need to come back for another session of the interview.

- The participant agrees to the first interview. Yes ☐ No ☐
- The participant **does not** agree to the first interview. Yes ☐

Participant's signature.....Date.....

Researcher's signature.....Date.....

APPENDIX G: RESEARCH QUESTIONS

1) What are the sexual practices that married women with migrant husbands engage in when their husbands are away?
2) What are the factors that influence women's sexual practices?
3) How vulnerable are these women to HIV/AIDS infection?
4) What strategies do women need to challenge factors that make them vulnerable to HIV/AIDS?

APPENDIX H: EXAMPLE OF AN INTERVIEW

Participant: C

Age: 46 years.

Duration: 1hour

Venue: Participant's home.

Background: The participant has been married for 20 years with 4 children. Her husband is working in Durban and only pays a visit on the month ends or alternative month ends.

Codes: **I**: Interviewer; **P**: Participant

(Please be reminded that the participants sometimes expressed themselves in second or even third person when referring to themselves because of the sensitive nature of the topic. After the necessary red tape the interview started).

I: Last month a fieldworker asked this household to be part of a study regarding migration and the effect it has to relationships between married couples and the impact this has on the HIV/AIDS epidemic. I'll read you the information sheet so that you know exactly what the study involves and what is expected of you. (I then read the informed consent (b) to the participant and thanked her for agreeing to join the study).

I: As a married woman, who has her husband working away from home, how is it to be a wife of a migrant man?

P: We (women in general) are staying here at home waiting for a man who comes back home after a month or two and he will have sex with you without using a condom.

I: Can you share with me why you are concerned that you sleep with your husband without using a condom?

P: A man can bring diseases because he has other women who do not want condoms. It is men who come with the virus because they can't control themselves. They do not tell when they are having an infection.

I: You are saying men cannot control themselves.

P: Men are *amasoka* (should have several women). They were brought up like that, they can't stay without a woman. That is why they sometimes are in polygamous marriage.

I: Surely they should use condoms if they have several women.

P: Men do not want condoms. My husband says that it is the condom that causes a virus. He says that those men who use condoms are the ones who are dying from this disease (AIDS). We once used it but he took it out before the end of the round. This was for a trial. When I asked him afterwards if he contracted any infection from it, he said that he did not get infection because he took it out before ejaculating.

I: Uhm!

P: Men influence each other that condoms cause infection.

I: You seem to communicate freely with your husband about sexual matters, how do you do it?

P: We communicate easily on sexual matters. Maybe this is because I joined the Microbicide study (conducted by Africa Centre). I told him before I joined. Now we can talk easily. I even told him that I was HIV negative after HIV test.

I: Was it going to be easy if you were HIV positive?

P: If I was having the virus I would show him the results.

I: You said men have several women, does this mean that men bring the infection to the relationship?

P: No, even the woman can come with the virus. We see women having other partners. This starts at girlhood when a girl has more than one partner. When she marries she continues to have many sexual partners.

I: As women are not supposed to be the *amasoka* (to have several sexual partners) then what causes them to have other sexual partners?

P: They do this when they don't get sexual satisfaction at home. The man becomes like a brother (does not have sex with her). When the husband is working away from home the woman then falls for other men. It happens when a man proposes, a woman becomes tempted and then agrees because even when her husband is there at home they do not have sexual intercourse. Some women do it because they want men to support their children. Sometimes it's just promiscuity.

I: Surely this is a new practice it did not happen with our parents, hey?

P: Even before our times it was known that when a woman did not get sex she could leave the marriage. But there was an arrangement made with the husband's brother *(isidikiselo)* to sleep with his brother's wife. This was known to some members of the family but was kept a secret from the husband. Even children born from the relationship looked like other family members and the husband could not suspect. When the husband suspected that the child was not his, older people would say "this child looks like a great grandmother who died" and the husband would keep quiet.

I: Is it only isidikiselo relationships that were practiced by married women?

P: No married women also had the *amashende,* a different kind of sexual practice which was unaccepted. Sometimes these relationships were known as *amadaka* or *amalongwe*.

I: You are saying that today women still engage in the same unacceptable sexual relationships. Do you think they know about AIDS?

P: Everyone knows now about AIDS. We have seen our children dying from AIDS and other people around are very ill.

I: How do you know that they are having AIDS?

P: The signs of this disease are known from the radios and the clinics. Some people even disclose, but some say they had *idliso* (witchcraft), but they are lying because you can see a person who is having AIDS – the signs are obvious.

I: But now if married women had such sexual practices long ago why is it that they are now the ones infecting their husbands instead? What has gone wrong with the *amashende* sexual relationships?

P: Women bring the virus today because it's everywhere in people's relationships. Everyone gets the virus from their own *ishende*. Today both men and women are *amasoka.* Therefore many people have the virus - both men and women have several *amashende*.

I: Uhm!

P: Married women had one *ishende* and the relationship took a very long time. Today married women do not stick to one *ishende* but are changing them frequently. Sometimes they have many of them at the same time and today there is a lot of HIV infection which makes the spread very rapid.

I: It is confusing why women have many partners concurrently or even change them frequently. Why is this actually happening?

P: This happens because people no longer have true love. Again men do not want to use condoms. Women do not want to stay without having sexual intercourse. *Bayashisa!* (Very sexually active).

I: Are they not scared to contract the disease?

P: They are not scared because they are misleading each other. They want sex but do not want to use condoms. It's surprising because they like sex so much. To them waiting for a week without having sex is like a year. They can't wait for their husbands even for that long. They want to have sex several times a week. What about a month then!

I: What do you think could be done to help women not o get this disease?

P: To talk with their husbands about women not being sexually satisfied might help. If women could also refuse to have sex without protection, it could also help.

I: Do you think it is easy for a woman to refuse sleeping with her husband?

P: *(Avoiding the question and expressing herself with pride).* A married woman has this right. Some women do not know that they have the right to refuse sexual intercourse. If I don't want to have sex with my husband, I simply refuse. He understands and leaves me alone.

I: I thank you again for your participation and your time. Do you know of any other married woman whose husband is working away from home and only visits after a month or more?

(The women directed us to another woman (Or other women) who fell in the same criterion).

APPENDIX I: FOCUS GROUP DISCUSSIONS

Duration of the FGD: 1 hour 30 minutes

Number of women : 08

Age range : 31 to 44

Marital status : 3 married according to the operational definition (cohabiting) and 5 married.

Background:

Among the married women only 2 went to the husbands' homes after getting married. Others cohabited first. The rest are still in cohabiting relationships.

These women's husbands' work in different places like: 4 in Johannesburg; 2 of these came home at month ends and 2 came home on Easters and Xmas. Two in Durban 1 came home at alternative months and one came home at month ends. One works in Ermelo and comes home on Easter and on Christmas holidays. One works in Empangeni (60 kilometer distance) comes home at the end of the month.

The income generating projects they are involved in are: beadwork, basket weaving, catering, sewing (A group of 4 shares a sewing machine), selling airtimes and gardening.

Both information sheets were read to the participants and the discussion was only commenced after they gave informed consent. Introduction was done without them calling out their names. The researcher gave them pseudonyms of A to G as they were 8 in number.

The focus group discussion commenced when the necessary red-tape was done to ensure that every one was relaxed.

Code: **I:** Interviewer; **A, B, C to G:** names of the participants.

I: Good people will you tell me what you are doing at home?

A: We are just staying in our homes waiting for men who come back home after a month or two.

I: Tell me about the emergence of *isidikiselo* and *ishende* that were practiced by married women in the previous generations.

(They were all very interested now, each one very keen to give an explanation but did not want to be the first to do it).

I: Can you share with us what is happening in your marriage life?

C: My husband is working in Johannesburg just like the others'. What I can say is that men are abusing us. I don't know whether it's because mine is older than me. Perhaps he thinks whatever I say is because I'm younger, he can't listen to me when I say anything. He sometimes says that a child cannot lay down rules for him. I just keep quiet. I see that sometimes what he says is true because he is older and maybe that's why her equals (women he stayed with) left him. I still love him because I'm a fool (*A sad and embarrassed laughter)*. He even says that I'm the 7th woman in his life and that all others left him and he does not care.

I: So you are unhappy in your marriage.

C: The way he treats me, I am very oppressed. I have even developed high blood pressure. Before this, I loved him but now I no longer love him. *(In despair)* Even if he does not come back I don't care.

D: Mine works in Johannesburg too. We met in Johannesburg where my home is and I'm staying here at home *(with a Sotho accent).* I understand that there are no jobs in this area, but if there were, my husband would be working here at Mtuba. It is just that when you are a woman you have to stay alone at home but this is due to work situation. If things went my way, if there was a place to live where he works, we would be staying together as a family. *(Hesitating)* But now it is not done like. We would not live together in Johannesburg even if there was a place there because there would be no home back here if everyone would go to where the husband works.

I: Good people will you tell me what you are doing at home?

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- There should be women's groups which educate women how to behave themselves – *"abanasimilo (Meaning that they have no morals)* when married you should be faithful.
- When a husband dies the brother is told to inherit the widow as *ilobolo* had been paid. Because they do not love each other, the women would later engage in other affairs.
- Education should thus be given to men to stop this practice and to women to refuse being inherited.
- Programmes to help women who are vulnerable should involve AA (Alcoholic Anonymous) meetings for those men and women who drink too munch. Other programmes should also help women with money to start their own income generating projects.
- Married women cannot talk with their husbands about these problems but there should be programmes to train women how to talk to their husbands on sexual matters.
- AIDS can be prevented by using condoms. People should be taught that condoms are easy to use.
- Programmes should provide a chance to talk to both the wife and husband as they both are aware of the situation. This can be made privately with them individually or they discuss as a family.
- If only there could be an office where people can come to talk about their problems one on one *(marriage counseling)*.
- If this could be done, the problem of promiscuity can be solved because sometimes it's due to lack of sexual desire in the husband. Men can be given relevant treatment.

(I thanked the group and they had a relaxed lunch to have a debriefing session, which made them more comfortable).

I: Good people will you tell me what you are doing at home?

A: We are just staying in our homes waiting for men who come back home after a month or two.

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APPENDIX J: DESIGNED INTERVENTION

"WOMEN MAKING DECISIONS ON SEXUAL MATTERS IN THE AIDS ERA"

A HANDBOOK DESIGNED IN FULFILMENT OF THE MASTERS DEGREE

Author: Thembeka M. Mngomezulu

November 2007

UNIVERSITY OF KWAZULU-NATAL

Content

INTRODUCTION

This handbook is based on findings from a study conducted in Northern KwaZulu-Natal in Mpukunyoni area in the Hlabisa sub-district of Umkhanyakude District Municipality. The study was towards obtaining a Masters Degree in Nursing Research done in the University of KwaZulu-Natal. It is crucial to mention that because the purpose was to achieve the degree, the requirement excluded testing the handbook. This means that this handbook was therefore not tested. Any inputs or comments that may emanate from the use of the handbook during training would be helpful for further improvement of this tool.

Why focus on women?

Reports (as revealed in the study) on HIV infection revealed that more females were infected than men. This can be attributable to socio-cultural dynamics of the patriarchal system of gender and culture that is embedded in culture, particularly in the Zulu ethnic group. This is inherent in the people's belief system so that it shapes their behaviour. Such is behaviour that places women in a vulnerable position to get infected with HIV. There are also socio-economic and political factors that aggravate the situation. These are unemployment, the political history of South Africa, poverty, unemployment and migration.

This handbook shows how women's group facilitators can help women in the rural settings to have knowledge of their sexual anatomy, gender and cultural issues that makes then vulnerable to Sexually Transmitted Infections, HIV/AIDS and Antiretroviral treatment, their sexual rights, life skills and economic skills that may empower and help them to be self reliant and have ability to make decisions regarding sexual matters.

Who should use this hand book?

The handbook has been designed and written for gender awareness projects, development projects and any organization which wants to empower women in life skills, economic skills and HIV/AIDS. It is preferable that female facilitators of the same age group use the handbook to train groups of women. However this is not a hard and fast rule. Thus both male and female facilitators of any age may use the handbook in training women.

Community Entry

It is crucial that the facilitator acquires knowledge and skills to enter into any community before s/he even thinks of starting a group. This process involves gathering of the following information about the community and its leaders.

1. The constituents of the community
2. The community's main problems
3. Organizations that help the community

Getting into the community

- The facilitator should introduce herself to the community leaders and other community key figures.
- She should get the buy - in of the community key figures and make them understand why she is there.
- It is only when they have reached consensus that she asks them to organize a meeting with the community.

Precautions for community entry

Some of the following activities may enhance community acceptance of the facilitator:

- Knowledge of the kind of dress code and behaviour that is acceptable to the community is crucial, as it shows that one respects the community culture.
- This will make the community open up to and accept strangers like the facilitator.

Some of the behaviour that is commonly acceptable to Zulu culture in many communities is the following:

- When visiting the *Induna*'s or the *Inkosi's* tribal court the cars should be packed outside the premises no matter how big the space is inside.
- The hats (by men) are not worn inside the premises. No shots or tight fitting trousers
- No short dresses, tight fitting clothing or see through clothing or pants if female, should be worn.
- No political party colours should be worn on the visit.
- The approach should be slow and with respect. The stranger should show kindness by greeting people as she enters.
- The *induna/Inkosi* should best be called by their clan names *(izithakazelo)*.
- Once the permission is sought to meet with the community the facilitator introduces herself as best she can.
- It should be born in mind that the first impression people have about a person stays for a long time.
- Such impression may either make them accepted and have a long-time relationship or be rejected and never allowed for another visit.
- Therefore a concise introduction that has neither double meanings nor raising false hopes is appropriate.

A meeting with the community:

The following information should be collected during the meeting:

1. Their living conditions and the evidence of socio-economic groups in the community

2. Explanation from the onset that the focus is particularly to the poor women is crucial.
3. However it is important to find out more about the community, of how it generally solves its socio-economic problems.
4. The community social patterns: who talks to who should be known?
5. This also applies to the community power structure i.e. leaders and opinion makers.
6. Informal and formal organizations operating in the area.
7. Links between the community and supply of services and who controls them.
8. This will make the facilitator know the community better. Learning about the community does not end with this visit but visits to the community, talking to people and observing what they do should be a continuous process.
9. Identification of the women's projects in the community is also done and a plan made to have a meeting with women who are not in any income generating programs. This is a step further towards helping women to overcome their economic problems.
10. This is obviously a lot of information to gather in one meeting. It is to the discretion of the facilitator and more importantly, to the attitude of the community to collect it in several meetings or sessions.
11. Alternatively, the facilitator may have even gathered some of the information from the community leaders. Meeting with the rest of the community will be to serve to introduce the facilitator to the community and to acquire the rest of the information.
12. There is no one way to do this. It all depends on the kind of community and the discretion of the facilitator.

MODULE 1

ANATOMY OF THE FEMALE GENITALIA

(THE FEMALE GENITAL ANATOMY)

1.1 Glossary of terms

Though the topic is about female genitals it is important that the female participants learn about male genitals. The participants themselves should give the accepted and common names of the genitals to avoid mentioning of offensive/sensitive words which may overwhelm them. This may result to the participants withdrawing from participating in this training. Female sexual organs are explained in the section on "Female external/internal genitalia" in this module.

Penis: Male external genital organ

Foreskin: Skin that covers the tip of the penis

Testes: Male reproductive organs that produce spermatozoa

Sexual intercourse: Any sexual encounter between people.

1.2 Objective

The objective of this module is to provide participants with basic understanding of anatomy and physiology of their external and internal genitalia. This will make them treasure their bodies and control them as their owners and no one else's.

1.3 Expected outcomes

At the end of the module participants will have:

1. Knowledge of and ability to talk about their genital anatomy.
2. Adequate understanding of the functions of the genitals.
3. How they get infected with STIs and HIV.
4. Courage to talk about issues related to their reproductive health

1.4 The Female Reproductive System

1.4.1 Female body changes at different stages

1.4.1.1 Female body changes at birth

At this stage the reproductive organs of a female are not well developed. For instance the breasts look like those of a male until the stage of puberty. This also applies to the uterus.

1.4.1.2 Female body changes at the stage of puberty

Puberty, usually occurs between the ages of 8 and 14 and the following changes occur:

- The ovaries and uterus reach maturity
- Ovulation and menstruation begins
- The breasts become larger
- The pubic and the axillary hair begin to grow
- The height and the width of the pelvis increases

- There is increase in subcutaneous fat so that the body becomes fully formed and the skin beautiful
- This is a reproductive stage of a woman

1.4.1.3 Female body changes during pregnancy

- A woman produces an female egg (ovum) at ovulation and a male produces male eggs (sperms) at ejaculation
- A woman can get pregnant during ovulation which normally occurs 2 weeks after menstruation has stopped
- This occurs during sexual intercourse between a man and a woman
- Once the female egg is made in the ovaries, it travels along the fallopian tube to the uterus and waits for a sperm along the way
- During sexual intercourse the sperms are left in the woman's vagina
- They swims up to the uterus to look for the female egg in the tube
- When the sperms meet the female egg in the fallopian tubes they form a foetus which grows into a baby
- This is called fertilization and one sperm fertilized one egg
- When 2 sperms fertilize one egg identical twins occur but usually twins occur when a woman has produced 2 eggs and un-identical twins occur
- There should be an egg when the sperm reaches the uterus. When the egg is not there the sperm dies after 4 days
- The fertilized egg moves to the uterus and settles on the side of the uterine walls and it starts to grow into a baby
- The hormones make the uterus grow and it gives blood supply and food to the foetus
- Normally pregnancy is the period that allows the baby to grow inside the uterus. This lasts for 9 months and a baby is born.

1.4.1.4 The female body changes at menopause

- Menopause occurs at the end of the reproductive stage of a woman
- This is usually between the ages of 45 and 55 years but extremes may occur.
- The uterus becomes smaller and also undergoes other degenerative changes
- The ovaries stop producing female eggs and menstruation no longer occurs
- At this stage, the women cannot produce children. However this does not mean that the woman cannot enjoy sex life
- On the contrary women enjoy sex life more than before and this period usually goes up to the age of 60.

The signs of menopause are:

(Signs of menopause vary from woman to woman).

- Changes in the woman's normal menstrual periods and become irregular, heavier and longer or lighter and shorter, which later stops
- Hot flushes or flash. This is a hot feeling in the face and the body sometimes with sweating
- Hot flushes can be triggered by hot food or drink, emotions, alcohol or by getting too warm. Some women in menopause also get night sweats.
- Vaginal dryness occurs less commonly, vaginal walls become thinner
- Sexual intercourse may become painful or difficult
- Mood changes due to stopping of female hormones
- These are normal changes and women should know that. Men too should know this so that they understand their partners' behaviour.

1.4.2 The female external genitalia

The female external genitalia or vulva comprise the following:

Vulva is found between a woman's thighs. The different parts of the vulva make up the woman's outer sex organs. These are as follows:

- **Mons pubis** is fleshy part over the pubic bone, which is covered by hair
- **Labia majora** are two fleshy outer lips of the vagina. These lips protect the urinary and vaginal openings
- **Labia minora** are two thin inner lips. These are without hair and are sensitive.
- **Clitoris** is found where both the outer and the inner lips meet just below the fleshy, hairy part below the pubic bone. This is an erect part which resembles the male penis. This is a very sensitive and plays a very important part during sexual intercourse. At menopause the clitoris becomes smaller.
- **Urethra** is the outside opening of the urinary passage found just below the clitoris and in front of the vaginal opening. The urethra leads to the urinary bladder in the inside
- **Vaginal opening** is the outside end of the vagina. This expands during sexual intercourse and during childbirth.
- **Hymen** is a thin mucus membrane that partly covers the opening of the vagina and allows for the passage of menstrual flow. The hymen is very thin and easily breaks. This can happen with exercise, sexual intercourse or with any direct force on it.
- **Perineum** is the area that lies between the end of the vulva and the anus.
- **Anus** is the opening below the perineum. Body wastes (faeces) pass through this opening.

1.4.3 The internal female genitalia

- **Vagina** is the passage from the outside to the womb or uterus. It is moist and self cleaning. After puberty the vagina becomes lined with folds which stretch during intercourse and birth. It is in the back part of the vagina where semen collects after ejaculation.
- **Uterus** or womb is continuous with the vagina inside the lower abdomen. It is hollow and is shaped like an upside down pear. The upper part which is dome shaped has arms like protruding tubes on both sides looking like arms known as the fallopian tubes. It is inside the uterus that the baby grows during pregnancy. **The uterus** opens into the vagina.

- **Cervix** is the mouth of the uterus. It connects the vagina with the uterus. The cervix protects the woman's uterus. It makes it impossible for objects like penis, tampons, condoms and fingers to enter the uterus.
- **Fallopian tubes** are the arms like protruding tubes on both sides of the uterus. The hands of the tubes reach out to the ovaries. During ovulation the ovum (egg) from the ovaries is carried into the tubes where it meets with the male sperm and they form the baby. It is then moved down to the uterus where the fertilized ovum embeds into its walls. When the baby is not formed menstruation occurs.
- **Ovaries** are two structures found on both sides of the uterus at the end of the fallopian tubes. The female egg and the hormones are made in the ovaries.

1.4.4 The lining of the female genitalia

- The Labia minora and the vagina are made up of a soft tissue covered by the mucus membrane
- The mucus membrane in the genitals is the same as the lining found in the oral cavity (mouth).

- The labia minora, the vestibule which is an area with the vaginal and urethral openings and the vagina are covered with a mucus membrane which secrets mucus
- Mucus keeps the vagina clean and also protects it from minor infections
- This covering is very sensitive to injuries and a slight friction may cause a break in the skin
- It is natural that the lining is moist. Drying of the vaginal lining may cause the skin to break and makes an inlet for the STIs
- Women should avoid using drying agents because they want men to enjoy having sex with them

1.5 Who does my body belongs to?

The question of ownership is important for decision-making

Exercise:

Women are asked the following questions and discussions made so that they can eventually understand that they own theirs bodies and that they can make decisions about what they want to do with their bodies.

- What does it mean to own something?
- Can a woman own or control her body?
- Who else might own and control a woman's body?
- Why is it important that women own themselves
- How is owning and controlling yourself important if you want to make decisions about your body?
- Is the issue of controlling our body different for women than it is for men? Why?

MODULE 2

HIV/AIDS AWARENESS

2.1 Glossary of terms

AIDS	**Acquired Immune deficiency Syndrome**
HIV	**Human Immune deficiency Virus**
STI	**Sexually Transmitted Infections**
TB	**Tuberculosis**
ART	**Anti Retroviral Therapy**
CD4	**One type of cells that make up the immune system**
PMTCT	**Prevention of Mother to Child Transmission**
VCT	**Voluntary Counseling and Training**

2.2 Objective

To equip participants with knowledge and skills needed to engage in any discussions that they may engage in regarding HIV/AIDS and their lives as married women.

2.3 Expected results

At the end of this module learners will be able to:

1. Define and make distinction between STIs and HIV/AIDS.
2. Identify signs and symptoms of HIV/AIDS
3. Understand modes of transmission
4. Understand the progression of HI/AIDS
5. Explain how condoms work and how they are used

6. Explain the importance of taking precautions regarding AIDS as a disease

2.4 HIV and AIDS questionnaire

Please tick in the correct block e.g. **Yes or No**

Question	Yes	No
1. Does HIV cause AIDS? Explain:		
2. Is HIV inflicted on mankind as a punishment for the wicked? Explain:		
4. Can you tell by looking at someone that they have HIV infection? Explain:		
5. Can someone who is HIV positive, pass the virus in his/her partner? Explain:		
6. Can you get the HIV virus from kissing? Explain:		
7. Can you get infected by the HIV virus from shaking hands with an HIV+ person? Explain:		
8. Can you get infected by the HIV virus from using the toilet? Explain:		
9.Can you get infected by the HIV virus from someone who is not HIV positive Explain:		
10. Can a mosquito infect you? Explain:		
11. Can you get infected by the HIV virus from intercourse with an HIV infected person? Explain:		
12. Are all children of HIV infected mothers at risk of becoming HIV positive? Explain:		

13. Can a child get HIV from their HIV + mother's breast milk? Explain:		
14. Can you get AIDS from caring for AIDS patients? Explain:		
15. Is the HIV test performed at the doctor's surgery only? Explain:		
16. Does using a condom properly lower the risk of getting infected with a sexually transmitted infection? Explain:		
17. Can we treat HIV infection? Explain:		
18. Can doctors treat HIV infection? Explain:		
19. Is AIDS and HIV infection a gay disease? Explain:		
20. Can you cure HIV infection by having unprotected sex with a virgin girl or boy? Explain:		
21. Do you think HIV/AIDS will solve the unemployment problem in South Africa? Explain:		
22. Do you think HIV/AIDS is someone else's problem and not your own? Explain:		
23. Do you think that someone with TB always has HIV/AIDS? Explain:		
24. Do you think people with HIV/AIDS will solve the unemployment problem in South Africa? Explain:		
25. Do you think people with HIV and/or AIDS should have sex? Explain:		
26. Do you know your HIV status?		

2.5 HIV/AIDS, as a Sexually Transmitted Infection (STIs)

Exercise:

The facilitator asks the participants what they know or have seen or have heard about AIDS. She leads them through use of different topics e.g. what it is, modes of transmission, signs and symptoms and prevention. Their responses are enlisted and at the end, the facilitator irons out myths and misconceptions. This will show the facilitator how much the participants know about HIV/AIDS. It will also help her evaluation of how much they have gained from the session.

2.5.1 Definition of HIV and AIDS

- HIV is a virus that causes AIDS.
- When the virus enters the human body it attacks the white blood cells which form the strong protection against diseases.
- These cells are commonly called the soldiers that protect our bodies from diseases
- HIV can stay for many years before making a person sick
- During this period the infected person has no symptoms of AIDS and feels healthy but can infects people

What is AIDS?

- AIDS is Acquired Immune Deficiency Syndrome caused by HIV
- It is acquired from an infected person
- It causes makes the immune system so that it becomes weak
- When the body has a very weak immune system a person is attacked by different illnesses

2.5.2 How can a person get HIV infection?

The main mode of transmission is through unprotected sexual intercourse
Women are more vulnerable to HIV infection than men (as discussed in module 1).

1. Sexual intercourse:

- HIV is abundant in the seminal fluid and the vaginal fluid of infected people
- When an uninfected person has unprotected sex with a person having HIV gets also infected.

2. Blood:

- Through transfusion of blood or other blood products.
- Through needle stick injuries or scarification by the traditional healers.
- Through injuries

3. Mother to child:

- During pregnancy
- During child birth
- During breastfeeding

2.5.3 Behaviour that increases the risk of transmission

Exercise:

Participants should brainstorm the behaviour that they feel are risky to them, to get infected from HIV. The facilitator should encourage them to explain why each risk factor mentioned is risky.

Among the mentioned risks there should be the following; they should agree or disagree if these are a risk to them and if they are how:

- Unprotected sex
- Multiple sexual partners

- Having sex with signs and symptoms of STI
- Alcohol abuse
- Traditional practices like widow inheritance, masculinity,
- Lack of knowledge of and not exercising sexual rights
- Lack of economic independence

2.5.4 Social factors that influence the transmission of HIV

1. Poverty:

- Women in the rural areas are mainly having low education and cannot earn their own income
- These women are mainly depended on their husbands for income
- Husbands sometimes do not give their wives enough money to cater for both themselves and their children
- This may lead to women engaging in extra marital partners for money and get infected with HIV

2. Migrant labour:

- Lack of local employment drives men to leave their wives to towns and cities for employment
- They get infected by other partners
- Women also in the absence of their husbands get lonely and involve themselves with others partners
- Both men and women can bring infection to their relationship

3. Cultural and gender issues:

- Role expectation of men and women may cause men to have multiple partners

- Women are expected to be submissive and subservient to their men
- This may cause women unable to assert themselves in such a situation
- Women cannot even negotiate condom use with their sexual partners
- Where widow inheritance is still in practice, as a dead partner may have died of AIDS leaving the widow infected with HIV

4. Poor and inaccessible health services:

- In many areas health services are very far and transport is scanty
- The attitudes of health providers may deter patients to seek medical help
- Poor management due to staff shortage in health services

5. Delay in treatment of STIs:

- Women may delay to seek treatment because:
- Due to their biological makeup women may not realize early that they are infected with an STI
- They may not tell their partners about the infection due to stigma attached to STIs
- They may lack relevant information
- They may sought alternate treatment while the condition deteriorates

6. STI as a risk factor

- STIs are infections passed from an infected person to an infected person during sexual intercourse
- STIs causes inflammation of the skin, rashes or sores on the genitals of an infected person
- These skin lesions caused an entry point for the HIV an a person gets the infection more easily than she would have been when she had no STI

- STIs cannot be easily detected in a female's genitals because of their anatomy
- The skin lesions are usually inside the vagina and cannot be seen externally and can results to getting HIV infection

2.5.5 Diagnosis of HIV infection

- How can you tell that a person is infected with HIV?
- It not easy to tell when a person has HIV infection
- Signs and symptoms are not enough to make a conclusion that the person in infected
- There are other diseases which manifest more or less in the same way as AIDS (TB, cancer)
- The only way to make a diagnosis is by blood test
- This is done by nurses in Voluntary Counseling and Testing clinics, counselors in the Counseling Centres and by the doctors in surgeries
- There is time when the virus cannot be detected even by a blood test
- This is known as a window period, which is from 6 to 3 months
- During this period an infected person can be tested HIV negative while he is in fact HIV positive
- Thus a person who tested negative should repeat HIV test after 3 months

2.5.6 HIV/AIDS progression

1. A person who is infected with HIV stays for a long time living with the virus without manifestation of any significant signs and symptoms.
2. This is why an infected person cannot tell when he got infected. When infected a person can live from 3 years to 12 years depending on how strong his/her immune system is.
3. Initially the patient has no signs of HIV infection.
4. Later there is development of mild episodes of illnesses.

5. This grows to more severe and persistent illnesses.
6. The patient then dies.

2.5.6.1 Signs and symptoms

Stage 1

In the first weeks of the infection there may be the following ailments:

- Raised temperature with episodes of feeling cold and hot (fever).
- Tiredness, muscle and joint pains
- Rash
- Sore throat
- Muscle and joint pains
- Swelling of the glands (lymph nodes)

Stage 2

- This is a period of good health where the virus lies silently without causing any illness to the person.
- CD4 cell which has fallen rises during the asymptomatic phase.
- During this period the infected person looks ad feels healthy.
- Depending on individual, this stage takes from 3 to 7 yeas (may take to 10 years in some people).
- The person however is able to spread the virus to who ever he comes to contact with.

Stage 3

This stage usually occurs between 2 to 3 years after infection
Signs and symptoms at this stage are:

- Colds and flu (fever) with recurrent upper respiratory tract infection
- Skin rashes, and nails infections (fungal infection)
- Herpes zoster (shingles)
- Oral thrush/fungal infection
- Ulcers in the mouth and throat and difficulty in swallowing
- Loss of weigh
- Swelling of lymph nodes on the neck axilla and groins

Stage4

After 5 to 8 years (or even earlier with some individuals) of infection the immune system has become very weak. The body develops AIDS where the person suffers episodes of illnesses which are more severe and more prolonged than in the previous stages. This shows that the body is no longer coping no matter what the CD4 cell count is. Viral load has increased more than the CD4 cell count. The most common symptoms of this stage are:

- Oral thrush
- Vaginal thrush
- Sores in the mouth and throat causing difficulty in swallowing
- Skin infections and mostly a skin rash characterized by elevated edges
- Herpes zoster or shingles
- Persistent fever and night sweats
- Severe loss of weight
- Tuberculosis
- Persistent diarrhea

Stage 5

At this stage the person is at full blown stage where the viral load is very high and the CD4 cell count is very low (refer to session on ART below). The person with full blown AIDS may develop the following illnesses:

Exercise:

The facilitator demonstrates condom use. Both a male and a female condom should be demonstrated. At the end of the session female condom supply should be done to women who stay with partners at home for them to try with their partners. On the last day of the training the participants are given a chance to share their experiences of using a female condom during the past days.

2.6 Anti-retroviral Therapy (ART)

- The abbreviation, ART, is it interchangeably used with ARV therapy. This is treatment used to weaken HIV.
- ART does not kill HIV or cure AIDS
- ART is a 3 drug therapy
- Some doctors who issue ART give patients only one or 2 drugs. This is not adequate and is dangerous as it may cause drug resistance.
- A person should have 3 drugs plus Cotrimoxozole (Bactrium)
- Cotrimoxozole is not an ART but is just an antibiotic to help body fight infections but it does not have any effect on the virus
- Cotrimoxozole is stopped when the CD4 count is 350 and more.
- ART is now available from the clinics
- However there are selected clinics which supply ART (all 15 clinics in the Hlabisa Sub-district provide ART).

2.6.1 What happens in the human body?

- CD4 are kind of cells in the immune system that are attacked by HIV
- The normal CD4 count in a healthy person is above 600
- CD4 depletes when a body is attacked by any infection but regains very soon
- As HIV kills the CD4 cells, AIDS progresses and viral load rises

- As the disease progresses the immune system is compromised
- This means that the CD4 count lowers and HIV multiples. Increase of the virus is known as the viral load increase.

2.6.2 Eligibility to initiate ART:

- In order to get into the ART programme, the patient should have been tested HIV positive.
- Positive HIV test results are not enough to qualify for the initiation of therapy. A CD4 count should be done.
- To get therapy CD4 count should be 200 or less. The person should produce an ID in order to have her CD4 tested.
- A Cd4 test that is more than 200 may render treatment ineffective.
- A person may start in ART even if her CD4 is more than 200. This a doctor's discretion when the person is at stage 4 of the disease and very ill.

2.6.3 Procedure:

- In order that ART is effective pre-initiation training is provided.
- This consist of 3 different training sessions and continuous counseling
- Training session include the following information:
  - ART side effects,
  - Pregnancy and HIV, ART, TB,
  - ART adherence,
  - Regimens and changing of regimens
  - Practical sessions on taking treatment

- At the end of the sessions when the person understands all about the therapy and is ready, treatment is initiated
- Other requirements are to have someone (contact person) to disclose to

- This is important so that the contact person encourages and monitors the intake of the treatment.

2.6.4 Precautions to take when on therapy:

- Treatment is taken daily for the rest of a person's life
- Treatment is taken at the same time every day
- Avoid sharing of treatment
- Avoid mixing of ART with other treatment. When side effects appear it will not be clear which one caused them and will therefore not be easy to treat
- Side effects are reported so that they can be treated early

MODULE 3

GENDER, CULTURE AND HEALTH AWARENESS

3.1 Glossary of terms

- **Gender**

This term refers to socially constructed role expectations of men and women from childhood through the process of socialization where both learn which behaviours and attributes are socially sanctioned or reinforced.

- **Sex**

Genetic or physiological characteristics of a person which indicate whether one is a female or male.

- **Gender equality**

Absence of discrimination on the basis of a person's sex in opportunities and the allocation of resources or benefits or in access to services (Klugman, 1997: 5).

- **Gender equity**

The concept refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that men and women have different needs and power which needs to be addressed in a manner that rectifies imbalance between the sexes.

- **Gender mainstreaming** .

Integration of gender concerns into the analysis, formulation and monitoring of policies, programmes and projects, with the objective of ensuring that these reduce inequalities between men and women.

- **Gender roles**

Gender roles refers to particular social and economic roles which a society considers appropriate for men and women. Gender roles differ between men and women so that women have a triple role: domestic responsibilities, productive work and community activities. Men are identified with productive roles. Gender roles and responsibilities vary from culture to culture and change over time. In almost all societies women's roles are undervalued.

- **Sex Role Stereotype**

Society has also ascribed reinforcements of these roles and behaviors. For instance when they are not adhered to sanctions are applied and when done as expected incentives in the form of praises and phrases are awarded. These are known as sex role stereotypes.

3.2 Objective

To sensitive participants of their subordinate position in society, of factors that keep them in a subordinated position, of how this makes them vulnerable to sexually transmitted infections like HIV and to empower them to take control their bodies.

3.3 Expected results

At the end of this module participants will:

1. Be familiar with conceptual differences between sex and gender
2. Develop understanding of how gender is constructed, maintained and reinforced
3. Learn how gender links to health and therefore how it makes them vulnerable to STIs including HIV/AIDS.

3.4 Conceptualization of gender concept

(This is the most interactive session of the intervention.)

Exercise:

1. The group participants are paired and each one tells her childhood experiences when she felt she was unfairly treated because of her being a girl. Here participants should compare themselves with their male siblings when they were all young.
2. The participants are told to think of how the way they were treated, affects them as adults in their relationships.
3. Each participant makes a presentation to the whole group, where they tell what the other had shared with her.

Exercise 2

- The participants are given the following statements to read. They mark as "B" where they feel the statement is based on the biological factors and as "G" where they feel it is based on gender discrimination.
- Where participants cannot read or write, statements are read out in the way that is understandable to them. They are made to respond verbally in a participatory manner so that every one understands.

Statements: (These statements have been compiled to be at the level of the participants. These may be changed to suit the participants' level of understanding. Participants giving answers should explain why they chose either "G" or :S")

1. The majority of traditional leaders in South Africa are men and most Home Based Care givers are women.
2. Women suffer from menstrual pains and men don't.
3. More women are raped compared to men.
4. Most sexually transmitted infections are asymptomatic in women while in men it is acute.
5. When infertility occurs in a couple women are blamed and isolated.
6. It is acceptable for a man to propose to a woman and not acceptable if done by a woman to a man.
7. A woman can breastfeed a baby and a man cannot.
8. Women need protection from men and men do not.
9. Men should have more women because they cannot control their sexual feelings but women can.
10. Women are at a higher risk to get infected with HIV than men.

Answers to the statements:

1. G	2. S	3. S	4. S	5. G
6. G	7. G	8. G	9. G	10. S

3.5 Agents of gender socialization

The following are the ways in which gender is taught, internalized and maintained in the society:

3.5.1 The Family

- Socialization occurs in the family where children are taught belief, norms and values of a society
- This occurs from early childhood and goes on through adulthood life
- Boys are taught differently from girls. Such gender role expectations lead to boys being treated differently from girls.
- In the family this is done in the following ways (let them brainstorm what happens in their families and ask them why does it not happen the other way round:

Toys: girls play with dolls....; boys play with cars...
Household chores: girls cook...; boys look after the premises...
General behaviour: Girls talk and laugh softly...; boys sit anyhow they feel comfortable...
Sexuality education: Girls are told to have one boy friend...; boys are not restricted...

Exercise 3
Participants should brainstorm how they bring up their girl children differently from their boy children.

3.5.2 The Church

The church is also an agent of gender socialization. Participants are asked to mention gender role expectations within the church and where they think gender equality is not exercised. For instance in the following areas:

- Church leadership e.g. priests, church choir conductor...
- Decision making...
- Sanctions e.g. in pregnancy...
- Judgement when adultery was committed ...

3.5.3 The school:

The school is also an agent of gender socialization and does this in the following ways:

Assembly area:

- Depending on a particular school, boys stand on their own lines either on the side or at the back
- Girls start songs or hymn
- Girls are the first to enter the classrooms and boys last (ladies first)

Classroom setting:

- Boys sit at the back
- When they are punished they are brought to the front and when punishment is over they get back to their desks at the back

School chores:

- Boys clean the board
- Girls clean the toilets, wash floors
- Gardening for boys

Sport:

Children are assigned to different sports events according to their being either girl or boy

- Soccer for boys (only in few schools that soccer is played by girls)
- Netball for girls
- Recently in the ethnic groups boys' netball has been introduced. However this is different from the boys' kind of netball

- Rugby for boys

3.6 How are gender stereotypes reinforced?

Exercise

The participants make contributions as to how gender stereotypes (in their environment) are reinforced in the following structures:

- The community…
- The workplace…
- The state (depending on their level of understanding)…

3.7 Gender and health

Exercise: "But Why?"

The aim of "But why" exercise is to connect gender issues with HIV/AIDS epidemic, so that participants may be able to understand how gender related issues make them vulnerable to HIV infection. The facilitator needs to have a bostic/prestic adhesive and different colours of cardboard papers cut into circles.

The facilitator starts a story about a girl who had left the school at grade (G) 8 and later got pregnant at the age of 16. It was discovered that she also had HIV infection. (Answers are written on the cardboards and arranged on the board using bostic in such a way that causes are in sequence from the first cause to the last one in a row).

1. Why did the girl leave the school at G 8?
2. The facilitator will keep on asking "Buy why?" Participants will be giving reasons making up their own story until the facilitator feels that all the answers are exhausted.

3. The facilitator will keep on asking questions like "Why did the girl get HIV infected at age 16?" "But why?" etc.
4. The facilitator will pursue any answer that leads to another relevant story and will also probe.
5. When the facilitator feels that she has exhausted the answers she will make a summary of all the stories so that it is clear to the participants how gender links with the epidemic.

Example: (Each box can have several reasons. As an example, please note the way to ask the 'but why' question in each box. This is done until all possible reasons are exhausted, but only one cause was provided in the boxes as an example).

Exercise: "But Why?"

Gender issue: socialization

A woman cannot defend herself *(But why can a woman not defend herself)*

Because she is a woman and she is powerless *(Buy why powerless?)*

She was raped *(But why was she raped?)*

Mother was infected by her husband, the girl's father

Mother died from AIDS and now she is staying with her father *(But why did mother contract AIDS?)*

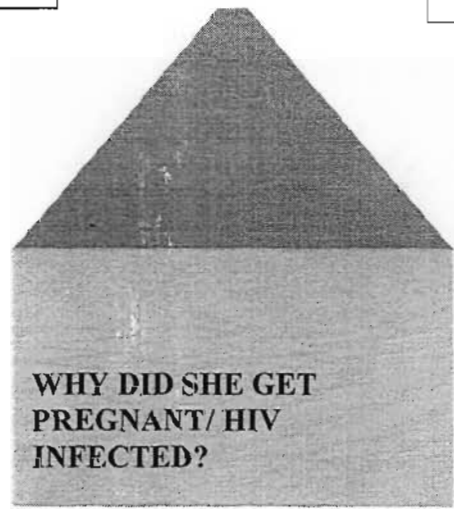
She was molested by her father *(But why?)*

Gender and culture inhibiting people to talk freely about mattes relating to sex

Because of sex being taboo. *(But why is sex taboo?)*

Mother /health services didn't inform her. *(But why didn't the mother inform her)*

She lacked adequate information. (*but why did she lack adequate information?)*



3.8 Linking gender and health (socio-cultural, economic, political, gender and sexual factors)

Exercise:

Nomusa's story (the exercise will be brought to participants' level of understanding).

Nomusa is the only girl among 4 boys in the family. All her brothers have professions but she went no further than G 7. She got married in the church to a man much older than her. Her husband decided to take a package and leave work. He is now having 2 taxis. Nomusa does not know how much income the business brings in, let alone owning her own bank account.

Daily while her husband is asleep she wakes up at 4am, prepares his fresh lunch box. Thereafter she prepares the family breakfast and cares for the children and the family. She is 30 years old and is 6 months pregnant with 7^{th} child. She is not using contraceptives. Mostly women here believe in traditional healing and though they encounter problems, they mostly do not seek medical help until it is too late.

Tonight Nomusa's husband is not at home she comes for medical help accompanied by her mother-in-law. She is presenting with PV bleeding and mild depression.

(The facilitator asks the participants to state which parts of the story are due to socio-cultural, economic, political, gender and social factors and explains clearly to them how the story links to these factors).

MODULE 4

WOMEN'S SEXUAL/REPRODUCTIVE RIGHTS

Sexual rights

"The human rights of women include their right to control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect of integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences" (WHO/RHR/01.29: 34).

It is of importance that the participants know their body parts. The facilitator let them brainstorm the parts and the facilitator helps them explain how each body part functions.

Female participants believe that they cannot have a say about their bodies where their husbands are concerned.

4.1 General objective:

To raise awareness of women's sexual rights (to female participants) and to educate them on the importance of improving their quality of life. It is to encourage women to make choices and decisions for themselves about themselves through the understanding that they have rights to control their bodies.

4.2 Expected results

At the end of this module participants will:

1. Be aware of the human rights in general and the sexual/reproductive rights in particular.
2. Develop understanding of how and when one can exercise their rights.
3. Understand political, social, cultural and economic factors that contribute to their susceptibility to HIV infection.

Exercise:

- The facilitator enlists different jobs and let the participants mention whether each belongs to males or females;
- e.g. Chef, housewife, teacher, farmer, nurse, dressmaker, traditional leader, head of the family, dressmaking, police, etc.
- Ask them what they think about these and if women can do those said to be men's
- Ask them about things that only a man can do and which a woman cannot do and vise versa. Participants are encouraged to do anything and everything that men do because they can also do it.

4.3 Body ownership

The facilitators ask the participants the following questions:

1. What does it mean to own something?
2. Can a woman own and control her own body just, as a man do?
3. If they say no: who else might own the body of a woman?
4. Why is it important that one owns her own body?

The above questions are discussed with the participants. Those who say their

bodies are theirs and they have control over them, the facilitator will probe to raise a discussion that clarifies that in real life situation they are able to state that and have power to control

In most cases though, women can say they can control their bodies but it is not like that in practice. Their bodies are controlled by other people and factors like culture, gender and economic status and other environmental factors.

4.4 What is a right?

A right means that we have rights to control our bodies, choice when and how to have sex, right not to be forced to have sex and accepting responsibility for consequences of our sexual behaviour

What are sexual rights?

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters pf sexual relations and reduction, including fill respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (Beijing: 1995).

Rights are mentioned to the participants as follows:

- The right to make choices about our bodies
- The right to sexual enjoyment
- The right to decide if and when she wants to have sex
- The right to say Yes or to say No to sex
- The right to protect ourselves from the risk of disease such as sexually transmitted diseases like HIV/AIDS

- The right to avoid unwanted pregnancy
- The right to choose the spacing of our children
- The right to choose how many children we want to have
- The right not to have sex if we do not want to
- The right to not to feel about ourselves during pregnancy
- The right to express our sexual orientation (homosexuality/heterosexuality)
- The right to have information on sexuality and sexual health in order to make informed choices
- The right to information

A short story:

Fikile is a young married woman who has a husband who works in Johannesburg. He comes home after every 3 months i.e. 4 times a year. During her visit he sometimes does not sleep with her because he is either too tired, drunk from celebrating in the neighbourhood or is with his local girlfriend.

Even when she is sometimes not well the husband demands sleeping with her and when she refuses, she is accused of having other men. She therefore agrees to sleep with him to show that she does not have any man. When Fikile suggests that they use a condom she is beaten and forced to sleep with him without a condom. He threatens of calling the family or send her back to her home.

Fikile wants to secretly go for sterilization but cannot have relevant information as she does not attend the clinics. They only use traditional healers in the family and her mother-in-law is a spiritual healer and a famous "mid wife". The family said that she will only stop having children once she gave birth to a boy. This is the reason why the husband is having another woman so that the new woman can "bear an heir to the family" Fikile's father forced her to marry this man as he had

'disgraced the family' by falling pregnant with his child. She now hates her father for forcing her to marry this man.

Exercise:

The participants listen to the story attentively and identify areas where Fikile's rights were violated. They mention each right and the facilitator makes corrections where there has been mismatching of the rights. This exercise will also enable the participants to look broadly at other factors that affect women, namely; socio-cultural, economic, political, gender and sexual factors.

MODULE 5

LIFE SKILLS DEVELOPMENT

5.1 Objective

The objective of this module is to incapacitate married women with assertiveness skills. Assertiveness would empower them with skills to communicate and negotiate with their husbands in matters pertaining to sex.

The participants will be able to engage in decision making in sexual matters so that they can protect themselves from getting infected from their partners. In summary, assertive training aims to enhance self-esteem among married women.

5.2 Expected results

At the end of this module participants will:

1. Have understood the importance of communication, ways of communication and how to communicate.
2. Develop understanding hoe conflict situation that may result to aggression can be addressed.
3. Understand the importance of assertiveness in communication and that assertiveness includes the ability to exercise one's human rights and how this is done.

5.3 Communication and Assertiveness Skills

5.3.1 Communication

Though there are several types of communication (verbal, non-verbal, visual, tangible, aromatic), we will discuss only two of these namely:

- Verbal
- Non-verbal (body language)

5.3.1.1 Communication process

- The sender e.g. the person talking to you
- The medium e.g. the telephone, facial expression, hand out or material etc.
- The receiver e.g. you

Statistics on the role of 5 senses in communication shows the following:

- Hearing represents only 11% of communication
- Sight makes use of 83% of the communication process
- Smell makes use of 3.5%
- The tongue makes us of only 1%
- The skin makes use of 1.5% of the communication process

Communication is a two-way process where on speaks while one listens i.e. the sender is coding his message by speaking and the receiver receives the message by listening. The receiver gives feedback to the sender by saying he understands the message. If he does not understand the sender has to repeat the message.

It is important to stress that it requires a skill not only to transfer information, but also to receive it requires a sensitivity to identify any disturbances, in the communication process and above all, to remove or to solve it.

5.3.1.2 Verbal communication

The following suggestions are made to improve the participants' communication skills:

Making sure that people you are talking to hear you. When people do not hear what a speaker is saying they do not pay attention

- Vary modulation and tone of voice to suit the situation-this adds emotion and meaning to the words
- Be ware of the pace when speaking: speaking quickly can be as detrimental as speaking too slowly
- Use pauses for clarity and emphasis
- Smile-this is a marvelous ice-breaker to reduce awkwardness and tension
- Relax and take your time: do not be in a hurry

5.3.1.3 Non-Verbal communication

This refers to body language whereby a person only speaks with gestures only. There is a an old say "Action speaks louder than words" meaning that even if a person says something if she means something else even if she did not say it the body language will say it.

Examples

- Posture:
- Facial expression:
- Tone of voice:

5.3.1.4 Double messages

When communicating with people it is imperative that we do not send double messages. The meaning of what we say should be seen in our actions if we want to be taken seriously.

Role-play 1

The facilitator asks one participant to show how young girls refuse sexual advancements from men, which ends up in a rape. She will tell the participants

that she should put the finger in the mouth, look at the perpetrator with begging eyes, make rocking body movements, sometimes look and write down with her foot, refusing very softly to sleep with him. This will lead perpetrator to grabbing and raping her.

The facilitator then encourages a discussion on what non-verbal language caused the perpetrator to rape the girl despite her saying, no.

Role-play 2:

The facilitator asks for one of the participants to play the part of the girl who shows in non-verbal language that she means what she says. Definitely, the results will be that the perpetrator will not be able to rape the girl.

Exercise:

The facilitator chooses one of the problematic issues in their relationships, as raised by the participants during the workshop. She asks them to show how they have sent double messages using verbal and non-verbal language when dealing with it. She asks them to role play how they would have done otherwise. The facilitator shows them how they can tell their husbands (or sexual partners) what they do not want.

5.3.1.5 The art of listening

Listening is an integral part of communication. The art of listening needs:

- Concentration
- The desire to understand and awareness of what is meant and
- Judgement of what is meant

Empathy is also very crucial to attentive listening:

- Empathy means getting in someone's shoes so that you feel what he feels. Looking at someone's point of reference and seeing the world through someone's eyes.
- This will make the listener to hear what is said as well as what is not said.
- A bad listener will make decisions that the subject is not interesting, will listen to facts, form an opinion too soon, be selective in what to or not to listen and day dreaming.

Requirements

- Make your message understood
- You must receive/understand the intended message sent to you
- You should exert some control over the flow of the communication

Techniques

- Silences:
- Paraphrase:
- Reflect:
- Summarize:

5.3.1.6 Confrontation

1. It you have a difficult encounter, keep your cool, do not lose your self-control because that will not help.
2. Insults and rudeness are ineffective. If you call people names, they are unlikely to actually *listen* instead if they have more power than you they can hurt you.
3. If you are going to criticize someone, always assume that you have misunderstood the situation and ask questions first to check your facts. The following could be done:

- Rephrase/paraphrase
- Clarification: if a point is too wooly or to vague ask for greater clarity "What exactly are you saying?"
- Reflection:
- Context: providing a broader picture can make full understanding of the situation. There is less scope for alternative interpretations or ambiguities

In communicating with others state clearly what you want to communicate across Acknowledge what is being said; State your own point of view clearly and concisely with perhaps a little supporting evidence; State what you want to happen next (move forward).

This is what is called assertiveness and is discussed in the next section.

5.3.1.7 Relationship conflict Skills

Most people lack relationship conflict resolution skills. It is important to know that conflict is not always destructive. This means that sometimes conflict should happen in order to solve certain problems. However it should be very minimal for the survival of the marriage. The following hints can sharpen our skills in this regard. Remember that your marriage was meant to be a lifetime commitment.

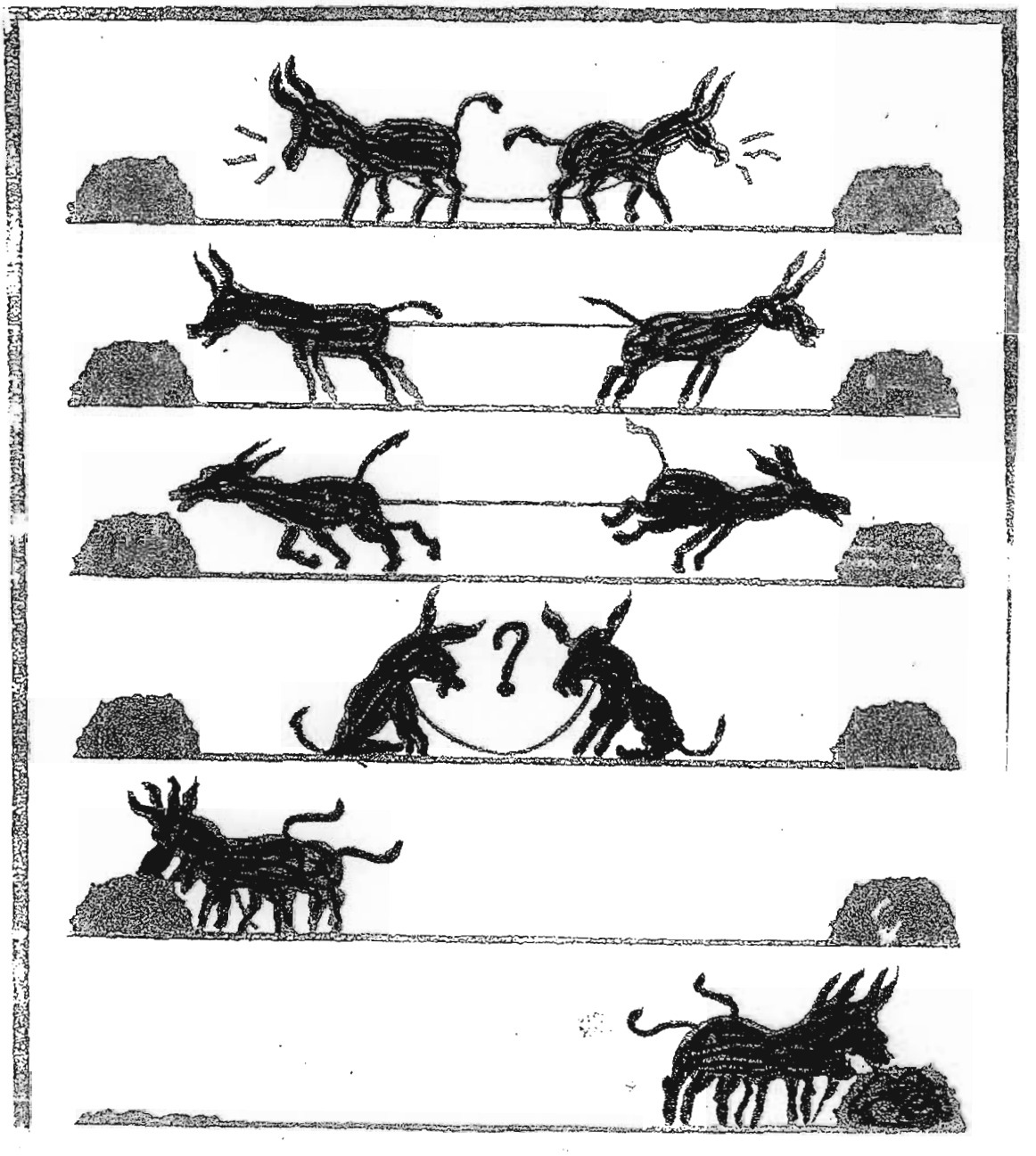
1. **Be respectful.** Do not call names, use sarcasm or belittle your partner. If you relapse in harsh words then apologize immediately.
2. **Keep the problem the problem.** Do not personalize it. Attacking your partner will only result to disagreement. Use "I" or "we" words instead of using "you" statements.
3. **Stay on one subject.** If the problem is the mother-in-law, the other problems like money, drinking etc. should not be mentioned. Handle one problem at a time.

4. **Use time-outs as needed.** If there is a burst of tempers and you find it difficult to control it agree to discuss the issue later when you have calmed down. Take a shower to calm down.
5. **Listen for understanding.** Make a real effort to try to understand what your partner is saying as much as he also should. We need to feel that what we have to say is important.
6. **Do not mind read your partner** by assuming that you know what he thinks and feels because feelings and thought change over time.
7. **Try to see things from your partner's point of view.** This does not mean that you agree with him. When you are on the same understanding of the problem it both of you stand a chance of solving it.
8. **Seek to solve the problem.** Work as a team. The attitude should be "What can we do together to solve this problem?" Strive to the same goal.
9. **Forgive and accept each other.** Truth can be spoken in love, trust and forgiveness. Remember that the disagreement belongs to both of you so is the solution.

The process of conflict management discussed above shows the importance of communication, problem solving and reaching consensus to achieve solution as shown on the picture of the two donkeys below.

TEAM WORK

AN EDITORIAL WITHOUT WORDS



(The following exercise will show what the kind of relationship that provides adequate atmosphere for people to solve problems).

Exercise:

The name of this exercise is called "I am **the** man" meaning that I am a real man. The facilitator will need 2 participants, a stick, 4 bags taken from the participants, a large towel or a jersey to carry a baby with and a baby which could be anything.

1. The facilitator calls for two volunteers from the participants: one will be the real man and must have good understanding of how a real man acts. The other will be the real wife who is submissive and bears everything.
2. The woman is given a 'baby' to carry on her back
3. She is also given as many bags as she can carry. She is carrying them even on her head
4. The man is only carrying a stick very proudly or many (as a Zulu man would do)
5. They walk with man in front of a woman with the gap in between them
6. As they are walking the facilitator shouts, "Freeze"! and they stop motionless in those positions
7. The two would be in suitable positions to portray a real man and a real woman respectively.
8. The facilitator asks them who are you (representing)? Each would say who they are (representing).
9. How do you feel now? They would both say how they feel in their positions as a man and a woman in the road of life.
10. The facilitator would now ask other participants to change the scene/picture if they feel it is not correct.
11. Each participant will stand up and try to make a picture of a man and a woman in a relationship.

12. The ideal picture would be when they are both seated with the baby on the father's lap, a man hugging his wife with the other hand, with all the bags down near them.
13. The facilitator would ask the participants what was wrong with the first picture and what did it mean?
14. They should be able to say that the woman was having all the family burdens on her including bearing of children and bringing them up with the man only appreciating his manhood without bothering about the family problems.
15. The facilitator asks them about the gap between the man and the woman on the first picture.
16. They should be able to see that the gap between them meant that they were not close as a couple, that one did not know what was happening to the other, and the gap meant that anyone could come and go in their relationship infecting them with STIs and even HIV.
17. The facilitator asks them what is happening in the new picture.
18. Expected responses would be: love, sharing of burdens and responsibilities including child upbringing, decision making etc.
19. The facilitator asks them if they can take the initiative to change the picture in their relationships.
20. The facilitator listen to their responses and note the difficulties they are stating and tries to make them solve those difficulties
21. If they verbalize real difficulties the facilitator asks them to role play them and let them try ways to make changes.
22. She tells them that the next session would help them to acquire skills to communicate with their husbands.

5.2.2 Assertiveness Skills (National Institutes of Health: Head injury Hotline, 1998:1-3).

To be assertive is to stand up for your own rights or for what you want and stating your needs clearly. It means expressing opposition, confrontation and it takes courage, but in such a way that you do not violate someone else's rights. Rights also involve responsibilities. The aim should be to solve the problem.

Assertiveness should not be confused with aggression because aggressive people adopt a 'I win-you lose" mentality to archive their objectives.
Non-assertive people are either aggressive or passive. Passive people are not committed to their own rights and are likely to allow others to infringe on their own rights than to stand up and speak out.

5.2.2.1 Aggression

1. Aggressive people are most likely to defend their own rights and work to achieve their own goals but are likely to disregard the rights of others.
2. These insist that their feelings take precedence over other peoples'.
3. They tend to blame others fro problems instead of offering solutions.

Assertive people recognize that other people have rights
The assertive people's behaviour is designed to promote communication and problem solving. This person uses variety of behaviours depending on the situation. The assertive person appears energetic yet relaxed.

The assertiveness quiz below helps one to have an idea of how assertive they are. These are general questions not specific to the experiences of married women. The facilitator should be able to explain the quiz as shown below to enable the participants to think about their own experiences of non-assertiveness when communicating with their husbands.

5.2.2.2 Assertiveness quiz

1. Do you buy things you do not want because you are afraid to say no to the salesperson?
2. When you do not understand what a person is saying to you ask for an explanation?
3. Do you feel responsible when thing go wrong, even if it is not your fault?
4. Do you look directly at others when you talk to them?
5. Do people often ask you to speak more loudly in order to be heard?
6. Do you feel intimidated by people in authority?
7. Do you generally have good posture?
8. Do you often feel so angry you could scream?
9. Do you know how to ask for help without feeling dependent?
10. If someone cuts in front of you in a line, do you usually tell them off?

Assertive responses

1. No	2. Yes	3. No
4. Yes	5. No	6. No
7. Yes	8. No	9. Yes
10. No		

Explanation of answers to the Assertiveness Quiz

1. The assertive person is not afraid to say no. She or he feels free to make choices.
2. The assertive person takes responsibility for getting his or her needs met. Fear of seeming ignorant does not prevent the assertive person from asking questions
3. The assertive person takes responsibility for his or her behaviour but does not take responsibility for the behaviour of

others or for situations which are beyond his or her control. To feel responsible for things beyond your control leads to unnecessary feelings of guilt.

4. Direct eye contact is assertive and suggests sincerity, self-confidence and the expectation that others will listen
5. An assertive person wants to be heard.
6. An assertive person does not allow status to intimidate him or her.
7. Good posture communicates a positive self image. When posture is limited by a disability, good eye contact and facial expression can be used to express a positive self-image.
8. The assertive person works to get his or her needs met, and does not let situations build to the point of crisis.
9. The assertive person is able to ask for help without feeling depended because he or she maintains a strong sense of self worth and self-respect.
10. Telling someone off is an angry, aggressive response. The assertive person would state that he or she is irritated by the unfairness and ask the person to move to the end of the line.

Exercise:

1. Participants are divided into groups. They discuss about their own situations or experiences.
2. They choose 5 situations where they feel they have lacked assertiveness.
3. They all discuss and then brainstorm the solutions or how they should have been assertive.
4. The facilitator asks them to choose one or two issues that they feel are most critical in their lives.

5. A few participants are asked to role-play the situation and a discussion follows where a "why" question is asked for each behaviour that the participant did in the role play.
6. While still in role play each participant answers why she behaved as she did. After all of them gave answers for their behaviour they de-role.
7. Other participants in the group are asked to role play the previous situation in an assertive manner.
8. In the process of the role-play if any participant feels that one does not do it appropriately she stands up and takes the place and do it the way she feels is appropriate.
9. This is done in a funny way so that they all enjoy and feel free to participate in the role play as they feel.
10. This is done until they are all satisfied and confident that they can go home and apply the skills to the situation with their partners.

As assertiveness is a right, knowing our rights will help us exercise assertive behaviour.

If you are clear about your own rights you will be able to see if you are violating other's rights or if they are violating your rights.
Some rights are based on laws such as consumer rights and equal opportunities

Other rights are based on accepted standards or norms of behaviour such as the socially expected in a given situation. The following are a suggested bill of rights of assertiveness which are part of the Constitution of South Africa.

Activity: While the facilitator goes through the following human assertive rights she will explain what they mean as much as possible.

1. The right to do anything which does not violate the right of others
2. The right to be assertive or non-assertive
3. The right to make choices
4. The right to change
5. The right to control over body, time and possessions
6. The right to express opinions and beliefs
7. The right to think well of oneself
8. The right to make requests
9. The right to express sexuality
10. The right to have needs and desires
11. The right to fantasy
12. The right to have information
13. The right to have goods and services which have been paid for
14. The right to be independent and to be left alone
15. The right to say no
16. The right to be treated with respect

Exercise:

The participants are divided into small groups. Each group is given a number of assertive rights to discuss as a group. For each right they make an example of where the rights apply in their married life situations. Each group comes back to make a feedback.

5.3 Support systems

(In order to conduct this session it is essential that the facilitator has at list lay counseling skills)

Most people today lead a stressful life. To different people stress may be due to different stressors, which emanate from the following environmental factors:

- Economic : unemployment, poverty
- Social : lack of resources due to the social class
- Cultural and gender : men or women expected to behave in a particular way
- Political : spatial, health system, burden of disease and death

Exercise:

Participants are asked to brainstorm stressors they feel are most common and most problematic in their lives. They are then divided into groups and each group is given one or two stressors to discuss on the following:

1) What causes each stressor?
2) How they have coped or are coping;
3) Who do they share their problems with and why they chose that person.

Each group will chose a representative who presents their input. They all participate in asking the presenters questions. They can also share problems or barriers they encounter when adopting coping strategies they have mentioned and how they feel about it (this may be a touching experience for the participants as they will sometimes wish to narrate their own painful experiences but it is essential and is a healing exercise).

5.4 Coping strategies

Ways of coping differ from person to person. Whatever a person chooses, it is crucial that everybody has her own way of coping. Where there are no coping

strategies health is affected. The following signs manifest when a person is having stress and is not coping:

- **Psychological** : headaches, irritability, sleeplessness, forgetfulness, faintness
- **Physical** : abdominal pains, general body aches, palpitations, raised blood pressure, ulcers, heart failure and death.

The facilitator enlists coping strategies that participants can choose from. However, participants can stick to coping strategies that work for them.

MODULE 6

ECONOMIC SKILLS DEVELOPMENT

6.1 Introduction

From the study, poverty came out as one of the factors that drive women to engage in extra marital relationships. One of the strategies pointed out by women to enable them to become economically independent so that they do not engage in practices that make them vulnerable to contacting HIV infection, was economic skills development. Therefore to empower married women, so that they do not depend entirely on their husbands, they need training on economic skills.

6.2 Objective

This module aims to incapacitate women on how to start their own small businesses; how to raise funds and how to enter into the labour market.

6.3 Expectations

At the end of the module women will have acquired economic skills that:

1. Would empower them to make their own decisions regarding sexual matters.
2. Enable them to fight against being economically dependent on men and be infected by them with HIV.

6.4 Group formation

6.4.1 Income-generating group

It might not be the whole group that needs economic skills. However in order that a group functions effectively it should constitute eight to fifteen members. The group should be homogenous. This means that members should be live under similar economic conditions, have similar background and should live closely together in one community.

The facilitator should:

- Do a skills audit by enlisting all the skills that the group members have. These may vary from beadwork, mat making, *ubumba* (clay), sewing etc.
- Choose the most common 3 skills that the group has
- Look at the quality of knowledge the group members have
- Start with the skills that least need polishing.

6.4.2 Set specific objectives:

The group should express their goal as to what they want to achieve and how to achieve it. They should not expect too much too soon but should make goals that are SMART:

S-simple

M-measurable

A-achievable

R-rational

T-time bound

The facilitator should help members establish their goals

6.4.3 Membership

- Make a list of people who are interested in forming a group.
- Choose the name of the group

6.4.4 The elements of a self- help group

A group that is cohesive and sustainable consists of 4 key elements or building blocks.

- **Leadership**

  A group that is well led usually succeeds. Leaders and committee members must be chosen carefully.

- **Contributions**

  A group contributes to their group activities so that they can build a sense of group ownership and solidarity

- **The group constitution**

  A group draws a constitution which is a written record of purpose and rules for the group to avoid internal conflicts and clarifies responsibilities for each member of the group

- **Record-keeping**

  Records help the group to remember what has been discussed in meetings.

  Recording also acts as an important tool for monitoring and evaluation.

6.4.4.1 Leadership

The group should have a structure consisting of ordinary members and management committee made up of a chairperson, secretary, and treasurer.

Desirable qualities of leaders

- Active, energetic, and good at motivating others

- Respectful but not shy
- Brave honest and patients
- Able to work with others
- Able to communicate with others
- Not a drunkard and not a gossip
- Able to keep group secrets

All the members of the community must know their duties e.g. the chairperson, the secretary and the treasurer

6.4.4.2 Member contributions

- Members should make contributions either in cash or in kind
- The facilitator should discuss with the group why and how members should pay contributions.
- Contributions should be made in kind or in cash by group members It should be specified in writing what the money is for
- Contributions should be made regularly weekly or monthly
- Treasurer gives the receipts and keeps proper records of expenditure

6.4.4.3 The Constitution

The constitution will set out the rules that will minimize conflict and improve efficiency of a group decision making. Rules are necessary to guide and discipline members.

The following are the contents of the constitution.

	Item	Issues for discussion
1.	Objectives of the group	
2.	Membership	Names, qualities, duration, responsibilities.
3.	Committee	Types of posts, duties of the committee and the committee members, how long elected for.

4.	Disciplinary action against committee members	What to do if are not carried out e.g. fines, dismissal.
5.	Meeting schedules	Place time, day. Number of members needed for decisions, unanimous or majority decision making, reporting absence, representation fro absentees allowed? Can representatives vote?
6.	Contributions	When to pay and how much. Joining fee and regular contributions. Installments of payments. Who to pay. Where to keep the money. Purpose of contributions What to do if money is lost. Record keeping.
7.	Disciplinary action against members	For absence, late arrival, accepted excuses, amount of fines. When to pay, what to do in case of non-payment of fines. What to do if non-payment of contributions
8.	Record keeping	What to be recorded, by whom.
9.	Savings	Purpose, where o be kept; how to save; record keeping
10	Profit	Use of profits' sharing; when and who; what to do in case of death, drop out, absence and negligence of work
11.	Loans	Rules for re-lending of group savings to members; interest rate; terms of payment; penalties of non-repayment.

Record keeping

It is imperative that all records are kept safely for future reference and monitoring and evaluation purposes of the project.

Income-generating project

There are steps that the group needs to follow if it is going to be successful and sustainable. Successful income generation requires a number of key building blocks. These are the following:

Building blocks

- **Feasibility:** The group activity must be able to produce a product that people want to buy.
- **Profitability:** The activity must produce more income than it spends. Planning: The group must decide in advance the goal, tasks and resources of the activity.
- **Marketing:** The group must strive to satisfy its customers.
- **Savings:** Savings provide the resources needed to start or expand the group activity.
- **Loans:** Loans can be sought for a group activity- but only after the group has demonstrated its ability to save regularly.
- The following section describes each of these building blocks in detail.

6.5 Feasibility study for the chosen project

- Before starting a project members should know if the exercise is practical;
- Whether there is market for their product; and whether or not it is likely to make them money.
- The feasibility study will address such questions. Conducting the feasibility study will take at least a month.

Why the feasibility study?

- The study will help the group avoid investing money, time and energy in an enterprise that might fail to produce a profit
- The study will also help the group to decide on the best way to set up their enterprise, in terms of market, resources and risks.

Steps in the feasibility study:

Step 1 Find out if there is market for the project

Help the group to study

- The market i.e. the customer who buy the product
- The competition i.e. those who sell similar products.

Gather information about potential customers

- Who are they (men, women, children, education)
- Where do they live?
- How much can they afford to pay?
- When do they need the product?
- What do they expect from the product?

Gather information about competitors

- Who are they?
- Where do they sell
- What do they sell and to whom?
- What price do they ask?
- What conditions of payment do they offer (cash, credit, barter)?
- When do they sell?

This information the group will get from the customers, sellers and producers. It there is a chance for the project success the next feasibility study would be

Step 2 Resources analysis

It is necessary to find out what resources will be needed to start the enterprise. Needed resources may include the following:

Material: Kind of materials needed, and if they are accessible.

Transport: The kind of transport needed, when and how often.

Skills: Skills that are needed and how it can be arranged.

Facilities: Electricity, water, etc

Time: If all members are available to help start and run the project

Labour: If hired workers are needed and who will do what?

Sample checklist of required resources			
Items	***What we need***	***What we have***	***What we need to buy and where***
Material			
Transport			
Training			
Facilities			
Labour			
Packaging			
Promotion			

This information may be gathered in he same way it was gathered for the materials. The above checklist may be useful to finding out the what resources are required and where to get them.

Step 3 Start up and operating costs

In order to estimate the start-up costs and operating expenses list all resources that cost money and estimate expenses for one production cycle (i.e. the period of time needed for producing one batch or set of items) and for one year

This information could be obtained from other sellers, producers and specialists. Train the members to have confidence to approach authorities or expects.

Sample worksheet for estimating start-up costs			
Items	***What we need***	***Quantity***	***Costs***
Material			
Transport			
Training			
Facilities			
Labour			
Packaging			
Promotion			

Step 4 Identify sources of money for start-up and operating costs

Among skills the members should acquire is self reliance. They should not be encouraged to be dependent on money lenders. They should be able to fund their own enterprise thus they are the ones to identify the source of funding. It should be stressed that the group's own resources should be always be the primary resource of funds.

The following is the sample worksheet for identifying what the members need at how much for one production and at how much for the whole year.

Sample worksheet for estimating operating expenses				
Items	***What we need***	***Quantity***	***Costs x cycle***	***Costs x year***
Material				
Transport				
Training				
Facilities				
Labour				

Grants or subsidies

The group should discuss whether grants or subsidies to start off the project are needed.

The group should consider sustainability of the projects should the grants cease or come to an end.

It may be a good alternative to have a once off start up grant to enable the group to start off so that their self-reliance is not undermined.

Loans

- Loans should be considered carefully whether repayment is possible in a specified time.
- It is better to start small with existing means than to make more sophisticated business which could be more riskier.
- If members decide to take a loan, savings - first approach must be emphasized. Credit should be linked to savings.

Step 5 Risks

1. The group should discuss the risks, as the enterprise may fail for several reasons. The following are some of the risks:

- Members may not cooperate
- Members may not have the necessary management skills to run the project
- Government policies may affect the progress of the project
- Changes in demand of the product
- Costs or prices
- Weather
- Diseases
- Theft

2. The group should discuss these risks and determine how their intensity can be reduced.

3. Proper training of members may help reduce the risks.

4. Adequate information on some issues related to the business may help reduce the risks.

6.6 Profitability Assessment

1. It the enterprise seems feasible in terms of the market, resources and risks it is crucial to assess profitability.

This is to see if the money earned is enough to cover the costs and produce a profit.

The following steps will be useful.

Steps in profitability

Step 1 Estimate the sales price

Cost + profit = Sales price

Step 2 **Estimate annual income from sales**

Calculate the sales price per year by multiplying the sales income by the number of weeks, months or cycles in the year as appropriate.

Step 3 Prepare a cash flow chart

Prepare a cash flow chart which is a summary of cash coming from in and gong out as seen on the chart below.

Step 4 Calculate the profit of the enterprise

The profit or loss can now be calculated from the cash flow chart. First calculate the cost of sales:

Cost of sales = Start up expenses + operating expenses - repayment of loans

Then calculate profits or losses like this:

Profit = income from sales – cost of sales

Cash Flow Chart for Group Activities

Months	1	2	3	4	5	6	7	8			11	12	Total
Expenses													
Start up expenses													
Materials													
Transport													
Training													
Facilities													

Labour													
Packaging													
Promotion													
Sub-total													
Operation costs													
Materials													
Transport													
Training													
Facilities													
Labour													
Packaging													
Promotion													
Loan repayment													
Sub-total													
Income													
Sales													
Contributio n													
Loan													
Sub-total													
Total Profit or loss													

Step 5 Planning

The facilitator should discus planning with the group. They should know that everything in life should and is planned for.

Planning will also help the group to do the right things at the right time in order to achieve their objectives.

- The facilitator helps the group to draw a work plan.
- The group makes a 'do-to' list first. This is a list of things that the group needs to do, when to do them and people who will do them.
- This is done in a chronological manner.
- Them they draft a time table starting with the most important activities
- Ensure to include time needed to do the activity

The following is a sample the work plan:

Sample work plan of bead work group				
What to do	***When***	***By whom***	***When done***	
Fee	August	10 members	15/8-30/08	
Buy materials e.g. beads et	September	Mrs. P.	1/9-15/9	
		Mrs. Q		
Start first production	September	Four members	20/9-30/10	Mrs. T. Mrs. U. Mrs. V. Mrs. X

6.7 Marketing: The six P's of marketing

- **Product**

The product should be of good quality, readily available, well stored, properly packed and attractive

- **Place**

He place where the product is sold should be central, easy to find and clean with good display and storage facilities

- **Price**

The price of the product must be reasonable, competitive and displayed clearly.

- **Promotion**

Promotion of the product should consists of good slogans, names and signs attractive sales techniques, product displays and demonstrations.

- **Plan**

Operation of the business should be flexible. The group should review its plans regularly and make changes if necessary.

- **People**

The people who sell the product should be polite and honest and provide good service.

6.7 Savings

1. Savings refers to setting aside available resources or income for use.
2. Savings can be in cash or in kind.
3. Savings in kind can be any materials that cold be sold and turned into cash.

The importance of savings

Exercise

The group discusses the different ways of saving and the different reasons for saving, advantages and disadvantages of saving.

Hey should then enlist the differences of keeping the money in the bank or at home.

The facilitator draws the following structure so that the group sees the pros and cons of saving at home and in the bank.

Keep savings in the bank or at home?

	Pros	Cons
Local	Easy access	Easy to steal
Bank	Much safer	Difficulty in access

Points to emphasize when promoting saving

Methods of group saving

There are many ways to see money. The following some of the options a group can choose from.

Bank accounts

Open a group account in a nearby bank and the group puts the group contribution into the account regularly.

Savings kept by the treasurer

Group members save regularly but keep their funds locally with their treasurer.

Cash contribution

Every member brings to a group meeting an equal amount of cash, which is added to the group savings fund.

Rotating funds

- Everyone brings an equal amount of grain to a meeting, which is then put in a storage container by the group treasurer.

- Once the container is full the grain is sold and the cash is used to increase the group savings funds.
- Alternatively, every week members bring equal amount of money to the treasurer.
- At the end of an agreed period the savings are given to one of the members. Then saving begins again and another member gets the money after the same period of time.
- The process continues until all members in the group have benefited from the fund.

Lending of group savings

- If the bank is far away the group may prefer to hold their group savings locally.
- Once the fund becomes large enough they may decide to lend part of their funds to individual members for short term emergency credit needs.
- Loan issued from the group funds should be small and be repaid in a short time e.g. one or two months.

6.9 Loans

- A group should not be encouraged to seek credit until it has demonstrated its ability to save regularly and has already saved an amount equal to a significant part of the proposed loan.
- The facilitator should explain to the group that the bank makes interest out of borrowing money. If the group borrows from a bank and does not repay the loan or the interest, the bank may take immediate legal action against them.
- Governments and donors sometimes provide loans often with very low interest rates. The facilitator should rather encourage the group to take these kinds of loans. However the group should be aware that sometimes

politicians borrow money to people because of personal reasons. For instance to influence voting at election time.

- Group should be careful about accepting such loans, i.e. they should carefully assess hidden dangers and risks.

How much to borrow

- The groups tend to borrow more than they can use properly.
- The loan should not be more than three times the amount of money the group has saved.
- The group should have a well defined plan before applying for a loan. (as in above section).
- The group should ensure that the loan is paid back.
- A group that fails to pay back the loan damages its social and business reputation.
- None payment may lead to problems with the police.
- Groups which do not repay loans will be denied further loans by the bank.

6.10 Self – reliance and sustainability

Now the group has been formed and has developed its own rules, record keeping system and in-generating activities the role of the facilitator changes to that of an advisor.

6.11 Guiding the group

- To guide the group towards self-reliance and sustainability is a slow process.

- At the beginning the facilitator spends more time with the group but later s/he assistance will be reduced to irregular visits to monitor progress and to discuss new progress
- As the group grows financially the members will be empowered to take the initiative and so become less dependent on the facilitator.
- At this point the group may even want to start other projects. They may decide to use their profits to start these income generating activities.
- The facilitator can help the members to connect with other people or organizations who can assist them.
- The facilitator can strengthen the group members' confidence and self-esteem by recognizes their knowledge skills and positive aspects of their group or enterprise. The group should also be made aware of their weak points as well
- They should be told that setbacks or failures should be looked at positively as means to improve their performance to avoid further failures.
- At this point the group may be encouraged to form other groups if they feel like that.
- The group is not isolated from the community and will be influenced by local social, political and economic changes
- To help them grow stronger they must meet regularly in order to exchange ideas, to solve problems, to organize help from outside agencies.
- Cooperation may be informal or formalized through inter-group association, which is organized and registered easily.
- An association of groups is more powerful that the single groups. However association requires more skills to manage as it may involve several activities.
- Achieving group sustainability also requires links between the groups and the outside organizations.

- Groups must be taught how to approach and deal with government and Non-governmental (NGOs) officers. Such officers are not always sympathetic to the poor as they often target the big organizations and members of the rural elite.
- Inter-group associations can help in linking groups to government and NGO services.

6.12 Measuring self-reliance

The facilitator should be able to recognize when a group has reached a point of self-sustainability and no longer require s/her assistance.

Indicators

- Regularity of group meetings and level of member attendance
- When group member attendance of the meetings is still high even in the facilitator's absence the group is ready for self-reliance.

Shared leadership and member participation in group decision-making

- Shared leadership responsibilities and high level of shared decision making, develop strong leadership base. Groups dominated by a minority are unstable and vulnerable to leadership crises.

Continuous growth in group savings

- Group savings is a key measure of members' faith in and financial commitment to the group activities.
- It is also a good indicator of the profitability of the group activity

- Groups who do not save or save very little are less likely to achieve sustainability.

High rates of loan repayments

- A group's capacity to repay loans on time is an indicator of group discipline and profitability of its income-generating activity.

Group problem-solving

- A group that solves problems and takes initiatives for its self development in the absence of the facilitator has a high level of member confidence.

Effective links with development services

- The self-reliance of a group depends on its ability to maintain links with government and NGO development services, in the absence of its facilitator.

6.13 Monitoring and Evaluation

- M&E is an essential function of any development effort. It helps to identify the problems, to measure progress toward objectives and to evaluate results.
- It is a tool that helps groups to strengthen their problem solving capacity and achieve self-reliance.
- The group should be made aware of the importance of monitoring and evaluation tools.

6.13.1 What is Monitoring and Evaluation?

- **Monitoring** is about keeping regular records of group decisions, actions and finances and checking that actions are taken according to plan.
- **Evaluation** can be ongoing or once after a period of time. It ensures that the group is achieving the objectives and helps to identify possible improvements if the group lags behind.

6.13.2 The Monitoring and Evaluation process

- To asses whether the group's activities are on the right track
- To suggest ways of adjusting or changing plans if necessary to improve the performance.
- Should involve members in the planning and implementation of activities as much as possible.
- Helps the group to improve its effectiveness by continuously assessing its own progress and periodically evaluating the results.
- Therefore learns from past mistakes and increase its self reliance and strength.
- Thus there should be a system of reporting progress and results to higher authority. The group members should decide what areas they will monitor and evaluate. Thus they should draw indicators, develop systems and processes that will make them assess if they are still going to the right direction.
- To do this, the group may organize an external auditor or any person who is an expert in this regard.

SOURCES

Advice Desk. Durban: University of KwaZulu-Natal Atlas printers.

Assertiveness skill training courses 2005). Conflict management dealing---total success training LTD London. www.tsuccess.dircon.co.uk/assertiveness.html.

Blair, G.M. 2006. *Communication skills.* University of Edinburgh Chatwel-Brat (UK) and the institute of electrical and electronics Engineers (USA). www.see.ed.ac.uk/~Gerard/mnt/art7html.

Cottingham, J., Fonn, S., Garcia-Alarino, C., Gruskin, S., Klugman, B., Mwan, A.N., Ravindran, T.K.S., Snow, R. and Xaba, M. (2001). *A training curriculum for health programme managers. Transforming health systems: gender and rights in reproductive health.* Johannesburg: University of Witwatersrand.

Cook, J. and Thomas, G. 2000: *The group promoter's resource book: a practical guide to building rural self-help groups.* Food and Agriculture Organisation of the United Nations Vale Delle Terme of Caracalia: Rome.

De Bruyn, M., Jackson, H., Wijermars, M., Knight, V.C. and Berkvens,R. KIT SAFAIDS 1998. *Facing the challenges of HIV/AIDS, STDs: A gender based response.* Royal Tropical Institute. Netherlands.

Decker, M.J. 1991. *Society for human sexuality: article on negotiations.* www.sexuality.org/1/bdsm/deckneg.html.

Jewkes R., Penn – Kekana, L., Levin, J., Raskana, M. and Schriber, M. 1990. *"He must give me money, he must not beat me": Violence against women in 3 South African provinces.* CERSA (Women's Health) MRC, Pretoria.

Human Rights, South African Constitutional ACT 1996.

KwaZulu-Natal Administration. *Sexual Harassment Policy Section 20 of the Public Service Act 1994.* Pietermaritzburg.

Nelson*Taylor*Langer (1998) National Institute of Health Traumatic Brain Injury Rehabilitation Consensus Statement. www.headinjury.com/assertquiz.html.

Ravindran, T. S. 2001. *Transforming Health Systems: Gender and Rights in Reproductive Health.* WHO Department of Reproductive Health and Research Family and Community Health. Switzerland: Schuler S.A.,

Wallstan, E. (200). *Handbook for mainstreaming. A gender perspective in the health sector.* Women's Health Project Department for democracy and social development health division. University of Witwatersrand, Johannesburg.

WHO and the Department of Reproductive Health Research. 2001. *Family and Community Health.* Switzerland: Schuler SA.

discussions at the Africa Centre premises. The Africa Centre uses the open plan space and some of the board rooms are not sound proof and have very thin wooden partitions as walls around them. During the focus group discussions, when participants' excitement was at its peak, this sound transfer caused a disturbance to other people in the building. It was not always easy to organize the FGD. When another FGD was organized, the organizers reported that participants withdrew and so the FGD did not occur as planned. Organizing the FGDs was more difficult than organizing the interviews as participants were scattered around the *izigodi* of the Demographic Surveillance Area and had to be organized in order to come together.

3.17 Introduction to the designed intervention

One of the objectives of the study was to 'design an intervention programme that would inform and sensitize married women about sexual practices that influence their vulnerability to HIV infection'. Among factors participants mentioned as causal to women's vulnerability, were economic factors, limited knowledge on health and diseases, lack of access to environmental resources, lack of awareness of their reproductive rights, and engaging in risky behaviour.

Van Dyk (2005: 147) recommends that HIV/AIDS education "form part of a life-skills education programme that includes sexuality education as well as information on HIV and AIDS". Designing of the intervention was underpinned by this connotation, as it provides both life skills training and HIV/AIDS education.

relationships of factors that make them vulnerable to HIV/AIDS and to provide them with the necessary life skills that will enable them to protect themselves from acquiring HIV infection from their sexual partners.

3.17.4.1 Module 1. Anatomy of female genitalia

In order that women understand how microbes enter their bodies (genitals) and cause diseases that make them sick, they should have the necessary understanding of their reproductive system, particularly their external and internal genitalia. This knowledge was seen as crucial to include in this module as it would create awareness of how women are biologically vulnerable to Sexually Transmitted Infections (STIs), including AIDS. There is no excerpt extracted from the study that directly substantiate this, however, it was easy to deduct from both interviews and focus group discussions that if women should understanding HIV infection, which is mostly transmitted through sexually intercourse, they should have clear understanding of their genitals.

3.17.4.2 Module 2: HIV/AIDS Awareness

Though it was obvious that there is some degree of knowledge of the AIDS epidemic and the HI virus that causes it amongst the participants. It came out clearly that there are still myths and misconceptions about the disease and its prognoses. A section on HIV/AIDS will strengthen the women's understanding of the disease and will give them adequate knowledge. Statements like these:

4.2.3.2 Sub-theme: Migrant men as a scarce resource for their wives remaining at home

According to the participants, men are a scarce resource because as breadwinners they leave their families and migrate to cities to earn an income to support their families. Tin the cities they stay in the cities for a long time without visiting their wives who are left lonely and in need of sexual satisfaction. In a focus group discussion, one of the married participants showed her sadness when she shared her feelings with the others in the following statement:

> *"I have come to a decision that men do not have love for their wives. It is months now that my husband is in Johannesburg without coming home. He does not even phone me. This worries me so much that I feel I am abused. On the other hand, I am expected to control myself and have no other partner but wait for him while he obviously has another woman. This is abuse".*

It was revealed that while married women's migrant husbands are a scarce resource, men who are not employed or who work around the area are a useful resource for the married women whose husbands are working away from home. When key informants, unmarried and married participants were asked who were *amashende* for those women, they mentioned many categories of men like, *"taxi drivers, tribal authorities, Ministers of religion, unemployed men and others"*, who are not migrant workers, as was referred to in Section 4.2.1.1.2 above.

Having their husband as a scarce resource drives women to engage in behaviours that place their health at risk. The unavailability of husbands is viewed against the availability of other men than their husbands at home. There are many men who are not employed. Some men in the rural areas work in the

64. Sibiya, D., 2005. *"Ubulale intombi nengane walala nabo",* Ilanga newspaper, 15 August pp 1.

65. Silbershmidt M., 2001. *Adolescent girls, illegal abortions and "sugar-daddies" in Dar es Salaam: vulnerable victims and active social agents:* University of Copenhagen Elsevier Science Ltd. Denmark.

66. South Africa Department of Health, 2000 HIV/AIDS/ STD Strategic Plan for South Africa 2000-2005.

67. Tallis, V. and Welbourn, A. 2002. Cutting the edge pack – gender and HIV/AIDS. Bridge: UNIFEM.

68. Tallis, V., 2000. "Empowering women for gender equity" . Durban: Agenda Number 44:

69. Tallis, V., 2000. *Empowering women for Gender Equity.* Durban: Agenda Number 44.

70. Trigiani, K., 1998. *Out of the Cane: Exploring Grey's Analogy*

71. Tuchman, A. Daniels, AK. and Benet, J., (eds) 1978. *Health and Home: Images of Women in the Mass Media.* New York: Oxford University.

72. Uche, C., 1994. *Household socio-economic status and sexual behaviour among Nigerian female youth.* Abuja: University of Ibadan.

73. UNAIDS, 1999 *Gender and HIV/AIDS: Taking Stock Research Programmes.* Geneva. UNAIDS.

74. UNAIDS/WHO, 2005. *AIDS epidemic update. Special Report on HIV prevention.* Geneva: UNAIDS.

75. Van Marle, K., 1997. *Siren News. Institute for gender studies newsletter, Volume 5 (1), Pretoria:* University of South Africa.

76. Van Zoonen L., 1991 *Feminist Perspectives on the Media in Mass media and Society.* London: Edward Arnold.

77. Varga, C. A., 1997. *Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu-Natal*, South Africa.

78. Wells, G. J., 1983 *Current issues in marriage and the family*. McMillan Publishing Company, Inc. Canada.

79. Zambuko, O., and Mturi, A., 2003. *ACDIS Monograph. The effect of the HIV/AIDS epidemic on Fertility in South Africa*. Durban: University of KwaZulu-Natal.

- Pneumonia
- Inflammation of the covering of the brain (meningitis)
- Meningitis may result to severe headaches, loss of memory, blindness, paralysis, fits and other related symptoms
- Cancer of the skin manifested by dark rash with elevated edges
- Severe Tuberculosis
- Severe swelling of lymph glands
- Ongoing diarrhea
- Usually death is inevitable at this stage

Prevention

- Abstinence from sexual intercourse
- Being faithful to each other in a relationship
- Correct and consistent use of condoms
- Prompt treatment of STIs
- Joining of pregnant women into Prevention of Mother To Child Transmission programme (PMTCT)
- (This will help them get necessary counseling and testing and get treatment that will prevent the infection passed on to their children. They will also be referred to the ART programme).
- Refraining from risky sexual behaviours, e.g.
  - Alcohol abuse
  - Multiple partners
  - Unprotected sex
  - Cultural practices e.g. widow inheritance
  - Dry sex

NB: Any lower abdominal pains or abnormal discharge should be treated as early as possible and a condom worn during sexual intercourse while on treatment.