AN EXPLORATION OF THE UNDERLYING SOCIAL DYNAMICS THAT MAKE WOMEN VULNERABLE TO HIV INFECTION

Leáne Ackermann

A thesis submitted in accordance with the requirements for the degree

MAGISTER SOCIETATIS SCIENTIAE

IN SOCIOLOGY

In the Faculty of Humanities
Department of Sociology
at the
University of the Free State.

31 May 2002

Supervisor: Prof GW de Klerk (D Phil)

Declaration of candidate

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ACKNOWLEDGMENTS

Gratitude to the following:

- My God for guidance and wisdom.
- Prof de Klerk for his support and guidance, without his encouragement I would not have undertaken this endeavour.
- Mirriam Mohapi for the way she conducted the interviews and for all she does in the everyday lives of HIV positive women – she is a truly remarkable person.
- All the HIV positive women who were brave enough to share their experiences.
- My parents and family for their support.
- Liesl van der Westhuizen for her language skills and proof reading.
- All members of the Sociology Department for their help and encouragement.
- The NRF for financial assistance towards the costs of this research.

I dedicate this dissertation to my mother and father.

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CHAPTER 1

METHODOLOGY

In this first chapter attention is given to why it is necessary to conduct research about this subject. An explanation of the aims and objectives of the research will be given as well as a discussion of the research design and the delimitation of the study. This will be followed by a discussion of the limitations of the study, ethical considerations and a description of certain concepts.

1.1 RATIONALE FOR THE STUDY

Being a South African, the researcher is confronted with the reality of HIV infection and the pain and misery caused by this devastating pandemic. In addition, in the quest to stem this disease, HIV/AIDS research has become an important focus area within the social sciences. For these reasons the author was motivated to do research within the HIV/AIDS domain. The AIDS/HIV pandemic remains a source of global concern, particularly in developing societies where rates of transmission are alarmingly high. South Africa has the dubious honour of having the greatest number of HIV positive people in the world. Estimates of the World Health Organisation (WHO) put the number of

HIV positive people in South Africa (in 1999) at 4,2 million (UNAIDS, 2000:9). This figure is increasing with about 1600 new cases daily (Kruger, 1999: 8).

The demographic, economic and social implications of this disease for a developing society, like as South Africa, are staggering. The population growth rate is expected to fall, and changes in the population structure are predicted. In addition, the increased demand for health care and care of orphans is already being felt. Apart from the human misery and suffering caused by HIV/AIDS on a micro level, this disease also holds serious economic consequences for a society both in terms of economic production and health care usage.

The economic damage caused by HIV/AIDS is largely due to the fact that HIV mainly affects the economically active section of a population. In the case of heterosexual spread, HIV affects all social classes and income groups. Knight (1997:1) observes that AIDS will have an impact on a country's participation in a globalized world, as foreign companies will have to take into account more expenses for health coverage, death benefits, labour training and replacement, but also of much smaller consumer markets.

Another area that is directly affected by the pandemic is the health care sector. More and more money is required to treat HIV related

illnesses – an expense that individuals and companies are increasingly unable to cover. In this regard, the South African mining company, Gencor, estimated that in the time period 1997 to 2000, 60% of its expenditure on health matters was HIV-related, fifteen times higher than before (Knight, 1997:1). The impact of HIV related diseases are being felt in South Africa, with tuberculosis and other early manifestations of HIV related diseases being rife in certain areas of the country. The increasing number of HIV- infected children born each year is similarly a cause for concern because many will require care within the first two years of life. The impact on the health service is particularly worrying because hospitals have to cope with an ever increasing demand for care (Knight, 1997:1). The responsibility for caring for the sick, dying and their dependants are increasingly being placed on individuals in the community who simply cannot bear the burden anymore.

The researcher decided to focus on women in this study, as it appears that women are at particular risk in Sub-Saharan Africa where in many areas the infection rate for females is higher than that of males (Paterson, 1996:8). The South African male:female HIV infection ratio is estimated at 0,73 : 1 (Department of Health, 1997:187). The increase of the sero-prevalence rate for women, revealed in the annual antenatal surveys, emphasises the urgency of doing research among South African women regarding this disease. The well-being of women has an

impact on the entire South African society, therefore it is essential to discover and attempt to address the factors that make women vulnerable to HIV infection.

Any social scientist hopes to make a contribution, albeit small, to the improvement of the lives of people in society. Another motivation of the study is to contribute to the formulation of effective preventative strategies. In light of the fact that, to date, no cure for the disease has been discovered, prevention remains crucial and strategies to prevent the disease are urgently sought. Once a certain population has been identified as being more vulnerable to the disease, interventions and research should be targeted at that specific population. Coleman and Wilkinson (1997:53) make mention of two instances (USA and Thailand) where targeting (homosexuals and sex-workers), although politically sensitive, was considered a valid strategy and that ultimately reaped rewards. In South Africa, for reasons that will be discussed in this thesis, it appears that a great impact could be had, by targeting interventions at women. In this regard the researcher believes that it is important to reveal under which circumstances women are being infected. Clarifying this issue will enhance the effectiveness of preventative strategies in this regard.

1.2 NECESSITY OF STUDY

It has long been realised that disease is related to social behaviour, HIV being a clear example. Therefore it is not surprising that many authors in the HIV field have indicated a need for studies of this kind. Strebel (1993:23) says in this regard that "..much has yet to be done in South Africa. If preventative and care initiative are to be successful, they need to be based on a thorough understanding of the issues relating to AIDS for women". Along a similar vein, Fransen (1998:10) and Karim and Karim (1995:1521) argue that it is important to investigate the social context in which behaviour occurs. It has been realised that the following factors influence HIV infection levels of a population: cultural norms; educational level of the population; the desire to have children; the acceptability of condom use; male and female circumcision practices; influence of political systems; distribution of income; gender relations; urban/rural balance and migration and mobility. The success of interventions depends on an understanding of the aforementioned social context within which behavioural changes must occur.

While government and other educational programmes have been relatively successful promoting AIDS/HIV awareness, a survey conducted in 1998 (Department of Health, 1998:13) revealed that 97% of women had heard about the disease, but that there is little evidence that peoples' behaviour have changed. Over the past

years, attempts to address the HIV/AIDS epidemic have focused on prevention through individual behaviour change. However, little empirical evidence has been collected about the motivations for behaviour and the effectiveness of various policies to bring about behaviour change and reduction of HIV transmission or acquisition. Among researchers, only a few have tried to study factors underlying risk behaviour. This clearly hinders the design of new and potentially effective prevention programmes.

1.3 AIM OF THIS STUDY

The general aim of this thesis is to explore the underlying dynamics that make women vulnerable to HIV infection. More specifically this translates into the following primary objectives:

1.3.1 Primary objectives

- To uncover the underlying cultural values, shared meanings, practices of daily interaction that put women at risk.
- To record women's suggestions for the modification of behaviour.
- To develop recommendations for reducing the vulnerability of women in this regard.

The researcher is of the opinion that if the factors that make women vulnerable could be identified, strategies to prevent HIV transmission, could be better targeted. The aim is therefore to make a positive contribution to addressing this problem.

1.4 RESEARCH DESIGN

The researcher is of the opinion that an exploratory study was best suited to investigate this topic. The main aim of an exploratory study is to explore a relatively unknown field and is usually used by social scientists under the following conditions (Mouton & Marais, 1989:43):

- to gain new insights about a certain area/domain.
- to serve as a pre-investigation to a more structured study of a phenomenon.
- to explicate central concepts and constructs.
- to set priorities for future research.
- to develop new hypothesis for an existing phenomenon.

The three methods that can be used in exploratory research include:

- an overview of relevant literature.
- a survey of people that have practical experience of the problem or situation.
- an analysis of insight stimulating examples.

Mouton and Marais (1989:157) add that an exploratory study is more aimed at gaining insight than the collection of replicable data. Researchers usually make use of in-depth interviews, analysis of case studies and the use of informants. Hypothesis flow from the research rather than directing the research.

The researcher is of the opinion that the experiences of women can best be uncovered and understood by taking the route of a qualitative investigation. According to Mouton and Marais (1989:157) quantitative research can be described as an approach in the humanities research that is more formalised, explicit and controlled with a width that is clearly demarcated. This approach also lies relatively close to the approach of the natural sciences. In contrast to this, qualitative research involves those procedures that are not so formalised and explicit, the width is not so strictly limited and a more philosophical path is taken.

The qualitative investigation was preceded by an extensive literature study regarding HIV and women. It was against this background that the in-depth interviews took place.

1.4.1 Sampling

The study was conducted in Bloemfontein, a city in the Free State Province in South Africa. The study was conducted within a sample of HIV positive women who reside in this area. The participants in the study were selected by means of purposive (non-probability) sampling. In a study of this nature this type of sampling is really the only sampling option open to the researcher. Babbie (1993:204) states in this regard that there are situations where it would be either impossible or unfeasible to select probability samples. Neuman (1997:206) asserts that " [p]urposive sampling is an acceptable kind of sampling for special situations. It uses the judgement of an expert in selecting cases or it selects cases with a specific purpose in mind. With purposive sampling, the researcher never knows whether the cases selected represent the population. It is used in exploratory research or in field research." Neuman (1997:206) goes on to argue that purposive sampling is appropriate in three situations:

- The first is when a researcher uses it to select unique cases that are especially informative.
- In the second instance, a researcher may use purposive sampling to select members of a difficult-to-reach specialised population (in this case HIV positive women). It is impossible to list all HIV positive women in South Africa and then sample randomly from the list. Instead the researcher can use locations or experts to identify a

sample for inclusion in the research. In this study an expert was consulted in order to identify the "sample".

- The third valid situation for purposive sampling is when a researcher wants to identify particular cases for in-depth investigation. The purpose is less to generalise to a larger population than it is to gain a deeper understanding of types.

Due to the fact that the entire population of HIV positive women is unknown and also because of the sensitive nature of the study the only option available to the researcher was that of purposive sampling. An expert was used (in this case, the same person who acted as the interviewer) to identify the "sample".

1.4.2 Data collection

In-depth interviews were used to gather information. The specific interview method that was used in this study was the semi-structured interview. This means that topics are selected in advance and the respondent is encouraged to talk about the topics. The interviewer thus does not approach the participant with a list of questions she has to answer. Rather, broad topics are listed and once the topic has been introduced to the respondent, the interviewer can use probes in order to get more information, but the actual direction of the answer is up to

the participant. After all, the aim of the study is to learn more about the participant's experiences.

The interviews were recorded on a tape recorder. These recordings were later transcribed. After initially planning to conduct focus groups, the researcher followed advice from a HIV-positive woman who explained that the women were reluctant to talk in a group, even if everyone else present was HIV-positive. The researcher then opted for individual in-depth interviews.

The semi-structured interview has the following advantages:

- Flexibility – the interviewer can ask more specific questions (probes) or repeat questions if the respondent does not understand.
- Better response rate – particularly if the interviewer has to interview people who are illiterate, it is easier to ask and explain the questions verbally.
- Ability to assess non-verbal behaviour – the interviewer can also gauge the non-verbal behaviour of the respondents ("I see this question makes you uncomfortable.") and can adjust their questioning accordingly.
- Ensure privacy – the interviewer can arrange a date and time that will ensure that the interview is conducted in privacy.

- Record spontaneous answers – in other words, if the respondent brings up an issue that the researcher never thought about, it can be included and recorded, so adding to the relevance of the study.

The interview method, like all other methods of data collection, has its problems. The researcher took cognisance of these potential problems in order to try and avoid them:

- The interviewer could make mistakes when writing down what is said (that is why the researcher used a tape recorder).
- Sometimes the time will not suit participants and when you meet them to do the interview they may be tired and stressed.
- There is less anonymity (in other words the interviewer meets them face to face). However, in this study this was an advantage, because the interviewer was known to the participants, they were more prepared to discuss the issue more openly. They were, however, reassured that their identity would never be revealed.
- When probing, questions may be formulated differently – which will lead to different answers.
- Respondents may lie (if they don't know an answer, if the truth is too sensitive/painful or if they do not want to give a socially undesirable answer). This hopefully was reduced due to the fact that they knew the interviewer. The fact remains that there are some things that most people would not even share with their closest friends.

- Accidental errors may occur if the respondent misunderstands the question.
- Memory failure on the part of the respondent (this is when respondents does their best to remember, but simply cannot).

Much of the above problems can be avoided if the participant feels at ease with the interviewer. In this regard the researcher was fortunate to have an excellent interviewer who was very well suited for the job.

The interviews were not conducted by the researcher herself, as the HIV-positive women did not want to share their experiences with a stranger. In addition to this, the researcher cannot speak the mother tongue of the participants, which would have detracted from the interviews. The interviews were conducted by a HIV support group leader who is also a qualified nurse. The interview schedule was discussed and explained to the interviewer who also underwent training in how to conduct an in-depth interview. The researcher was confident that the interviewer was well informed about what the researcher was trying to find out. The interviews were all conducted in the mother tongue of the participants.

1.4.3 Data analysis

The tape recorded interviews were transcribed and translated into English. The transcriptions were then studied by the researcher. The researcher analysed the data by organising it into categories on the basis of themes, concepts or similar features. The aim was to develop new concepts, formulate conceptual definitions and to examine the relationships among concepts. Eventually concepts were linked to each other as sets of similar categories and interwoven into theoretical statements (Neuman, 1997:421).

1.5 DELIMITATION OF STUDY

Although HIV affects both men and women, the researcher has decided to limit the research to women, specifically women of the black community in the Bloemfontein area. The reason the study is limited to women is because they are, as been argued throughout the study, particularly vulnerable to this disease. Women of the black community in particular were selected, as at present, black women are more vulnerable to HIV infection than white women (Crothers, 2001:13). This is due to the double jeopardy of being female and black in a country with a history of apartheid and patriarchy.

1.6 LIMITATIONS OF STUDY

Because of the nature of the sample and focus, generalisations to the broader population cannot be made. However, as many social scientists admit, this does not render the information worthless, instead it reveals something about a particular group that is studied and thus complies with the intentions or aims of the study.

Regarding problems during the research process, the researcher encountered many difficulties finding participants, particularly if one considers the stigma associated with being HIV-positive. Although assurances were given by various institutions and individuals that the study could be conducted, when it came to the actual data collection phase (which originally would have taken the form of focus groups) participants were unwilling to take part. The general sentiment was that they felt like guinea pigs and were not prepared to share their experiences with a stranger or even within a group of fellow sufferers. The only condition under which the women were prepared to share their experiences was if they could talk to someone they were comfortable with, on a one-on-one basis. The subjects were remunerated for their participation in the study.

1.7 ETHICAL CONSIDERATIONS

In this study as with all sociological research, it should always be borne in mind that one is working with human beings that may be harmed. It is every social scientist's ethical responsibility to ensure that the participants in his/her study are not harmed in any way. This is particularly true in research involving HIV positive people. Apart from being stigmatised within the community, many HIV positive people have expressed the sentiment that they are regarded as nothing more than guinea pigs that are researched and discarded. The researcher was sensitive to this issue even before starting the research, and this sentiment was confirmed when trying to organise the participants. In order to protect the participant in this study the researcher used the Human Sciences Research Council's (HSRC) code of ethics as a guideline when conducting the research. The following principles of the HSRC (1997) were adhered to:

- *Informed consent* - although the HSRC recommends getting the participants consent in writing, many participants were not prepared to sign their names in order to protect their identity. The participants were, however, fully informed about the nature and purpose of the study and what the value of their contribution would be. Participants were welcomed and encouraged to contact the researcher if they had any queries or misgivings about the study.

- The participants *right to refuse to participate* in the study and their right to withdraw their participation at any stage was respected at all times. No respondent was forced to take part in the study. Participants were repeatedly made aware of their right to refuse to take part and were also informed that they were free to stop the interview at any stage if they did not wish to continue (with no effect on their remuneration). This was also communicated in a covering letter to each participant.
- *Confidentiality* - The interviewer pledged to hold the identity of all participants in the strictest confidence, never to repeat it to anyone but the researcher, who is also bound by a pledge of confidentiality. The researcher was convinced that the interviewer, being a qualified nurse and an individual that is sensitive to the needs of HIV positive people, is absolutely trustworthy in this regard. Relating to the aforementioned, respondents' names were never mentioned and they cannot be identified by outsiders in the research report.
- The HSRC also recommends that no financial or other inducement should be offered to participants to ensure a particular research result. However, they state that participants may be rewarded on condition that all participants are offered similar rewards and that such rewards are related to the sacrifices required of them to make their contribution, e.g. transport costs, meals and token of appreciation. In this regard participants were paid R100 each, as a

token of appreciation for their participation and to cover all costs the interview may have incurred.

1.8 CONCEPTUALISATION

In the following section certain concepts used in this thesis will be clarified in order to eliminate misunderstanding:

AIDS – It is an acronym for Acquired Immune Deficiency Syndrome. AIDS is the final stage of HIV infection where a person suffers from a variety of opportunistic diseases.

HIV – This is the abbreviation for the Human Immunodeficiency Virus – the virus that causes the condition known as AIDS.

Sero-prevalence – Refers to the presence of a pathogen (in this case HIV) in the tested fluid (serum) of an individual.

Gender - This refers to the social and psychological expectations that accompany a certain sex.

Pandemic – An epidemic that is prevalent throughout the whole world.

Epidemic – A disease that is prevalent among a large segment of a population at a given time.

HIV-positive – Once a person is infected with HIV he or she is known as being HIV-positive.

1.9 THESIS OVERVIEW

The thesis consists of the following chapters:

- Chapter 1 - Methodology
- Chapter 2 – Theoretical orientation
- Chapter 3 – The disease in global perspective
- Chapter 4 - HIV/AIDS in South Africa
- Chapter 5 – Women and HIV/AIDS
- Chapter 6 – Physical and social risk factors
- Chapter 7 – Culture and sex
- Chapter 8 – Discussion of findings
- Chapter 9 - Recommendations

CHAPTER 2

THEORETICAL ORIENTATION

In this chapter attention will be given to the theoretical contextualisation of the study. Seeing that this thesis will be concentrating on the underlying social dynamics that make women vulnerable to HIV infection, the focus will be on the daily interactions of individuals. In this regard attention will be given to:

- The micro orientation in sociology which concentrates on this level of social reality.
- Certain concepts relating to the broader theme such as: definition of the situation, culture, gender and sexuality.
- Due to the fact the women's vulnerability may stem from a lack of power in interpersonal relationships, the politics of interaction will also be addressed.

2.1 THE SOCIOLOGY OF EVERYDAY LIFE

Douglas et al. (1980:1) defines the sociology of everyday life as a "...sociological orientation concerned with the experiencing, observing, understanding, describing, analyzing, and communicating about people interacting in concrete situations." Thus the sociologist of everyday life studies social interaction by observing and experiencing

them in natural situations. Other names referring to this orientation include: micro-sociology and interactionism.

The analysis of social reality on a micro level involves an analysis of individuals' meanings. "Meaning" is used to refer to the feelings, perceptions, emotions, moods, ideas, values and morals of the members of society. In short, "meaning" refers to the internal experience of the members that is most relevant to a particular social situation. The emphasis in this orientation is on understanding from the view point of the members (Douglas et al, 1980:2). Micro-sociologists argue that all explanations of human behaviour must in some way recognise and consider the intentions, motives and subjective understanding of individuals. Any effort to understand the operation of society as a whole, must begin with and be built upon, an analysis of people's everyday life world.

Karp and Yoels (1993:1) state that the value of this approach lies in its ability to provide insight into the underlying structure of day to day life. Furthermore, that although sociology should provide one with a way to understand how society as a whole is organised and ordered, a sociological way of looking at things should also be immediately applicable to everyday life. They emphasise that there is an "...order and predictability to everyday life which becomes visible once you

begin to look very hard at behaviors and situations you may otherwise take for granted." (Karp & Yoels, 1993:1).

Analysing these everyday behaviours sociologically enables one to see them in a new way. Our attention is drawn to the fact that talking and relating to members of the opposite sex are all behaviours that happen in culturally predictable ways.

2.2 RELEVANT CONCEPTS

While close observation is needed in order to understand how daily life is organised, one also needs tools to help one organise and interpret observations. Sociological theories and concepts provide a blueprint for identifying and understanding the underlying patterns in social life. Concepts such as culture, norms, values, roles, gender, socialisation, sexuality will briefly be dealt with, as they are relevant to this thesis.

2.2.1 Definition of the situation

When studying daily life, it is important to consider the way in which individuals define situations. This brings us to Blumer's three basic premises of symbolic interactionism (Stark, 2001:75):

- Human beings act towards things [including people] on the basis of meaning that things have for them.
- The meaning of things is derived from, or arises out of social interaction.
- The meaning of things are handled in, and modified through, an interpretative process used by people when dealing with things they encounter.

If the definition of the situation is important in determining the way in which individuals act it is also important to consider the factors that influence our perceptions (Cole, 1975:74). Thus, from a micro level it can be argued that people's interpretations and definitions of social situations (the meaning they ascribe to them) direct behaviour and that these meanings are derived from interaction. It can further be argued that many meanings are derived from and are guided by the culture of the individual. Sexuality, for instance, holds different meanings to individuals, depending on their cultural context. It is also very difficult to change behaviour (or the motivations behind behaviour) that are deeply ingrained in the minds of people. Paterson (1996: 17) rightly notes that "...traditional approaches to sexuality and to personal relationships are too deeply rooted for educational programmes devised by professionals from outside the community to be effective in producing change."

2.2.2 Culture

We are born into a complex culture which includes the knowledge, beliefs, customs, norms and values shared by members of a society. Culture has been defined as the way of life of members of a society (Giddens, 1993:31). Our culture becomes so familiar to us that we take it for granted, and do not question what we do or even why we do it. Everyday life is a reality that rarely requires explanation. Social life would be chaotic, if not impossible, if it were not so.

We learn an extraordinary number of cultural expectations from birth. These expectations or norms constitute the fundamental social rules in accordance with which persons normally act. Norms are defined as expectations of how one should act, behave and even feel in certain situations. Norms are situation bound, and vary according to the position and role that is relevant. Cultural expectations underlie almost every facet of daily interaction with others, and gives structure to our daily social lives.

However, although culture may guide behaviour, individuals are not robots behaving as their culture has "programmed" them to behave. If it were so, the job of the social scientist would be easy as it would simply entail "..cataloguing all the rules that people conform to" (Karp

& Yoels, 1993:18). The aforementioned authors point out that these rules, although important guidelines, are just that, guidelines. They are only boundaries within which people interact and are not sufficient to explain how daily encounters are managed and to what degree culture actually does direct behaviour. This must be investigated in the process of interpretation and this is what this study attempts to do. Relevant in this regard is the concepts of ideal and real culture, referring to a clash between what people believe and what they actually do (Popenoe, 1995:65). Furthermore one should also ask oneself if people do deviate from the ideal, is this as a result of new expectations (cultural change) or the emergence of a subculture?

2.2.3 Gender

Another pivotal concept in any study concerning women is the concept "gender". Sex is described as the biological differences between men and women, while gender refers to the characteristic traits and appropriate behaviour of members of each sexual category. Paterson (1996:31) gives a excellent description of the concept gender when she states that: "The meaning I attach to "being a woman", the meaning my brother attaches to "being a man" is deeply ingrained in our identities, and in our sense of what it means to belong in our own society. From the moment of birth, we started to learn these rules and

conventions so that, as we grew up, we internalized the expectations other people had of us as male and female people, learned to judge ourselves according to them, and to see our own future roles in society reflected in them. It's in this structuring of people's roles, in the family and in society at large, in accordance with what's expected of them as male and female people, that we now define as **gender.**"

When studying the literature on gender roles, one cannot help but to come to the conclusion that perhaps even more than class or age, gender defines one's identity. The way that men and women assign meaning to and experience their relationships is affected by differences in their socialisation and by their social positions in society.

Gender influences how much power you will have in social situations. Paterson (1996:32) states in this regard that "([t]here is almost no society on earth where you can become "gender aware" without reaching two conclusions: first, that women are less socially privileged than men; and second, that men are the ones with the economic, political and commercial power." Stark (2001:335) adds that there is no known society where women have equated men in terms of power.

In this study the concept of gender is important as it relates directly to the meaning people ascribe to sexuality, but also to the power

imbalances that may occur within relationships. Power imbalances that may make it difficult for women to protect themselves against various forms of dominance.

2.2.4 Intimacy as a social construction

As noted before, social life would be difficult, if not impossible, if there was no general consensus concerning the meaning people attach to objects, events and situations in their lives. The definition given to intimacy largely depends on both the general values of the society and the more specific values of the groups to which people belong, or with which they identify.

2.2.4.1 Sexuality as a form of intimacy

The ways in which individuals pursue and engage in sexual relationships reflect the social attitudes of both society as a whole and the groups with which the individuals are affiliated. Although the origin of sexual behaviour may be biological, the particular way chosen by people in order to achieve sexual gratification is socially learnt.

Sexuality has always occupied central importance in all societies. Berer (in Harrison, Xaba, Kunene & Ntuli, 2001:70) describes sexuality as being "... at the core of human identity and personhood." This "centrality" is

reflected in the importance surrounding rituals pertaining to sexual maturity (in more traditional societies) and the emphasis placed on sexuality in modern societies. Norms governing sexual behaviour vary widely from society to society (and subcultures within a society) and from one period of history to the next.

When looking at sub-Saharan Africa, Pozniak (1993:93-94) explains that in many parts of sub-Saharan Africa women receive their sex education between the ages of 12 and 16 years from maternal aunts or grandmothers, and girls are sometimes sent to villages from urban townships in order to learn about sexual matters from rural aunts. It is interesting that sex education is received from someone other than the parents. This issue of intergenerational communication (or lack of it) between parents and children, will be touched on later. Pozniak (1993:94) describes how girls are told about their future duties as wives and how to build relationships with the husband's relatives. In some regions polygamy is taken for granted. Polygamy will also be discussed later. Sex education of girls is preparative and continues until they marry. In sub-Saharan Africa, as in most other parts of the world the "double standard" exists, and much more emphasis is placed on the purity of a girl than that of a boy. In some societies adolescent girls have to undergo routine inspection for virginity monthly or twice a year until she marries. Virginity in first marriage is expected from girls in

Eastern and Central Africa. In contrast to the ideal of female purity, male chastity is not praised.

When looking at South Africa, the multicultural reality of the South African society makes it very difficult to make a statement about a "South African" set of cultural norms regarding sexuality. However, in general, Popenoe, Cunningham & Boult (1998:272) describe sexual norms in South Africa as traditionally being quite strict, a legacy first of tribal norms and then the morality of Protestantism. However, they add that attitudes about sex and to a lesser extent actual sexual behaviour are changing quite rapidly in modern societies. There is much more tolerance for sexual activity among singles. Several recent studies among teenagers (Tillotson & Maharaj, 2001; Harrison, *et al.*, 2001) have in fact pointed to a new culture of sexual promiscuity, where young girls and boys engage in sex at a relatively young age and also have many sexual partners before marriage.

2.2.4.2 Gender and sexuality

When looking at gender and sexuality, it becomes clear that in the actual interaction process sexual behaviour is largely regulated by gender driven norms (Harrison et al., 2001:70). In most cultures (particularly the more traditional cultures), men are traditionally portrayed as the sexual aggressors while women are expected to be

relatively passive. In this regard Rose and Frieze (in Brannon, 1996:240) found that gender role behaviour was evident in dating behaviour, with the men taking the lead, initiating and controlling the activities, including sexual activities. The women in their study were found to take the reactive, passive role. This was also reflected in the study of Harrison *et al.* (2001:74) where young girls indicated that it is the boys that should initiate the romance and not the girls.

Gender differences are also reflected in the language used when talking about sex. The study of Harrison *et al.* (2001: 70) can be cited as an example, where it was found that Zulu girls used more polite terms than Zulu boys did, when referring to the sex act and that participants in this study indicated that it was unacceptable for girls to use certain words. The following table reflects this difference in language use among Zulu adolescents.

Table 1: Gender differences in language use when referring to sex.

Words that girls use	Words that girls say boys use
Ukuhlangana	Ukubhoboza
(meeting)	(making a hole)
Ukudlana	Ukuvukauza
(eat each other)	(soil turning)
Ukulalana	Ukuphendulwa
(sleep together)	(be turned around)
Umkhuba	Ukubhebhana
(habit)	(rude word for sex)

Source: Harrison *et al.* (2001:72).

Another aspect of sexuality entails the motivation for engaging in sexual intercourse. It is often accepted that the motivation for having sex differs for men and women. Young men are usually regarded as wanting sex for pleasure and esteem while young women are regarded as wanting to engage in sex in order to please her partner or for the sake of love. In this regard Mbananga (1994:36) states that "[y]oung, sexually active girls were more likely to engage in sexual behaviour to please their boyfriends without actual enjoyment of sex."

Another study by Spangue and Quadagno (in Brannon, 1996:261) confirmed this (stereotypical) idea that younger men wanted sex for pleasure and women wanted sex for love (however, it must be added that these motivations were seen to change in older groups of men and women).

The question could be posed: "why is love such an important motivation for women?". One explanation for this is provided by the idea of the "feminisation of love". This entails the argument that with industrialisation, women became responsible for the maintenance of the home and family (the sanctuary from the "outside" world). This largely expressive function and responsibility made women "experts in love". They were the ones who had the tender feelings and experienced the emotions. They were the ones who needed love and

depended on men and children for it. They were the ones most capable of providing love to others. Of course, changes have heralded the entry of women into the formal labour market, but they remained the "experts on love" (Brannon, 1996:238). This is not to say that love is not important to men, but love is often used as a motivation for women entering into sexual relationships and is often used by men to persuade women to enter into a sexual relationship.

2.3 THE POLITICS OF INTERACTION

Social inequality is a reality of all societies where people with differing ascribed and achieved statuses have varying degrees of access to opportunities, decision-making processes and other scarce resources in a society. These differences are reflected in the prevailing systems of stratification. Although we are free to make choices and decisions in our everyday lives, the range or alternatives from which we choose is limited by the social structure into which we are born (Karp & Yoels, 1993:165-166).

2.3.1 Power relations in the macro and micro worlds

From a micro perspective, sociologists acknowledge that in most relationships the parties involved have unequal power. This is especially

the case in the relationships between men and women. The cultural norm of patriarchy relevant in most societies, attach more honour and prestige to males than to females. Traditional gender roles allocate more power to men than women and thus it is inevitable that in most relationships men do in fact have more power than women.

According to Lukes (in Archer & Lloyd, 1985: 149) there are three different ways of looking at asymmetric power relations:

- The first view is in terms of compliance: The powerful person or group can impose their decision or will on the less powerful. This includes the fact that the physical size, strength and greater aggressiveness of men is used to overpower or subjugate women.
- The second view emphasises that power can be exercised through dependence: Power relations that arise from conditions of economic dependence of women on men is an example.
- The third view of asymmetric power relations is in terms of inequality: Those in positions of power have greater access to material and social rewards. In this regard many thinkers have pointed out how women are kept in low paid jobs and encounter difficulty in career advancement or, as is the case in many parts in Africa, women are not allowed to own land or property.

Those who have comparatively greater access to scarce and highly valued resources such as jobs and money have a power advantage in everyday face-to-face relations. Interactions between men and women, husbands and wives, boyfriends and girlfriends are inextricably bound up with the issue of power between superiors and subordinates (inferiors). Face-to-face relations between members of different social classes, races and gender must also be seen within the broader context of power relations. In this sense everyday interaction can also be seen as political acts where one person has more power than the other.

Some people are able to elicit far more consideration and respect for their wants, desires and needs than others. It is in our daily lives and our interaction with others that power relations are experienced. People with more power can force those to comply to them by using the resources at their disposal to punish people who ignore them or to reward those who comply. Therefore it stands to reason that men who have more power to their disposal, can force women to comply to their demands.

2.4 THE LINK BETWEEN MICRO AND MACRO REALITIES

In this chapter, the emphasis is on individual behaviour. This is because HIV/AIDS has been described as a *social disease*, something that is brought about by the individual actions of people. This chapter describes aspects of behaviour that must be scrutinised, on a micro level, in order to uncover patterns in behaviour that place women at risk of being infected with HIV. Aspects such as unequal power relationships between men and women and women being in a subordinate position because cultural definitions of gender are examined. When explaining these patterns, it is inevitable that one will move to a macro level of social analysis, taking into account the social forces that shape the behaviour of people. In addition, macro trends (such as the incidence of HIV/AIDS) that result from individual acts, must also be considered.

CHAPTER 3

HIV/AIDS IN GLOBAL PERSPECTIVE

"Fifteen years ago the terms HIV and AIDS would not have been found in any medical dictionary, and would certainly have caused blank looks on the faces of health and development economists. Today the epidemic is one of the most serious problems facing southern Africa" (Loewenson & Whiteside, 1998:13).

Fifteen years have passed since they isolated the virus that causes AIDS. Millions have been spent throughout the world on public information campaigns and care for people that have AIDS. However, despite growing concern and awareness the virus continues to spread.

3.1 HIV/AIDS IN GENERAL

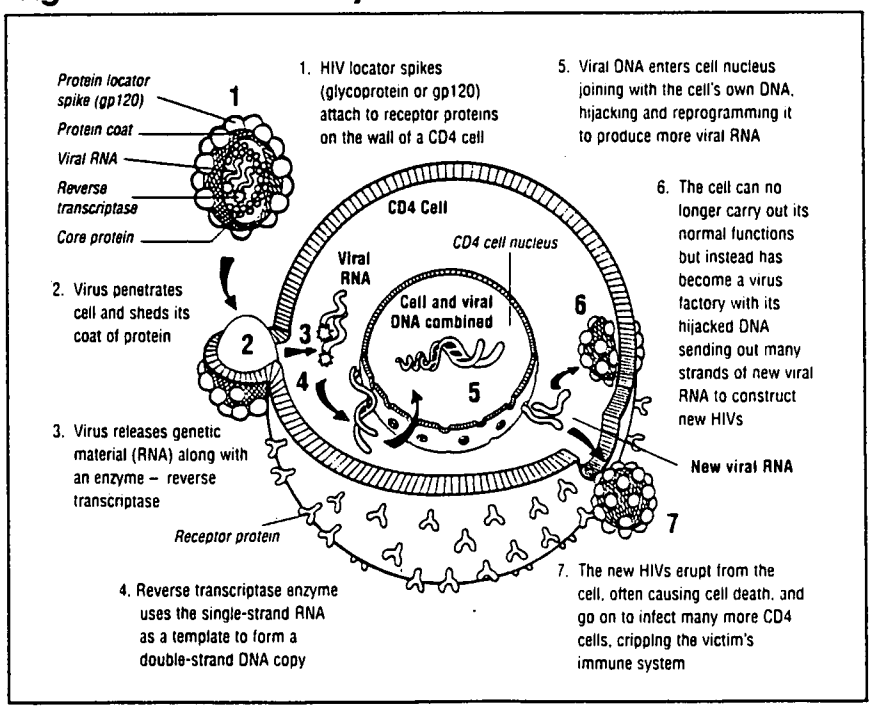
3.1.1 What is AIDS and HIV infection?

The history of AIDS can be traced to 1981 when the disease was first recognised as a clinical entity in the USA, although it has been argued that the first cases were probably seen much earlier (Mwale & Burnard, 1992:8). What started off as strange inexplicable deaths of homosexual

men, lead to the identification of a disease that was to become a major pandemic within 15 years. At first it was unknown what caused the disease and how it was spread. A group of scientists concluded that the spread must be sexual as they discovered a causal link when studying the network of infected individuals (at this stage the disease was restricted to the gay population). Later the exact modes of transmission were uncovered.

HIV, the virus which causes AIDS, was isolated for the first time in 1984 (Fransen, 1998:6; Loewenson & Whiteside, 1998:14). Two main types of HIV have been identified: HIV-1 and HIV-2. They are both strains of the HI virus. HIV-1 is thought to be transmitted about three times more readily than HIV-2, which is mainly seen in West Africa (Loewenson & Whiteside, 1998:13; Van Dyk, 2001:5).

Figure 1: The HIV life cycle.



Source: Sifris (2000)

The HI virus is a retrovirus, which means it is able to convert its genetic material into DNA inside an infected cell (see figure 1 above). The infected cell thus acts as a factory producing copies of the virus that originally infected it. HIV attacks mainly the cells in the body known as CD4 or T-helper cells, a key part of the body's immune response (Loewenson & Whiteside, 1998:13; Crewe, 1992:4). Van Dyk (2001:8) states that "[t]he feature that makes HIV so effective in destroying human lives is the fact that *the defensive components of the human immune system (the CD4 or T helper cells) have no known way of defending themselves against the HI virus*."

HIV does not attack all these cells at once, so initially the body does not produce anti-bodies to fight the disease – this is also known as asymptomatic stage. In this stage someone may be HIV positive, but may be unaware of it and even the tests that test for antibodies will prove negative. Yet all this time the person is infectious to others. In contrast to HIV, most other sexually transmitted diseases manifest in physical symptoms very early on, so that one is quickly aware of having contracted a disease that can subsequently be treated. The fact that one can be infected and show no symptoms is one of the most dangerous aspects of the disease and adds to its rapid spread (Crewe, 1992:4).

With the destruction of the immune system the body becomes increasingly unable to fight infections, giving rise to opportunistic infections. Being infected with the HI virus can result in a continuum of conditions ranging from no signs and symptoms, through varying states of immune dysregulation and immune deficiency (Mwale & Burnand, 1992:8).

AIDS is regarded as the final stage of the HIV infection, where a person suffers from a variety of opportunistic diseases (such as pneumonia, tuberculosis, persistent diarrhoea, herpes and thrush) and other symptoms such as chronic fatigue, minor skin irritations, sustained weight loss, persistent swelling of the lymph nodes due to the weakened immune system. Apart from the above-mentioned opportunistic infections HIV can also affect the nervous system, causing intellectual and emotional changes (AIDS dementia) and ataxia and cryptococcal meningitis as well as Kaposi's sacroma (Crewe, 1992:6; Loewenson and Whiteside, 1998:13). These collections of opportunistic infections are also known as the AIDS related complex or ARC. The more severe phase can continue up to two years before death, with progressively longer periods of illness. Full-blown AIDS is the end result of HIV infection and is terminal – it results in death (Crewe, 1992: 6).

Those who are infected usually have a limited life expectancy as this virus destroys the body's ability to prevent infections and other fatal

conditions. The median time from infection to development of AIDS in industrialised countries is 10-11 years (Loewenson & Whiteside, 1998:14). In developed societies this life expectancy may be in excess of 10 years and recent medical developments suggest the course of the disease can even be reversed, not eliminated, but at a high cost. In South Africa this period is probably much shorter, 5-8 years as being suggested by Mühr (1997:1) and 5-10 years by Loewenson and Whiteside (1998:14). This means that the present AIDS cases are people who were infected about 5 years ago. The life expectancy of HIV positive infants is much shorter, with most infected children dying before their fifth birthday.

3.1.2 Key characteristics of HIV/AIDS infection

Loewenson and Whiteside (1998:77) identify the following key characteristics of HIV/AIDS:

- AIDS is a relatively new epidemic. It was first recognised as a specific condition in 1981 and it was not until 1984 that the virus that causes it, was isolated and identified.
- It has a long latent period. Persons who are infected by the virus may have many years of normal productive life, although they can infect others during this period.

- The disease is fatal and the prognosis for people infected with HIV is not good. Although life-prolonging treatments are available these are unaffordable for the developing world.
- The scale of the epidemic is also different from most other diseases. In some urban setting more than 30% of at risk groups are infected.
- The majority of people are infected in their late teens.
- The disease is found predominantly in two specific age groups, infants and adults aged between 20-40 years. In the developing world, slightly more females than males are infected, and are infected and develop the disease at a younger age than men.
- HIV interacts with other diseases, both in terms of causing HIV/AIDS to spread (eg. other sexually-transmitted diseases increase the rate of HIV transmission ten-fold) and arising from HIV infection, (eg. significant increases in tuberculosis cases are directly related to HIV). This implies that HIV will not only be a public health burden in itself, but is directly linked to the burden of other significant health problems.
- In general the epidemic is still spreading. In some southern African countries it may have peaked in some urban centres, but it continues to spread in the rural areas.
- The majority of cases are sexually transmitted, and this raises issues of morality and openness.

3.1.3 Modes of transmission

Based on available data, scientists have concluded that HIV is spread by contact with the body fluids of a person that is already infected. HIV has already been isolated in blood, semen cervical/vaginal secretions, lymphocytes, serum, plasma, cerebrospinal fluid, tears, saliva, urine, mother's milk and alveolar fluids of infected patients (Mwale & Burnard, 1992:8). Of the above, however, only blood, semen, cervical secretions and mother milk has been directly linked to the transmission of HIV. The incubation period appears to range from a few months to 3 years. The dose or the amount of the virus, route of exposure and duration of exposure probably influences an individual's chance of becoming infected. In order for a person to become infected the virus has to enter the bloodstream. The routes along which HIV is transmitted can be summarised as follows (Van Rensburg, Fourie & Pretorius, 1992:188; Loewenson & Whiteside, 1998:14-15):

- Transmission by means of blood inoculation – e.g. by the transfusion of contaminated blood or blood products; the sharing of non-sterile syringes (for example among intravenous drug abusers; needle pricks and contact with open wounds in the case of health care workers).
- Through sexual intercourse - including homosexual and heterosexual intercourse.

- From mother to child (MTC). It is estimated that about one third of infants born to infected mothers will be infected. In this case the HIV is transmitted via the placenta to the fetus from the infected mother on the one hand, or the baby is infected during the birth process or via breast milk. These infections account for about 15% of the cumulative HIV infections in sub-Saharan Africa (Loewenson & Whiteside, 1998:19). It is generally believed that between 2,5 and 4,0 of every 10 children born to HIV-infected women in sub-Saharan Africa are infected with HIV (Loewenson & Whiteside, 1998:19).

Globally about 75% of HIV transmission occur through sexual intercourse. Of these sexual transmissions, 75% occurs via heterosexual transmission and 25% by means of sex between men (Fransen, 1998:4). The predominant sexual mode of transmission makes HIV/AIDS particularly difficult to counter as sex is a fundamental human activity and is surrounded by complex norms and issues of morality that makes many people uncomfortable to talk about it.

The following infective risk groups result from these transmission routes:

- *Recipients of transfusions and organs* via infected blood and blood products – in many countries these groups were exposed to contaminated blood prior to the implementation of HIV screening.
- *Intravenous drug users* using unsterilised needles.

- *Health workers or carers of HIV positive people* who come into contact with the infected blood/fluids of infected patients.
- *Sexually active people* whether homosexual, heterosexual or bisexual who become infected by means of sexual contact with a HIV positive person.
- *Infants* who can become infected by means of vertical transmission. (Van Rensburg et al., 1992:188).

Identifying risk groups allows one to see how HIV is spread in a society. Thus, if most people with HIV are predominantly homosexual, then the virus is in all probability being spread through homosexual contact in that particular society. If the majority of people infected are drug abusers, the predominant mode of transmission could be unsterile needles. This information is crucial when targeting interventions.

3.2 HIV/AIDS: THE GLOBAL PICTURE

3.2.1 Global statistics

The availability and reliability of HIV information varies. In industrialised countries the quality of information is reliable, as the surveillance techniques are sophisticated and surveillance is carried out in a structured manner (Ancelle-Park & De Vincenzi, 1993:1). In developing

countries however, national information is scarce and has to be obtained from surveys (particularly surveys of those attending STD clinics and pregnant women attending antenatal clinics). HIV/AIDS statistics vary significantly in figures and predictions.

Since the early 1980's more than 40 million people world-wide have contracted HIV, and almost 18 million have died, leaving at least 13 million orphans (Fransen, 1998:1; UNAIDS, 2000:6). In 1997 alone, nearly 6 million people (close to 16,000 a day) acquired HIV (Mann & Tarantola, 1998:62). Table 2 gives a summary of global estimates of the HIV/AIDS epidemic at the end of 1999.

Table 2: Global estimates of the HIV/AIDS epidemic including 1999.

People newly infected with HIV in 1999	
Total	5,4 **million**
Adults (men and women)	4,7 million
(Women)	2,3 million
Children < 15 years	620 000

Number of people living with HIV/AIDS	
Total	34,3 **million**
Adults (men and women)	33,0 million
(Women)	15,7 million
Children < 15 years	1,3 million

AIDS deaths in 1999	
Total	2,8 **million**
Adults (men and women)	2,3 million
(Women)	1,2 million
Children < 15 years	500 000

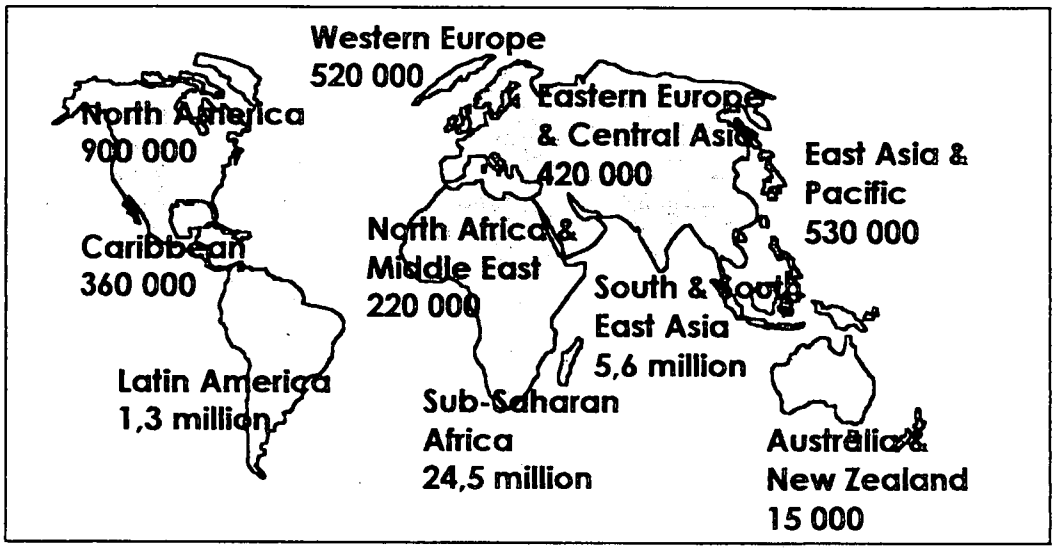
Total number of AIDS deaths since the beginning of the epidemic	
Total	18,8 **million**
Adults (men and women)	15,0 million
(Women)	7,7 million
Children < 15 years	3,8 million

Total number of AIDS orphans since the beginning of the epidemic	
Orphans	13,2 million

Source: UNAIDS (2000: 6).

When one looks at the global distribution of HIV/AIDS in the following diagram (figure 2), all indications are that the pandemic is particularly rife in developing nations, where the majority of people reside (Basset, 1993:8; Mann & Tarantola, 1998:62; UNAIDS, 2000:6). The irony being that although more than 90% of HIV-infected adults live in developing nations, well over 90% of money for care and prevention is spent in developed societies (Fransen, 1998:3; Mann & Tarantola, 1998:62).

Figure 2: Worldwide distribution of HIV.



Source: UNAIDS (2000:6).

It is clear from the above diagram that sub-Saharan Africa is the region most affected (Mann & Tarantola, 1998:62; Basset, 1993:8; Fransen, 1998:3). Two thirds of the world's HIV infected population reside in sub-Saharan Africa. Ninety per cent of the infants worldwide born with HIV are found in this region (Mann & Tarantola, 1998:62). In addition to having the greatest number of HIV infected people, the pandemic is also spreading faster in this region than in any other region of the world with the number of new infections during 1999 totaling 4.0 million (Mann & Tarantola, 1998:62,63; UNAIDS, 2000:8).

What is even more disturbing, is that the WHO has estimated that only one-forth of the AIDS cases in developing countries are reported. In this

regard, the *National AIDS Control Programme* in Zimbabwe, estimates that only one third of AIDS cases are reported (Loewenson & Whiteside, 1998:16).

3.2.2 Patterns of spread

When the worldwide distribution of HIV/AIDS is considered, two patterns or types come to the fore in the manifestation of the disease: the *type 1* and *type 2* patterns. These patterns are based on the ways in which the disease is transmitted to the risk populations.

The *type 1* pattern results from homosexual transmission, as well as transmission via blood, where intravenous drug abusers share non-sterile needles. Homosexuals and individual drug users are two subcultures at the biggest risk of contracting the type 1 HIV. *Type 1* transmission is accompanied by relatively few cases of vertical transmission (mother to baby). This transmission pattern is also known as the "Western pattern" and is typically found in industrialised societies. AIDS in the USA manifested a typical *type 1* pattern (Department of National Health and Population Development, 1990: 4). This was also the first pattern to be identified and that initially caused AIDS to be labeled as a "gay disease".

The *type 2* pattern involves the spread of the disease primarily by means of heterosexual transmission. Where the *type 1* pattern displays a male:female ratio of 8:1, the ratio in the case of the *type 2* pattern is 1:1. This means that within this pattern males and females are equally affected. What is relevant about this mode of transmission is that the entire heterosexual population is at risk, not a particular subculture within a population. Vertical transmission also increases with the *type 2* patterns since women can pass HIV on to their babies. This pattern is also known as the "Africa pattern" and appears to be the dominant type in the developing countries of Africa, the Caribbean region and possibly also part of South America (Department of National Health and Population Development, 1990: 4).

Throughout Africa the major route of spread of infection is heterosexual intercourse (Anderson, 1993:269; Manuh, 1998:4). If one looks at table 3 regarding transmission group (as it relates to women), it is evident that in developing societies the main mode of transmission is heterosexual contact.

Table 3: Distribution of percentages of female AIDS cases by transmission group in selected areas – August 1992.

	Injecting drug users (%)	Heterosexual contact (%)	Transfusion recipient (%)
USA (n=230 301)	55	37	8
South America (n = 4921)	35	51	14
Caribbeann Islands (n=3419)	>1*	98	2
Europe (n = 91	59	32	9
Australia (n=91)	31	27	42
Africa (n = 751)	-	94*	6*
Thailand (n=271)**	5*	92*	3*

* Estimates – detailed data not available.
** Includes individuals with Aids Related Complex.
Source: Ancelle-Park & De Vincenzi (1993:3).

Regarding the sex ratio in which the disease is manifesting, it is interesting to note that in areas where the virus was introduced at an early stage among homosexuals and intravenous drug users, the sex ratios of male to female AIDS cases is decreasing. This means that even with the *type 1* pattern where originally more men then women were affected, the ratio is beginning to even out, with more women being affected. In Africa, where the virus was introduced in the heterosexual population and still continues to spread in this population, the sex ratio

of AIDS cases available for some countries indicate that it is slightly lower than one (0.8:1 in Kinshasa and 0.9:1 in Uganda in 1989). Affecting more women than men (Ancelle-Park & De Vincenzi, 1993:1).

3.2.3 Implications of a heterosexual mode of transmission

This mainly heterosexual epidemic is having profound effects on family life and is bringing into sharp focus the problems of women with, or at risk of acquiring HIV. The number of AIDS orphans are also becoming a source of global concern. The heterosexual spread of this disease, has major implications for the prevention of the disease as prevention strategies have to be aimed at sexual behaviour and women in particular.

3.3 THE INTERNATIONAL RESPONSE TO HIV/AIDS

Although the disease was identified in 1981 the international response to the epidemic only started in 1986-87 (Fransen, 1998:4). The WHO's *Global Programme on AIDS* (GPA) was established in 1986 and HIV prevention programmes were launched in various developing countries.

National governments responded in a variety of ways: some were open about the disease admitting its existence and seriousness (such as Uganda), others ignored it and down played the seriousness for reasons such as fear of losing tourists and investments (Fransen, 1998: 4).

Along a similar vein, Whiteside (1998a:89-90) offers the following reasons why HIV/AIDS was and is not immediately considered by policy makers:

- Because the epidemic is relatively new, there is no example of a country that has experienced the epidemic from start to finish, thus it is hard to understand and believe the forecasts.
- It is difficult to communicate bad news in a forecast - people do not like being told that something bad is going to happen to them and prefer to ignore it.

Regarding developing societies there were also certain factors which "delayed" an appropriate response:

- Most sources of information regarding the disease were foreign, with developing societies not asking for or funding the research carried out in their countries and then often not believing ("owning") the results.
- AIDS is not seen as an immediate problem in the same way that poverty, drought and unemployment is.

The lack of prompt response has been detrimental for most developing societies where the HIV epidemic is out of control and threatens the social fabric and precarious economies. With the increasing numbers of people dying daily from the disease, it has become impossible to ignore the disease: "Coffin makers are having a field day...Undertakers advertise on the roadside, and everywhere you will see cyclists wobbling along with long black boxes strapped to the backs of their bikes. Death is ever-present, and you can't avoid knowing it." (Paterson, 1996:12).

Governments have "woken up" to the threat of HIV. Unfortunately the "wake up call" in the form of AIDS deaths, only occurred 5-10 years after infection, giving the epidemic enough time to establish itself within a population.

CHAPTER 4

HIV/AIDS IN SOUTH AFRICA

"With a total of 4.2 million infected people, South Africa has the largest number of people living with HIV/AIDS in the world." (UNAIDS, 2000:9)

With the diagnosis of the first case of AIDS in South Africa in 1982, the epidemic was also recognised in this country (Van Rensburg et al., 1992:187). In the beginning, up until 1986, South Africa followed a typical *type 1* pattern, where 87% of all AIDS cases were homosexual and bisexual males. However, this picture started changing as more and more heterosexual cases were reported. Today the HIV/AIDS senario in South Africa displays, like the rest of sub-Saharan Africa, a typically heterosexual HIV pattern.

4.1 SOUTH AFRICAN HIV/AIDS STATISTICS

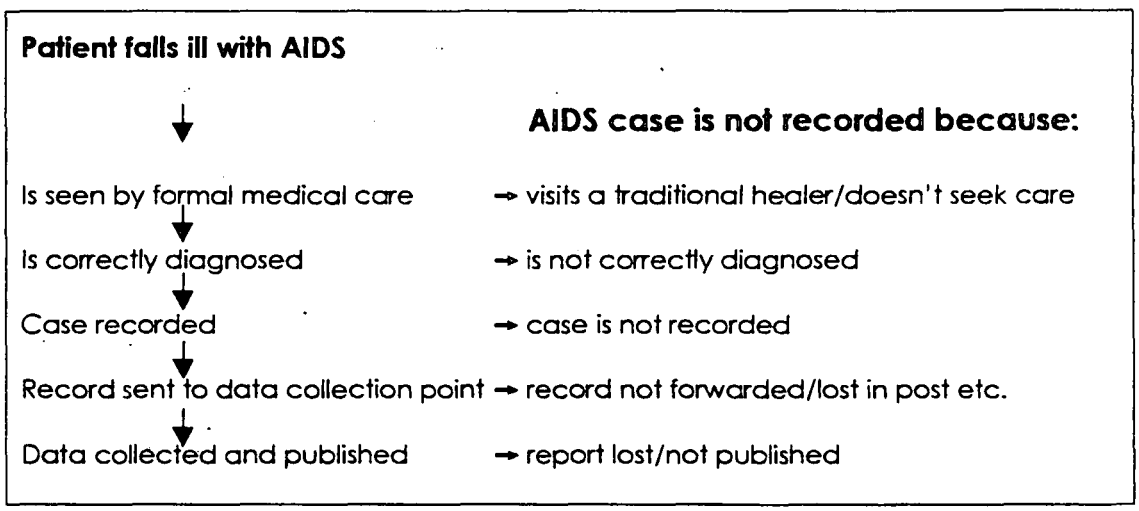
Data relating to HIV/AIDS infection is gleaned primarily from three sources: statistics about actual AIDS cases; passive monitoring of HIV data and from active or planned surveys in specific populations in order to ascertain the incidence of HIV infection. When looking at the

South African situation, two types of data will be considered: AIDS data and HIV prevalence data.

4.1.1 South African AIDS data

Recording AIDS cases is a complex process, even if the disease has been made legally notificable. The problems related to AIDS reporting can be schematically represented as follows:

Figure 3: Problems related to AIDS reporting.



Source: Loewenson and Whiteside (1998:15).

Because a person with full-blown AIDS dies from a specific disease (or a syndrome/collection of diseases and infections) the death certificate does not always state "AIDS". In addition to this, the stigma attached to being HIV positive and having AIDS also causes health workers and families of the deceased person not to link the death to AIDS.

Therefore, the cause of death on the death certificate will often read 'TB" or "pneumonia" etc.

Related to the unreliability of AIDS data, Loewenson and Whiteside (1998:16-17) caution that the number of AIDS cases are of little value in looking either at the current or future impact of the disease. The level of under-reporting means that data have to be treated with suspicion. However, they argue that when one graphs the case data by age and sex as done in the following two tables, it can at least give an idea of the location of the epidemic. The researcher is aware of the fact that the information contained in the following graphs is not very recent, but this is because for the past few years the Department of Health has ceased collecting AIDS data, the emphasis is now on HIV monitoring.

Table 4: AIDS cases by mode of transmission and race group.

	ASIAN		BLACK			COLOURED			WHITE			U	Total
	M	F	M	F	Un	M	F	Un	M	F	Un		
Homo/bisexual	4	-	61	-	-	29	-	-	396	-	-	3	493
Heterosexual	1	1	1150	1143	29	63	80	-	29	12	1	11	2520
Haemophilic	-	-	3	-	-	1	-	-	18	-	-	-	22
Transfusion	-	-	6	1	-	1	1	-	12	5	1	1	28
IVDU	-	-	1	-	-	-	-	-	1	-	-	-	2
MTC	-	-	265	234	9	7	4	-	-	-	-	-	519
Unknown	-	-	154	81	6	3	8	1	5	1	-	6	265
Total	5	1	1640	1459	44	104	93	1	461	18	2	21	3849

M = male
F = female
Un = unknown
IVDU – intravenous drug user
MTC = mother to child
Source: Department of Health (1994: 154).

Table 4 illustrates the following points:

- The strong manifestation of the **heterosexual pattern** is evident as 65,5% of all cases are of this type. This type of AIDS cases is also by far the most evident among the black population, which comprise 73,9% of all AIDS cases in this population.
- There is a corresponding **high incidence of mother to child** transmission. Most of the pediatric cases have occurred in the black population (97,9%). This emphasises the fact that the black population, particularly black children, are in danger when one considers this mode of transmission.
- 12,8% of all cases fall within the **homo/bisexual** category. This pattern also appears to be by far the dominant one among white males (85,9%) but not of the entire male population.

Compared with world figures, South Africa's 12 825 reported AIDS cases on 15 November 1999, comprise 0,58 % of the world figures released by the WHO (WHO, 1999:401,403). Stated conversely, this means that 1 out of every 172 AIDS cases in the world is South African. South Africa, like other developing societies, has a predominantly heterosexual mode of transmission. This is reflected in the AIDS cases where 65,5% are heterosexual. Thus HIV infection does not threaten a small subgroup of the South African population, it endangers virtually the entire heterosexual population.

Table 5: Age and sex distribution of reported South African AIDS cases (as at 27 July 1994).

Age group	Male	Female	Unknown	Total
0 - 4	261	222	9	492
5 - 9	10	6	-	16
10 – 14	4	3	-	7
15 – 24	28	129	1	158
25 – 29	212	320	8	540
30 – 34	386	284	10	680
35 – 39	407	235	7	649
35 – 39	291	137	6	434
40 – 44	191	76	2	269
45 – 49	98	30	-	128
50 – 54	94	23	-	117
55 – 59	27	14	-	41
60 – 64	11	8	1	20
65 – 69	11	2	-	13
70+	6	2	-	8
Unknown	178	88	11	277
Total	2215	1579	55	3849

Source: Department of Health (1994: 154).

As is the case with other diseases, there are important differentials apart from population group according to which AIDS manifests itself in South Africa, and here sex and age are particularly important. When one considers the age and sex distribution one can get an idea of which groups are at risk (keeping in mind the 5-8 year infection period). In particular the following can be deduced from table 5:

- With regard to the age distribution of South African AIDS sufferers it appears that most AIDS cases fall into the 30-34 age category (17,6% of all cases). Just under two thirds (58%) of all cases in the 25-39 year old category. These findings confirm the assumption that the sexually active population runs the greatest risk of contracting this disease. Moreover, it is precisely those people in this age category that comprise the economically active component of the population. This again emphasizes the serious social and economic consequences of the disease.
- AIDS in the 0-4 category is relatively high, confirming the predominantly heterosexual mode of transmission.
- With regard to the sex distribution of AIDS in South Africa, the statistics reveal that in 1994, 58% of AIDS cases were male and 42% female. Most of the males fall into the 35-39, and females in the 25-29 year old category. This confirms other findings that suggest that women are being exposed to HIV at younger ages than males (UNAIDS, 2000:11). The 15-24 year old women being at particular risk (remembering that infection that took place approximately 5 years earlier, manifests as AIDS).

Table 6: Number of AIDS cases reported by region and year of diagnoses (as at 27 July 1994).

Province	82-86	87	88	89	90	91	92	93	94	Total
Eastern Cape	-	-	1	4	10	32	68	146	95	356
Western Cape	12	2	20	32	39	44	66	104	7	326
Northern Cape	-	-	-	1	3	4	5	38	31	82
KwaZulu/Natal	4	5	19	35	130	159	318	801	22	1493
OFS	1	2	4	9	8	38	44	34	36	176
PWV	29	31	44	92	118	153	251	194	74	986
Eastern Transvaal	-	-	1	2	3	15	5	85	23	134
North West	-	-	1	-	3	4	4	59	53	124
Northern Transvaal	-	-	1	1	5	2	7	106	50	172
Total SA	**46**	**40**	**91**	**176**	**319**	**451**	**768**	**1567**	**391**	**3849**
Other Countries	12	9	6	3	8	18	15	112	49	232
Unknown	-	-	-	-	-	-	-	2	-	2
Total	58	49	97	179	327	469	783	1681	440	4083

Source: Department of Health (1994:154).

Regarding the various regions in South Africa (table 6), although the data is relatively old (and still in pre-1994 provincial format), it is interesting to note the high incidence of AIDS cases in KwaZulu-Natal even then. Current HIV statistics also indicate that this is the province most affected by the disease.

4.1.2 South African HIV data

Another source of data is that of HIV prevalence. According to Loewenson and Whiteside (1998:17) sentinel surveys, which measure the level of HIV prevalence in a given population at a given time, are the best source of data. In South Africa the most common source of data is collected during screening at public antenatal clinics. These surveys form the cornerstone of HIV surveillance in South Africa.

Since 1990 a yearly surveillance of pregnant women at antenatal clinics of the public health services were conducted. From the outset the purpose of this surveillance was to collect a geographically representative sample of routinely submitted antenatal blood specimens to monitor the progress of the epidemic. The first five surveys were geographically stratified according to provinces and national states (Homelands). The sampling plan was adapted in 1995 to reflect the nine provinces that came into being after the 1994 democratic elections. Important about this surveillance, is that it provides useful information of HIV infection in members of the populations that are conventionally categorized as low risk. According to Loewenson and Whiteside (1998: 17) these data can be used to estimate the level of prevalence in the adult and national populations and can be used to develop models to predict the course of the epidemic. Although their

risk may be lower than that of commercial sex workers or people with sexually transmitted diseases (STD's), these pregnant women also clearly suffer a substantial risk. Another advantage concerning these surveys is that women attending these clinics are regarded as being reasonably representative of the fertile sexually active population – the results of these surveys can thus be very useful in guiding the design and evaluation of prevention and care programmes (Coleman & Wilkinson, 1997:50).

The fifth annual HIV survey showed a sharp increase in the number of HIV sero-prevalence rates: it increased from a rate of 0.76% in 1990 to 7.6% in 1994 and that in a rural area in KwaZulu-Natal one in five rural women aged 20 to 24 years were HIV-positive in 1995 (Coleman & Wilkinson, 1997:50). This high trend for KwaZulu-Natal has continued with 36,2% of the antenatal attendees found to be HIV-positive in the year 2000 (Department of Health, 2000:9).

The 1997 results showed that in all age groups HIV prevalence had increased since the last survey and the highest was among women in their 20's. It was alarming to see such high prevalence in the under-20's for two reasons, firstly these mothers-to-be reflect an age group where pregnancy is usually unplanned. Secondly, it is in this group that one would expect to see a decrease in new infections as an indicator that

the incidence of new HIV infection is decreasing – this *is* not happening yet (N.A., 1997:1).

The latest surveys (since the 8th survey in 1997) are considered very reliable due to a revised research protocol that was used from the 8th survey onwards. Table 7 sums up the results of a decade of antenatal surveys.

Table 7: HIV prevalence among pregnant women attending public antenatal clinics, by province for the years 1990-2000.

	90	91	92	93	94	95	96	97*	98*	99	2000
KZ-Natal	1.6	2.9	4.8	9.6	14.4	18.2	19.9	26.9	32.5	32.5	36.2
Mpumalanga	-	-	-	-	12.1	18.3	15.8	22.6	30.0	27.3	29.7
Free State	0.6	1.5	2.9	4.1	9.2	11.0	17.5	20.06	22.8	27.9	27.9
Gauteng	-	-	-	-	6.4	12.0	15.5	17.1	22.5	23.9	29.4
North-West	-	-	-	-	6.7	8.3	25.1	18.1	21.3	23.0	22.9
E.Cape	-	-	-	-	4.5	6.0	8.1	12.6	15.9	18.0	20.2
Northern P	-	-	-	-	3.0	4.9	8.0	8.2	11.5	11.4	13.2
N.Cape	-	-	-	-	1.83	5.3	6.5	8.6	9.9	10.1	10.2
W.Cape	-	-	-	-	1.2	1.7	3.1	6.3	5.2	7.1	8.7
South Africa	**0.8**	**1.4**	**2.4**	**4.3**	**7.6**	**10.4**	**14.2**	**17.04**	**22.8**	**22.4**	**24.5**

* This data has been worked out with a confidence levels of 95%

Sources: N.A. (1997:1); Department of Health, (2000:9).

It is estimated that 24,5% of women attending antenatal clinics were HIV positive at the end of 2000. The province with the highest level is

Kwazulu-Natal where more than a third (36,2%) of the women attending these clinics were HIV positive. Mpumalanga also had a high level of infection, with 29,7% followed by Gauteng with a prevalence of 29,4% (Department of Health, 2000:9).

Table 8: Age specific HIV prevalence – results of the 8th and 9th national HIV surveys of women attending public antenatal clinics.

Age group	1997	1998	1999	2000
<20	12.70	21.0	16.5	16.1
20-24	26.1	19.7	25.6	29.1
25-29	26.9	18.2	26.4	30.6
30-34	19.1	14.5	21.7	23.3
35-39	13.4	9.5	16.2	15.8
40-44*	10.5	7.5	12.0	10.2
45-49*	10.2	8.8	7.5	13.1

Note: * Figures based on very small samples

Sources: N.A. (1997:1); Department of Health (2000:11).

Regarding age prevalence, the 25-29 year old group appears to be at greatest risk. Fortunately the prevalence rates in the <20 group, that was extremely high in 1998, has dropped.

Table 9: Estimated number of people living with HIV/AIDS in South Africa (including 1999)*.

Adults and children	4 200 000
Adults (15-49)	4 100 000
Women (15-49)	2 300 000
Children (0-15)	95 000

* These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1999).

Source: UNAIDS (2000:3).

In South Africa it has been estimated that there are 4.2 million people infected with HIV and that 19.9% of adults (15-49 year old) are HIV positive. This makes South Africa the country with the largest number of people living with HIV in the world (UNAIDS, 2000:9).

4.2 FUTURE PREDICTIONS

Making predictions about the future state of affairs concerning the epidemic is difficult. The reliability of predictions decrease as the time span of the projection increases, because of the possibility of behavioural change and other factors such as improved drugs etc. (Gregson, Zaba, Garnett & Anderson, 1998:38). Various future scenarios

exist, the reason for this variation being the different models used when making predictions.

While the spread of the pandemic has stabilised in some regions and countries such as Uganda, in most of the SADC (Southern African Development Community) countries, which includes South Africa, the epidemic continues to increase at an alarming rate (Fransen, 1998:3). The epidemic is still emerging in South Africa and Doyle, Muhr, Steinberg and Broomberg (1998:60) assert that South Africa will also experience increasing prevalence rates already seen in other African countries[1].

As mentioned above there are various models for making future predictions. Doyle et al. (1998:68) forecast that almost a quarter of South Africa's adult population will be HIV positive by the year 2010.

4.3 IMPLICATIONS OF THE DISEASE FOR SOUTH AFRICA

There is no doubt that the epidemic will have a demographic, economic, social and developmental effect on the South African society. Each of these areas will be briefly discussed.

[1] It is generally accepted that the epidemic reached South Africa several years after it had hit Central and Eastern African countries (Gregson *et al.*, 1998: 46).

4.3.1 Demographic implications

HIV/AIDS will affect the country's demographic profile by having an impact on the growth rate of the population as well as the age pyramids of society. In addition to this the mortality and morbidity rates will also be affected.

Projections for 13 African countries in the year 2010, predict a total population of 303-331 million without AIDS and 276-310 million with AIDS, a difference of 30 million (Fransen, 1998:3). The impact of AIDS is projected to be large enough to affect the growth (slow down) and structure of the population. The 20-40 year olds cohort, as a proportion of the entire population will decline which increases the dependency ratio[1] (Lowenson & Whiteside, 1998:20). This means that The dramatic change in the population pyramid occurs about 10 –15 years after the age at which people first become sexually active, when those infected with HIV early in their sexual lives begin to die. The cohorts of women above their early 20's and men above their early 30's will shrink radically, changing the population pyramid into what is called a population chimney (UNAIDS, 2000:22).

[1] People in certain age categories are dependent of the productivity of others. These age categories include young children and the elderly.

The implications of this change in the population structure are devastating. Ever shrinking numbers of young adults (the group that has traditionally provided care for both children and the elderly) will have to support large numbers of young and old people. Many of these young adults may themselves be infected and thus require care from their children or elderly parents rather than providing it (UNAIDS, 2000:23).

However, contrary to popular belief, the epidemic will not stop population growth or result in negative population growth, because of the large numbers of people in their child bearing years and because of a total fertility rate that is above 2 (Loewenson & Whiteside, 1998:20). Although negative population growth is not expected for any African country, including South Africa, both the life expectancy and the dependency ratio will be adversely affected. This will, in itself, seriously affect societies and human development in regions already facing a multitude of problems and difficulties (Fransen, 1998:8).

In terms of mortality it is projected that efforts and successes of the past decades to decrease infant and child mortality will be lost due to the increasing impact of the HIV/AIDS epidemic in most sub-Saharan countries (Fransen, 1998:8). In addition to this HIV/AIDS will have a considerable effect on the morbidity profile of a country. AIDS is the

main contributor to the infectious disease component of present and future disease burden (Fransen, 1998:3). The impact of HIV on the spread of other infectious diseases such as tuberculosis (TB) will increase and will, to a large extent, have to be dealt with by the public sector.

Regarding life expectancy, the US bureau of census projects that by 2010 the HIV/AIDS epidemic will lower life expectancy by an average of 20% compared to what it would have been without the epidemic in several of the worst affected African countries. The *World Bank* projects that the life expectancy in sub-Saharan Africa by 2020 will be 43 due to AIDS, compared to 62, without AIDS (Loewenson & Whiteside, 1998:22).

4.3.2 Social impact

The effects that the disease will have on the community and households is unclear as research is limited in this regard (Loewenson & Whiteside, 1998:23). However, it is unlikely that the present social network will be able to support the sick and dying as well as look after orphaned children.

It is also predicted that the growth of the school age population will decline due to the deaths of HIV positive infants and women of the child-bearing age. This could result in a reduction of primary school enrolment. In addition to this, more orphaned children may be forced to leave school due to financial problems (Whiteside, 1998b:86).

4.3.3 Economic implications

At household level there will be increased medical care and related costs, the loss of income of economically active people as well as the burden of orphans[1]. UNAIDS (2000:27) states that the households having a members suffering from AIDS show a dramatic decrease in income resulting in fewer purchases and diminished savings.

Productivity could also be negatively affected as many producers will be ill with HIV, resulting in high levels of absenteeism or be dying from AIDS and will have to be replaced. This is especially true of labour

[1] It has been projected that their will be one million orphans (caused by AIDS) in South Africa by 2005 (Loewenson & Whiteside, 1998:20).

intensive industries. Along a similar vein Whiteside (1998b:85) states that "The skill and experience losses will present a major setback to efforts to raise labour productivity. The problem of unemployment may also be compounded by a shift to capital-intensive modes of production prompted by uncertainties about the labour supply." A number of industries, known as "consumption industries", that rely on a critical growth rate in a population, could also be affected by the HIV epidemic (Doyle et al., 1998:72).

Decreased productivity is one aspect of economic implications, the other involves increased demands on health and welfare funds. In countries such as Zimbabwe and Rwanda, AIDS treatment consumes 27% and 66% of the health spending respectively (Loewenson & Whiteside, 1998:21-22).

4.3.4 Impact on development

In recent years it has become apparent that the measure of a country's success regarding development cannot simply be measured by growth in the per capita income. The United Nations Development Programme devised an alternative measure: the human development index (HDI). This is a composite of three basic components of human

development: measured life expectancy, knowledge and standard of living. It is evident that AIDS has the potential to seriously affect countries' human development indicators (Fransen, 1998:8, Loewenson & Whiteside, 1998:23). Loewenson & Whiteside (1998:23) summarise the situation as follows "The effect of AIDS will be to reverse hard-won development gains and make people and nations worse off. In addition it will make further developmental attempts that much more difficult as the HIV/AIDS hurdle will have to be surmounted in addition to the other pressing developmental problems. It is possible that the effects may last for decades."

CHAPTER 5

WOMEN AND HIV/AIDS

"...the way in which women live can make them sick. Their problems take different forms at different stages of their lives and in different parts of the world." (Hoffman, De Pincho & Cooper, 1998:562).

5.1 WOMEN AND HEALTH

In the last few decades there has been an increasing focus on the position of women in general and on women's health in particular. It is increasingly being realised that gender differences affect the health of men and women. According to Hoffman *et al.* (1998:562) this difference is mainly reflected in the way that men and women seek help, their actual health status and the way in which the sexes are represented in clinical trials. As a result of this increasing focus of women, a speciality area known as 'women's health" has developed which focuses on diseases and conditions that:

- Affect women differently than men.
- Are unique and are more prevalent in women.
- Are more serious in women.

- Have different risk factors or different exposure risks for women from those of men.
- Require different interventions for women as opposed to those for men.

The focus on HIV and women from a 'women's health" perspective is viable because: i) Although HIV affects both men and women, women are physiologically more vulnerable to infection[1] and women can develop diseases, such as cervical *intraepithelial neoplasia,* that men cannot (LaGuardia, 1993:246). ii) HIV, though not unique to women, is more prevalent in women in sub-Saharan Africa. iii) The disease could be considered more serious for females in the specific context of female-headed households and child-caring role of women, as well as the fact the women can transmit it to their babies. iv) Women also have certain risk factors unique to them (to be discussed in the following two chapters). v) Due to the social position of women in society and the unique risk factors affecting them, interventions have to take the specific situation of women into account and do therefore differ from those aimed at males.

[1] This will be discussed in the next chapter.

5.2 HIV AND WOMEN

In the beginning stages of the HIV/AIDS epidemic, it was generally regarded as a male disease, as at that stage specifically homosexual males were affected. As a result, intervention strategies were aimed at men. Later, when more became known about HIV transmission, it was realised that women too could be, and were being, infected. However, the concerns of women regarding the disease were ignored in the reaction to the disease (Strebel 1993:23). In this regard Doyal (1994: 147) states that "AIDS, too has been treated for research purposes as a predominantly male disease. Though it is now growing as fast among women as among men, there is very little known about sex differences in its effects. Indeed, the very definition of the clinical entity of AIDS continues to be based on male experience...". When studies did start concentrating on women, most of what was known about HIV in women was derived from studies of prostitutes or pregnant women, or those that focused primarily on prenatal issues. Many studies have focused on female prostitutes to the exclusion of other women, the data often been interpreted as meaning that without prostitutes there would be no epidemic. It was not realised then that these women, probably infected by their clients, were in fact experiencing the brunt of the epidemic (Pozniak, 1993:94).

However, in the early 1990's several feminist writers called for studies that concentrate on women and this marked the beginning of a sub-field in AIDS research that is known as "women and AIDS". In 1990 the *Women and AIDS Research Program* was established by the *International Center for Research on Women.* Some of the early studies conducted in South Africa on women and AIDS were initiated and funded by this organisation (LeClerc-Madlala, 2001:40). Since then, a number of women related projects have been initiated and specialist working-groups have arisen to address the issue of women and AIDS (Strebel, 1993:23).

With ever increasing numbers of HIV positive women associated with the rampant heterosexual spread of the disease, it was eventually realised that all sexually active women, whether prostitute or not, whether pregnant or not, were at risk of HIV infection. This was particularly true for the African continent.

5.2.1 Statistics regarding women

The proportion of women among those newly infected is, rising everywhere in the world (Paterson, 1996:ix). As mentioned in chapter 3, even in countries where the epidemic manifested a typical *type 1* pattern with proportionally more males being infected than females,

this too is starting to change with increasing numbers of female cases. In the US for instance, women are proportionately the fastest growing group of people with AIDS (Hirschhorn, 1999:187).

Table 10: Percentage women among HIV positive adults per region and main mode of transmission per region - end November 1999.

Region	Women among HIV positive adults %	Main modes of transmission*
Sub-Saharan Africa	55	Hetero
North Africa and Middle East Asia	20	IDU, hetero
South and South East Asia	30	Hetero
East Asia and the Pacific	15	IDU, hetero, MSM.
Latin America	20	MSM, IDU, hetero
Caribbean	35	Hetero, MSM
Eastern Europe an Central Asia	20	IDU, MSM
Western Europe	20	MSM, IDU
North America	20	MSM, IDU, hetero
Australia and New Zealand	10	MSM, IDU
Total	**46**	

*MSM = sexual transmission among men who have sex with men; IDU = transmission through injecting drug use; hetero = heterosexual transmission.

Source: WHO (1999:404).

From table 10 it is clear that women in sub-Saharan Africa are at greatest risk, accounting for 55 per cent of HIV positive adults in this

region. Also relevant is the fact that the main mode of transmission in Africa is heterosexual intercourse. In much of the world, women, (who account for 46 per cent of all HIV infections), have low social status and lack the power to insist on condom use or other safe sex practices.

HIV has also had a devastating effect on the well-being of South African women. In 1999 it was estimated that 19,4 % of adult women in South Africa are living with HIV (UNAIDS, 2001) and that 24,5 % of women attending antenatal clinics in 2000 were HIV positive (Department of Health, 2000: 9).

5.3 WHAT TYPE OF WOMAN IS AT RISK?

When HIV is spread heterosexually, the entire sexually active female population is at risk. However, one can identify variables that put some women at greater risk than other. These will briefly be discussed.

5.3.1 Younger women

Women are infected at a younger age than men, and in some regions the percentage of women infected already exceeds the male

population infected. HIV prevalence for regions in Africa[1] generally reveal higher levels for females. Recent data also indicate that up to 60 per cent of all new HIV infections are among 15-24 year olds, with females outnumbering males by a ratio of two to one in that young population. "The fact that in Africa, women's peak infection rates occur at earlier ages than men's helps explain why there are an estimated 12 women living with HIV for every 10 men in this region of the world. Not only do the young age groups account for a bigger proportion of the population, but individuals who are infected at a younger age tend to survive longer and continue to be counted among those living with HIV" (UNAIDS, 2000:11).

One reason for the high prevalence among girls is the relatively young age (15) that these girls are becoming sexually active. In addition to this and perhaps the overriding cause of infection in the younger female group is "age-mixing". In this regard the UNAIDS (2000:48) report states that " (i)f the girls' sole sex partners were boys their own age, they would run little risk of becoming infected...However, girls also have sex with older men – men who have been sexually active for many

[1] Angola (Luanda), Botswana (Gaborone), Lesotho (Maseru), Malawi (Blantyre) Mauritius, Mozambique (Maputo), Namibia (Windhoek), Swaziland, Tanzania, Zambia (Lusaka), Zimbabwe (Harare) and South Africa (Loewenson & Whiteside, 1998:18-19).

years and who therefore tend to be more heavily infected than younger males."

5.3.2 Sex workers

Prostitution is found in all societies in the world. Although male sex workers exist it remains a predominantly female occupation. Sex workers, probably originally represented one of the core HIV-infected groups and remain a high-risk group due to the very nature of their occupation. The HIV prevalence among female sex-workers in major urban areas in South Africa was estimated at 61.1% in 1998 (UNAIDS, 2001). Leggett (2001:101) provides the following reasons why female sex workers are a high-risk group:

- The range and number of sex partners.
- Their exposure to sexually transmitted diseases other than HIV.
- The greater than average likelihood of intravenous and other drug use.
- Financial incentives to forgo condom use.
- The possible effects of drug use on judgement during transaction and the influence of this on safe sex.
- High levels of forcible rape.

- Physical "wear and tear" of the vagina and an increase of blood-to-blood and semen-to-blood transmission.
- The likelihood that clients made use of other sex workers on previous occasions.

Leggett (2001:106) however, does make a distinction between street-walkers and higher class escorts. He found that "an accurate predictor of HIV sero-prevalence with this population (sex workers) is race, and black sex workers show substantially higher levels of HIV than other ethnic groups."

5.3.3 Women in the black population

Another important variable in the risk of acquiring HIV is race. Many studies have indicated that the black population, has a higher HIV prevalence rate than the white population. Leggett (2001), as mentioned above, found that race was an accurate predictor of sero-prevalence among sex workers. This is often due to the double jeopardy of being black and female. It is widely recognised that being black and female places one at a serious disadvantage, particularly in a society like South Africa, that has a history of racial discrimination and a culture of patriarchy.

However, Crothers (2001:13) warns that although it is true that "..blacks are victims to a degree that totally outnumbers that of other groups.....the HIV/AIDS infection rates of non-black groups are seldom publicised."

5.3.4 Women in stable partnerships (wives and girlfriends)

Despite the emphasis on women who sell sex, it is important to realise that these women are a minority of women with HIV. It is interesting to note that the rampant heterosexual spread of HIV may have started due to contact with a highly infected core group (sex workers). Table 11 reveals that sex workers originally had a higher sero-prevalence than other groups of women. However, the majority of women currently infected with HIV, are monogamous married women (Basset, 1993:9). Nowadays the sero-prevalence rates among women who are not sex workers and also do not display what is termed 'risky behaviour" are also extremely high. This means that the epidemic has spread beyond the core group[1] and that all sexually active women are at risk. Just being in a sexual relationship in the role of wife or girlfriend puts women at risk.

[1] Leggett (2001:108) found low levels of HIV among sex-workers with high client volumes, which according to him, may indicate correct and consistent condom use. He goes on to state that it is debatable whether sex work is the primary contributor to the spread of the epidemic.

Table 11: HIV sero-prevalence rates for risk groups in three geographical areas (1990).

	Sex workers	STD patients (male and female)	Pregnant women
Cameroon	8,6%	2,9%	0,2%
Nigeria	2,9%	2,3%	0,3%
Kinshasa	35%	-	5%*

*1989

Source: Ancelle-Park and De Vincenzi (1993:7-8).

Much of what has been written about women and HIV focuses on prostitutes. Few studies concentrate on women who are wives – and virtually nothing has been done on the relationships between these often co-mingled groups (Basset, 1993:8). Married women have been neglected in both research and AIDS prevention programmes. The warning to avoid multiple partners has little relevance to these women as it is their husbands who are the ones likely to have multiple partners. The emphasis on women who sell sex has further confused the message, for it implies that "good wives" are not likely to get AIDS.

With regard to partnerships before marriage it can be said that in South Africa, teenagers become sexually active at a relatively young age (13-15) (Tillotson & Maharaj, 2001:87). Studies have also revealed that

within these premarital relationships, condoms are not used consistently (Tillotson & Maharaj, 2001:87; Frame, Ferrinho & Evian, 1991:7). Thus, a lot of infection could be taking place before marriage when the women assumes the role of "girlfriend". The youth may in fact be the new "epicentre" of this disease.

It is important to realise that although HIV is more common among those who engage in high risk behaviour and those with many sexual partners, most cases of infection in women in the developing world result from straightforward sexual relations with regular partners, usually between and infected husband and his wife (Mwale & Burnard, 1992:12).

5.4 IMPLICATIONS OF AN INCREASE IN WOMEN WITH AIDS

Due to the multiple roles women fulfil in society (health care providers, educators, wives, income providers, daughters, siblings, sexual partners, girlfriends, child bearers and carers) this disease will have a profound effect on the social structure of society.

5.4.1 Impact on motherhood

One of the saddest aspects of HIV and women is the fact that they can transmit it to their babies. This is particularly true of sub-Saharan Africa, where 90% of all mother to child (MTC) infections occur. With the increasing number of women with AIDS there is a corresponding increase of babies with HIV. The estimated vertical transmission rate is estimated at about 40%. (Mwale & Burnard, 1992:10; Van Dyk, 2001:28). Most women do not know they are infected and because HIV infection does not affect fertility, women continue to have babies.

More than 60% of mother-to-child (MTC) transmissions occur during labour and delivery. Transmission is related to the viral load of the mother at the time of delivery. In addition to transmission that occurs during labour and delivery, it is estimated that 30% of MTC transmissions occur during breast feeding. Transmission in this case is also related to various factors such as the viral load of the mother and vitamin deficiencies in both mother and child and conditions such as cracked nipples and mastitis (Van Dyk, 2001: 28-29).

Thus, the mother carries the guilt of infecting her baby, even as she tries to nourish it. In addition to this she has to care for an ill child, while she is

ill herself. The stigma of HIV and AIDS often also leads to the social isolation of these women and they are often left to fend for themselves.

5.4.2 AIDS orphans

Women have traditionally fulfilled the role of nurturers and carers of children. With the increase in numbers of HIV infections and subsequent deaths, the numbers of orphans increases on a daily basis. Although men also care for children it is the mothers that take primary responsibility, and with the increase of female headed households, the death of a mother often leads to children left orphaned. In this regard UNAIDS (2000:28) state that "Wherever they turn, children who have lost a mother or both parents to AIDS face a future even more difficult than that of other orphans.....AIDS orphans are at greater risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes. They must grapple with the stigma and discrimination so often associated with AIDS, which can even deprive them of basic social services and education".

One of the greatest sources of stress for HIV positive women revolves around who will care for their children when they die. The anxiety and stress associated with this often undermines the mother's (already compromised) health. Families are left disrupted, grandmothers (who

themselves are nearing the end of their lives) often resume responsibility for caring duties. Reports of grandmothers caring for up to nine orphans abound. The result is an increase in households headed by children, this in itself bringing a host of new social problems.

5.4.3 Informal carers

It has widely been acknowledged that women provide most informal care for the elderly and sick, traditionally taking the role of carer when a family member falls ill. This is particularly true in developing societies where daughters and daughters-in-law constitute the largest group of informal carers of elderly people (Etten, 1995:134; Fisher, 1994). "Family care" actually equals care by women. This fact has prompted authors such as Finch (in Fisher, 1994:661) to reject community care because it exploits women.

The caring role of women has been highlighted in a study which reported that women may expect to spend 17 years of their lives bringing up children and another 18 years caring for an ageing parent (Etten, 1995:131-132). Women are also the main providers of care for those infected with HIV (Strebel, 1993:22). With the increase of AIDS this caring burden will increase. Mwale and Burnard (1992:12) state in this

regard "(t)he physical burdens imposed by AIDS on women are heavy; if a family member or members, are ill, she must add long term care for those who are sick to other daily responsibilities of farming, trade and housekeeping."

In addition to caring for others, women will also have to care for themselves. A situation may arise where the carers will not be there to boost and support the family as they have been doing for years (without acknowledgement). The effects for society, particularly developing societies is devastating. It is as if the very fabric of the family is unraveling. Without women to care one can only foresee an increased burden on the already overburdened health and welfare system.

5.4.4 Women as partners

HIV also influences the role of women as sexual partners. Often people who have been diagnosed with HIV experience feelings of contamination and being dirty (Chapman, 2000:847). This can be related to the fact that HIV has been stigmatised. Within relationships HIV positive status affects sexuality negatively as well as the quality of the relationship.

5.4.5 Increasing marginalisation of women

Apart from affecting women in the roles they fulfil, another effect of HIV infection is that it could in fact exacerbate the subordinate position of women. In a very interesting article by LeClerc-Madlala (2001:45) she explains that "...predominantly women are being blamed for the presence and spread of HIV/AIDS among the Zulu in KwaZulu-Natal province.....this process both reflects and contributes to women's already marginalised and subordinate status in society."

Blaming women for the cause of HIV is not unique to KwaZulu-Natal, but has been found in many other parts of Africa (Haram, 2001:49). This is consistent with the inferior status of women where they are the scapegoats for many ills in society.

This chapter has given a brief overview about the prevalence of HIV among women as well as the effect that this disease will have on society due to the mortality and morbidilty of women. The next two chapters will deal with the factors that put women at risk.

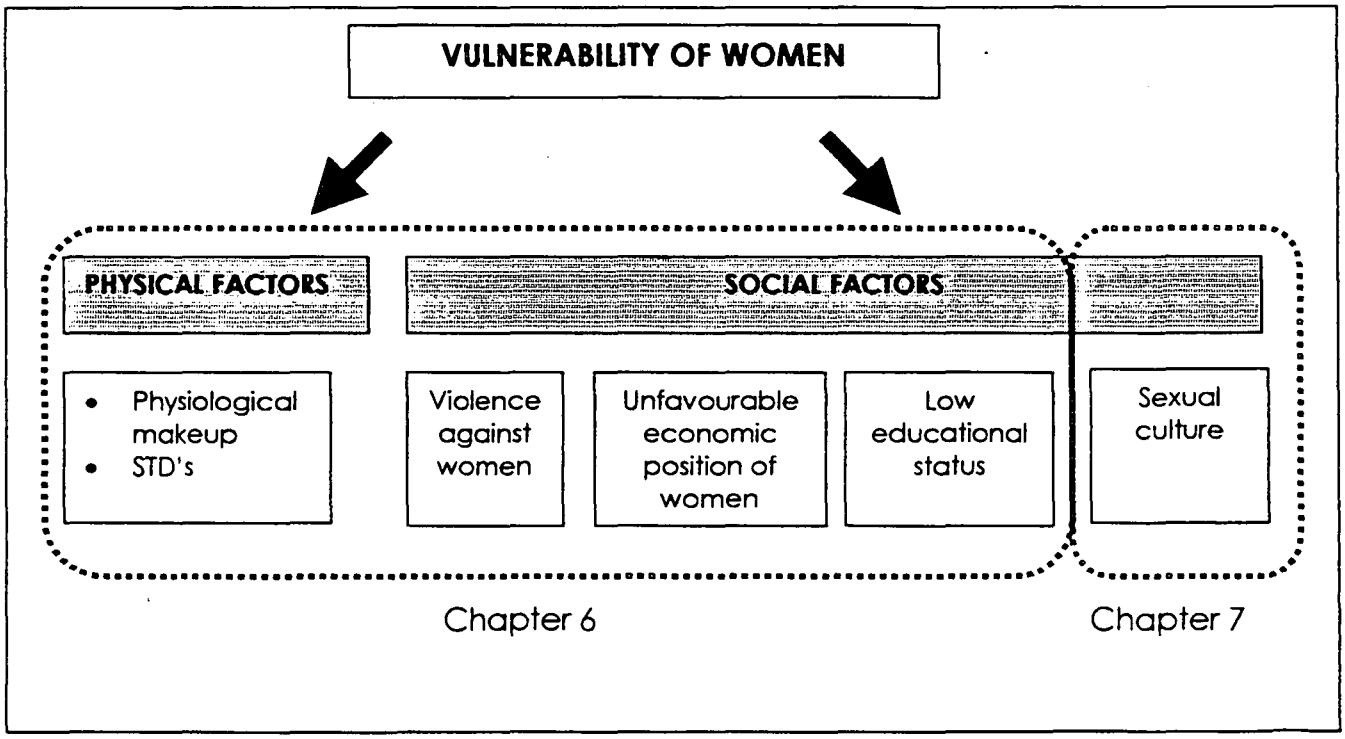
CHAPTER 6

PHYSICAL AND SOCIAL RISK FACTORS

"Compounding their biological vulnerability [to HIV infection], women often have a lower status in society at large and in sexual relationships in particular." (UNAIDS, 2000:47).

The risk of women can be divided into two categories; physical and social. The physical vulnerability of women and the social factors rendering women vulnerable to infection will be discussed in this chapter. The other social factors relating more directly to sexual culture will be dealt with in the next chapter.

Figure 4: The vulnerability of women to HIV infection.



6.1 PHYSICAL FACTORS

Women of all ages are more likely than men to become infected with HIV during unprotected vaginal intercourse (Mwale & Burnard, 1992:33; Strebel, 1993:22). This increased likelihood is estimated at 2 – 4 times (Van Dyk, 2001:20; Hoffman *et al.*, 1998:566). The following reasons account for the greater physical vulnerability of women (Hoffman *et al.*, 1998:566; Van Dyk, 2001:20):

- Women are the recipients of semen and thus are exposed to semen for a relatively long time (a few hours). Men are only exposed to the vaginal secretions for a short time (duration of intercourse).
- Higher concentration of HIV may be found in semen than in vaginal fluids.
- Large surface area of mucosa exposed during intercourse in the case of women.
- Vaginal conditions caused by sexually transmitted diseases (STD's), dry sex practices and the use of spermicides may damage the vaginal wall and make transmission easier.
- Menstruation causes raw areas in the inner uterine lining which also aids transmission.
- Young girls are also particularly vulnerable because their genital tracts are not fully developed. Hoffman (*et al.*, 1998:566) explains it as follows: "....young girls even more so due to the presence of delicate, easily traumatised columnar cells on the vaginal portion of the uterine cervix."

6.1.1 Women and STD's

Individuals who have STD's are particularly prone to HIV infection (Lush & Makoala, 1999:19; Hoffman *et al.*, 1998:566). It has been estimated that an untreated STD in either partner can increase the risk of HIV transmission ten-fold (Van Dyk, 2001:20).

STD's are amongst the top five causes of death among young adults worldwide and are also a public health concern in South Africa. STD's represent one of the most common reasons for attendance at primary health care centres (Department of Health, 1999(a):2; Department of Health, 1999(b):3). In South Africa over 50% of all antenatal clinic attendees has at least one sexually transmitted disease. The South African Health Review (as reported by the Department of Health, 1999(a):3) revealed high levels of infections, as is portrayed in table 11.

Table 11: Percentage of antenatal clinic attendees presenting with sexually transmitted diseases in 1995.

STD	Percentage
Syphilis	15%
Chlamydial infections	16%
Gonorrhoea	8%
Other vaginal infections	20-50%

Source: Department of Health (1999(a):3).

Unfortunately, in many cases women do not realise that they have a sexually transmitted disease particularly when their sexually transmitted infection is asymptomatic, and even if they are symptomatic they often do not seek help (Lurie & Harrison, 1999:22 ; Strebel, 1993:23). For example, in a study in Kwazulu-Natal, Lurie & Harrrison (1999:22) found that only 2% of symptomatic women sought care and of this group only 65% were adequately treated, the other 98% did not even seek care!

Of those who do seek help, not all will be adequately treated as it is more difficult to identify sexually transmitted diseases in women than in men. As a result, many women go untreated, leading to chronic infections and long-term complications such as increased levels of infertility and increased incidences of cervical cancer (Hoffman *et al.*, 1998:566 ; Strebel, 1993:22). The consequence, for women, apart from the above-mentioned complications is an increased risk of HIV infection. It is little wonder then, that STD's are "...the second largest cause of years of life lost in women aged 15-54 years..[and]...that more than a million women and children died from complications of the reproductive tract infections (RTIs) during the 1990s (Department of Health, 1999(a):2).

In light of the preceding section of this chapter it is undeniable that physiologically, women are at greater risk of contracting HIV than men.

6.2 SOCIAL FACTORS

Apart from the physiological vulnerability of women it is important to consider the social aspects that put women at risk of infection.

The second part of this chapter outlines some of the social factors that make women vulnerable to HIV infection. Each will be discussed separately for analytical purposes, but it is important to remember that these factors influence each other.

In most parts of the world, including South Africa, women are born into inequity characterised by low social status and subordinate positions in both society and the family. While lower status differs in detail and in degree from country to country it has the effect of restricting women's ability to take control of their lives and to protect themselves from sexually transmitted diseases.

6.2.1 Violence against women

Violence against women can be considered one of the most overt manifestations of male domination. Violence against women makes women vulnerable to HIV infection in a number of direct and indirect

ways: directly, in the case of rape and indirectly when a woman is afraid to refuse sex.

According to *The Global Report of Women's Human Rights* (Mohapelao, 1995:3), violence against women is a leading cause of female injury in almost every country in the world and is typically ignored by the state or only erratically punished. Mohapeloa, (1995:3) states that "Violence against women embraces a wide variety of acts:

- physical, sexual and psychological violence in the family including battering, sexual abuse of female children in the family, marital rape, female genital mutilation and violence related to exploitation.
- physical, sexual and psychological violence occurring within the general community. This includes rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution.
- physical, sexual and psychological violence condoned by the State wherever it occurs."

Gender violence is widely recognised as being a big problem in South Africa, yet the exact levels are not known. This is partly because this type of violence is often not reported. However, the information gained about gender violence come from a number of smaller research

projects[1] and from police statistics and these indicate high levels (Penn-Kekana, 1997:5).

6.2.1.1 Rape

Rape as a form of gender violence, remains one of the least notified crimes in South Africa. The rates of rape in South Africa are considered to be of the highest in the world and appear to be increasing every year. In 1993, 27 056 rape and attempted rape cases were reported in South Africa. In 1994, 32 000 women laid charges of rape. It is estimated that only 2,8% of rapes are reported, bringing the total rapes in 1995 to about one million a year (Human Rights Watch, 1995). A shocking thought if one considers the possibility of contracting HIV under these conditions.

Another insidious face of this crime is rearing its head in the form of child rape. An in-depth investigation has revealed that the popular myth "that sex with a virgin will cure AIDS", is the root of the recent upsurge in child rapes (the rape of children under the age of eight years). This is particularly true in the case in the KwaZulu-Natal province (Govender, 1999:13). Cases of baby rape received extensive media coverage recently (Coetzee, 2001:1). One cannot help to wonder if

[1] It is interesting that in the South Africa Demographic and Health Survey 1998 (Preliminary report) the level of gender violence is relatively low, however, the same report warns against under-reporting and states that smaller studies that were conducted, consistently revealed higher levels (Department of Health, 1998:23).

the motivation behind these recent horrendous acts is the "AIDS cure" myth.

Gang rape also appears to be on the increase in South Africa and elsewhere, where "...roving gangs of young men, many infected with HIV...engage in what is known as 'catch and rape'....Similar situations have arisen in the West Indies where gangs assaulted women and girls as part of their initiation ceremonies." (Deen, 1999:11).

Rape increases the risk of HIV transmission as the torn tissue creates and easy entry-point for HIV (UNAIDS, 2000:51). In addition to this there is the risk that the rapists themselves are more likely to be HIV infected because of their indiscriminate actions.

Women do not report the rape for a variety of reasons. UNAIDS (2000:51) explains the reluctance of women to report rapes as follows. One of the reasons is that victims of rape feel embarrassed about what happened. In a study in Egypt one of the reasons given by women why they did not report sexual abuse was that they were to shy (many had been raped by a relative or friend of the family). In addition to this, often a reported rape does not lead to arrest and if the rapist is convicted the punishment is often so lenient, that it just does not seem worth it. In Botswana, for example, just a fifth of reported rape cases in

1997 ended in an conviction and three quarters of the convictions were given a prison sentence of four years[1] or less.

6.2.1.2 Violence from an intimate partner

For many years, violence within intimate relationships such as marriage was considered acceptable under certain conditions. For example, Songca & Letseku (1998:58) state that it was acknowledged that a husband could chastise an erring or delinquent wife. Along a similar vein Penn-Kekana (1997:6) notes that men are conditioned to viewing women as their property and when a woman is unfaithful or is disrespectful it is widely felt by men *and* women that the man has the right to punish or discipline her.

Gender violence, often perpetrated by close male partners, is increasingly recognised internationally to be a common feature of adult womens' daily experiences (Wood, Jewkes & Maforah, 1997:21). Violence in intimate relationships often occurs, so often in fact, that it has come to be perceived as almost normative and to a large extent accepted rather than challenged (Penn-Kekana, 1997:5). Worldwide studies indicate that between 20-50% of women have been beaten or otherwise physically assaulted by an intimate partner (Hoffman *et al.*, 1998:566; UNAIDS, 2000:50).

[1] As a result of lobbying in Botswana, the minimum sentence for those convicted of rape is 10 years and rises if the rapist is found to be HIV positive (UNAIDS, 2000:51).

A study by the University of the Witwatersrand revealed that more than 60% of South African women are regularly battered by boyfriends and husbands (Ramsay, 1995:8). There is often a thin line between physical violence and sexual coercion. It has also been estimated that 50-60% of all marriages involves physical and sexual violence (Penn-Kekana, 1997:6).

Violence, however, is not limited to the marital relationship. It also occurs at an earlier stage in the relationship (boyfriend/girlfriend phase). A study among teenagers in Khayelitsha in the Western Cape province revealed that in most cases men used violent strategies at the beginning of a relationship, forcing the girl to have sex with them (Wood *et al.*, 1997:22). These authors also mention that other studies have indicated that 30% of young girls' first sexual encounters were forced.

In addition to the initial forced contact, men were reported to continue using physical assault to enforce contact, beating their partners if they refused to have sex and that this was the main reason why the girls continued to have sex (Wood *et al*, 1997:22). Girls were also beaten by their partners if they were seen talking to other men. In some cases punishment included gang rape. The gang raping of adolescent girls

by friends of the male partner is reported to happen often in the community as a way of punishing girls for actual or suspected infidelity.

6.2.1.3 Violence experienced by sex-workers

As a result of their stigmatisation in society and the fact that they are mainly female, female sex workers are vulnerable to violence (Sloan, 1999:26). Karim & Karim (1995:1523) in their study of prostitutes found that many of the women were often physically abused and raped by clients. Several women testified that clients were more likely to behave aggressively when condoms were used or suggested, which made the women fearful of suggesting their use.

6.2.1.4 Alcohol abuse and violence

Domestic violence and rape have also been associated with drug and alcohol abuse (Songca & Leseku, 1998:59; Mwale & Burnard, 1992:48). Female farm-workers identified the availability of cheap alcohol as part of the explanation of high levels of gender violence on farms and this has also been linked to increased levels of rape and child abuse (Penn-Kekana, 1997:7).

The study of Karim & Karim (1995:1524) found that clients frequently consumed beer purchased from sex workers. They argue that

negotiating for safer sex practices with a client under the influence of alcohol not only reduces the sex workers chances to succeed but also increases the possibility of a client reacting irresponsibly and perhaps violently. Obviously the underlying causes of gender violence runs deeper than mere alcohol abuse, but it does seem to be a compounding factor.

6.2.1.5 Laws prohibiting violence

Although there are laws[1] prohibiting domestic violence and rape, violence against women often occurs anyway. It has been argued that more is needed than law reform, as legal changes have to be accompanied by ideological and cultural changes (Songca & Letseku, 1998:59). Ramsay (1995:7) argues that although the new constitution and Bill of Rights give full rights for South African women, we are left with a legacy of social attitudes of male dominance in both black and white cultures. It is crucial that the state does not tolerate any form of violence against women. It is futile having laws against violence if the state does not take active steps to halt these activities (Songca & Letseku, 1998:58).

[1] The *Prevention of Family Violence Act 133 of 1993* that includes persons who are married or living together as husband and wife. The *Domestic Violence Bill* was introduced to address some of the shortcomings of the Family Violence act and it includes homosexual and lesbian couples and those who are or were in an engagement or dating relationship.

Apart from other reasons (such as the battered-wife-syndome), women often remain in the abusive relationship because of fear of violence and because of economic dependence (Songca & Letseku, 1998:59; Ramsay, 1995:7). Whether violence is inflicted by strangers or intimate partners, the fact remains that violence increases women's risk of exposure to HIV and other sexually transmitted diseases. Women lose the power to negotiate safe sex in a culture of gender violence.

6.2.2 The unfavourable economic position of women

Another factor that can put women at risk is their greater economic vulnerability (Strebel, 1993:22; N.A. 1998/1999:11). According to Manuh, (1998:7) the economic crisis in Africa has worsened the employment situation for women and men alike. Women, however, face even greater vulnerabilities in the labour market because of their relative lack of education and training. In addition to this, the continuous heavy burdens of unpaid domestic work, child bearing and child care, restricts the time and energy available for income earning activities.

Of the limited resources that are available, little is directly allocated to women. Women also do not own as much land as men, in fact in some areas in Africa, they are not allowed to own land[1] (Manuh, 1998:5) In addition to this, few women own land and often have little say over

financial matters (Avotri & Walters, 1999:1129). The net result being that in economic terms, women often face financial uncertainty and have limited access to jobs, land and credit (Avotri & Walters, 1999:1125).

6.2.2.1 Female headed households

Female-headed households are on the increase in Africa (Offei-Ansah, 2000:11). It has been estimated that women head about 31% of households in urban and rural areas across Africa, often with no working resident males (Manuh, 1998:5). This has increased the number of women living in poverty and the number of households in the poorest categories headed by women.

This type of family structure is on the increase due to widowhood, separation, divorce or desertion. A study by Avotri & Walters (1999:1129) revealed that "...women [were expected to] provide for their children on a day-to-day basis...Many of the women in the study complained that their children's fathers had refused to help them, leaving to them the entire financial responsibility for their children." Women are typically responsible for the care of their families and for the economic support of their children and often have to engage in several jobs to earn enough money .

[1] In some African countries, land tenure reform has enabled women to own, use and inherit land (Offei-Ansah, 2000:11).

The migrant labour system also has the effect of impoverishing women. The migrant labour system usually entails the man leaving the (rural) household in search of employment (in the cities). The women that remain have to maintain the entire household and often do not get financial assistance from their husbands. With the decline of national and local economies and the migration of men to cities, many men have been unable or have refused to contribute their share towards household expenses.

In some cases men desert the rural household and start a new family in town. Male migration has left women as heads of household in the rural areas and separation had become a feature of life in many parts of Africa. Sexual relationships outside marriage have also changed with husbands having other partners in towns. These liaisons can lead to loss of income from the town back to the rural areas where the man maintains a family in town and cannot afford to send money back to the rural areas. Men who cannot afford to maintain urban wives as well as their rural wives might opt for more casual arrangements. This will be discussed in more detail in the next chapter as it also pertains to the sexual culture that emerged due to this system.

Being in an economically disadvantaged position, puts women in a less powerful position: preventing them from leaving abusive or unfaithful

husbands and forcing women to supplement their incomes in ways that add to their risk of infection.

6.2.2.2 Transactional sex

With increasing pressure on them, women are forced to find some means of supplementing their economic situation in order to attain some measure of autonomy and self-reliance. In this regard, Basset (1993:8) argues that the number of women who sell or barter sex at one time or another is larger than is known. Very often women involved are divorced mothers who have children to support and for whom remarriage is an unlikely prospect. Add to this many rural (often unskilled) women forced by drought and widespread crop failures to migrate to the cities to look for jobs and unemployed young women who have no real future prospects due the poor economic conditions in the country.

In a Malawian study (N.A., 1998/1999:11), interviews with poor, widowed, divorced and abandoned women revealed that sexual favours granted to occasional partners can guarantee some security and better access to resources. The predicament for many of these women is straightforward. Sex is a strategy for survival, with women selling sex to meet a specific obligation, such as paying school fees. The transactions cover all sorts of arrangements, many of which are not

socially considered prostitution (Basset, 1993:8). Reward for sexual services may range from occasional cash payments from stable partners through to supplementation of income with gifts.

Commonly, girls from low-income families are especially vulnerable to the "favours" of older men, "sugar daddies", who will offer money and gifts for sex (N.A., 1998/1999: 11). Many young girls who have financial problems exchange sex for money to buy the basics such as soap and food and some even use this money to pay for their education. Relationships are contractual in nature, with the girls expected to be available in exchange for presents of money, clothes and food. One participant in the study of Mwale & Burnard (1992:38) put it in a nutshell when she commented: "..they are not looking for the disease...they are looking for money...that's the big problem ...in looking for money, they acquire the disease".

These women are reportedly being motivated mainly by economic need, and have rejected HIV prevention information and have failed to reduce the number of sexual partners (N.A., 1998/1999, 11). Economic dependency of women on men is one of the most important factors for female prostitution. If viable alternatives to trading on sex existed, most women dependent on these exchanges would seize them. Female poverty can thus be regarded as a threat to the

wellbeing of women, particularly as it encourages behaviour that increases the risk of HIV infection.

6.2.2.3 Attitude of fatalism

Another contributing factor to women's vulnerability is an attitude of helplessness and hopelessness, due to the dire economic circumstances that many women live under. LeBeau, Fox, Becker & Mufune (2001,65) describe fatalism as "...an orientation or a behavioural disposition in which people see themselves as powerless to effect change. They see events as unrelated to their will but to a generalised other that is understood as fate or chance. This belief that individuals are helpless in the face of difficulty may be quite deadly in the age of HIV."

Among the poor HIV is just one more problem to face. A respondent in Paterson's (1996:20) study stated that "HIV kills in three to ten years; hunger kills in three days". Some women and men are caught in a situation where there is no escape, no plans for the future and therefore modifying behaviour or not taking part in high risk behaviour, just doesn't make sense. Karim & Karim (1995:1524) say in this regard "For these women who are living in overcrowded conditions, in poverty with poor health and with many dependents, the risk of an infection that may not materialise for many years is perhaps not so alarming a

spectre. A high risk of HIV infection is just one more vulnerability to be faced, one more consequence of their lack of social and economic power."

Because women have traditionally been in relatively powerless positions, this feeling of fatalism may in fact be more strongly felt by women.

6.2.3 Low educational status

It has long been realised that there is a positive correlation between education and standard of living, "[i]n general, people with more education lead healthier more productive lives. There are several reasons for this association: better educated people generally have greater access to information than those who are illiterate or uneducated, and they are more likely to make well-informed decisions and act on that information. In addition educated people generally have better jobs and greater access to money and other resources which can help them support healthier lives" (UNAIDS, 2000:42).

One of the barriers facing women in Africa is the lack of access to formal education. In Africa, female illiteracy rates were over 60% in 1996 compared to 41 % for men (Manuh, 1998:10). In many African countries parents still prefer to send boys to school, seeing little need for

education for girls. In addition, factors such as adolescent pregnancy, early marriage and girls' greater burden of household labour, act as obstacles to their schooling. As a result, female enrollment numbers decrease as they move up the educational ladder (Manuh, 1998:10).

This lack of education has a direct influence on the quality of life of women. Studies have shown that a woman's education beyond primary school is a reliable route to economic empowerment and long term changes in the status quo as well as a determinant of a family's health and nutrition. Education beyond ten or more years of school is also a reliable predictor of lower fertility, improved infant survival, reduced maternal mortality and enhanced levels of infant and child development (Manuh, 1998: 10).

Table 13: Fertility rates and contraceptive use by level of education of South African women as reported in the 1998 SADHS.

Level of Education	Total fertility rate	Use of contraception (any method) %
No education	4.5	35.1
Sub A – Std 3	3.9	45.0
Std 4 – Std 5	3.5	53.9
Std 6 – Std 9	2.7	65.7
Std 10	2.2	73.5
Higher	1.9	79.4

Source: Department of Health (1998:19, 22).

Table 12 clearly reflects how a woman's level of education influences her use of contraceptives and the number of children she has. This can be interpreted as the more educated a woman is, the greater level of control she has over her life.

However, the current barriers to formal education of women and girls is a factor that contributes to their vulnerability (Mwale & Burnard, 1992:10). In Karim & Karim's (1995:1523) study of prostitutes, the respondents (with the exception of one woman who attended school for 9 years) had an average school attendance of 5 years which they saw as a barrier to obtaining other employment.

6.2.3.1 Limited access to information

Related to education is the limited access to information that many women have. Women who are home based and/or rural may not have access to information about how HIV is transmitted because they may not receive AIDS prevention materials which are often distributed in public places such as workplaces, social organisations or schools (Mwale & Burnard, 1992:13). This lack of information is often reflected in misconceptions about HIV/AIDS. In the study of Mwale & Burnard, (1992:30-32), respondents indicated that they did not now how the disease is transmitted or that women are not as likely as men to get the disease because women have menstrual periods that "cleanse" them.

In some societies ignorance of sexual matters also indicates purity and if a girl has knowledge of sexual matters she is considered to be promiscuous. As a result many women do not know much about their bodies and STD symptoms (such as pain, itching, back ache) are accepted as being part of being a woman, with dire consequences (N.A., 1998/1999:11).

CHAPTER 7

SEXUAL CULTURE

"Few women have the status or autonomy to negotiate sexual encounters which will ensure their safety from possible HIV infection." (Strebel, 1993:22)

The focus in this chapter will be on sexual culture as a risk factor in HIV/AIDS susceptibility.

An important factor that puts women at risk is male control over sexuality, or conversely stated, the lack of female control over sexual matters. As men traditionally have more power than women in most areas of social life (as pointed out in previous chapters) it is inevitable that this dominance will also extend to the sexual lives of men and women.

Wood *et al.* (1997:22) state that "[f]rom the outset of their relationships the male partners dictated the conditions and timing of sexual intercourse. Women are generally aware of the power inequalities and double standards operating within constructions of love and sex, but find that resistance is difficult because of the cultural norms regulating behaviour and because of the threat of male violence.

The following facets of the sexual culture will be discussed:

- Womens' lack of control over the sexual lives of their partners and the role migration played in establishing this situation.
- The inability of women to insist on the use of condoms.
- The need for or expectation of women to satisfy male needs, however risky the behaviour may be.
- Age mixing.
- The importance of fertility.

7.1 WOMENS' LACK OF CONTROL OF THE SEXUAL LIVES OF THEIR PARTNERS

For many African women the threat of HIV infection begins with a lack of control over the sexual lives of their partners. For wives the danger lies in their husbands' sexual relationships outside marriage (or sometimes from polygamous marriages). Often women are not at risk because they have many partners, but rather because they are in an exclusive relationship with a high-risk individual (LeBeau *et al.*, 2001: 66).

Gender differences concerning sexual expectations is clearly reflected in the idea that men have stronger sexual urges than women and that

it is natural for men to have more than one partner is widely accepted by many men and women. Traditionally a man's need for sex and the right to more than one partner have been sanctioned in most African cultures[1]. These sexual partnerships were arranged by the family, where a man was allowed to have more than one wife only if his wealth permitted. This requirement limited polygamy to those able to maintain additional households (Bassett, 1993:8). Although polygamy still exists in Africa, multi-partnering out of wedlock also became common, due to the migrant labour system.

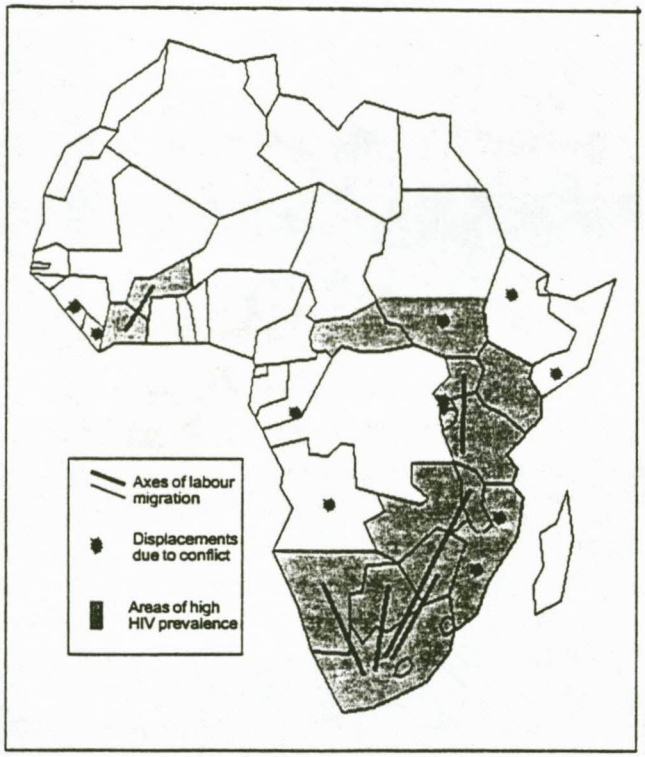
7.1.1 Migration and a culture of multi-partnering

Migration has also been linked to the spread of AIDS with migrants and their partners constituting a high-risk group. Hunt (1989:356-357) in his article on migrant labour and sexually transmitted diseases explains that the migrant labour system resulted in men moving to the cities to the sites of industry, often living in single sex hostels. The result for the women left behind was a depletion of males and an increase of female-headed households. The long separations caused a breakdown in family and sexual patterns and gave rise to a new culture of multi-partnering and the use of prostitutes. The unequal sex ratios and lack of finances made it difficult for men to establish stable

[1] About 50 % of women in Africa are married by age 18 and one in three women is in a polygamous marriage (Manuh, 1998:4).

relationships with women (they often also had families in the rural areas). For the women who struggled to find work, prostitution was often the only option (they were compelled to live off the meagre wages of the migrants). The same author (Hunt, 1989: 356-357) goes on to state that an explosion of prostitution and STD's in these populations occurred well before the AIDS virus made its appearance.

Figure 5: Labour migration and HIV prevalence in Africa.



Source: Decosas (1998:11)

When plotting zones of high HIV prevalence it comes clear that there is a link between labour migration and the spread of HIV (see figure 4). These countries form what is known as the "AIDS belt" across eastern, central and southern Africa (Hunt, 1989:354).

Decosas (1998: 11) states that migrants live in two social environments: their place of origin and their place of destination, often having sexual partners in both environments. Migration led the way from traditional marriages to cohabitation and changed sexual practices where bar-girls and prostitutes became alternative male sexual outlets.

This configuration of relationships has led to the rampant spread of sexually transmitted diseases including AIDS, a situation where migrants, their wives and casual partners are all put at risk (Basset, 1993:7; Mwale & Burnard 1992:49).

Migration, together with urbanisation and modernisation have changed the organisation of traditional sexual partnerships and what has emerged is a more sophisticated sexual structure allowing mistresses and love affairs, which still persists today. Multi-partnering has become a characteristic of the sexual culture in Southern Africa. In a study in Zimbabwe, Basset (1993:8) found that 4\5ths of married men had girlfriends in addition to their wives. Along a similar vein, a South African study revealed that although the male respondents said that people are supposed to have only one partner and be monogamous, more than half of the same group of respondents reported having at least one casual partner in the past year (UNAIDS, 2000:59). Multi-

partnering also seems to be accepted and even encouraged among teenage boys. In this regard, Tillotson & Maharaj, (2001: 90) states that the boys "..are also under pressure of peers and social norms that encourage them to engage in multiple sexual relationships to prove their virility...". The same author found that many boys had more than one girlfriend they were having sexual relations with.

Yet although women are aware of the fact that their husbands or partners are not monogamous, they feel powerless to change the situation and in most cases accept it. In a study in Zambia (UNAIDS, 2000: 50), fewer than a quarter of the female respondents believed that a married woman could refuse to have sex with her husband even if he had been unfaithful and was infected. Only 11% of these women thought a woman could ask her husband to use a condom under these circumstances.

Encouraging women to be monogamous, therefore, does not eliminate the threat of HIV infection, as often it is the husband who is not monogamous. In this regard a female participant in the study of Mwale & Burnard (1992:55) stated: "...I am married and I respect myself and I don't have extra marital affairs....but then you find that men still have affairs so we are still at risk..."

7.2 PROBLEMS RELATING TO CONDOM USE

In the effort to stem the HIV pandemic, the correct and consistent use of condoms has to be a priority. Many studies have been conducted regarding condom usage (Warren, 1997; Sankar & Karim, 1991; Pesa, Syre & Fu, 1999) and most have found that condoms are not used correctly and consistently.

Table 14: Use of condoms among women aged 15-49 who had sexual intercourse in the 12 months preceding the 1998 SADHS survey.

Age	Percentage ever used condoms
15-19	28.4
20-24	32.4
25-29	28.4
30-34	27.5
35-39	19.7
40-44	17.0
45-49	15.9
Total	**22.2**

Source: Department of Health (1998:17).

The South Africa Demographic and Health Survey conducted in 1998 found that only 22.2% of women aged 15-49 who had sexual intercourse in the 12 months preceding the survey, had ever used a condom. Only a third of teenagers were protecting themselves, the

other two thirds were having unprotected sex. Looking at the total figure, just under 80% of sexually active South African women are *not* practicing safe-sex. It is clear that barriers to condom use must exist.

Women are generally more positive towards the use of condoms than men are, as they believe it will protect them from STD's. Men, on the other hand, are more negative towards the use of condoms. The negativity of men revolves around a few issues:

- *Reduction in physical pleasure*. Men claim that condoms reduce pleasure and many men insist on "flesh-to-flesh" sex.
- *Myths surrounding condom use*. Another reason men dislike condoms is because of several misconceptions that exist around the use of condoms: some men believe that free condoms actually carry HIV. Other myths include beliefs that the use of condoms will cause sperm to be retained in the body causing physical and even mental problems (Tillotson & Maharaj, 2001:90,93).
- *The association with distrust and prostitution*. Lastly condoms are disliked because the perception exists that only prostitutes (or those with STD's) use condoms.

Because condoms are a male device, men have to want to wear them and/or women have to "convince" men to wear them. Combined with the above mentioned male negativity there exists an

inability of women to insist on condom usage due to their lack of power in interpersonal relationships and because of a lack of communication regarding sexual matters.

If a woman suggests the use of a condom she is suspected or accused of being unfaithful, or that she is hiding a sexually transmitted disease. Her call for condom use may also be interpreted as distrust in her partner. Men feel insulted if a condom is suggested. Condoms are seen as an act of hostility that calls your partners health and morals in question (LeBeau, *et al.*, 2001:66). "How do I tell my husband to use a condom?" asked one participant in a study by Oliver (1996:317). Another admitted that she had talked about condom use with her husband and he promptly called her a prostitute.

Another reason that women (and men) fear condom use is the stigmatisation that could result. This is related to association of condoms with STD's (as mentioned above). In Paterson (1996:16) a respondent explained that when a person suddenly insists on using a condom everyone will guess or suspect that they are HIV positive and then they run the risk of losing their jobs and being abandoned by their families and left to die.

Strebel (1993:23) also mentions some practical barriers to condom use: "...if women are not supposed to see or touch male genitals, and if many sexual encounters occur hastily in the absence of privacy and comfort, it is inappropriate to talk about 'eroticising condom use' ". Related to the above, condom use can be compromised because "..putting on a condom requires putting on the light to see what you are doing. Apart form there being no electricity, it was taboo for a man to show his private parts, for fear that others, for example children, would see them." (N.A., 1993/1994:3). So often sex occurs in the dark in lack of privacy and this on a practical level influences the use of condoms.

In addition, the dependence of women on men financially also makes it difficult for a women to insist on condom use if her partner refuses. LeBeau *et al.* (2001:67) point out that women who are dependent on men for economic support find it difficult to enforce condom use even when they know that their husbands are having extramarital affairs. Also related to economic dependency is the issue of condom use in the sex industry.

In the area of sex work, the use of condoms is also resisted. In a study among South African prostitutes Karim & Karim (1995:1523) found that

clients were more likely to behave aggressively when condoms were used or suggested, which made the women fearful of suggesting their use. The same study revealed that although condoms were obtained from government clinics they were used infrequently. Also relevant is that they reported that condom use led to physical abuse by clients. Clients insisted on paying less for sex, when a condom was used. The women who insisted on condom use charged only one quarter of the average price. With economic pressure on women they are less likely to opt for the "safe" option if it means a substantial loss in income.

A study in Cambodia, where HIV prevalence amongst sex workers had risen to 40% and where condom use was low, showed that the men visiting the sex workers were also heavily infected and were passing the disease onto their wives (UNAIDS, 2000:46). Some prostitutes never asked clients to use condoms and of those who did, most of the clients refused.

7.3 THE IMPORTANCE OF MOTHERHOOD

In most cultures, children define an individual's, especially a woman's self worth. (N.A., 1998/1999:11). In many African societies, motherhood is regarded highly and a childless marriage is not considered good. It is

also associated with an increase in status for the woman. Estimates of average total fertility rates in Africa were 5,7 children per women (in 1995), although some Southern African countries have begun to show declines. High fertility arises from the economic value of children, high infant mortality and low levels of contraceptive use. Also it is as mothers that women secure claims in their marital home and to their husbands' assets (Manuh, 1998:4).

A study in a Durban township found that such a high value is placed on having children that for some woman (in the urban setting) it is more important than marriage. Because of the high value placed on pregnancy and birth, having children provides girls with an alternative route to adult status (Prestonwhyte in Bernstein & Van Rooyen, 1994:377,379).

Whatever the motivation for having children , heterosexual sex with the purpose of producing children, is incompatible with condom usage. Thus, it is unfortunate that one of the most basic desires of individuals, to have children, can only[1] be fulfilled by engaging in unsafe sex.

[1] With the exception of artificial insemination, which is not the common method of conception.

7.4 SEXUAL PRACTICES TO ENHANCE MALE ENJOYMENT

"Women are, at all times, especially vulnerable since they are from birth socialised to please and defer to the authority of males, particularly in sexual relations. No woman will feel confident enough to refuse what is pleasurable to a male however risky such activity may be" (N.A., 1998/1999:11). This is particularly true of the practice of "dry sex".

Many women insert herbs, powders, household detergents and antiseptics into their vagina before sex to make sure that they are "hot, tight and dry" (Baleta, 1998:2; Bassett, 1993:8; N.A, 1998/1999:11-12). This promotes friction and is apparently very pleasurable for males. "This is the way their men like them...[t]he agents increase friction during sex and although painful for women, they are prepared to forego their own pleasure to ensure their partners return to them" (Baleta, 1998:2).

Dry sex practices have been found in many African countries including Zaire, Malawi, Zambia, Zimbabwe and in South Africa. This practice is reported to be most prevalent in KwaZulu-Natal (Baleta, 1998:2; Bassett, 1993:7). Karim & Karim (1995:1524) also found extensive practice of douching and a wide array of vaginal insertions used by female sex workers.

These practices to ensure male pleasure result in mucosal irritation and inflammation and enhance HIV transmission. In addition, the effective use of condoms is compromised by intravaginal substance use.

7.5 AGE MIXING

Another characteristic of the sexual culture in South Africa and indeed in most parts of the world is that of age mixing. Age mixing refers to the discrepancy in ages of sexual partners. It is generally known that men are more likely to have sex with younger women than women with younger men. Age mixing is considered to be one of the reasons that the HIV infection rate is higher for women than for men in the teenage years (UNAIDS, 2000:48).

Girls are having sex with older men – men who have been sexually active for years and are also more likely to be infected. In Tanzania, for example, 17% of unmarried teenage girls reported having sex with a man at least 10 years older then themselves. In another study, about a third of men identified as clients of sex-workers, also had casual sex with teenage girls (UNAIDS, 2000:48). One of the reasons men engage in sex

with younger girls is the (mistaken) belief that teenagers are less likely to be HIV positive.

7.6 WOMEN AND A LACK OF CONTROL

When one takes the social factors discussed in the previous chapter, and those discussed in this chapter into consideration one cannot help but to admit that women are truly in a disadvantaged position. The degree to which women are, or feel, able to control various aspects of their sexual lives is clearly a critical question for health promotion. Failing to take the factors that make them vulnerable into consideration, limits the design and hence the appropriateness and impact of reproductive health interventions.

Most women do not have control over their sexuality and that they cannot police their partners' sexual drive and sexual practices. The literature overview clearly indicates that many women may find themselves unable to negotiate the timing of sex and the conditions under which it occurs. In this context, many may feel powerless even to protect themselves against pregnancy, let alone sexually transmitted diseases through condom use.

CHAPTER 8

DISCUSSION OF FINDINGS

"The biggest risk group of all are the women in love." (Paterson, 1996:60)

This chapter will give a brief overview of the profile of the participants in this study, followed by a discussion of the themes that emerged during the interviews.

8.1 PROFILE OF PARTICIPANTS

The ages of the participants ranged from 19 to 46[1]. The home languages of the participants were: Sesotho, isiXhosa, Setswana and English[2]. Two of the participants were married, one was divorced and the rest were single or cohabiting. Only two of the participants were employed by a business, one was self employed and the rest described themselves as unemployed.

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[1] 36, 22, 23, 30, 19, 30, 26, 46, 39, 31.

[2] This woman came from Zambia, but did not specify what her home language was, she participated in English.

8.2 ASPECTS THAT EMERGED FROM THE STUDY

8.2.1 Lack of information about HIV

One of the issues resulting from the interviews, is the lack of knowledge these women had before they acquired the disease. The message that HIV is a dangerous disease, seems to have filtered through to the community and is reflected in statements such as: *"I did not know much about HIV, I only used to hear people saying HIV kills people especially when they are drunk talking about HIV." "I had little information, what I knew was that it kills." "I knew it was fatal and incurable".* Sadly though, the way to prevent it or the actual details regarding the virus seems to be unclear: *"I only knew there was such a virus from other people but I didn't know its effects on a persons body." "No [I didn't know about the virus]. I always heard people talking...they said HIV was infectious when you sleep with a person."*

So although it is important to stress the serious consequences of the disease, the specific actions that cause transmission need more exposure. Another perception held by some of the participants, was the stereotypical view that HIV only affects promiscuous people, and that living with someone somehow protects one against HIV infection.

"I had knowledge, but I believed I would not have it. I thought only people who do bad things will contract the virus. I even used to point fingers and say 'so and so does this and he has this'... I never thought I would be affected because I told myself that I don't do those things...I thought it only affected promiscuous persons."

"I knew that when you have many boyfriends/men it could affect you and that when you have a man living with you, you wouldn't be affected. I trusted the man I lived with. I knew he loved me and that he would never do that to me. I didn't even worry about using a condom because I trusted him."

This corresponds with the Demographic and Health Survey which found that 87,4% of respondents believed that staying faithful to one partner would protect them against AIDS (Department of Health,1998:13). Mutual monogamy is important and it is misleading to encourage monogamy without emphasising that *both* partners must be monogamous.

One participant that acquired the disease quite early had no knowledge, which is understandable: *"No, I knew nothing...HIV was scarce at that time so I suspected nothing".* This participant has had

knowledge of her HIV status since 1991 and at that time there was not much public awareness about the disease. Only one person mentioned that they knew something about the mode of transmission: *"I knew that you get it from sex or from someone's blood through injection."*

8.2.2 Type of relationships

When exploring this aspect of the women's lives, the following three things are striking. Firstly, their relationship with the person they acquired the disease from was a stable relationship in terms of duration, secondly, the majority of relationships were loving relationships and thirdly the relationships were also characterised by infidelity.

8.2.2.1 Stability of relationships

Almost all the participants reported that they acquired the disease from their boyfriends. What is important to note is the length of time these women were sexually involved with their boyfriends. The shortest time of involvement was 3 years and the longest, 9 years. This corresponds with the assumption that people are engaging in sexual intercourse at an early age, but also that marriage is being postponed

and that stable pre-marital relationships do exist. This corresponds with global trends where marriages are being delayed and cohabitation is increasing. (Gelles, 1995:120; Benokraitis, 1996:232).

As mentioned before these are not one-night-stands and it is inevitable that after a certain time a measure of trust (or rather the expectation of trust) develops in the relationships, which ultimately put the partners at risk. In this regard, LeBeau *et al.* (2001:66) assert that for many people the length of the relationship seem to function as a guarantee against contracting STD's, including HIV. Apart from the trust that develops another issue comes to the fore: how faithful can one expect people in dating relationships to be? Is a boyfriend less bound in terms of fidelity than a married man is?

Two women acquired it from their husbands to whom they had been married for 7 and 13 years respectively. Trust also characterised these relationships, perhaps more so than with those in a dating relationship.

8.2.2.2 Positive aspects of the relationships

When asked about the nature of the relationship the following positive aspects emerged.

- **Love**

The overwhelming sentiment expressed by the participants was that they were involved in a loving relationship. The relationships described were normal, considerate relationships in which the men showed their affection.

"He used to phone me because he was working at Klerksdorp and when ever he was home he would visit me first and he was loving and doing everything for me I needed."

"..he was supportive, whenever I had problems he would help me."

"It was filled with warmth. He cared a lot and I said, 'this person loves me'. So I also didn't want to hurt him with anything....He didn't want to do things that might hurt me. That is why I think it was hard for him to tell me that he had the virus."

"I have good memories, I feel like we could be together again and continue with our love."

"It was wonderful because there was love. I think he knew that I loved and trusted him even though he gave me the virus. He did all the bad

things [infidelity] *knowing that I would forgive him, because love overshadows many things."*

"He never beat me. Whenever there was a mistake, we talked about it and we both begged for forgiveness."

"He loved me. His actions also showed his love."

What is disturbing about the above is that it was a natural, loving relationship that held the danger of infection. These men were not monsters or rapists, they were the husbands and boyfriends of these women. It is within loving relationships where people do not anticipate a threat and are therefore unlikely to protect themselves. Most people regard sex as a natural, satisfying part of an intimate relationship. In this lies the greatest potential for the spread of HIV. It is difficult for people to change behaviour at the best of times, but even more so when the behaviour does not seem threatening or when people do not perceive themselves to be at risk.

Another interesting aspect is that two women equated their love with the presence of children: *"We loved each other a lot to the extent that I had his child...."*. *"We share a child together."* Because of the importance placed on fertility and the idea that to share a child

somehow connects one to another person it is not surprising that these women believe that having a child expressed love and commitment.

These relationships were consequently characterised by good communication. Yet at times, these women felt constrained to approach their partners in other areas, such as condom usage.

- **Gifts**

There are indications that some of the women received gifts from their boyfriends. However, although the researcher is aware of studies that reveal that many girls and women engage in sex in order to acquire basic necessities and in some cases luxuries (LeBeau *et al.*, 2001:63; Harrison *et al.* 2001:73), in this study this was not the overwhelming sentiment. So although there was talk of gifts it was in a sense of the boyfriend showing how much he loved them.

"He used to take me out. He bought me presents. He even promised to marry me."

"We were happy, he did almost everything for me...He bought me a house , a big radio and also chairs."

8.2.2.3 Negative aspects of the relationships

Apart from the more positive aspects of the relationships the following negative aspects were present.

- **Violence**

As discussed in chapter 2 the asymmetrical power relationships between men and women may result in violence. Some of the relationships in this study involved physical and emotional violence. The men in these relationships clearly have more power than the women even to the extent of engaging in assault and the removal of a child (which surely has legal implications).

"...he used to hit me with his fist or throw me with stones...he still comes to me and tells me that he has changed and that I should go back to him, he says everything will change...I've realised he would never change...".

"His people wanted to make things bad between us. They wanted to bring conflict between us. At some moments when we had a disagreement, he would take our child to his parents, knowing that I would go after him."

- **Family interference**

Another negative aspect was the family interference on behalf of the husband's family. The quotation above expresses this as well as the one that follows. These were the words of a woman who said she was in a customary (lobola) marriage with her husband.

"I thought of how my husband was like before he died. His parents didn't even want to inform me of what was happening...I wasn't allowed to go with him to the clinic/hospital. But finally his brother told me that the parents think I bewitched their son but that he is actually HIV positive. I started to worry...especially when I lost weight because he also started losing weight. I thought it might be TB but unfortunately the nurse at the clinic said I was HIV positive...."

His parents had such power, that they could even refuse her access to her dying husband. In addition to this, this woman did not feel that she had enough power to go against their wishes and to see him anyway. This is typical of a patriarchal society where the wishes of the husband's family takes precedence over that of his wife. What is also revealed by the above quotation is the idea that it was somehow the woman's fault that their son fell ill and that she "bewitched" him. This confirms the

notion expressed by LeClerc-Madlala (2001)[1] that HIV/AIDS can lead to the increasing marginalisation of women because women are blamed for the spread of the disease.

8.2.3 Reasons for engaging in sex

An important aspect of the study involved investigating the reasons that women engaged in sexual intercourse with men, keeping in mind the many coercive factors that may directly or indirectly force women to have sex. The overwhelming response from the participants, concerning the reasons they engaged in sexual intercourse was simply that they loved their partner. This corresponds with the discussion (in chapter 2) concerning the reasons individuals engage in sexual intercourse, where it was found that young women usually engage in sex in order to please their partners and for the sake of love. The whole idea of love and a loving relationship was also emphasised in the discussion about what type of relationship they had with their partners.

" I felt like sleeping with him because I loved him. He never forced me into it."

"Its because he asked me to sleep with him...I loved him dearly."

[1] This was discussed in more detail in chapter 5.

"I believed it was something that... it was something that must happen between a man and a woman."

"I got it from someone I trusted, I loved him and respected him. I never thought he would love someone else besides me."

"He told me how much he loved me and that he was going to marry me and I also loved him."

"It was because of love"

"We trusted each other and he was a nice person."

Some of the participants did, however, indicate that coercion was involved in the sexual relationship. Indirect coercion such as threatening to find someone else and direct coercion or rape occurred. What was not pursued in the interviews and perhaps should have been, was whether or not these women actually considered what happened to them as rape.

"He said if I didn't sleep with him, then I don't love him and so he will sleep with other girls...so, I loved him....It was difficult because some people didn't like him. I was the only one who loved him. They had

their reasons...but I always protected and defended him because I loved him...I feared him. He used to play tricks on me, like he would say to me 'lets go to my house to get my shoes'. We could not leave before we had sex."

"He worked outside away from me and he would come back with his problems and complaints [STD's]. *When I asked him to go to the doctor, he refused. I saw he was taking pills...I started to have my doubts about him. I refused to sleep with him after that, but he forced me to have intercourse with him without a condom."*

Once again the politics of interaction come into play in this regard. Where a powerful person can impose their decisions or will on the less powerful, due to their larger size or strength.

8.2.4 Trust and the use of condoms

Another central idea that runs through these women's reports is that of trust. This is especially true when the issue of condoms is raised. Several studies have highlighted the fact that "condomless sex" is seen as a demonstration of trust in ones sexual partner (LeClerc-Madlala, 2001:41). Many women state that they trust their partners and therefore

do not use condoms. In other cases men use the aspect of trust to convince the women not to use condoms. The following responses illustrate why condoms were not used:

No, I didn't. it was like...okay, we trusted each other and he said I was his only girlfriend."

"It was because I trusted him"

"Sometimes, but he didn't prefer them and said that I didn't trust and love him."

"No, he didn't understand them...he said condoms are for people who like girls and boys and asked if I don't trust him."

What is relevant is that many of these woman in fact knew about their boyfriends/husbands infidelity, and yet were unable to insist on condom usage even in light of this knowledge. What is interesting about the next quotation is that this same respondent knew or had caught her boyfriend sleeping with other women. One wonders if she thought her fidelity was enough to protect her.

"No, we did not use them...I think this is because we never though that we could be infected because we thought that is was for the people who sleep with many people at the same time."

As argued in chapter 2, the behaviour of individuals are determined by their definition of the situation. Their definition of the situation is, in turn, influenced by their beliefs and the cultural context within which they find themselves. In this regard there is the belief that monogamy, faithfulness and trustworthiness protects one from sexually transmitted diseases and that stable relationships (in terms of time) are "safe", regardless of the prior sexual histories of the partners and their current lack of fidelity. Sexual encounters in these relationships are not defined as threatening and therefore no protection is used. An even in cases where a threat to health is perceived by the women, the expectation exists that women should not question the danger of the situation but that they should comply - with detrimental consequences.

Here the issue of ideal versus real culture is also relevant. The value of trust appears to be important in these relationships (ideal culture). Partners forego condoms because they *trust* their partners, men ask women if they don't *trust* them when the women ask for condoms and yet the real culture is something totally different; a culture of infidelity

and a tolerance of infidelity: *"Yes, I think that every person will end up with this disease because our people are not faithful at all".*

8.2.5 Infidelity

Almost all of the participants mentioned infidelity in their relationships. This was often the only thing that marred what appeared to be good relationships. Unfaithfulness was found to occur particularly when men worked out of town, which is in line with the theory that migratory labour has contributed to the spread of HIV.

" ...he was working outside [town]. One day he told about a certain girl who wanted to go out with him. I think he was afraid to tell me the real truth...He didn't want us to tell our parents that we had the virus. He said HIV is not like AIDS and that it can be cured. That's one of the reasons I think I got it from him."

"When men work out ...they should stop sleeping with prostitutes even at the shebeen they must not have sex with any women they come across there."

"...he was doing bad things with other women, he was doing them outside where I did not see him because sometimes he goes and work outside Bloemfontein."

LeClerc-Madlala (2001:40) points out that women continue to accept that men have numerous partners and the men seem to regard numerous partners as part of a cultural norm. Therefore it is not surprising that the indiscretions of the husbands and boyfriends in this study were forgiven.

"...he has come back to me and I have accepted him back. He has left that other woman because her husband was fighting with him and I have forgiven him...but he is still working out sometimes."

" ...the only bad thing was that he used to love girls. I would most of the time find him with girls but we used to sort things out."

".. I think we (men and women) are both the same because we are both unfaithful."

"He disappointed me. I found him with a certain girl, but he begged for forgiveness and said it would never happen again...but it did continue."

8.2.6 Can women persuade men to use condoms?

Here the reponses were mixed. Some of the participants believed that it was not possible for women to insist on condom usage. This is because women cannot make their own will override those of men because they do not have the power to insist, perhaps fearing violence: *"No, women cannot make men use condoms. Because I myself.. if he says no I just leave him and I am afraid to ask him further to use condoms."*

In order to please men and because of the perception that the will of a man overrides that of a woman, condoms were not used: *"At some time I had a problem of a discharge (vaginal) and I was sick internally, so I told him, but he refused to listen and he told me that my discharge was no problem to him. I really respected him and I was totally faithful to him. So when he didn't want something , I had to give in."*

However, some of the participants felt that it was possible for a women to ask a man to use a condom. The main reason offered in this case was that modern women have more say. This was expressed in the following two statements:

"Of course yes, if we can have the courage to stand for what we believe in and discard that old idea that a man is a man and you have to give in to him. He must know that you have the right to decide for yourself to say no or yes to condoms."

"I think its easy, a women must tell the man what she wants and these days I think there is no women who wants to sleep with a man without using a condom unless she knows she is HIV positive and wants to spread it."

The last two quotations of this section reflects a change in culture, where women are gaining more power in interpersonal relationships. This could be due to the increasing awareness of the rights of women (as propagated in the media and constitution) and because of the increasing upward mobility of women.

8.2.7 Talking about sex

There is a general lack of openness when talking about sex. Harrison *et al.* (2001:70) refers to several studies that emphasise this lack of openness. The above authors state that this is a modern outcome rooted in tradition where children and parents do not discuss sexual matters. In this regard Paterson (1996:89) states that "...the saddest

thing of all is this: that with all the paper, screen and celluloid sex that goes on in the media, there is considerable evidence that for the majority of families, in all parts of the world...talk about the *reality* of sex is virtually taboo."

As mentioned in chapter two, in the African context sex education for girls traditionally came from a specific family member (other than the mother), usually an aunt or older sister. The modern version is peer education.

What seems interesting is that while girls do not appear embarrassed discussing sex with each other (sometimes in graphic detail as Harrison *et al.* (2001:75) tells us) and that men will discuss sex with men, a trans-gender and trans-generational embarrassment appears to exist around the topic. As a result young women and men are ill-informed, are subject to peer pressure and on top of it all, cannot communicate their needs and wishes to their partners.

It appears that communicating with men about sex is particularly difficult for women. In this study the participants indicated that they were embarrassed to talk about it and secondly they could not communicate with men because they are unapproachable (the same men who they had described as being loving and caring). These

women did not feel that they could speak openly with their partners and used words such as "afraid" and "scared". This may be because it would be breaking a norm (the norm that suggests that it is inappropriate to discuss sexual matters with someone of the opposite sex).

"No, we don't [talk to men about sex]. Especially black women. We just do what the men tell us to do...we think that a man is the only one who has the right to decide and to guide the marriage. The only one who can think. We were taught that a man is a man. Even when you want to tell him that you love him, you are afraid to do so because of what he might say."

"No, its not easy...Its because women are scared of sitting down with men and discussing these things."

"It is not easy because we are ashamed of talking about those kind of things."

"No it is difficult. Look now I am afraid to tell my boyfriend ... today I want this, not that. "

"Men never talk about those things with their wives or girlfriends. Yes, they will discuss things like 'I don't' find sexual satisfaction in my relationship' with others, but never with you."

This lack of communication also seems to extend to the issue of death and the stigma of HIV. In the following case a dying man could not bring himself to tell his partner what was wrong with him even though their relationship was good. At the same time she did not feel that she could pursue the issue, even though she really wanted to know what was wrong with him, and in this case had a right to know.

"Before he died he got sick and during this period of sickness he must have realised something or they might have told him at the hospital since he was admitted. He said there was something he wanted to tell me. He said "I will tell you what's wrong with me." Then I said "what is wrong with you anyway." He said he would tell me all about it when he come home because he was still at the hospital in Kimberley. When he came, he talked about other things and didn't want to tell me anything. So we never spoke about it."

8.2.8 Culture

Cultural norms and practices (such as dry-sex and wife inheritance) have often been seen as contributing to the spread of HIV. Many of these participants also mentioned cultural norms that put people at risk. Practices such as polygamy as a marriage form and the visiting of sangomas were mentioned.

Polygamy is a relatively common feature of most ethnic groups throughout sub-Saharan Africa particularly those that follow more traditional lifestyles. As mentioned before, a man's right and need for more than one partner was traditionally accepted and expected. Some of the participants saw this as a danger to women: *"The culture increases the virus if a man is permitted to marry two wives..."* and *"... because a man is allowed to have five wives simultaneously and at the end he infects five women."*

The other traditional practice that was highlighted was the visiting of sangomas. These women did not believe that sangoma's had the ability to diagnose or cure the disease and that those who approached them (the sangomas) concerning HIV would not receive the help they deserve.

"It adds by not believing that HIV is here and by believing more in sangoma than in professional doctors..."

"If I didn't go to the clinic and went to a witch doctor (sangoma) I would be dead as we speak because he would tell me all the things of the world without knowing what is actually wrong with me. Our culture doesn't have the truth. It is not like you who can freely tell a person 'we can't cure the disease', they can never admit the truth."

In this instance culture can be dangerous when the perception exists that sangomas can cure HIV (Tillotson *et al.* 2001:94). A second, latent feature that was raised by a participant when she said: *"he* [the sangoma] *would tell me things of the world...our culture doesn't have the truth...cannot freely tell a person 'we can't cure this disease'"*. The idea that is expressed here is that because sangomas often have a holistic approach when treating/healing people they have an indirect way of confronting problems and often do not directly state what is wrong with the person, which in the case of HIV, is detrimental.

On a more micro-level the practice of non-condom usage combined with infidelity was considered dangerous. This was expressed as a cultural issue.

"Yes, Black men don't use condoms even though they sleep around and they expect to sleep with their wives when they get home still unprotected. So , they are helping to spread the virus." In addition to this the more general norm relating to non-condom use in married couples also applies: *"...people say a condom is a plastic and they usually say "flesh to flesh" and that marrieds* [spouses] *should "know" each other."*

One participant raised the idea of the changing culture that was putting people at risk.

" In some cases it does contribute while in others it doesn't. The culture increases the virus if a man is permitted to marry two wives, but when it comes to those customs that a girl is not supposed to have an affair or sex before marriage it decreases the virus" This participant did not however express the idea that boys/men also have to be chaste.

8.2.9 Prevention

When speaking about prevention the women raised the following aspects:

- Condom usage - Using a condom was mentioned by most women even though they had mentioned the problems associated with insisting on condom usage.
- Regular testing – Testing as a step towards preventing the spread of the disease was also mentioned.
- Abstinence was also seen as a possible way of curbing the spread.
- Fidelity within relationships.
- Increased openness about previous partners.
- Empowerment of women.

"I would advise them to always use a condom when having sex outside marriage. It is between the wife and husband to decide whether to use condom when having sex, especially when they are unfaithful."

"I think they abstain from sex. In other words, when you are young, you should totally abstain from sex. Married people can have sex, but they must be faithful to each other. Maybe they should go for testing every month because most of them don't want to use condoms..."

"We must change our ways of having affairs and be faithful in our marriages. Try to relax and talk about sensitive things for example when you know you slept with someone, don't be scared to tell your partner.

Even if he or she gets angry but the fact is you are trying to save a life..."

"It is a good thing for woman to sleep with one man and this should happen only when they are married. Those who aren't married should abstain from sex."

If only people can change their behaviour, be decent and respect themselves, They must know that sex is not love. When someone tells you to sleep with him, it doesn't mean he loves you. If you do feel like sex, you should at least use a condom and sleep with the one person you love."

"I would advise women to make their voice heard. When you don't want something, don't allow a man to suppress your feeling because we are in this trouble because of fearing men."

"When you are a woman, rather abstain from sex. If your husband doesn't want to use a condom don't be afraid to tell him you don't trust him if he asks."

"When you meet someone, go for a blood test and use condoms...We should teach our children to abstain from sex. She should find a

boyfriend who will marry her. They should go to be tested before doing anything."

8.3 MAIN FINDINGS REGARDING VULNERABILITY

The main factors that contribute to the spread of the disease among this specific group of participants can be summarised as follows:

- A lack of information regarding the spread of HIV. Although participants knew that the disease was fatal, they were unaware of the detail concerning transmission routes.
- Misconceptions regarding one-sided monogamy. The idea exists that if *you* are faithful you are safe.
- The misconception that being in a stable relationship protects one from HIV infection (regardless of previous histories and current infidelity). The fact that all of these women were in a stable relationships when they acquired the disease emphasises the vulnerability of women as wives and girlfriends.
- The relative safety experienced in stable relationships puts women at risk as trust evolves and the value of trust translates into the norm of non-condom usage.
- A real culture of infidelity as opposed to an ideal of trust.

- The belief that the will of men overrides that of women.
- A lack of openness when communicating about sexual matters.

CHAPTER 9

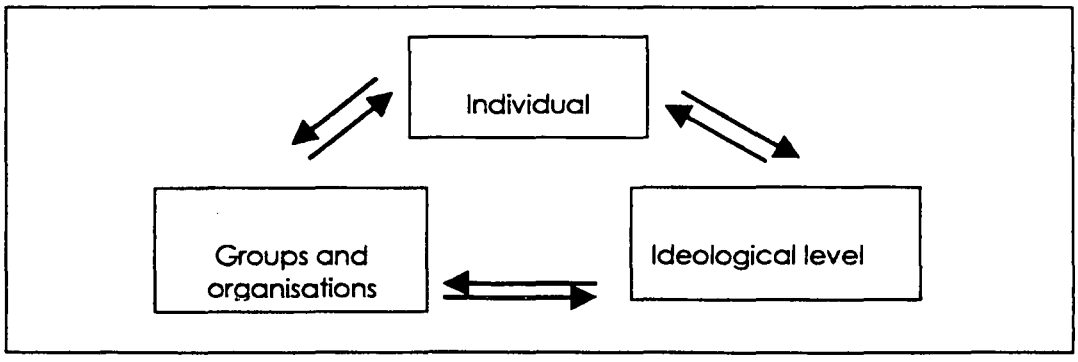
RECOMMENDATIONS

This chapter focuses on ways of reducing the vulnerability of women.

9.1 THREE LEVELS OF ACTION

Considering the pandemic, changing individual behaviour is a presequisite. This, should form the basis of HIV/AIDS prevention strategies. However, two other levels must also be considered when attempting to reduce the vulnerability of women to HIV infection. The second level, includes groups and organisations and involves practical and tangible aid to women. The third level, the ideological level, is the most abstract level and perhaps is the most important level to be addressed. This level involves the values and beliefs that guides behaviour on a daily basis.

Figure 6: Three levels of action



9.1.1 The individual level

When looking at protecting women on a micro level and making recommendations in this regard, the model of Ajzen (as explained in Van Dyk, 2001:82-90) is relevant. Ajzen asserts that before behavioural change can be brought about, it is necessary to understand (and change) the cognitive structures that govern behaviour. Barring rape or coerced sex, the individual remains the final decision maker regarding sex. One must have an understanding of the individual's intentions, beliefs, attitudes, subjective norms and of his or her efficacy (belief in his/her ability to change behaviour). This model states that an individual will only change their behaviour if they:

- Realise the need for behavioural change.
- Know exactly what behaviour has to be changed.
- Have the intention to change behaviour.
- Have a positive attitude towards the behaviour.
- Have the support of friends in changing the behaviour.
- Have a strong belief in their ability to perform the specific behaviour.
- Know exactly how to perform the behaviour.
- Perceive more benefits to come from the modified behaviour than obstacles.
- Have the necessary skills to perform the behaviour

9.1.1.1 Realising the need for behavioural change

Before people will modify their behaviour they have to recognise the *need* to change their behaviour. In the HIV context this involves the person perceiving themselves as a high risk group. While sex-workers and people with multiple partners know that they are at risk and have been portrayed as such, the message that HIV threatens *all* women should be propagated. Many people cling to the stereotypical views that only promiscuous people get HIV/AIDS and that by only having one partner somehow protects one against infection. Women must be made aware of the fact that *their* monogamy does not protect them and that the infidelity and past histories of their partners threatens them directly (no matter how loving and stable the relationship is).

9.1.1.2 Know exactly what behaviour should be changed

The second important point is the fact that talking "about 'safe sex practices' in general will rarely have any effect on ...behaviour because the concept 'safer sex practices' is vague and refers to a whole category of behaviours instead of to be specific behaviour" (Van Dyk, 2001:84). This was true of the participants that had some vague notion that HIV kills and is fatal, but were not equipped with the specific information about transmission and how to prevent it. More specific information dissemination is needed.

Another specific behaviour that should be encouraged is abstinence. Although marriages are been postponed and abstinence is not always possible or practical, at the very least, abstinence should be encouraged for younger girls and boys who currently are starting their sexual lives at a very young age. The hope is that older women will have more skills to negotiate and demand safe sex.

Many participants indicated that one could learn a lot about HIV from the media. In this regards more specific detailed information could be given to people and not only the general safe-sex campaign.

9.1.1.3 Intention to change behaviour

Intention refers to all the motivational factors that influence behaviour. This is connected to how hard people are prepared to try and how much effort and planning they are prepared to put into changing their behaviour. Here it is important that women and young girls should be motivated to protect themselves and to carry out certain preventative behaviour. This can be achieved by regular talks at schools and messages from people that are role models. It is important to keep reinforcing the motivation to prevent HIV transmission. In addition to this, it is necessary to reinforce the intention that directly corresponds to the specific behaviour. So although general motivations are important

it must not be forgotten that specific behavioural patterns, such as the advantages of staying healthy, must also be encouraged as mentioned in the preceding section.

9.1.1.4 Attitudes towards the behaviour and the influence of subjective norms

The attitude of the individual towards the behaviour (be it condom use, abstinence or remaining faithful) must be positive to increase the likelihood that the behaviour will be carried out. Often the attitude towards a certain behaviour is influenced by group norms and expectation. Thus condom use will be negatively perceived if it is associated with infidelity or abstinence will also be negatively viewed if the group norm of sexual prowess exists. In my opinion attitudes are directly related to the subjective norms surrounding the behaviour.

In this regard the importance of reference groups or individuals in a person's life and the desire to fulfil expectations is relevant, because it is reference groups that hold certain norms that in turn influence the behaviour of individuals. Recognising this, is a crucial aspect in preventing transmission. Peer pressure to engage in sexual behaviour is well known and the study of Harrison *et al.* (2001) reveals that girls encourage each other to become sexually active. In addition to this,

pressure to please a partner also leads women to engage in sex or unsafe sex against their better judgement.

Peer pressure and the desire to fit in or please others is a part of social life. However my recommendation in this regard is utilising other significant groups that can act as opposition to the pressure to have sex or unsafe sex. Firstly parents should be educated to speak more openly about sex and the dangers of unsafe sex. Secondly church groups should preach about sexuality and how it should be handled. In this regard then, one at least has counter pressure groups.

9.1.1.5 Self efficacy

Having the intention to change behaviour however, is not enough. People should also believe that they have the ability to perform the desired behaviour. Efficacy refers to a person's belief in his/her ability to control behaviour (Van Dyk, 2001:86). This is something that is strongly influenced by macro social forces. If a woman does not believe that she has the right to ask her boyfriend to use a condom, or that she has to accept her boyfriends infidelity she is unlikely to change her behaviour simply because she does not think she has the power to do so.

Apart from changes that have to take place on an ideological level, that will be discussed later, practical ways of increasing the choices women have should be investigated. In this regard the introduction of the female condom can be important. The importance of condoms and the difficulty surrounding the fact that it is a male device has been discussed in detail. However, recently the female condom has been manufactured which indeed gives women more control over behaviour as it is a female device. Although it is visible – so the partner will know about it (although some sex-workers have reported their inebriated clients often do not even notice) it does give women more control over this method than the male condom does. Studies have shown that use of the female condom has lowered STD infections and that once tried, women like it (UNAIDS, 2000:63). The greatest barrier remains the price, as it is more expensive than the male condom.

9.1.1.6 Rewards and obstacles

All individual weigh up rewards and costs when considering behaviour. A woman may find that the costs of insisting on condom usage (arguments, threats of violence) may outweigh the rewards thereof. Or that the costs of abstinence (being rejected by partner and perhaps ridiculed by friends) might outweigh the rewards of abstinence.

In this regard the researcher is of the opinion that individuals must constantly be made aware of the rewards of avoiding HIV infection. Particularly the long term rewards of avoiding HIV infection should be stressed. However this can only be achieved it women have something to look forward to such as real jobs and better lives. This relates to the macro level of analysis where improving the economic status of women should be a priority in our country. All agencies should work at minimizing the costs of safe sex behaviour.

9.1.1.7 Skills to convert intentions to actions

"For an individual to change his or her sexual behaviour may require complex negotiation with sexual partners who may not have the same degree of commitment towards change" (Van Dyk, 2001:90). For girls this means the promotion of life skills by schools and parents teaching their daughters and sons how to refuse sex or what to say to an insistent partner. For women it may mean re-education and role modeling in order to give women the courage to say what they feel without fear of reprisal. On a macro level, economic empowerment of women will give them the power of financial and personal independence.

9.1.2. Groups and organisations

At this level the role of government and NGO's are important. There must be external support for women, to aid in the behavioural change mentioned above. This support can come in the form of lobbying, support groups, services rendered and policy changes.

9.1.2.1 Support for HIV positive women

- **HIV Counselling**

It has been found that effective counseling encourages people to be tested and to deal in a positive way with their HIV status. This can be done by nurses and support groups. The advantage of testing is that it could, in the long run, actually contribute to the prevention of the spread of the disease. Once known to be positive and correctly counseled (as were the participants in this study) people usually engage in safe sex or abstain and thus do not infect other people. It has also been argued that having to undergo a test even if it turns out to be negative encourages people to change their behaviour. The fact remains however, that testing can only have positive consequences if it is accompanied by counseling and support. Caring for those that are HIV positive thus encourages testing. If no support is

available why should one be tested at all? Most people would simply prefer not to know.

- **Antiretroviral drugs for rape victims and pregnant women**

Antiretroviral medication during pregnancy is a contentious issue. It has been found that the correct use of antiretrovirals significantly reduce the chances of mother to child transmission (Kinghorn, 1998:6). Groups lobbied for the provision of antiretrovirals to pregnant mothers. The government originally refused to approve the supply of antiretrovirals, and even appealed a court order that stated that nevirapien (a type of retroviral drug) must be given to HIV positive mothers to prevent transmission to their unborn babies. It was argued, by government, that antiretrovirals are toxic and that they are too expensive. This stance received much criticism and critics such as Matchaba (1999:357) argue that "To argue that the cost of R80 million is too much, implies that it is cheaper for the state to look after babies with AIDS. To visit any of the provincial pediatric wards will prove that argument to be fallacious." The same author goes on to argue that if women are denied treatment, there is no ethical grounds for testing them. By offering antiretrovirals, other benefits could go with testing, such as: offering permanent contraception; counseling; nutritional advice; provision of drugs to combat TB etc. In addition, to this it has also been argued that

antiretrovirals prolongs the life of the mother who will at least be able to care for her children for a longer period of time before they become orphaned.

Regarding rape victims many groups such as POWA (People Opposed to Woman Abuse) have been advocating for the free provision of antiretrovirals for victims of rape. It has been found that there is an 81% chance of preventing HIV infection if the antiretrovirals are taken within 24 hours (Verster, 1999:13). The argument (apart from the moral obligation to aid rape victims) is that the R600 that it costs the state for a months supply of the antiretrovirals is much less than what it will cost to treat a person with AIDS.

However, in an about turn of face, the government has abandoned the court appeal, and has recently announced that nevirapien will also be made available to rape victims (N.A, 2002, 10).

- **Prevention and treatment of STD's**

As it is known that STD's increase the risk of HIV infection, it is important that health care personnel, particularly those at primary health care clinics be trained to identify STD's and actually make a point of informing women about the symptoms of STD's. UNAIDS (2000: 72) in this

regard states that "[p]atients seeking health care for a sexually transmitted infection should be a primary target for renewed prevention efforts. This is especially true of people who are experiencing their first such infection.". It is important that the attitude of staff regarding any aspect of sexual behaviour should not be judgemental but supportive. Lurie (1999:22-23) makes the following suggestions of how to prevent STD's. He suggests improved case management by health care officials – if women receive adequate treatment it will prevent them from remaining infectious. Another way is to improve women's recognition of STD symptoms and to include partners in the treatment programme. If STD's in women can be controlled it at least decreases the rate of transmission.

- **Eliminating violence against women**

In this regard the government has already taken steps to challenge the acceptability of violence against women. This was done in 1994 when the government signed the Convention on the Elimination of All Forms of Discrimination Against women and in addition to this established a Gender Commission and an Office on the Status of Women in the Deputy Presidents Office (Penn-Kekana, 1997:9). On a more practical level Songca & Letseku (1998:70) make the following suggestions to decrease domestic violence against women:

- Police sensitisation

- Statement of women to be recorded
- Provision of shelters by the government
- Domestic violence courts
- Community awareness programmes
- Mandatory counseling for offenders

Regarding rape, many argue for heavier sentences, without the possibility of parole. In this regard the ideological aspects come into play as the researcher believes that the rape statistics in a country reveals something about the status of women in that particular society.

9.1.2.2 Targeting men

Another aspect that needs to be addressed is the exclusion of men in many programmes. Basset (1993:9) says in this regard "How many researchers who have talked to women about AIDS prevention have been admonished: 'Don't talk to us. Go talk to the men'? They are right; we have to talk to the men. Because men are seen as the 'winners' in patriarchal society and thus presumed not amenable to change, they have been by-passed by researchers eager to find ways to empower women".

Much has been made in our country concerning racial equality and sensitivity to other races and ethnic groups but what about gender

sensitivity? More studies have to be targeted at men regarding the perceptions they hold about women. Stereotypical perceptions have to be challenged.

9.1.2.3 General values regarding monogamy and fidelity

From a functionalist point of view it can be argued that religious norms and values hold certain benefits for society. Seeing that 80% of South Africans claim to be Christians, norms and values regarding sex have to be emphasised. Old fashioned or conservative is not the point in this regard, the point is that religion is important to many people and should be used to reinforce safe sex practices and should speak out against acts such as rape and violence.

9.2 IDEOLOGICAL LEVEL

Although change must occur on the individual level it is imperative that macro-social forces that influence behaviour also have to change before substantial behavioural change will occur. It has been argued by many feminists that teaching women to deal with, and to make the best of their current situation, does not address the root of the problem of an ideology of male dominance.

If rape remains acceptable to many people in a society then it will continue. If men are allowed to beat their wives and get away with it, will continue. As long as women are regarded as subordinate and inferior to men they will be in a disadvantaged position. Of all the challenges surrounding the HIV/AIDS pandemic, changing the subordinate position of women is going to be the most difficult of all to meet, but the most important.

Change on an ideological level probably is the greatest challenge faced. An individual quote in Paterson (1996:29) expresses this idea as follows: "Your head tells you this [to abstain, be monogamous and use a condom] is right: but the entire fabric of the culture into which your own life is woven says it's impossible....Our behavior is dictated by tradition, by habit, by the expectations and lifestyle and values of those around us. Cultures don't change unless they are forced to, either by events from outside or by the threat of destruction from within."

The relationships between men and women lie at the very heart of culture. Shifts of balance of power between them are impossible without agreement of both. Lasting change can only be negotiated if it's seen to benefit the whole community. HIV may be the catalyst that

will change the way gender roles are perceived or it may lead to the increased marginalisation of women.

The researcher is of the opinion that in order to bring about positive change, HIV/AIDS will have to be addressed on all three levels by sensitising and educating individuals, involving government and NGO's to provide support for HIV women and lastly, by continually challenging the subordinate position of women.

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SUMMARY

In South Africa, as in the rest of Sub-Saharan Africa, HIV/AIDS has become a source of national and international concern. After many prevention campaigns and education programmes the virus continues to spread at an alarming rate, forcing one to look more carefully at the underlying social organization that could be conducive to the spread of this disease. In particular the position of women is being investigated in order to uncover the social dynamics that increase their vulnerability to this disease. In the year 2000, almost a quarter (24,5%) of South African women attending antenatal clinics were HIV positive.

Physiologically, women appear to be at greater risk of contracting HIV than men. Apart from the physiological vulnerability of women it is important to consider the social aspects that put women at risk. This thesis considers the following social factors that put women at risk: *violence against women,* rape in particular; *the unfavourable economic position of women* that threatens the well- being of women as it encourages behaviour that increases the risk of HIV infection; *the low educational status* of women; *a sexual culture* which includes practices and expectations that put women at risk.

This exploratory study revealed that women lack specific knowledge concerning the disease and hold certain misconceptions about how

being in a stable relationship protects one against the disease. Another important finding was that these women, who acquired the disease, were in stable relationships that were generally positive and rewarding and that the overriding motivation to have sex was based on love. This emphasises the fact that all women are at risk and that the very nature of a stable relationship (that encourages trust and complacency) is what puts women at risk. Some relationships were negative and this involved forced sex. Regarding the non-use of condoms, the main reason cited was that people who trust one another, do not use condoms. Unfortunately the real culture of infidelity coupled with the emphasis on trust (no condoms) was one important reason why these women acquired HIV. In addition to the above, the study revealed that the trans-gender and trans-generational lack of communication regarding sexual matters makes it difficult for women to insist on condom use when they suspect their partners to be unfaithful.

This study recommends that action to protect women must be taken on an individual, organisational and ideological level. On an individual level, it is important that all women perceive themselves to be at risk and that they know exactly how to go about protecting themselves. In addition to this, individuals should continuously be motivated to practice behaviour that will protect them from HIV infection. This motivation can come through socialisation agents such as schools, parents, churches and the media. It is also important that women have

the power to dictate sexual behaviour. Regarding the organisational level, HIV counselling and antiretrorviral therapy should be available. Sexually transmitted diseases should be prevented with the help of the health care sector and the mobilisation of organisations that work to combat violence against women. Ideologically, the patriarchal nature of our society must be changed before wide spread behavioural change will occur. The rampant spread of this disease can only be stemmed if the subordinate position of women is acknowledged and addressed.

Key words

Women

HIV

AIDS

Gender

Vulnerability

Culture

OPSOMMING

MIV/Vigs het in Suid-Afrika, soos in die res van Sub-Sahara Afrika, 'n bron van nasionale en internasionale kommer geword. Ten spyte van vele voorkomings veldtogte en onderrig programme, versprei die virus nog steeds teen 'n geweldige tempo. Dit vereis 'n indringende ondersoek na die onderliggende sosiale organisasie bevorderlik vir die verspreiding van MIV is. In die besonder is die posisie van die vrou ondersoek om vas te stel watter sosiale faktore hulle vatbaarheid tot die siekte verhoog. In die jaar 2000, was ongeveer 'n kwart (24,5%) van alle Suid-Afrikaanse vroue wat antenatale klinieke besoek het, MIV positief bevind.

Dit wil voorkom asof vroue 'n groter fsiologiese risiko het om met die MI-virus besmet te word, as mans. Afgesien van die fisiologiese kwesbaarheid van vroue, is dit belangrik om die sosiale aspekte te oorweeg wat vroue vir die siekte vatbaar maak. Hierdie studie fokus op die volgende sosiale faktore wat vroue se kwesbaarheid verhoog: *geweld teen vroue en* verkragting in besonder, die *ongunstige ekonomiese posisie van vroue* wat die welvsyn van vroue bedreig, omdat dit hoë risiko gedrag aanmoedig; *die lae opvoedkundige status van vroue, 'n seksuele kultuur* wat praktyke en verwagtinge insluit wat vir die vrou nadelig is.

Hierdie verkennende studie het bevind dat vroue oor spesifieke kennis rakende die siekte ontbeer en onder die wanbegrip is dat 'n stabiele verhouding, in sigself, teen MIV besmetting beskerm. 'n Ander belangrike bevinding was dat vroue in die studie, wat MIV opgedoen het, wel in stabiele verhoudings betrokke was wat oor die algemeen positief en belonend was en dat die oorhoofse motivering om seks te hê, op liefde gebaseer was. Dit beklemtoon die feit dat alle vroue 'n risiko loop en dat dit die aard van 'n stabiele verhouding is (wat juis vertroue en valse gerustheid bevorder) wat vrouens se kwesbaarheid verhoog. Sekere verhoudings was negatief en het wel gedwonge seks ingesluit. Die hoof rede wat aangevoer is vir die nie-gebruik van kondome, is dat die een persoon die ander vertrou. Ongelukkig is die ware kultuur van ontrouheid gekoppel aan 'n oorbeklemtoning van vertroue, (geen kondome) en dit is een van die belangrikste redes hoekom hierdie vroue MIV opgedoen het. Die studie bevind ook dat daar 'n gebrek aan kommunikasie oor seksuele aangeleenthede tussen mans en vrouens en tussen verskillende generasies bestaan. Dit maak dit moeilik maak vir vroue om op kondoom gebruik aan te dring (wanneer hulle vermoed dat hulle metgesel ontrou was).

Hierdie studie beveel aan dat aksie om vroue te beskerm op 'n individuele, organisatoriese en ideologiese vlak moet geskied. Op 'n individuele vlak, is dit belangrik dat alle vroue bewus moet wees dat hulle 'n risiko loop om MIV op te doen en dat hulle presies moet weet

hoe om hulleself te beskerm. Tesame hiermee, moet individue voordurend gemotiveer word om gedrag te beoefen wat hulle teen MIV infeksie sal beskerm. Sosialiserings agente soos skole, ouers, kerke en die media kan hierdie motivering doen. Dit is ook belangrik dat vroue die mag het om hulle gedrag te verander. Rakende die organisatiese vlak, moet MIV berading en vigmedikasie beskikbaar wees. Daar moet gepoog word om seksueel oordraagbare siektes te voorkom met die hulp van die gesondheidsorgsektor en organisasies wat geweld teen vroue bekamp moet ook gemobiliseer word. Ideologies, moet die patriargale aard van die samelewing ook verander voordat gedragsverandering sal plaasvind. Die verspreiding van die siekte kan slegs gestuit word indien die ondergeskikte posisie van die vrou erken en aangespreek word.

Sleutelwoorde

vrou

MIV

vigs

geslag

kwesbaarheid

kultuur