# AN EXPLORATIVE STUDY OF RURAL WOMEN'S PECEPTIONS OF SEXUALITY AND HIV PREVENTION IN THEIR LOCAL SOCIO-CULTURAL CONTEXT: A CASE STUDY OF RURAL SCHOEMANSDAL, MPUMALANGA


**by**

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## DECLARATION

I, Tinyiko Chauke, declare that **An explorative study of rural women's perceptions on their sexuality and HIV prevention within their local socio-cultural context: A case study of rural Schoemansdal, Mpumalanga** is my own work and that all sources I have used or quoted have been acknowledged by means of complete references.

Signature..... .....

Tinyiko Chauke Date

**ABSTRACT**

Socio-cultural factors oppress and construct women as men's objects of desire and pleasure, thus increasing women's vulnerability to HIV infection and, subsequently, maintaining the HIV and AIDS epidemic and prevalence in South Africa's rural areas. South Africa's rural women and their sexuality has not received adequate attention to date. This qualitative study sought to explore rural women's perceptions on their sexuality and HIV prevention within the socio-cultural context of Schoemansdal (South Africa). A sample of ten participants, who are women from the Swazi ethnic group between the ages of twenty and fifty, were purposefully drawn to participate in this study. Data were collected by means of tape–recorded, face-to-face interviews and focus group discussions. Results of the study reveal that women's social and cultural contexts have an influence on their perceptions of sexuality and HIV prevention; and that this poses a hindrance to women's HIV-prevention behaviours such as condom use. The study's findings reveal that in examining HIV infection and prevention, women's diverse contexts and experiences cannot continue to be overlooked. This is because they may provide relevant understanding of the epidemic that is plaguing South Africa's rural women.

**Key terms**

**Rural women, sexuality, HIV prevention, socio-cultural context, Religion, Social constructionism, Sexual scripts theory, Mpumalanga, HIV and AIDS**

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## LIST OF ACRONYMS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **FGM** | Female Genital Mutilation |
| **HBC** | Home-based Care |
| **HIV** | Human Immunodeficiency Virus |
| **NSP** | National Strategic Plan |
| **OVC** | Orphans and Vulnerable Children |
| **PLWHA** | People Living with HIV and AIDS |
| **STI(s)** | Sexually transmitted infection(s) |
| **UNAIDS** | Joint United Nations Program on HIV and AIDS |
| **WHO** | World Health Organisation |

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# CHAPTER 1

## INTRODUCING THE STUDY

### 1.1 Introduction

This study's focus is on women's perceptions about their sexuality in the context of HIV and AIDS. African rural women's sexuality is an enigma. Society is preoccupied with the female body and sexuality, and this is attributed to the long-standing social and cultural patriarchal norms that oppress and construct women as objects of men. As a result, women in Schoemansdal may be oppressed by the harmful prevailing cultural frames that construct their views of sex and sexuality. This inhibits their sexual freedom and expression. Indeed, socio-cultural factors potentially oppress and construct women as men's objects of desire and pleasure, thus increasing Schoemansdal women's vulnerability to HIV infection and subsequently maintaining the HIV and AIDS epidemic and prevalence in that area. Using Schoemansdal as a case study, this study seeks to understand and explore ways that rural women perceive their sexuality and how these perceptions pose a hindrance to HIV prevention. The study utilises face-to-face interviews and focus group discussions to collect data. This study is informed by Radical Feminist Theories as well as Social Constructionist and Sexual Scripts Theories.

### 1.2 Background of study

The World Health Organisation (WHO 2006), expounds that individual risk of HIV infection is influenced by social and environmental factors; such as gender and power imbalances, resulting in women often bearing the brunt of these social ills. Similarly, Nyoni (2008: 4) in her study conducted in Zimbabwe found that women perceived cultural prescriptions in their ethnic settings to condone male infidelity, resulting in their contracting HIV. Furthermore, the women maintained that it is these traditional beliefs that hinder them from practicing safe sexual behaviour to prevent HIV and AIDS (Nyoni 2008: 20). In contrast, Tamale (2006: 24), in a study conducted in Uganda, found that Baganda women rejected the ideology that

privileges men over women. The women demanded that men also receive training on how to please their female sexual partners. In fact, the Baganda women regard sex not primarily for purposes of procreation but for leisure and pleasure. As a result, the erotic has the potential to be an empowering resource in the context of HIV prevention for women (Tamale 2006: 24).

South Africa is a country situated at the tip of southern Africa and is bordered in the north by Namibia, Botswana, Zimbabwe and Mozambique. South Africa consists of nine provinces, the main cities being Cape Town and Pretoria (SA Fast Facts 2013: 1). In 2013, Statistics South Africa estimated the mid-year population of South Africa to be 52, 98 million, 51 % of it being female (Statssa 2013: 2). Although the HIV-prevalence rate in South Africa has been reduced to 41%, data collected from population-based sero-surveys and sentinel surveillance of pregnant women indicate that the epidemic has reached a plateau among adults aged between 15 to 49 years (UNAIDS 2012). The history of HIV and AIDS in South Africa is perhaps the most controversial of any country. It is littered with examples of government inaction and harmful interference and conflict between politicians, HIV and AIDS organisations and scientists (Butler 2005: 592).

The after-effects of two decades of counterproductive policies are still being felt today in a country that has the world's largest HIV epidemic (Butler 2005: 592-603; Johnson 2004: 107-109; Avert 2013: 2).To demonstrate this, Mpumalanga is reported as being one of the provinces where South Africa's plan to fight HIV and AIDS has been most poorly implemented (Maluka and Mdletshe 2012: 1). Furthermore, (Malan and Masinga 2013: 1) highlight that the Mpumalanga Provincial AIDS Council was only launched in November 2009. This comes after three years of the National Strategic Plan of 2007-2011 for HIV, Sexually Transmitted Infections (STIs) and Tuberculosis, had been implemented (Malan and Masinga 2013: 1).The province's poor implementation and malfunctioning of the AIDS council is linked to a lack of political will from the premier of the province (Maluka and Mdletshe 2012; Malan and Masinga 2013). As a result, Mpumalanga remains one of the provinces with a high HIV prevalence and infection rate among women, young people and farm labourers (Maluka and Mdletshe 2012).

## 1.3 Geography and social characteristics of the Mpumalanga Province

Mpumalanga is the second-smallest province in South Africa and is located in the north-eastern part of the country bordering Swaziland and Mozambique to the east. It covers an area of 76 495km² and has a population of 4 039 939, making it the sixth most populous province in the country (The Local Government 2012: 1). This province is reported as having a high HIV prevalence rate - the second highest after KwaZulu-Natal. In 2011, the HIV prevalence rate of the female population aged 15-49 in Mpumalanga was recorded at 36.7%. Furthermore, Mpumalanga's poverty rate of 39.4 % was higher than the national rate of 37.7%; this was the fifth lowest among the nine provinces of South Africa. It was estimated that 1.59 million of Mpumalanga's citizens lived in households with an income less than the poverty income. However, over the 15-year period from 1996 to 2011, the poverty rate in Mpumalanga improved by 5.1 % (Elsenburg 2009: 30).

Schoemansdal is situated within Ehlanzeni District Municipality in Mpumalanga (The Local Government 2012: 1). Ehlanzeni District was reported as saying that HIV and AIDS is its greatest challenge (Yende 2013; HIV and AIDS 2013). Since women are more at risk of HIV infection, particularly due to socio-cultural factors, it becomes essential to understand sexual behaviours in the socio-cultural settings within which they occur so as to explore the manner in which Schoemansdal women perceive their vulnerability and HIV prevention. It is fitting that research should be conducted in this area so as to increase literature in the hope that this will give rise to more effective strategies to minimise the impact of HIV and AIDS in Schoemansdal.

In the year and a half that the researcher was employed in Schoemansdal, she observed that the area is plagued by unemployment and poverty, and, subsequently, the HIV and AIDS epidemic. As a result, women are often the ones who bear the brunt of the many social ills in Schoemansdal, thus rendering them as a high-risk group with regards to HIV infection. The contributing factors to women's low social status and risk of HIV infection are that more than 50% of them are married, and, both young and old, lack formal educational training with many being illiterate. This decreases their prospects of employment, further increasing their economic dependence on their husbands. A majority of the husbands work in the cities and return home once a year while others return every fortnight. Some of the male partners may

seek multiple, concurrent relationships while away from home with implications for HIV infection. The use of condoms may not be an option for some of the married women. For this reason, socio-economic circumstances render women vulnerable to HIV infection as they do not have the authority to negotiate and express the terms of condom use in sexual relationships.

Additionally, cultural practices, values and beliefs disadvantage women in terms of expressing their sexuality in the context of sexual relationships, because they are required to maintain these relationships for economic survival, out of respect for male partners and culture, or to improve their chances of marriageability. Therefore, women are forced to participate in high-risk sexual behaviours due to the various influences of their social environment. On the one hand, in response to the growing HIV and AIDS epidemic large numbers of HIV-prevention programmes have been implemented in the area one of which the researcher and the research participants participated in. Despite this, HIV is still rampant in the village particularly among women and children. Since women are the most affected group in the area in terms of HIV infection, the study aims to explore the impact of the socio-cultural environment on women's perceptions of their sexuality and on HIV prevention. In order to gain insight into women's susceptibility to HIV infection, their perceptions of sexuality and HIV prevention need to be studied in the contexts within which they occur. This makes the study relevant to the academic knowledge base because very little academic research to date has been conducted in the area of rural women's perceptions of sexuality and the implications on HIV infection and prevention. Literature fails to recognise that South African women are a heterogeneous group with various socio-cultural contexts impinging on their HIV-prevention behaviours.

## 1.4 Research problem

Due to patriarchal socio-cultural impositions and expectations of women's 'natural' roles in sexual relationships, women in South Africa have come to represent a key population most at risk for HIV infection (SANAC 2011: 33). In addition, rural South Africa has a prevailing silence on gender norms and stereotypes relating to sexuality, leading to women's vulnerability to sexual abuse and subsequently HIV infection (Gillbert and Selikow 2011: 326). Literature suggests that women are conditioned to submit to patriarchal and socio-

cultural constructions and definitions about their sexuality (Jewkes and Morrell 2012: 1729). On the other hand, through religio-cultural institutions women are involved in shaping the contours of heterosexual relationships by virtue of socialising young women and girls to be respected and accepted women of the community (Moyo 2011: 73-74). This results in women being coerced to engage in high-risk sexual behaviours in order to maintain stereotypical roles expected of them, thereby making them vulnerable to HIV infection (Moyo 2011: 73-74).

Moreover, patriarchal socio-cultural and religio-cultural constructions of women's sex roles and sexuality unfairly positions rural women in particular, at increased risk of HIV infection due to limited personal resources, limited knowledge and exploration of their sexuality (Moyo 2011: 74). Dowsett (2003: 21-24), puts forth that literature on female sexuality offers a universal conception in terms of women and sexuality, whilst overlooking the fact that women come from different socio-cultural contexts. It is these contexts that influence the manner in which women define and understand their sexuality and the way in which they negotiate for safe sex practices regarding HIV prevention (Blackwood 2000: 226; Jewkes 2009: 31). By employing Schoemansdal as a case study, this study endeavours to understand and explore ways that rural women perceive their sexuality and how these perceptions pose a hindrance to HIV prevention,

## 1.5 Significance of the study

The significance of the study is to offer recommendations to the Mpumalanga Provincial Operation Plan on HIV and AIDS and the South African National Strategic Plan on HIV prevention, by emphasising a focus on the manner in which women perceive their sexuality as part of HIV prevention, as well as making recommendations in advocating African women's sexual reproductive and health rights as an option of curbing increasing HIV prevalence among women. Furthermore, the study also aims to fill the astounding gap in literature on rural South African female sexuality within the context of HIV and AIDS. Notably, academic literature offers limited information required to understand rural South African women's perceptions and experiences on sexuality in the context of HIV prevention. Literature on HIV and women's sexuality instead offers a generalised view of women's sexuality and their vulnerability to HIV infection. In particular studies such as those of Crewe

and Brouard 2013; Jewkes and Morrell 2012; Gillbert and Selikow 2011; Leclerc-Madlala, Leickness and Simbayi 2009; Jewkes 2009.

## 1.6 Aims and Objectives of the study

The objectives of the study were as follows:

1. To explore rural women's perceptions and experiences on issues of sexuality and HIV prevention within their rural socio-cultural context.
2. Explore the differences and similarities of traditional and modern perceptions of female sexuality and HIV prevention within the socio-cultural context of these women.
3. Explore the manner in which perceptions and some sexual practices decrease rural women's vulnerability to HIV infection.
4. Explore the manner in which some sexual practices increase rural women's vulnerability to HIV infection.

## 1.7 Research questions

This section will discuss the research questions that the study sought to answer. The central question that this study aimed to answer was: What are rural women's perceptions about their sexuality and HIV prevention within their local socio-cultural context of Schoemansdal?

This overall research question was further investigated using the following specific questions:

1. How do rural women perceive and experience sexuality issues and HIV prevention within their socio-cultural context?
2. What are the perceived similarities and differences in traditional and modern female sexuality and HIV prevention amongst rural women?
3. How do rural women's perceptions on sexuality decrease their vulnerability to HIV and AIDS?
4. How do rural women's perceptions on sexuality increase their vulnerability to HIV and AIDS?

## 1.8 Research methodology and design

This study employed a qualitative approach and followed an exploratory design. Qualitative research involves the study of things in their natural settings and attempting to make sense of or to interpret phenomena in terms of the meanings people attach to them. Thus, the aim is to understand rural women's perceptions of sexuality and HIV prevention from the perspectives and meanings that they have constructed to make sense of their world (Babbie and Mouton 2010: 646).

The study followed an explorative design because it intends to describe a phenomenon within a group of people, this allows the researcher to gain insight into the phenomenon under study (Babbie and Mouton 2010: 80).This type of research is considered open and flexible to the degree that the researcher involves participants by means of different data-collection instruments (Durrheim 2006: 44-45). Data were collected by means of focus group discussions, one-on-one interviews and observation while working in the field. The defining feature of these collection methods is that they utilise open-ended questions followed up by probes in response to the participants' responses (Kelly 2006: 304). The rationale behind these methods was to obtain different perspectives on the phenomenon being studied within their natural settings (Kelly 2006: 304). Data were analysed through thematic analysis.

## 1.9 Definition of key terms and variables

**Gende**r - A socially constructed and fluid category applied in order to determine individuals' social status and identity in society (Lorber 1996: 146; Dowsett 2003: 23; Monk 2001: 5929).
**Key populations** - In HIV and AIDS refers to those most likely to be exposed to or to transmit HIV, as a result their engagement is critical to a successful HIV response. For purposes of this study, key populations include women for whom the risk of HIV infection is driven by inadequate protection of their human rights and by prejudice. (SANAC 2012: 6).
**Patriarchy** - A social practice in which men appropriate all social roles to keep women in subordinate positions on the basis of gender organisation (Nyoni 2008: 25).

**Rural women –** this describes women living anywhere outside of the eight urban metropolitan municipalities in South Africa (Constitution of the Republic of South Africa: Local Government 2012).

**Sexual risk behaviour** - Described as sexual actions which jeopardise the individual's physical health (Reinhold 2001: 14012).

**Sexuality** - A broad encompassing term used to refer to all aspects of being and the embodiment of pleasures and sex object choices (Lorber 1996: 146; Gott, *et al.* 2011: 85).

**Socio-cultural** - Consideration of populations' characteristics, lifestyles and beliefs (Nyoni 2008: 24).

**Religio-cultural** - The expression of social and religious values in a given setting and attempts to safeguard them by endowing them with divine sanction, a way of living learned from and shared by the members of that group.

## 1.10 Outline of Chapters

The dissertation is organised in the following manner:

**Chapter one** provides the introduction and orientation of the study giving an overview of the HIV and AIDS pandemic in South Africa and in the province of Mpumalanga. Four specific research questions are posed. The problem statement, aim and purpose of the study are explored. The research procedure and techniques for the study are summarised.

**Chapter two** reviews current literature about the association between women's sexuality and their vulnerability to HIV infection. The chapter discusses various views about how socio-cultural practices related to sexuality prohibit HIV prevention.

**Chapter three** presents the methodology and the research design that was utilised by the study. It describes the sampling techniques and data-collection tools that were used including the measures to ensure the trustworthiness of the findings and concludes with the ethical considerations of the study.

**Chapter four** presents and analyses the findings, including the verbatim transcriptions captured during the focus group discussions and face-to-face interviews. The chapter

summarises and analyses research findings. Thematic analysis was utilised to analyse the data.

**Chapter five** presents the key findings of the research and provides recommendations that could assist the Schoemansdal community based on these findings.

# CHAPTER 2

## LITERATURE REVIEW

### 2.1 Introduction

Chapter 1 introduced the study and its purpose, and discussed the epidemiology of HIV and AIDS in South Africa locating it in the Mpumalanga Province. The type of research methods and study design appropriate to the study were discussed.

This chapter presents the literature reviewed on the socio-cultural contexts that shape women's perceptions on their sexuality and on HIV prevention. This chapter highlights previous research conducted in the area of African female sexuality within the context of the socio-cultural environment and its impact on HIV-preventative behaviours. The chapter explores how the socio-cultural and religio-cultural environments perceive and construct female sexuality and the impact this has on how women perceive their sexuality and how this impedes on HIV prevention. It concludes with theoretical frameworks underpinning the study namely; Social Construction Theory and Radical Feminism, and will also look into Sexual Scripts Theory.

### 2.2 African women's perceptions of sexuality and HIV prevention

> 'Sexuality is a key site through which women's subordination is maintained and enforced in Africa' (Tamale 2006: 10).

Indeed, societies' preoccupation with the female body and sexuality is attributed to the long-standing social and cultural patriarchal norms that oppress, and construct women as objects of men (Moyo 2004: 72). Moreover, in South Africa, sex is perceived by both males and females as a taboo subject and the discussions around it are concealed in the use of polite language and euphemisms (Ndida, Uzondike, Chimbwete and Mgeyane 2011: 1) . Due to this, masculinity is constructed around the domination of women, that requires men to control sexual decisions including if, when and how sex takes place and whether condoms are used

or not (Lindegger and Quayle 2009: 44). This impedes women's efforts to prevent HIV infection (2009: 44).

Moreover, in South Africa socio-cultural contexts contribute to giving meaning to the common assumptions and expectations and values people hold, some of these behaviours are found to increase people's vulnerability to HIV infection (Leclerc-Madlala, Simbayi and Cloete 2009: 16). Similarly, Oriel (2005: 402) concedes that the male demand for sexual pleasure produces a demand for women to participate in the types of sexual activity such as dry sex and sex with no condom that place them at high risk for HIV infection. Therefore, Dowsett (2003: 26) maintains that secrecy will not protect people against HIV, but denial of sexual practices and the cultures built from them will simply exacerbate the epidemic.

### 2.3 Women and perceptions of their sexuality

Lerclerc-Madlala, Leickness, Simbayi and Cloete (2009: 14) state that patriarchal society and culture influence women's passive experiences of sexuality. However, Jewkes and Morrell (2012: 1730), found that although South African women negotiate their sexuality under conditions of patriarchal inequality they, however, are not sexually passive, and that they want good sex. Despite this, there are still a number of young, black women who find it difficult to explore and express their sexuality due to negative stereotyping and purposive marginalisation of black sexuality (Dickerson and Rousseau 2009: 315) . Similarly, black sexuality is demonised and associated with overpopulation (2009: 315). In addition, most older black women associate sexuality as necessary for having babies, and many of them are not aware of what a female orgasm is and have never experienced it (Francoeur, *et al.* 2004: 59-60). This is because African culture and religion conjures feelings of shame, sin and passivity in women with regards to their nakedness, thus enforcing the message that self-pleasuring and sexual exploration is sinful.

Shaw (2004: 39) agrees, in stating that most African women are repulsed by masturbation; this stems from being ashamed of their nakedness and socialised to not name or say *vagina*. Contrary to this, Tamale (2006: 24) in a study on women's sexuality found that women perceive sex not only for procreation but also for pleasure. Tamale (2006: 24) further states that within the sexual initiation institution, traditional sexuality is complemented and

enhanced with ‘modern’ and ‘foreign’ sexual practices on sexual self-discovery; such as lessons in oral sex, masturbation and women’s ejaculation. Part of these lessons include encouraging women to use sex to undermine patriarchal power behind a façade of subservience (Tamale 2006: 24). Spronk (2009: 517), counter argues that although for most African women sexuality entails the promise of pleasure and entitlement to modern personhood, but it also harbours anxiety because of the risk of being considered un-African. This is because African womanhood is associated with motherhood and wifehood (2009: 517).

## 2.4 Socio-cultural construction of female sexuality

Leclerc-Madlala (2001: 54) and IIkkaracan (2004: 56) observes that once women become sexually active, their bodies conjure up notions of danger, disease and the ability to weaken men and bring all manner of misfortune to society. As a result, dominant narratives of blame for the AIDS epidemic in South Africa’s rural communities are framed within the common discourse of female sexuality (Leclerc-Madlala 2001: 54). Subsequent to this, women’s sexual agency in South Africa has strong and diverse cultural roots to messages girls receive that they should be passive, innocent and will be held accountable for how they are treated by men (Jewkes and Morrell 2012: 1730). In agreement, Oriel (2005: 397) asserts that heterosexually women’s primary pleasure is derived from pleasing men, rather than themselves. This is due to sexuality being gendered, resulting in different sexual scripts for women and men (Lorber 1996: 148). Youdell (2005: 256) supports this argument, in her illustrations on observations of the interplay between gender and sexuality among the learners in a school setting. She observes that learners are socially expected to sit in a way that concealed their genitals; symbolically the female feminine body is required to take responsibility for the control and constraint of the body thereby denying the body’s desires. In contrast, the masculine body need not be controlled; it is in control (Youdell 2005: 256).

## 2.5 Historical socio-cultural constructions of African female sexuality

Vance (1991:880) suggests that constructions of sexuality and sexual practices vary with culture and history, the author further states that sexuality definitions and meanings change

over time and within populations. Blackwood (2000: 225) substantiates the view of sexuality and gender as culturally produced and a product of complex social processes. Blackwood (2000: 225) conducted a study in Lesotho, which documented intimate friendships between younger and older girls and women, and affirms that these relationships gained popularity throughout much of Black southern Africa in the 1950s. In these 'mummy-baby' relationship two women start a relationship by arranging private encounters and exchanging love letters and gifts, the older girl (mummy) might already have a boyfriend and other babies (younger girls). Mummies are considered sources of guidance and advice on sex and appropriate partners for the young girl's first sexual encounters. In this relationship, the two women learn the pleasures and responsibilities of growing up and relationships. The relationship entails kissing, hugging and sexual relations (Blackwood 2000: 225). These cultural practices reflect an ideology of sexuality that sees women as agents of their own sexuality in that their experience with other girls was teaching them to develop and manage their own sexual feelings (Blackwood 2000: 227). These intimate bonds between women were viewed by the community as a natural part of growing up (2000: 227).

In light of this, Blackwood (2000:227) indicates that historically such intimate friendships for both sexes were quite common in cultures of sub-Saharan Africa, such as the Azande women in the countries of Sudan and the Democratic Republic of Congo (2000: 227). However, with the changing times and evolution of cultures, literature suggests that intimate relations between the same sexes came to be viewed as deviant due to Western culture's dichotomous construction of sexuality. As a result, the nature of these relationships would not fall under pre-existing scripts that define what is to be done within a sexual relationship (Lorber 1996: 148-149). Although the abovementioned relationships appear to not be practiced anymore; they give the reader a glimpse of the historical background of African sexuality as changing and consistently defined socio-culturally. Notably, to some these relationships may be viewed as bordering more on the lines of homosexuality, but it depends on the lenses that one chooses to define or view sexuality. Kendall (1998: 221) puts forward that the freedom, enjoyment, and mutual respect of Basotho women's ways of loving each other, occurring in a context in which what women do together is not defined as sexual suggests a need to look freshly at the way Western constructions of sexuality and of homophobia are used to limit and oppress women.

## 2.6 African sexual practices around HIV prevention

In many sub-Saharan African cultures, such as in Nigeria, South Africa, Zimbabwe, Uganda and Malawi, sexual intercourse is only for the man's satisfaction and for childbearing (Francoeur, Noonan and Opiyo-omolo 2004: 62). As a result, sexual relations in many African cultures are male-dominated with the male initiating and dictating the pace, with the missionary style position (man on top) as standard, and marital sex is for making babies not pleasure (Francoeur, *et al.* 2004: 62). In addition, Lerclerc-Madlala, Leickness, Simbayi and Cloete (2009: 16), attest that in South Africa socio-cultural contexts contribute to the common expectations and values people hold, albeit that some of these behaviours increase women's vulnerability to HIV infection. Leclerc-Madlala, *et al*. (2009: 17) further explain that women are the ones most commonly implicated for bringing HIV into a relationship while their male counterparts are culturally absolved of blame for the disease. African socio-cultural factors that have been reported to contribute to South Africa's rural women's vulnerability to HIV infection are briefly discussed below.

## 2.7 Dry sex or vaginal douching

Women prepare themselves to pleasure their male partners with a dry vagina by mixing a powdered stem and leaf of a tree; this also includes antiseptics and detergents. Thus, 'wet sex' is indicative of female infidelity, and moral 'looseness' (Francoeur, *et al.* 2004: 62; Lerclerc-Madlala, *et al*. 2009: 19). The main purpose of the practice is to increase friction during intercourse thus increasing the male's experience. This practice renders women vulnerable to HIV infection as the vaginal flora is disturbed and the vaginal walls are inflamed making it favourable to HIV infection (Inungu and Karl 2006: 3).

### 2.7.1 Elongation of Labia Minora (Labial Elongation)

Labial elongation begins very early in a girl's life before her first menstruation. In Buganda, Tanzania, Rwanda and Mozambique, elongation is performed through massaging and stretching the labia from the top to the bottom, with the tips of the thumb and index finger of each hand (Khau 2012: 764; Koster and Price 2008: 192). Additionally, women use different

locally available herbs which are ground into a paste to ease the pulling (Khau 2012: 764). These herbs are believed to promote stretching of the labia by softening and lubricating them such that the pulling does not cause any skin laceration (Khau 2012: 764). Notably, practices that aim to 'beautify', enlarge or reduce the external female genitalia are highly controversial because they are considered harmful as well as dangerous to women (Lewis 2009: 203; WHO 2011: 5 ; Khau 2012: 765). In 2000, the World Health Organisation classified inner labia elongation as female genital mutilation (FGM) and recommended that it should be banned (Khau 2012: 764; Mariano and Bagnol 2008: 2).

In contrast, Mwenda (in Khau 2012: 765) affirms that there should be a distinction between voluntary labia elongation and other forms of FGM that compromise the health of women or are nonconsensual. The argument is that, if women choose to undertake this practice then it is not a violation of their rights. Similarly, Koster and Price (2008: 192) report that women regard these practices as a positive force in their lives. Bagnol and Mariano (2008: 2) concur that women perceive labia elongation to be a 'woman's secret' and express an area of power that women have been developing and protecting despite many forms of oppression over generations. Presently, the practice of labia minora elongation is relevant to the study as it is a representation of gender behaviour associated with femininity and masculinity incorporated as a result of social norms amongst which heterosexuality plays a fundamental role (Bagnol and Mariano 2008: 3).

### 2.7.2 Religio-cultural constructions of sexuality

Moyo (2004: 72) argues that through religio-cultural institutions older women socialise younger women sexually into being acceptable women in their communities. The reality of patriarchy in such communities means that women find themselves submitting to the patriarchal tradition that treats them as sexual objects unable to make decisions regarding their sexual life (2004: 72). By the same token, in Islam female sexuality is viewed as leading to social chaos, thus control of women is deemed necessary to safeguard social harmony. As a result, Muslim women's sexuality is fraught with dangers ranging from social exclusion to death (IIkkaracan 2004: 58).

Furthermore, early Christian Protestant Evangelical sex manuals unequivocally affirmed that true Christians who interpret the Bible correctly will have frequent and mutually satisfying sex within a marriage, thus witnessing to faith (DeRogatis 2005: 114). Moyo (2004: 74) puts forth that some religions believe that males engage in sex to meet their sexual needs while women do so primarily to meet their socio-economic needs. In sharp contrast, Buddhism strongly opposes the political concepts of patriarchy and the social construction of gender, thus emphasising the importance of men and women to relate to each other as individuals by moving beyond exclusive identification with biological sex (Smith and Munt 2012: 239-24). Religion has become a dominant tool for patriarchal control of women's sexuality in order to sustain the desired social order (IIkkaracan 2004: 58). This leads authors Lorber (1996: 151) and IIkkaracan (2004: 60) to conclude that heterosexuality is the main source of oppression and patriarchal control of women.

## 2.8 Socio-cultural factors increasing women's vulnerability to HIV Infection

Various researchers agree that poor education in women may be associated with unsafe sexual behaviours such as the inability to negotiate condom use (Youdell 2005: 255-256; Gillbert and Selikow 2011: 328). Moreover, women in long–term, committed relationships believe that condom use is unnecessary and a sign of distrust (Kennedy and Jenkins 2011: 143). For this reason, Green (2001: 586) agrees that the sexual pressures women experience are often enmeshed in loving and caring relationships. Due to this, most African women experience low self-efficacy in the context of sexual relationships**.** This is explored in the next section.

### 2.8.1 Intergenerational sexual relationships and transactional sex

Both young and older women in some relationships express their sexuality for financial gain and arguably express their sexual agency in so doing. South Africa's Health Minister Dr Motsoaledi, during a speech in Mpumalanga in 2013 expressed concern that transactional and intergenerational sex contributes to young women's vulnerability to HIV infection. He also reported that 28 per cent of schoolgirls are living with HIV (Sowetan: 2013). Age differences between sexual partners may lead to issues of unequal sexual assertiveness. Kennedy and

Jenkins (2011: 143-145) suggest a link between sexual assertiveness and HIV infection risk - the implication is that women in most relationships and especially those with power imbalances experience challenges when negotiating condom use.

Gillbert and Selikow (2011: 329) affirm that transactional and intergenerational relationships are key drivers of the HIV and AIDS epidemic in South Africa in the context of female sexuality. In addition, these relationships involve the exchange of sex for material gain (Gillbert and Selikow 2011: 329). The motivation for the relationships are that of consumerist pressures to acquire goods and social status, as well as being linked with culturally-based notions of gender and love (Potgieter, Strebel, Shefer and Wagner 2012: 193). Contrary to this, Brouard and Crewe (2012: 49) are of the understanding that all relationships, including marriage, are transactional, as they have elements of exchange and obligation. This also depends on the context as socio-economic contexts inform and affect personal relationships; the outcome becomes a product of an intense relationship with social and economic circumstances (Brouard and Crewe 2010: 49).

Young women's perceptions of sexuality in the involvement with older men poses a risk of infection since the older men would likely have been sexually active for many years. The older man will thus be more likely to be infected by sexually transmitted infections including HIV (Leclerc-Madlala, *et al.* 2009: 17). Potgieter, *et al*. (2012: 193) add that although to some extent women assert their sexuality in transactional relationships, these transactional sexual relationships involve power dynamics including age and access to resources which also play a significant role in unsafe, unequal and coercive sexual practices, thus placing them at a disadvantage. Despite this, transactional sex has given rise to a vocabulary that describes men as 'ministers' of transport, fashion, education and the like (Gillbert and Selikow 2011: 329). This is because young women view relationships with older men as a relatively easy way to meet their growing desires (Leclerc-Madlala and Leickness *et al*. 2009: 17). Women engage in these relationships in an active process of securing benefits and exerting power over their lives in the contexts of poverty using their sexuality. Even so, Jewkes and Morrell (2009: 39) echo the realities of the power dynamics that severely limit women's capacity for influencing the terms on which sex takes place once the relationship is established.

However, Strebel and Shefer (2012: 59) challenge literature's focus on the powerlessness and vulnerability of young women in relation to negotiating safe sexual relationships. Strebel and Shafer (2012: 59) argue that evidence of agency and control exist, this is observable in the ways that these girls negotiate the terms of the relationship. In addition, various authors (Crewe and Brouard 2012: 49-50; Potgieter, Strebel, Shefer and Wagner 2012:193; Gillbert and Selikow 2011: 326), concur on the importance of not viewing women as passive victims regarding their sexuality. Examples of these are campaigns and health literature whose aim is to stigmatise the manner in which women choose to express their sexuality in these relationships. This further enforces the women as 'the-victim-discourse', disempowering women and denying their sexual agency, and runs the risk of stigmatising them as well (Crewe and Brouard 2012: 49). Jewkes and Morrell (2012: 1736) add that campaigns on sexuality frame African women's agendas to the pursuit of material reward. Shafer and Strebel (2013: 60-61) support this argument in stating that the gaze on women's sexuality in intergenerational relationships and their transactional nature may be serving the function of 'othering' Africans and poor communities.

Interestingly, intergenerational relationships are not unknown to societies across history and were often encouraged, for instance in Greece in the 5$^{th}$ Century BC among the upper class an older man would take a boy as his protégé. As mentioned previously, in the African context, there were the 'mummy–baby' relationships between the younger girl and an older woman (Crewe and Brouard 2012: 50; Blackwood 2000: 225). The authors, conclude that intergenerationality in this world was constructed through the language of power and identity. Thus sex in those days was a vehicle for power and not simply an expression of desire and was not spoken of in the language of morality (Crewe and Brouard 2012: 51).

### 2.8.2 Gender inequities and HIV

Power disparities between men and women are reflected and maintained by the social conditioning of women and men (Gillbert and Selikow 2011: 328), where specific roles are considered gender appropriate. As a result, most girls and boys grow up learning that differences between their bodies imply differences in the manner in which they are treated and how they are expected to behave (Runeborg 2010: 3). As a result, the gender roles learned and adopted by young boys and girls influence the ways in which they relate to one

another later in life (Mofolo 2010: 3). Such gender scripts privilege male dominance and female subservience, and are one of the socio-cultural factors linked to the HIV and AIDS epidemic (Gillbert and Selikow 2011: 328). Furthermore, Runeborg (2010:3) expounds that in many societies girls and women are held in low esteem, thus restricting their ability to make independent sexual choices. Oriel (2005: 396) contends that manhood is proven most effectively when men use another person (women) as an object to satisfy male sexual pleasure. Sex in some traditional African cultures has mainly been for the pleasure of men. Khan, illustrates this in a comment made by a male participant in the study:

> "I begin intercourse with a condom ... Just before ejaculating, I love to discharge my semen inside her vagina ... I know inside a vagina is safe for men and not for her. However, that is not my concern. They are already diseased. Ejaculation inside a vagina is real sex for a real man" (Khan quoted in Oriel 2005: 401).

This idea of male dominance was further emphasised during the Apartheid era when black African men migrated to the urban centres in search of employment in the mines. Men in the mines felt that they worked very hard and constantly faced the risk of death as a result of working in highly adverse and dangerous conditions (Mofolo 2010: 3). Therefore, this entitled them to various sexual partners ultimately creating an opportunity in which to relieve sexually the stress and tension they experienced on a daily basis, thus simultaneously providing an avenue in which to express their masculinity (Mofolo 2010: 3). Similarly, Mofolo (2010: 2) observes that historically in most African cultures, the male figure has always had a dominant position in the household. African boys are taught from a young age that they are to provide for their families and are to also be the 'heads' of their households. Whereas, young African girls are socialised into being nurturers and caregivers, and to be respectful and humble to their husbands (Mofolo 2010: 3).

## 2.9 Prevention of HIV transmission

### 2.9.1 Newer interventions to HIV prevention: Women's sexual and reproductive health and rights

The fight against HIV infection forces institutions to find innovative ways to combat the virus. Literature states that sexuality needs to be included in human rights programmes as it is used as a central mechanism in the patriarchal control of women (IIkkaracan 2004: 60). Therefore, sexual and reproductive rights are essential in addressing the foregoing factors that render women vulnerable to HIV infection (Germain and Woods 2005: 56). According to the 1995 Beijing Platform for Action as quoted in Runeborg (2010: 4) women's human rights include the right to have control over and decide freely and responsibly on matters related to their sexuality. In addition, women are to do the above free of coercion, discrimination and violence (Runeborg 2010: 4). Moreover, reproductive health rights are defined by WHO based on the recognition of the fundamental right of all couples and individuals to decide freely and responsibly over the number, spacing and timing of their children and also the right to attain the highest standard of sexual reproductive health (Runeborg 2010: 4). Sexual rights also encompass the right to experience pleasurable sexuality, which is a fundamental vehicle of communication and love between people (Jolly 2005: 1).

However, Jolly (2005:1) warns against the excessive emphasis on violence and gender inequality as causes of unsafe sex, it offers the impression that women only ever have unsafe sex because they lack power to negotiate with male partners. Nicholas (2010: 491) counter argues that if HIV-prevention efforts are to be effective for women, it is essential that policies be informed by gender-specific research that recognises the impact of socio-economic conditions. In agreement, UNAIDS (2009:7) advises that there needs to be increased understanding of the specific needs of women and girls in the context of HIV so as to ensure tailored national AIDS responses that protect and promote the rights of girls and women *'Knowing your epidemic response'*. Furthermore, authors Ramkissoon, Searle, Burns and Baksinska (2010:34), observe that when the Millennium Development Goals (MDGs) were conceived, several sexual and reproductive health (SRH) related key policies and guidelines were implemented in South Africa. However, the main challenge South Africa is facing is the

effective implementation of these good policies (Ramkissoon, Searle, Burns and Baksinska 2010: 34).

In 2009 the South African government created a Ministry dedicated to Women, Children, and Persons with Disabilities. But the challenge is that combining these diverse vulnerable groups into one ministry may not address the individual needs of each group, particularly the specific needs of women (Ramkissoon and Searle, *et al*. 2010: 35). Jolly (2005: 5) expounds, that a focus on pleasure and women's safety on their terms may assist in making women less vulnerable to unsafe sex. As opposed to concentrating on ABC (Abstain, Be faithful and Condomise) and family planning, these are more of a shock tactics type of education. Due to this, women are less able to understand the importance of consensual sex and negotiation skills (Jolly 2005: 5). Kennedy and Jenkins (2011: 144) attribute sexual assertiveness to condom use among women. Jewkes and Morrell (2010: 8) report that some women admit that within the prevailing gender order, they perceive that had they asserted themselves, the price would have been relationship breakdown.

### 2.9.2 Transforming social structures, environments and HIV prevention

HIV prevention for women does not happen in a vacuum; it is deeply bound up in gendered social cultural and economic contexts (Nicholas 2010: 496; Takyi 2003: 1223). Nicholas (2010: 494) found through study results that accurate knowledge of HIV and awareness of personal risk does not necessarily result in protective behaviour. In the South African government's response to the epidemic, as outlined in the National Strategic Plan, one of the objectives state a need to address social and structural drivers of HIV (SANAC 2010:14). Similarly, in South Africa religious beliefs play an important role in communities, and such beliefs affect the manner in which people view themselves, how they think, how they act and how they view disease (Toefy 2009: 237; Takyi 2003: 1222). Thus, the social value of church-based social interactions has long been held as a critical element in the successful dissemination of AIDS-related information thereby influencing how people react to the disease (Toefy 2009: 237). However, authors Toefy (2009: 239) and Takyi (2003: 1224) argue that rather than promoting healthy behaviours, religion could also be used to maintain the status quo such as equating HIV and AIDS with promiscuity and also the anti-condom stance by some religious groups.

Moreover, social interventions are necessary in order to create the infrastructure required for an effective and sustainable response to the HIV and AIDS epidemic (Auerbach 2009: 1656). This is because they aim to address the social drivers of HIV vulnerability such as economic independence, poverty and lack of education (Auerbach 2009: 1656). This is echoed in South Africa's National Strategic Plan (SANAC 2010:14), which aims to support efforts focused on poverty alleviation and enhancing food programmes. For instance, these include micro-finance projects aimed at empowering women to reduce their economic dependence on men. The interventions have been reported to have improved social networks, increased self-esteem, control over decision making, bargaining power and contraceptive use among women (Auerbach 2009: 1659). A similar intervention known as IMAGE (Microfinance and Gender Equity program) was launched in Limpopo and was found to have various positive effects on women(2009:1660). Similarly, studies conducted in South Africa and elsewhere found that women who received government housing support are unlikely to engage in risky sexual behaviour. Thus, provision of housing to people living with or most vulnerable to HIV infection is an effective strategy to prevent and mitigate HIV and AIDS (Auerbach 2009: 1661). Newer HIV-prevention strategies aimed at addressing and transforming socio-cultural drivers that oppresses and abuse women, namely the Brothers for Life programme are targeted at changing male behaviours and attitudes towards women. Their message is as follows (Brother's for Life 2013);

- Brothers who stand for responsible parenting
- Brothers who stand for responsible behaviour
- Brothers who live positively
- Brothers who do the right thing
- Brothers who stand for life
- Stand for responsible relationships.
- Take responsibility and test for HIV and encourage others to test too.
- Keep to one sexual partner.
- Protect themselves and others from HIV and other STIs.
- Always use a condom.

### 2.9.3 The Female condom and HIV prevention

Prevention strategies must seek to increase women's options and control over how to protect themselves without having to depend on their partners' willingness to practice safe sexual behaviour (Germain, Zonibel and Woods 2005: 58). The female condom appears to be a key method of prevention that is controlled by women (2005: 58). Moreover, condom programmes in South Africa should be comprehensive and take social and environmental factors into account (Ramkissoon, Searle, Burns and Baksinska 2010: 36).

It is observed that one of the reasons South African women do not consider condom use, is that culturally it is not acceptable to carry condoms or propose condom use as these indicate assertiveness and taking control to set terms in sexual interactions, which all go against cultural norms (Jolly 2005: 2-3). As a result, the impact of condom distribution and promotion is hindered by cultural and religious barriers to their supply. This is evidenced in the unbalanced approach to ABC that promotes abstinence over condoms (Germain, Zonibel and Woods 2005: 58). Despite this, the same authors assert that prevention programmes need to make the female condoms available as an integral part of prevention strategies as it is a barrier method that can greatly reduce the risk of HIV infection (2005: 58). South Africa's female condom programme has expanded since 1999 and, to date, over four million female condoms are distributed per year, mainly through the public sector (Ramkissoon and Searle *et al.* 2010: 36). However, female condoms are not available at all sites that provide family planning services so distribution sites are still limited compared to the male condom.

## 2.10 Theories

The rationale behind the use of the three theories is that rural women's sexuality and their perceptions of it are rarely explored in literature. As a result, the researcher considers it right to explore the theories as they are crucial in exploring the research problem. For instance, the radical feminists' views on women's perceptions of their sexuality is relevant in order to answer the study's research questions. As well as, socio-cultural constructions of sexuality in accordance with the Social Constructionist Theory and also the social scripts of sexual

behaviour reinforced by society in sexual relationships that is in line with Sexual Scripts Theory. Within the context of this study, the preceding theories highlight the socio-cultural perceptions of women's sexuality and sexual practices that underlie Schoemansdal women's vulnerability to HIV infection.

### 2.10.1 Radical Feminist Theory

Radical Feminist Theory was used to guide this study. This is because radical feminists observe that culture imprisons women, leading to their subordination and objectification in the context of sexual relationships. The theory applies to the study because according to prevailing social norms sexuality is characterised by the eroticisation of male dominance and female submission (Ferguson, *et al*. 1984: 110; Shulman 1980: 602; Chambers 2005: 329). Thus, the system of masculine domination owes its success to the biological explanations - men and women have different body parts and different biological functions (Chambers 2005: 327). These differences justify different positions on a hierarchy in that they dictate different behaviours for men and women such as child care and 'heads' of households. In sum, the success of male domination is the ability to make itself appear natural (Chambers 2005: 328; Ferguson, *et al*. 1984: 108). Gender is therefore, constructed through the division of the active male and the passive female. Concurrently, gender inequality is defined as symbolic violence in that women comply with no coercion and also its effect creates symbolic normative images of ideal gendered behaviour (Chambers 2005: 330). As a result, the dominated (women) apply categories constructed from the point of view of the dominant (males) to the relations of domination, thus making them appear as natural (Chambers 2005: 330). For most African women culture has conditioned them to accept male dominance in sexual relationships.

Furthermore, it is well documented in literature that various feminists use the concept of *habitus* to explain the manner in which social norms become embedded in individuals. Moreover, *habitus* is the means by which objective social structures are reproduced in the body through human interaction and thereby influence individual's actions (Chambers 2005: 330). Subsequently, in response to the social sphere that the individual lives and acts in, a space termed the field is created. A field is defined as a sphere of action that places certain limits on those who act within it, in accordance to their status, while the status, in turn, is

determined by capital or the collection of resources the individual has. In the case of Schoemansdal the field being the socio-cultural context that has the majority of women unemployed and uneducated, making them dependent on males for economic support. This leaves no space for women to negotiate terms of sexual relationships in order to protect themselves from HIV infection for some due to their low status in the community and for fear of economic loss. Therefore, the field Schoemansdal women find themselves in inhibits HIV prevention. The author adds that people understand socio-cultural norms and obey through acting them out, and they do not think consciously about them and consider on each occasion whether to comply with them (Chambers 2005: 331).

Feminist literature asserts that in order for women to acquire sexual liberation, they need to assert themselves and share equal enjoyment of sexual activities without fear of exploitation and punishment (Ferguson, *et al.* 1984: 106; Shulman 1980: 604; Kambarami 2006: 1).This may be key in reducing women's vulnerability to HIV infection. However, Marso (2010: 268) puts forward that instead of prescribing freedom to individual women affirmation of a feminist community, a genealogical community of women needs to be formed a space where they will look to the past and speak of commonalities as well as differences in their lives. Women's self-help movements have the potential to encourage women to examine their own and each other's bodies, in order to overcome ignorance and shame associated with their sexuality (Shulman: 1980: 596). Thus, with this research the researcher hopes to open a dialogue where women can share their past and present experiences of sexuality within the cultural sphere and come up with ways to assists each other, and, in that way, create new social norms within that community that can be embedded in the individuals. In applying this theory the researcher hopes to gain an understanding of and explore rural Schoemansdal women's perceptions on sexuality and the socio-cultural factors that impede on HIV preventative behaviours among women (Parker 2010: 58; Bellamy, *et al.* 2011: 85).

Radical feminists observe that culture imprisons women leading to their subordination and objectification in sexual relationships. Therefore, the study will apply this theory as its emphasis is on equality in sexual relationships and it requires women to assert themselves and share equal enjoyment of sexual activities (Kambarami 2006: 1; Ferguson 1984: 106). However, in the context of the study, radical feminist theory poses a challenge as its focus is based on individual sexual freedom and desires, and the Schoemansdal socio-cultural context impedes women's freedom of sexuality and expression (Marso 2010: 263). Thus, sexual

freedom to women in this context is not dependent on individual volitional control. Marso (2010: 267) explains that sexual freedom can only be achieved by belonging to a community of other women who share the same struggles and challenges.

Instead of prescribing freedom to individual women, Marso (2010:268) suggests that for affirmation of a feminist community, a genealogical community of women needs to be formed - a space where women will look to the past and speak of commonalities as well as differences in their lives. Ferguson, *et al*.'s (1984: 106) observation is that the limitation in feminist theories is the perpetuating of patriarchal society's ideals of women as the weaker sex and victims. As a result, women do not recognise themselves experiencing sexual fantasies of male dominance and submission, due to patriarchal society's stereotypes and now feminists viewing them as victims and the second sex. Subsequent to this, feminism appears to be prescribing to patriarchal society's labels of women as the weaker sex, while also enforcing the notion that women do not experience sexual freedom in heterosexual relationships. This may lead women to not assert themselves in heterosexual relationships.

### 2.10.2 Social Constructionist Theory

The second theory which was used in the study is Vance's (1991) Social Constructionist Theory. Fundamental to this theory is the view that sexuality is historically, culturally and socially constructed and that all common sense knowledge is derived and maintained through social interactions (Bellamy, Gott, Hinchcliff and Nicolson 2011: 85; DeLamater and Hyde 2010: 13). The theories' concession, is that sexual beings have varying meanings in different cultures as well as considerations of power, identity and views of the self (Bellamy, Gott, Hinchcliff and Nicolson 2011: 85; Vance 1991: 278-279).

The theory expounds that people's experiences of the world are ordered, therefore the world is experienced as objective reality consisting of events and persons that exist independently of individuals' perceptions of them (DeLamater and Hyde 2010: 14). Similarly, language provides the means by which new experiences are interpreted. Shared events and people's practices lead to what is termed *habitualisation. Habitualisation* makes the behaviour of others predictable and facilitates joint activity. However, authors warn that once a practice becomes habitual others come to expect it, thus perpetuating the development of mechanisms

of social controls (2010: 14). Vance (1991: 878), adds that culture provides different categories, schema and labels for framing sexual experiences. These constructions, not only influence individual subjectivity and behaviour, but also organise and give meaning to collective sexual experience (Vance 1991: 878). In addition, according to this theory, there is no sexual impulse, sex drive or lust which resides in the body due to physiological functioning; this implies that sexual desire is constructed by culture, history and the capacities of the body (Vance 1991: 878). DeLamater and Hyde (2010: 14), acknowledge that although sexuality is 'rooted in biological drives' they in turn, provide motivation. But, biology does not dictate where, when, and with what object a person engages in sexual behaviour (DeLamater and Hyde 2010:14). Therefore, sexuality is channelled in specific directions socially rather than biologically.

According to the authors, sexuality is derived through language, and each society has a discourse about sex, a way of thinking and talking about the broad behaviours and actors involved in sexual expression (DeLamater and Hyde 2010: 15). As a result, the authors expound that due to the aforementioned drivers, women's awareness of a more diverse understanding of their sexuality and preventative behaviours are potentially impeded by heterosexual and patriarchal circumstances (Parker 2010: 58; Bellamy, Gott, Hinchcliff and Nicolson 2011: 85).

### 2.10.3 Sexual Scripts Theory

The last theory which guided this study is Gagnon's (quoted in Parker, 2010) Sexual Scripts Theory. Fundamental to this theory is that sexual meanings are socially, historically and culturally constructed. Furthermore, sexual experience as well as what is done sexually by individuals is a result of the particular learning circumstances of a specific culture (Parker 2010: 58; Gagnon 1990: 4). Other concepts underpinning Sexual Scripts Theory as discussed by Gagnon (1990: 5) are as follows; the meaning of sexual conduct resides in the reading of individuals' bodily activities, sexuality is acquired, unlearned and maintained, and is also organised by social structure and culture. Lastly, gender and sexuality are both learned forms of conduct and linked differently in different cultures.

It is argued that scripts are involved in learning the meaning of internal states, organising the sequences of specific sexual acts, decoding novel situations, setting limits on sexual responses and linking meanings from nonsexual aspects of life to specific sexual experience (Gagnon 1990: 6; Parker 2010: 59). Moreover, a script connects feelings of desire, pleasure, disgust and physical signs of arousal and physical touching. The sequence of what ought to be done in a sexual act depends on the pre-existence of a script that defines what is to be done with certain people, in what kind of circumstance and time, and what feelings and motives are appropriate to the event (Parker 2010: 59; Gagnon 1990: 6). Parker (2010: 60) explains that even solitary sexual acts and masturbatory fantasies, become socially constructed because they are typically articulated in relation to the world of images and meanings that are appropriated through intra-psychic scripting from the wider universe outside the individual and his or her subjective experience.

In terms of HIV prevention, the author asserts that sexuality needs to be approached as an extension of broader struggles of human rights and social justice (Parker 2010: 61). The author further emphasises the issue of empowerment for at-risk populations. Empowerment is a key precondition for reducing risk and vulnerability and for the promotion of erotic justice and sexual freedoms (Parker 2010: 61). Ultimately, what the author describes as sexual citizenship is the right to pursue a satisfying, safe, and pleasurable sexual life, however, this depends not only on the rights that are protected by government policy. Since the idea of pleasure, its definitions, its language and its expression all come from socio-cultural, religious and other sectors, they are all primarily responsible for respecting (or not) the right to sexual pleasure by adhering (or not) to fundamental principles of social inclusion, freedom and human dignity (Parker 2010: 61). The limitation of this theory within the context of Schoemansdal is that through its magnification of sexual scripting it may covertly generate sexual anxiety in women and enforce heterosexual submissive behaviour of women in sexual practices in the process. In addition, the theories explored appear to lack further exploration of structural and socio-cultural factors that possibly contribute to individual's conformity to social scripting and constructions of sex and sexuality.

## 2.11 Conclusion

The literature review highlighted that the socio-cultural environment and low social status among some women may be associated with their vulnerability to HIV infection. Different sexual behaviours practiced by or on African women were explored in detail. A number of authors agree that socio-cultural perceptions of sexuality among women impedes on HIV prevention. The negative impact of women's expressions of their sexuality within intergenerational and transactional relationships in the context of HIV was discussed and the statistics further highlighted the challenge among young women. It is apparent that the battle against HIV still continues and newer preventative strategies, such as women's sexual and reproductive health rights framework and addressing structural barriers to HIV prevention, will potentially improve the prevention strategy if accompanied by existing methods. For example, when addressing issues of condom use, the socio-cultural environment which plays a significant role in deciding condom use particularly among women, must not be neglected. Thus both methods need to complement each other. The following chapter will discuss the methodology used in this study.

# CHAPTER 3

## RESEARCH METHODOLOGY AND DESIGN

### 3.1 Introduction

Chapter 2 discussed literature on the impact of culture on perceptions of female sexuality and HIV prevention, and the theories of Simon and Gagnon (1990), Vance (1991) and Ferguson, *et al.* on social constructionist views on sexuality and feminist theories on female sexuality. This chapter addresses the research design, sample and sampling techniques. Thereafter, it looks at measures to ensure it discusses the credibility of the findings. It further discusses data collection and data analysis procedures. This chapter concludes by highlighting the ethical considerations of the study.

### 3.2 Research methodology and design

A qualitative research method was used for this exploratory study. The qualitative research approach emphasises studying human behaviour and attitudes within their natural setting (Terre Blanche, Kelly and Durrheim 2006: 287). Employing this paradigm was appropriate in this study as the researcher is interested in gaining insight and comprehension of African rural women's perceptions on their sexuality in the context of HIV prevention (Babbie and Mouton 2010: 80; Terre Blanche 2006: 44). Babbie and Mouton (2010: 53) indicate that a qualitative approach provides the researcher with an insider perspective on social action. In addition, a qualitative approach is consistent with the researcher's aims of wanting to make sense of women's feelings and experiences relating to sexuality as they occur in their world. As a result, the focus will be on process rather than outcome (Babbie and Mouton 2010: 271). This yields richer responses from participants (2010: 80).

This qualitative study follows an exploratory research design. Maxwell (2013: 4) affirms that a good design is one in which components such as research questions, aims and objectives, and study methods work harmoniously together and promote efficient and successful functioning. Babbie and Mouton (2010: 80) add that exploratory studies lead to insight and

comprehension rather than the collection of accurate and replicable data, these studies frequently involve the use of in-depth interviews and the review of literature. Therefore, the explorative nature of this design is applicable to this study as the research questions were not fixed at the start of the study and were significantly modified in line with what the researcher has learnt during the study (Maxwell 2013: 4-5; Babbie and Mouton 2010: 80). Similarly, to obtain data, guided individual interviews were conducted. Moreover, face-to-face interviews facilitated the process of obtaining in-depth information about research participants' perceptions of sexuality, the role of culture and of HIV risk and prevention within the context of the social environment.

### 3.3 Data sources

The research participants in this study comprised 10 female home-based carers working at an HIV and AIDS project. The researcher conducted focus group discussions with the 10 women and thereafter proceeded with face-to-face interviews with four women. The basis for identifying these research participants as key informants was that they were easily accessible and easy to locate, and that they worked in the HIV and AIDS field.

### 3.4 Sampling design

Sampling is defined as a selection of research participants from an entire population that involves decisions about which people, settings and social processes the researcher needs to observe (Terre Blanche, Kevin and Durrheim 2006: 49). Purposive sampling was utilised in this study based on the researcher's knowledge of the population, its elements and the nature of the research objectives (Babbie and Mouton 2010: 166). Ten female home-based carers working at an HIV and AIDS project were recruited and are between the ages 25 and 45 residing in the rural village of Schoemansdal.

The rationale behind utilising purposive sampling in this study was that the researcher had built successful relationships with most of the participants, and rapport between researcher and participants had already been established making it possible to conduct face-to-face interviews. The researcher purposively chose these women as they have experience in the

subject of HIV and AIDS, work closely with their community in terms of educating about HIV-preventative behaviours, and also have contact with people living with HIV (PLWH). The researcher was confident that this sample would provide in-depth responses during the face-to-face interviews.

## 3.5 Data collection techniques

### 3.5.1 Face-to-face interview guide

Interviews are defined as a more natural form of interaction between the researcher and the participants, and thus fit well with the qualitative research paradigm employed in the study (Kelly 2006: 297). The face-to-face interviews were tape recorded and were about 15 to 35 minutes long. In order to capture the meaning of what the researcher observed data were collected by means of tape–recorded, in-depth guided interviews (see Appendix E). Although, the participants spoke *siSwati* as it is their main language; the interviews were conducted in Zulu as most of the participants understand *isiZulu.* The interview and focus group discussion guide topics were submitted in both English and i*siZulu*. In order to understand the manner in which women in rural Schoemansdal construct sexuality within their context, the researcher was able to create an environment of openness and trust that enabled participants to express themselves authentically. Moreover, occasional 'why' questions were asked, followed by probes which served a purpose of receiving responses in more depth without biases in later responses. With regards to the context of this study sexuality is a sensitive and taboo topic, and this may limit the process of getting robust responses from participants (Babbie and Mouton 2010: 288-289; Kelly 2006: 297).

### 3.5.2 Focus group discussions

In this activity, the researcher had initially planned on recruiting eight female participants for the focus group discussions. However, upon consideration and consultation of the literature the researcher decided to add two more participants so as to ensure that the focus group did not fall flat if some members chose to remain silent or if others did not show (Babbie and

Mouton 2010: 292).The focus group discussions were tape recorded and were approximately 2 hours long and one day. In addition, the 10 participants were set up in a circle which made the group easily manageable for the researcher. As a result, all the participants were able to speak and the researcher was able to receive 'individual' responses from all members of the group (Babbie and Mouton 2010: 292). This focus group discussion provided the participants a platform on which to respond and debate on less sensitive and non-personal questions (2011: 293). The rationale for this type of research activity was that in a group information is more accessible than in individual interviews. The focus group allowed a space for Schoemansdal women to come together and create meanings of sexuality within their context, as opposed to doing it individually. Moreover, in the context of the focus group discussion, the researcher was able to observe direct evidence about similarities and differences in participants' opinions and experiences. On completion of the face-to-face interviews and focus group discussions, the researcher transcribed the recordings verbatim.

### 3.5.3 Participant observation (while working in the field)

In this data-collection technique the researcher was simultaneously a member of the group being studied and an observer (Babbie and Mouton 2010: 293). Notes were also taken on the researcher's observations as participants responded to questions. The challenge became when the participants behaved differently due to the fact that the researcher was taking notes on everything they said and did, thus note taking became minimal. Babbie and Mouton (2010: 295) explain that participant observation should include empirical observations and researcher's interpretations of them. Examples of non-verbal communication that were observed by the researcher include facial expressions, pauses and the language behaviour of participants. The focus group discussions and face-to-face interviews were conducted at a convenient and safe location - the suggested location was a local community centre where all of the participants are employed.

### 3.5.4 Literature review

Despite the researcher's limited experience in this area of research, the intention was to fully immerse herself in the literature and on previous research conducted in the area of African

female sexuality. Thus, genuinely possessing an interest in understanding women's accounts on this topic and allowing activities with participants to flow out of the relationship developed between the researcher and the Schoemansdal women. Moreover, there was little separation between the researcher and the participants in terms of language, experience, gender and culture. Subsequently, this yielded candid, intimate interviews and discussions with the female participants (Jewkes and Morrel 2012: 1731).

## 3.6 Measures to ensure trustworthiness

### 3.6.1 Reflexivity

Mauthner and Doucet (quoted in Malacrida 2007:1329) encourage qualitative researchers to develop a practical and visible process of reflexivity. This process allows the researcher an understanding of the self in relation to the research. Authors note that reflexivity focuses on the implications of the researchers' epistemological positions on their analytic and interpretive approaches to conducting research and conveying research findings (Malacrida 2007: 1329). Thus the position of the researcher in terms of the reality of the text and the researchers' values, norms and institutional pressures form a core set elements that affect the ways that texts are read, interviews are coded, and research participants' narratives are represented in the writing of research data (Malacrida 2007: 1329).

### 3.6.2 Reflectiveness

The researcher kept a research journal on her experiences and feelings as she progressed through the research process so as to be able to view the women's behaviour through the participants' world and not through her own views. Thus, the researcher came to the realisation that it is never about the researcher wanting information from research participants and then leaving, but rather a research study needs to be motivated by positive emotions such as respect, compassion and care (Malacrida 2007: 1330). Malacrida (2007: 1330) further emphasise that positive emotions hold the potential to produce knowledge that is passionate and liberating, and more likely to produce emancipatory social change. This is the aim in the

context of Schoemansdal. In addition, to produce research that serves the interests of the rural Schoemansdal women, it was imperative that the researcher acknowledge her own biases, motivations and privilege regarding female sexuality (Malacrida 2007: 1330). However, Babbie (2010: 42-43) puts forth that objectivity in social research is marred with controversy, in that all our experiences are inescapably subjective, we can only see through our own eyes and anything peculiar to our eyes will shape what we see.

## 3.7 Dependability and credibility

To ensure and enhance the preceding qualities, the researcher employed triangulation which entails collecting material in different ways and from diverse sources, thus assisting the researcher in understanding the phenomenon of rural African women's sexuality by approaching it from different angles (Kelly 2006: 287; Babbie and Mouton 2010: 275). To achieve this, the researcher used multiple methods from different sources such as interviewing and observation while working in the field, and a review of documentary sources on African female sexuality in the context of HIV risk and prevention. To interpret the collected data, the researcher employed theory triangulation. The theories used are as follows; Radical Feminism, Social Constructionist Theory and Sexual Scripts Theory. In addition, the researcher wrote extensive field notes that describe the participants' environment. The research participants were also persistently observed (Babbie and Mouton 2010: 275). Babbie and Mouton (2010: 275) stress the benefits of field notes as they can be referred to regularly so as to accommodate required adjustments to the study's research design. Lastly, the researcher made certain that the data obtained were documented by making use of a tape recorder.

## 3.8 Data analysis

### 3.8.1 Transcribing interviews, focus group discussions and interview notes

The face-to-face interviews and focus group discussions were tape recorded, then transcribed. In the transcripts, participants' personal information that may lead to identification of the

participants was disguised - for instance, place of resident, and names of participants that were mistakenly mentioned by fellow research participants. The interview notes made by the researcher captured non-linguistic expressions made by research participants during interviews and group discussions - for instance, body language, sighs, smiles, nervous giggles, loud laughter and covering face with hands. Moreover, in order to yield richer results, the researcher noted the manner in which some words were spoken. In addition, the researcher recognised the value of transcribing the interviews and group discussions on the same day when they were still fresh. As a result, the researcher was able to recall unclear expressions made by participants and also contextual details (Terre Blanche, Kelly and Durrheim 2006: 302).

### 3.8.2 Thematic analysis

Rural women's accounts on sexuality were to be based on the analysis of qualitative data obtained from focus group discussions and face-to-face interviews. Content analysis, also referred to as thematic analysis, was utilised in this study (Babbie and Mouton 2010: 492). Upon looking at the relevant literature on female sexuality, the researcher decided in advance on relevant key terms and codes, such as cultural influences on women's perceptions of sexuality and HIV infection risk and prevention (Babbie and Mouton 2010: 492). Moreover, the researcher made a decision on the level of analysis of a specific word, a key phrase or a string of words (Terre Blanche, Durrheim and Kelly 2006: 323).

From the emerging themes, meanings were formulated and clustered into subthemes. The researcher made use of coloured marker pens to highlight pieces of text. Segments that were related were marked with the same colour (Terre Blanche, Durrheim and Kelly 2006: 323). The notes were cut and placed in a folder according to identified themes (Terre Blanche, *et al*.2006: 324-325; Babbie and Mouton 2010: 399). In the final steps of thematic analysis process - coding - the researcher read and reread the texts in an effort to make sense of the patterns and themes that emerged from the data (Babbie and Mouton 2010: 493). Thus, all emerging themes were integrated into an in-depth description of women's perceptions. The analysis was concluded with a summary presenting the findings of the research study (Terre Blanche, Durrheim and Kelly 2006: 326).

## 3.9 Ethical considerations

### 3.9.1 Procedure, permission and ethical clearance

Before this research was conducted ethical clearance was requested from and granted by the University of South Africa (UNISA) in September 2013. In June 2013, the researcher obtained permission to conduct focus group discussions and face-to-face interviews with female participants working at the Home-based Care Centre. The researcher requested permission to conduct the aforementioned research activities from the project coordinator and team leader who were contacted telephonically. A date was set for a meeting where the researcher presented a letter (see Appendix B). Thereafter, all the research participants were informed of their right to withdraw at any time from the study should they wish to do so. This is because their participation in the study was completely voluntary (Babbie and Mouton 2010: 521). Furthermore, the participants were informed about the purpose of the study and what was requested of them to participate in the study. Informed consent was obtained from the research participants prior to the start of focus group discussions and interviews (see Appendix D). Participants were assured that their names and any identifying information would be kept with strict confidentiality. This is explored further in the ethical consideration section below. Once the participants consented to group discussions and interviews, the research process commenced.

During the focus group discussion one of the participants indicated that she wanted to withdraw from the study, citing reasons of discomfort in opening up and talking freely about the topic at hand. The researcher respected the participant's wish and freedom to withdraw, as a result the participant was not persuaded to take part in the discussions and face-to-face interview as that would be constituted unethical.

### 3.9.2 Voluntary participation

Wassenaar (2006: 61) puts forward, that the essential purpose of research ethics is to protect the welfare of the research participants; however, the focus extends into areas such as

scientific misconduct and plagiarism. Babbie (2011: 477) concurs that ethics is typically associated with morality and both deal with matters of right and wrong. Research access was gained through the negotiation with the gatekeepers, in this case the team leader and project coordinator of the Home-based Care Centre. However, the researcher did not place emphasis on gaining gatekeepers' permission to conduct the study. The researcher negotiated consent with the participants themselves given the fact that they had worked together on a number of occasions and they were well aware of the study beforehand. The management was informed as a matter of principal. Arguably researchers are encouraged to not get too caught up in obtaining permission from gatekeepers, and should rather follow a path of practical experience (Terre Blanche, *et al.* 2006: 313).The research participants were informed of their voluntariness to participate in the research process and were supplied with consent forms agreeing that they wanted be a part of the study. The researcher explained to the participants that failure to participate would not result in any penalty or loss of benefits to which they are entitled such as the stipends they receive at the community centre (Babbie and Mouton 2010: 520; UNISA 2012: 13).

### 3.9.3 Informed Consent

The research participants based their voluntary participation on a full understanding of the possible risks involved, such as being labelled a 'bitch' or 'loose' for openly talking about their sexuality (Babbie and Mouton 2010: 523). The standards of consent that the researcher adhered to are listed as follows as outlined in Wassenaar (2006: 72)

- Provision of appropriate information regarding the proposed study.
- Participant's competence and understanding of the topic.
- Voluntariness and freedom to withdraw after the study has started.
- Formalisation of the consent. This was in writing, and served the purpose of providing research participants with clear, detailed and factual information about the study and its methods (see Appendix D).

### 3.9.4 Confidentiality

Due to the sensitive nature of the topic and issues discussed, confidentiality was achieved by safe storage of recording equipment used for the focus groups and interviews. These will be locked away in a safe location for later use at the end of the research study. Similarly, only the researcher and researcher's supervisor have access to the data. All participants were referred to by pseudonyms, focus group participants were requested not to divulge any details and discussions of the research study to individuals outside of the study; in order to respect fellow participants' confidentiality (Van der Riet 2006: 100).

## 3.10 Conclusion

This chapter discussed the method in which the research was conducted utilising a qualitative study. It addresses the research design, samples and sampling techniques. Thereafter it looked at the procedure that was followed when conducting the research study and the data analysis instruments used. It concluded with the ethical considerations for the study. The following chapter will discuss the findings of the research study. Emerging themes and interpretation of the research will be explored in the chapter.

# CHAPTER 4

## FINDINGS AND DISCUSSION

### 4.1 Introduction

Chapter 3 discussed the methodology and the design utilised in the study. It addressed the research design, sample and sampling technique. The chapter further explained the procedure to be followed when implementing the research, the data-gathering instruments used and the plan for the analysis of data. This chapter interprets and describes the findings from the in-depth interviews and focus group discussions (FGDs) with the ten female home based carers working at a Home Based Care Centre in rural Schoemansdal.

The purpose of the study was to explore women's perceptions of their sexuality and on HIV prevention within the local socio-cultural context of Schoemansdal.

The objectives of the study are as follows:

1. To explore rural women's perceptions and experiences on issues of sexuality and HIV prevention within their rural socio-cultural context.
2. Explore the differences and similarities of traditional and modern perceptions of female sexuality and HIV prevention within the socio-cultural context of these women.
3. Explore the manner in which perceptions and some sexual practices decrease rural women's vulnerability to HIV infection.
4. Explore the manner in which perceptions and some sexual practice increase rural women's vulnerability to HIV infection.

### 4.2 Characteristics of the sample

The common characteristics of the research participants is that they are all black African women residing in a rural area who speak siSwati and working with the community on HIV and AIDS issues. The researcher is familiar with the language, the face-to-face interviews

and focus group discussions were nevertheless conducted in IsiZulu because the researcher is more familiar with it and the participants understand it. The research participants are described below.

### 4.2.1 A profile of Schoemansdal women

The common characteristic of the ten participants is that they are women; economically they are reliant on their male partners' salary, the children's social grant and the monthly stipends they receive from volunteering at the community centre. Their home-based care involvement has exposed them to various workshops and training on HIV and AIDS issues. The workshops covered topics such as taking care of terminally ill and bedridden patients, educating the community on HIV and AIDS, and providing psychosocial support to people living with HIV and their families. At the centre, the women provide support to orphans and vulnerable children and assist child-headed households with food parcels and school work. A majority of the participants do not have Grade Twelve qualifications to improve their employment prospects, however, three out of ten of the participants obtained their certificates less than two years ago through Adult-based Education and Training. The research participants shared briefly about their social circumstances during the introduction session of the face-to face interviews and focus group discussions.

A profile of participants is shown below:

| **Participant** | **Age** | **Marital Status** | **Education** | **Religious affiliation** | **Employment status** |
|---|---|---|---|---|---|
| Cindy | 29 | Married | Grade 12 | Roman Catholic | Self-employed, HBC volunteer |
| Ellen | 47 | Married | Grade 12 | Roman Catholic | Self-employed, HBC volunteer |

| | | | | | |
|---|---|---|---|---|---|
| Peggy | 30 | Single | Grade 8 | Roman Catholic | HBC volunteer |
| Lindy | 37 | Married | Grade 7 | Roman Catholic | HBC Volunteer |
| Angel | 22 | Single | Grade 9 | Roman Catholic | HBC volunteer |
| Felicity | 34 | Married | Grade 12 | Anglican | HBC volunteer, part-time domestic worker |
| Elizabeth | 49 | Single | Grade 12 | Roman Catholic | HBC volunteer |
| Zenzile | 29 | Single | Grade 6 | Roman Catholic | HBC volunteer |
| Patricia | 32 | Married | Grade 5 | Anglican | HBC volunteer |
| Busisiwe | 59 | Divorced | Grade 12 | Anglican | HBC volunteer, self-employed |

### 4.2.2 Focus group discussions and face-to-face interviews

Focus group discussions (FGDs) were chosen as the data-gathering technique for this research process. The open-ended nature of the FGDs was expected to aid exploration through interaction of the participants as they engaged, debated and contradicted each other regarding the impact of the socio-cultural context on their sexuality and on HIV prevention. Face-to-face interviews were performed in order to assess the nature of the problems that impede on women's quest for good sexual health. The chosen participants for the study represented different age groups and marital statuses. The diversity of the participants was meant to give the discussions the necessary push to bring out the different socio-cultural

practices and views on sexuality that prevent women from protecting themselves against the scourge of HIV and AIDS.

Regarding face-to-face interviews and FGDs, pseudonyms for participants were utilised to refer to direct quotes gathered. Babbie and Mouton (2010: 523) state that the greatest concern in research studies is the protection of the participants' interest and wellbeing and the protection of their identity. Therefore, if revealing the responses will injure them in any way it is important for the researcher to adhere to this norm. The first theme discussed below relates to the first question as mentioned above and the subsequent themes will follow in a similar order.

## 4.3 Rural women's perceptions and experiences of sexuality and HIV prevention

### 4.3.1 Sexuality defined as heterosexual sex

Women struggled to define their sexuality and argued that they perceive sexuality to be experienced through heterosexual sex. This is similar to Bellamy, Gott, Hinchcliff and Nicolson's (2011: 88) observations that sexuality is a socially constructed phenomenon, whereby a singular meaning does not exist. Therefore, women experience sexuality according to the manner in which their social and cultural environment defines it, that is in terms of heterosexual sex. Cindy, a 29-year–old, married woman explained that the only time that she is able to experience her sexuality is if she is experiencing sexual arousal and erotic sexual desires signalling the right time to have intercourse with a male. The findings are relevant to the tenets of social constructionism (Vance 1991: 878), for the reason that culture constructs sexual desire and provides labels for framing sexual experiences thus influencing individual subjectivity and behaviour through ideologies and regulations.

Moreover, Cindy's understanding of sexuality corresponds with the radical feminists' argument that the subordinating patriarchal norms and expectations of women have constructed women's sexuality and sexual desires to be experienced and explored in the presence of the heterosexual male (Shulman 1980: 593). All the participants - young, older, married and single - reported that when they are feeling aroused they do not entertain the

sexual desires or attempt to explore the erotic desires if the male partner is not home, as a result the participants opted for a cold bath as a distraction to the desires and with the hopes of 'cooling' off. According to literature, women perceive sexuality in terms of inequality and as condemnable if expressed in contexts other than those that are heterosexual (Lorber 1996: 145). Lorber (1996: 145-146) adds that in accordance with social constructions and sexual practices, heterosexual sex is deemed normal and anything else (exploring one's body) is considered gender deviance. Owing to the fact that women passively experience their sexuality through a male, their subordinate positions in a patriarchal society therefore shapes their risk of HIV infection (Jewkes 2009: 27). South Africa's statistics on HIV and AIDS reflect HIV as most prevalent in the heterosexual population, hence women bear the brunt of the epidemic (Gillbert and Selikow 2011: 327). Sexuality in this case is understood in the context of sexual activity between a man and woman (heterosexual relations) and feelings leading to sexual activity.

### 4.3.2 Perceptions on HIV prevention and vagina as 'semen ditch'

All the participants stated that they perceived their genitalia as bowls that men dish their sperms into during sex. Additionally, it is observed that women perceive their genitalia to be disadvantaging them in terms of HIV prevention and entrenching them to subordinate positions in relation to males. The findings resonate with Runeborg (2012: 3) that girls grow up learning that the differences between their bodies imply differences in the manner that they are treated and how they are expected to behave. Accordingly, due to these constructions of gender inequalities, the women reluctantly accept that they are men's 'sperm bowls' to the detriment of their sexual health. The above views expressed illustrate sexual scripts that privilege male dominance and female subservience, this impedes on women's HIV-prevention efforts. According to literature (Turman 2003: 413; Jewkes 2009: 28) women are biologically more susceptible to HIV infection than men, due to the larger surface area of the vagina.

Moreover, due to the manner in which the vagina is positioned together with the taboo nature of socio-cultural constructions of women's genitalia, the participants expressed that they fear to check what is 'down there'. This leads to the male sexual partner doing as he sees fit during intercourse because women have been conditioned not to explore their genitalia so as

to discover what they find pleasurable during intercourse. The preceding statement may be a solution for women who feel that sex is something that is done to them, hence the phrase 'semen ditch'. This is equivalent to, Simon and Gagnon's (1986: 107) argument that society created sexual scripts and constructions because the idea of female interest and pleasure may be threatening to most males. Indeed, it would be threatening to the social order should women discover their sexual interest. This would imply that they can dictate the pace and the how of sexual intercourse thus thwarting the cultural expectations of the submissive woman.

According to Felicity, a 34-year-old woman – "culturally there is a belief that if a man does not ejaculate inside of a woman during sex then he has insulted that woman".

Felicity's statement illuminates the manner in which the external environment constructs female sexuality and genitalia hinders HIV prevention in women and promotes risky sexual behaviour rendering women vulnerable to HIV infection. Furthermore, the pressure that is exerted in women forces them to allow men to ejaculate inside them, implying the non-use of a condom. This positions women at a great disadvantage in particular those who find themselves in long-term intermittent relationships, as this creates favourable conditions for HIV infection risk. According to Leclerc-Madlala, *et al*. (2009: 16) condom use is viewed as a 'waste' of sperm and conflicts with the emphasis on fertility in African culture, thus these women are encouraged to engage in risky sexual behaviours and risk HIV infection. The extent of the participants' oppression by males brought on by their genitalia is echoed in the study of Oriel (2005: 396) where male participants in the study explained that ejaculation inside a vagina is real sex for a real man. Thus, Oriel (2005: 401) in agreement with radical feminists concludes that manhood is proven most effectively when men use women as objects to satisfy their sexual pleasure.

### 4.3.3 The effects of technology on sexuality and HIV prevention

More than half of the participants expressed that in order to gain insight and better understanding of their sexuality they seek pornographic films to assist in their sexual performance and find exciting ways to pleasure their male partners. Notably, Ellen a 47–year-old married woman explained that:

"Those movies helped me to gain the confidence to initiate sex and do the woman on top position". In support of Ellen's position Cindy, a 29-year-old married woman, said that "Even the young one's [young girls] you cannot teach them anything, everything they know comes from those movies … they know everything now".

It had been observed during discussions and interviews that the participants perceived women in the pornographic films as sexually liberated and sexually assertive. Additionally, participants added that the actresses in the films appear to know what they are doing and are doing it well. Moreover, women's pursuit of a liberated sexuality and the desire to unveil their enigmatic sexuality through technology is a surprising finding, one that has not been documented in literature. Turning to the relevance of social constructionism and sexual scripting to the research data, women's responses highlight the view that their sexual reality is socially constructed (De Lamater and Hyde 1998: 13). This is manifest in the way that they observe technology in order to understand and to learn how to express their sexuality. Technology is a form of social construction that poses a challenge to women. Since women acquire sexual knowledge through technology, they are unknowingly allowing society to dictate to them how their sexuality should be experienced and expressed.

Society informs technology leading to women being oppressed and subverted by males because they will be producing what patriarchal society has provided in technology. Pornographic films have largely been a male-dominated sector largely directed and viewed by men. Most pornographic films are directed or produced by men which implies that they determine how images of women are projected in the films so as to make it appealing for the male viewer. As a result, women internalise the images and sexual scripts generated by males, which are often for the benefit of the male viewer. The above argument ties in well with Chambers' assertion that women's desires are a product of the norms and expectations of a patriarchal society (2005: 327).

In stark contrast, Ferguson asserts that women who watch pornographic films reflect the nature of their repressive society, therefore pornography becomes an outlet for sexual liberation and rebellion (1984: 114). Ferguson's sentiments are in line with participants' revelations that pornography makes them feel liberated and a sense that they are rebelling against cultural notions of the woman as a passive sexual being. However, what concerned the participants in terms of films is that instant gratification of sexual desires is glamorised

and accepted as the norm and this often entails the non-use of condoms. It was a general agreement that the pornographic films that the majority of individuals have been exposed do not encourage the use of condoms. Therefore, this implies that condoms are a hindrance to sexual satisfaction and pleasure. WHO (2013) identifies HIV to be transmitted through unprotected sexual intercourse either anal or vaginal. The danger with the films is that they are potentially enabling the stereotypical societal views on the unattractiveness of condoms in sexual encounters.

### 4.3.4 Rural women and HIV prevention

What was common in discussions was that all women (young, older, married and single) have created a persona of what makes them women within their rural context. This includes how they need to behave and act so as to uphold the image of a respectable, rural, cultural woman. The participants expressed that the manner in which rural women express their sexuality and how they carry themselves in a sexual encounter should be a reflection of respect for culture. Evidently, participants' responses revealed that rural women separated themselves from city women and view their positions and duties as upholding the moral values and standards as constructed by their cultural context as opposed to some city women who behave and act as they please. Angel, a 22-year–old, single woman asked a controversial question in her articulation of rural women's sexuality she said; "Where have you heard of a black rural woman sucking a man down there?"

Angel's response highlights a weakness in the literature which separates the two categories of women as revealed by the participants. Furthermore, literature on female sexuality needs to recognise that South African women are a heterogeneous group originating from unique contexts that shape their perceptions of sexuality and HIV prevention behaviours, values and practices. As a result, the researcher has observed that literature that addresses female sexuality has combined urban and rural women. This poses a challenge in understanding women's sexuality and the socio-cultural factors underpinning those sexualities. Similarly, women inferred rural women engage in sexual practices that are deemed appropriate in accordance to their context. In the same way, some city women engage in sexual practices that the participants deem inappropriate for a woman of their character, for instance; the participants made reference to sex toys that some city women use while other participants

mentioned ladies' 'sex parties' (where women gather to talk about sex and view the latest sex toys). The findings corroborate with Sexual Scripts and Social Constructionism theories in that participants' sexual life is subject to socio-cultural moulding of the good traditional woman, this includes passivity and submissiveness as symbols of respect (Gagnon in Parker 2010: 59).

According to Mofolo (2012: 3) African women are socialised into being respectful and humble to their husbands, this includes being passive during sexual activities and accepting the male partner's decision on non-condom use during sex. As a result, rural women will continue to remain vulnerable to HIV infection.

## 4.4 Perceptions of traditional and modern female sexuality and HIV prevention

### 4.4.1 Western culture, sexuality and HIV prevention

According to Tamale (2006: 24), traditional sexuality is complemented and enhanced with 'modern' and 'foreign' sexual practices. Participants explained that when it comes to sexual matters they find that Western culture's sexuality is easiest to relate to because it is highly popularised in the media as an exciting means to explore one's sexuality and to keep the male partner interested in them.

All the participants agreed that they at times envy city women as it seems they have fully embraced Western living and are sexually liberated with no negative consequences. Consequently, literature asserts that women's gloom-ridden perceptions of African or traditional sexuality may be attributed to negative stereotyping and purposive marginalisation of black sexuality as associated with overpopulation (Dickerson and Rousseau 2009: 315). Under Apartheid, social constructions of black sexuality led to their White counterparts blaming Black people for being responsible for spreading HIV (Petros, *et al.* 2006: 70). Moreover, the participants stated other reasons for finding Western culture desirable such as the dual view of sexuality as a means of pleasure and procreation. Patricia, a 32-year–old, married woman retorted that Western society's views of sex are mostly those of having 'fun'. They further reported that with African culture they felt that there must be a reason to have

sex, "it is either 'ba-be' (husband) wants to have sex or you are planning for a baby". Other participants disagreed in stating that culture has no issues when two married people are enjoying themselves, the problem lies with the individuals engaging in sexual activity. In the statement below Felicity, a 34-year–old, married woman explains in the face-to-face interview how the FGDs made her realise the dilemma that faces women who want to have sex to pleasure themselves as well:

> "I feel I will enjoy sex more if I start to utilise my body in a way that I will feel pleasure too. But in my mind I will always think, culturally it is not allowed and acceptable to even initiate sex because I am a woman."

It is observable that women view Western culture as offering sexual equality in the context of sexual relationships. This interprets as women needing to have sexual freedom and rights to control their sexuality. Moreover, Oriel (2005: 398) affirms that male control over women's sexuality is measured by their refusal to wear condoms during sexual intercourse, thus threatening women's sexual health (Oriel 2005: 398). In contrast, despite participants' apathy on their sexuality within their 'oppressive contexts' Tamale (2006: 25) offers hope in stating that women can use sexuality as a manipulative tool that can be empowering, and even subversive women can interpret this to HIV-preventative behaviours. Indeed, feminists concur that sex and its history of power may become a possible weapon of self-assertion for women (Shulman 1980: 600).This presents a possibility of decreasing the HIV-prevalence rate among women in South Africa's rural areas. On the other hand, a concern is that HIV infection is linked to African sexual norms and practices only. Furthermore, those that are practicing Western cultural norms appear to be exempted from the disease, this creates a false sense of security through denial of one's own cultural groups' exposure and vulnerability to HIV (Petros, *et al.* 2006: 70).

### 4.4.2 Women, Lobola and HIV prevention

Lobola is a significant element of marriage among the participants, translated into English as bride wealth or bride price. According to Lindegger and Quayle (2009: 44) the social

construction of lobola bestows on men the right to be in control of all aspects of their wife's life, in particular her sexuality. This observation correlates with the study's findings, where women reported that for married women their duty is to engage in sexual activities that please the husband so as to ensure that he does not leave and is kept satisfied. As a result, women are left in vulnerable positions in relation to condom use, Jolly (2005: 2-3) concurs that culturally it is not acceptable to propose condom use.

Moyo's (2004: 75) assertion ties in well with the findings that in order for women to maintain their marriages, their main goal should be to satisfy their husbands sexually, thus women serve and the men enjoy the fulfilment. Participants'(both young, married, single and older) responses manifested the perception that for women the expectation is that they need to satisfy the sexual desires of their husbands and this serves as a means of complying with the 'marriage contract' (Kambarami 2006: 4; Oriel 2005: 397). In the context of this study Kambarami (2006: 5) views lobola as an instrument of patriarchy that perpetuates the subordination of women. Seen in this light, it is observed that lobola dehumanises women and relegates them to the status of commodities. In line with this study's findings Chireshe (2010: 212) argues that lobola is part of the patriarchal nature of African societies that breed inequality and widen the gap between men and women thereby placing women in subordinate positions. Felicity, in agreement with the above statement, explains that:

> "In our tradition, when a woman is about to get married the elderly women such as aunts and grandmothers advise her on what to do once she arrives in her matrimonial home. Her duties extend beyond cooking and cleaning, the main task is to open up the legs and serve. It is considered a 'sin' if a woman is too tired or too sick to have sex with her husband, because you not there to sit and stare him in the eyes."

Felicity's argument resonates with radical feminists' notion that marriage and relationships are patriarchal society's design to oppress women, and such relationships are a manifestation of gender inequality occurring in a wider social space (Ferguson 1984: 111) . Felicity's argument is a raw account on the objectification of women that simply states that 'He paid for you, so give him his money's worth'. What is more, is that the negative constructions of married women are imposed by women. This demonstrates that some of the women do not hold themselves in high esteem fostering the image that their duties in the household end at

catering to the male's satisfaction and nurturing the family. Therefore, Ferguson, *et al.* (1984: 111) label this type of behaviour as 'cultural sadism' that men are consumers of sex and that women are providers of sex. Peggy, a 32-year–old, married woman illustrates the extent of women's subordination as she argues that: "Even if you are cooking, he makes you leave the pots and go 'sika le khekhe'." (Translated as 'cut the cake', where ikhekhe is slang for a woman's genitalia.)

Kambarami affirms that socio-cultural constructions of men's sexual entitlement obstruct women's HIV-prevention efforts, because women cannot insist on safer sex measures (Kambarami 2006: 4; Oriel 2005: 397). In addition, participants explained that when lobola has been paid for a woman it places limits on her decision making particularly with condom use, Ellen conveyed that for married women negotiating terms of condom use is not an option. Moyo (2004: 75) corroborates this finding and explains that women and girls are socialised to embrace the feminine role of submissiveness, thus they cannot communicate the need for condom use in the sexual relationship.

The findings relate to those of Chabata (2012: 12) whose participants stated that they found it hard to negotiate safe sex since their husbands simply say "Did the cattle we paid go with condoms on?" While most of the women viewed lobola as a valued part of African tradition, however, they also viewed it as a financial transaction which disadvantages women particularly in HIV-prevention efforts. As a result, radical feminists maintain that women are subordinated within marriage and, at the same time, are forced to marry for social legitimacy (Wellis 1984: 98).

This study's findings correspond with Chabata's (2012: 13) study findings where women are happy with the idea of lobola because it confers a certain status on them within their socio-cultural contexts and among their kin. However, women have concerns about the manner in which they are disadvantaged by lobola in particular if a man has paid a substantial amount for the woman she is then forced to do anything that pleases the husband because he has paid a lot of money for her, thus impeding on women's HIV prevention. Accordingly, feminist tenets maintain that sexual relations are constructed through the fundamental principle of division between the active male and the passive female (Chambers 2005: 330). Women are advised to endure the hardships of marriage because the husband has paid lobola, the participants revealed that older women would even advise a woman that if she leaves her

marriage or disrespects her husband where will they get the funds to pay the husband's family back?

### 4.4.3 Women's sexual repression is a Habitus

The perceptions of female sexuality requiring control and repression was a central focus throughout the face-to-face interviews and FGDs. First, women likened exploration and expression of their sexuality with moral looseness and bitchy behaviour. Secondly, the participants emphasised that most male sexual partners do not appreciate a woman who freely expresses her sexuality and find it to be culturally unacceptable behaviour. Wellis (1984: 105) identifies feminine behaviour as both enforced by the environment and internalised by the affected individual, in this case, women. More than half of the married participants agreed that women must control their sexual urges and desires lest they commit indecent acts with a male that is not their partner. Most of the participants attributed sexual repression to cultural norms and teachings, this is reflected in Felicity's response as she articulates that: "I think the elders taught us to control ourselves because with us they know everything develops".

Felicity makes manifest the shared sentiments by participants that a woman cannot possibly explore or express her sexuality freely whether alone or with a male partner as this may be regarded as non-feminine behaviour. As a result, Wellis (1984: 105) concludes that women are trained from birth to conform and accept the unequal roles as right and natural. Consequently, the participants excusing male behaviour is an integral part of the socially constructed dominant femininity and essential for keeping a male partner, the disadvantage is that it often entails tolerance of non-condom use (Jewkes 2010: 6). In line with the study's findings Wellis (1984: 107) affirms that this patriarchal stereotype of the good woman entails the need to suppress bad desires (sexual). Felicity explained that: "You must wait on him to ask for it, you need to suppress your feelings, because women do not ask for it" [sexual intercourse].

Felicity's argument demonstrates that sex is a matter of power and control, women are therefore socialised not to display power within sexual relationships because it is only acceptable for males to display that power. Additionally, women are disadvantaged by this as male power descends to other parts of their lives and threatens their sexual health. According

to participants the consequences of not suppressing or repressing their feelings will lead them to being referred to as prostitutes or bitches. In line with these findings, literature observes that women's perceptions of repressing sexuality are rooted in the strong cultural messages that women receive that they should be passive, innocent or be held accountable for how they are treated by men (Jewkes and Morrell 2012: 1730).This resonates with Shulman's affirmation (1980: 595) that because patriarchal norms enforce that women should control and repress their sexuality, failure to do so results in women being held responsible for being raped.

The concept of *habitus* is introduced in this study due to its relevance in understanding participants' perceptions of their sexuality. Habitus explains the manner in which social norms become embedded in individuals. Thus, as people respond to the circumstances within which they live they become accustomed to those responses and over time repeat them with little or no conscious awareness or choice (Chambers 2005: 330). In terms of the study's participants it is observed that patriarchal prescriptions of sexual repression do not need to rely on heavy-handed and a resistance-prone mechanism, instead compliance is secured from women and they are accepting this as right and natural. Therefore, this corresponds with Jewkes and Morrell's observations that women are involved in shaping the contours of patriarchal norms and expectations (2012: 1729) . In addition, Bourdeieu (in Chambers 2005: 330) affirms that women apply 'categories' constructed from the point of view of patriarchy, thus patriarchy succeeds in making these constructs natural to women.

In general, some of the participants reported that until they took part in the FGDs and interviews, they took it as natural that women are subordinated in sexual relationships and that they have to repress their sexuality without consciously thinking about its relevance in the current relationships that they are in. They understood free expression of sexuality as wrong and even they themselves viewed some women who are sexually liberated as loose because those are the conversations they grew up with, they mentioned that they fear being called *Ingwababane* (bitch) hence they comply by repressing their sexuality. It was further debated that their perceptions of repressing their sexual desires is mainly out of the fear of losing sexual control. Generally, the participants critically discussed the notion of repressing their sexuality and reported that even if they were sexually aroused they would never be sexually promiscuous. They then presumed that they were encouraged by elders to repress their sexuality out of fear that they would fall pregnant at a young age.

However, some women stated that the general perceptions of HIV prevention in their contexts is that condoms are a new thing and women who suggest their use or even carry them are referred to as *ever ready*.

### 4.4.4 Traditional sexuality and HIV prevention

Through constant laughter and giggles sexuality was framed by the participants as an area of embarrassment and laughter (Bhana 2009: 598). This is because traditional African sexuality is riddled with mystery, taboos and secrecy, thus probing on issues of sexuality invoked varied reactions from participants. This is due to the fact that in traditional societies like Schoemansdal, sexual communication between partners or amongst women themselves is considered culturally inappropriate. Ellen added that topics of sex are considered vulgar language and a disrespect to cultural norms. Therefore, metaphors and symbols play a central role in the Schoemansdal context. In the interviews and discussions metaphors and symbols provided an acceptable medium for communicating about sexuality, shifting from the 'private' to the 'public' realm (Tamale 2006: 21). Again, Tamale adds that such coded communications about sexuality are decipherable by women and other adults, but hidden from children and outsiders (2006: 21).

In line with the study's findings Francouer, *et al*. (2004: 570) outline that African cultures' sexual communication taboos are reinforced by male privileged social controls designed to repress sexual communications and to keep women misinformed about and often ignorant about their sexuality and sexual pleasuring. This is discussed in greater detail in preceding subthemes, where women equated their sexuality to heterosexual sex and sexual pleasuring to the sexual pleasure of the male partner. As a result, participants presupposed that the silence surrounding sexuality in their community and families poses a risk of HIV infection particularly in women. They further reasoned that in the area harmful sexual practices are still performed by a large percentage of women, but because women isolate themselves with regards to sexuality they end up performing these harmful sexual practices in order to please the male and unknowingly increasing their chances of HIV infection. Felicity a married, 34-year-old woman in the face-to-face interview explained that by being silent, culture has jeopardised their sexual health as opposed to protecting them:

> "What I have realised is that nothing should be kept secret (in the age of AIDS), so I feel culture has greatly misled us in keeping sex a secret … hiding things leads to wrong doing."

Participants' perspectives concur with Turmen's (2003:412) finding that social norms reinforce women's lack of understanding of sexual health issues, leaving women to bear the brunt of social stigma and discrimination. Thus, the sexual experiences recounted by women indicate that traditional sexuality regards silence and submission as appropriate responses expected of women (Outwater, Abrahams and Campbell 2005: 141) .The study's participants added that traditional sexuality dictates that they remain silent and passive in sexual decisions and allow men to take the lead (Moyo 2004: 73). As a result, this poses a hindrance in women's decision making regarding condoms as a woman who is assertive in a sexual relationship is understood as showing disrespect and defiance to culture and to the man (Jewkes and Morrell 2012: 1730). Even if women are aware of their risk of HIV infection they will not contest non condom use because it is not a representation of an Africa traditional woman. These findings highlight authors' assertion that accurate knowledge of HIV and awareness of personal risk does not necessarily result in protective behaviour (Nicholas 2010: 496; Takyi 2003: 1223).

The study's participants (married, single, young and older) responded that in terms of traditional sexuality, culture dictates the where, when and the how of sexual behaviour. Sexual drives, desires and sexual activities are learnt from the socio-cultural environment. This is the view expressed by social and sexual constructionist theorists (Gagnon 1990: 6; DeLamater and Hyde 1998: 14). Furthermore, parallel to social and sexual scripting theories, Felicity stated that she has conditioned herself that during sexual intercourse only her husband will enjoy the first round of sexual intimacy because that is all she knew and was advised. This implies that traditional sexuality requires that the satisfaction of male pleasure supersedes female pleasure (Oriel 2005: 398). Indeed, Busisiwe, a 59-year-old divorcee highlighted that she feels pressured to fake an orgasm "You have to scream to show him you are enjoying and its stupid" because it is considered pleasing to the male. The responses by participants corroborates with Shulman (1980:594) who affirms that an orgasm is a sign of male virility and that the woman is enjoying the sex. The findings reveal that women's

sexuality is defined for them and are taught to utilise it for the benefit of the male (Kambarami 2006: 2).

### 4.4.5 Elongation of the Labia minora and HIV prevention

In examining the phenomenon of rural women's sexuality, it has been observed that a high percentage of women in Schoemansdal perform the cultural practice of 'pulling amalebe' (labial stretching) for factors such as beauty and sexual pleasure. This finding correlates with Tamale's (2006: 26) findings that women have always transformed their bodies to fit their cultural norms and labial stretching is one such way. The participants stated that labial stretching formed a part of sex education in the initiation schools that they attended, and they were assigned an older woman to assist with the pulling while in the fields picking wood. Some of the women who have done this practice expressed that it was a painful experience and that it diminished their sexual excitability while, on the other hand, increasing the men's.

Relevant to this study's findings, Khau (2012: 771) puts forward that African sexual practices that aim to prepare girls for womanhood and marriage display an absence of female sexual pleasure. Thus, socio-cultural society's intent to repress and silence women's sexual voices is maintained through such sexual practices that aim to modify and mutilate women's genitals for male satisfaction. What is more, these practices are performed and maintained by older women to prepare girls for male enjoyment. The participants also stated that this practice is most effective in the absence of condom use in order to achieve maximum pleasure. This exposes women to various infections including HIV.

In contrast, more than half of the participants (married and single) stated that women who perform these rituals maintain that even though it is an old, traditional practice its effectiveness is proven by the male reaction and this becomes a competition of who has the longest 'amalebe' (labial). Interestingly, in studies on labial elongation women reported that this practice was their secret to express an area of power that they have been developing and protecting (Bagnol and Mariano 2009: 2). Conversely, the study's findings contradict this notion as women reported that they would prefer not to continue to perform this practice any longer. The concerns among participants were that they found it demeaning 'to have things hanging from their genitals' some recounted that some men, particularly city men, are not

familiar with this practice and may be turned off by them or even terrified. Busisiswe, one of the older women, argued that: "If you can review them (amalebe) you'll see that they are useless, a few men nowadays are put off by a woman who has them, so then what's the use and they also bring disease". In agreement: Elizabeth, a 49–year-old woman argues that: "Even if women are aware of the dangers of HIV infection that these practices pose. I mean we have known about HIV even before the year 2000, but they still do it as long as they believe its pleasing to the man, you cannot tell them nothing when it comes to that".

The above statements illuminate that women's sexuality has been constructed in a manner that is pleasing to men, thus male pleasure supersedes that of the female. Furthermore, authors agree that labial elongation does not pose a health risk to women (Bagnol and Mariano 2008; Khau 2012; Korster and Price 2009). However, participants' responses refute this argument citing that the herbs and botanicals women use to ease the pain of stretching pose a risk of HIV infection and STIs because they produce a discharge-like substance in the vaginal area, promoting favourable conditions for infections to occur. The participants further noted that stretching promotes swelling, and because topics around sexual practices are taboo some women are not well informed on which types of botanicals to use. In contrast, Tamale (2005: 273) describes that these practices offer empowerment to women's silent struggles against colonialism and post-colonialism forces whose aim is to impose a modern view on African sexual behavioural practices and beliefs. However, research findings dispute Tamale's viewpoint for the reasons that women find labial elongation to be a degrading experience and demeaning to women. In addition, the elongated vaginal labia are often described by the metaphor of a door (Bagnol and Mariano 2008), thus below Busisiwe explains that the word hole is used when the labia are not elongated in a form of ridicule or insult to young girls and women: "My grandmother used to pull us and a few of my cousins and friends she said that girls who do not pull they are 'ingwababane' (bitches) because their things [vagina] are holes that men can drown in".

In agreement with the study's findings Tamale (2006: 26), adds that if a bride was found not to have elongated her labia minora, she would be returned to her parents with disgrace as she is regarded as having a pit. This reveals the extent of women's degradation. As a result this practice can be classified as genital mutilation because women are discriminated against on the basis of not pulling *amalebe* thus constructing distorted perceptions of femininity. Again, participants explained that in the olden days if a woman did not have amalebe she was not

considered a ‘real’ woman, thus they had to resort to this practice not for pleasure but to gain the identity of being called a woman. Despite the reported disadvantages, little or no research has been conducted in an effort to understand the impact of this cultural practice on the transmission of HIV and other related infections such as STIs (Sexually Transmitted Infections) (authors include Leclerc-Madlala *et al*. 2009; Bagnol and Mariano 2008; Khau 2010; Inungu and Karl 2006).

In summary, the study’s findings are in conflict with Tamale (2006: 27), who asserts that the labial elongation practice enhances sexual experience for both the male and the female, when touched or manipulated during foreplay they may be a sense of immense pleasure to the couple. Moreover, Chapter two of this study highlights that African genital modification practices are classified and condemned as type-IV female genital mutilation because they pose health hazards to women. However, harmful cosmetic procedures that are sometimes performed in the contexts of Western culture are not listed as female genital mutilation, these include clitoral piercings and vaginal cosmetic surgery (Tamale 2006: 27).

### 4.4.6 Dry sex and HIV prevention

According to Mariano and Bagnol (2008: 10) amongst the various reasons for the use of vaginal products is the association of the idea of virginity with narrowness of the vaginal orifice. Participants reported that some women within their social context insert alum, dried leaves or snuff inside their vagina in order to reduce lubrication and to increase friction during sexual intercourse. The older women outlined that the use of these drying agents ensures that women remain virgins forever even in old age. In addition, all participants stated that women in the community who prepare themselves for dry sex do so to steal other women’s men because sex would be more enjoyable with them. In addition, participants’ stance on women who utilise drying and tightening agents ties in well with Leclerc-Madlala, *et al.* (2009: 19) that these agents are used as love portions to retain the affections of a partner. The study’s findings on perceptions of female genitalia resonate with radical feminist views that women are forced to live up to genital labels that regulate the division of genitals into groups (Chambers 2005: 339). Thus, in the context of this study hard and soft (men) versus dry and wet (women). It was observable from the discussions that women do not

question the value judgements which are attached to the aforementioned characteristics, subsequently contributing to structural inequalities (Chambers 2005: 340).

Dry sex can exacerbate women's risk of HIV infection, as their vagina tightens it becomes inflamed due to friction leading the vagina to tear, thus creating an entry point for infections (Inungu and Karl 2006: 3; Mariano and Bagnol 2008: 11). Some of the participants were vociferous in their disapproval of harmful sexual practices and choose not to perform them. The perceived consequences of dry sex as reported by the participants were swelling as well as the peeling away of the skin in the vaginal area due to alum and snuff. To corroborate this study's findings, in Mariano's (2008: 11) study conducted among Mozambican women, the participants also reported experiencing exfoliation of the vaginal mucosa, vaginal lacerations, burns, swellings and increased secretions. Thus literature asserts that excessive use of these products has severe and unexpected effects (Mariano and Bagnol 2008: 11).

The study's participants suggested less harmful and severe measures to women among them in the group who may be participating in this practice and are concerned about male pleasure and their sexual performance. To tighten the vagina two participants - Ellen and Cindy who come from different generations - suggested that women immerse the vagina in cold water and wipe it completely drying it out. The participants considered this as a safer option for women and increases pleasure for both partners. However, although the practice appears safe for women, the researcher contends that any form of vaginal tightening requires that there be direct contact between the vagina and the penis in order to obtain greater sexual pleasure. This practice is not vastly different to utilising drying agents because both practices aim to tighten the vagina to increase friction thus promoting tearing during sexual intercourse. The study's findings are parallel to literature that social structures are reproduced in the individual through interaction, thus individual sexual behaviour is a derivative of the social process (Chambers 2005: 330; Simon and Gagnon 1984: 111). As a result, the study agrees with Vance that Schoemansdal women's sexuality is channelled socially rather than biologically (Vance 1999: 878; DeLamater and Hyde 2010: 14).

### 4.5 The effect of religio-cultural perceptions on female sexuality on HIV prevention

### 4.5.1 Beliefs and constructions of sexuality

Schoemansdal society is a very religious society of devout Christians, at the same time upholding cultural beliefs and rituals. However, religion has the strongest influence upon the thinking and actions of the women. Research has found that religious affiliation has the greatest impact on the dynamics of HIV and AIDS behaviour (Toefy 2009: 237). In accordance with participants' discussions the cited religion exposes women to the risk of HIV infection through various teachings. It can be observed that women are perceived as husband's helper and object of pleasure. The study participants alluded to the bible in the book of Genesis chapter 1 verse 8, "God said unto them, be fruitful, and multiply…". This gels with participants' views that they are continuously subjected to subordination due to teachings and beliefs that border on patriarchal values and norms.

In addition, women who are members of the Roman Catholic Church maintained that condoms are a taboo topic due to the view that they go against God's will and His plans for procreation. Takyi (2003: 1224) concedes that religious organisations' views of female sexuality hinder individual actions of using condoms because they go against the church tenets. The study's findings corroborate with Moyo (2004: 61) that African women struggle to grapple with religio-cultural definitions of them. As with society, women in church are in continuous conflict with the quest for gender justice within the church (Moyo 2004: 61). Correspondingly, in the quest to explore the indoctrination of women within the participants' religious organisations the researcher alludes to a quote found in the bible in the book of 1 Peter chapter 3 verse 7, "In the same way you husbands must live with your wives with the proper understanding that they are the weaker sex…". This illuminates Moyo and participants' arguments of the inequalities women experience due to them being females. Thus, because women are viewed as the weaker sex they are then compelled to be submissive in sexual relations as well, this includes being passive in matters relating to condom use. For this reason, Moyo (2004: 73) argues that African religion plays a vital role in gender construction.

In addition, the women stated that the church has managed to silence their voices regarding sexuality and HIV prevention even amongst women themselves, an example of ladies' prayer meetings is given. In the same way participants stated that even if the subject of HIV comes

up, the women are guided by older women within the church to always remain faithful to their partners and submit to them. Notably, the participants further reported that even if the male is unfaithful it is 'ok' as long as she remains faithful to him. This statement echoes feminist tenets that men appear to be excused for bad behaviour, in fact it is expected from them as a sign of masculinity, whereas women are educated on remaining with one partner or be blamed for bringing disease into the home. As if to say that, by being a good wife and staying at home God will reward them and exempt them from HIV infection. In relation to the foregoing argument, Ellen stated that she has confidence in this quote from the bible as, according to her, it teaches repression of sexual feelings which that may lead to wrong doing and HIV infection:

> "The book of Corinthians says that [Corinthians 1 chapter 7 verse 3-5] "the husband should fulfil his wife's sexual needs, and the wife should fulfil her husband's needs. And the wife gives authority over her body to her husband, and the husband gives authority over his body to his wife… you should come together again so that Satan won't be able to tempt you because of your lack of self-control".

Ellen's quotation confirms that it is believed by the women within their religious organisation that women need to exercise self-control so as to avoid committing sin and getting infected with HIV and sexually transmitted infections. It is observable that the male is exempted from practicing self-control because it is in their nature. The concerns the participants put forward were that the implication is that they are responsible for bringing disease and they question what happens to their sexual health and safety if the husband has multiple partners. Thus, they perceive that the messages they receive from church are not geared towards HIV prevention but to stigmatise and subordinate women. Busisiwe argues that pastors: "Must practice what they preach [concerns that wrong messages are sent to men], otherwise it is up to me as an individual to take the decision to protect myself against HIV".

In response to the above statement the participants reported that church has turned a blind eye on HIV prevention, instead the focus is on general health, social support and coping mechanisms for People Living with HIV and AIDS (PLWHA) as that appears to require less effort and behaviour change among the individuals within the church. Cindy, in frustration at

the silence and inequality within the church, states that: "We black people are dying … we choose to stay silent".

Cindy's sentiments collaborate with literature that both silence and denial about HIV and AIDS in the church can be dangerous in that it prevents people from accurately assessing their own personal risk of infection and also reinforces the view that HIV and AIDS are conditions that affect not the self but others (Petros, *et al*. 2006: 68).

### 4.5.2 Acquisition of sexually transmitted infections

The study's findings are in tandem with various literature which states that high levels of HIV knowledge do not necessarily lead to sexual behaviour that inhibits STIs or HIV infection (Outwater, *et al*.2005: 144; Nicholas 2010: 494). Some of the women (both married and single) revealed that they have had visits to the clinic numerous times for STI treatment. According to the literature (Gillbert and Selikow 2011: 327; Turmen 2003: 411) biologically women are predisposed to higher susceptibility to STIs and subsequently increasing their risk of acquiring HIV during sex. Felicity explains that when she sees an abnormal discharge and rash in her vaginal area she explains that she is aware that she has acquired an STI. Then she will visit the clinic and from the clinic she will discuss with her husband that because of the STI they will need to start using condoms. She explains that her husband does not object - he cooperates every time.

Felicity's experiences are socially constructed. This is evidenced by the male partners' perceptions of a diseased female sexuality - the females are the ones with a problem and thus they are in need of treatment and, in the meantime, condoms will be utilised. This view is highlighted by participants who are married reporting that they have never been unfaithful within their marriage but are constantly faced with the task of seeking treatment and not questioning the male about his sexual behaviour or even suggesting treatment for him. The study's participants attempted to normalise their STI experiences within their relationships citing it as female problems and likening it to premenstrual syndrome symptoms and their monthly family planning visits to the clinic. The alarming perceptions of normalising STIs that women unveiled creates a challenge for HIV prevention and increases their prevalence of getting infected with HIV.

The findings on possible reasons for women's seemingly blasé attitudes towards infections are in line with literature, this is because in African culture sex is viewed as essential for women's success (Jewkes and Morrell 2010: 4). Thus cultural practices of respect have promoted obedience and passivity as hallmarks of African femininity (Jewkes and Morrell 2010:4). Therefore, the concept of *habitualisation* corresponds with how women have learned to internalise the good woman image that has been firmly established in them and appears natural and normal, hence references to women's premenstrual cycles are made because those are a natural part of women's lives.

### 4.5.3 Condoms and HIV prevention

From the interviews and discussions, women hinted at the fact that condoms diminish the pleasure of both partners and that they may be viewed as a sign of distrust. In addition, studies have found that women are not passive in their sexual relationships and they are in positions to both facilitate and oppose the use of condoms (Jewkes 2009; Jewkes and Morrell 2012). In line with the study's findings, literature reports that women in committed relationships believe that condom use implies distrust and unfaithfulness on the part of the individual initiating the use of the condom (Kennedy and Jenkins 2011). Felicity expressed that as a married woman a condom for her is not an option because she knows that she is faithful and she expects her husband to be the same. In agreement Lindy said a condom delays her husband's ejaculation during sexual intercourse. Ellen raises the same experience as she explains that her husband complains when using condoms as he feels as though he is not with a woman.

This highlights that condoms are not accepted as way of protecting oneself from HIV infection because they conflict with both women and men's desire for pleasure. Moreover, in agreement with the literature, the participants' observable suspicions that chances of keeping their partners in the competitive world of multiple concurrencies are greater with flesh-to-flesh sex (Jewkes and Morrell 2010: 6). Consequently, the findings concur with literature that women opposing the use of condoms in their relationships makes relevant the report that they are equal participants in activities that position them at risk of getting infected with HIV (Jewkes and Morrell 2011: 1732) .The participants also detailed that condoms are readily

available in clinics and they do not perceive to be judged negatively at the clinic by taking condoms. With this said, half of the participants stated that condoms still do not appear as an attractive solution to HIV prevention and the fact that it is not an individual decision makes it more challenging. On the one hand, others were positive about condoms citing that they have the same effect as 'skin-to-skin'. However, what was common is that women would be pleased to utilise condoms as long as their partners support and accept their decision.

## 4.6 Limitations of the study

The results of this study cannot be generalised to all women in South Africa's rural areas because the research participants represented a small sample of women from Schoemansdal that had been selected to participate in this study. Travelling was also a challenge as the research participants' location is in a different province to that of the researcher. Another challenge was synchronising the times that all the participants were available.

## 4.7 Conclusion

This chapter presented the profile of the rural women who participated in the face-to-face interviews and focus group discussion. It also critically analysed and discussed the research findings. Research findings of the study led the researcher to draw the following conclusion: That the findings of the study are consistent with the literature reviewed in Chapter 2. The findings of this study reveal that women are at risk of HIV infection as a result of their socio-cultural contexts and gender constructions that favour men over women. The study's participants displayed an awareness of HIV-preventative methods, but their behaviour is not always in harmony with such practices, this includes the use of condoms during sexual intercourse. The following chapter will present the key findings of the study and some recommendations.

# CHAPTER 5

## CONCLUSION AND RECOMMENDATIONS

### 5.1 Introduction

The analysis and the interpretation of the research findings were discussed in Chapter 4. This chapter presents the key findings and recommendations of the study. The aim of the study was to explore rural Schoemansdal women's perceptions of sexuality and HIV prevention.

The study's objectives were as follows:

1. To explore rural women's perceptions and experiences on issues of sexuality and HIV-prevention within their rural socio-cultural context.
2. Explore the differences and similarities of traditional and modern perceptions of female sexuality and HIV prevention within the socio-cultural context of these women.
3. Explore the manner in which perceptions and some sexual practices decrease rural women's vulnerability to HIV infection.
4. Explore the manner in which perceptions and some sexual practices increase rural women's vulnerability to HIV infection.

### 5.2 Key findings of the study

The study's findings are that cultural power dynamics of gender and the constructions of femininity along with sexual cultural practices impact negatively on women's ability to protect themselves from HIV infection. The study corroborates with Social Construction and Sexual Scripts theories because the participants' subjectivity and behaviour are given meaning by the cultural labels that frame and influence the participants' sexuality and affective experiences. This research study has answered the four research questions posed earlier and has identified women's socio-cultural contexts as factors that hold women back from exploring and understanding their sexuality and impede upon their HIV-preventative behaviours. The research participants, both young and old, indicated that they understood

sexuality as being sexually intimate with a male. They further added that passivity in a sexual relationship is often encouraged. As a result, women manifested that they now have distorted images of their sexuality, leading to labels of their genitalia as 'semen ditches' because of the constructions of the passive nature of a traditional rural women. Consequently, this renders women vulnerable to HIV infection, because they do not view themselves as sexually liberated as compared to some women in the cities.

Moreover, the young and old participants added that they identified with women featured in pornographic films as they make it appear possible for women to explore their sexuality and to experience sexual freedom in intimate relationships. However, the detriment to women of exposure to these films is that they are recreating social constructions of what is expected of women in sexual relationships and what female sexuality to be. For this reason, it can be observed that technology is a product of a patriarchal society that subordinates women with regards to gender constructions and inequalities. The context of pornographic films may contribute to women's HIV infection risk in that the films are seen to be omitting condom use during sexual intercourse. As a result, the image of sex without a condom is cultivated in women and the belief that condoms offer no spontaneity and excitement during sexual intercourse is enforced. Thus, the study's findings affirm the relevance of social construction, sexual script theories and Radical Feminist Theory because women have internalised socio-cultural expectations and norms of their sexuality, thus leading to their subordinated positions in their contexts.

In the same way, the study's results found that women sought sexual liberation but want to be viewed as respectable cultural women. This reflects the standpoint highlighted in the literature that individual (women's) behaviours are a derivative of social processes. This correlates with feminist literature that women have adopted qualities of femininity entrenched by the patriarchal socio-cultural environment. It was also observable that women wish to explore a playful side of their sexuality, citing that with Western culture individuals engage in sexual activity to have fun as opposed to African tradition that insists on suppression of sexual desires in women and the view that sex is for procreation and for the male's request. Thus, this resonates with literature arguments that if women find themselves sexually fulfilled during sexual intercourse, then they should count themselves blessed because it does not form part of the patriarchal culture that subordinates women and emphasises the control of bad sexual desires.

In summary, the study found that there were no sexual practices that appeared to decrease women's vulnerability to HIV infection. In addition, factors that appeared to diminish women's opportunities to decrease their vulnerability were identified as the religious beliefs and religious culture. It was observed that religion impacts women's HIV vulnerability, in particular because condoms are perceived by religious organisations as going against the Church's principles. As a result, the participants reported that the bible is utilised as a means to keep them in subordinate positions both in the household and in their intimate relationships. Consequently, religion is observed as a reflection of patriarchal societies' norms aimed at oppressing women by virtue of fostering gender inequalities that mirror women's struggles to adopt safe sexual practices in order to decrease their vulnerability. The study found that some women oppose the use of condoms citing that it diminishes their sexual pleasure and performance. Thus, women as much as men perceive condoms to be a hindrance in acquisition of pleasure. This is despite the fact that heterosexual sex is the most common mode of HIV transmission in South Africa.

In light of the discussed findings and arguments, the following recommendations flow from this study:

### 5.3 Recommendations:

- The core values of the South African Constitution need to be promoted particularly for purposes of human rights, dignity and gender equality in the case of women. This will, in turn, promote the deconstruction and reconstruction of cultural norms than favour men over women.
- Community needs to discard the views of harmful sexual practices as pleasing to men.
- Consultations with women about their perceptions of sexuality and HIV prevention need to be harnessed by community leaders and health workers in understanding women's vulnerability to HIV infection.
- HIV-prevention messages targeting individual HIV-preventative behaviour need to be reconsidered as there are other factors at play that affect individual HIV-preventative behaviours such as those of socio-cultural context and sexual partners.

- Harmful cultural constructions of gender and female sexuality need to be discarded as they place women at risk of infection. This can only occur with community involvement.
- The view of women as victims in their intimate relationships needs to be discarded as this renders Schoemansdal women more vulnerable due to societal stereotypes and stigma that see women as AIDS carriers.
- Elderly women need to promote sexual assertiveness in women as part of modern sexuality to mitigate against the prevalence of HIV in women.
- Women need to be re-socialised in serving their own needs first in this era of the HIV epidemic.
- Female condoms as the safest mode for female protection need to be marketed more and women orientated on their use and benefits, which can be translated to independence in deciding whether or not to use condom.

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## APPENDIX A: UNISA ETHICAL CLEARANCE LETTER

*Follows on next page.*

## APPENDIX B: INVITATION TO PARTICIPATE IN RESEARCH

PO Box 5071
Halfway House
Midrand
1685

Dear Mr/Miss……..

AN INVITATION TO PARTICIPATE IN A RESEARCH PROJECT FOR AN MA IN SOCIAL BEHAVIOUR (HIV/AIDS).

You are hereby requested to participate in a research project that is undertaken as a requirement of an MA in Social Behaviour (HIV/AIDS) degree with the University of South Africa (UNISA).

The title of the research project is: An explorative study of rural women's perceptions of sexuality and HIV prevention in their local socio-cultural context: A case study of rural Schoemansdal, Mpumalanga

Empirical research will be primarily done by:

1. Face-to-face interviews
2. Focus Group Discussions (FGDs)
3. Participant Observation

You are requested to participate in the first two parts. The objective of the study is to understand rural women's views and experiences on issues of sex and sexuality within their socio-cultural context.

The duration of the interviews and focus groups is estimated to be between 30 to 45 minutes. The participation and input obtained during the research will be treated with extreme care to maintain confidentiality. Real names will not be divulged in the final report to ensure anonymity. The results of the interviews will be shared with the researcher's supervisor only and they will be kept in a locked safe place. The final product of the research will be

published and will be on the library shelves at UNISA and other libraries around the world will access to it through UNISA library. Participation in this research is voluntary, should the participant wish to withdraw at any time they will be free to do so. The researcher will ensure that all ethical obligations and considerations are adhered to.

If permission is granted may I request that you sign the attached consent form.

Kind Regards,
Ms Tinyiko Chauke
Cell: +27 83 2160 504 and email 44446012@mylife.unisa.ac.za

## APPENDIX C: ACCESS LETTER FROM VEZUKUHLE HBC

*Follows on next page.*

## APPENDIX D: INFORMED CONSENT FORM

An explorative study of rural women's perceptions of sexuality and HIV prevention in their local socio-cultural context: A case study of rural Schoemansdal, Mpumalanga.

Informed Consent for Participants

I Ms (Full name and surname in capital letters)

……

do accept to participate in the research process with …… an MA student in Social Behaviour Studies in HIV/AIDS at UNISA.

1. I am aware that my participation in this project is entirely voluntary.
2. I am aware that I am free to withdraw from the project at any time without any problem.
3. I understand that my personal information including recordings and narratives will be kept confidential. I understand that my true identity will not be divulged in the final project to ensure anonymity.
4. I understand that I will receive no payment or compensation in the study.

Date……

Signature of applicant……

Signature of Witness……..

## APPENDIX E: INTERVIEW SCHEDULE

### Focus Group discussion Guide

1. **What is your perception of sexuality and HIV prevention? Does culture and religion play a role on your perceptions?** Ini isipiliyoni sakho mayelana nezocansi kanye nokuzivikela kwigqiwane le HIV, ingabe usiko nenkolo yakho linobizo mayelana nalokhu na?
2. **In your view are there any similarities and differences between traditional and modern female sexuality and HIV prevention?** Ngokubona kwakho ingabe ukhona yini umehluko noma mhlawumbe iyafana yini indlela abesimame besimanjemanje naba abalendela amasiko ngokwe cansi na?
3. **In what manner do you think that culture has socialised you to perceive sexuality?** Iziphi izindlela zokuziphatha mayelana nokocansi ofindiswe zona ekhaya?

### Face-to-face interview Guide

1. Date of Birth - Usuku lwakho lokuzalwa
2. Ethnicity -Umhlobo bani
3. Completed years of education - Izinga lokufunda
4. Marital status - Uganiwe
5. Occupation - Umsebenzi owenzayo
6. Affiliation with religious group - Ukhonza kuphi

7. **What do you understand about your sexuality and HIV prevention?** Ingabe unolwazi ngo buntombi bakho nomahlambe isimame sakho ne HIV?

8. **Why do you think that openly expressing your sexuality in your ethnicity would be considered a taboo**?

Ukuya ngawe kenzwa yini ukuthi akuvamile ngokwesiko ukuthi kukhulunye obala ngezocansi?

9. **How does your religion construct sexuality, and has it had an impact on how you perceive and understand sexuality and HIV prevention?** Uvo le nkolo yakho ngezocansi luthini kanye nokuziphatha kwabesifazane.Ingabe lokhu kwakha indlela ozizwa ngayo ngokwe cansi nokuzivikela kwi gciwane le HIV na?

10. **What are the sexual practices in your culture that may expose you and prevent HIV infection?** Iziphi zinto ozenzayo ngokwesiko mayelana ngezocansi ezikhuphula noma zehlise izinga lakho lokuthola igciwane le HIV?