WOMEN'S CULTURAL PERSPECTIVES ON REASONS FOR HIV/AIDS PREVALENCE IN A RURAL AREA OF THE KWAZULU-NATAL PROVINCE OF SOUTH AFRICA

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ABSTRACT

The transmission of HIV through sexual intercourse remains a challenge, especially where women are not able to negotiate the use of condoms. KwaZulu-Natal (KZN) Province has the highest globally reported antenatal HIV prevalence. In this study, women in a rural area of Msinga in KZN were aware of the dangers of having unprotected sex with men who had many sex partners, but could not demand that their husbands/partners use condoms as polygamy, as well as the practice of having many sex partners, reportedly remains culturally acceptable in this area.

Methodology: A focus group interview, conducted with 12 women, deliberated on their perceived reasons for the continued spread of HIV/AIDS in the study area despite the availability of much information on the prevention of HIV/AIDS.

Results: The participating women knew about the dangers of unprotected sex, but were not in a position to insist that their husbands/partners, use condoms. Despite their HIV/AIDS knowledge, these women did not disapprove of their husbands/partners' multiple sex partners; and accepted "widow inheritance" by widowers' brothers as a cultural reality.

Recommendations: Health education messages should incorporate cultural and traditional realities. Men should be targeted for health education messages. Women need to be economically empowered and financially independent of their husbands/partners before they can insist on their partners' condom use. The prevention of HIV/AIDS requires practices and solutions that will not interfere with cultural customs.

Keywords: HIV/AIDS, male condom use, polygamy, South Africa, Zulu cultural influences

INTRODUCTION

HIV/AIDS is one of the main challenges facing society today. Southern Africa is in the epicenter of this pandemic. Of the estimated 39.5million people living with HIV/AIDS worldwide, more than 63% are in sub-Saharan Africa. Lesotho, Malawi, Mozambique, South Africa and Swaziland, have adult HIV prevalence rates above 15% (UNAIDS 2007). In these countries life expectancy has declined as a result of AIDS. In 2003, Zimbabwe had a life expectancy of 34 years, a reduction in lifespan of 18 years since 1990 when life expectancy in that country was 52 (Barnett and Whiteside 2006). In 2004, Swaziland, with the highest HIV prevalence rate in the world, had the lowest life expectancy of only 31.3 years (UNDP 2006; UNAIDS 2006).

HIV infections in Southern Africa occur mostly through heterosexual encounters, especially in those cultures where monogamous unions are not culturally enforced (Whiteside, Barnett, George and Van Niekerk 2003). According to UNAIDS (2006), South Africa's HIV prevalence is 18.8%. Ramjee, Williams, Gouws, Van Dyck, De Deken and Karim (2005), reported that one out of ten (1:10) people infected with HIV live in Southern Africa. South Africa also experiences significant provincial differences in the HIV infection rates. In 2003, the reported antenatal HIV infection rates ranged from 13.35% in the Western Cape Province to 37.5% in KZN (Ramjee et al, 2005). With a population of about 10 million and a one to three (1:3) ratio of infected pregnant women, KZN has the highest reported antenatal HIV prevalence rate in the world (Statistics South Africa, 2007).

The impact HIV/AIDS has on the community cannot be comprehended from statistics and numbers. It can however be appreciated from the comments made by community members who live in communities affected by the HIV/AIDS epidemic on a daily basis.

Study site

Msinga is a rural municipal area in central KZN. It covers an area of 2500 km2. The area is barren, rocky and dry with bitterly cold winters and unbearably hot summers, making the cultivation of crops problematic. Emhlangana is an area within Msinga. It is without running water but with electricity supply only in some schools and clinics. There are no employment opportunities in the area. Many able-bodied men leave the area to look for employment, mainly in Johannesburg, Durban or Pietermaritzburg. These migrant working men, however, return home to get married to local girls. The extended family structure system still exists, where the in-laws, grandparents, uncles and cousins live within short distances of each other and in some instances are neighbours. Polygamy remains culturally acceptable. Education is not a priority because boys seek employment at a young age and girls marry young, without completing their schooling. Information relating to HIV/AIDS prevention has been made available through health

education provided by KZN health care workers and by voluntary organisations. Despite the availability of this information, a number of orphans and also a number of child-headed households exist in this area probably as a result of AIDS as indicated by non-governmental organisations working in the area

Background information

While the authors were gathering data for a study on child-headed households in the area, local women informed the authors that the HIV/AIDS prevalence would not stabilise nor decrease in this area unless, and until, men used condoms. As the authors were informed about the social, cultural, economical and health status of the area, comments such as these immediately interested the researchers. The researchers thus decided on investigating these women's claims. Twelve women were willing to participate in an independent study during which a focus group interview was utilised to explore these women's perceptions about the sustained high prevalence of HIV/AIDS in this area.

STATEMENT OF THE PROBLEM

From the researchers' (authors') background knowledge and preparation for the aforementioned research into child-headed households, they were aware of the fact that information about the prevention of HIV/AIDS and free condoms are available in this area. However, the prevalence of HIV/AIDS, the number of persons dying from HIV/AIDS, as well as the numbers of orphans and child-headed households continue to increase in this area. The research problem was that knowledge about the prevention of HIV/AIDS and free condoms apparently had no impact on reducing the prevalence of HIV/AIDS in this area.

Purpose of the study

The purpose of the study was to identify women's perceptions about the sustained high HIV/AIDS prevalence in the study area and to recommend ways in which issues raised could be addressed.

Objective of the study

The study's objective was to identify the participating women's perceptions about:

- HIV/AIDS as a prevalent disease
- Reasons for the continued spread of HIV/AIDS in the area despite available information on its prevention.

RESEARCH METHOD

A generic qualitative research design was followed. A focus group interview was conducted with 12 women during November, 2007.

Permission to conduct the research was obtained from the Media in Education Trust (MiET) Africa, a non-profit organisation (NPO) working in the area, empowering schools and communities to provide care and support services for orphans and vulnerable children. The NPO was also the entry point to the area. Following the explanation on the purpose of the study, each focus group participant gave informed consent to participate in the study, and that their conversations could be recorded. Participants were assured of anonymity as no names would appear on any document(s).

The researchers met the 12 women at Emhlangana, in Msinga and conducted a focus group interview about HIV/AIDS in their area. The selection of the women was based on their previous reference made to HIV/AIDS and the men's contribution to the spread thereof. Two questions were asked:

- Is HIV/AIDS a common disease in this area?
- Why is HIV infection continuing to spread even with so much information available on the prevention of the disease?

One researcher conducted the focus group interview, while the others took notes and operated the digital voice-recorder, ensuring that all the discussions were captured. The data recorded during the focus group interview were verbally transcribed and verified by comparing these statements with the written notes. Coding was initially done independently by the researchers. Comparing and contrasting their individual classifications of categories, the authors agreed on the final presentation of the research results.

RESEARCH RESULTS

Biographic details

The participants' ages ranged from 31 to 49 years of age. All women were unemployed except for one who was a traditional healer and another, a retired teacher, who periodically volunteered her services at a local school. The women were married and all had children of their own. Their husbands, except for one, lived and worked in Johannesburg, Durban or Pietermaritzburg. Two participants were married to two brothers who were working in Johannesburg. These two participants lived side-by-side, their properties separated by a fence only. All the women had their own homes, and relatives lived nearby. These women kept their homes and looked after their children while their men returned home

only on holiday mainly during Easter weekends and Christmas breaks (usually 16-31 December).

Participants' views on the prevalence of HIV/AIDS in their area

The women regarded HIV/AIDS to be a common disease in their area, even though the patients and their immediate families never disclosed the diagnosis of HIV/AIDS to community members. A lay diagnosis of AIDS was made based on extreme and rapid loss of weight, persistent coughing, sores on the body and in the mouth and uncontrollable diarrhoea. Many of the young parents who had died in the community presented with these signs. One of the women reminded the others "… *niya khumbula umfana wa kwa… wa buya e goli e zacile e khwhlela. Kwa thiwa u phethwe iTB. Sathi siyezwa kwa se kuthiwa ukhishwa isisu ga lendlela aka sakwazi no kuphakama embedeni uphelelwa mandla*" ("remember Mr …'s son, who came back from Johannesburg thin and coughing and it was said that he had TB. After a short while we heard that he had severe diarrhoea and was so weak that he could not even get out of bed"). This, the women reported to be the pattern of the recent illnesses in the area "…*bonke ba buya be gula komaGoli, nase Thekwini la besebenza khona, ba shone, ba shiye a bantwana bodwa*" ("… all come back sick from Johannesburg and Durban where they were employed. They die and leave children alone"). This citation indicated that the women perceived young productive people to be most affected by HIV/AIDS.

Participants' perceptions about reasons for the continued spread of HIV/AIDS in their area

The responses to the question ("Why is HIV infection continuing to spread even with so much information available?") were categorised according to four cultural practices of the area, '*isithembu*' (polygamy), '*Ukungena*' (widow inheritance by the deceased husband's brother) and '*ubusoka*' (multiple sex partners for a male) and '*ijazi*' (condom use). Some of these cultural practices have been observed from a very long time as it will be shown in the paragraphs hereunder.

Polygamy

Krige (1965) refers to a man marrying two or more wives with the assistance of his father in relation to the payment of '*lobola*'. Lobola in the zulu custom is a bridal price or dowry that is paid to the bride's family in exchange for their daughter. In this study the women explained that '*isithembu*' (polygamy) is culturally institutionalised in Emhlangana, where it was common for a man to be married to two or more wives. The eldest wife would be consulted on subsequent wives "…*U makot'omdala uya tyenwa ukuthi ubaba o zo lobola omunye unkosikazi omcane*" ("… the eldest wife is usually informed about the wishes of the husband to marry another, usually a younger wife").

The first wife is merely informed about a subsequent wife; her approval is not required nor sought. However, the first wife must be part of the team negotiating the nature and size of the "*lobola*" and any other requirements of the husband's family. According to the participants, the additional wives are not as rigorously selected as the first wife. Little might be known about the lives and behaviours of subsequent wives. They might have been leading reckless lives in relation to sex and sexual behaviours and could be HIV positive, increasing the risk of spreading HIV to all the other wives.

Widow inheritance

Another factor was that of "*ukungena*" (widow inheritance). In the Zulu custom, when a woman gets married into a family, dowry is paid to commit her to stay in that family mainly for procreation to enhance the chances of that clan's continued existence. According to Krige (1965) in a family, a man refers to his wife and to the brother's wife as "umkami" (my wife). This is in preparation for 'widow inheritance'. When the husband dies, the woman cannot return to her home or get married elsewhere. One of the men in the family, usually the brother of the late husband, must continue to procreate children with the widow. *Ukungena* or *Ukungenwa* is therefore a long standing Zulu cultural practice where a widow is inherited by the brother or a very close male-relative of the late husband. This brother is culturally expected to take over all responsibilities in his brother's house including conjugal rights. The widow cannot refuse, regardless of the husband's cause of death or the health status of his brother. This means that if the man died from AIDS related illnesses, the wife could be HIV positive, infecting the brother and his wife/wives as well. However, an HIV negative widow could be infected by the deceased husband's brother, if he is HIV positive. Some of the women were born within these families and had witnessed their uncles becoming fathers through '*ukugena*' (widow inheritance). One woman stated " …p*hela, nawe uyazi ukuthi uma ushonelwa ngumkhwenyana wakho, ubuti wakhe ufanele azongena*" (" …you also know that in the event of your husband's death, his brother must take over, especially the sexual intercourse aspect").This, one of the two women married to two brothers mentioned as a joke. However, the women admitted this to be a reality.

Men's multiple sex partners

On the issue of '*ubusoka*', the participating women explained that culturally it is acceptable for a Zulu man to have more than one sexual partner. A man who has many sexual partners is known as '*Isoka*' (virile man). A man who has one or no sex partner is regarded as '*isishumane*' (impotent person), a derogatory term for someone with no women lovers. This would imply that he is a man who is afraid of women, does not know how to propose to women, or whom women dislike. In Zulu culture it is taboo for a man to have only one woman lover/sex partner, as stated: "…*Mina ngiyathanda um'isoka lami lina'banye. Lokho ku khombisa ukuthi u yaphila. Nami ngiya ziqhenya*

ngoba ungikhetha phakathi kwaba ningi" ("…personally I like it if my boyfriend has many girlfriends. That is a sign of being healthy. I am also proud of my achievement because if I finally marry this man, he would have chosen me from many women). This was said as a way of showing support to the issue of many sexual partners. The women supported this statement, indicating that men's many sex partners kept them on their guard, even after they were married. The participating women not only knew about the men's sexual practices, but accepted and approved these practices. Because of the cultural acceptability of the men's many sex partners, the women reported that they could not even complain to their extended family members about their men's extramarital sexual encounters. The common response from the family would be "…*nawe uyazi makoti, ukuthi indoda ayipheli*" (" …you also know, as a woman, that a man's ability to have sex is never exhausted"). The participating women confirmed that in the Emhlangana area, many men work away from home. They come home periodically on weekends, monthly, half yearly or even annually. These men are expected to have other sex partners while away from home and their wives are not expected to raise this issue.

Condom use

Although the women knew that their husbands/partners had other sex partners, they could not insist that the men use condoms. A woman's request to use a condom is equivalent to being unfaithful, as someone else, who had sex with her, would have taught her about condoms "*ubani o se ku tjena ngama condom… ubani lo o 'busy' naye okufundisa ngama-condom… itsho phela*?" ("… who is this person you are having sex with who is teaching you about condoms … who is he?). These tensions could lead to the dissolution of that marriage. In this area where joblessness is rife, and where women depend on their husbands' financial support for their own and their children's survival, women remain unable to insist on condom use.

DISCUSSION OF THE RESEARCH FINDINGS

The women did not work (except for one retired teacher and one traditional healer). Consequently men were the sole sources of income for the majority of these women, providing food, shelter and all necessities for the women and their children. Similarly the women were trapped in cultural practices where they were custodians of cultural practices and were unable to protest against polygamy, men's multiple sex partners, widow inheritance and men's refusal to use condoms. Lack of mobility out of Emhlangana had disempowered the women as they had never been exposed to other situations where they could demand safe sex. The women are aware of the spread of HIV infection through unsafe sexual practices and were desperate for their husbands to use condoms, but were too scared to raise this issue because it could lead to a divorce, depriving the women and their children of their only source of income.

CONCLUSIONS

The participants in the focus group interview agreed that many, especially young economically productive people died from HIV/AIDS in their area. There were reportedly many orphans and child-headed households attributable to AIDS deaths.

The society in Msinga remains patriarchal. Although the women knew about the prevention of HIV/AIDS, they were powerless to enforce the required action from men. Polygamy was culturally acceptable, as well as men having multiple sex partners, and widow inheritance continued to be practised. Although the women knew about the life-threatening risks of getting HIV infected by men with other sex partners, they accepted and even condoned these practices.

Talking about condoms remained a taboo in Msinga. The women perceived themselves to be powerless in enforcing condom use as the men refused to do so. A woman's insistence on condom use, could lead to divorce, leaving the woman and her children destitute, as the men were the sole income generators in this area. The women wished that condom use could be discussed at higher level that can lend authority to this information.

The main limitation in this study could be that the 12 women were known to each other and this could impact on their freedom in expressing their perceptions about cultural practices in the area. Different data might have been obtained with different participants if follow-up focus group discussions or individual interviews on this aspect were conducted. To this effect it could be recommended that follow-up studies should conduct individual semi-structured interviews with questions on each of the four identified aspects.

Despite knowing about the prevention of HIV/AIDS and despite the availability of free condoms, women could not insist on their sex partners' condom use. Unless condom use becomes acceptable in this area, and unless women become empowered to insist that men use condoms, HIV/AIDS deaths will continue to increase in this area, resulting in ever larger numbers of orphans and child-headed households.

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