WOMEN AND SEXUALLY TRANSMITTED DISEASES: AN EXPLORATION OF
INDIGENOUS KNOWLEDGE AND HEALTH PRACTICES AMONG THE
VHAVENDA

by

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Submitted in accordance with the requirements for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the

DEPARTMENT OF HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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JUNE 2003
DECLARATION

I declare that:

WOMEN AND SEXUALLY TRANSMITTED DISEASES: AN EXPLORATION OF INDIGENOUS KNOWLEDGE AND HEALTH PRACTICES AMONG THE VHAVENDA

Is my own work and that all sources that I have used or quoted have been indicated by means of complete references.

FHUMULANI MAVIS MULAUDZI

.................................................. 26th day of November 2003
ACKNOWLEDGEMENTS

First of all I would like to thank God the Almighty for making this study possible for without His help none of this would have been achieved.

I would also like to express my sincere gratitude to the following people who helped me directly and indirectly in the completion of my study:

Prof Makhubela-Nkondo, my Supervisor, for encouragement, support, understanding, patience, kindness and guidance through the worst of times, and for the long hours and time spent in reading and discussing the material.

Dr Motsa, my Co-supervisor, for the special kindness, warmth and caring attitude I received from her.

The authorities of the Limpopo Province, the Superintendent of Donald Fraser hospital, the learners, the traditional healers, and key respondents for the co-operation and understanding they showed me during the collection of data.

My research assistants, Thizwi Muda and Mavis Masutha who helped me with the interviews.

Colleagues and friends who have supported and assisted me in so many ways during my course of study for this degree.
I am also indebted to the National Research Foundation and the Democratic Nursing Organization of South Africa for financially assistance I received which contributed to the success of this study.

A word of appreciation goes to Welcome Sekwati for his enormous work in editing the language of this thesis.

My beloved children Mukovhe, Shandu and Tondi for their continuous encouragement and always giving me a shoulder to cry on, and for enduring my frustrations.

My husband Eddie, for his endurance and all the support he gave me.

My brothers Ephraim and Lufuno, my sisters Itani and Nditsheni, for giving me their never-ending support. Lastly, Anna Mulatwa Mphidi Raliphada, my mother for being my role model, for giving me a listening ear and for sharing her ideas that were valuable to this study.
ABSTRACT

Health care service providers in South Africa and elsewhere in the world are increasingly faced with an enormous challenge of modeling their approach to health care to meet the needs and expectations of the diverse societies they serve. The norms and customs that are inherent in these indigenous cultures are fundamental to the day-to-day existence of the people concerned and may hold a key to the understanding of many aspects of their lives, including the understanding of disease, in the case of this thesis, those transmitted sexually.

- A grounded theory study was used based on its theory of symbolic interactionism to explore the indigenous knowledge and health practices of the Vhavenda in sexually transmitted diseases. Data was collected through in-depth interview with traditional healers and key informants. Snowball sampling was used to identify key informants as categories continued to emerge. Data was analyzed using three basic types of coding namely, open coding, axial coding and selective coding.

The findings of the study revealed a variety of terms used to identify STDs. Also emerging from the results was that cultural gender roles in the Vhavenda society justify women as sole agents of STDs. In accordance with grounded theory the descriptions of types of diseases, disease patterns, signs and symptoms culminated in "dirt" as the core category. It came out clear that dirt in the form of women's vaginal discharges and moral dirt is the main course of a STDs. It was also evident that strategies for combating STDs will have to take into account popular beliefs and attitudes regarding views on STDs as well as the role and influence of traditional healers. Based on the above findings guidelines for designing a module for teaching health professionals has been formulated to aid them in understanding the beliefs and practices of people they serve.

KEY TERMS
Sexually transmitted diseases, indigenous knowledge, cultural beliefs, health practices, Vhavenda, gender, traditional healers, grounded theory.
GLOSSARY

- Bapedi - A tribe that is a sub-group of the Sotho people who live in the Northern part of South Africa.

- Divhu (u wela)- A type of a sexually transmitted infection.

- Domba - The last stage of initiation school, in the dance and snake-like filing, that young women undergo before they get married.

- Dorobo - A type of a sexually transmitted infection.

- Dzithevhula- a feasts in which traditional beer is used to connect with the ancestral spirits.

- Fembo-A practice by which the traditional healer connects the patient with his/her ancestors, or engages in exorcism by sniffing at the patient.

- Gokhonya - A type of a sexually transmitted infection.

- Goni (Lekone)- An eagle (in this case it refers to a type of a sexually transmitted disease as explained in the study).
- Ludodo - The punishment meted out to a young woman for arriving late for the Domba dance.

- Lukuse - A type of a sexually transmitted infection.

- Mafa (boswagadi, makgome) - A type of sexually transmitted infection.

- Maine - A traditional healer who uses medicine to cure illnesses (family physician).

- Makhadzi - Term used to refer to a married woman's sister-in-law (her husband's sister).

- Mamalo (lobola) - Money paid by the bridegroom to the in-laws, asking for their daughter's hand in marriage.

- Mbuya vhuhadzi - A woman divorcee.

- Mozambique - One of the countries found in Southern Africa.

- Muporofita - A spiritual healer.

- Murundu - A type of initiation that is practised by men for circumcision purposes.
• Musadzi - A woman.

• Setswana - The culture, language and tradition of Tswana-speaking people.

• Shona - The largest black ethnic group in Zimbabwe.

• Swaziland - one of the countries found in Southern Africa.

• Thusula - A type of sexually transmitted infection.

• Tshikanda - The initiation that comes prior to the snake dance (domba) that is practised by young women in preparation for the hardships associated with marriage.

• Tshovela - A type of sexually transmitted infection.

• U thavhelwa - An incision by razor into which traditional medicine is smeared in order to make a person impervious to bad luck and magic-induced illness.

• U thuswa - An act that is performed on newly born children in order to protect them against bad omens and evil deeds.
- **U vhea mudi** - An act that is performed in the household in order to protect it against witchcraft.

- **Ukuhlowa** - A ritual practised by Zulu people to examine the vaginas of teenagers to see if the hymen is intact.

- **Vhadzimu** - The ancestral spirits.

- **Vhavenda** - One of the small black ethnic groups of South Africa, mainly occupying the northern part of the country.

- **Vhembe** - A district in the northern part of Limpopo Province.

- **Vhuhadzi ndi nama ya thole ya fhufhuma ri a fhunzhela** - An idiom that stresses that in marriage there should be tolerance.

- **Vhukomba** - A stage that women reach when they become mature (teenage hood).

- **Vhusha** - A type of initiation practised by the Vhavenda girls to symbolize teenage hood.
# TABLE OF CONTENTS

**CHAPTER 1**
ORIENTATION TO THE STUDY

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Background of the problem</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Outline of the problem</td>
<td>3</td>
</tr>
<tr>
<td>1.4 Research Questions</td>
<td>6</td>
</tr>
<tr>
<td>1.5 Purposes of the Study</td>
<td>6</td>
</tr>
<tr>
<td>1.6 Significance of the Study</td>
<td>7</td>
</tr>
<tr>
<td>1.7 Methodology</td>
<td>8</td>
</tr>
<tr>
<td>1.8 Assumptions</td>
<td>10</td>
</tr>
<tr>
<td>1.9 Definitions of Concepts</td>
<td>11</td>
</tr>
<tr>
<td>1.9.1 Sexually Transmitted Diseases</td>
<td>11</td>
</tr>
<tr>
<td>1.9.2 Reproductive Health Care</td>
<td>12</td>
</tr>
<tr>
<td>1.9.3 Culture</td>
<td>12</td>
</tr>
<tr>
<td>1.9.4 Folkways</td>
<td>12</td>
</tr>
<tr>
<td>1.9.5 Indigenous knowledge</td>
<td>13</td>
</tr>
<tr>
<td>1.9.6 Ethno Nursing</td>
<td>13</td>
</tr>
<tr>
<td>1.9.7 Transcultural Nursing</td>
<td>13</td>
</tr>
<tr>
<td>1.10 Outline of the Study</td>
<td>14</td>
</tr>
<tr>
<td>1.11 Summary</td>
<td>15</td>
</tr>
</tbody>
</table>
CHAPTER 2
REVIEW OF RELATED LITERATURE

2.1 Introduction 16

2.2 Cultural beliefs of the vhavenda and its influence on health care delivery 17

2.3 Social status amongst the Vhavenda 18

2.3.1 Marriage and family life 18

2.3.2 Sex education 20

2.3.3 The status of women in Venda society 23

2.3.4 Sexual behaviour 25

2.4 Culture and health care system 27

2.4.1 Diviners 27

2.4.2 Specialist 28

2.4.3 Magicians 28

2.4.4 Spiritual Healers 28

2.5 Summary 30

CHAPTER 3
METHODOLOGY

3.1 Introduction 31

3.2 Overview of the grounded theory method 31

3.3 Population 33

3.4 Sampling 33

3.5 Data Collection 35

3.5.1 Negotiating entry 35
3.5.2 Initial data collection procedures 35
3.5.3 The second phase of data collection 37
3.5.3.1 The interview process 38
3.5.3.2 Recording of interviews 39
3.5.3.3 Research setting 39
3.6 Document analysis (Audit) 41
3.7 Validity and reliability 42
3.7.1 Credibility 42
3.7.2 Triangulation 43
3.8 Ethical considerations 45
3.8.1 Informed consent 45
3.8.2 Gaining trust 46
3.8.3 Establishing rapport 46
3.8.4 Dress code 47
3.8.5 Respect 47
3.9 Summary 48

CHAPTER 4
DATA ANALYSIS AND INTERPRETATION 49

4.1 Introduction 49
4.2 Organization of data 51

4.3 Theme 1
Cultural beliefs and health care practices of the Vhavenda in the context of sexually transmitted diseases 51

4.3.1 Open coding 52
4.3.2 Axial coding 53
4.3.3 Frequent recurrence 54
4.3.4 Connection with other data 54
4.3.5 Implication of a more general theory 54
4.3.6 Sexually transmitted diseases 57
  4.3.6.1 Dorobo 57
  4.3.6.2 Thusula 60
  4.3.6.3 Divhu 61
  4.3.6.4 Tshovela 62
4.3.7 Sexually related diseases 63
  4.3.7.1 Tshimbambaila 63
  4.3.7.2 Mafa 64
  4.3.7.3 Gokhonya / goni 65
4.4 Theme 2 66
   Dirt (Women's physiological discharges)
  4.4.1 Menstruation 66
  4.4.2 Post-delivery discharges 67
  4.4.3 Post abortion discharges 69
4.5 Theme 3 70
   Beliefs and practices of the Vhavenda
  4.5.1 Sexuality education 71
  4.5.2 Initiation Schools 71
  4.5.3 Virginity inspection 72
  4.5.4 Premarital counseling amongst the Vhavenda 75
  4.5.5 Respondent's views about polygamy 76
| 4.5.6 | Widow inheritance | 78 |
| 4.6 | **Theme 4**  
Forbidden periods | 79 |
| 4.6.1 | Menopause | 79 |
| 4.6.2 | Widowhood | 80 |
| 4.6.3 | Conjugal rights | 81 |
| 4.6.4 | Cleansing ceremonies | 83 |
| 4.7 | Gender differences in diagnostic measures, care, preventive methods and treatments | 84 |
| 4.7.1 | Legal Factors | 84 |
| 4.7.2 | Economic Factors | 84 |
| 4.7.3 | Patriarchy | 85 |
| 4.8 | Document analysis | 87 |
| 4.8.1 | Sexually transmitted infections policy | 87 |
| 4.8.1.1 | Partner notification and treatment | 87 |
| 4.8.1.2 | Promotion and provision of condoms | 91 |
| 4.8.2 | Cultural sensitivity | 92 |
| 4.9 | Summary | 92 |

**CHAPTER 5**  
CREATION OF A THEORY | 93 |
<p>| 5.1 | Introduction | 93 |
| 5.2 | The definition of a theory | 93 |
| 5.3 | How a theory evolves | 94 |
| 5.4 | Paradigm model | 95 |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4.1</td>
<td>Phenomenon</td>
<td>96</td>
</tr>
<tr>
<td>5.4.2</td>
<td>Causal conditions</td>
<td>96</td>
</tr>
<tr>
<td>5.4.3</td>
<td>Context</td>
<td>96</td>
</tr>
<tr>
<td>5.4.4</td>
<td>Intervening conditions</td>
<td>96</td>
</tr>
<tr>
<td>5.4.5</td>
<td>Action/interaction strategies</td>
<td>97</td>
</tr>
<tr>
<td>5.4.6</td>
<td>Consequences</td>
<td>97</td>
</tr>
<tr>
<td>5.5</td>
<td>Creation of conceptual meaning</td>
<td>97</td>
</tr>
<tr>
<td>5.5.1</td>
<td>Menstruation</td>
<td>101</td>
</tr>
<tr>
<td>5.5.2</td>
<td>Post Abortion Discharges</td>
<td>101</td>
</tr>
<tr>
<td>5.5.3</td>
<td>Post Delivery Discharges</td>
<td>103</td>
</tr>
<tr>
<td>5.5.4</td>
<td>Women as carriers</td>
<td>103</td>
</tr>
<tr>
<td>5.6</td>
<td>Biblical perspective</td>
<td>105</td>
</tr>
<tr>
<td>5.7</td>
<td>Biological perspective</td>
<td>106</td>
</tr>
<tr>
<td>5.8</td>
<td>Treatment of STDs</td>
<td>106</td>
</tr>
<tr>
<td>5.9</td>
<td>The dirt theory</td>
<td>108</td>
</tr>
<tr>
<td>5.10</td>
<td>Validating the theory</td>
<td>112</td>
</tr>
<tr>
<td>5.10.1</td>
<td>Are concepts generated?</td>
<td>113</td>
</tr>
<tr>
<td>5.10.2</td>
<td>Are the concepts systematically related?</td>
<td>113</td>
</tr>
<tr>
<td>5.10.3</td>
<td>Are there many conceptual linkages? are the categories well developed? do they have conceptual density?</td>
<td>113</td>
</tr>
<tr>
<td>5.10.4</td>
<td>Is much variation built into theory?</td>
<td>113</td>
</tr>
<tr>
<td>5.10.5</td>
<td>Are the broader conditions that affect the phenomenon being studied built into its explanation?</td>
<td>113</td>
</tr>
<tr>
<td>5.10.6</td>
<td>Has process been taken to account</td>
<td>114</td>
</tr>
</tbody>
</table>
5.10.7  Do the theoretical findings seem significant and to what extent?  114

5.11  Summary  115

CHAPTER 6
GUIDELINES FOR INTEGRATING BELIEFS AND PRACTICES OF THE COMMUNITY IN THE CURRICULUM  116

6.1  Introduction  116

6.2  Module structure  120

6.2.1  Knowledge  120

6.2.2  Skills  120

6.2.3  Attitude  121

6.3  Content  121

6.4  Proposed unit standard title: apply knowledge of beliefs and practices of the community in sexually transmitted diseases  124

6.5  Teaching and learning methodology  127
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.6</td>
<td>Assessment</td>
<td>127</td>
</tr>
<tr>
<td>6.7</td>
<td>Summary</td>
<td>128</td>
</tr>
<tr>
<td>7.1</td>
<td>Introduction</td>
<td>129</td>
</tr>
<tr>
<td>7.2</td>
<td>Purpose of the study</td>
<td>129</td>
</tr>
<tr>
<td>7.3</td>
<td>Outcomes of the study</td>
<td>130</td>
</tr>
<tr>
<td>7.4</td>
<td>Findings and recommendations</td>
<td>131</td>
</tr>
<tr>
<td>7.4.1</td>
<td>What are the cultural beliefs and health care practices of the Vhavenda in the context of sexually transmitted diseases?</td>
<td>131</td>
</tr>
<tr>
<td>7.4.1.1</td>
<td>Sexuality education</td>
<td>133</td>
</tr>
<tr>
<td>7.4.1.2</td>
<td>Biological factors</td>
<td>135</td>
</tr>
<tr>
<td>7.4.2</td>
<td>Are there any gender differences in the indigenous treatment, care, prevention and diagnostic measures of sexually transmitted diseases?</td>
<td>135</td>
</tr>
<tr>
<td>7.4.2.1</td>
<td>Gender roles</td>
<td>135</td>
</tr>
<tr>
<td>7.4.2.2</td>
<td>Women do not have the right to refuse sex</td>
<td>136</td>
</tr>
<tr>
<td>7.4.2.3</td>
<td>Vulnerability of the girl–child who is viewed as clean</td>
<td>137</td>
</tr>
<tr>
<td>7.4.3</td>
<td>How can training and health policies facilitate the health care workers’ understanding of indigenous diagnosis, treatment, prevention and care of STDs and their gender bias?</td>
<td>138</td>
</tr>
<tr>
<td>7.4.3.1</td>
<td>Partner notification, treatment and condom use</td>
<td>138</td>
</tr>
<tr>
<td>7.5</td>
<td>Customer beliefs and practices</td>
<td>139</td>
</tr>
<tr>
<td>7.6</td>
<td>Cleansing mechanisms</td>
<td>142</td>
</tr>
</tbody>
</table>
7.7 Health workers education 142
7.8 Policies of management of sexually transmitted infections 143
7.9 Conclusions of the study 144
7.10 Implications to nursing 145
7.11 Implications for research 148
7.12 Limitations of the study 149
7.13 Summary 149
8 References 151

**ANNEXURES**

Annexure A
Interview schedule 159
Annexure B
Interview transcripts 162
Annexure C
Interview skills (Slides) 245
Annexure D
Letter of permission to conduct the study 248

**TABLES**

Table 4.1
STDs as described by the Vhavenda 56
Table 4.2
Media release on sexual abuse 74
Table 4.3
STDs statistics 89
Table 6.1
Four table typology 117
FIGURES

Figure 5.1  The paradigm model  95
Figure 5.2  The understanding and beliefs of the vhavenda in sexually transmitted diseases  100
Figure 5.3  The effects of post abortion discharges on an individual  102
Figure 5.4  The pathology of lochia as viewed by the Vhavenda  103
Figure 5.5  Women as carriers of STDs  104
Figure 5.6  Conceptual framework on how STDs are viewed in the social context  106
Figure 5.7  Diagrammatic mind map of the theory  111
Figure 6.1  Diagrammatic mind map of the theory  116

PICTURES

Picture 4.1  Pictorial depiction of dorobo (Gonorrhea)  59
Picture 4.2  Pictorial depiction of thusula (Syphilis)  61
Picture 4.3  Pictorial depiction of tshovela (Condylomata)  63
CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Traditionally, sexually transmitted diseases (STDs) were believed to be infections spread by women. According to McGlynn (1998:43) during World War II, men were warned to keep away from the easy girlfriends as they spread venereal diseases. In the early 1980s when the spread of HIV/AIDS infection took its toll, gay men and drug addicts were labeled as possible carriers of the infection. So far there is no evidence to suggest that heterosexual men have ever been associated with any form of sexually transmitted diseases. Many studies have already been conducted on the origin, causative organism, and methods of spread and treatment of sexually transmitted infections, like parasitic infections, sexual transmissions of hepatitis, trichomonal vaginalis, genital herpes and many others.

Currently there is no documentation to substantiate assertions regarding indigenous health care methods of the African communities relating to sexually transmitted diseases. According to oral evidence, Africans had their own beliefs and practices on how to prevent, treat and diagnose sexually transmitted diseases. They had their own methods of sexuality education relating to prevention of teenage pregnancies.
The problems of controlling the spread of sexually transmitted diseases as experienced presently have always been there among black people even though there are no statistics to affirm that because of lack of proper recording and reporting. The counter argument is that practices such as polygamy seemed to have had a decreasing effect on the rate at which sexually transmitted diseases spread or tended to ease the process of tracing contacts. Added to this also is a claim that the traditional health practices included methods of preventing the spread of such diseases.

The above statements will be adequately substantiated through an investigation of verbal accounts of the Africans themselves.

1.2 BACKGROUND TO THE PROBLEM

The increase in the literacy rate amongst Africans has resulted in a mode of acculturation whereby people condemned traditional reproductive health care practices in favour of western cultural aspects such as Christianity. The shift from traditional practices to new medical practices left a vacuum that has not been filled to date. New government structures such as the civic organizations have eroded the powers of the traditional chiefs who controlled traditional institutions like initiation schools, and have exacerbated the prevalence of reproductive health problems. Potter & Perry (2001:104), advance the view that folk practices of ancient times have been abandoned due to modern health care belief systems. In support of this same statement, Sodi (1997:20) argues that western psychology colluded with colonialism to denigrate indigenous knowledge systems. Although this is a psychological perspective,
one realizes that the same collusion occurred in medicine and nursing to undermine the knowledge systems of the colonized.

Karim, Ziqhubu- Page, and Arendse (1994:1) state, “When an African patient consults a biomedical doctor a third figure is often present, albeit unseen”. Furthermore, they assert that 80% of black patients visit traditional healers before or after they consult with a biomedical doctor. This view is supported by Pitje (in Mafalo 1998:63) in the observation that blacks use traditional healers because it is believed that there are certain diseases that cannot be treated by western medicinal doctors.

1.3 OUTLINE OF THE PROBLEM

An estimated 250 million cases of sexually transmitted diseases (other than HIV/AIDS) occur each year. Sexually transmitted diseases are infections grouped together because they spread by transfer of organisms from person to person during intimate sexual contact (Clark 1996:372). Sexually transmitted diseases (STDs) can have serious repercussion for women’s health, as well as the health of their children and sexual partners. STDs contribute to the incidence of blindness, brain damage, pelvic inflammation, spontaneous abortions, ectopic pregnancies and cervical cancer. In addition, they are also a major cause of infertility.

The reproductive role of women and their subordinate role in society make them particularly vulnerable to STDs. These infections are not easily detected in women. As a result, most women remain unaware that they have
contracted the disease until it complicates. Men in turn have an advantage of seeking treatment early because their symptoms are more obvious. Moreover, it is usually easier for them to seek medical assistance, as they are usually financially better off than women, due to gender stratified employment patterns.

Traditional beliefs about gender, health and illness differ from one cultural, ethnic and religious system to the other. Culturally based folk beliefs often determine the definitions of health and illnesses for people who embrace traditional belief systems. The ethnic identities and cultural backgrounds of individuals influence their health care attitudes, values and practices, and could influence the achievement of goals and objectives of the National Health care system. According to Helman (1996:152), in every culture there are laid down norms of sexual behaviour that are different for women and men, and in turn those gendered patterns of sexual behaviours may contribute to the transmission of several diseases, for example, sexually transmitted diseases.

Leininger (1999: 64; 65) suggests that indigenous health systems have been providing care to the people for many years even before western professional health systems were integrated into their culture. Due to current training models and policies, where both gender issues and indigenous healing issues are either ignored or undermined, professional health workers now often view indigenous practices as inadequate, primitive, superstitious, magical and quackery. As a result, the opportunities of understanding the values, norms,
beliefs, needs and practices of women and men in a traditional health context continue to be remote.

Abdoel-Karim, Ziqhubu- Page and Arendse (1994:1) illustrate this 'blind spot' in western medicine, when they argue that despite the strength of modern medicine, clients' and patients' beliefs and attitudes will always determine the type of health care they need. According to the researcher's experience, women usually sneak from the hospital to go and consult with the traditional healer. African women generally believed that they must go and be treated against the vaginal infection called "goni" (martial eagle). This belief has been supported by a study conducted by Mabogo (1990:63) on ethno-botany, where he described a plant called "lito la ndau" (an eye of the lion) as a treatment for the vaginal infection "goni". He further describes the infection as a predisposing factor in infant mortality rate. This view is corroborated by Bodibe (1988:55), who explains that "lekone" (martial eagle), is a common infection among the Bapedi women. She shares the same notion with Mabogo (1990:64) by relating it to infant mortality when she points out that, this can be diagnosed by a red spot on the occiput of the baby immediately after birth.

Currently, the syndromic management of STDs is based on a biomedical model that focuses on secondary prevention by treating infected individuals. The issue of prevention is also emphasised in the use of a condom and restricting one's number of sexual partners. The issue of cultural beliefs and behaviours, knowledge and attitudes of individuals is never taken into
consideration. The communities are also not involved in decision-making concerning their strategies of health care. This prompted this researcher to explore more on sexually transmitted diseases that are "unknown" in western medicine, and to focus on the gender bias in their diagnosis, treatment, care and prevention.

1.4 RESEARCH QUESTIONS

In view of the strong cultural influences and traditional belief systems in relation to sexually transmitted diseases, the research will be conducted among the Vhavenda, to document their traditional beliefs on sexually transmitted diseases and the gender bias in the diagnosis, treatment, prevention and cure of such diseases.

This study is based on the following probing questions:

- What are the cultural beliefs and health care practices of the Vhavenda in respect of sexually transmitted diseases?

- Are there any gender differences in the indigenous treatment, care, prevention and diagnostic measures of sexually transmitted diseases?

- How can training and health care policies facilitate the health care workers' understanding of indigenous diagnosis, treatment, prevention and care of STDs, and their gender bias?

1.5 PURPOSE OF THE STUDY

Given the lack of existing documents, this subject was never fully explored in the South African context, especially in the Venda area. The shift in practice from hospital to community based care makes it urgent that health care
professionals make a conscious effort to increase their knowledge of the varied cultures of the communities that they serve, as well as the gender bias in health care. The study aims to achieve the following:

- To document the beliefs and practice of the Vhavenda in the treatment, care, prevention and diagnosis of STDs.
- To determine the extent of perceived gender bias in treatment, care, prevention and diagnosis of STDs.
- To generate a theory that will assists as a point of departure in developing gender sensitive guidelines, health policies and appropriate training materials that can be used in the treatment of sexually transmitted diseases.

1.6 SIGNIFICANCE OF THE STUDY

The development of gender sensitive indigenous health practices in the control of sexually transmitted infections will be one of the most important outcomes of this study. Furthermore the findings and the theory generated from this study may be used to formulate guidelines for training, policies and allocation of budgets in relation to the control and treatment of sexually transmitted diseases in Limpopo province and also amongst the Vhavenda themselves.

Capacity building of less experienced and young graduate students will be a priority in the study. It is of critical importance to make nursing students aware of the gender dimensions of health care and to enhance their research capacity to undertake similar studies on a variety of other diseases and
conditions. Young students will participate in all the phases of the project as outlined below: gender analysis, in-depth interviews, designing of training material and evaluation of the programme. Guidelines for a teaching module will be designed which will incorporate indigenous health practice methods so as to enhance quality control in sexually transmitted infections as well as the issue of making the community aware of gender discrimination in the indigenous health care and treatment of STDs. This endeavor may enhance and facilitate control of STDs. This is important, as there is a need to provide ethno-nursing and culturally congruent care to the community.

1.7 METHODOLOGY

Grounded theory within the qualitative research paradigm is the appropriate approach to study the phenomenon involved. This approach is appropriate as its roots are found in the interpretive tradition of symbolic interactions. Polit & Hungler (1999:195) explain that the purpose of field studies used in qualitative research approaches is to examine the practices, behaviours, beliefs and attitudes of groups and individuals as they normally function in real life. This view is supported by Streubert & Carpenter (1999:99), who indicate that the approach is based on the assumption that each group shares a specific social and psychological problem that is not necessarily articulated. The Vhavenda were respondents, who were examined to explore how they view STDs in terms of promotive, preventive and curative health measures.

Furthermore Talbot (1995:446) asserts that

"Unlike ethnography, grounded theory does not seek to understand culture and cultural processes; rather reality is perceived as a social construct".
In this study the theory will be generated from indigenous knowledge, beliefs and practices that have been systematically obtained and analysed through the constant comparative methods.

Unlike in other research designs in Grounded theory, sampling method cannot be decided upon during research proposal or planning, the theory evolves during the process of data collection as concepts emerged. This sampling technique is supported by Strauss and Corbin (1990: 180) who argue that the initial interviews and observational guides in grounded theory are just used as the guidelines which helps the researcher to focus as theoretical sampling emerges during the collection of data. Purposive sampling was used a beginning focus of the researcher because only people with information according to the researcher's experience were selected. Powers and Knapp (1990:98) support this method of sampling, arguing that key information interviewing involves selective use of members of the culture who are specially knowledgeable, insightful, and articulate or who have specialised knowledge which is not shared by the rest of the community (Streubert and Carpenter 1999: 103). As data collection continued theoretical sampling was used. Theoretical sampling dictates that comparison groups be selected based on their potential for contributing to the emerging theory. The focus of research questions was on biographical information examined in oral histories that shed light on past experiences. As the theory starts evolving theoretical sampling was used to select key informants who were then interviewed in all areas of Vhembe district to shed light on past experiences and indigenous
knowledge with regard to sexually transmitted diseases. More information will be explained in the methodology chapter.

Triangulation took place because numerous instruments for data collection were used; that is, auditing, in depth interview with traditional healers and key respondents as well as focus groups done during the initial data collection.

In grounded theory data collection and data analysis occur simultaneously. Data was analyzed according to the three steps of coding as described by Strauss and Corbin (1998: 54-247) that is, open coding, axial coding and selective coding. In this study all the steps of analysis were followed. Description and conceptualisation were both used in the study, as the main aim of the study was to document the beliefs, diagnostic measures, preventive and promotive care of the Vhavenda in sexually transmitted diseases. Talbot (1995:445), attests to this view indicating that in analysis of a grounded theory research, the researcher returns to the data frequently, revises research questions and seeks out additional or missing data. As the researcher continued with the process of constant comparison of data and categories that were emerging, a theory started developing. The development of the theory will be discussed in chapter 5.

1.8 ASSUMPTIONS

The following assumptions underlie the study:

- The grounded theory will be a point of departure based on symbolic interactionism.
• According to Burns and Groves (1997:67), symbolic interaction theory explores how people define reality, how their beliefs are related to their actions, and how the theoretical construct of preference in explaining the methodology underlying the grounded theory research translates into reality. This study seeks to explore how the Vhavenda define sexually transmitted diseases and how their beliefs are related to their actions in prevention, promotion and curative health care.

• People of a certain culture attach meanings and symbols to situations that are used for interactions. In social life a group of people shares these meanings. The Vhavenda have been chosen as a group under focus as it is assumed that they attach like-minded meaning and interpretation to STDs.

1.9 DEFINITION OF CONCEPTS

The present section is created to avoid misconceptions and misinterpretations of important concepts used in the study.

1.9.1 SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases are infections grouped together because they spread by transfer of organisms from person to person during intimate sexual intercourse (Clark 1996: 372). In this study sexually transmitted diseases will be defined as diseases described as such by the respondents.
1.9.2 REPRODUCTIVE HEALTH CARE

Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being preventing and solving reproductive health problems. It also includes sexual health as well as counselling and care related to reproduction, cancer and sexually transmitted diseases (Cook in Raliphada- Muludzi 1998:8).

1.9.3 CULTURE

Culture represents non-physical traits such as values, beliefs, attitudes and customs shared by a group of people and passed from one generation to the next. (Potter and Perry 2001:98). Aihienbuwa (1995:xii) defines cultures as forms of social interaction accepted by particular communities at particular times, according to their worldviews and historical experiences.

For the purpose of this study Culture is the sum of beliefs, practices, habits, likes, dislikes, norms, customs and rituals learned from the family during the years of socialization folkway. Thus the health care practices and beliefs are parts of the culture of a society.

1.9.4 FOLKWAYS

Folkway refers to life way concepts that are known and used by a local group in relation to specific cultural knowledge, practices and meaning found in a designated culture.
1.9.5 INDIGENOUS KNOWLEDGE

Indigenous knowledge systems (IKS) refer to the complex set of knowledge and technologies existing and developed around specific conditions of populations and communities indigenous to a particular geographic area. IKS can also develop within communities descended from populations that inhabited the country at the time of conquest or colonization. These populations, irrespective of their legal status –retain some of, or their entire own social, economic, cultural and political institutions. (Find detailed information in [http://www.nrf.ac.za/focusareas/iks](http://www.nrf.ac.za/focusareas/iks). In the case of this study, IKS refers to cultural beliefs and practices in relation to the sexually transmitted diseases.

1.9.6 ETHNO NURSING

Ethno nursing is the study of nursing-care beliefs, values, and practices as perceived and cognitively used by a designated culture through their local language, experiences, beliefs and value systems.

1.9.7 TRANSCULTURAL NURSING

Transcultural nursing is the learned sub field of nursing which focuses upon the comparative study and analysis of different cultures and subcultures with regard to nursing and health-illness caring practices, beliefs and values with the goal of generating scientific and humanistic knowledge and of using knowledge to provide culture-specific and culture-universal nursing care practices.
1.10 OUTLINE OF THE STUDY

This thesis is organized into seven chapters. The first chapter introduces the reader to the problem under investigation. It outlines the Introduction, Background, Problem Statement, Purpose, Significance, Assumptions, Scope and Limitations of the study, as well as Definitions of concepts referred to in the study.

Chapter 2 provides some information about the Vnavenda culture intended to enable the reader to understand more about the ethnic group under focus.

Chapter 3 describes the study design, data collection methods, research setting, validity and reliability as well as ethical considerations.

Chapter 4 deals with the analysis and interpretation of the research findings.

Chapter 5 concerns itself with theory generation, discussion of findings, and recommendations.

Chapter 6 focuses on guidelines to be used in teaching sexually transmitted diseases while chapter 7 contains the findings, conclusions and recommendations.

List of sources represents those references used throughout the thesis and a list of works consulted (whether references were made to them or not).
The appendices contain the interview schedule as well as letters requesting and granting permission for conducting the research.

1.11 SUMMARY

Indigenous knowledge is an area that has been neglected for many years. It has therefore become necessary that studies of this nature be conducted so as to document these practices in order to render culturally congruent care. Furthermore reproductive health care is a field that needs further research, more especially the sexually transmitted diseases, as they are major causes of complications such as infertility and infant mortality.
CHAPTER 2

REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION

In Grounded theory there is no need to review all of the literature before conducting interviews to avoid information that can cause constraints in the discovery of the theory. In support of this, Leininger (1985:152) writes:

"a prestudy literature search is disadvantageous for three reasons: the search may lead to prejudgement and effect premature closure of ideas and research inquiry; (2) the direction may be wrong; and (3) the available data or materials used may be inaccurate".

Strauss and Corbin (1990:52) support this view but he went further by indicating that:

"Literature review can be incorporated when the theory evolves to stimulate theoretical sensitivity by providing concepts and relationships that are checked out against actual data".

In view of the above arguments the literature review related to sexually transmitted diseases and categories that emerged will be incorporated in chapters dealing with data analysis and theory generation (chapters 4 and 5).
This chapter will therefore focus on aspects of the traditional customs, beliefs, role of women and indigenous health care systems of the Vhavenda, in order to highlight their understanding and viewpoint regarding sexually transmitted diseases.

2.2 CULTURAL BELIEFS OF THE VHAVENTA AND THEIR INFLUENCE ON HEALTH CARE DELIVERY

Traditional health beliefs about health and illness differ according to cultures, ethnic groups and religions. People's cultural and ethnic identity and folk beliefs play a decisive role in shaping up their perceptions, attitudes and practices regarding health care and illness. Giger and Davidhizar (1998:4), indicate that nurses need to devise some means of learning people's cultures in order to provide culture-specific or universal health care practices. Lowdermilk, Perry and Bobak (1999:225), assert that reproductive beliefs and practices of a culture are embedded in its economic, religion, kinship and political structures. Indigenous systems reflect the use of medicines, care agents, home remedy practices and a range of other health practices. The folk health providers are prepared through apprenticeship or a preceptorship style of learning. Folk health practitioners are often viewed as primary care practitioners as they provide generalised health care and health education to the local people. Indigenous health systems have both generalists and specialists who provide services such as midwifery, childcare services, the treatment of common colds, pain, and other common illnesses. The folk system may also have folk specialists like bonesetters, injectors, magical
cures, witchcraft diagnosticians, sorcery cuirass and divination specialists (Leininger 1999:64).

Furthermore, Leininger (1999:64,65) affirms that indigenous health systems have provided care to the people for many years, even before western professional health systems got integrated into their culture. However, as she points out, professional health worker usually views indigenous practices as inadequate, primitive, antiquated, superstitious, magical and quackery. The danger attached to that is that health professionals are mislead and as a result undermine the importance of the indigenous health system. This further denies them the opportunity to understand the values, norms, beliefs, needs and practices of the indigenous people.

The health care system of a society cannot be studied in isolation from other cultural aspects of that society. Therefore it is necessary to highlight the social, religious, political and economic status of the Vhavenda.

2.3 SOCIAL STATUS AMONG THE VHAVENDA

2.3.1 MARRIAGE AND FAMILY LIFE

The Vhavenda regard a family as a very special unit. The family provides love, shelter, food, clothes and security. It is in the family where for the first time in their lives, children are introduced to norms and values that would guide them through life, that is, how to perceive the world and how to make choices. A Venda family structure is that of an extended nature. Although nowadays some of the families have adopted nuclear structures, they still
have a solid and dependent relationship with each other (Phaswana 2000:16). During weddings, funerals and performing of rituals, they still gather in one unit to demonstrate their solidarity and togetherness. There are also practices like dzithevhula, which compel them to gather as a unit when they are communicating with their ancestors and conducting their rites of passage.

Every family belongs to a community and those families are expected to live according to values and set familial norms that correspond with the mores of that particular society.

Amongst the Vhavenda, marriage has always been regarded as a very important event in a man/woman’s lives. Traditional marriage involves the negotiation and payment of bride wealth. According to Raliphada -Muludzi (1998:34), a study conducted by Dominique on nuptiality patterns of the Shona of Zimbabwe found that bride wealth payments consist of several parts, which transfer specific rights to the groom, including sexual rights, the right to cohabit and the right to offspring of union. This view is supported by Raliphada Muludzi (1998:21), who revokes an existing argument that paying lobola gives a man the rights over his wife’s body sexually, and also the right to determine the number of children he wants. In agreement with this notion Mabogo (1990:60), reveals that amongst the Vhavenda, mamalo can be paid in instalments, with the last payments made after the birth of a child.

Most of the marriages amongst the Vhavenda were arranged. Cattle, known as mamalo (lobola) accompanied the marriage of a woman. Marriages were
usually arranged by Makhadzi (the husband’s sister) who would then play a very important role throughout the couple’s married life.

Makhadzi is the main role player in her brother’s marriage. She even decides the number and spacing of her brother’s children. Polygamy is a common and acceptable practice among the Vhavenda. A woman’s role is to bear children to prove her femininity, more especially a male child who will keep the family name.

2.3.2 SEX EDUCATION

Boys and girls were usually prepared for marriage at the initiation schools. Girls attended their first initiation called musevhetho. During this period girls are taught good manners, behaviour, respect for their elders, etc. (Madima 1996:82)

Boys in turn attended murundu where they were prepared for manhood. The foreskin of their penis is cut to signify manhood. That was done to protect them from contracting dirt (infection) and sexually transmitted diseases that can be easily hidden under their foreskin. This practice is still going on even today, albeit under changed conditions. Due to acculturation and modernisation, circumcision is now done mostly in hospitals. Notwithstanding that, there are still a few communities who are still sending their children to the veld circumcision schools, as they believe that there is more in murundu than the cutting of the foreskin. Like the ancient Spartans, one is first a soldier, then a man. If a boy could withstand and survive the rigours and pain,
then he would be well prepared for the uncertainties that come with the responsibilities of manhood (Stayt 1939:110).

Between the ages of thirteen and nineteen, girls attended Vhusha. During this initiation the girl-child graduated to a higher initiation school known as Vhusha. In this school from which both girls and their parents graduated, families wanted to graduate with flying colours. For the purpose of symbolism two calabashes were used - one intact and closed and the other sown open. The girl's vagina would be examined to see if the hymen is still intact. If the girl was still a virgin, the elderly women would be presented with a closed calabash. If the opposite was the case, the family would hang their heads in shame. The chances of marriage would diminish. In addition the number of cows stipulated for mamalo would also decrease. According to a study conducted about vhusha by Madima (1996:52), there was a clear indication that in all the communities that are still practicing this initiation ritual, teenage pregnancy is very rare. She further indicated that the practice of examining virginity is also common among the Zulu nation, who call it "Ukuhlolwa".

After Vhusha girls had to go through tshikanda and ludodo. At this school they were made to perform very hard tasks like carrying heavy objects, and crawling on their stomachs. Like boys, they were being prepared for the future burdens and tribulations of womanhood and motherhood. The pinnacle of the girls' initiation was Domba where they were prepared for marriage, taught and trained to respect and obey their husbands, elders and in-laws. This is where their sexual roles and responsibilities were clearly defined and inculcated
(Mabogo 1990:28-29). This view is corroborated by Lumadi (1998:43), who asserts that Domba is a joint initiation school which also marks the beginning of the premarital unions or mixing between matured girls and young men.

In their initiation, boys were taught about the incidence of masturbation. They were also taught how to have sexual intercourse without penetrating the girl. Boys were also trained on the withdrawal method as a technique method to prevent sperms entering the vagina in cases where they are not ready to have children. This was done to promote virginity and to prevent pregnancy. The withdrawal method is still advocated in the modern contraception to date, although it is usually a failure, as men are not well-trained and take it as a form of docility or subservience to women.

Some studies already conducted show that these days teenage sexual intercourse is quite rampant as compared to the olden days when initiation schools were still part of the social fabric of the Vhavenda and were an effective means of social control. The vacuum left by the erosion of these social institutions has brought all sorts of social ills that come with teenage sex, such as teenage pregnancy, single parenthood and the general disintegration of the family unit. No institution has taken over the role of the initiation school, which basically offered sex education. This puts children at the risk of contracting sexually transmitted diseases, including the dreaded AIDS. A study conducted by Madima (1996:87), reveals that "of the 380 births recorded during December 1994 at one of the major hospitals in the former Venda, namely Donald Fraser, 99 were those of teenage mothers".
2.3.3 THE STATUS OF WOMEN IN VENDA SOCIETY

Among the Vhavenda, women are subordinated to men. The old adage that a woman's place is in the kitchen holds true among these people. This so perpetuates the inferiority status of women that they are expected to perform all the household chores in addition to formal employment. The continued societal support of such notions marginalises women in all social, economic and political spheres. Sexual discrimination amongst the Vhavenda is traditional and fixed, it begins at birth. The birth of a male infant is cause for much celebration by the father and other family members, whereas that of a female would largely pass without much fanfare. A woman who bears girls only is accorded no respect and in most cases a second wife will most certainly be married to bear the husband an heir and someone who will carry the family name after the passing on of the father (Lumadi 1998: 49).

Traditionally, a girl would never inherit the father's fortune, if he had any. Hers was to be married off so the family would receive bridal cattle, which her brothers would use as mamalo for their own spouses. With the advent of formal education, girls were not allowed to attend school for fear of their acquiring education. It was commonly believed they would rebel against their place in society as females, and that they would also mingle with boys without the supervision of the elders. Mental independence for the girl-child was perceived as queer, thus the vehement opposition to female education. This attitude is still prevalent nowadays in some communities in the deep rural areas. The results have been catastrophic, as most of their women folk are illiterate.
Division of labour is also gender based. The heavier chores like construction of the homestead, woodcarving, sowing, and ploughing are assigned to males. The family laundry, baby minding, cooking, sowing, harvesting and gathering of firewood, fetching water, cleaning the house are the responsibility of women. This type of job specialisation has subliminally brainwashed women into believing in male superiority, and their subservience. It has also been so internalised that any male seen helping his wife with such household chores is labelled a wimp. At worst, the woman will be accused of having bewitched the husband to make him “docile” Phaswana (2000:19).

Gender based division of labour reinforces the notion that women are nothing more than baby-making machines. Once a Muvenda woman is married, she becomes the “property” of her husband; a kind of modern slave. At the initiation schools, girls are taught to obey and serve their husbands. The woman’s plight was worsened by church teachings, which also reinforced this subservience. Now husbands can even invoke the Almighty in their demand for subservience. There is also an idiom which goes: “vuhadzi ndi nama ya thole ya fhuhuma ri a fhunzhela” (marriage is like venison, when one is cooking it boils over, but one does not stop cooking it because one cannot stop it from overflowing). This in simple terms means stick to your husband and marriage, no matter how unbearable your ordeal is. Clearly divorce is taboo. A woman who does that has a special title “mbuya-vuhadzi”(a woman who abandoned her marriage). Nowadays she would be called a “return soldier” and all sorts of degrading labels.
2.3.4 SEXUAL BEHAVIOUR

The Vhavenda practice polygamy. With the advent of Christianity and civil marriages, this practice (polygamy) was largely abandoned. Although it is publicly frowned upon, polygamy is still popular. For those who purport to be enlightened, it has been replaced by extramarital affairs. In addition, widow inheritance is still prevalent. This was mainly aimed at keeping the deceased's offspring and estate within the family as the inherited widow has no say in this regard. She is effectively inherited together with whatever the deceased would have left behind, lock stock and barrel. A case in point was when the former independent Venda homeland Government promulgated a law, which would allow polygamous unions. This applied to those couples married by civil law.

The majority of those who could afford it engaged into polygamous unions. In the olden days a husband, his wives, offspring and the whole extended family stayed in the same homestead. His wives had their own huts. The husband lived in the main hut, which was basically a "baby-manufacturing factory". Wives would take turns visiting this hut where upon falling pregnant, a wife would cease to visit. The makhadzi (sister in law) was the one who determined whose turn it was among the wives to visit the main hut. This system helped in the spacing of children as sex was for procreation and never for pleasure for the woman. So in essence, if a woman's child was still very young or it was still being breastfed, for her the main hut was out of bounds. These days those who are still polygamous buy several stands for their different wives.
Helman (1996:152), opines that patterns of sexual behaviour practised in certain cultures or societies may have influence in the transmission of sexually transmitted diseases. A verbal account of the Vhavenda themselves asserts that polygamy is a very good arrangement, as it tends to help in tracing contacts during sexually transmitted diseases. Helman (1996:359), opposes this view and states that polygamy is one of the sexual behaviours which increases the spread of STDs more especially AIDS, which can then be passed to all women and children. The custom of widow inheritance is also no longer advisable as the man could have died of AIDS, which could subsequently be spread to the new husband and all his wives.

A community health nurse who taught about the practice of safe sex in Venda and emphasised having one partner indicated that he was very shocked when a student reminded him that it is lawful to have more than one wife in their then Republic of Venda (Herbst 1990: 23). It is therefore very important to know the cultural and sexual behaviour of a society before embarking on health education. The average number of children amongst the Vhavenda is four. There is a belief that if a family has only one child, that child may die before taking care of the parents in old age. They even have an idiom that says "lito lithihi a li vhonwi nga tshilavhi" (two eyes are better than one, you can still see with one in the event that the other is damaged. This clearly explains why, in the Vhavenda society, for a woman to insist on safer sex to prevent pregnancy and sexual transmitted diseases, or to suggest that a man use a condom is impossible. Her husband could regard her as defiant or insolent. Furthermore, she may even be suspected of infidelity (Hay & Sticher
2.4 CULTURE AND HEALTH CARE SYSTEM

Historically, the Vhavenda people have depended on their natural environment for their health and survival. Traditional healers rendered health care until the 19th century, western civilisation and Christianity began to question its legitimacy and credibility. Ndou (2000:120), corroborates this view by stating that traditional healers have existed in South Africa long before the Dutch colonisation in the 17th century. Amongst the Vhavenda, the converted and the educated started to shun their culture and were left with no options but to visit the traditional healers only during the night to avoid being seen. The practice is still going on.

According to Mabogo (1990:31), traditional healers can be classified into diviners, magicians, generalists and specialists.

2.4.1 DIVINERS

Diviners are those traditional healers who do not treat diseases but cast bones for the divination of the causes and sources of people's complaints. The diagnosis is sometimes done using a process called Fembo (smelling). The cast bones also help them to refer the sick to the relevant practitioner. These diagnostic measures are also practised in biomedicine where diagnostic tests like x-rays, blood tests, and angiography are done before a final diagnosis can be made.
2.4.2 SPECIALISTS

Specialists have been defined by Mabogo (1990:31), as those traditional healers that use herbs for treatment depending on the symptoms. Furthermore, he also indicated that among these specialists there are those who specialise in children’s diseases, women’s fertility problems, enemas and emetics, aphrodisiacs, incurable ulcers related to cancer, fits, or sexually transmitted diseases. This view is supported by Snow (in Helman 1996:68), who also classified traditional healers and maintains that most of them are general practitioners. Those that are specialists are referred to as maine (Setswe : 1999:56). He maintains that they render curative services, which include preventive and prophylactic treatments.

2.4.3 MAGICIANS

They are those specialists who make use of natural objects to produce amazing effects. Their main role is to ward off evil spirits from people and properties that have been bewitched.

2.4.4 SPIRITUAL HEALERS

With the advent of Christianity, a new version of a healer emerged, called Muporofita originally from the word prophet. They heal through prayer, the laying of hands on patients or by providing holy water and ash. Most of these healers come from the Zion or independent churches. Recently there has emerged a plethora of charismatic churches that also heal the sick by invoking the Holy Spirit and prayer without using holy water and ashes. Both these types of faith healers believe that their powers of healing come from
God through ecstatic states and trance- contract with the Christian Holy Spirit.

Furthermore, the Vhavenda classified disease according to causes. There are those diseases that are believed to be caused by supernatural powers or the gods (Vhadzimu), and those that are caused through witchcraft and sorcery. This view is supported by a study conducted by Green (1994:122), asserting that Swazis distinguish between diseases or conditions regarded as African (indigenous) and those that are foreign (western). In addition they believe that indigenous diseases can be treated by traditional healers and western diseases by biomedical doctors. Primary health care takes place in the family and the main providers are usually women (Helman 1996:153). Women who were traditionally called birth attendants practised midwifery. Amongst the Vhavenda each and every household had a family physician called Maine. Traditional healers use a holistic approach in dealing with health and illness issues. The traditional healers rendered the preventive and promotive care amongst the Vhavenda. Herbs were used to strengthen the family to prevent it from contracting disease caused by sorcery and witches (u vhe a mudi). Immunisation against diseases was also done, and it was called (u thavhela). The prevention was also done in family planning for example u fhahea nowa. Maine would also help in boosting the immunity of children by using a method called u thuswa (method used to boost immunity of the child to prevent him/her from witchcraft). Although it is publicly frowned upon, u thusa is still a popular method to prevent childhood diseases. Paradoxically it was used to promote health and to prevent childhood diseases (Stayt 1939:139).
2.5 SUMMARY

This chapter outlined the history and customs of the Vhavenda to enable the reader to understand more about the group in focus. The next chapter will present the methodology used in the study.
CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter describes the methodology used for the study. It contains an overview of the grounded theory method and a discussion of the sampling procedures, data collection methods, descriptions of the instruments, the ethical considerations and issues of trustworthiness employed in the study.

3.2 OVERVIEW OF THE GROUNDED THEORY METHOD

As already indicated in chapter one the grounded theory methodology served as the research design for this study. This approach was found to be appropriate as its roots are found in the interpretive tradition of symbolic interactions. According to Talbot (1995:445) grounded theory examines the social context of human interaction. In this approach, theory is generated from and "grounded" in data that is systematically and simultaneously collected, coded, compared and analyzed using the constant comparative method.

The aim of this method is to generate a theory characterised by fit, relevance, workability and modifiability. Strauss and Corbin (1990):

"The concept of fit refers to the fact that, in grounded theory, the theoretical categories are generated directly from the data instead of from priori ideas gleaned from other sources. Relevance denotes an inseparable positive relationship between the emerging theory and the phenomenon under study."
Workability means that the theory is capable of explaining what has happened predicting what will happen, or interpreting what is happening in the area of inquiry. Modifiability describes the dynamic nature of the theory. The theory must always be considered as emerging and ever changing in light of additional data. 

Furthermore, the strength of the grounded research method is that it facilitates more flexibility and creativity in methodological considerations and settings. It allows the researcher to explore and get more information without delineating boundaries of the research activity. De vos, Strydom and Delport (2002:269) support this view. They indicate that symbolic interactionism is more exploratory and descriptive in nature. In addition, as a qualitative research design this methodology is well suited where there is little or no prior theory that has usually addressed the variable being studied. The cultural beliefs and practises of the Vhavenda in sexually transmitted diseases have never been explored. The grounded research design was therefore chosen because very little literature has been found about the phenomenon in African countries.

Polit and Hungler (1999:195), maintain that the purpose of field studies used in qualitative research approaches is to examine the practises, behaviours, beliefs and attitudes of groups and individuals as they normally function in real life. The Vhavenda were respondents who were examined to explore how they view STD's in terms of promotive, preventive and curative measures.
3.3 POPULATION

The study was also contextual. The sample comprises a group of people from the Vhavenda ethnic group. Most of the Vhavenda reside in the Vhembe district of Limpopo Province. This ethnic group has been chosen, as they are known to honour their traditional and cultural practices ardently.

3.4 SAMPLING

Unlike the sampling done in quantitative studies, in grounded theory sampling cannot be planned before embarking on the study. The specific sampling decisions evolve during the research process itself (Wheeler & Hollway 2002:157). In this study the researcher identified the hospital as the first source of information as it was the place where she experienced and observed the phenomenon under study. The above method of sampling is justified by Strauss and Corbin (1990:180) when they assert that the initial questions or areas of observation are based on concepts derived from literature review or experience. After asking for permission the matron identified the hospital cleaners as people who have more information on the topic under investigation. During the interview theoretical sampling started evolving based on the categories that were evolving (Names of sexually transmitted diseases). The hospital cleaners gave information and identified the traditional healers who are well known to be dealing with the treatment of sexually transmitted diseases in different areas of the Vhembe district.
Strauss and Corbin further stress that:

"Sampling is directed by the logic and aim of the three basic types of coding procedures (open coding, axial coding and selective coding). Furthermore, it is closely tied to theoretical sensitivity. For the more sensitivity you are to the theoretical relevance of certain concepts, the more likely you are to recognize indicators of them in the field and in the data."

This notion became clear when the researcher and her assistants were collecting data. Different concepts of data kept on emerging which compelled them to do some more sampling. As new concepts on beliefs and practices emerged the researcher was referred to the elderly who were identified as key informants thereof.

Elderly women formed the majority of identified key informants. Because of their experiences in child bearing, wifehood, first educators for young generations, child readers, and family educators, elderly women were ideal research informants (Neguisse 1988: 12). The above-mentioned roles put the elderly women in a better position to be transmitters of knowledge in an indigenous knowledge context concerning pregnancy, childbirth infancy and sexually transmitted diseases. As already explained in chapter one the process facilitated a snowball effect. Snowball effect is described by Burns and Groves (1997:307) as network sampling as social networks are used to find subjects with similar characteristics for the study. Furthermore as already mentioned earlier theoretical sampling was used as categories continue to emerge until saturation took place.
3.5 DATA COLLECTION

One of the major features of grounded theory, which makes it different from other research methods where data collection and analysis are separate and consecutive events, is that in grounded theory data collection and analysis occurs simultaneously. (Lobiondo and Woods 1994:267). The second phase of the interviews was held with key informants and subsequently the traditional healers and herbalists treating sexually transmitted infections.

3.5.1 NEGOTIATING ENTRY

According to Denzin and Lincoln (1998:58), negotiating entry to the setting requires that a researcher understand the language and culture of the respondents. In this study the criteria has been met as the research assistants were the Vhavenda themselves. Coming from the same culture and speaking the same language, made things easier for both the respondents and research assistants, who were also aware of what was expected of them in order to gain the trust of the respondents. The Vhavenda research assistants were chosen to eliminate the biases experienced during the use of non-Venda interpreters.

3.5.2 INITIAL DATA COLLECTION PROCEDURES

The researcher herself did the initial data collection. This enabled her to fully cover the main categories as they emerge. This endeavour also helped as the researcher became fully engaged in the process. The process resulted in
the formulation of an interview schedule to be used by the research assistants. During the prodrome the researcher visited the research site and talked with a few potential subjects to get the feeling and ideas on what questions would be appropriate.

In order to assess the efficacy and veracity of various methods, the researcher used different methods for data collection. Focus group interview was conducted with a group of women cleaners in a hospital. Permission to conducting the study was obtained from the Limpopo Province Department of Health who referred the researcher to one of the hospitals. The manager of Nursing Services and Head of Cleaning Services in the hospital also gave permission for the hospital cleaners to be sampled.

Interviews were conducted in the seminar room of the hospital. The researcher explained the nature of the study to the respondents and later asked for their permission to participate in her study. All participants were asked to sign consent forms after agreeing to participate. There were 10 respondents with ages ranging between 27 and 50 years. Other cleaners excused themselves with reasons ranging from being busy to not having enough or cogent information regarding the topic. The necessary responses were elicited from the respondents with great difficulty. The other respondents were passive with only two out of ten of them being active.

After the interview the respondents came as individuals to give more information in private indicating how difficult it was to discuss sensitive issues in public. As a result, the focus group method failed as respondents were not free to verbalize what they knew about sexually transmitted diseases. In
addition, it could be assumed that being cleaners at the hospital could have contributed to the women not being open as they did not want to be associated with traditional healing which is seen condescendingly and viewed as inferior to modern medicine (Mulaudzi 2001:15).

The results yielded from this endeavour were later included in the final data analysis of the study. Furthermore, the experience made the researcher aware that in-depth interview with respondents will be the best option. The researcher was referred and given names of known herbalists who could help her with more information.

3.5.3 THE SECOND PHASE OF DATA COLLECTION

In view of the above experiences, the researcher changed the focus group approach into in-depth interviews. In depth interviews or one-to-one interviews were later conducted with three female herbalists. The researcher had two assistants who helped in note taking as preferred by Glaser (1998:139). The keywords taken during this interview sessions were later converted to themes which were used as guidelines in second phase of data collection. The themes were developed to guide the research assistants who were later trained to collect data for the second phase. The research assistants using tape recorders, later interviewed eight females with ages ranging from 40 to 65 years and three males aged between 40 to 60 years.
3.5.3.1 THE INTERVIEW PROCESS

According to De Vos et al. (2002: 273), the purpose of an unstructured interview is to obtain information in the respondents' own words, to gain a description of the situation and to elucidate detail. In-depth interviews therefore do not need a structure or planned questions that will limit the respondents participating spontaneously. In this study, the use of an interview schedule was necessary, as the researcher was not going to conduct all the interviews herself. An interview guide was used with themes developed according to the findings of the initial data collection. The interview schedule comprised a set of brief questions providing some general structure for the research assistants. In supporting this view, Chenitz and Swanson, in van der Wal (1992:111) indicate that a set of brief, general questions, a topical outline, or major themes, are necessary to help the research assistants to have a guideline on what they are expected to ask during the interview with respondents. The questions allowed the respondents to explain their own views. The research assistants were trained to probe for more information without following the interview guide, see Annexure 3.

An interview is a very tricky method of data collection that requires the investigator to have reasonable skills and expertise. The training of research assistants was therefore necessary to equip them with required skills. In addition, lack of interviewing skills may result in inappropriate questions being asked and the wrong line of inquiry being followed (Ely et al. 1991:123).
3.5.3.2 RECORDING OF INTERVIEWS

A tape recorder was used to record the interviews. Recording the interviews enables the researcher to listen to the process as many times as she/he wishes, always adding to the repertoire of information. Furthermore, field notes were also taken to maximise the accuracy of information recalled from the interview. This was done in order to ensure that no information would be lost. There can be flaws in transcription of the tape and note-taking may also be in an incomplete state. Therefore both methods were used to complement each other.

3.5.3.3 RESEARCH SETTING

All of the interviews were conducted at the tranquillity and privacy of the respondent's own homes. Respondents signed the consent forms before answering the questions. Finally twenty respondents were interviewed, thirteen of who were key informants, and the other seven traditional healers. Thereafter the interviews were transcribed by a typist and later translated into English for general clarity keeping original phrases for example key words used by the respondents. The researcher compared the recording and the transcribed copy to update and correct any omissions on that might occurred during transcription. The researcher then went through each interview, listened to the tapes and making notes along the margins, memoing, sorting, and writing ideas down. Core categories (themes) began to develop during this process. See the diagram below on the process that was followed:
Where the researcher felt that there was a void in the information elucidated, she went back to the subjects or telephoned them for clarification.

The researcher felt that it was not necessary to continue with more interviews as the information from key informants and traditional healers was corroborated, and complementary views were identified. Moreover, saturation of data had already taken place. Saturation has been described as a situation in which:
"No additional data are being found whereby the (researcher) can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirical confident that a category is saturated when one category is saturated, nothing remains but to go on to new groups for data on other categories, and attempt to saturate this categories also. (http://www.nova.edu/sss/qz/qrz-4pandit.html)."

3.6 DOCUMENT ANALYSIS (AUDIT)

The next step in the research was to review literature and current health policies, programmes and practices around STDs as they apply in Limpopo Province. In support of this Talbot (1995: 446), indicates that document analysis of organizational charts and policies, patients records and other sources of data complicate analysis, but allow for depth in the theory generated.

In this study, document analysis was undertaken by studying written policies and investigating whether they are actually implemented. The statistics of sexually transmitted disease treated from the year 2000 to 2002 were also scrutinised in order to evaluate the trends of STD occurrence and the management thereof. This method was applied in this study due to its relevance in answering the following research question:

How can an integrated health care training approach, implementable health care policies and cost effective budgetary allocations translate into health care
workers' understanding of the diagnosis, treatment, prevention, care and
gender bias associated with STDs in an indigenous context?

3.7 VALIDITY AND RELIABILITY

There is a lot of debate concerning validity and reliability with regard to
qualitative studies. However Leininger (1985:175) contends that validity in
qualitative research refers to:

"Gaining knowledge and understanding of the true nature, essence, meaning,
attributes, and characteristics of a particular phenomenon under study. Unlike
in quantitative studies measurement is not the goal; rather, knowing and
understanding the phenomenon is the goal".

In this study the methods of trustworthiness in the evaluation of data quality
as described by Lincoln and Guba (in Polit& Hungler 1999:426) were used.

3.7.1 CREDIBILITY

Credibility refers to the accuracy of the findings. It can be described as "truth
formulating process" between the researcher and the informants. According
to Lincoln and Guba (in Mouton and Babbie 2001), truth-value is usually
obtained from the discovery of human experiences as they are lived and
perceived by informants. In this study credibility was ascertained when key
informants and stakeholders who were interviewed concurred with the
interpretation and descriptions of STDs by traditional healers.
The interviews were held in the respondent's language and translated into English. Furthermore, the research assistants remained in the field for a prolonged period to ensure credibility. The participants were involved in the research until the product (teaching module) was developed. This enhanced free communication and consequently, the respondents volunteered more sensitive information because of the increased rapport. At the end of the research the findings were discussed with respondents themselves to formulate guidelines for training health care providers.

3.7.2 TRIANGULATION

According to Polit and Hungler (1999:428), the technique known as Triangulation is also used to enhance credibility. The triangulation method involves several frames of references in the presentation of a theory, collection and analysis of data. The use of the triangulation method is recommended by many authors who also put more emphasis on the growing importance of integrating qualitative and quantitative data (Streubert and Carpenter 1999:307). In this study various methods of ensuring triangulation were met:

- INVESTIGATOR TRIANGULATION

This involves the use of multiple individuals to collect, analyse and interpret a single set of data. To ensure trustworthiness the researcher trained research assistants on different perspective of health education, that is, gender studies, nursing sciences and psychology (Streubert and Carpenter 1999:307). The research assistants understood the technique of conducting a good interview.
The tape recorder was used so that the information is transcribed verbatim. The audio taped information was compared with the notes taken by the notetaker to ensure consistency and this helped in ensuring investigator triangulation.

- THEORY TRIANGULATION

This involves the use of multiple perspectives to interpret a single set of data. Different perspectives were used that is document analysis, grounded theory steps of analysis, as well as description supported by literature review.

- METHOD TRIANGULATION

Streubert and Carpenter (1999:307) maintain that method triangulation is when researchers incorporate two or more research methods. They further indicate that the triangulation may either be at designs level, data collection, or data analysis level. In this study the use of multiple methods of data collection were used, that is, document analysis, focus group interviews as well as in depth interviews. Furthermore, the study was also approached from two different perspectives; the feminist and the interpretive approaches.

- CONFIRMABILITY AND DEPENDABILITY

Confirmability refers to the objectivity or neutrality of data to allow for agreement between two or more independent people about the relevance or meaning of the data. (Polit and Hungler 1999:430). Talbot (1995:428) asserts that confirmability and dependability may occur simultaneously. In this study both confirmability and dependability were achieved by reaffirming the
information heard and collected from the categories that emerged which was verified and compared by both the researcher and the research assistants. Information gathered was also verified with the respondents themselves.

- **TRANSFERABILITY**

Transferability refers to whether or not the findings of the study will have similar meanings and relevance in another similar situation or context. The purpose of a grounded theory is to elicit in-depth knowledge about the phenomenon studied rather than knowledge that can be generalised. In this study detailed descriptions are provided to enable someone interested in making a transfer to reach conclusion about whether transfer can be contemplated as a possibility (Polit and Hungler 1999:430).

3.8 **ETHICAL CONSIDERATIONS**

3.8.1 **INFORMED CONSENT**

The researcher obtained permission to conduct the research from the teaching institutions. The researcher also wrote to the ethics committee of Limpopo Province health care authorities for permission to conduct the research in the province. The researcher was invited to present her proposal orally. Thereafter the letter of permission was granted. Funding was obtained from the National Research Foundation. The respondents were told about the nature and extent of the research to gain their co-operation. They were also informed of their rights to withdraw from the study if they felt uncomfortable, without any fear of victimisation. The researcher and researcher assistants
tried their utmost best to establish a good relationship so as to ensure
trustworthiness, and to enable the interviewees to be free and open during the
research process. The interviewees' rights as regards confidentiality and
privacy, as well as anonymity in publishing reports findings were guaranteed.
Research assistants from the University of Venda were used as they were
able to use the language of the respondents.

3.8.2 GAINING TRUST

The issue of sexually transmitted diseases is a very sensitive topic. Gaining
mutual trust was therefore essential for the purpose of developing and
reciprocating honesty, thus enhancing the interviewer's success. The
research assistants were taught to be humble and introduce themselves as
students from the University who wanted to know more about indigenous
health care not forgetting to emphasise the aim of the study.

3.8.3 ESTABLISHING RAPPORT

According to Denzin and Lincoln (1998: 60), the goal of unstructured interview
is understanding the respondents' view. It is therefore paramount for the
researcher to establish good rapport.

The research assistants were trained to create good rapport with
respondents. They were made aware of the importance of putting themselves
in the shoes of the respondents and attempting to see the situation from the
respondent's perspective. Good rapport had to be established prior to the
introduction of the topic and its aim, and prior to obtaining the informed consent of respondents.

3.8.4 DRESS CODE

The type of dress, as indicated by Denzin and Lincoln (1998:58), as "dressing down to be presentable according to the culture of the respondents" was taken into consideration. Research assistants were advised not to wear trousers, as it is not acceptable among the Vhavenda elders that women wear trousers. Trousers would therefore show lack of respect.

3.8.5 RESPECT

The Vhavenda are known to respect their culture. Research assistants were therefore trained to show respect by genuflecting as expected in the salutary mannerisms or protocols of the Vhavenda. As the topic involved sensitive issues, it was also emphasised that there be a clear introduction before asking for permission. Research assistants had to explain the aim of the research and to inform respondents what is expected of them.

Traditional healers used in this study displayed their knowledge and insight regarding ethics as they refused the research observation method, feeling it would compromise patients' privacy. The researcher was left with no option except to use STD posters during member check for traditional healers to identify the diseases that they were describing.
3.9 SUMMARY

The present chapter discussed the research methodology used in this study. The objective was to provide a research strategy that would enable the researcher to provide answers to the questions raised in the study. An audit of documents was done to determine the strength and flaws in the policy documents used in sexually transmitted diseases. In addition interviews with key informants and traditional healers were conducted to document the beliefs of the Vhavenda in sexually transmitted infections and to generate a theory according to their own understanding.
CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The previous chapter dealt with research design. In this chapter data analysis procedures will be discussed. As stated in the earlier chapter, grounded theory was used for investigation purposes whereupon data was gathered without prior formulation of a hypothesis. Instead, perspectives of the respondents were used in order to generate the grounded theory.

Data analysis was done in accordance with three steps of coding as described by Strauss and Corbin (1998:54). These are open, axial and selective coding. Data analysis using grounded theory differs from other forms of qualitative data analysis in that in the former, data is designed to build rather than test a theory. It also allows the researcher to translate the theory into good science. Furthermore, it helps the analysts in breaking through the preconceived biases and assumptions and those that can develop during the research process. Finally it provides the grounding, builds the density, and develops the sensitivity and integration needed to generate a rich, tightly woven explanatory theory that closely approximates the reality it presents. In this study all the steps of analysis were followed as described by Strauss and Corbin (1990:54). Description and conceptualisation were both used in the study in line with one of the purposes of the study, that of documenting the beliefs, diagnostic measures, preventive and promotive care of the Vhavenda in
respect of sexually transmitted diseases. Talbot (1995:445) attests to this view in his explanation that in the analysis of a grounded theory research, the researcher returns to the data frequently, revises research questions, and seeks out additional or missing data. In this study, additional and missing data was sought and the research questions were visited frequently, mainly to answer the following questions:

What are the cultural beliefs and health care practices of the Vhavenda in response to sexual transmitted diseases?

Are there any gender differences in the indigenous treatment, care, prevention and diagnostic measures of sexually transmitted disease?

How can training and health policies facilitate the health care workers’ understanding of indigenous diagnosis, treatment, prevention and care of STDs, and the gender bias thereof?

Polit and Hungler (1999:587) also support this view by asserting that:

Data analysis might address one or more of the following: description of a phenomenon, generation of categories through open coding, linking categories around a core category in axial coding thus developing a substantive low level theory and a substantive theory linked to a formal theory.
4.2 ORGANISATION OF DATA

Data was organized according to themes used in the interview guide. Designed by the researcher, this guide was based on the categories that emerged during the initial data collection. This process enabled the research assistants to collect data with ease without any differences.

Although open coding, axial coding selective coding and theoretical sampling occur simultaneously, for the purpose of report writing and fostering understanding, in discussing the first theme the researcher will elaborate on each phase individually. This is done to enable the reader to understand how the categorization and reduction of data was done in subsequent themes.

4.3 THEME 1: CULTURAL BELIEFS AND HEALTH CARE PRACTICES OF THE VHAVENDA IN THE CONTEXT OF SEXUALLY TRANSMITTED DISEASES

During this phase, the researcher had to take a different stance. As a professional nurse, she had to put aside her conditioned responses towards sexually transmitted diseases in modern medicine and allow herself total receptivity to "the other person's views". This is described by the feminists as a "feminist belief", that describes beliefs as the attitude of the oral historian who wants to give voice to the voiceless and the interviewer who believes the interviewee (Reinharz 1992:242). In support of this, Talbot (1995:467) writes:

Bracketing is used by qualitative researchers to meet the ethical dictum of portraying accurately the phenomenon as it is lived and described by the researcher's informants. The qualitative researcher must have a humanistic orientation "an interest in 'going to the people', a desire to understand other perspectives, and a
willingness to see the researcher/participants relationship. The investigator must identify and empathise with participants in order to understand their perspectives. Every person’s perspective is viewed as equal to another’s. The participants’ viewpoints are seen as neither “true nor false, good nor bad. The researcher seeks not truth and morality, but rather, understanding”.

In this situation the voices of subordinated cultures in health care were heard. The researcher felt that it is therefore imperative to first document the beliefs of the Vhavenda themselves.

4.3.1 OPEN CODING

According to Polit and Hungler (1999:124), the analyst codes data in the margins of the field notes rather than coding on a separate page. The researcher listened to the tapes, transcribing, memoing, sorting and writing down ideas as they come to mind. See diagram in chapter 3.

The tapes were listened to repeatedly in order to better understand their contextual and semantic value. Data was transcribed verbatim, and compared with information gathered by field note-takers. The same procedure was followed independently by some of the research assistants. The notes taken down were later compared.

After a thorough reading of the data, the researcher started generating the categories as they emerged. Similar topics were then classified and grouped accordingly. Finally, the data belonging to each category were grouped and preliminary analysis was carried out. Strauss and Corbin (1998: 72), assert that an
early generation of categories becomes the basis of theoretical sampling that enables the researcher to know what to focus on in his/her next interview. In agreement, Streubert and Carpenter (1999:118), further point out that the core variable is the goal of grounded theory as it serves as a foundational concept for theory generation. Research assistants also helped by going back to the respondents for further clarification and further information where necessary.

4.3.2 AXIAL CODING

In axial coding, themes begin fitting together as in a puzzle. Each piece has its exact location in the overall explanatory theory and must fit with the others to form an integrated whole (Strauss and Corbin 1998:21). This research focused on specifying a category in terms of a condition that gives rise to it. As seen in open coding, under this theme the main categories that developed were the names of sexually transmitted diseases as indicated by the respondents. The sub-categories were therefore causes, signs and symptoms. Strauss and Corbin(1998:23), describes them as the context in which the phenomena appear. The treatment of disease served as strategies by which the category is handled while descriptions of complications and curative measures served as the consequences of those strategies.

The last stage was described as causal condition-phenomenon-context-intervening conditions. In this case the researcher used the causes of different diseases explained. The above information can be supported by information sought from the literature review, which will then lead to the formulation of a conceptual framework, and later to the generation of hypothesis or formulation of a theory. This process
was also supported by Streubert and Carpenter (1999:108) who described criterions which fit with the analysis of data. In this study the criteria were met as explained below:

4.3.3 FREQUENT RECURRENCE
The names of the diseases that appear frequently were used as core categories. Those that occurred once or twice were discarded after follow up 'from other respondents did not support the knowledge. Literature review followed after data was categorised to see if similar diseases with related signs and symptoms have been discovered in other African countries.

4.3.4 CONNECTION WITH OTHER DATA
E.g. the names linked with signs and symptoms: doropo linked to discharges that are main signs and symptoms of the diseases.

Explanation of data variation: This criterion has also been met as all information is centred on the name of the disease.

4.3.5 IMPLICATIONS FOR A MORE GENERAL THEORY
Streubert and Carpenter (1999:108) assert that as theory becomes more detailed it permits maximum variation and analysis. The above criterion has been met as the information gathered needed refinement to be able to meet the criteria of implications of a general theory. As the interviews continued, the theory became more detailed and it permitted maximum variation and analysis as explained in chapter 5.
The process was followed until different themes were generated. Under each theme categories and subcategories emerged. These are displayed in the form of tables.

The researcher wrote memos and started categorising the diseases as indicated by the majority of the respondents. In this theme sexually transmitted diseases were described after categories were generated through open coding. The diseases were then linked to categories in the form of signs, symptoms and treatment. The information on Table 1 and the discussions that are to follow are based on the results thereof.
<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Treatment</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of disease</td>
<td>Signs and symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Dorobo</td>
<td>A woman complains of heavy discharge, which later changes to a yellow colour. Man starts by having a plain colourless discharge, which later changes to a yellow colour if not treated early.</td>
<td>Both partners are treated together with medication that they take orally.</td>
<td>A woman suffering from dorobo will not fall pregnant.</td>
</tr>
<tr>
<td>Thusula</td>
<td>Sores in the private parts; These are itchy and they produce water-like substances. At first they are painless, but eventually become painful. If the person is not treated early, sores then spread to all parts of the body. A person starts having sores which look like blisters</td>
<td>Both partners receive oral treatment,</td>
<td>A person suffering from Thusula may fall pregnant, the baby will be affected and may be born with abnormalities</td>
</tr>
</tbody>
</table>
| Gokhonya | Types of gokhonya | Treatment | Neonatal death
Infertility
Unexplained miscarriages |
| | 1 | Saha: whitish in colour and is embedded at the floor of the vagina. A man experiencing pain during sexual intercourse with infected person | The warts-like structures are incised and burnt. They are then mixed with herbs and used for both mother and baby. |
| | 2 | Another type is found below the clitoris. The most common is found protruding on the walls of the vagina. | |
| | The baby whose mother has gokhonya is born with a red mark on the occiput. The baby doesn’t have good eye contact with the mother. The child may also vomit and have respiratory distress. The mother may complain of itchiness in the vagina, which is often relieved by scratching. | |
| Lukuse | It is a hair-like structure that has a head-like tip. | Both partners are treated. | Infertility |
| Dvhu wele (u) | Diarrhoea and vomiting. The man suffers weight loss, a dry mouth, protruding teeth makes it difficult for him to close his mouth, a distended vein on the forehead. In the last stages, the frontal fontanel will be pulsating like that of a baby and finally the man will die. | in the past it was difficult to treat the disease, as contact was supposed to be traced, that women used to hide fearing the stigma attached. The urine of both partners is mixed with herbs and they were given it as oral treatment to drink. Due to difficulty in tracing contacts a new method of treatment has been devised | There is an acute and chronic phase of the disease, depending on the immunity of the individual, in acute phase the man starts shivering, has rigor, and complains of inability to pass urine. If he doesn’t seek treatment he may die within three days. In chronic cases, the man goes through different stages as described under “signs and symptoms” |
Furthermore, in axial coding the researcher also looked at the theories behind the diseases as identified by the respondents, supporting them (the theories) with information gathered during literature review. Literature is used to support the emergent theory and also it gives alternative explanations of the data. (Talbot 1995:447). The respondents went further by categorising sexually transmitted disease into two different types; sexually transmitted diseases and sexually related diseases.

4.3.6 SEXUALLY TRANSMITTED DISEASES

The respondents reflected that amongst the Vhavenda sexually transmitted diseases were a family matter that should be known only by Maine (family physician).

Sexually transmitted diseases were described as diseases transmitted during sexual intercourse, whereas sexually related diseases are those diseases that affect the reproductive and sexual health of an individual although not necessarily being transmitted through sexual intercourse. The most common sexually transmitted diseases mentioned were dorobo, divhu and thusula as discussed below:

4.3.6.1 DOROBO

The disease is transmitted through sexual intercourse. It can be contracted by sleeping with a woman/man suffering from the same diseases. Dirt has been described as the cause of the disease. (for the signs and symptoms of the disease see the table above). The name "dorobo" is derived from the signs and symptoms where the sufferer has thick, purulent discharges. It was difficult to get the names of treatments from both the healers and key respondents, but they indicated that oral
treatment is usually given. One of the respondents indicated that changing sexual
behaviour is also emphasised.

The complications of the disease were described as follows: A woman who has
"dorobo" can't fall pregnant until she gets treatment. A woman who contracts
dorobo whilst pregnant will deliver a sick baby whose eyes will ooze those
discharges that women have when suffering from the disease. The symptoms
explained are more similar to a disease called gonorrhoea in western medicine.
When this was suggested to the healers, they showed that it can be the same, but
the treatment will never be the same as western medicine treats only the symptoms
and not the diseases itself. Due to the reoccurrence of the disease patients treated
by western medicine will come to traditional healers who eventually cure the
disease.

From the literature reviewed the same disease with its symptoms has been
described in Swaziland (idrop) and Mozambique. In addition in a study conducted
by Green (1994:181) on traditional medicine and sexually transmitted diseases in
Africa, a group of healers interviewed identified dorobo as a common STD in South
Africa. After categorising this disease the researcher went back to the respondents
to verify if they agree with her findings. This procedure is supported by Talbot
(1995:428), when he defines member check as:

"A process which involves checking with or getting feedback from the participants to
ensure that the researcher has captured their own words and their meaning by
"playing back" to them the interpretation of the data".
The above practice helps in increasing the credibility of a study. In this case during member check traditional healers were asked to identify dorobo from posters depicting various sexually transmitted diseases as used in modern medicine. (Below, see a diagrammatic representation of the incidence of Dorobo as identified by the healers.

PICTURE 4.1 PICTORIAL DEPICTION OF DOROPO(GONORROHEA)

The diagram has been used as the traditional healers denied the researcher and her assistant’s permission to observe the symptoms on the clients during consultations on the grounds of violation of patients’ privacy.
4.3.6.2 THUSULA

This disease is contracted through sexual intercourse with another infected person. Dirt is identified as the cause of the disease. The symptoms of thusula and its treatment have been described in Table 1 above. From the western perspective the thusula has almost similar symptoms as those found in syphilis. The disease thusula seems to be known even in Swaziland and other neighbouring countries where it is called Gcunsula or Gcushiwa in another language.

The botanist interviewed also agreed that there are similarities between thusula and syphilis, explaining that:

"We are not really sure what thusula is but the symptoms are those of syphilis. I have a student who is going to obtain his Honours degree this year who has been researching this disease. He found the symptoms to be the same. He extracted discharges from a sufferer, took them to the laboratory and after testing, found that they were the same as those of Syphilis. He treated these micro-organisms with traditional medicine and found it to be very effective. The problem that we have is that it is claimed that traditional medicine is not measured and standardised. That is why we still need to put up a strong argument to legitimise these medicines."
4.3.6.3 DIVHU

A man who has slept with a woman who had an abortion contracts the disease. The woman who aborted and had not undergone dilatation and curettage is said to be dirty and has infectious discharges, which will infect the man (see "signs and symptoms, treatment, and complications" in Table 1). Some of the healers explained that the symptoms look like those of HIV/AIDS. They further revealed that the disease might also be called Lufhiha (Tuberculosis).

The same findings have been revealed by a study conducted amongst the Tonga in Zambia where the disease is called "kahungo". There is evidence that this is one of
the diseases feared by men, which they relate to HIV/AIDS. To emphasise that aspect, one of the former patients found at a healer's house said:

"It starts with a terrible headache. If not treated quickly, the patient may die. Then you start getting thinner and thinner by the day. This is caused by the fact that the patient's appetite disappears and its cause is linked to the fact that the patient's bowel system stops functioning. Even the urine stops. Even if the patient feels like going to the toilet, nothing is released and this is very painful. Even if a little urine comes out, you will never want to go back to the toilet again.

(Here the respondent interrupts.) "A person with AIDS develops diarrhoea at some stage. This is when 'the' AIDS is said to be full-blown. But what I believe is that because this person's metabolism is not working, he/she went for treatment, and the excretion continued abnormally due to the disturbed metabolism. Normally people who are said to have AIDS are those who are used to going to hospitals and have been to hospital for treatment. And mostly these people are given laxatives to relax their bowel system".

4.3.6.4 TSHOVELA

Tshovela appears as warts, similar to cauliflower in form, and develops around the pubic area and on the vagina. These warts have been described by some healers and key informants as swelling white sores that grow and cover the genitals as they multiply (Green 1994:182). See the picture below.
The symptoms are similar to what in western medical nomenclature is referred to as condylomata.

4.3.7 SEXUALLY RELATED DISEASES

4.3.7.1 TSHIMBAMBAILA

Tshimbambaila is a disease that is also called u reiwa. One of the respondents described it as follows:

"Then there is u reiwa. Men mix medicines. I do not know how, but if a man sleeps with a woman for whom this has been done, he would get sick because the woman would not be compatible with him. Even women do get this disease. It is called Tshimbambaila and the local healers cannot treat it. Usually those who come from
Green (1994:182), describes the disease as a type of sorcery, a spell cast by a husband to prevent a woman from infidelity. It was reflected that the symptoms are like those of “Thusula”. The respondents in this study indicated that in certain instances the woman and her boyfriend might be “locked” together during intercourse. The treatment is to inform the husband who will decide to unlock them if he so wishes. They further explained that with modern medicine, unlocking the two partners might also be done in the hospitals. The disease is also common in Swaziland and is called likhubalo lenja.

After having been shown a poster with different types of sexually transmitted diseases, some of the traditional healers identified the last stages of syphilis (where an individual has sores all over the body) as tshimbambaila.

4.3.7.2 MAFA

Respondents described mafa as a disease that a man contracts through having sexual intercourse with a woman who had not been cleansed after her husband’s death. These same beliefs seem to be shared by other ethnic groups in South Africa. Shai-Mahoko (1996:114) for instance, describes boswegadi as one of the sexually transmitted disease that is common amongst the Batswana. She confirms that it is rife in the community and that it is thought to be associated with sexual intercourse with a widow. It is believed that during this period a woman will contaminate a man, who will in turn transmit the disease to any woman with whom he has sexual intercourse. There are forbidden periods where a woman is said to be dirty and therefore not supposed to have sex with men. This view is corroborated
by Helman (1996:357), who describes an indigenous Tswana sexually transmitted disease (meila) as an infection which is attributed to having sexual intercourse during forbidden periods, for example, during menstruation, or after childbirth. It is believed that during this period a woman would pollute a man who will in turn transmit the disease to any woman with whom he has intercourse.

A study conducted in Kenya also revealed that transgressing certain traditional rules is pathogenic. Those activities related to prescribed and prohibited sexual relationships are thought to lead to a disease called thavhu (Ginneken and Muller 1987: 285). All these researchers agree that those diseases can only be treated by indigenous health care methods, which poses a challenge in biomedical medicine.

4.3.7.3 GOKHONYA / GONI

The name gokhonya means knocking down, whereas goni means "martial eagle". The belief is, the martial eagle looks for chickens, picks one and knocks it down for its food. Similarly, if a baby has been misdiagnosed and goni is not seen and treated immediately after birth, it (the goni) will pick the baby (chicken) and knock it down or kill it. In Mozambique the same disease is known as "nyoka dzoni" (Green 1994:128).

One of the symptoms associated with the disease is the appearance of warts in the vaginal canal. It is believed that a baby contracts the disease during delivery as he/she passes through the vaginal canal. The infected baby is said to be weak and cannot maintain good eye contact. Another sign is that the baby will not be able to hold her head upright, resulting in the head always hanging forward.
According to the respondents, the disease was previously not common as vaginal inspections were conducted repeatedly while the girl-child grew up. With the advent of children's rights, which advocate privacy, vaginal inspections are no longer conducted and thus the disease is only discovered after such a person has delivered their own baby. This disease is believed to be one of the major causes of infertility and premature labour. Given the high statistics of infertility amongst women and unexplained premature labour and spontaneous abortions as well as cot deaths, it is imperative that further studies be conducted to research more about the condition.

4.4 THEME 2: DIRT (WOMEN'S PHYSIOLOGICAL DISCHARGES)

As the interview continued, it became evident that dirt was identified as the main cause surrounding sexually transmitted infections. In this case dirt was in the form of vaginal discharges such as menstruation, post delivery discharges, post abortion discharges. Women are also referred to as dirty when they are associated with such taboos as not having undergone the ritual of a cleansing ceremony after the death of a husband.

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<td>Post abortion discharges</td>
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<td>Post delivery discharges (lochia)</td>
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4.4.1 MENSTRUATION

A woman who is menstruating is said to be dirty. She is therefore not expected to
have sexual contact with a man. It is believed that menstrual discharges make a man to be physically weak. Furthermore the dirty blood is believed to cause infertility to the male partner by blocking the route of seminal fluids. This view has been asserted by many respondents with one of them saying:

"Then amongst men there is this thing of having sexual relations with a menstruating woman. What happens is that your nerves become thinner and they become painful. That is why if such a person bends at the waist for a long period, to unbend becomes a problem. If he forces to unbend there is a noise like that of a joint getting back in its rightful place. That's why in Tshivenda we use 'Tshipeiti' (enema) to treat this".

In modern medicine menstruation is regarded as shedding of dead endometrial tissue. It is therefore true that the discharges are "unclean".

4.4.2 POST-DELIVERY DISCHARGES

Postpartum discharges are strongly believed to be infectious. It is widely believed that when a man engages in sexual intercourse with a woman who has just delivered, he may suffer from weakness and other physical health related symptoms. To avoid these consequences during post delivery a woman has to move from the main hut if any and sleep with her mother-in-law who would also take care of her.
In a similar study conducted in Ghana it revealed that women are encouraged to practice post delivery sexually abstinence. They further maintain that the practice is done to prevent extra-marital behaviour of men suffering from sexually transmitted infections caused by lochia (post delivery discharges). In this case, men tend to have extramarital affairs that quicken the spread of STDs (Mills and Anarfi 2002: 325).

The critics of monogamy cite the above examples to illustrate that monogamy is an unrealistic method to prevent transmission of sexually transmitted infections. In polygamy it is easy for health care providers to trace contacts easily in cases of infections, as the husband’s wives are all known. (Gausset 2001:517).

In support of this, one of the respondents pointed out:

"Why would a man go outside the marital home for sex when he had his own harem at home? As for the wives, they were all bound to their husband. These days some of these diseases are a result of men having sexual relations with their wives immediately after the wife has given birth and the womb is still dirty or unclean."

To the pro-polygamists, having more than one wife allows women to have enough rest after delivery. They also maintain that this was a good way of spacing children compared to the family planning methods used in modern medicine that weakens women’s health.

A woman is also not allowed to cook until she is no longer having post delivery discharges; neither is she allowed to have sexual contact while she is still breastfeeding. There is a strong belief that breast milk can be diluted by the seminal
fluid. The breast milk will not have enough nutrients and as a result the baby will suffer from a disease called lukala. The description of lukala is more or less similar to marasmus (malnourishment) in modern medicine. During this period the man is at liberty to sleep with his other women, that is in case where polygamy is practised.

4.4.3 POST ABORTION DISCHARGES

Post abortion discharges were described as not only very dangerous but also fatal. A woman who has had an abortion is not allowed to have sexual relations until she has had her normal menstruation. It is believed that the normal menstruation will cleanse her from the dirt that she harboured due to abortion. A man who will have sexual contact with a woman who has had an aborted will contract a disease called Divhu. (See sign and symptoms in table 4.1).

The above findings are supported in the literature by Louistanau & Sobo (1997:38) when they indicate that:

"In such societies, which are patriarchal, men are in control, and the more patriarchal a society is the less important women and all that is associated with them are deemed. This devaluation serves as an ideological function, supporting male domination. Negative stereotypes of women also may stem from what is termed "procreation envy". In other words, men may feel jealous that women can have babies and they cannot. One way that men can gain the upperhand is by trivializing women's procreative power. For example, menstruation and birth become associated with nastiness and uncleanliness; Menstruating women are banned from certain places or tasks. Further sensibilities and skills" that are associated with female gender are devalue"
4.5 THEME 3: BELIEFS AND PRACTICES OF THE VHAVENDA

Under the beliefs of the Vhavenda the respondents asserted that the Vhavenda were moral people amongst whom adultery, divorce and illegitimacy were rare. In the olden days STDs were rare in the Vhavenda community, probably due to the fact that they strongly adhered to their culture, which discouraged promiscuity. Additionally, there was no migratory labour and education-induced mobility, as it is the case in modern times.

The cultural elements of the Vhavenda as described above are believed to have prevented both STDs as well as teenage pregnancies. The contributing role to the prevention of the spread of sexually transmitted diseases signify the emergence of what could be called a category of preventive practices to prevent the spread of sexually transmitted diseases. This category emphasised good social behaviour such as listening to the elders and fulfilling moral expectations of a society based on cultural values, e.g. sexual education, initiation schools, premarital counselling, polygamy and widow inheritance.

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<td>Initiation school</td>
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<td>Virginity inspection</td>
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4.5.1 SEXUALITY EDUCATION

Respondents asserted that sex education was taught at initiation schools. Talking to your own child about sex education was taboo. This view is supported by the fact sheets on HIV/AIDS (2000:6-2) which state that there is a cloak of silence related to issues pertaining to sexual practises. Such matters are often associated with taboo and engender embarrassment, shame, guilt and rejection. It goes further by stressing that nurses and teachers also conform to this culture of silence regarding sexual practices as they are also from the same cultures with the clients.

4.5.2 INITIATION SCHOOLS

In those days boys and girls who had come of age would be sent to initiation school (vhukombani for girls and thondoni for boys). As for girls who had started experiencing their monthly periods, they were warned that they were now of childbearing age and therefore should refrain from ever having sexual relations with boys. This started in the home front. With vhukombani, the girl was sent for the sole purpose of sex education by *other parents. One of the respondents said:

"We also had initiation schools. Men were taught about these things when they went to Tshitatamo and for females there was U imbelwa. Here girls were told that it is anathema to have sexual relations with a man before marriage. This made girls to be afraid to have sex before marriage as they knew it was wrong to do so. So, all girls waited for marriage before having sex. Boys would also be told that if they had sex before marriage, they would suffer unending headaches, swollen genitalia and other frightful diseases. So, I would say there was sexual education in the past. It just disappeared with time".
Lumadi (1998: 48) support the above findings when he describes the meaning of the term Khomba (female teenager) as "dangerous". Dangerous in this case implied that sexual intercourse may now result in pregnancy. In emphasising the importance of initiation schools, Pretorius and Madima (1997:23), state that traditional sex education devices have been abandoned without being replaced, thus leading to social disintegration. They base their arguments on the increased figures of teenage pregnancy, which in this study can be linked to high statistics of sexually transmitted infections more especially HIV/AIDS.

The above notion is shared by Phaswana (2000:204) in his study on marriage amongst the Vhavenda where he maintains that with the dying of initiation schools, there is a need for carefully planned system of general education for marriage, parenthood, and family so as to prevent further breakdown of marriage due to ignorance and false expectations.

4.5.3 VIRGINITY INSPECTION

Madima (1997:25) maintains that at initiation schools a great deal of time was spent on sexual teaching. Girls were warned against being deflowered before marriage, and taught how to have sexual intercourse without "deflowerment" occurring. Girls were therefore expected to stay as virgins until they were married. Vaginal inspections (tshitavha) to find out if the teenager is still a virgin were also conducted. Gluckmann (in Green 1994:95) refers to the existence of a similar practise among the Zulus people. Chastity was highly valued and was part of the ethically enforced code. The girl-child knew that if she could loose her virginity before going to a ceremony called Vhukomba (teenagehood) she was going to be a source of shame
to her family as virginity inspection were conducted (Madima 1997:25). The practice is no longer common due to women and children's rights. One of the respondents said:

"If I were to say I wanted to do vaginal inspections on your children, you would be the first to say I want to bewitch them. In my day, we were inspected, not only for diagnostic purposes, but also to see whether one is still a virgin or not. This went on until wedding day".

It is asserted that the above practices including abstinence from sexual intercourse would save teenagers from contracting sexually transmitted diseases. According to the Fact Finding Sheet (2000:10-2), younger women who are involved in sex are more at risk of contracting sexually transmitted infections as they are more prone to vaginal mucosa lacerations. They oppose the practice of virginity testing, they maintain that teenagers resort to anal intercourse to preserve their virginity and to avoid teenage pregnancy thus endangering their lives.

On the other hand, the virginity and purity of the girl-child is also undermined by the myth that indicates that sleeping with a virgin may cure sexually transmitted infections, especially HIV/AIDS. The media carries reports on sexual abuse of the girl-children daily that are never followed up. In certain cases the perpetrators are freed or given light sentences by the courts of law. (See the story on Table 2 below) as written by Jurgens (in Sunday Times:2002):
TABLE 4.2 MEDIA RELEASE ON SEXUAL ABUSE

Stop this horror!

Toddler ‘sodomised to death’ is one of hundreds of child rape victims

Andre Jurgens

Two-year-old Thendo Nenzhelele died after being sodomised so brutally that her wounds shocked doctors. She is one of 289 children whose rapes have been reported to just one trauma centre in a rural area of northern Limpopo over the past year. He-man who raped Thendo was never brought to justice after a policeman examined her corpse in a mortuary and decided that "nothing was wrong".

Doctors tried for more than an hour to save Thendo’s life at Tshilidzini Hospital, near Thohoyandou, but she died of dehydration and rape injuries in March. Her anus and rectum were so severely injured that medical staff could literally "see" 3cm inside her body. Her buttocks were septic. Twelve days ago an inquest into Thendo’s death found that it was not the result of an offence by any person. The inquest file incorrectly dates her death. In addition, she is identified as a male, and the hospital report could not be found in the file this week. A written note points out that the investigating officer’s affidavit was not a sworn statement.

Now the head of a family violence and trauma centre in Thohoyandou has accused police and the justice system of failing the child, whose rapist is still free. Thendo’s weeping mother, Takalani Caroline Nenzhelele, 22, said yesterday: "I want this man arrested. The public humiliation is unbearable." She has left Thohoyandou to escape community gossip about the rape and death of her child.

"It is painful because the person who did this lived with us and shared our food. I did not know what he was doing to the child," she said. Limpopo police on Friday promised a full investigation into the alleged bungling, warning that any "negligent" police officers would be dealt with harshly. This comes after Fiona Nicholson of the Thohoyandou Victim Empowerment Trust on Wednesday lodged a complaint at the Independent Complaints Directorate against police. She intends lodging further complaints with the Justice Department.

Nicholson has alleged that: A policeman lost interest in the case after parting Thendo’s legs in a mortuary, and later told colleagues there was "no evidence" of sodomy; Police took five months to collect the postmortem results; and Forensic evidence of rape was not collected. The trauma centre at Tshilidzini Hospital has treated 786 rape and sexual assault victims - 289 of them children - in the past year.

Affidavits by Thendo’s family state the toddler started vomiting at home in Khaokhanwa on Sunday, March 10. She was admitted to hospital on March 13 at 8.20pm and died at 9.50pm. Her mother, and aunt, Nyamukamadi Nenzhelele, said a hospital doctor showed them Thendo’s “swollen and open” anus. Both women and the child’s grandmother named a relative whom they "strongly suspected" of sodomising Thendo. Four days after the child died, the suspect denied raping her when questioned by police.

Nicholson told the Independent Complaints Directorate that when she asked for an update on the case, police told her a senior superintendent had examined the body and decided there was no evidence of sodomy. Police collected the report only on August 8, after Nicholson complained. "If the case had been investigated as a murder, we are convinced forensic evidence could have been gathered from the home of the alleged perpetrator," she said.

In a letter to Thohoyandou’s senior public prosecutor, Brian Pele, she said: "This is the third child death we have monitored in the past year, and I am sorry to report that each case has been handled by the SAPS with the most disturbing lack of professionalism that borders on downright incompetence, compounded by arrogance and insensitivity. A social worker’s report said the family “repeatedly indicated they hope justice will take its course”. The child told her family the suspect had “hit her with a stone”, it noted.
From the story in the above insert, it is clear that the myth that children are clean and as a result can cure men from HIV/AIDS, is responsible for the high incidence of sexual abuse of little girls. Furthermore, young girls who have sex are at risk of contracting sexually transmitted infections such as gonorrhoea and chlamydia as their cervix and vagina are less developed. In addition, they are more likely to sustain cuts and more seriously lack resistance to disease.

4.5.4 PREMARITAL COUNSELLING AMONG THE VHAVENDA

Premarital counselling was an imperative among the Vhavenda. The prospective bride was taught how to behave towards her husband including always consenting to intercourse with him. One of the respondents said:

"These sessions were never held for males. If boys go to initiation school it is assumed that they received all the sex education and premarital counselling they would need, but I personally think boys should go through the same sessions as girls" 

Lumadi (1998:43), stresses that premarital counselling started during the Isat initiation school(Domba) where the values of motherhood were inculcated to balance and maintain the stability of the social system.

Premarital counselling was basically planned around teaching the prospective bride about the role of an African woman. Hay and Sticher (1984: 53) maintain that the role of an African woman was that of a wife whose life is centred in her home and family. A woman passes through marriage from under the authority of her father to that of her husband which is equally not to be challenged. The respondents also
emphasised that a woman was taught to respect her husband and to have no say in the running of the household, including sexual matters.

Regarding the protection of the husband to be against diseases that the prospective brides may possibly have, one of the respondents said:

"Traditionally when a girl gets married, she does not immediately have sexual relations with her new husband. She first has to undergo vaginal inspections for the purpose of establishing her virginity, the existence of STDs and whether she is not pregnant by another man other than her husband. If found sick, she would first be treated before any sexual encounter".

When asked if the same treatment is given to men the respondent asserted that it would not be necessary, as men do not harbour sexually transmitted diseases.

4.5.5 RESPONDENTS' VIEWS ABOUT POLYGAMY

There was no consensus on the issue of polygamy among respondents. Some indicated that they were against polygamy as it facilitates the spread of infection. Those in favour of polygamy indicated that it enabled the affected to trace contacts.

One of the respondents said:

"Men with more than one wives lived longer because a man who is always solving problems is always active and therefore does not grow old. This is what I was told by some old man. And again this did not encourage the spread of STDs since the man was always indebted when it came to satisfying his wives. At the end of the circle, he needs to start again and so it goes. It also helped that the man did not sleep with strangers since he knew his wives. (laughter). As for wives being tempted, it was just
a matter of the wife being unfaithful. Even if she was the only wife she would still do it”.

In addition, they indicated that due to the fact that polygamy is no longer practised, men replaced the practice by having mistresses, which makes it difficult for one to trace contacts.

In South Africa polygamous marriages are covered in the Recognition of Customary Marriages Act No 120 of 1998. This law makes provision for the recognition of customary marriages. It is quite unfortunate that at the same time, the Act predisposes and increases women’s vulnerability to HIV/AIDS. Men working in urban areas often marry two wives. The senior wife remains in the rural areas and is only visited during holidays and the second wife lives with the husband in urban areas. This makes it possible for infections to be passed from one wife to the other. Gausset (2001:512) argues that it is not the issue of polygamy or monogamy that fuels the spread of sexually transmitted infections, but, fidelity or the practice of safe sex in extramarital relationships. He asserts that a polygamous family in which all partners are faithful to each other, or in which all partners practice safe sex is no more at risk than a monogamous family that has the same practices.

In addition to polygamy, on her study about reproductive health rights of women in rural areas, Raliphada-Muludzi (1998:22) noted that the practice of paying mamalo (lobola) under customary law also perpetuates women’s vulnerability to abuse. In this case, women will not be able to negotiate safe sex as mamalo puts them in subordinate positions.
4.5.6 WIDOW INHERITANCE

Another customary practice that emerged during the interview, was widow inheritance. Accordingly, the family of the diseased has the right to distribute the will of their son even if he was already married prior to his death. The husband's family chooses a new husband for the widow. If possible she is inherited by her deceased husband's brother. The new husband will then inherit the widow, the children and any money or property that the deceased had. This practice was done to protect the widow and the children, more especially the family name. Nowadays the inheriting spouse is usually interested in the property instead of caring for the widow and the family.

Added to this is the fact that this type of practice makes people, especially women, to be more vulnerable to sexually transmitted infections. A case in point is, where the deceased died because of HIV/AIDS there is a chance that the surviving spouse will also be HIV positive. In that case an HIV negative brother will also have inherited the disease thus spreading it to his wives too. The adults will therefore die leaving children orphaned. Guasset (2001:512) defends the cultural practise of widow inheritance by asserting that women need the support of a man to raise children. He therefore feels that condom use must be emphasised and where people are suspecting HIV/AIDS as the cause of death, blood must be tested. Ironically Guasset (2001:512) himself once remarked about the dehumanising effect of blood tests, as in most instances only the widow is tested while the brother of the diseased is reluctant. This practice perpetuates gender discrimination.
In many instances the death of adults leaves the girl-child with an enormous responsibility of caring for the siblings. Under such circumstances, the girl-child often resorts to risky “professions” such as prostitution. The practise amongst older men “sugar daddies” of enticing girls into sex with gifts or money is common in South Africa (Tselane 1999: 25). In other instances, female students befriend taxi drivers who allow them to commute ‘freely’ to school in taxis as taxi “queens”. The same phenomenon is said to be common in Ghana, where a partnership between older men and younger women is more favourable as men’s attempts to minimise their risk of infections (Mills and Anarfi 2002:327). With the impact of HIV/AIDS which continue to claim lives of parents leaving the girl-child orphaned and heading a family, poverty increases.

4.6 THEME 4: FORBIDDEN PERIODS

The cultural values and expectations of society need to be respected. There are therefore periods in women's lives where they are not supposed to have sexual contact. These periods occur during widowhood and menopause. See table below

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<td>Forbidden periods</td>
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<td>Widowhood</td>
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<td>Conjugal rights</td>
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4.6.1 MENOPAUSE

As already explained above, to have sexual contact during menopause is taboo. A
disease called Tshikwilimimba develops. It is believed that a woman who is in menopause gets distension of the abdomen if she can have sexual contact as semen accumulates in their abdomen. Men are also warned not to have sexual contact with such women as they may suffer from swollen scrotum. It is believed that semen accumulates in the scrotum, as it has nowhere to go. One of the respondents explained it this way:

"Then there is an STD called Tshikwilimimba. This one occurs if a man has marital relations with a woman who has reached her menopausal age and the man is still virile. To treat it, the woman's urine and that of the man concerned, are mixed with medicine and they both drink the mixture. Only then does it deflate."

According to Loustaunau & Sobo (1997:39) "healthy" for women is defined as childbearing and marriage while defiance from this norm as "disease–producing". It is therefore not surprising that a menopausal women is viewed as unclean and disease–producing. They went further by arguing that menopause is considered a "disease condition" expected to produce dangerous physical and psychological symptoms even though the number of menopausal women actually suffering from any bothersome symptoms is expected to be only around 20 to 30 percent.

4.6.2 WIDOWHOOD

A widow is also not allowed to have sexual contact with a man before she undergoes a cleansing ritual. The disease that develops is called mafa (see the discussion on mafa in table 1). One of the respondents said:

"Then there is u lovhelewa. If a woman's husband dies and she meets somebody else. Before they can have sexual relations they are bound together medicinally."
This is called u tanganyiwa. The problem is that you meet a woman whose husband has died and she says she is divorced instead of widowed. Maybe these women are scared of questions like how did the husband die. But this is what happens and it puts men at risk.

As this disease was greatly feared, this strengthens the belief systems of a society and thus provides a means of social and behaviour control.

4.6.3 CONJUGAL RIGHTS

In the findings the majority of respondents showed that it is not acceptable for women to refuse their husbands sex, as women are subordinates. In support of this Brycenson (1995: 175), writes that the rapid spread of HIV/AIDS is largely due to the powerless state that African women find themselves in when it comes to demanding fidelity or refusing sexual interaction. In addition, Obbo (in Brycenson 1995:176) adds that a woman who refuses sex is driving her husband to polygamy, be it of formal nature in terms of new wives, or informally by having mistresses and girlfriends.

Furthermore the findings also shows that male respondents were not keen on using condoms as preventive measures because it limits the sexual satisfaction during intercourse. One respondent described a condom as “a plastic that covers the penis and thus making the penis’s unable to breathe”. This belief is supported by (Gausset 2002:516), who reiterates that there is a belief that using a condom is like eating a sweet with a paper on. Women respondents indicated that it is good and safe to use condoms although it is not easy to suggest that to husbands. They
further explained that suggesting condoms may subject a woman to physical assault and the in-laws and her own parents may not support her if they are asked to mediate assuming that she is practising infidelity. African societies in general tolerate multiple sexual partners for men, but exert moral and social sanctions on women (Brycenson 1995: 176). Additionally when asked the questions:

"Whilst the husband was busy with one of his wives, were the others not tempted to be unfaithful?"

One of the respondents replied that:

“If a woman was to do that (extramarital affairs) and she was caught, it meant banishment from the bedroom for life. Mind you she would not be chased out of the marital home. But her husband would never touch her again”.

The above findings show the serious nature of gender inequality. Batti and Fikree (2002:115), state that:

“Although the condom is seen at present as the only effective preventive measure against the sexual transmission of HIV/STDs, for the majority of African women the suggestion that their partners or husbands use condoms is either seen as evidence of the woman’s infidelity or perceived as defiance or insolence. At best, this may result in a breach of relationship; at worst, in the woman being beaten or abandoned”.
This is exaggerated by premarital counselling where brides-to-be are told not to refuse their husbands sex except when menstruating. Men in turn are encouraged to make sure that their wives are sexually satisfied.

The above cultural practices portray women as highlight women's subservience and silence in matters of safe sex. Other socio-economic factors such as the high unemployment rate amongst women in Venda, expose women to abuse by their male partners as they are afraid of being abandoned or divorced. The sexual customs and norms of the Vhavenda put male needs and demands first in a marital relationship.

4.6.4 CLEANSING CEREMONIES

Like any other black rural population, the Vhavenda society still believes in consulting traditional healers for common complaints, including sexually transmitted diseases.

Studies conducted in different parts of Africa reveal that clients believe that traditional STD cures are more effective than biomedical cure (Green1994: 2). The same beliefs are shared in South Africa. The cleansing ceremonies are found to be effective ways of getting rid of physical and moral dirt. Many differing cultures and people have their own methods and herbal mixtures for this purpose, for example the use of herbs, needles and spiritual blessings.
4.7 GENDER DIFFERENCES IN DIAGNOSTIC MEASURES, CARE AND PREVENTIVE METHODS AND TREATMENT

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<td>Gender inequality</td>
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<td>Patriarchy</td>
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The term "gender" is used to describe the various characteristics assigned to women and men by a given society. 'Sex' on the other hand refers to the biological characteristics of women and men (UNAIDS 2001:1).

4.7.1 LEGAL FACTORS

Polygamy has contributed significantly on the inequality and subjugation of women. Polygamy was a cultural norm and accepted and mean who were monogamous were viewed as poor men with no clout at all. Polygamy therefore was legally accepted and this weakened the position of women and the inequality between genders. The dawn of new democratic era saw the perpetuation of gender inequality with the legal recognition of the polygamy. Men are still allowed to legally marry more than one woman whilst it's illegal to marry more than one man by women. Schenker & Eisebeg (1997: 175) asserts that it is unfortunate that in developing countries policymakers are mostly men who still find it difficult to empower women.

4.7.2 ECONOMIC FACTORS

The socio-cultural barriers and taboos associated with sexually transmitted
infections are major hindrances to women seeking help. Women initially ignore their symptoms and only seek treatment when their problems increase in severity. In addition, women are reluctant to seek treatment because of the cultural inhibitions and shame felt in consulting male doctors.

Lack of time and money are other factors, which precipitate the delay in seeking treatment. In those situations traditional remedies are often the first line of defence in health care (Bhatti and Fikree 2002:108). A survey in Kenya found that western medical practitioners were consulted for STDs only when herbalists and traditional healers failed to provide relief (Mulder 1994:201).

Women are unequal to men because of their economic status. Women are not producers and generators of income. They are consumers whilst men are producers. The economic dependency of women on men widens the inequality between men and women. Men often control women because of the economic power they wield.

4.7.3 PATRIARCHY

From the interview it was clear that women are perceived as carriers of sexually transmitted diseases. The main cause of the sexually transmitted disease mentioned was dirt, which was said to be coming from a woman in the form of her bodily discharges such as menstruation, lochia (post delivery discharges) and post abortion discharges. Women are thus accused of being carriers of sexually transmitted infections because of their biological and genetic makeup. Contrary to this, findings from the fact sheets on HIV/AIDS maintain that women are not the main carriers. Instead more susceptible to sexually transmitted infections due to their
larger surface area of mucosa (the thin lining of the vagina and cervix) that exposes them to their partner’s secretions during sexual intercourse.

Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual based on his or her sex. Gender roles are learned, rather than inherent and vary from culture to culture and from generation to generation. Although gender roles often change due to factors such as education, technology, religion, political and socio-economic structures, the findings of this study reflect a patriarchal society in which we live where men are never considered carriers of sexually transmitted diseases due to their gender role.

According to Bhatti and Fikree (2002:115), gender inequality must be highlighted in any discussion of communicable diseases especially sexually transmitted infections.

The lack of emphasis on a male partner’s role in the transmission of infections and the notion of clean penile discharges (semen) as opposed to dirty vaginal discharges reflect gender inequality.

Cultural women are seen as being superior to women. Women never participated in any decision-making within the family or the community (Khoro). Women can be consulted but they decide thus the final word always comes from the men. Women who generate income often hand over their incomes to the husbands who are decision makers. This patriarchal system disempowerment and disadvantage women hence the inequality between the genders.
4.8 DOCUMENT ANALYSIS

Document analysis was a second method followed to compliment the findings of the study. The documents were analysed to check the present statistics of the sexually transmitted infections in Vhembe district, in order to evaluate the effectiveness of the policies and protocols used in the district. The policies were analysed to determine if they are cultural and gender-sensitive. De Villiers and van der Wal (1995:61), asserts that a clear understanding of the connections between culture and health is necessary for the nurses to deliver appropriate transcultural nursing care.

4.8.1 SEXUALLY TRANSMITTED INFECTIONS POLICY

The strategy focuses on syndromic approach to sexually transmitted infections. This is realised through processes such as the national training programme, drug protocols, national algorithms and revision on guidelines in 1998 and 2001. Sexually transmitted infections are still managed at first contact at primary health care levels using the syndromic approach.

The policy was analysed focusing on the sub topic addressing sexual behaviour as outlined in the strategic plan. The subheadings were as follows:

Partner notification and treatment
Promotion and provision of condoms
Case reporting
Clinical follow up

4.8.1.1 PARTNER NOTIFICATION AND TREATMENT

One of the key factors in the sexually transmitted infection policy is partner
notification. Contact slips are given to patients suffering from sexually transmitted infections to give to their partners who are expected to also come for treatment. As already mentioned above, the statistics of sexually transmitted diseases in Vhembe district were analysed. The researcher used statistics for the year 2000 and 2002. Though the researcher wanted to observe the pattern for three consecutive years she could not succeed in getting the 2001 statistics.

In addition the statistics also failed to classify patients according to variables such as sex and age, as was expected. The statistics were as follows:
### TABLE 4.3 STD STATISTICS

<table>
<thead>
<tr>
<th>OU3Short</th>
<th>Vhembe DM</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>OU5Short</td>
<td>(All)</td>
</tr>
<tr>
<td>OUcategory</td>
<td>(All)</td>
</tr>
<tr>
<td>DEcategory</td>
<td>Sexually Transmitted Infections</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sum of EntryNo</th>
<th>dPeriod</th>
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<th>Feb-00</th>
<th>Mar-00</th>
<th>Apr-00</th>
<th>May-00</th>
<th>Jun-00</th>
<th>Jul-00</th>
<th>Aug-00</th>
<th>Sep-00</th>
<th>Oct-00</th>
<th>Nov-00</th>
<th>Dec-00</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Case treated as STI - new</td>
<td>6,163</td>
<td>6,503</td>
<td>6,495</td>
<td>6,459</td>
<td>5,869</td>
<td>5,621</td>
<td>5,736</td>
<td>6,169</td>
<td>6,028</td>
<td>7,060</td>
<td>6,540</td>
<td>6,451</td>
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<tr>
<td>26 Male urethral discharge - new</td>
<td>1,787</td>
<td>2,071</td>
<td>1,944</td>
<td>1,882</td>
<td>1,909</td>
<td>1,491</td>
<td>1,509</td>
<td>1,860</td>
<td>1,668</td>
<td>1,826</td>
<td>1,901</td>
<td>1,889</td>
<td>21,737</td>
<td></td>
</tr>
<tr>
<td>27 STI contact slip issued</td>
<td>4,226</td>
<td>4,515</td>
<td>4,414</td>
<td>4,322</td>
<td>3,692</td>
<td>3,965</td>
<td>3,745</td>
<td>3,805</td>
<td>3,822</td>
<td>4,186</td>
<td>3,957</td>
<td>4,078</td>
<td>48,629</td>
<td></td>
</tr>
<tr>
<td>28 STI contact treated - new</td>
<td>2,081</td>
<td>1,889</td>
<td>1,494</td>
<td>1,501</td>
<td>1,776</td>
<td>1,496</td>
<td>1,502</td>
<td>1,472</td>
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<td>1,924</td>
<td>1,792</td>
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<tr>
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<th>Vhembe DM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outype</td>
<td>(All)</td>
</tr>
<tr>
<td>OU5Short</td>
<td>(All)</td>
</tr>
<tr>
<td>OU4Short</td>
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</tr>
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<td>DEcategory</td>
<td>Sexually Transmitted Infections</td>
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</tbody>
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<tr>
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<th>dPeriod</th>
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<th>Feb-02</th>
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<th>Aug-02</th>
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<th>Oct-02</th>
<th>Nov-02</th>
<th>Dec-02</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Case treated as STI - new</td>
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<td>6644</td>
<td>7399</td>
<td>7246</td>
<td>6375</td>
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<td>5803</td>
<td>5797</td>
<td>5921</td>
<td>5530</td>
<td>76538</td>
<td></td>
</tr>
<tr>
<td>26 Male urethral discharge - new</td>
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<td>1402</td>
<td>1926</td>
<td>1959</td>
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<td>1357</td>
<td>1316</td>
<td>1519</td>
<td>1489</td>
<td>19120.8</td>
<td></td>
</tr>
<tr>
<td>27 STI contact slip issued</td>
<td>4078</td>
<td>3720</td>
<td>3480</td>
<td>4141</td>
<td>3617</td>
<td>3215</td>
<td>3283</td>
<td>3481</td>
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<td>3252</td>
<td>5834</td>
<td>5436</td>
<td>47039</td>
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</tr>
<tr>
<td>28 STI contact treated - new</td>
<td>2102</td>
<td>2157</td>
<td>2087</td>
<td>2303</td>
<td>1829</td>
<td>1856</td>
<td>2037</td>
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<td>1355</td>
<td>1695</td>
<td>1789</td>
<td>22222</td>
<td></td>
</tr>
</tbody>
</table>
From the above statistics it is clear that sexually transmitted infections are a problem in the district. Furthermore, the statistics also indicate failure of the use of contact slips. It is clear that out of 48,629 contact slips issued in the year 2000, only 20,385 partners were checked. The same phenomenon is evident again in 2002, where out of a total of 47,039, only 22,322 contacts were checked. It shows that out of 100 patients that are seen every year only 50 contacts comply and come for treatment.

Using the findings obtained in the themes above as parameters for this discussion, there are many factors that can be related to this lack of compliance. Although the statistics did not show the composition according to sex, one may assume that the majority of contacts who complied are women. In a patriarchal society, and taking into consideration the status of women amongst the Vhavenda as described in the themes, giving women suffering from sexually transmitted diseases letters to give to their husbands to come for treatment, is impossible. This shows that policy makers are not aware of the sexual customs and practices of the people they serve. The practice of women giving their husbands letters from the clinic often subjects women to assault and verbal abuse leaving hem with no other option but to either throw away the letter and thus continue being reinfected. In such situations the disease will only be treated if the man himself sees the symptoms and decides to seek help. Bhatti and Fikree (2002:115), reiterate this view by pointing out that gender exercises can be an important influence on providers' perceptions of male or female needs and on the manner and substance of the medical and nursing advise they provide to male and female clients.
In addition, contrary to our programmes on gender equality assert that makes the elimination of sexual violence against women and children and the promotion of equal rights for men and women a priority, the partner notification strategy seems to perpetuate more abuse.

4.8.1.2 PROMOTION AND PROVISION OF CONDOMS

From the findings of this study it is evident that for women to negotiate for safe sex in the form of condom usage is a far-fetched idea particularly amongst the Vhavenda. Health care workers who teach women to use or suggest using a condom with the husband, are oblivious of the cultural and gender roles among the Vhavenda. In Sexually transmitted diseases are commonly called malwadze a vhasadzi (women’s disease). If a woman suggests the usage of a condom it will be interpreted as saying that she is promiscuous.

In addition, in a study conducted amongst the Tonga in Zambia by Gausset (20001:516), revealed that Africans are unwilling to use condoms because of different prejudices and beliefs. They believe that the foetus becomes stronger if the pregnant mother is having continued sexual intercourse, due to the man’s semen. Furthermore, they believe that women have to receive sperms in order to feel the pleasure and reach orgasm. It is very interesting to note that the strength attached to semen transcends that of vaginal discharges, which are considered dirty.
Condoms are also associated with casual sex. Married couples therefore feel that they are not supposed to use condoms. In this instance also, suggesting condom usage means that the individual, be it a man or a woman, has been unfaithful.

If the findings of this study were any thing to go by whereby women's vaginal discharges are perceived to be the cause of sexually transmitted diseases, it would be rather easy to convince men to use condoms to protect themselves from being infected.

4.8.2 CULTURAL SENSITIVITY

In the strategic plan of the treatment of sexually transmitted diseases, it was indicated that the traditional healers have also been consulted but if one analyses it, clearly one realises that their expertise has not been acknowledged. There is also no suggestion of a referral method between the two sectors.

4.9 SUMMARY

This chapter dealt with data analysis. The chapter presented data in accordance with the questions and assumptions raised in the study. The data reveal and suggests specific beliefs, values, and attitudes that were articulated and put into context by respondents in their personal accounts. The subsequent chapter should facilitate the design of a theoretical framework.
CHAPTER 5

CREATION OF A THEORY

5.1 INTRODUCTION

In the previous chapter it was shown how data was analysed for this research project. During data analysis and the coding process, categories emerge, and as it is the case with grounded theory, the theory also emerges. This chapter serves to guide the reader through the various steps that the researcher has followed in developing the theory surrounding STDs as viewed by the Vhavenda. The analytical strategy was divided into three phases and included six essential characteristics as described by Streubert and Carpenter (2000: 93).

To that effect, Strauss and Corbin (1990: 57) as quoted in chapter 3 on the methodology, describe the analytic procedures of grounded theory as designed: “to provide the grounding, build the density and develop the sensitivity and integration needed to generate a rich, tightly woven, explanatory theory that closely approximates the reality it represents”

5.2 THE DEFINITION OF A THEORY

There are many definitions that scholars use in defining theory. The definition that is used in this study has been influenced by Chinn and Kramer (1999:50) who define theory as “An imaginative grouping of knowledge, ideas and
experience that are represented symbolically and seek to illuminate a given phenomenon."

They further add that theory can simply be regarded as a collection of ideas or explanatory hunches. This definition puts emphasis on creativity, which is also regarded as a vital component of grounded theory. Creativity in this instance was shown by the ability of the researcher to name categories, and also to let her mind wander until she comes up with explanatory hunches (Strauss & Corbin 1990: 27). It is for this reason that this chapter will link categories and thereby try to develop a theory surrounding sexually transmitted diseases, as understood by the Vhavenda in their own context.

5.3 HOW A THEORY EVOLVES

According to Chinn and Kramer (1999:49), formulating a theory involves two procedures, namely creating the conceptual meaning and structuring and contextualising the theory. This explanation corresponds with the basic elements of grounded theory, which are concepts, categories and propositions.

Theory uses concepts. In this study, data was gathered, grouped and given conceptual labels. Later on categories were generated through the analytic process of making comparisons to highlight similarities and differences used to produce concepts. Lastly the propositions were also posed under
discussions to indicate generalised relationships between a category and its concepts.

5.4 PARADIGM MODEL

In accordance with grounded theory during open coding the description by respondents, of types of diseases, disease patterns, signs and symptoms as well as causes as described in chapter four takes place. In axial coding the paradigm model as described by Strauss and Corbin (1990:99) as a way of linking subcategories to the core category emerges. The paradigm model enables the researcher to think systematically about data and relate them in complex ways.

The paradigm model can be depicted diagrammatically as follows:

```
causal condition
    ↓
phenomenon
    ↓
context
    ↓
Intervening conditions
    ↓
actions / interactions
```

Figure 5.1 the paradigm model
The paradigm model consists of causal conditions, phenomenon, context, intervening conditions, action strategies and consequences.

5.4.1 PHENOMENON
In this study STDs are the phenomenon as they constitute a central idea or instance which a set of interactions is directed to manage (Strauss and Corbin 1990: 100).

5.4.2 CAUSAL CONDITIONS
Causal conditions are the events that lead to the development of a phenomenon. The concept of "dirt" becomes the dominant single category that is not only central but also iatrogenic and pervasive in the phenomenon of STDs. The concept of "dirt" reveals some conceptualisation as well as related "myths" that become a toehold towards change. Other conditions are therefore related to the core category as shown in figure 5.7.

5.4.3 CONTEXT
The notion of "Context" refers to the particular set of conditions, the location of events or incidents pertaining to a phenomenon along a dimensional range (Strauss and Corbin 1990:101). In this case the phenomenon is happening among the Vhavenda. The STDs are described according to their own views and understanding.

5.4.4 INTERVENING CONDITIONS
Intervening conditions are the broad general conditions bearing upon the
action/interactional strategies (Strauss and Corbin 1990:103). The intervening conditions are the cultural values, which determine gender roles and power roles in the Vhavenda community.

5.4.5 ACTION/INTERACTIONAL STRATEGIES
It relates to the action/interaction directed at managing, handling, carrying out or responding to a phenomenon as it exists in context. In this case biomedical and traditional ways of treating STDs can be regarded as a form of action in responding to STDs.

5.4.6 CONSEQUENCES
Action taken in response to a phenomenon may either be positive or negative. In this study alternatives in terms of changed moral behaviour, cleansing roles and treatments have been suggested to prevent the spread of STDs.

5.5 THE CREATION OF CONCEPTUAL MEANING
In this study the concept "dirt" is understood and depicted as the cause of sexually transmitted diseases. "dirt" as a theme is understood in the context of "uncleanliness". It is equated with contamination, a contagious condition. A woman who is affected is regarded as someone who harbours "dirt" or contagion during certain periods of her life. This "dirt" is excreted together with her vaginal discharges. Among modern (conventional practitioners) vaginal discharges are symptomatic of health problems or may be an indication of pathogenesis. The disparities among the pathological discharges
are easy to discern. However, vaginal discharges have not been fully
to explore given the mysticism associated with this physiologic process. The
colour, volume and the odour of the secretions may prompt more mysticism
or the degree of depth of "dirt" associated with it. This is partially evident
during menstruation, post abortion period, and post delivery.

According to Weaver the anthropologist, (in Bloor and Taborroli 1994:77), TB
has also been described by certain cultures as dirt, which has to be washed
away. It is therefore very important for research to be sensitive to the
cultural meanings attached to the disease and the dynamics of society.

The issue of dirt is also confirmed in western medicine, especially as regards
the extent to which sterility is upheld. Weaver (in Bloor and Taborroli
(1994:78), points out in agreement that sterilisation is emphasised to avoid
contamination, which can be caused by some invisible dirt, for example,
bacteria and viruses. Green (1999:163), also emphasises that:

"Dirt seems a simple concept, something that results from mere lack of
hygiene, but is more than the equivalent concept in English, it is something
that results from violation of moral codes and taboos."

The above corroborate the findings of this study in which "moral dirt" or
"moral rot" is described as the cause of sexually transmitted diseases. The
respondents, for instance asserted that in the event where a woman loses her
husband through death and without undergoing cleansing rituals immediately
engages in sexual intercourse with another man, that man will be susceptible to a disease called *Mafa*. See the description of the disease in Chapter 4.

The study conducted by Green (1999:163), shows that sexually transmitted diseases are also caused by *Dirt*. It is revealed that dirt underlies and gives rise to insects or germs.

What emerged quite strongly in this study is that among the Vhavenda, the concept "*dirt*" or uncleanness is equated with contamination or a contagious condition that is widely regarded as the cause of all sexually transmitted diseases. Women are unfortunately fingered as main carriers of "*dirt*" and ultimately solely responsible for STD infections.

The diagram drawn below represents the understanding and beliefs of the Vhavenda as regards sexually transmitted diseases. As pointed out above, the discharges, its characteristics, colour, volume and the odour of the secretions may prompt more mysticism or the degree of depth of "*dirt*" associated with it. See figure 5.2 below:
Figure 2: The understanding and beliefs of the Vhavenda in sexually transmitted diseases

The characteristic of the vaginal discharge can also be regarded as a symptom of decay or moulding that is setting in. The setting, in this case, the vagina with its moist nature, is often thought of as providing an idea breeding place where bacteria may thrive thus causing infection. This is partially evident during menstruation, post abortion period, and post delivery.
5.5.1 MENSTRUATION

The menstrual discharge is regarded as dirt that is shed monthly by a woman. A comparative analysis between cultural and western views regarding menstruation does indicate similarities. Menstruation is regarded as an excretory product that is produced during the shedding of the endometrium, a process that is not considered "clean". Among the Vhavenda the dread for contact with this "dirt" is profound, as it is believed that menstrual discharge is absorbed during sexual intercourse. It is regarded as contagious and may have adverse effects on male sexual partners such as affecting their virility causing weakness and loss of libido.

5.5.2 POST ABORTION DISCHARGES

A patient having post-abortion is regarded as being dirty due to discharges coming from the vagina. Also in modern medicine, dilatation and curettage is done to clean the women from post abortus, which can lead to infection. The theory that traditional healers hold is that if a man sleeps with an unclean woman he will contract a disease called Divhu (see description of the disease in Chapter 4). Although they do not have the dilatation and curettage method they believe that if a woman menstruates the post abortus discharge and the conceptus that are left in utero will automatically be shed. It is asserted that the post abortus discharge causes infection that will spread into the bloodstream of the affected person. The severity and fatality of the disease will depend on the immunity of the individual, that is, whether he is strong or not. See the diagram below:
FIGURE 5.3 The effects of post abortion discharges on an individual

Figure 5.3 shows how the abortion discharges cause dirt, which enters the bloodstream. The prognosis depends on the immunity of an individual as reflected diagrammatically. The stronger the immunity the higher the chances of living longer as compared to those with weak immunity whose chances of survival are less.
5.5.3 POST DELIVERY DISCHARGE (LOCHIA)

Just like menstruation and post-abortion discharge, lochia is also regarded as dirty. The vagina is still sensitive as the foetus caused damage during delivery. Similar to post-abortion discharge, the dirt can only be cleared when the woman has menstrual periods to shed the dirt associated with delivery. In modern medicine, if there were injuries incurred and the woman is still having lochia there is a possibility of the vaginal canal forming a mould, which enables bacteria to thrive, thus leading to infection called "puerperal sepsis". Although the reasons are not clearly explicated, mothers are also advised to resume sexual intercourse after the third or fourth post-delivery week by which time lochia flow will have stopped (Ladewig, London and Olds 1998:741). See the flow chart below:

![Flow chart diagram]

Figure 5.4 the pathology of lochia as viewed by the Vhavenda
The diagram above reflects lochia as dirt, which makes the vagina a good breeding place for bacteria, as the place is still soft and raw. Traditionally women are advised not to resume intercourse early.

As a proposition the above discussion suggests that:

"Men having sex with women who have just given birth have a higher chance of developing sexually transmitted diseases than those who took time before engaging in sexual intercourse with such women".

5.5.4 WOMEN AS CARRIERS

While Africans generally believe that diseases are caused by evil spirits and witchcraft, in the case of sexually transmitted diseases, power play puts blame on a woman as a villain, a carrier of STDs. The blame is placed on an individual woman although sex involves two people a man and a woman. The above theory clearly indicates the extent to which women are discriminated against. This is worsened by the connotation of the name STDs in the Venda language, i.e. malwadze a vhasadzi (Women’s diseases). It is therefore quite evident that the dirt theory discriminates against women. The Vhavenda are still living in a patriarchal society which demeans women.

The diagram below shows that the woman is perceived to be the carrier of dirt and at the same time a victim as a result of such perceptions. Women are regarded as carriers due to their physiological, make up whereby their bodies secrete discharges during certain periods of their lives. It is quiet interesting though to find out that one of the findings of this study suggests that older
women who are no longer menstruating (on menopause) are also regarded as carriers of STDs. A disease called Tshikwilimimba may result if a man engages in sexual contact with a woman who is in menopause. See chapter 4 for more information.

![Diagram](image)

Figure 5.5 Women as carriers of STDs.

From the above diagram and the discussion, the following proposition may be generated:

"Men who sleep with women who are dirty have a high inclination of contracting sexually transmitted diseases".

5.6 BIBLICAL PERSPECTIVE

The woman takes the responsibility, as she is the one who attracted the man just as Eve in the Bible is indicated as having wooed Adam into sin.
5.7 BIOLOGICAL PERSPECTIVE

Biologically the structure of a woman also makes her susceptible to infection during sexual intercourse. The woman is a reservoir as the vagina is structured in such a way that it serves as a receptacle for sperms. Because of its moist state, the vagina is a good mould for the breeding of bacteria. In turn, a man also produces sperms that in this study are in comparison with women's discharges, clean and uncontaminated. From the above discussion it emerges as a proposition that:

"The physiological structure of a woman predisposes them to high incidence of sexually transmitted infections as compared to men".

5.8 TREATMENT OF STDs

The theory surrounding the treatment of STDs revolves around being cleaned from dirt that is regarded as the cause of the disease. As Green (1999: 165) maintains: "The therapies found in every society stem from prevailing causality beliefs which form the rationale treatment".

Roth, the Anthropologist, (in Bloor and Taborroli 1994: 78), describes a disease as specific form of dirt. hygienic rituals bear similarities with more symbolic purification rituals. Douglas (in Bloor and Taborroli 1994: 94), further differentiates between modern and traditional medicine. He criticises an assumption that states, "in order to analyse the clean/dirt binary it is also necessary to deconstruct the sacred/profane hierarchic opposition". His feeling is that the above statement exaggerates the differences between modern and traditional medicine: "Our practices (modern medicine), he
maintains, "are solidly based on hygiene theirs (indigenous medicine) are symbolic ideas: we kill germs, they ward off spirits"

In view of the scientific approach to the phenomenon of STDs, the statement seems controversial. According to Douglas (in Bloor and Taborrelli 1994: 93) this promotes the idea that truth lies in modern medicine thereby repressing religious and supernatural beliefs and practices of other cultures. The fact that dirt and ritual pollution are hygienic or symbolic is really only a matter of detail. Below, see the conceptual framework to indicate how STDs are viewed in the social context.

![Conceptual Framework](image)

**FIGURE 5.6** Conceptual framework on how STDs are viewed in the social context
From the above diagram it is clear that grounded theory is based on symbolic interaction theory. People define reality and how their beliefs are related to their actions. This study shows that human beings staying together form an interaction which culminates in a relationship. This relationship is usually based on the cultural norms and values of that society. The society forms meanings that it understands and thus determines social behaviour acceptable to the particular community. The above diagram shows the meanings attached by society to the causes of STDs. The meaning of dirt/clean continuum is a belief of the Vhavenda culture based on their societal norms. Sexual intercourse occurring in instances of dirt such as menstruation, afterbirth discharges (lochia), not cleansed after husband’s death, and also not cleaned after abortion, causes a mould. Furthermore, the mould becomes a thriving place for bacteria which causes infection. The above view or beliefs need to be changed or modified.

5.9 THE DIRT THEORY

At the super structural (epistemological) level, the "dirt"/"uncleanliness theory is problematised by its comparative analysis in which culture becomes the main determinant of gender perceptions. Universally the view persists that males are superior to females. This almost pervasive "truism" needs to be mentioned as it provides a macrocosmic for the comparison of one cultural ethos with another. Notwithstanding cultural differences, such a (macrocosmic) view does have a confluential effect on the proposition being propounded, namely:
• Cultural defined gender roles in the Vhavenda society justify women as sole STDs agents.

• The rationale for the postulation above is underlined by male roles having formed the dominant culture of the primary social group which is male in orientation. By that very assumed fact, power-relations are determined on the basis of gender, rather than non-sexist socio-economic status.

In virtually all democratised societies, women have the same status as men—legally, sexually, socio-economically, and otherwise. The naturalist/biblical view is thus nullified as women are empowered to have a choice over their bodies and sexual preferences, among other legally provided rights. Their status as citizens of the same country has therefore enabled their culture to adapt to changing circumstances. Morally rectitude is thus a value of good citizenship expected with equal input from both men and women. Biological and physiological differences are therefore “unscientific” grounds for ascribing the preponderance of STDs to women only.

At the microscopic level (The Vhavenda society) level, the “dirt” theory accumulates another dimension to the propositions posited earlier:

• The impermeable male roles lend their culture incompatible with and resistant to changing circumstances.

• The rationale being that, with the advent of cross-cultural exchanges
(no culture is entirely pure!), such as bio-medical solutions to hitherto problematic STDs, women are fast rising in stature.

The stereotypical attitudes and perceptions labelling women amongst the Vhavenda as morally deficient are contradicted by some customs which condone the prevalence of STDs. The two propositions posited above are thus validated by the existence of such customs, for example:

- Wife inheritance not only relegates women to the status of commodities that are easily "owned" at the death of a husband. The fact that the "new" husband could already be in a polygamous marriage is not mitigating enough for the woman to exercise her choice in the choice of another husband. The most important determinant is the cleansing ceremony after the husband's death. The concept of "dirt" itself highlights the state of cultural preparedness and willingness to accept the legitimacy of gender equality. Seminal attitudes are not easily eroded as they had been genealogically transmitted.

Hygienically, "dirt" presupposes the prevalence of something that spoils the aesthetic wholesomeness of the particular object. To eradicate that bodily "taint", water or a chemical substance could be used to clean that spot. Biomedically, the "dirt" could be associated with an infectious organism afflicting the body; to cure (rather than "clean") the body of the "taint" (in the form of an ailment) a surgical procedure or medical treatment could be opted for. In
the traditional Vhavenda belief system "dirt" has a diametrically different semantic value. Its nomenclature attaches more than a physical and bodily consequence. For instance a widow, who engages in sexual intercourse before the mourning period is over, is presumed to be the sole cause of the partner's miseries in the event that he contracts an STD. For the widow to be restored to her womanhood (and therefore to prevent her being a presumed STD agent), she has to be cleansed (rather than to clean), which is not just the function of water. To make peace with her deceased husband, a cleansing ceremony is conducted to cast away the "shadow" of the "jealous" husband as potential "punishment" for her "infidelity".

The inference being made here is that with regard to the notion of "dirt" of a woman, cultural differences are seminally extant. The only common denominator is the universalistic (but incrementally changing) view that men are ordained and endowed with "superiority" over women. Linguistic and semantic values are, but sub-systems in an analytic and conceptual paradigm shift that distinguishes the epistemological variants in all cultural systems. "Opposition" to the nature of women as sole STD agents is therefore, basically an interrogation of the assumed power that men use to condone their control of women. It is not an interrogation of the Vhavenda culture as practiced in the Vhembe district as such. The diagrammatic "mind-map" below illustrates the conceptual premises discussed so far.
Figure 5.7 Diagrammatically mind map of the theory

Looking at the above mind map there is a chain of evidence that shows that the theory was grounded from data.

5.10 VALIDATING THE THEORY

Strauss and Corbin (1990: 112) in de Vos et al (2002: 353) suggested that apart from Lincoln and Guba 's measures of ensuring trustworthiness as described in chapter 3 on methodology, a grounded theory study must also meet the following criteria posed hereunder in a question form:
5.10.1 ARE CONCEPTS GENERATED?
In this theory concepts have been generated from data through coding. The concepts were also put to technical use by being clarified and defined.

5.10.2 ARE THE CONCEPTS SYSTEMATICALLY RELATED?
In this chapter systematic conceptualisation through conceptual linkages was done. Figures were also drawn to show the linkages grounded from the data.

5.10.3 ARE THERE MANY CONCEPTUAL LINKAGES AND ARE THE CATEGORIES WELL DEVELOPED? DO THEY HAVE CONCEPTUAL DENSITY?
This criterion was met by using the paradigm model to describe the phenomenon, causal conditions, the context, interactions/actions as well as consequences. The theory itself expands the conceptual density, which shows the understanding of the phenomenon under scrutiny.

5.10.4 IS MUCH VARIATION BUILT INTO THEORY?
This study displayed the knowledge of different types of interactions/actions as well as variations generated from the data and built into theory.

5.10.5 ARE THE BROADER CONDITIONS THAT AFFECT THE PHENOMENON BEING STUDIED BUILT INTO ITS EXPLANATION?
de Vos et al (2002: 353) maintain that:
"The grounded theory requires that the explanatory conditions be brought into analysis and not be restricted only to those that seem to have immediate bearing on the phenomenon being studied. That is, the analysis should not be so "microscopic" as to disregard conditions that derive from "macroscopic" sources".

This criterion has been met as reflected in the theory itself whereby both the microscopic and macroscopic view of the phenomenon under scrutiny have been described.

5.10.6 HAS PROCESS BEEN TAKEN INTO ACCOUNT?
Process is the way of giving life to data by taking snapshots of action/interaction and linking them to form a sequence or series (Strauss & Corbin 1990: 144). This chapter outlined figures that reflected the sequence of events, which captured the analytic process followed by the researcher in putting together the concepts of building up the theory.

5.10.7 DO THE THEORETICAL FINDINGS SEEM SIGNIFICANT AND TO WHAT EXTENT?
As already indicated, building a theory and grounding it from data need analytic qualities and creativity. To meet this criterion the researcher made sure the data collection technique is of high quality by training the research assistants and making follow up interviews where further clarification was necessary. This facilitated the process of data analysis. The concepts were generated from data collected thus enhancing the significance of the study.
5.11 SUMMARY

This chapter dealt with theory generation. In purely qualitative research the process of theory generation includes the creation of conceptual meaning and an accusatory pattern.

The dirt theory and the taboos are complementary to explanations of sexually transmitted infections, as they are used to explain the origin of the virus. (Weaver 'in Bloor and Taborroli (1994:78'), Gausset (2001:510), states that the belief that STDs occur because of sleeping or having sex with an impure women, cannot be looked down upon or taken irrationally as modern medicine also used to believe that HIV/AIDS virus originated from green apes. He went further by indicating that it was believed that men contracted the virus by having sexual intercourse with an ape. Similarly the findings and the emergence of the dirt theory need to be respected.

The next chapter provides strategies that can be used in designing a curriculum for incorporating the dirt theory.
CHAPTER 6

GUIDELINES FOR INTEGRATING BELIEFS AND PRACTICES OF THE COMMUNITY IN THE CURRICULUM

6.1 INTRODUCTION

Since the introduction of transcultural nursing as outlined in Leininger's theory, there is more pressure on health care practitioners to design ways of incorporating culture in the curriculum. Surprisingly enough, in our South African situation the dream is not yet a reality. Delivery of culturally appropriate health care in our society demands that literature and information on indigenous health care models be documented and made available in libraries. This view is supported by Hildebrandt (1996:155) who asserts that teaching on transcultural issues is still on superficial levels and does not include practical applications based upon the lack of availability of materials on local practices and beliefs. This chapter aims at developing proposed guidelines that can be incorporated in the training of nurses, students of gender studies, and other health care workers about philosophies and strategies for indigenous health care methods in relation to sexually transmitted diseases.

Furthermore, the findings of this study assert that the STD education programme must incorporate cultural, religious, social and ethical values of a society. The health workers must also include belief assessment as part of their assessment in order to discover harmful beliefs and practices. It is also evident that sexuality education and safe sex practice is a sensitive issue,
more especially due to the HIV/AIDS pandemic. The programme must be designed in such a way that the community members will also be involved. Although the study has been conducted amongst the Vhavenda ethnic group only, there is clear evidence that the same diseases, beliefs and meanings are shared amongst different ethnic groups in South Africa and Africa at large (Green 1999:120).

The guidelines and the contents will be developed from the dirt theory as described in chapter 5. The diagram below illustrates the theory, which will be used as the point of departure.

![Diagram](Figure 6.1 Diagrammatic mind map of the dirt theory)
Figure 6.1 indicates that in the Vhavenda context where cultural values are important determinants on how they view health care, gender roles, power roles, morality and polygamous ramifications are the consequences and predisposing factors of dirt which lead to STDs. It is therefore clear that students need to be taught both biomedical perceptions and cleansing roles (traditional healing). This paradigm shift is relevant to the nursing curriculum where transcultural nursing is viewed as a priority. To simplify this theory a four-table typology as generated from figure 6.1 and the data will be used see the table below:

<table>
<thead>
<tr>
<th>Dirt (cause or agent)</th>
<th>Disease (results)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human being or a person (carrier or host)</td>
<td>Cleansing (mechanism to remove the agent)</td>
</tr>
</tbody>
</table>

Table 6.1: four table typology.

DIRT

Dirt is regarded as the cause of sexually transmitted diseases. Students must be taught the different types and forms in which dirt can manifest itself in order to cause the disease or ill health. From the findings of this study it was clear that there are two types of dirt that is moral dirt and uncleanness. In the present curriculum viruses and bacteria are the major causes of STDs. Incorporating predisposing factors and causes of STDs as viewed by the
community will help the health care worker to design cultural congruent strategies in promotive and preventive care.

DISEASE
The different types of diseases, their signs and symptoms need to be known. See table on STDs in chapter 4. One of the findings of this study shows that certain diseases are similar in signs and symptoms with those in modern medicine, for example Gonorrhea and Dorobo. It will be advisable for the health care trainers to use terms and names of STDs as commonly known in the community. This endeavor will help a health care worker during assessment more especially history taking.

THE CARRIER
There is a need to understand the carrier in his or her own context. By making students aware of the belief that women are viewed as sole carriers of STDs, may help in enhancing their intervention skills. This will also help the policy makers to formulate gender sensitive guidelines and policies to combat the spread of STDs.

CLEANSING
Cleansing is described as a purgative way of letting the body get rid of those elements that are not pure. Similarly antibiotics are used in modern medicine to rid the body of viruses and bacteria.

Using the above typology an integration of knowledge from modern medicine and indigenous knowledge may be designed using the topics below
6.2 MODULE STRUCTURE

Duration: The duration of the module will depend on the target group's level of education and experience.

Content: The content of the module being developed must be compiled and based on knowledge skills and attitudes.

6.2.1 KNOWLEDGE

The core of this programme will be the knowledge of beliefs and practices of the community that they serve in relation to STDs. The information will help students to develop a health education knowledge base according to the needs of the community. The impact of gender roles in the community must also be emphasised. In addition, the dirt-clean continuum must be incorporated in such a way that it will be beneficial to the community. The vulnerability of women will also be emphasised.

6.2.2 SKILLS

The curriculum must incorporate learning opportunities and teaching strategies such as role-playing responsible behaviour that fosters assertiveness and negotiating skills to ensure safe sex. Other strategies must empower learners to challenge cultural practices that increase the
transmission of STDs for example polygamy/monogamy and extramarital affairs. Issues such as cohabitation versus marriage, advantages and disadvantages thereof, should be included for the advancement of knowledge and negotiating skills.

6.2.3 ATTITUDES
The programme must promote issues that foster moral upliftment and behavioural change; promotion of good behaviour, for example, abstinence and delay in getting involved with sex, avoidance of multiple partners (including polygamy) and being vocal about abusive relationships. In addition, empowerment of women must also be included in order to boost their self-esteem. Moreover, it also enables women to take control of their reproductive health, thus being able to negotiate for safe sex. Prejudice, such as labeling sexually transmitted diseases as women’s diseases, must also be stopped.

6.3 CONTENT
The content of this programme can also be incorporated into other modules that were already in place, for example:

TOPIC 1  EPIDEMIOLOGY
The epidemiology of sexually transmitted diseases has always been a point of departure in teaching about sexually transmitted infections. It is therefore necessary that the dirt theory be incorporated in epidemiology to enable students to understand the importance thereof. In addition, by fostering a deeper understanding of STDs and their epidemiological variation, they will
understand clients better. The issue of sterility will be emphasised and cleanliness and hygiene will be promoted.

TOPIC 2 THE HISTORY AND DEVELOPMENT OF TRADITIONAL HEALING

In the history of nursing or health care methods, traditional healing also needs to be emphasised. In the past only the negative aspects were emphasised. It is now imperative that there be comparisons between modern and traditional healing. The positive aspects thereof must be emphasised. The belief and indigenous knowledge systems of the people that we serve must be known and respected, for example, types of rituals performed, diagnostic apparatus used, etc. The information on different types of healers must also be emphasised, just like nurses are taught about various components of the health care stratum.

TOPIC 3 ETHICS, PRINCIPLES AND METHODS

Ethics is always part of the teaching of sexually transmitted diseases. In this case, issues such as privacy, confidentiality, self-determination and informed consent come in. Clients tend to prefer going to traditional healers due to the fact that they maintain confidentiality and privacy as compared to staff in modern medicine. A case in point is where staff at a health center gives a client’s partner notification slips. Issues such as these need to be brought to the attention of students in such a way that they will be able to clarify that with clients.
TOPIC 4    PHARMACOLOGY AND MEDICINE

From the findings of this study it was clear that traditional healers were not keen to discuss the types of medicine that they are using for fear of their remedies being stolen. Despite those limitations the type of medicines and routes used should be incorporated into the module.

TOPIC 5    THE NAMES OF DISEASES

Table 4.1 in Chapter 4 can be used as a good starting point in the description and classification of diseases as perceived by clients themselves. The table describes the disease, sign and symptoms, treatment as well as complications thereof. One of the traditional healers suggested that pictures that are used in modern medicine in poster forms must also be compiled for traditional healers to enable them to show their clients the complications. He further reiterated that it would help in combating the spread of sexually transmitted diseases.

In the past it was difficult to treat the disease, as contact was supposed to be traced, that women used to hide fearing the stigma attached. The urine of both partners is mixed with herbs and they were given it as oral treatment to drink. Due to difficulty in tracing contacts a new method of treatment has been devised.
6.4 PROPOSED UNIT STANDARD TITLE: APPLY KNOWLEDGE OF BELIEFS AND PRACTICES OF THE COMMUNITY IN SEXUALLY TRANSMITTED DISEASES

FIELD
Health sciences and social services (NSB 09)

SUBFIELD
Preventive Health, Promotive health and development but also Rehabilitative services

NQF LEVEL
6

CREDITS
4

REVIEW DATE

PURPOSE OF THE UNIT STANDARD
The purpose of this unit standard is to provide students with modern and indigenous knowledge and skills on sexually transmitted diseases to enable them to promote good sexual behaviour and intensify mechanisms of avoiding the spread of infections and subsequently the spread of HIV/AIDS.
RANGE STATEMENT

The learners will function within the scope of a relevant health care practitioner.

CRITICAL OUTCOMES

 Learners credited with this unit standard will be able to use knowledge of beliefs and cultural practices of the community to plan, monitor and evaluate health in relation to the transmission of sexually transmitted diseases more especially HIV/AIDS.

CRITICAL FIELD OUTCOMES

- Identify and solving problems and making decisions.

- Working effectively with other members of a team, group, organisations or community.

- Organising and managing themselves and their activities responsibly and effectively.

- Collecting, organising and critically evaluating information.

- Communicating effectively using language skills, both oral and written.

- Using science and technology effectively and critically, showing responsibility towards the environment and health of others.
• Demonstrating an understanding of the world as a set of related systems by recognising that problem solving contexts do not exist in isolation.

EMBEDDED KNOWLEDGE

• Communication
• Empathy
• Listening
• Problem-solving

SPECIFIC OUTCOMES

At the end of this unit standard students must be able to:

• Describe more clearly the relationship between health related issues and the socio-cultural beliefs and practices.
• Analyse the relationship between gender and perception on health care processes

• Discuss the link causes, preventive measures and promotive health care with the dynamics of the community arrangements

• Use the critical approach in the exploration of the belief that social inequality and power are primary determinants of health and health care.
• Familiarise themselves with different names of sexually transmitted diseases as understood by the people they serve.

• Discuss and develop the strategies to change the attitudes of health care providers and clients

• Identify an appropriate referral method between traditional healers and modern biomedical practitioners that will be acceptable to all.

6.5 TEACHING AND LEARNING METHODOLOGY

A teamwork approach must be used to encourage participants to share their experiences. A behaviour change model will be appropriate to facilitate the change in attitudes, beliefs and practices. Therefore teaching strategies such as role-play, group discussions and lectures will be appropriate.

A training manual with all diseases, beliefs and practices of the community that the students serve must be developed, based on the findings of this study.

6.6 ASSESSMENT

Both formative and summative assessments can be used to achieve the listed outcomes. Formative assessment may be used in the class where students will be asked questions. At times role-plays may be used to assess the change of attitudes. Group discussions in the form of debates may also be
used. Checklists may also be used to assess the practical component of change in attitudes.

Summative evaluation is the evaluation done at the end of the programme where tests and examinations will be written. Assignments may also be given where students will do home visits in the community to see if the programme is acceptable.

6.7 SUMMARY

The above programme can enhance the integration of both modern and indigenous medicine, thus facilitating more scientific research into promotive, preventive, and diagnostic measures of sexually transmitted infections.
CHAPTER 7

FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

7.1 INTRODUCTION

This chapter consolidates the crucial phases of the research process, as well as findings and recommendations.

As listed in chapter one, the study is anchored on the following questions:

- What are the cultural beliefs and health care practices of the Vhavenda in respect of sexually transmitted diseases?

- Are there any gender differences in the indigenous treatment, care, prevention and diagnostic measures of sexually transmitted diseases?

- How can training and health care policies facilitate the health care workers' understanding of indigenous diagnosis, treatment, prevention and care of STDs, and their gender bias?

7.2 PURPOSE OF THE STUDY

The area of sexually transmitted diseases has largely been sidelined in terms of the extent of probing that has been done. This is more true, particularly as regards indigenous knowledge around this area by groups such as Vhavenda. As a result very little documentation exists in this area regardless of the mounts of information that exists as has emerged in this study.
The shift in practice from hospital to community based care makes it urgent that health care professionals make a conscious effort to increase their knowledge of the varied cultures of the communities that they serve, as well as the gender bias in health care. As outlined in chapter one, this study would like to add more flesh to the rather skeletal information base on the beliefs and practices of the African people, specifically the Vhavenda people, around the area of STDs. Among other things, the study would like to achieve the following:

- To document the beliefs and practices of the Vhavenda in the treatment, care, prevention and diagnosis of STDs.

- To determine the extent of perceived gender bias in treatment, care, prevention and diagnosis of STDs.

- To generate a theory that will assists as a point of departure in developing gender sensitive guidelines, health policies and appropriate training materials that can be used in the treatment of sexually transmitted diseases.

7.3 OUTCOMES OF THE STUDY

As one of its significant outcomes, the study is aimed at contributing meaningfully towards the development of gender sensitive indigenous health practices in the control of sexually transmitted infections. The development of gender sensitive indigenous health practices in the control of sexually
transmitted infections will be one of the most important outcomes of this study.

This study also lends itself to the important dimension of capacity building, particularly as regards less experienced and young graduate students. Nursing students need to be aware of the gender dimensions of health care and to enhance their research capacity to undertake similar studies on a variety of other diseases and conditions. As a point of departure the researcher made it a point to involve some young students in all the phases of the project namely gender analysis, in-depth interviews, designing of training material and evaluation of the programme.

7.4 FINDINGS AND RECOMMENDATIONS

The findings and recommendations of this study will be documented in accordance with the research questions. The recommendations will flow from the findings to enhance clarity and to show the rigorous research methods followed. The first question of this research was:

7.4.1 WHAT ARE THE CULTURAL BELIEFS AND HEALTH CARE PRACTICES OF THE VHAVENDA IN THE CONTEXT OF SEXUALLY TRANSMITTED DISEASES?

The dirt theory is the emergent variable in the findings of this study. As already clarified dirt is placed in the context of uncleanness in the form of discharges such as menstruation and lochia (post partum discharges). Furthermore, uncleanness following the death of a spouse (husband) is also
considered as a cause of ill health. These beliefs and practises can serve as points of departure in teaching clients about sexually transmitted diseases by moving from the known to the unknown. In summary, the beliefs of the Vhavenda and health care practices in sexually transmitted infections are as follows:

Few of the diseases that were mentioned have the same symptoms and complications as those in modern medicine, for example doropo (gonorrhoea) tshovela (condylomata) and thusula (syphilis). This was verified during member check where the traditional healers were shown posters with different types of STDs and identified those that were familiar to them. However, certain diseases, for example, gokhonya which is more like “warts” in modern medicine, need further research. The disease is said to be one of the major causes of infertility, a point that has not yet been proven in modern medicine as far as warts are concerned. A disease such as Divhu is unknown in modern medicine as it is said to be caused by post abortion discharges. In modern medicine dilatation and curettage is done after abortion to clean the uterus. It rarely occurs that one can find a woman who stays at home after abortion without having undergone dilatation and curettage. If that is not the case, infections that lead to sepsis, may occur. There is no evidence, which shows that women can have sexual intercourse during that period as verbalised and shown by indigenous practitioners. Diseases such as lukuse, tshimbambaila and mafa are also unknown in modern medicine.

The above findings provide a realistic portrayal of people’s beliefs, meanings and practices associated with sexually transmitted infections.
RECOMMENDATION

Further research needs to be done, more especially for diseases that are unknown in modern medicine. For example gokhonya is said to be a major cause of infertility, abortions and neonatal death.

Divhu has also been described as a very fatal condition that is either acute or chronic, depending on the patient’s immunity system. There is a need to do more research to see if there is a relationship between Divhu and HIV/AIDS.

Diseases such as mafa and tshimbambaila are related to taboos that helped in the preventive and promotive health by promoting good sexual behaviours and discouraging people from infidelity.

The findings of this study show that most of the traditional healers who are able to treat sexually transmitted infections are herbalists. They can therefore be used and incorporated into primary health care that will help in trying to ease the strained economy and ease the implementation of health service planning.

7.4.1.1 SEXUALITY EDUCATION

Amongst the Vhavenda cultural taboos inhibit parents from discussing sex with their children, and this creates obstacles to effective sex education. Sexuality education was taught at initiation school. At initiation schools girls were prepared for marriage and childbearing. Girls were taught to be obedient and submissive to males. Furthermore, sexual abstinence till marriage was
emphasised by practices such as virginity testing. There is a vacuum as the initiation schools are no longer common, and where they are still in existence only a few attend. Traditional sex education devices have been abandoned without being replaced, thus leading to social disintegration where teenagers are also victims of early involvement in sexual intercourse without the knowledge of the consequences thereof, for example, of teenage pregnancy and sexually transmitted infections.

RECOMMENDATIONS

As it was evident that it is taboo for women to discuss sexuality issues with their children, sexuality education must be included in the curriculum at school.

Education on sexuality must move from the known to the unknown, taking cultural needs, practices, and beliefs into consideration, for example, teaching abstinence instead of emphasizing condom use. Their education must also follow the initiation school curriculum, which focused on abstinence by using virginity testing. Although virginity testing is not a practice that can be continued due to its dehumanization of a girl-child, one feels that the educational curriculum must encourage the youth to abstain, rather than emphasizing safe sex which subjects the youth to having sex at a tender age, thus subjecting them to vaginal tears that increases their susceptibility to sexually transmitted diseases.
Girls must be empowered to be self-assertive and to be able to initiate safe sex. In addition, they must also be taught to take control of their sexual needs and their own bodies.

7.4.1.2 BIOLOGICAL FACTORS

Women are vulnerable to sexually transmitted infections than men due to among other things, menstrual periods, which tend to leave the uterus raw. In addition, semen remains in women after sex thus making them reservoirs of infections.

RECOMMENDATION

Gender prejudices must be avoided as both men and women produce discharges even during intercourse.

7.4.2 ARE THERE ANY GENDER DIFFERENCES IN THE INDIGENOUS TREATMENT, CARE, PREVENTION AND DIAGNOSTIC MEASURES OF SEXUALLY TRANSMITTED DISEASE?

7.4.2.1 GENDER ROLES

Women lack the power and skills to negotiate safer sex. They lack complete control over their lives and are taught from early childhood to be obedient and submissive to males. The subordination, social and legal status of women and girls amongst the Vhavenda and other ethnic groups in Africa, make it difficult for them to negotiate safer sex to protect themselves from sexually transmitted diseases.
RECOMMENDATIONS

Women must be empowered economically to be able to generate their own money, which will reduce their economic dependency and their "insubordination".

The laws of the country that perpetuate the spread of sexually transmitted infections need to be revised to protect women from their vulnerability, for example, the customary union.

The law or practices of inheritance and succession amongst the Vhavenda need to be looked into as it is increasing the spread of sexually transmitted infections more especially HIV/AIDS. Health cares providers to be trained on gender sensitivity and couple counseling.

7.4.2.2 WOMEN DO NOT HAVE THE RIGHT TO REFUSE SEX

Women are taught never to refuse having sex with their husbands, regardless of the number of partners he may have. This situation puts women at risk as they cannot refuse their husbands sex even if they are unwilling to use condoms, or even if he is suspected of having sexually transmitted diseases.

The use of a condom is believed as a way of spoiling the pleasure of sex. A woman is expected to please her male partner even if it is at the expense of her own pleasure or well being.
RECOMMENDATIONS

Women must be empowered to control their own sexuality and sexual needs, to have the rights to refuse sex and also to negotiate safe sex.

On the other hand the dirt-clean continuum related to the vaginal discharges may be a good point of departure if the use of condoms is emphasized as the way that men could protect themselves from the vaginal fluid of women during sexual intercourse.

7.4.2.3 VULNERABILITY OF THE GIRL CHILD WHO IS VIEWED AS CLEAN

The dirt-clean continuum perpetuates the abuse of the girl child who is viewed as clean. Abuse of girls, especially through sexual violence or other forms of sexual abuse increases their vulnerability to sexually transmitted infections. Nowadays the practice of sexual abuse of girls is accentuated by the myth that sexual intercourse with a virgin can cure a man from HIV/AIDS. The dirt theory perpetuates the abuse of a girl-child as she is viewed as clean. Thus the myth of HIV/AIDS being treated by having intercourse with a virgin becomes a belief, which is detrimental to children’s health and rights.

Furthermore, the belief that women who suffer from sexually transmitted disease are promiscuous, they are “women’s disease”, prostitutes’ diseases often subjects the youth to abuse as they are still viewed as new and clean.
RECOMMENDATION

Youth-friendly services, where the youth will be able to be free to go and discuss their sexuality problems should be put in place. The services must include counseling, health education and peer counseling.

Victim support is needed, where the Government must provide legal protection for girls who have been subjected to sexual abuse.

Heavy sentences to the perpetrators meted out.

7.4.3 HOW CAN TRAINING AND HEALTH POLICIES FACILITATE THE HEALTH CARE WORKERS' UNDERSTANDING OF INDIGENOUS DIAGNOSIS, TREATMENT, PREVENTION AND CARE OF STDs, AND THEIR GENDER BIAS?

7.4.3.1 PARTNER NOTIFICATION, TREATMENT AND CONDOM USE

It is evident that there are problems with contact slips given to the women and to the men patients. Most of the contacts do not come for follow up. It is therefore clear that the above findings suggest that socially defined gender roles influence the prevention, transmission and care of sexually transmitted diseases. In addition, the traditional stereotypes of masculinity, which require men to show their power, prevent some men from either seeking care or to admitting that they are infected, especially if the contact slip has been given to their wives.
It was also evident that there is lack of proper communication where both spouses are afraid to suggest the use of condoms for fear of being suspected that they are unfaithful.

RECOMMENDATION

The designed programme must include men as pioneers in designing promotive and preventive measures of STDs. Further, the programme must emphasize the use of condoms as a mechanism which fosters trust, faith, responsibility and communication between partners.

7.5 CUSTOMARY BELIEFS AND PRACTICES

POLYGAMY

There is a clear indication that the majority of women are in a polygamous relationship and of those in a monogamous relationship, most of their husbands are involved in extramarital affairs. Women who are married are at the greatest risk of sexually transmitted disease because of male promiscuity, which is tolerated by social and cultural norms. Practices leading to poor sexual behaviour such as those occurring in polygamous relationships increase the rate of the transmission of sexually transmitted infections.

Safe sex is rarely practised within marriage and the chances for negotiating for it are limited.
WIDOW INHERITANCE

Widow inheritance perpetuates the risk of the transmission of sexually transmitted infections, more especially HIV/AIDS. In cases where a man dies, the chances of her spouses being infected are high, thus infecting the new husband who inherited her and subsequently his wives.

INITIATION SCHOOLS

In these rituals, submissiveness is emphasized, thus subjecting women to sexual abuse. In addition, practices such as virginity testing, are conducted on the girl-child, which are humiliating, and a violation of her self-determination and self-esteem.

PATRIARCHY

By virtue of their patriarchal status and perceived roles in traditional society, men have power over women.

RECOMMENDATION

Integrate cultural practices that are harmless to health education. Promote awareness of the dangers of cultural practices that are detrimental to women’s health, especially those that put them at risk of HIV/AIDS.

Engage traditional leaders, healers, civic organizations and student’s representative councils to give health education on issues relating to sexually
transmitted diseases and also in recognizing and addressing traditional practices that further women's vulnerability.

Discriminatory practices against girls and women must be addressed.

Women need to be empowered to be assertive and able to negotiate for safe sex. Interventions intended to empower women must be coupled with interventions to sensitise and educate men. In a patriarchal society all interventions that do not involve men can be viewed as outside interference, and may be resented as men feel it erodes their power or control over their wives. Mothers-in-laws and sisters-in-law must also be involved more especially because amongst the Vhavenda both the mother-in-law's and the sister-in-law's voices have more authority than the wives are.

Cultural practices that put girls at risk of STDs must be improved in a way that they will incorporate the needs as well as children's rights.

The girl–child must be empowered and kept in a safe environment.

There must be increased condom use.

Sexual behaviour of the community need to be improved and other stake holders such as the church need to be involved to build the community with good morals.
Practices such as polygamy, although embodied in customary law, must be addressed and practised in a way that will not be detrimental to women’s health.

7.6 CLEANSING MECHANISM

The traditional healers believe that the cleansing mechanism is the appropriate method in trying to rid the body of dirt (unhygienic discharges). This is evident in rituals such as the cleaning process that women undergo after the husband’s death, and the cleansing ritual conducted after abortion. Herbs are used for the cleansing procedures. Antibiotics are also used in modern medicine as a form of treating sexually transmitted diseases.

RECOMMENDATION

The dirt-cleansing strategy must be emphasized in the treatment of sexually transmitted diseases. The use of antibiotics must be explained in such a manner that lay men will also understand them as herbs used for cleansing the body from dirt.

7.7 HEALTH WORKER’S EDUCATION

Health workers lack the indigenous knowledge about sexually transmitted diseases as well as the knowledge of attitudes, beliefs and practices of the people they serve, thus making it difficult for them to draw programmes that will meet the needs of the community.
RECOMMENDATIONS

There is a need for special training in gender sensitivity, gender violence and child abuse amongst nursing professionals and educators. Furthermore, health care professionals must also be trained on cultural knowledge, attitudes and practices in relation to sexually transmitted diseases.

7.8 POLICIES OF MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

Lack of gender sensitivity amongst all the stakeholders including policymakers and health care workers should be seriously addressed. This was evident by the way sexually transmitted diseases are commonly called in Venda (malwadze a vhasadzi-women's disease). Secondly, the practice that women suffering from sexually transmitted diseases are given letters to give to their husbands to come for treatment should be improved and designed in a way acceptable to the community. This practice subjects women to assault and verbal abuse. Women resort to throwing the letter away, thus continuing to be reinfected. The disease will only be treated if the man himself sees symptoms and decides to seek help.

The Department of Health didn't take cultural issues and gender roles into consideration when it drafted the policy of management of sexually transmitted infections. The policy was drawn with the view to protecting the Department itself, not the vulnerable groups such as women. It was also based on the superiority of the Western culture in comparison with the indigenous cultures.
RECOMMENDATION

The management strategy must be revised to include issues of gender and culture.

Policymakers must encourage a relationship between traditional healers and primary health care personnel, as well as networks for information sharing on indigenous methods of STDs care between healers and practitioners from all sectors.

Policymakers must also take steps to put mechanisms for the prevention of the spread of the infection. To eliminate misconceptions about causes of sexually transmitted diseases the use of radio and dramas and involvement of the church is also of importance.

7.9 CONCLUSIONS OF THE STUDY

The conclusions of the study are as follows:

Cultural beliefs and practices, including the high values placed on fertility, makulo (bride wealth), polygamy, widow inheritance and social acceptance of men's extra marital affairs, perpetuate women's vulnerability. Also avoidance of cultural relativism needs to be encouraged.

Dirt theory has been created based on the findings of the study which showed that physical dirt and moral dirt as main categories of STDs.
A variety of terms used to identify STDs as used and known by the Vhavenda themselves.

Vulnerability of the girl child who is viewed as clean.

Health care providers health behaviour, actions and policies perpetuates gender and other stereotypes.

Gender issues such as unequal power relations and economy and educational status influence women's vulnerability to STDs.

7.10 IMPLICATIONS TO NURSING

Training of nursing students is one-sided. Indigenous knowledge was dubbed unscientific, unhygienic, inferior and unworthy of being taught. The effect of modernisation, urbanisation, and socio-political change has also resulted in healing increasingly changing from indigenous healing, faith healers, charismatic churches and modern medicine.

It is clear from the findings of this study that the cultural beliefs and practices of the people that we as nurses serve, must be taken into consideration and put into proper perspective. Lowdermilk, Perry and Bobak (1995:865), support this view by reiterating the fact that nurses need to be culturally competent in order to provide culturally competent care.
The guidelines for the training of health workers has been proposed to help in incorporating indigenous health practice methods so as to enhance quality control in sexually transmitted infections as well as the issue of making the community aware of gender discrimination in the indigenous health care of STDs.

One of the things that have become clear is that the multi-cultural environment that they operate in in health care provision, requires more than one approach to treating diseases, hence the tendency among Venda women to secretly consult traditional healers while at the same time receiving treatment in hospitals.

The western approach, which is quite predominant, is mostly built around western beliefs and culture. As a result, it is quite oblivious of the complex cultural make-up of the indigenous people and thus can scarcely meet their needs.

The norms and customs that are inherent in these indigenous cultures are fundamental to the day-to-day existence of the people concerned and may hold a key to the understanding of many aspects of their lives, including the understanding of disease, in the case of this thesis, those transmitted sexually. Also inherent in culture are socially generated behaviours, e.g. sexual, that are often different for women and men. In the case of the Vhavenda and other indigenous groups, for instance, it is some of these gendered behavioural patterns and practices that are arguably, as shown in
this thesis, linked to the spread of sexually transmitted diseases. The understanding and incorporation of these into conventional ways of health care could go a long way in solving most of the problems facing the medical professionals these days.

The dirt theory has many implications to the nursing practice as it emphasizes the need to be clean, in order to be healthy. Dirt theory can be linked and incorporated into the theme of sterility and infection control. By teaching this community to abstain from sexual intercourse during menstruation, post delivery and post abortion, the nurse will be able to combat the spread of infections. In so doing it will also help in emphasizing the use of condoms which is also preventing dirt (discharges) of both man and woman to be mixed during intercourse. Furthermore, the dirt theory must be integrated into the formal health education and reproductive health systems.

In our endeavor to fight against HIV/AIDS we must strive to involve the community. Their beliefs and practices illustrated above may serve as tools to enhance our strategies in health education. Their good and harmless practices such as abstinence must be emphasized. The issue of being faithful may also be stressed, in cases where the community members are practicing polygamy stressing the fact of being faithful and sticking to your wives only may be emphasized. The dirt theory may also be useful in enhancing the use of condoms by stressing that using a condom prevents the discharges from mixing, thus preventing the spread of STDs.
Presently enculturation leads to different labeling, diagnosis and treatment of men and women. Health care providers must examine and correct the own stereotypes and biases in relation to gender sensitivity, attitude, beliefs and values of the people they serve.

7.11 IMPLICATIONS FOR RESEARCH

Further research must be conducted on diseases that are unknown in modern biomedicine namely Lukuse, tshimbambaila, mafa and divhu. Gokhonya must also be researched further as it is indicated as one of the major causes of infertility. More research must be conducted on the indigenous reproductive health issues such as family planning, infertility, menopause, cancer, etc.

Further studies must be conducted based on the following propositions that emerged in the study:

- Physiological structure of women predisposes them to high incidence of STDs as compare to men.

- Men who sleep with women who are dirty have a high inclination of contracting STDs.

- Culturally defined gender roles in the Vhavenda society justified women as sole agents of STDs.
- Men having sex with women who have just given birth have a high chance of developing STDs than those who took time to resume intercourse.

In addition studies on the dirt theory to be explored among other cultures in South Africa.

7.12 LIMITATIONS OF THE STUDY

As already indicated in Chapter 3, the instrument used to collect data was drawn to guide the research assistants in the line of questioning. Training was also provided to enrich their interview skills. Despite all the efforts done there were other interviews that were not of good quality, especially the issue of probing. The research was also conducted amongst the Vhavenda only, which could have effects in terms of policy changes and implementation due to different beliefs between cultural groups in the province. Furthermore, due to ethical reasons the researcher was not allowed to do observations as planned.

7.13 SUMMARY

Culture is dynamic and capable of adapting to new conditions. It is therefore imperative that practices that are harmless be incorporated in trying to reduce the spread of sexually transmitted infections and those that are harmful be looked into or refined, to meet with new challenges faced by society.
Hopefully the findings of this study will also bring about changes to enable governments, especially the Department of Health to ensure the application of women's rights to health care, equally to that of men.
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ANNEXURE A

Women and sexually transmitted diseases: A case study of health practices and cultural beliefs of the Vhavenda community

INTERVIEW SCHEDULE

THEME 1
What are the cultural beliefs and health care practices of the Vhavenda in relation to STDs?

What do you understand about sexually transmitted diseases?

What are the common sexually transmitted diseases in your community?

Where do people go when they get sexually transmitted diseases?

What would one do to avoid getting infected with sexually transmitted diseases?

Which preventive methods do you think can work best?

In your own opinion which methods are best for the treatment of STDs?
THEME 2
What are the beliefs and practises of the Vhavenda in sexuality education?

Where do people learn about sexual practises?

Do you have premarriage counselling?

If yes how is it done?

THEME 3
How do you perceive polygamous marriages?

How do the number of sex partners influence the spread of sexually transmitted infections?

Are women allowed to refuse having sex with their husbands?

HIV/AIDS is one of the sexually transmitted diseases that is a scourge in our society?

Are women in this area at risk of getting HIV/AIDS?

If YES,

What do you think puts them at risk?
What precautions need to be taken to avoid those risks

What is your opinion about openness about one's HIV/AIDS status?

To what extent do you think HIV/AIDS is discussed?

Do you think people must talk openly about HIV/AIDS?
ANNEXURE B

TRANSCRIPTIONS

INTERVIEWS WITH KEY INFORMANTS

RESPONDENT NO 1

Question
What do you know or understand about the traditional beliefs of the Vhavenda’s health care system?

Answer
To answer your question I need to explain or clarify a few things about this system. What you should know is that I believe in traditional medicine. At the moment I would say I’m more inclined to trust and believe in traditional medicine than western medicine. By the way I also have some of the treatments of some of the ailments. I also think scientific medicine is still working in the dark whereas traditional medicine is established.

Question
How do you regard traditional medicine?

Answer
It is the best. Maybe the problem lies in the fact that when scientists want to test whether the Vhavenda can successfully treat a certain disease, they
might use a name of that disease which the Vhavenda do not use or even know. Obviously if that was to happen, one would expect to have anomalies in the answer given especially if the name given to a particular disease is known those that are asking the question, be it those from western or scientific medicine.

**Question**

What about STD’s?

**Answer**

Most traditional healers are very good at treating those, especially the ones that are general practitioners. I can also treat most of this (laughter). I can treat Dorobo and Thusula. These are the most common ones. I have medicine to treat those. The Vhavenda can also help with a man who is weak in bed. They have herbs that can help restore his power, so to speak.

**Question**

What about an ailment called Lukuse? What is it?

**Answer**

I’ve heard about it but I’ve absolutely no clue as to what it is. Several traditional healers have mentioned it to me.
Question
What about Ndonda?

Answer
This is when a person simply grows thin and thinner even when he is being treated, especially by those who do not have the know-how.

Question
Is it sexually transmitted?

Answer
Mostly people believe it is sexually transmitted even though it also affects children. We believe it is because maybe the child got it from the mum at birth. When I first came across this disease, it was through a friend of mine who sold me this car who then told me that his mother can treat it and she specialises in treating children. I still have a standing arrangement with him to the effect that I will take his mother to the hospital where I hope she differentiate for me between children suffering from Ndonda and those that are suffering from Kwashi.

Question
Do you treat people with STDs?

Answer
It is not really my job but if someone comes to me I do help.
Question
How frequently do you come across people in need of this help that you've just mentioned?

Answer
On average I make about 50 litres of medicine per week for different ailments.

Question
Let's focus on STDs

Answer
Yes, in most cases many of the ailments that afflict men are STDs. These usually cause other ailments whereas initially it was an STD, which he had contracted from someone.

Question
Let's be specific and talk about the treatment of STD's. How do you treat them?

Answer
I give them medicine or do you want the name of the medicine? (laughter) I cannot disclose that. You only need to know that I give them effective medicine. There are a number of different types of medicines that treat STD's. Most of them we have even tested them in a laboratory and found
them to be very effective. The information that we get after testing, we simply incubate it since we cannot develop the medicine further.

**Question**

What is Thusula and how is it treated?

**Answer**

We are not really sure what it is but the symptoms are those of Syphilis. I have a student who is going to obtain his/her honours degree this year who has been researching this disease. He/she found the symptoms to be the same. He/she extracted discharges from a sufferer, took them to the laboratory and after testing, found that they are the same as those of Syphilis. He/she treated these microorganisms with traditional medicine and found it to be very effective. The problem that we have is that it is claimed that traditional medicine is not measured and standardised. That is why we still need to put up a strong argument to legitimise these medicines.

**Question**

As a traditionalist what do you think can or should be done to avoid the spreading of STD's?

**Answer**

Option number one is that people should be treated by traditional healers. Scientific medicine simply makes these diseases dormant for a while. I've come across a great number of people who have told me that they have been
on treatment (scientific) for a year or more and haven’t been cured. I gave them medicine and they were cured. As for behaviour, well that’s another story. Nobody or let’s say almost everybody claim they do not have sex. (Laughter.) Another problem that we have is that there are con-people in this business. Those who would claim to be traditional healers whereas they are not. Those are the ones to whom if you go for consultation you end up not being cured. So for me, a long term solution would be to identify those traditional healers who can do the job because even in scientific medicine, normally you would expect a doctor to refer you to somebody who specialises in a particular disease but unfortunately it does not happen that often. They all act as general practitioners. In the case of traditional healers, we need to have a database of all the specialists in particular fields so that we know who to consult and for what. We should also have their particulars such as addresses and telephone numbers. But for this to be possible, scientific medicine must open up opportunities for traditional healers to have their medicines tested.

We have also realised that western medical practitioners does not want to do this because it would prove that traditional medicine is effective and that would affect their market. That is all commerce.

Question
But won’t we have a problem of traditional healers refusing to open up?
You’ve just told me you cannot disclose the name of your treatments.
Answer

I'm not saying traditional healers should show us their treatments. They only need to come with their medicines and then we would test these in a laboratory. If it is okay then fine. Maybe we would also need to screen them to identify them chemically then at least we would know that so and so has a particular treatment. The name is not important. Even in western medicine they do not tell us the names. What we know are only trade names. It usually claimed that the Vhavenda are very secretive but in western society they have patents. Once the medicine is patented we never know what it is and what really composes it.

For instance I went to Tshilidzini Hospital as a researcher and lecturer who has students doing research work. I wanted them to allow us to get a patient who after being diagnosed with a STD would then be taken to a traditional healer for treatment. Thereafter, the patient would be tested. They refused. Two black female doctors came and we explained what we wanted and one of them said her religion does now allow her to diagnose a patient and then let him/her go and be treated by a traditional healer.

We argued with the doctors that this is for the benefit of science and that the patient has agreed to be treated by a traditional healer. We also impressed upon them that this is the only way that we can bridge the gap between scientific and traditional knowledge but this was to no avail. As far as I'm concerned, scientific knowledge is very far behind our traditional healing.
One other major problem that I have with scientific healing is that it only treats the symptoms rather than the ailment itself. We know and accept that western medicine can treat these symptoms but that is not enough. The level of treatment is not the same. For example if we were to treat a treat branch of some ailment with western medicine, we would end up only treating that particular branch whereas with traditional medicine we would treat all the branches and effectively the whole tree.

Another STD, which I will not claim to be able to treat but there being others who can, is that of U WELA. This is one STD that is very close to AIDS. It affects men who have sexual relations with a woman who has just had an abortion. If AIDS has not been manufactured in a laboratory as some people would like us to believe, and it is a natural affliction, then I really believe AIDS has been there since a long time back and it is in thee form of U WELA. The patient grows very thin just like one with AIDS. At a certain level the disease is called Lufhiha. At this stage the patient has developed a very severe cough. The symptoms overlap significantly with those of AIDS. At this stage, the patient’s immune system is very low. Traditionally the healer makes a Gumululo for the patient.

Here is Mr X whose friend just cheated death because of this disease. He might explain better. Mr X is a teacher at school B.

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<td>Mr X, what are the symptoms of u wela?</td>
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Answer

It starts with a terrible headache. If not treated quickly, the patient may die. Then you start getting thinner and thinner by the day. This is caused by the fact that the patient’s appetite disappears and its cause is linked to the fact that the patient’s bowel system stops functioning even the urine stops. Even if the patient feels like going to the toilet, nothing is released and this is very painful. Even if a little urine comes out, you will never want to go back to the toilet again. (Here respondent no 1 chips in.) A person with AIDS develops diarrhoea at some stage. This is when the AIDS is said to be fully blown. But what I believe is that because this person’s bodily functions are not working, he/she went for treatment, and the bowel started functioning non stop since the body is not functioning well. Normally people who are said to have AIDS are those who are used to hospitals and have been to hospital for treatment. And mostly these people are given laxatives to relax their bowel system.

If a person is suffering from UWELA and he goes to hospital, normally at home we start preparations for his funeral because we know that the hospital is not going to treat him for what he is suffering from but will rather treat the symptoms. Even relatives in distant areas are notified before the person dies.

Question

Was there any sexual education for children in those days?
Answer

Yes. These were incorporated with initiation schools. Girls used to attend Musevhetho, Vhusha, Tshikanda, Domba etc. This is where girls were taught general sexual principles so that they would not land into trouble. Boys would attend Murundu, Tshitambo and even Domba if it were deemed necessary. To top it all there was also adult education that was passed on to youngsters through associating with elders. Today, this is no longer the case. We no longer have contact with the generation that could impart this knowledge.

Question

What was the mainly imparted to these two groups?

Answer

That they should not go sleeping around. They were also warned of the consequences of such action. Anyway, a woman who is always having STD will definitely not have a husband since he would also get sick. On top of all this, children were told of scary stories of what would happen if they transgressed these teachings and because society was still closed we believed these stories. But today nobody would believe those. Another problem is that STDs also affect the woman’s ability to have children and remember women were married in order to come and have children.

Question

Was there any premarital counselling for women in those days?
Answer

Oh yes. Plenty of it. When we say O LAIWA it means the girl is now an expert in good behaviour. She has gone through all the stages. The last stage is the attending of Domba where she is taught how to behave in the marital home and also cautioned to always communicate anything she does not understand with her mum-in-law.

Question

Did it ever happen that a woman would get married without attending the Domba?

Answer

Yes, it happened but then the in-laws would be informed before hand and it would then be their duty to take her to the Domba. Even if she already has children, she would still be sent there so that there is no stage that she has skipped. Unfortunately when we grew up, men no longer went to the Domba and girls had almost stopped this practice. But go get someone who understands what really happened at this school and obtain the information. Especially people like Nyamungozwa and those from royal families.

Question

What about polygamous marriages? Didn’t we have a problem of women straying from the marital home due to sexual starvation?
Never! The man always kept a pot of Maheu behind his door. The wife who is sharing his bed at that stage needs to keep the pot refreshed. She has even been shown the medicine that needs to be mixed with the maheu. Most of these medicines which had been said to be for making the man powerful, were mostly meant to treat STDs because it is believed that the weakness of a man in bed is due to having contracted these STDs, some of which are unknown. And the bacteria that causes them is also unknown. So the medicine in the Maheu simply decontaminates the man. So the man is always clean from STDs. (laughter) There is also a Tshivenda medicine which if given to a man, if he meets a woman with any STD, he would never have an erection. The woman may try all the tricks in the book but it will never happen that the man has an erection (laughter!) Thi is called U THAVHELIWA.

I know an old lady who is still alive who can do this. May be this is another way in which people can be immunised because I think that women can also use this. I believe that if a woman meets a man with STDs nothing would happen.

Question
Was it allowed for wives to refuse their husbands sex?

Answer
No. Unless she was sick or she suspected her husband to have STDs. Or if she simply wanted to discipline her man if she thought he was only
demanding sexual favours from her after failing where ever he might have been. (laughter). Furthermore, men with more than one wives lived longer. Because a man who is always solving problems is always active and therefore does not grow old. This is what I was told by some old man.

And again this did not encourage the spread of STDs since the man was always in debt when it came to satisfying his wives. At the end of the circle, he needs to start again and so it goes. It also helped that the man did no sleep with strangers since he knows his wives. (laughter). As for wives being tempted, it was just a matter of the wife being unfaithful. Even if she was the only wife she would still do it.

**Question**

Have you ever come across an AIDS Patient needing help from you?

**Answer**

No it has never happened. But what is strange is that I’ve got some medicine which I call Magic which people claim it treats or cures AIDS but nobody has ever said that to my face. I’ve got it now if you want it. If I were to call my daughter and ask her to bring Magic, she would do it because she also knows it. What I know is that it cures diabetes, high blood pressure and whole range of STDs. The problem with STDs is that people go to hospitals, get an injection and come back saying they have been treated. In essence they have not.
Question

What do you think needs to be done to prevent the spread of STDs?

Answer

I think the campaigns that I have seen so far about people being faithful and so on are useless.

Question

What do you think needs to be done?

Answer

People must be treated properly and at the moment they are not. You see, people who are not treated at hospitals do not have these STDs but those who do, go there and come back with the symptoms having disappeared and they think they are cured. But that is not the case. When it is as hot as it is now, these diseases resurface.

Question

Whatever this AIDS is, do you think sufferers should disclose their status?

Answer

I don’t believe in AIDS. I also do not believe we should have a special budget for it. Its definition does not satisfy me enough for it to be treated as a special disease. There are statistics that are being bandied around this area of people who are said to suffer from AIDS and a number of people who are said to
have died from it in SA. But even Mr X and I have not had any close associates who have died from it. The problem is that the symptoms that are said to indicate AIDS can also be seen in those who do not suffer from it. Traditionally we have medicines that can treat these symptoms.

For instance, a person suffering from Lufhiha does not eat because he/she has no appetite and a person like that would never have normal stomach functions. He or she would normally vomit or have diarrhoea if they do eat. But if you give them my Magic, everything gets back to normal. Then there is a disease called Goni. This is a female ailment and I'm not sure if it can be transmitted to a man. Then there is Lukuse of which I'm sure it can be transmitted but for women who suffer from it, it is said that they would never have children.

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<td>It is said that the healers mix medicine for you and they get it out. I once obtained it from one sufferer and kept it with the intention of taking it to the laboratory to check whether it is a human tissue or not. Unfortunately I lost it and so I will have to go to another healer again. Then there is Gokhonya. I don't really understand it but it is no transmissible to men. It can however be transmitted to children from mothers. I do not know if it is like AIDS which can</td>
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be transmitted to children by their mothers. Children who suffer from it die if not treated.

The problem with Gokhonya is that women these days refuse to be inspected for these diseases by healers or elders of the family, especially the so-called modern women. I remember my brother’s wife refused and the child died. Even to date she hasn’t had another child because the child will still die. But this disease can be treated.

Did you know that there is a disease whereby a girl suffering from it does not become Khomba? But this is not an STD but it is sexually related.

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Answer

The girl just grows tall but never matures into Khomba. In other words she does not develop breasts and will never menstruate. But traditionally the condition can be treated. Then amongst men there is this thing of having sexual relations with a menstruating woman. What happens is that your nerves become thinner as they develop a payer inside. That is why if such a person bends at the waist for a long period, to unbend becomes a problem. If he forces to unbend there is a noise like that of a joint getting back in its rightful place. That’s why in Tshivenda we use Tshipeiti to treat this. Then there is U LOVHELWA. If a woman’s husband dies and she meets somebody
else, before they can have sexual relations they are bound together medicinally. This is called U TANGANYIWA. But call me and I'll tell you the name of the disease. The problem is that you meet a woman whose husband has died and she says she is divorced instead of widowed. Maybe these women are scared of questions like how did the husband die but this is what happens and it puts men at risk.

Then there is U REIWA. Men mix medicines I do not know how, but if you as a man sleep with a woman for whom this has been done you would get sick because the woman would not be compatible. Even women do get this disease. It is called Tshimbambaila and the local healers cannot treat it. Usually those who come from the Reef with the disease, they are said to have been REIWA by the Zulus. This is a disease, which only those who know it can cure.

We can even ask these ladies. There are said to be bad-hearted women who would mix herbs to make sure that the husband cannot have sex with anybody else except herself. (Ladies agree). That is U REIWA. It is all the same. The only difference might lie in the symptoms. In some cases, some men have been known to be unable to pull out their organs after having sex. It has also happened here at Makwarela. In some cases one might just get sick and die. This is not a natural disease but a man-made or artificial one.
RESPONDENT NO 2

Question

Answer
Traditionally a girl is taken to Tshitaheni by her folks. After marriage, this will be the responsibility of her in-laws to do it. Diseases that are easily detectable such as Gokhonya would be cut out so that by the time the woman has sexual relations with the husband, it has already been treated. But you should know that it is said that Gokhonya is not sexually transmittable to a man. It affects a child though.

Question
How is this Gokhonya diagnosed?

Answer
Whoever is doing the diagnoses will see whitish sores in the patient's privates. This is cut out with a razor blade and the blood that comes out is cleaned. Then the patient is given two types of medicines. One is to be taken orally and the other one has to be inserted into the vagina where it is expected to absorb all the poison.

Question
Any other STDs you know?
Answer
There is another one called Thusula, which those who had the know-how could treat. But it could only be treated if one had tried to get help in time. If you fail to seek help in time, nothing could be done for you and it would lead to death. The patient develops sores in her privates and would always be scratching herself, as the sores tend to be itchy.

Question
Any other STD?

Answer
The other one is called Lukuse and it also affects children. I do not really understand this one but then there is also another one called Mulilo. It is said that, women who suffer from this ailment, develop a reddish color in their privates even though they might still be virgins. I have never heard as to whether it is sexually transmitted. What I know is that it could be treated before the woman had had any sexual relations with her man. There is another one called Thoho whereby the man is always complaining about a headache. I do not know if this was transmitted from a woman or not. But this headache would persist until it is treated.

Question
What do you think can be done to avoid these sexually transmitted diseases?
Answer

In those days girls were inspected for diseases before they were married. These days, kids are uncontrollable and have no manners. Even if my own girl is to get married, there is no way she would agree to be inspected. You now what you call Shower but what is surprising about it is that we never hear you people talking about sexual issues. We only hear you talking about doing laundry and ironing for the husband as well as cleaning of the bedroom but nothing about things of a sexual nature. In the past a girl would be inspected for any STD's. If it were found that you had one or other of those, you would be treated first before getting married. Also, these days girls are simply doing their own thing without involving either parents or elders in the family.

Question

Did the Vhavenda had what we could call sexual education?

Answer

Oh Yes. Like I said, a girl was inspected for diseases. If she were found to be sick, she would be treated. They would also tell her that if she realises that her husband is sick, she should tell a designated elder of the family. So, these diseases were not a problem and neither did they spread because there were rules and regulations to be followed. We also had initiation schools. Men were taught about these things when they went to Tshitambo and for females there was U imbelwa. Here girls were told that it is anathema to have sexual relations with a man before marriage. This made girls to be afraid to have sex before marriage as they knew it was wrong to do so. So, all girls waited for
marriage before having sex. Boys would also be told that if they had sex before marriage, they would suffer unending headaches, swollen genitalia and other frightful diseases. So, I would say there was sexual education in the past. It just disappeared with time.

**Question**

What about premarital counselling was it practised?

**Answer**

If a girl matured or started menstruating, the Makhadzi to the girl was called in. It was her duty to tell the girl that now that she has reached maturity, she is regarded as Murathu WA vhasadzi (younger sister to women), as such, she should guard against having sex with boys. If she does, she should know that they would make her sick and she would die. If that does not happen, she might fall pregnant and if that happens she would die, as she is not married. You know as well as I that nobody likes the idea of dying. So this acted as a deterrent. On the other hand, the male elders of the family would deal with the boys who had reached maturity in the family.

**Question**

Would you say polygamy lead to the spreading of STDs?

**Answer**

Not at all, a man could have as many as six wives and there would be no problem. Remember, all these women had to pass the sexual fitness test.
before they had any sexual relations with their husband. Any woman who was added to the harem had to be inspected for diseases before she would sleep with her husband.

**Question**

Was it permissible for a wife to refuse her husband his conjugal rights?

**Answer**

If the reason is that you are menstruating, yes you could but other than that, no woman would dare refuse. If a woman is menstruating, she was required to go to her designated confidante and report that indeed she is in her period. The confidante would then report her status to the husband who would understand. After seven days, the woman is required to go back to her marital bed.

**Question**

Is there a possibility that women in your area are contracting AIDS?

**Answer**

The possibility is there because most women these days are not married. Even those who are married, have no manners. They sleep with anything in pants. What makes matters worse is that nowadays we have these nuclear families where in-laws are out of the picture. Say, for instance your husband is a soldier or policeman. If he leaves for long periods without coming home and you have no manners, you are bound to go out of the marital home and do
your thing. Who will know? There are no in-laws, so immediately the kids go to bed, you go out and nobody will any wiser. In the past, you never found a family comprised of a husband and wife only. It was always advised that there must be an elderly woman in the family whose role would be to teach the wife the right behaviour, so, diseases such as these were not there.

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<th>Question</th>
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<tr>
<td>What do you think should be done to prevent the spread of STDs?</td>
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Answer

Maybe it would help if officials from the Ministry of health went from area to area teaching people about the dangers of promiscuity but I doubt it.

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<tr>
<td>Do you think that those who are HIV positive should disclose their status?</td>
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Answer

What I think does not matter. The problem is that not many people will be willing to do it. You must remember that being HIV positive is not a novelty. If it were a good thing, everybody would disclose his or her status. In any case what would people think of me? Where will they say I contracted this dreadful disease? It would even be worse if I am not married. People would start speculating as to where I might have contracted it, Zimbabwe, Lesotho and some such far away countries whereas I never went anywhere and had contracted the disease here at home.
Question
Do you think people should talk about HIV/AIDS?

Answer
People do talk about it at civic meetings or gatherings at the chief's kraal, but to say so has got the disease is another story. That and disclosing one's HIV status never happens. I think people should talk more about this disease. You see, in the past STDs were discussed. This happened within the confines of a home and not at gatherings.

RESPONDENT NO 3

Question
In health matters, how did the Vhavenda deal with STDs?

Answer
In those days, if one was sick, it was only logical to seek the help of a traditional healer.

Question
Can you tell me the most common STDs prevalent in those days?
Answer

There is Thusula whose symptoms are sores that are whitish in colour. These sores are itchy and painful. Then there is what is called U Wela. This happens if a man has sexual relations with a woman who has had an abortion. The man would develop a searing headache and lose weight. In some cases, the person's health would just deteriorate. Some men do not tell as to what is making them sick but they eventually say whom they had slept with when they are already dying. Some tell their folks immediately. If this happens, they would obtain the woman's discharges, mix it with medicine and let the patient drink. After a while he will recover.

Question

Any other STD you know?

Answer

There is Gokhonya, which may be transmitted by a husband to his wife. This prevents a woman from having children.

Question

How is this Gokhonya diagnosed?

Answer

If I have it, I'll always feel itchy in my privates and on consulting a traditional healer, he/she will ask what the problem is. I will then say how I feel and on inspection he/she will see it and then cut it out. In some people it is diagnosed
long before they even get married. After it has been cut out, it is burned to a
crisp and then mixed with medicines. The woman is required to apply this
medicine to her genitals every morning. If she has an infant who has
contracted this Gokhonya from the mother, some of the medicine must be
applied at the back of the infant's head where it will be reddish in colour.

Question
What role if any, did polygamous marriages increase the spread of STDs?

Answer
Polygamy increased the spread of STDs in the sense that if a man has three
or four wives, it would be very difficult to know which one of them had brought
the disease into the family since nobody is going to admit having done it.

Question
Were there any places in the past where people received sex education?

Answer
There was no institutions, but at maturity, female elders in the family would
counsel a girl. In any case, girls were always inspected for diseases as well
as determining their virginity. After marriage, a woman does not simply rush to
the marital bed. She was first inspected for diseases and virginity. These tests
or inspections went on for days, especially after the evening bath. Thereafter
she would be given a clean bill of health and then she can have sexual
relations with her husband. Apart from the inspections, girls were warned
against sex before marriage and were told that if they do it, they would contract Thusula at a very early age. They were also taught the proper way of behaving.

**Question**
Are there any possibilities that women in your area suffer from STDs?

**Answer**
The possibilities are there.

**Question**
Why do you think these possibilities exist?

**Answer**
The problem is that many a woman are not married and this causes promiscuity. If a woman has sexual relations with more than one partner, how will she know who infected her with a disease and how will she know to which of her partners she has passed the disease?

**Question**
What do you think should be done to curb this?
Answer
It would help a lot if women have one partner to whom they are faithful because if the man infects a woman, she would know and tell him that before I slept with you I never had this disease.

Question
Do you think people with AIDS should disclose their status?

Answer
Nobody would ever disclose it. They would rather keep it to themselves and continue spreading the disease.

Question
Do women in this area talk about HIV/AIDS?

Answer
Women do talk about it although not in the sense of discussing the disease itself. They usually tell each other that so and so of a far off area has the disease but never somebody from their own locality.

Question
What do you think should be done to prevent AIDS?

Answer
Never answered!
RESPONDENTS NO 4

Question
What do you understand about STDs?

Answer
Well, I know them because my ancestors help me to understand them, as I am a healer. What I would do is to go out and get medicines to cure these diseases, be it Thusula or any other STD.

Question
How do you know that a person has Thusula or how do you diagnose it?

Answer
A person who has Thusula cannot walk properly because she has itchy and painful sores in her private parts.

Question
Any other STDs you know?

Answer
There is also Dorobo and Gokhonya. The latter causes headaches and itchiness of private parts.
Question
How do you diagnose Gokhonya?

Answer
After the birth of a child, the kid is always looking down. He/she is not as energetic as other normal kids. If you do not seek help from those with the know-how, the child dies and any other child you will ever bear. So the child must be given the right medicines. The woman must also get medicines to drink and to apply to her private parts. The Gokhonya is like a worm. If a person is being treated with medicines, it will eventually come out with the stools.

Question
What do you think can be done to avoid contracting these diseases?

Answer
People should stop being promiscuous and have one partner.

Question
Do you think there is a possibility that women in your area have STDs?

Answer
Yes, even young children have these diseases.
Question
Why do you think is the reason for this?

Answer
They love money and the only place to get it is from men.

Question
Was there any sexual education in the old days?

Answer
Girls were taught that they should never play with boys. Girls used to play on their own and boys would do the same. But these days nobody cares.

Question
Did polygamy increase the spread of STDs?

Answer
What do you think? If a man has more than one wife there was a possibility that one of his wives would infect him with one of these diseases.

Question
Do you think there are women in your area who have contracted AIDS?

Answer
All of them, children, mothers and grannies are infected.
Question
Do you think people should disclose their HIV status?

Answer
Why not? It is a disease like any other.

Question
Do you think there is enough discussion about AIDS in your area?

Answer
People do talk about it but mostly it is the radio that broadcasts about AIDS.

Question
Was it allowed for wives to refuse their husbands sex?

Answer
Never, unless one was in her period but otherwise it was unheard of.

RESPONDENTS NO 5

Question
Traditionally how were STDs understood and diagnosed?
Answer

When I was growing up, people used to have sex with baboons. The woman would then develop sores on her private parts and lips. Now these diseases which people got from baboons are spreading. That is why we have so many different diseases such as Thusula.

Question
What is this Thusula?

Answer

It is when you develop sores on your private parts. It can be cured. In our area there was one old man who used to treat it by the name of Vho Rammela. This disease nearly wiped out a lot of people. It like AIDS because AIDS is also about sores.

Question

Any other STDs you know?

Answer

There is one called Lukuse. If you give birth to the first child and it dies, the next one survives and the third one dies, the elders take you to a traditional healer. It happened to my sister who was eventually taken to a known traditional healer with her husband. The traditional healer mixed medicines and gave to the husband to drink. Immediately thereafter, the Lukuse came
out from his penis. It is like hair. Thereafter all my sister's children survived and today she has ten kids.

**Question**

Are there any other sexually transmitted diseases?

**Answer**

There is also Dorobo. This is very painful. You are always wet with whitish discharges. The symptoms are the same in both male and female. Both partners have to be treated if you want to get rid of it.

**Question**

Did you have any sexual education in those days?

**Answer**

Most certainly, that is why there is U imbelwa for girls at the chief's kraal. Nothing was ever hidden from those girls. They knew everything there was to know about sex. We were told that "Ni songo tamba Tshapfumba ni tambe Mutavhanani." We were not afraid of boys. We would have simulated sex. In other words a boy would rub his penis on the thighs until he ejaculated. But he never ever penetrated you. That was the cardinal rule. We would do this until we were ready for marriage. But today, you have real sex on the first date. All these girls who go to U imbelwa know all these rules because that's where they are taught.
Question
Was there any premarital counselling?

Answer
Without a doubt. When you got married, you would not just jump into the marital bed. You were first warned as to what to expect in the marital hut. Then one day one of the female elders would come to you and say today is the day that you go into the marital hut. The following morning you were expected to report back on what transpired. If there were any shortcomings on your part, they would revise with you what they taught you on arrival. If the shortcomings were on the husband's side, they would sit down with him and advise him what to do. You would be surprised the husband asking you as a wife what he needed to do sexually.

Question
How did polygamy contribute to the spread of STDs?

Answer
It contributed a lot because each of these people have their own problems although the elders first inspected you for diseases to prevent them spreading throughout the household.

Question
How much of a possibility is it for women in this area to contract STDs?
Answer

With men being as promiscuous as they are, there is no doubt in my mind that the possibility is there. Especially knowing that most of them are not even protecting themselves. If as a wife you suggest that your husband use a condom with his mistresses, he would beat you up. A lot of people are sick.

Question

What do you think can be done to prevent the spreading of these diseases?

Answer

I do not know because people are not going to stop having sex. To make matters worse, men do not want to use condoms. Another thing, old as I am now, I no longer sleep with my husband. He is old and I am also old. We were told that at this age we could no longer have sex since we can get sick but these days people do not care. They do it until they drop dead.

Question

Is there enough discussion among women about HIV/AIDS?

Answer

We do discuss it and we also talk about it with our children.

Question

What do you think about the disclosure of one's HIV status?
Answer

Personally I'm sure I would disclose it in order to get help but it is a pity a lot of people would never dream of doing so.

RESPONDENTS NO 6

Question
What are traditional health beliefs concerning STDs?

Answer
The way I understand it is that if a man who has had sexual relations with someone with an STD, and then he sleeps with another person, that particular person will also contract the STD. In other words, if a husband sleeps around with other women, the wife is the one who will suffer from these STDs.

Question
Which STDs do you know of?

Answer
There is one called Goni, which you can contract from another person. In this case the disease will be seen after you have given birth since it will be seen on the child.
Question

How will you know that you have this Goni?

Answer

The main symptom is the itchy feeling you have in your private parts and the newly born baby has some strange colouring on the neck. If the baby does not get treatment in time, it will surely die. If the colouring is spotted, the elders will immediately want to establish whether the mother experience some itchiness in her private parts and she says yes, they will then take her to a traditional healer. He/she will administer some medicine on the woman and a Dithu will come out.

Question

How does this Dithu look like?

Answer

Laughter... Well, it looks like a tick on a dog. In fact, the traditional healer will inspect the baby's neck and when he/she sees the colouring on its neck, will immediately know that the woman has Goni and he/she will cut it out with a razor blade. The Goni is then burned and mixed with medicine and applied to the baby through a process called u thavhela. The disease will end up Mafhandeni.
Question
How does it end up Mafandeni?

Answer
The burned Goni will be buried there by the traditional healer and somebody else will contract it there.

Question
Which other STD do you know of?

Answer
I can only remember Goni and Thusula

Question
What do you know about Thusula?

Answer
Obviously if you contract it you will suffer a lot and you will Xaxara in your privates. Actually you develop sores in your privates. Nowadays white people are the ones treating Thusula unlike in the past when traditional healers used to treat it.

Question
Do these sores make the sufferer feel itchy?
Answer
No, they are just painful and they secrete puss or Vhulwa.

Question
What do you think should be done to prevent these diseases?

Answer
In the old days, I would say people should go to traditional healers for treatment but presently the doctors are the ones who are at the forefront of treating these diseases.

Question
What do you think would be the best way to prevent these diseases?

Answer
The problem is that these days we put more faith on doctors than traditional healers. We even scorn traditional healers whereas they are the best in treating these diseases.

Question
Traditionally what was done in terms of sexual education?
Answer

We did not care about that. It is you people with education who do that. In my day you just hauled to the traditional healer without knowing which disease you were suffering from.

Question

Do you want to tell me that traditionally there were no places where girls or even women were taught about the dangers of STDs?

Answer

There were people who were good at U laya. Telling youngsters what to guard against in life. Traditional healers also played an important part in this education as they were the ones who were knowledgeable about these diseases. The rest of us had no say in the matter, as we were ignorant. Traditional healers would throw down their bones and see these diseases.

Question

When a girl was about to get married, was she counselled in terms of married life?

Answer

Oh, definitely yes. The family would designate a surrogate mother who would tell the prospective bride what to expect in the marital home. She would advise that even if the in-laws accuse her of witchcraft she should ignore them. Even if they say she does not clean the marital home properly, she must just
keep quiet. Unless they send you home to be taught manners, you stay put. If they do that, it is only then that they would have to send you home with an elder who will come and inform the family that the bride needed to be counselled again. We will then sit down with our child and ask her whether she has forgotten what we told her before marriage and if she says yes, we would ask why she is not following what we had instructed her to do.

**Question**

What do you think of polygamous relationships?

**Answer**

I was married in a household of three wives including myself. The chief wife was told that the new wife is her younger sister and that she needed to guide her. Sometimes the chief wife would be jealous of the other younger wives and the solution for the man was to divorce the chief wife.

**Question**

Do you think polygamy played a role in the spread of STDs?

**Answer**

What used to happen is that if the husband gets sick, all the wives including the husband were treated for STDs. That was meant to ensure that the disease is eradicated in the home.
Question
Was it permissible for a wife to deny her husband his conjugal rights?

Answer
Never!.. laughter..... You would never dare. If you were to do it, they would send you packing. In any case why would you refuse whereas that is the main reason you were married in the first place? Whether you wanted or not, if it was your turn to have sex with your husband you had to do it.

Question
What do you know about AIDS?

Answer
This is a modern disease. It was not there in the old days.

Question
Do you think there are any possibilities that women in this area could contract AIDS?

Answer
If you are promiscuous and after drinking sleep around, you are bound to contract it. But if you behave accordingly, you will remain safe.
Question
What do you think should be done to prevent this disease?

Answer
People should refrain from denying that they can contract this disease.

Question
What do you think of the disclosure of one’s HIV status?

Answer
Nobody will ever tell. They might tell their own relatives who would then take them either to hospital or traditional healers.

Question
Do you think there is enough discussion around the AIDS pandemic?

Answer
People never talk about it. It is a secret that everybody keeps to themselves.
**RESPONDENTS NO 7**

**Question**
We would like to ask you a few questions about sexually transmitted diseases especially in women. We would like to know how these diseases are understood traditionally?

**Answer**
I believe that they are only transmitted if the man with whom the woman has sexual intercourse has been afflicted by one of these diseases. The disease could be doropo and thusula.

**Question**
In your area, which sexually transmitted diseases are most common?

**Answer**
I wouldn't like to specify or limit my answer to this area as I am consulted by people from far-flung areas. Most of them come to me for Gokhonya. This is an inborn or natural ailment common among women. In the olden days it was not that common as young girls were regularly inspected from youth to marriage age. If it was diagnosed the particular girl would immediately be treated. But unfortunately in these modern times the practice of vaginal inspections is no more. This is why the ailment is usually diagnosed when the girl is already in her marital home. When it comes to sexually transmitted diseases, the person concerned would simply be given medicine to drink.
Question
Personally, how do you think the transmissions can be stopped?

Answer
Let people use condoms because even if we cure them, they will still go and contract the next disease.

Question
How do you diagnose these STD's?

Answer
If it's the common doropo the patient will explain that her discharge is emitting a nasty smell and that its colour is not the normal one it usually turns into a yellowish colour. If it is Thusula, on inspection of the patient's privates, there will sores on her genitalia. I then give her the appropriate medicine plus tshipeiti(enema) and by the end of the day she is as good as new.

Question
Traditionally it is anathema to discuss sex with children, let alone STD's. Now with the spread of these diseases how do we make these children aware of the dangers of STD's

Answer
You are the educated ones. I would very much love to ask you the same question. If I were to say I wanted to do vaginal inspections on your children,
you would be the first to say I want to bewitch them. In my day, we were inspected, not only for diagnostic purposes, but also to see whether one is still a virgin or not. This went on until wedding day.

**Question**

How would you know whether one is still a virgin or not?

**Answer**

Every virgin has a hymen. If she engages in sexual relations, it's gone forever.

**Question**

These days use tampons during their menstrual periods. Wouldn't these interfere with the hymen?

**Answer**

No way. The tampon can never inflict the same damage as a man's organ.

**Question**

In your day, what were girls told about sexual relations prior to marriage?

**Answer**

There were no words of expressing this. What happened was that just on the eve of a girl's marriage, she would be taken to the river for virginity inspection. This was done by female members of her own family and a delegation from the prospective in-laws. If she was found to be still intact, the inspectors would
take an uncut pumpkin and put it in a traditional reed basket and closed it. This basket would then be sent to the prospective in-laws who on opening the basket will know that their prospective bride has still known no man. This was a source of pride for both families.

After this, the girl is married and brought to the marital home where her new husband will not touch her. They wait for her period, which when it finally comes, she reports to the elders in the family. She and her husband will then be taken to a traditional healer where they will be united in marriage. What happens is that the healer will take a portion of both husband and wife’s urine, mix them with herbs and the couple drinks the mixture. That very same day, the couple may indulge in sexual relations.

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<th>Question</th>
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<td>What was the purpose of this ceremony?</td>
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<tr>
<th>Question</th>
<th>Why would a man go outside the marital home for sex when he had his own harem at home? As for the wives, they were all bound to their husband.</th>
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<td>What about polygamy. Didn't this system exacerbate the spread of STD's?</td>
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These days some of these diseases are a result of men having sexual relations with their wives immediately after the wife has given birth and the womb is still dirty or unclean.

**Question**

What do you understand about HIV / AIDS or is there another disease that you know that has the same symptoms?

**Answer**

As a traditional healer I don't even know what the words mean.

**Question**

What do you think of the disclosure of one's HIV status?

**Answer**

I think disclosure is the way to go, but you must understand that most people will not disclose for fear of being ostracised.

**Question**

Traditionally, does it happen that a woman is said to be unable to give birth?

**Answer**

Yes, if it is how she was born.
Question
Are there any beliefs that this could have been caused by the hands of people?

Answer
That involves witchcraft.

Question
If for argument's sake a person is bewitched, say for instance whoever bewitched her had used a piece of her clothes. Was it possible to reverse this?

Answer
Yes. It is possible. If it is as you say, they would simply replace the clothing, and with some herbs reverse whatever affliction she might have.

Question
Can you cure thusula?

Answer
Yes. Traditionally you are given medicine to drink, which would kill all the eggs of the disease inside you, and you would be cured.
RESPONDENT NO 8

Question
Traditionally what do you understand about women's STDs?

Answer
Traditionally when a girl gets married, she does not immediately have sexual relations with her new husband. She first has to undergo vaginal inspections for the purpose of establishing her virginity, possible STDs and whether she is not pregnant by another man other than her husband. If the diagnosis says she is sick, then she would first be treated for whatever she is suffering from before any sexual encounter can take place.

If they realised that the husband is incapable to sire children, they would approach a suitable male member of the family to sire children on his behalf. This was obviously done without the knowledge of the husband. But the main thing was that this man would also not have sexual relations with the woman before he has been treated for whatever STD he might be suffering from so that he does not transmit these to the woman. A ritual called U TANGANYISIWA first had to be performed during which they would drink Mabundu mixed with a particular medicine. Only then could they have sexual relations.
Question
Which STDs are most common in your area?

Answer
It is a great pity that Africans have abandoned their culture. Now they engage in sexual activities in a drunken stupor and they get sick. Their offspring is also weak and sickly. In this area there is a prevalence of a sexually transmitted TB, which is incurable. People are dying from it. The symptoms such as the sudden loss of hair are the same as those of a person suffering from AIDS. This disease occurs when a man has sexual relations with a woman who is in her period or suffering from Goni. The only way to treat Goni is by cutting it out of the man.

Then there is an STD called Tshikulumimba. This one occurs if a man has marital relations with a woman who has reached her menopausal age and the man is still virile. To treat it, the woman's urine and that of the man concerned, are mixed with medicine and they both drink the mixture. Only then does it deflate.

Question
How can we prevent these STDs?

Answer
Let people become more faithful to their partners. If one of the spouses knows that he/she has a STD, then he/she should desist from engaging in sexual
activity until cured. People must also use condoms and use them in the prescribed way to avoid unnecessary mishaps. Those who do not know how to use them, must be taught. We must also trust in our traditional healers instead of regarding them with derision. We must go back to eating indigenous fruit and sexual education in schools must be encouraged.

Question
Traditionally the question of talking about sex with children was taboo, let alone talking about sexually transmitted diseases affecting women.

Answer
No it was never discussed. In those days boys and girls who had come of age would be sent to initiation school (vhukombani for girls and thondoni for boys). As for girls who had started experiencing their monthly periods, they were warned that they were now of childbearing age and therefore should refrain from ever having sexual relations with boys. This started in the home front. Vhukombani the girl was sent for the sole purpose of hearing this from other parents. Even if the girl had committed abortion, she was warned that it is very dangerous at that stage for her to have sexual relations with any man. If she did have that, the boy would get sick (u wela). The symptom to this sickness was the visible throbbing of a vein on the boy’s forehead. If this were not treated in time, the boy would die.
Question
What happened, if anything, at pre-marriage counselling sessions? What advice was given to the prospective bride and groom?

Answer
They were separately told that what they are getting into was serious business. Marriage was said to be equivalent to death. In fact AIDS is not a new disease. Even in those days it was there though not known in the same name as today. The name came with researchers but traditional healers always knew about it.

Question
When you say the disease is not new, are you saying that there were other diseases which had the same symptoms as AIDS in those days?

Answer
Yes. If for example, a married couple has sexual relations whilst one of them is drunk, the child would be weak and sickly. One should also stay away from a woman who is menstruating. If she had just given birth, leave her alone until she stops breast feeding otherwise the child also becomes sickly and weak. Artificial milk is okay but breast milk is the best for the child.

Question
What do you think of polygamy?
Answer

It depended on whether the man felt he would be able to satisfy all of them sexually.

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<td>Is it possible that one man can satisfy more than one woman?</td>
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</tbody>
</table>

Answer

Oh, Yes. Men in those days were strong and at any rate they had their own medicine which kept them strong which comprised of medicine which was mixed with Mageu Drink. Even their diet was the best. As we all know, nobody can be sexually active on an empty stomach. That's why traditionally the first thing that any married woman does in the morning is to prepare a meal for the husband. The aim here was to replenish the energy that was expended the previous night during lovemaking.

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didn't polygamy lead to the spread of STD's?</td>
</tr>
</tbody>
</table>

Answer

No. A woman was expected to sleep with her husband for at least six months or until she fell pregnant.
Question
Whilst the husband was busy with one of his wives, were the others not tempted to be unfaithful?

Answer
If the woman was to do that and she was caught, it meant banishment from the bedroom for life. Mind you she would not be chased out of the marital home. But her husband would never touch her again.

Question
Whilst the husband is busy with the one wife, what about the sexual feelings of the rest of the harem?

Answer
What you must know is that in those days there were some things that women were not allowed to eat. These days they eat things like cheese, milk, eggs and so on. Obviously these are going to make the woman more sexually active, maybe even more than a man. This food was forbidden to save the man from the embarrassing situation where he could not satisfy his wives.

Question
Are we not venturing into countries like the Sudan where women's clitoris were cut to reduce their sexual desire?
Answer

This was also a cultural practice amongst the Vhavenda although it has been discontinued.

Question
Did the practice really reduce sexual desire?

Answer
Oh yes!

Question
Is a woman traditionally allowed to refuse to have sexual relations with her husband (for whatever reason)?

Answer
Yes. If for instance she is tired. The man also gets tired!

Question
Does it mean that if she refuses, then the man would seek sexual favours from the other wives?

Answer
No. She would also be giving the man time to replenish whatever energy he might have expended during other sexual encounters with her.
Question
Have had cases of AIDS in your area?

Answer
Definitely. The other day a man afflicted with the disease came.

Question
Any women with AIDS in your area?

Answer
Plenty and I think it's gonna get worse since it seems the Government intends to legalise prostitution.

Question
How can we prevent HIV / AIDS?

Answer
Governmental child support for single mothers should be stopped because I think these girls think it is a license to have sex. The use of condoms should also be encouraged.

Question
Do you think it is proper that the HIV / AIDS status of individuals should be disclosed?
Answer

For me disclosure is good because having the disease does not mean one loses his or her sexual desires. If it is not disclosed, this person would kill a lot of people, so his or her status should be disclosed so that whoever has sexual relations with him or her should insist on using protection.

Question

What can be done to prevent the spread of this disease?

Answer

Let there be campaigns that would entail visiting schools and chiefs' kraals where people would be taught about it. Those who are charged with educating the community about it must be brutal about it. They must call a spade a spade. Show people shocking pictures of genitalia with gonorrhea, syphilis and other STD's. People should also learn to have one partner and be faithful.

RESPONDENT NO 9

Question

What do you know about STD's?
There are different types of these diseases. Some, like Gokhonya, lead to childlessness. With this one even if the child is born, it will be a sickly and weak one, which will eventually die. In some cases you have stillborn babies. There is also Khumela, which causes the woman to abort very early in the pregnancy.

**Question**
Can you treat these diseases?

**Answer**
Oh yes. I've helped a number of people already.

**Question**
Do you treat STD's?

**Answer**
No, but there are those who can.

**Question**
How can we stop the spread of STD's?

**Answer**
We can't, as long as people are promiscuous.
Question
Traditionally it is taboo to talk to children about sex. What should be done about the sex education for them?

Answer
Let's cut to the bone and talk about it. If we don't, how do we expect our children to understand these issues. Even in the olden days it was discussed though in a different way. The female elders of the family used to carry out vaginal inspections on all the girls in the home. It was a virginity test. This was done until marriage when if the girl were still a virgin would be her parents' and in-laws' pride and joy.

Question
What about polygamy? Did it not help spread STD's?

Answer
There was a problem. A man will always go out to other women outside his kraal even if he has more than one wife. So, yes it did spread diseases. Anyway it was okay in those days. Nowadays it is no longer feasible.

Question
Do you know anything about HIV / AIDS?
Answer
Well, traditionally we know nothing about this disease. It is completely new to us.

Question
What do you feel about disclosure of one's HIV / AIDS status?

A. Those who have the affliction should disclose it so that they can be helped.

RESPONDENT NO 10

Question
What does tradition has to say about STD's?

Answer
Traditionally it is accepted and well-known that there are STD's and that they can be treated.

Question
What do you say about STD's?

Answer
I know and believe that they are only transmitted through sex.
Question
Which are the most common STD's in your area?

Answer
Those that I'm aware of, are Gonorrhea, syphilis and HIV / AIDS.

Question
As far as you know, where are those with STD's treated?

Answer
According to studies done, it has been established that Africans prefer traditional healers to hospitals. They only go to hospitals as a last resort or having had no meaningful help from healers.

Question
What are the main reasons for this preference?

Answer
There is a strong belief that western medicine does not cure STD's but rather make them dormant which makes recurrence a strong possibility.

Question
What can be done to prevent the spread of these diseases?
Answer

People can either abstain, be faithful to one partner or use condoms.

Question

How can these diseases be prevented?

Answer

As I said abstention is the best method of prevention.

Question

Which is the best method of treating STD's?

Answer

I'm one of those who advocate for traditional methods of treatment, as I know they are good and effective.

Question

What does tradition has to say about sex education for children?

Answer

In the old days there were initiation schools where these issues were taught. In some areas these practices continue though at a much lower scale than before and some communities have even abolished them. Where parents did not have a problem with discussing sex with their offspring, children were taught at home.
Question
Was there any sexual education at premarital counselling sessions for girls?

Answer
Yes. The prospective bride was counselled by the female elders of the family. She was taught how to behave towards her husband. But these sessions were never held for males. If a boy goes to initiation school, it is assumed that he got all the sex education he would need, but I personally think boys should go through the same sessions as girls.

Question
What is your opinion on polygamy?

Answer
It's okay. I've no problem with the practice.

Question
Doesn't this practice help in the spread of STD's?

Answer
If the man is faithful to his wives I do not see how this can happen.

Question
Was it permissible for a woman to refuse to have sex with her husband?
Answer
Yes. If she does not want to then she can refuse. She could either be sick or simply doesn't feel like it. The man must understand.

Question
Are there any women that you are aware of who are HIV positive in your area?

Answer
Yes. Especially those whose behaviour is unbecoming.

Question
What do you think of HIV / AIDS status disclosure?

Answer
I support total disclosure because then we would know how to deal with the person and help her.

Question
How can we spread AIDS awareness?

Answer
The present campaign is enough.
Question
Should people discuss AIDS?

Answer
Yes. It will help us understand the disease.

Question
Do you know any medicines that traditional healers use to treat STD's?

Answer
Yes. There is Mukuvhazwivhi and Tshituka, which are used to treat doropo.

**RESPONDENT NO 11**

Question
What do you about STD's?

Answer
There are a number of them such as Lufhiha.

Question
Which STD's are most prevalent in your area?
Answer

There is Tshimbambaila, doropo etc. Goni is not a STD. A man cannot be infected by a woman with it. It is the same as Lukuse in men. It cannot be transmitted to a woman but a man can have Lukuse Ludenya, which will kill his wife, and any other woman he might marry until he is treated.

Question

Can these STD's be treated?

Answer

Goni is not known to western medicine. Doctors can also not treat thusula. They can only make it dormant. These can only be treated with traditional medicine.

Question

What can be done to prevent these diseases from spreading?

Answer

I do not know but traditionally people do not share the same bar of soap. In the old days the situation was made worse by polygamous marriages. In this scenario if one of them contracts a disease then all of them would be affected.

Question

Were there any traditional schools were sex education was offered?
Answer

When boys and girls were of marriage age, they would attend these social gatherings together. Traditional beer would be brewed and in the evening whilst drinking and socialising, the elders would teach them the facts of life. On the eve of a girl's marriage, she would be surrounded by elders who would inform her of the right behaviour at the marital home so that she would not bring shame to the family.

Question

Polygamous marriages. Didn't they increase the spread of STD's?

Answer

They did. Even though there is a myth that people in those days were not unfaithful, men were and this brought diseases into the home.

Question

Did women have the right to refuse their husbands sex if they thought they might contract STD's?

Answer

They wouldn't dare because the man was told that he does not sleep with any other woman until the one he is sleeping with is pregnant. However this did not stop men from straying outside the home. At any rate if a woman were to refuse, she would find herself answering to the elders in the family.
Question
Are there any women in your area who are HIV positive?

Answer
Yes, they must be there but we shall never know since no one will ever admit it. The only people who would know would be the patient and her doctor. People are scared of being ostracised. So I believe that this disease is widespread in this area.

Question
What do you know about this disease?

Answer
Nothing. This is a modern affliction. Traditionally we know of Tshimbambaila, thusula and Tshovela. This one which a person simply becomes thin and then die, or even die whilst being fat is new to us. The people who would know about it are doctors.

Question
What do you think of disclosure?

Answer
People should not be secretive about it. It would be better to tell someone you trust. Maybe that someone might know somebody who might be able to help.
Question
What is Ndonda?

Answer
It is a disease of veins and prevalent among men. It was better treated by the Vhalemba but eventually the Vhavenda also learned to treat it.

RESPONDENT NO 12

Question
How do you treat STD's such as thusula?

Answer
I simply give them medicine to drink and give them Tshipeiti. Gokhonya is simpy cut out and burned.

Question
Which female diseases do you know?

Answer
We have thusula and Gokhonya but the former also affects males.
Question
What are the symptoms of thusula?

Answer
I first consult the bones to determine what the problem is.

Question
Which are the main diseases that women complain about?

Answer
The most prevalent complaint is that of menstrual pains and some such ailments.

Question
Where do these people get help?

Answer
In most cases by the time a person comes to me I know she has been to hospitals and doctors to no avail.

Question
What advise can you offer these women for them to avoid contracting these diseases?
Answer

These days there are condoms but traditionally both partners were treated to avoid one of them spreading it and even infecting the other partner again.

Question

How can we prevent these diseases?

Answer

People should simply be faithful to their partners.

Question

Traditionally what are prospective marriage partners told at the premarital counselling sessions?

Answer

In the past, girls underwent vaginal inspections to see if they were still virgins or not. These days thing have changed.

Question

When a girl has reached marriage age, was she ever taught about sex?

Answer

Yes when she went through what is called uImbelwa she was told to be were of men.
Question
Do you think this was a good idea? (u imbelwa)

Answer
The practice must be continued. Children these days have no manners.

Question
What is your opinion on polygamy?

Answer
In those days it was okay but these days's children are expensive. What with education fees so high.

Question
Did polygamy prevent the spread of diseases?

Answer
Never because men are dogs. He may have ten wives but will still stray from the marital home.

Question
Were women allowed to refuse their husbands sex?

Answer
Yes, women get tired and men too.
Question
Have you ever had people with AIDS coming to you for help?

Answer
Yes they have.

Question
Was this disease there in the old days?

Answer
Yes it was there. It has the same symptoms as thusula, which causes sores on a woman's genitalia and her womb. The patient also cannot walk and is always feeling itchy in her privates. If a person with AIDS is brought to me on time I can cure it but if the patient is already vomiting and having a running stomach, there is nothing that can be done.

Question
What can be done about this disease?

Answer
The problem is that some men do not understanding. If they would agree to use condoms, things would be better.
PILOT STUDY INTERVIEWS

DOROBO OR GONORRHOEA

A woman can contract Dorobo and transmit it to her husband or any man with whom she might have sexual relations. One of its symptoms is the increase in discharges. As time goes on the discharges turn yellow. Men experience penile discharges, which also turn yellow in time if the man is not being treated. A woman afflicted with this disease would never fall pregnant. To treat it, the couple is given medicine, which they drink.

THUSULA - SYPHILLIS:

A woman with this disease develops a rush which releases some watery substance which in turn leads to itching of her privates. As time goes on, the rush becomes painful. If the person is not getting treatment, the rush spreads throughout the body. The patient looks like someone who has suffered burns. A woman suffering from this disease can fall pregnant but then it will be passed on to the unborn child. For treatment, medicine is prepared for both husband and wife to drink.

GOKHONYA

If a woman who is suffering from this ailment can give birth but the child has a reddish colour at the base of the skull. There is also another strain or type of Gokhonya, which makes the child sick. One of the symptoms of this ailment is that the child's head is always forwardly inclined as if it is too heavy for the body. Then there is the other version of this disease. In this case the child is
always vomiting and groaning in pain. The mother also gets itchy just below the clitoris. Gokhonya affects females of all ages. Males can also be affected.

LUKUSE

In treating this disease, both husband and wife must undergo the treatment. For diagnostic purposes, the privates of both husband and wife must be examined and then given medicine to drink.

LUKALA MARASMUS

U wela: Only the man gets sick.

DOROBO - GONORRHOEA

For men sufferers, penile discharges coupled with sores on the penis become evident. When it comes to women, they develop vaginal sores and discharges.

GOKHONYA

The child spots a reddish color at the back of the skull. The mother’s privates become itchy whilst the child vomits and develops a continuous diarrhoea. To treat it, it must be cut off and medicine is applied on both mother and child.

ANOTHER PAGE (II)

1. Gokhonya - diarrhoea - dehydrated - vaginal warts
TREATMENT

- It is cut;
- burned;
- ground; and
- let the child drink.

Complications - Infertility: mukopokopo + termite hill soil

Gopokopo - they create an image of a
human

Males are not treated, as it is believed they should not interfere.

2. Lukuse

- Vhuku
- se
- Dongo


3. Abortion - u wela - u lunwa (to be bitten)

- The centre of the patient's head throbs \{Thina - Makonde\}
- Urine is mixed with medicine \{Tshinanne Nemavhola\}
  \{Ramudingane Mukwinda\}
SEXUALLY TRANSMITTED DISEASES

Husband and wife must avoid sex for seven days when the wife is in her period.

VHULUNGWANA - GOGORRHoeA

- The affected person is always drowsy. If a woman has contracted gonorrhea, the child contracts Goni.

MADEVHU - GONORRHoeA

THUSULA

- Urine from both the husband and wife is mixed and they drink.

TSHISESEVHAFA AND BOPHAVHAFU

- It looks like the leaves of a Musesese tree in appearance. Medicine from these two are mixed with blood extracted from husband and wife’s vulva.

U WELA

- Granite or Dolomite stone (musalasala) is heated nad used as a sauna. Cuts are made on the man’s head and the hot stone is placed there so that the hot medicine. Luhatsi lwa Mulala or the Mulala reed is used for the treatment of U wela (men). This is mixed with ground python skin.
DOROBO

- The main symptom is when a woman’s discharge stinks. If a man has sexual relations with the woman, he contracts it and will definitely transmit it to the next woman he sleeps with. The symptoms appear after about three days. It is treated with urine from the person from whom the patient contracted the disease.

USA THUSIWA

- It is said the child who has not gone through this ritual feels uncomfortable in the presence of those who have. The child will have fits (Tshifikhole or Davhi).

LUKALA

- The child is born with a pronounced vein on the forehead.

U WELA

- This is when a man has sexual relations with a woman who has aborted and her womb is not yet clean. His penis swells and his fingernails and (eyes) teeth turn white. Lips become chapped. The patient loses weight considerably and the bladder stops working. The patient’s skin becomes dry and the voice changes to a shrill tone. Some sufferers die as a result of the non-functioning of the bladder.
DOROBO: *Vho Masindi*

The man develops penile rash, which oozes a water-like substance. The rash is itchy and the penis tip turns red. The woman also discharges a whitish substance and always feels itchy. To treat this the traditional healer will prepare bottles of medicine for them.

GOKHONYA

The woman suffering from this normally does not bear children. If she does, the child usually has a red neck. The woman gets itchy in her privates and when the child gets older it tends to vomit endlessly. The vomiting is coupled with non-stop diarrhoea or.......... Eyes get sunken into their sockets and the child is abnormally shy. The type of Gokhonya that occurs in the anus is usually a ruthless killer, which does not react to treatment.

DOROBO: *KHUBVI*

The amount of discharge increases abnormally in women. It not only increases, but also stinks and has a yellowish colour. Men also start oozing a yellowish discharge with the appearance of semen. To treat it, a bottle of medicine is prepared for the couple to drink.

THUSULA

The patient develops itchy and painful blisters on the privates and throughout the whole body. Western medicine can only treat this superficially and it normally recurs. A newborn baby can have it after having contracted it from the mum at birth. One litre of traditional medicine is enough treatment.
GOKHONYA
Firstly, although men do not necessarily suffer from this disease, they do contract it from time to time. A child who was born to a mum suffering from it usually avoids eye contact and always has his/her eyes downcast. Thirdly, these children usually live for two days and die.

GOKHONYA: S/S
• Occipit is red in color
• Causes infertility
• Diarrhoea is common in children
• Child has an incurable cold
• Eyes sink into their sockets
• No eye contact
• Rush develops
• Liduna

DOROBO
• Itchy blisters oozing a whitish substance
• Penis becomes reddish
• Watery and itchy discharge

LUKUSE
• Treated with a bottle of medicine
• Diagnosed when reasons for infertility are being sought
• Medication given
- Bedpans given separately
- Urination (vhukuse)

LUKALA
Marasmas - ......

U WELA – Abortion

- The uterus must be completely cleaned before isome of the symptoms are:
- Swollen scrotum
- Teeth protrude from the mouth
- Bladder stops functioning
- Acute or chronic
Annexure c

Interviewing skills
Annexure c

Interviewing skills

Overview

- Training and experience is essential for you to be a good interviewer
- Your training will consist of a combination of classroom teaching
- Practical experience
- You will also be given a manual and an interview schedule

Practical experience

- You will get a chance of interviewing each other
- You will discuss the interview schedule in detail
- You will have homework assignment for the evening
- You will practice to read questions aloud to another person

Second phase

- A chance to role play
- Practice by interviewing another trainee
- One becomes an interviewer and one will be the respondent

Third phase

- Field practice in the presence of the researcher
- You will be observed to check if conducting yourself well asking questions in the right manner interpreting the answers correctly
Conducting an interview

- Successful interviewing is an art
- Make it interesting and pleasant
- Be prepared
- Establish and maintain rapport
- Remember first impressions last

Conducting an interview

- Ensure privacy
- Be a good listener
- Don't hurry the interview
- Stress confidentiality of responses
- Always remain neutral
- Answer any questions from the respondents frankly

Conducting an interview

- Never suggest answers to the respondents
- Handle hesitant respondents tactfully
- Do not form conversations
- Discourage conversations that are not related to the topic
LETTER FOR PERMISSION

ANNEXURE D
Ms Mavis Fhumulani Mulaudzi
University of Pretoria
PRETORIA
001

Dear Ms Mulaudzi

WOMEN AND SEXUAL TRANSMITTED DISEASES: AN EXAMINATION OF CULTURAL BELIEFS AND HEALTH PRACTICES OF THE VHAVENDA COMMUNITY

1. Provisional permission is hereby granted, to conduct a pilot on your instrument in the Vhembe District.
2. The information collected, will help researcher in making a presentation to the research committee early in 2002.
3. Please announce your arrival to the institutional management before the pilot.

Thank you

[Signature]

ACTING GENERAL MANAGER
CHIEF DIRECTORATE-PCPSSS
DEPARTMENT OF HEALTH & WELFARE
NORTHERN PROVINCE