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CHAPTER 1

INTRODUCTION AND ORIENTATION

1.1. INTRODUCTION AND BACKGROUND

Sexuality is an area that has long attracted Sociology, Anthropology and Demography because of the identified relationship between sexual behaviour and certain health problems. Human sexuality is not a simple act of biological expression, but a symbolic, cultural and subjective organization associated with numerous meanings, including belief systems through which human sexuality is conceived (Kerr-Pontes, Gonzalez, Kendall, Leao, Tavora, Caminha, do Carmo, Franca and Aguiar 2004:4).From the time the biblical instruction, "***Be fruitful and multiply, fill the earth and subdue it***", (Genesis1:28) was given to Adam in the environs of Eden, sex has become part of the human race serving the noble functions of reproduction and expressing love and emotional feelings. Sex is an important and enormous part of our lives as human beings, complete with its own rules, etiquette and rituals. Unfortunately, it has resulted in the gravest danger of our era - the transmission of HIV/AIDS (NACP 1998). Oppong, Oppong and Odote (2006:xi) concur that "for women and men, sex is a source of pleasure, expression of love, purpose of relationships, path to procreation and creator of kinship. But it is also for some individuals a means to survival and accumulation; to feeding their children, making money and amassing wealth. However, it may in addition be a terrible harbinger of disease and death". The World today faces an onslaught from the menacing Human Immunodeficiency Virus (HIV)

and the resulting Acquired Immuno Deficiency Syndrome (AIDS) disease. The last 15 years have seen HIV/AIDS evolve into a global pandemic. Speth (in Reid 2001:8) acknowledges that "during the last fifteen years, the Human Immunodeficiency Virus (HIV) has entered our consciousness as an incomprehensive calamity, already laying claim to millions of human lives, inflicting grief and pain, causing uncertainty and fear, and threatening economic devastation".

In Africa, the HIV/AIDS pandemic has reached tragic proportions. World Health Organization's Merson (in Bethel 1995: 17) says of the AIDS problem that "there is no other disease, on the African continent with any where near this impact". AIDS is indeed a tragedy in Africa having long surpassed any other major killers on the continent (Jackson 2002:35). Of all regions in the world, HIV/AIDS has reached pandemic proportions in Sub-Saharan Africa (SSA) with more than twenty-two million adults living with the disease. Jackson (2002:8) points out that "Sub-Saharan Africa, especially Southern Africa is the hardest hit region in the world." Southern Africa is the epicentre of the global HIV/AIDS pandemic (UNAIDS 2004:8). The World Population Data Sheet (2007:15) and www.avert.org/worldstats (2006) concur that Sub-Saharan Africa has by far the largest number of people living with HIV/AIDS, with just over 22.5 million people of the world's 33.2 million people, living with the virus. The World Population Data sheet (2007:15) further observes that "Sub-Saharan Africa remains the most affected region in the global AIDS epidemic. More than two thirds (68%) of all people HIV-positive live in this region where more than three quarters (76%) of all AIDS deaths in 2007 occurred". Countries that have featured the highest HIV/AIDS prevalence rates in the world include Swaziland (33.4%), Botswana (24.1%), Lesotho

(23.2%) and Zimbabwe (20.1%) (http://www.globalhealthfacts.org). The National Youth Policy (2003:17) observes that “Zimbabwe is in the midst of a severe and worsening epidemic. The magnitude and scope of HIV/AIDS is alarming.” The Zimbabwean generation is a generation swarmed by a sexual monster and the situation looks gloomy.

Manhanga (2004:74) drives the point home when he notes that “the hard reality on the ground of snaking lines outside cemeteries with families wanting to bury their loved ones, over burdened mortuaries that operate 24 hours a day, 7 days a week and the growing number of people who have gone into the coffin making business, have starkly brought home the point of the seriousness of the crisis that we have with us.” Williams, Blibolo and Kerouedan (1995:1) concur that "the epidemic is losing its cloak of invisibility, as growing numbers of people develop HIV-related illnesses, funerals become more frequent and children are orphaned. Added to the above, Zimbabwe’s Human Development Index (HDI) plummeted from 0,507 in 1995 to 0.444 in 2001 indicating a move from the medium human development category to a category of low human development. Life expectancy has also fallen by 26% during the 1995 to 2001 period. Both these falls are attributable to the growing grip of HIV/AIDS on the country.

1.2 PROBLEM STATEMENT

The Government of Zimbabwe is a signatory to The Millennium Development Goals particularly Goal 6 that seeks to halt and reverse the spread of HIV and AIDS epidemic by 2015 (2000), The Maseru Declaration on HIV and AIDS (2003), The

Gleneagles G8 Universal Access Targets (2005), Brazzaville Commitment on Universal Access (2006), The African Union's Abuja Call for Accelerated Action (2006) and The SADC Strategic Framework on HIV and AIDS (2006) (United Nations General Assembly [UNGASS] Report 2008:11). With these declarations, the African leaders, Zimbabwe included, bound themselves to put in place measures to better the health and social welfare of their subjects and recognise HIV/AIDS as a deadly hindrance to developments. Makinwa (in Johnson 2000:7) says of the African leaders that "the commitment to confront AIDS has never been higher. The pronouncements of African political leaders attest to their recognition of the problems caused by HIV and AIDS and their readiness to fight the epidemic." Further still, the Government of Zimbabwe has selected Millennium Development Goals (MDGs) 1 and 6 on HIV/AIDS as the priority goals to be monitored over the decade to 2015 (Zimbabwe Human Development Report 2003). Piot (in UNAIDS 2004:4) concurs that "declarations of intent are not lacking. Ever since the Convention on the Elimination of All Forms of Discrimination Against Women was written a quarter of a century ago Africans have listened to lofty declarations from the UN General Assembly, sonorous pronouncements from heads of state and regional organisations such as the Southern African Development Community (SADC) and landmark agreements at international conferences. But not enough of these global and regional commitments have been acted upon." Iyer (1999) in the introduction concurs that such pronouncements have largely remained on paper as mere statements of intent.

Zimbabwe has undertaken to achieve the target of reducing HIV prevalence levels by 2010. This comes in the wake of devastating and moral sapping statistics that one

Zimbabwean dies of an AIDS related illness every five minutes (UNICEF 1999:15). As a result Zimbabwe now has one of the highest rates of infection and number of HIV/AIDS cases in the world, to such an extent that it has transformed into the nerve centre for the AIDS pandemic. The demographic impact of HIV/AIDS has started to show. Mortality rates have started increasing across all age groups but it is most pronounced among infants and women. According to the Zimbabwe Demographic Health Survey (1999), the proportion of female deaths attributed to HIV/AIDS has risen faster than overall mortality. The Zimbabwe Human Development Report (2003:87) maintains that "the infant mortality is now 72% higher than it would have been without the pandemic." It is thus an undeniable fact that HIV/AIDS is wreaking havoc among the Zimbabweans especially women and children.

Contrary to the urgency demanded by the rate of spread of the pandemic, policy and program interventions have not risen to the challenge having been slow to develop and being largely fragmented and uncoordinated at the national level. The first HIV/AIDS case in Zimbabwe was diagnosed in 1985 and Zimbabwe only recently in 1999 developed an official HIV/AIDS policy to try to manage and mitigate the impact and continued spread of HIV/AIDS. The reason for the late development and adoption of the HIV/AIDS policy, a pivotal instrument in the fight against the pandemic on the part of the Zimbabwean government are not entirely clear. Makinwa (in Johnson 2002:35) concurs and notes that "the writing has been on the wall for years yet responses within and outside Africa have been desperately inadequate". The result is that we have targeted the symptoms of the pandemic rather than the underlying causes, and the consequences of this failure have been catastrophic (Bellamy in

UNAIDS 2004). To date Zimbabwe has reported a decline of HIV/AIDS cases from 24.6% in 2003 to 21% in 2005 and 18.1% in 2006. The Zimbabwe Human Development Report (2003:68) however queries such indications noting, "there is no evidence that the epidemic is levelling off nor declining." The report notes that assumed decline is due to antenatal clinics (ANC) data having been reclassified as urban, rural or other and the exclusion of data points considered inconsistent such as the Chiredzi sentinel site which had previously reported the highest prevalence rate of 70.7% in 2001 (Zimbabwe Human Development Report 2003:50). According to http://data.unaids (2006) the supposed declines are riddled with inconsistencies and biases to the extent that the decline in HIV prevalence might not be as substantial as indicated by the antenatal clinic HIV/AIDS data. Even if indeed the rate had declined, it is still considered very high, as Zimbabwe is still among the five worst affected and afflicted countries in the world. The above scenario gives credibility to the widely held view that the history of HIV/AIDS in Zimbabwe has been and is still shrouded in secrecy, controversy, misinformation and official rhetoric. Makinwa (in Jackson 2002: 7) summarises the general feeling among stakeholders in the fight against HIV/AIDS that "the overall response and actions are much less than optimal. It is time we get our priorities right. No terrorist attack, no war has ever threatened the lives of more than 40 million people worldwide. AIDS does". As the plunder of HIV/AIDS continues, it is apparent that more needs to be done to curtail the deadly HIV/AIDS disease. The evidence lies bare for everyone to see that the onslaught of HIV/AIDS is unrelenting. Zimbabwe stands at the precipice of national chaos and disaster as HIV/AIDS wantonly ravages the nation. As Izumi (2006:1) observes "the pandemic is biting deeply into the fabric of many communities".

It is thus obvious that the facts are grim, especially for women in Sub-Saharan Africa, the worst affected region in the world. Today more women than men are dying of HIV/AIDS and the age patterns of infection are significantly different for the two sexes (Common Wealth Secretariat 2002:30). HIV/AIDS prevention strategies continue to be explored to arrest the situation but these have failed to include the greatest group now at risk – the women. Parirenyatwa cited in the Zimbabwe National HIV and AIDS Conference Report (2004:4) concurs that "… several response initiatives have been put in place at various levels throughout the country yet the problem remains…" Preventing and mitigating the impact of HIV/AIDS is a growing challenge for Zimbabwe. Ways need to be explored urgently in a systematic fashion to reduce the incidence and risk of exposure of women to HIV/AIDS. To date, relatively very little has been done at national level in this direction. Intervention programmes that are sensitive to the norms and values of the respective cultural groups need to be put in place if the fight against HIV/AIDS is to yield any results. Jackson (2002:137) concurs that "sensitive approaches are required to promote discussion and involvement, not top-down instruction from outside the culture." The Common Wealth Secretariat (2002:30) notes that "… very little is known about HIV in women as men formed the vast majority of subjects in studies that form the foundation for the treatment of HIV and opportunistic infections". The voices of the African subjects - peasants and urban elites – have been almost exclusively male. Although women have occasionally been enlisted as informants they have not been interviewed as women, gender has not been incorporated into the historical and cultural analysis, and the African perspective has remained androcentric (Schmidt 1996:2). Further investigation is required to

unravel the problem of women and HIV/AIDS. More studies are needed that go beyond the exclusive conception of women as vessels for transmission of HIV/AIDS to their babies. Further still, intervention programmes have been unfortunately grouped for every cultural group. The relevance and practicality of intervention programmes currently running in Zimbabwe is precariously assumed given that there is no detailed systematic study of Zimbabwe's diverse ethnic groups and their socio-cultural traits. Instead response programmes have been grouped for every ethnic group without necessarily looking at what works in each distinct cultural set up. Jackson (2002:133) says of the grouping of the intervention strategies that "we fail to look at the fertile soil in which AIDS is flourishing. We believe that individuals and whole communities have the inherent capacity to change attitudes and behaviour…the power to fulfil this capacity is often denied or not exercised." Van Dyk (2005:99) concurs that "…there is no standard programme that will be meaningful, relevant and effective for all the people in all times and places". Given this, why has Zimbabwe employed intervention programmes with a "coca-cola flavour for every ethnic group" – the same programme for every ethnic group? Isn't it that prevention programmes must be contextualised so that they are sensitive to local customs, cultural practices and religious beliefs and values, as well as to other traditional norms and practices? Isn't there a need to make intervention strategies sensitive to individual ethnic cultures that regulate sexual behaviour if the epidemic is to be curtailed? While the above issues remain unanswered, the subject of women and HIV/AIDS also continues to be neglected.

Farmer et al (1996:5) ask the all-important question regarding our low activity with regards to the field of women and HIV/AIDS. They note: "Given the intense concern

with the human body that any conceptualisation of AIDS entails, how do we account for the striking silence on the topic of women in AIDS discourse?" Why has the subject of women and HIV/AIDS been neglected given that HIV/AIDS is largely transmitted through heterosexual contact (92%, Table 1)? Whatever the reason is, it is a truism that HIV/AIDS continues to hold a tight grip on the Zimbabwe population with the women being more heavily buttressed. Today more women than men are facing death due to HIV/AIDS.

Table 1: Routes of HIV Transmission in Zimbabwe

Transmission Rate	**Percent Contribution to HIV Transmission**
Heterosexual intercourse	92%
Mother to Child	7%
Other (blood transfusion sharing needles, syringes	1%

Sources: Zimbabwe Human Development Report 2003:47

1.3 TENTATIVE HYPOTHESES

A functionalist paradigm is employed in the quest to analyse and interpret the stated research problem and to realise the aim of the study. In order to guide this mostly qualitative research tentative hypotheses are formulated. The following tentative hypotheses will be investigated in an exploratory study to establish that:

- Women in Zimbabwe are hindered by the different socio-cultural factors and practices defined from their ethnic set-up to demand and enjoy safe reproductive health. The research does attempt to understand some

socio-cultural factors and meanings surrounding women that make them partake in unsafe sexual practices.

- Women who reside in urban centres are more informed on the deadliness of the HIV/AIDS pandemic and therefore have a better leverage to determine the circumstances under which they have sexual intercourse. The research will attempt to show that some women have advantages over others when it comes to sexual decision making.
- Women in employment (career women) have control over their own sexuality unlike those not gainfully employed. Socio-economic dynamics influence the manner in which women are affected by HIV/AIDS.
- Cultural taboos in different social and cultural settings inhibit the women from seeking safe sexual intercourse. The notion of inevitable passivity of women contracting sexually transmitted infections (STIs) prevents them from understanding their situation.
- Inequality between males and females (patriarchy) engraved in different cultural groups hamper women from seeking safe sexual intercourse in an era of HIV/AIDS. Traditional and cultural beliefs are hindrances for women in practising safe sexual behaviour from HIV/AIDS.

1.4 RESEARCH QUESTIONS

In the light of the formulated tentative hypotheses, the following overarching research questions are posed. They have to be investigated and answered in order to change and rectify the myths, misconceptions and falsehoods attached to the subject of female sexuality and HIV/AIDS.

i) How do specific socio-cultural **factors** hinder and disempower women from changing sexual behaviour relating to HIV/AIDS? Are women inherently unable to change their sexual behaviour?

ii) What are the specific socio-cultural **practices** preventing women from attaining safe sexual behaviour in an era of the menacing HIV/AIDS pandemic?

iii) Why have the "**safe sex messages**" being propagated every time on the country's communication lines (radios, newspapers and televisions) been unable to result in sexual behavioural change of women?

These three research questions act as guidelines in the search for answers to the research questions flowing from the problem statement. They can also serve as tentative hypotheses in this qualitative study.

1.5 AIM AND PURPOSE OF THE STUDY

The manifest aim of this study is to provide scientific answers to the aforementioned three research questions. It seeks to understand the interaction between culture and HIV/AIDS by identifying the different socio-cultural **factors** and **practices** that impede upon behavioural change of Zimbabwean women with regards to HIV/AIDS. Doing so will improve our understanding of the dynamics of behaviour modification and change with respect to female sexuality. This thesis seeks to explore and place before the readers issues and matters pertaining to sex and sexuality among Zimbabwean women in the context of gender roles and relations that inform behaviour with a view to situating socio-cultural dimensions of the sexual transmission of disease and death.

The purpose of the study is to identify and explore barriers to safe sexual behaviour among Zimbabwean women. In order to attain this aim, the theoretical perspective adopted to explore the socio-cultural practices that predispose women to HIV/AIDS in Zimbabwe is an overarching functionalist perspective with a focus on aspects of the related theory of gender development in a cultural, patriarchal society. It is used to emphasize and to analyse existing literature and data gathered through a combination of research techniques, called triangulation. Within the context of this study, these theories are used to explore and highlight those factors and practices that underlie Zimbabwean women's vulnerability to HIV/AIDS.

The study is specifically intended to:

- Investigate current socio-cultural **factors** specific to the major ethnic groups in Zimbabwe that inhibit behavioural change of women in the light of the devastating HIV/AIDS pandemic.
- Investigate contemporary socio-cultural **practices** of the major ethnic groups in Zimbabwe that inhibit behavioural change of women with regard to HIV/AIDS.
- Provide for and assist in the formulation of a set of proposals and relevant guidelines for behaviour transformation among women using cultural approaches in the design, implementation and adoption of AIDS prevention strategies and programmes.

Some conventional assumptions and ideas will be assessed and future recommendations be made.

1.6 THE RESEARCH PROCEDURE AND TECHNIQUES

The study employs a combination of different related techniques, called triangulation where issues are observed from different viewpoints to substantiate findings which enhance the validity of the study. A combination of mainly qualitative and also quantitative methods of data collection and analysis are used. This involves mixing qualitative and quantitative styles of research and data. The two methods or styles have different complementary strengths and a study using both is fuller and comprehensive (Neuman 2000:125) There is a dearth of documented information on issues related to socio-cultural factors that impede upon behavioural change among Zimbabwean women with regard to HIV/AIDS. Fragmented studies such as Chikovore (2004), Goercke (2004) as well as Kambarami (2006) to date stand as some of the few researches dedicated to the welfare of women that have however not tackled the influence of culture on behavioural change of women in their ethnic setups conclusively. As such this being an exploratory kind of research, seeks to fill the gaps. This triangulation of research techniques employed in this research study hopes to unravel the problem of women and lack of behavioural change in the light of HIV/AIDS. The following specific research procedures are adopted to obtain answers to the posed questions and to verify hypotheses put forward:

1 Documentary study of literature to substantiate empirical research data and findings on women's vulnerability to HIV/AIDS will be undertaken.

2 A survey using a questionnaire with closed ended questions will be administered to mature and adult 1002 women in the age ranges 18 to 59 years.

3 6 Focus group discussions will be conducted with 48 respondents to understand the concepts broadly and to define the main concepts of the study.

4 In-depth interviews with 50 key informants (women of social standing in society) will be conducted as follow-up to issues raised from focus group discussions.

5 Quantitative analysis of survey data will be done using the Statistical Package for Social Scientists (SPSS) computer package. This involves identifying the various variables being explored in the study and giving each variable a name that is used in describing the variable to SPSS. This process enhances quick data entry and analysis. The research methodology is further discussed in the Methodology Chapter 4.

1.7 CONCEPTUALISATION

The following concepts are important to this study: patriarchy, impede, socio-cultural, factors and practices, HIV and AIDS, gender, sex and role.

The following terms will be defined as used in this study:

- Impede -prevent from doing or attaining, hamper or obstruct
- Patriarchy - a social practice in which men appropriate all social roles and keep women in subordinate positions on the basis of being born male.
- Prevalence - pool of all infections at a given point in time
- Socio–cultural - considering a population's characteristics including lifestyles and beliefs as essential references to the creation of action plans.
- Susceptibility – the chances of an individual becoming infected with the Human Immuno Virus.

- Vulnerability – the likelihood of significant physical, social or economic impact occurring on individual and household level.
- HIV- Human Immuno Virus
- AIDS - Acquired Immuno Deficiency Syndrome
- Gender roles – those socially created behaviours and expectations assigned differently to women and men. These are social constructions and contain self-concepts, psychological traits as well as family, occupational, and political roles assigned dichotomously to members of each sex (Lipman-Blumen 1984:2)
- Sex roles – behaviours stemming from biological sexual differences that define male or female (Lipman-Blumen 1984:2).
- Power – the process whereby individuals or groups maintain the capacity to impose their will upon others, to have their way recurrently, despite implicit or explicit opposition (Lipman-Blumen 1984:6).
- Culture - is a particular way of life according to specific norms and values of a society (Feldman 1990:6).

1.8 LIMITATIONS OF THE STUDY

The study has been limited in that it has not managed to take aboard the minor ethnic groups of Zimbabwe who have always cried that they are overlooked. This is because of constraints encountered, such as lack of financial resources to go around the country, time, distance and human resources. Given time and opportunity, this is another grey area for research so that we have a complete understanding of the Zimbabwean women's sexuality and the problems they face relating to HIV/AIDS. Time constraints were experienced as the researcher

was refused sabbatical leave by the employer; as a result data gathering was done on semester breaks only. Financial resources available permitted only the use of three research assistants to conduct the study. A bigger sample of more than 1002 respondents used in the self administered questionnaire was envisaged, but because of financial constraints this was restricted to the above sample. Organisational complications emanating from the long distances that the research team had to travel were always a challenge. Despite these limitations, the focus group discussions, in-depth interviews as well as the administering of the questionnaires were done and yielded sufficient information to draw conclusions about women's sexuality and socio-cultural factors and practices that hinder behavioural change of women in an era of HIV/AIDS.

1.9 THE PRESENTATION OF THE STUDY THROUGHOUT THE THESIS

Chapter 1 has given the introduction and orientation of the study which gives an overview of the pandemic in the world and in Zimbabwe. Three research questions are posed. The problem statement, aim and purpose of the study are explored; the tentative hypotheses focussing on the problem are formulated. The research procedure and techniques for the study are further explored. It has also presented the conceptualisation of key terminology used in the study including such key concepts as patriarchy, impede, socio-cultural, factors, HIV, AIDS and practices. The chapter has provided the research technique (triangulation) used in this research and has highlighted the limitations and challenges encountered during the research process.

Chapter 2 presents the theoretical foundation of the study, which in this case is an overarching functionalist theoretical perspective and related gender development theory, as well as theories promoting behavioural change, which grounds the theoretical foundation that informs this empirical research. It gives a theoretical analysis of the factors and practices from the socio-cultural angle of why Zimbabwean women continue to experience the brunt of HIV/AIDS despite the knowledge on the dangers posed by the unrelenting pandemic.

Chapter 3 presents the analysis of related literature on socio-cultural factors and practices that hinder behavioural change of women with regards to HIV/AIDS. The chapter first gives a general overview of the origin of HIV/AIDS in the world, in Africa and specifically in Zimbabwe. The vulnerability of women to HIV/AIDS relating to the socio-cultural factors and practices that impede upon behavioural change among Zimbabwean women in an era of HIV and AIDS is given and elaborated. The chapter further traces Zimbabwe's response to HIV/AIDS and analyses the shortcomings in the response strategy, thereby highlighting the need for a rethink of the response system premised on a study of this nature.

Chapter 4 presents and discusses research methodology employed in this study and looks at why those particular research methodological techniques were followed. The techniques utilised in data gathering for this research are tackled and justification for the choice of such techniques is given. This chapter further looks at how data was gathered using the identified research tools and also highlights how the areas of study

were selected. How the data gathered was to be reduced to meaningful information is also explored in this chapter.

Chapter 5 gives the findings of qualitative and quantitative data gathered from focus group discussions, in-depth interviews and questionnaires. Specific socio-cultural factors and practices that hinder women from behavioural change as prescribed by different ethnic groups are explored, analysed and debated upon. The overarching functionalist theoretical perspective and related gender development theory that underpins the study is applied in the analysis of findings in this chapter.

Chapter 6 is the presentation of discussion, summary of findings and drawing of final conclusions as well as recommendations for the study. It further presents a summary of the results and the way forward in the form of major findings and recommendations for policy formulation and guidance.

1.10 VALUE OF THE STUDY

The sociological relevance and contribution of this study underlies the fact that information was described, analyzed and explained from an overarching functionalist theoretical perspective and related gender development and behavioural change theories. Attempts to identify and list factors and practices which describe why, what and how women are held back by socio-cultural factors to change their behaviour in an era of HIV/AIDS serve as contributions and recommendations to policy makers and aid agencies. In the light of the present predicament of women contracting HIV/AIDS in Zimbabwe and looking at social environments beyond Zimbabwe that are constituted the same, it is necessary and of great value that a sociological

investigation of such a nature be undertaken to ensure that women are empowered in the fight against the HIV/AIDS pandemic. This will eventually ensure a stable Zimbabwean society without gender inequalities.

The following chapter will therefore lend itself to the theoretical foundation of this study.

CHAPTER 2

THEORETICAL FOUNDATION OF THE STUDY

2.1 INTRODUCTION

Due to the widespread phenomenon of the HIV/AIDS pandemic, there have been efforts at analyses and approaches developed by various scholars and agencies to understand the nature of the problem. Theories and concepts play a critical role in any social science research in generating ideas, formulating and evaluating hypotheses and building new theories. Due to this, it is very important to choose theories and appropriate concepts for the problem to be based on in order to be researched. The main overarching theoretical perspective of the different approaches in this study is the functionalist perspective as the research is based on aspects of functionalism and gender development theories. The notion is that social phenomena can best be explained in terms of the functions they fulfil or contributions they make to the stability and continuity of society. Cultural factors and practises are regarded as functional for the well being of traditional society. On the other hand, behavioural change is also functional for women in all societies in order to prevent contracting HIV/AIDS. As such, data gathering and analyses will be based on these theories in order to answer the three research questions. Within the context of this study, these theories highlight those socio-cultural factors and practices that underlie women's vulnerability to HIV/AIDS in the contemporary Zimbabwean society. As this study is grounded in

functionalism and some aspects of gender development, it follows closely the work of such scholars such as Durkheim, Parsons, Merton and Chodorow who note that the roles that are ascribed to individuals in socialisation and the gender labels attached to individuals are functional for the wellbeing of society and make a contribution to the behaviour of individuals.

2.2 FUNCTIONALISM

"Functionalist theories are founded on a conception of societies as systems of interrelated and interdependent parts and of the parts as having an inbuilt tendency to adapt to each other so that the society as a whole is in a state of equilibrium or balance" (Elliot 1988:9). Functionalism therefore provides a perspective on society as a whole. It views society as an organism in which all the parts are integrated to function as a whole for the benefit and wellbeing of the whole. Rather than being a closely knit and coherent theory, functionalism is more or less a body of knowledge whose authors such as Comte, Durkheim, Parsons and Merton are linked together by what Burr (1995:2) terms, "a family resemblance". That body of knowledge is used to conceptualise and explain that the roles and functions that women play in traditional societies like Zimbabwe are functional and based on consensus for the well-being of their specific societies. Elliot (1988:99) acknowledges the above point and observes that "task differentiation is not necessarily seen as entailing gender inequality; rather the different roles of men and women may be seen as complementary and of equal value in maintaining the society as a functioning whole". For Parsons (Elliot 1988:99), family tasks are either "expressive" (nurturant, emotionally supportive) or

“instrumental” (directed towards material goals) and it is in principle possible for women and men to perform either set of tasks, therefore tasks are complementary.

The concept of interrelatedness and interdependence of structures is emphasized by Durkheim (in Cheal 2005:16) who maintains that individuals who specialise in the work they do are never truly isolated and independent but are constantly engaged in transaction with other people and the division of labour is made possible by agreements between them about who do what tasks. The above view is based on the organic analogy of the human body in which particular organs have specific functions to fulfil for the wellbeing of the whole. There is overall emphasis on social integration of parts on the basis of consensus (Elliot 1988:9). This research utilises the notions of functionality and dysfunctionality in functionalist theory and therefore emphasizes that each part should play its distinct role or function in keeping with the aim to ensure stability in society. The various parts of society are seen as performing functions (having effects) which contribute to the maintenance, integration and continuity, like in Zimbabwean society where women fulfil their respective roles and functions in childbearing, irrespective of the dangers of contracting the HIV/AIDS disease. Social arrangements thus tend to be accounted for in terms of the functions they are presumed to serve or the contributions they make to society. Traditional factors and practices that expose women to HIV/AIDS are understood in the context of the need to maintain and uphold stability and order in society. The various roles Zimbabwean women play and their subsequent exposure and vulnerability to HIV/AIDS are thus understood as arrangements which meet certain basic societal needs. According to

Elliot (1988:10) “functionalism tends to treat the nuclear family and women’s mothering role as performing functions necessary to the survival of the society”.

Collective conscience that bind Zimbabwean society as they share the same beliefs and morals give grounding on the reasons why women still can not change risky sexual behaviour in the light of HIV/AIDS. To act morally according to the functionalists is to act in terms of collective interest (Blackledge and Hunt 1985:68). According to Parsons (1955) the ideal way for society to maintain order is to develop a cultural system that emphasizes co-operation and then have that set of ideas internalised in the actors through socialisation, because there is order in society when people share the same values. For Durkheim (Cheal 2005:16), the individual is very much the product of society. Therefore, the values we hold and the normal patterns of behaviour we display are the result of the pressures to conform exerted by society and society must ensure that this conformity occurs, like in the case of Zimbabwean women adhering to patriarchal, traditional socio-cultural practices.

Since Zimbabwe is mainly a traditional, patriarchal society it is necessary to distinguish between pattern variables as value orientations in traditional and modern societies differ. These value orientations account for the nature of role relationships in different societies. Parsons (in Hoogvelt 1976:55-56) distinguishes between the traditional and modern societies by identifying the respective pattern variables for each type of society. He identifies the traditional society as affectively rewarding or emotionally gratifying against the affectively neutral modern society and notes that a traditional society emphasizes collective orientation of the specific tribe or clan as

against self-orientation and self-interest in a modern society. He also emphasizes ascription and social standing as a principle being allocated by birthright in traditional society as against being achievement oriented for modern society where every one should achieve their own social standing and position by working hard. Parsons (in Elliot 1988:124) further observes that a traditional society is functionally diffuse, meaning that roles are interchangeable, whereas a modern society is functionally specific and roles are specialised. Because of the pattern variables identified by Parsons (in Elliot 1988:34; Hoogvelt 1976:55-56), the analysis of the Zimbabwean society will fit the traditional realm as given by Parsons. Zimbabwe as a traditional society fits the description of a society where "…obligations to the kin group are paramount while affective inclinations within the nuclear family are checked so that the interests of the group are not threatened" (Elliot 1988:35). According to Ollenburger and Moore (1998:49) "this mystique incorporates societal beliefs that assume that women's ultimate achievement is in becoming a "good" mother that is one whose exclusive devotion is to mothering, with positive outcomes for the home, children and husband". Thus analysis of factors and practices that expose women to unsafe sexual intercourse are to be understood and explored from the functionalist vantage point that the whole is greater than the sum of all the (parts) individuals and therefore group interests matter more than individual interests or the interests of women in this case. Individual interests are thus subordinated to group interests and roles in the quest to maintain harmony in society. The subordination of the individual interests and roles such as ensuring personal good health and well-being, as well as freedom from diseases versus cultural prescriptions to bear children is an example of the

"…collectivity orientation of the role" women occupy as they enhance harmony and equilibrium within the whole (Hoogvelt 1976:55).

This study is guided by the functionalist perspective and therefore a functionalist analysis of the socio-cultural factors and practices that impede upon behavioural change of Zimbabwean women posits that the roles women occupy in society are complementary and legitimate, thus the social ordering of gender relations that pertains in any given society is functional for the well-being of society. Women have to fulfil and honour the "expectations" associated with their roles, especially in a traditional, patriarchal society like Zimbabwe.

Merton (in Macionis and Benokraitis 1998:43) distinguishes between latent and manifest functions as consequences played by social institutions, like families in ensuring individuals fulfil certain functions and expectations. Manifest functions are those expected and intended by the participants in a specific type of social activity, like childbearing, while latent functions are unintended consequences of that activity which participants are unaware of, like contracting HIV/AIDS. Manifest functions generally relate to functionality and latent functions relate to dysfunctionality. From the functionalist perspective therefore, consensus and cooperation regarding gender role differentiation are functional and seen as a manifest function in especially traditional societies.

2.3 GENDER DEVELOPMENT THEORY

While gender classification is the way of organizing social life, gender inequality is infused into the world we live in (Zinn et al 2008:180). From institutions to interpersonal relations gender is used to divide and assign roles according to sexual differences. Sex refers to the biological differences between females and males and gender refers to the socio-cultural constructions attached to femininity and masculinity. Gender divisions essentially rank men and women differently and make them unequal, and more so in traditional societies. According to Lott (1994:41) “Girls (and boys) observe, organise, relate themselves to their appropriate category, try out various behaviours, experience feedback from others, and acquire a gender identity that matches to some degree the ideology of their culture”.

A gender role approach takes gender differences as roles learned or socialized, while the structural or gendered institutions approach focuses on factors external to individuals, such as social structures that reward men and women differently on the basis of their sexuality (Zinn et al 2008:181).

The gender development perspective notes that human differentiation on the basis of socially constructed gender roles is a fundamental phenomenon that affects virtually every aspect of people’s daily lives. The social institutions, like the family, in the context of Zimbabwe construct and uphold the sexualities, gender identities and relational roles that define acceptable behaviour for men and women. In line with gender development theory therefore, men and women can be seen to act the way

they do as a result of social construction and an expression of masculinity and femininity, concepts that they adopt from their contexts and environments and which are desired for their identity survival. Sexual behaviour is one of the issues which are culturally mediated and displayed in different ethnicities in Zimbabwe. Misra and Chandiramani (2005:131) observes that “sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships”.

In this theoretical perspective therefore, gender conceptions and roles are the product of a broad network of the social ordering and influences and are functional for the harmony in society. Gender divisions constitute the basis of social life as a result of the socially and culturally constructed socialisation experiences individuals undergo, according to Chodorow (in Elliot 1988:30; 31). According to Lipman-Blumen (1984:53) “sociologists use the concept of socialisation to describe the fundamental processes by which individuals develop the attitudes, expectations, behaviours, values and skills that coalesce into roles”. Learning to be masculine or feminine and to act male or female is a very early learning experience an infant gets deriving from the infant’s attachment to its parents. Children are gender labelled through social construction. They are biologically designated female or male at birth, given a sex appropriate name and sex typed clothing and have sex appropriate appellations applied to them (Elliot 1988:9).

Block (1984:69) observes that “the gender label becomes an organizing rubric around which the child actively, selectively and with increasing complexity constructs a

personal sex role definition". It should be highlighted that the process of socialising individuals into their respective future roles entails both systematic and random experiences given to the people. According to Lipman-Blumen (1984:5) "…gender roles provide the blue print for all other power relationships. Gender roles are the model for power relationships between generations…" This is inclusive of sexuality. Parker, Barbosa and Aggleton (2000:8) observe that "because sexual cultures organize sexual inequality in specific ways, cultural rules and regulations place specific limitations on the potential for negotiation in sexual interactions and in turn condition the possibilities for sexual violence, for patterns of contraceptive use, for HIV/AIDS risk-reduction strategies". Because of the above realisation, how people relate to one another is tied to the power matrix between the two sexes and relates to the inequality of women. In line with the theory of gender development, women's vulnerability to HIV/AIDS is understandably traced from a perspective in which gender plays an integral part.

According to Chodorow in Elliot (1988:31) "…gender categories, women subordination as well as gender hierarchies are socially constructed and fixated into the minds of individuals as they are prepared for future roles" and this is based on the ground of being born female. In line with Chodorow's theory of gender development, women therefore are found to act in ways that expose them to the dangers of HIV/AIDS because of culturally prescribed roles and duties they have been socialised to believe that they define acceptable women behaviour, which duties they have internalised by fulfilling the expressive task role in families. It should be acknowledged that in traditional set ups such as that of Zimbabwe, socialisation determines what men and

women should know in as far as sexual matters are concerned. Wheelan (1999:3) acknowledges that “in most societies, gender determines how and what men and women are expected to know about sexual matters and behaviour”. Vance (in Feldman 1990:iii) notes that “…cultural values are the medium through which sexuality, drug use and disease are interpreted and acted upon. They define how a woman will conceptualise, define and label the behavioural choices she will make”. The mothering role is one of the distinct roles women are expected to play, especially in traditional Zimbabwe. Chodorow in Elliot (1988:31) posits that “…women’s mothering role is not simply a set of behaviours, but participation in an interpersonal, diffuse, affective relationship”. This notion relates to the traditional value orientations of Parsons’s pattern variables referred to earlier. Though women who become mothers may not even be conscious of their impact, women draw on these taken-for granted meanings to make sense of their experiences and gain a feminized sense of themselves as mature adults. This process of drawing on deeply ingrained cultural beliefs about mothers and motherhood illustrates how gendered institutions shape people’s lives and a sense of self. Perelberg and Miller (1990:104) thus rightly observe that because of socialisation “family members are not free to organise their relationships in a way that they alone negotiate and decide upon. Instead, they are influenced and therefore limited by societal expectations and traditions.”

Women’s interaction with men that exposes them to HIV/AIDS according to this theory is thus understood from the point where women as a result of gender roles are “…groomed from early childhood to bridle their anger and ambition ...learn that their psyches and intellects are bent into a position of powerlessness. This self concept of

helplessness and dependence, coupled with nurturance, intuition, and people orientation, leads to fashion adult lives consistent with this definition" (Lipman-Blumen 1984:65). Thus conditions that expose women to the dangers of HIV/AIDS are to be understood in the light of cultural behavioural constructs informing women's behaviour towards men.

For functionalists, for society to function well, it should be accepted that by virtue of an individual's biological identity which is his biological sex, men and women must accordingly take up their culturally prescribed roles, which are unequal gender roles because they are socially constructed by society. In this perspective, men assume their traditional instrumental roles of fending for families while women fulfil the expressive roles that are limited to child bearing and child rearing duties. The conditions under which women perform these duties are defined and prescribed for them, and a functionalist society demands that women fulfil these duties to be complementary to their husbands. It is something they can not shirk away from, especially in traditional societies. Having looked at the theoretical perspective, theories and models of behavioural change are examined next.

2.4 THEORIES AND MODELS OF BEHAVIOURAL CHANGE

Interventions of HIV/AIDS throughout the world are as varied as the contexts in which we find them. Sexual behaviour, which remains the primary target of the AIDS prevention efforts worldwide, is widely diverse and deeply embedded in individual desires, social and cultural relationships (UNAIDS 1999). This makes prevention of

HIV, which could be an essentially simple task, enormously complex involving a multiplicity of dimensions.

Either implicitly or explicitly nearly all intervention strategies are based on theories. These theories vary and their effectiveness depends on varied factors. Theories and models of behavioural change discussed in this thesis will specifically focus on models of behavioural change related to functionalism and the notion of equilibrium and stability in society. These include the:

- Diffusion of Innovation Theory
- Social Learning Theory or Socialisation
- Social Network Theory
- Exchange Theory
- Cultural Transmission Theory
- Labelling Theory

2.4.1 Diffusion of Innovation Theory

The diffusion of innovation theory according to Rogers (1983) (http://www.who.int/hiv/strategic/surveillance/en/unaids_99_27.pdf) describes the process of how an idea is disseminated throughout a community. According to the theory, there are four essential elements: the innovation, its communication, the social system and time. People's exposure to new ideas, which takes place within a social network or through the media, will determine the rate at which various people adopt a new behaviour. The theory posits that people are most likely to adopt new behaviour based on favourable evaluation of the idea communicated to them by other members whom they respect (Kegeles 1996 in UNAIDS 1999:9). Kelly (1995) in UNAIDS

(1999:9) explains that when the diffusion theory is applied to HIV risk reduction, normative and risk behavioural changes can be initiated when enough key opinion leaders endorse behavioural changes, influence others to do the same and eventually diffuse the new norm widely within peer network. When beneficial prevention beliefs are instilled and widely held within one's immediate social network, an individuals' behaviour is more likely to be consistent with the perceived social norms (Kelly 1995 in UNAIDS 1999:9). These prevention strategies can lead to behavioural changes of Zimbabwean women to empower themselves.

2.4.2 Social Learning Theory or Socialisation

This educational model is based on the concept that young people engage in behaviours including early sexual activity partly because of general societal influences, but more specifically from their peers (Howard 1990 in UNAIDS 1999:9). The model suggests exposing young people to social pressures while teaching them to examine and develop skills to deal with these pressures. The model often relies on role models such as teenagers slightly older than program participants to present factual information, identify pressure, role-play responses to pressure, teach assertiveness skills and discuss problem situations (Howard 1990 in UNAIDS 1999:9) with reference to contracting and avoiding HIV/AIDS.

2.4.3 Social Network Theory

The Social Network Theory looks at social behaviour not as an individual phenomenon but through relationship, and appreciates that HIV risk behaviour, unlike many other

health behaviour, directly involves two people (Morris 1997 in UNAIDS 1999:9) With respect to sexual behaviour and relationships, social network theory focuses on the impact of selective mixing (that is how different people choose who they mix with) and the variations in partnerships patterns (length of partnership and overlap). The intricacies of relations and communication within the couple, the smallest unit of a social network, is critical to the understanding and avoiding of HIV transmission. The scope and character of one's broader social network, those who serve as reference people, and who sanction behaviour, are keys to comprehend and explain individual risk behaviour (Auerbach 1994 in UNAIDS 1999:9). In other words, social norms are best understood at the level of social networks, especially in traditional societies like Zimbabwe where the kinship structure is paramount. It is therefore important that changes be introduced to traditional socio-cultural practices as an intervention strategy to be more preventative towards contracting the HIV/AIDS disease.

2.4.4 Exchange Theory.

The theory of gender and power is a social structure theory, related to functionalism, addressing the wider social and environmental issues surrounding women, such as distribution of power and authority, affective influences and gender-specific norms within heterosexual relationships (Connell 1997 in UNAIDS 1999:6). The theory is a cost-benefit analysis of who has the power and who not. The rewards in relationships should be proportional to the costs thereof and even greater. Women trade sexual favours for men's affection and money. This is based on the principle that women can maximise the benefit to them. Using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment

to a relationship and apparent lack of power can influence her risk reduction choices of contracting HIV/AIDS.

2.4.5 Cultural Transmission Theory

According to the Cultural Transmission Theory, we are engulfed in a social environment that constantly provides us with sex-stereotyped conceptions. It asserts that individuals are essentially neutral at birth and that biological differences are insufficient to account for later male and females differences in gender identities. Individuals acquire those ways of thinking, feeling and acting characteristic of males or females through their social experiences most particularly socialisation. Shortly after birth infants are given “boys” and “girls” names, linguistic markers of male or female status. Males are provided with short, brisk and hard-hitting names such as Bret, Lance, Mark and Bruce. Girls in contrast are given names that tend to be longer, more melodic and softer such as Deborah, Victoria, Jessica and Virginia. It is these cultural stereotypes that shape how a woman should behave towards a man that will have the effect of making the woman behave “irrationally” thereby exposing herself to HIV and AIDS (UNAIDS 1999:10).

2.4.6 Labelling theory

According to the Labelling theory children actively seek to acquire gender roles. According to Kohlberg in UNAIDS (1999:10), children come to label themselves as “boys” or “girls” when they are between eighteen months and three years old. Once they so categorise themselves, children undertake to acquire and master those behaviours that fit their gender concepts, a process termed self–socialisation. The

child undertakes the following sequence: “I want rewards; I am rewarded for doing girl things; therefore I want to be a girl”. According to Kohlberg in UNAIDS (1999:10), the following sequence depicts:” I am a girl; therefore I want to do girl things; therefore the opportunity to do things (and to gain approval for doing them) is rewarding”. According to the Labelling theory at the age between four and six years, they acquire the notion of gender-constancy - the idea that one’s gender is a permanent part of the self. Interventions conceived along this theory seek to capacitate women and make them see that gender labels and constructs are socially constructed and can not stand in the way of ensuring good health for oneself on the basis of gender.

2.5 CONCLUSION

This chapter discussed the theoretical foundation of this empirical research study. It has highlighted that the functionalist theory grounded in the works of Durkheim, Parsons and Merton informs this research. Therefore, the main overarching theoretical perspective utilised is functionalism on which different assumptions regarding gender theories are based with some aspects of gender development theory and models of behavioural change fused. These theories have been used to conceptualise that negotiation and expression of sexuality is culturally engraved depending to a great extent on cultural norms and roles moulding behaviour. Social constructs influence matters of conduct and relations among people. Socialised individuals, “…culturally given guidelines for gender-appropriate sexual behaviour become the principal ‘lens’ through which individuals perceive, feel and act upon their own sexuality” (Parker et al 2000:202). The most common discourse emerging from the gender theories discussed

above is the view that women and men occupy different social roles in life which makes them essentially unequal on the grounds of being born differently. According to functionalism, the gender roles they occupy are complementary in nature and these define the social duties expected of each individual. According to social construction, women are seen as behaving in the manner they do and expected of them in such traditional societies like Zimbabwe, as this is a social requirement that should be upheld for stability. Women and men derive therefore their gender identities from the specific social situations, relations and networks that they are supposed to act and that they are in constant interaction with.

This chapter has provided the functionalist theoretical perspective as the overriding framework of related theories. In this way, the chapter highlights the need to understand socio-cultural factors and practices and meanings surrounding the participation therein, albeit, functional or dysfunctional to the Zimbabwean women. This understanding will assist in answering the three research questions of the study. Finally the chapter has included the theories and models of behavioural change as intervention strategies for counteracting the spread of HIV/AIDS.

Having looked at the theoretical foundation of this empirical study, the following chapter will lend itself to the global overview of socio-cultural factors that impede upon behavioural change of women with regards to HIV/AIDS. Parallels will be drawn from the world over, the Africa content, Sub-Saharan Africa and the Zimbabwean context.

CHAPTER 3

WOMEN, HIV/AIDS AND SOCIO-CULTURAL FACTORS AND PRACTICES

3.1 INTRODUCTION

This chapter presents a general overview of the origins of AIDS in the world, Africa and specifically Zimbabwe, which is in the grip of the pandemic. The vulnerability of women to HIV/AIDS relating to socio-cultural factors and practices that impede upon behavioural change of Zimbabwean women regarding HIV/AIDS will be elaborated on. In this case, specific conditions like gender inequalities and patriarchy resulting in women participating in sexually risky behavior, despite the full knowledge of the danger of contracting HIV/AIDS are the subjects under review.

3.2 THE ORIGIN OF HIV/AIDS

The origin of the virus that causes HIV/AIDS has caused a lot of controversy. There has been many views and counter views that have been put forward to explain the emergence of this dreaded virus but none has been conclusive. As Feldman (1990:1) notes “we do not know where and how AIDS originated and perhaps we will never know”. The above view has been put forward by Jackson (2002:3) who notes that “despite extensive research, the origins of HIV itself remain incompletely understood”. From one line of thinking, HIV/AIDS originated from the monkeys in Africa and human

contact with these infected animals resulted in human beings being infected also. The other line of thinking attributes AIDS to God as punishment for sexual promiscuity while others have blamed the biological warfare experiments that released the virus into the global population, either deliberately or accidentally. Another line of thought is that polio vaccines, widely given in Central Africa in the 1950s and 1960s using monkey serum, could have been contaminated with simian (monkey) immunodeficiency viruses (SIVs) (Jackson 2002:2). Feldman (1990:1) observes that "…simian immunodeficiency virus mutates into human immunodeficiency virus, type two (HIV-2) perhaps from blood contamination while skinning an infected monkey, possibly in a remote West African village many decades ago".

All these lines of thought go on to show that there is no one acceptable and concrete theory on the origins of HIV/AIDS. As a result, this has caused a lot of controversy with accusations and counter accusations on the origins of the deadly virus. Feldman (1990:2) contends that "speculation on the origins of AIDS has already caused consternation, distress and harm. Current speculation that AIDS may have begun in Africa has allowed anti-African bigotry to flourish. AIDS is blamed on Africans, or blamed on gays or blamed on Haitians". With this debate raging on, the poverty-HIV/AIDS nexus as advanced by President Thabo Mbeki of South Africa and the so-called dissident medical team has worsened the situation. The team wrongly holds that poverty causes HIV/AIDS for Africa and until the aspect of poverty is addressed, nothing meaningful will be done to address HIV/AIDS in Africa. Jackson (2002:6) concedes that "in 1999/2000, President Thabo Mbeki of South Africa gave the so-called 'dissident' view considerable support, blocking the use of drugs to prevent HIV

transmission from mothers to their babies and, without intending to, undermining other prevention efforts." Poku (2005:53) observes that "it is fair to say that for much of the past two or more decades, the rational pursuit of knowledge in the hope of advancing mitigation strategies against the impacts of HIV/AIDS has run parallel to (or often been super ceded by) a darker murder–mystery motivation of finding a culprit to blame".

3.3 THE WORLD, AFRICA AND HIV/AIDS: AN OVERVIEW

Human history has been known to be dogged by different challenges ever since and much of these challenges have left calamities on the human race. Among such challenges that stand distinguished is HIV/AIDS that has brought with it suffering, death and poverty. As Nath (2001:92) observes "catastrophes and challenges have riddled human history over the ages. The challenge that this epidemic (HIV/AIDS) is posing is unique". Weinreich and Benn (2004: x) concur that "…HIV/AIDS constitute one of the most serious threats to human life in our era, and represents one of the greatest problems of the socio-economic development of many countries. All forces must therefore be united to do everything possible to counter this catastrophe". To date HIV/AIDS has burrowed deeper into the people's social and economic fabric to such an extent that it is everywhere now.

According to Lamptey (1995:3) "the virus has circled the globe relentlessly, penetrating into every community and level of society". Baylies and Bujra (2000:xii) emphasize that "Africa is facing a devastating crisis at the dawn of the twenty first century with over 70 percent of the world's HIV positive people. Many are struck at the

height of their productive and reproductive years, stretching hard-pressed medical and welfare capacity beyond breaking point, undermining present developmental efforts, casting a long shadow over the future. And this in the least developed region of the world, least able to respond effectively to an epidemic of rising deaths and incapacity". Africa is thus facing a devastating problem that threatens to bring the continent on its knees. Africa's ill preparedness to deal with HIV/AIDS decisively is a point further highlighted by Bicego (in SAfAIDS 2003:4) who notes that "the largest HIV/AIDS epidemic has occurred in a continent which is least able to deal with its ramifications".

The magnitude of the HIV/AIDS problem is further put into focus by Piot (in UNAIDS 2003:23) who observes that "the scale of the AIDS crisis now outstrips even the worst case scenarios of a decade ago. Dozens of countries are already in the grip of serious HIV/AIDS epidemics and many more are on the brink". The extent of suffering caused by HIV/AIDS is worrying and innumerable. While people try to come to terms and grapple with the damage caused by this disease, it's evident that the epidemic is on course to surpass every other catastrophe that has befallen the human race as a result of the people's immorality. Observations made note that men drive the epidemic and it is time for them to own up. As people continue to ponder over this disease, various pointers on the management of HIV/AIDS leaves humanity with some egg on its face. Johnson (2002) highlights disparities in world attention and cites the case of armed conflict and the HIV/AIDS pandemic. The writer notes that armed conflict that killed 340 000 people in 2001 the world over, was given an almost limitless budget and received worldwide media attention compared to the external assistance of only US $215 million for HIV/AIDS, equivalent to the value of a jumbo jet, when the disease

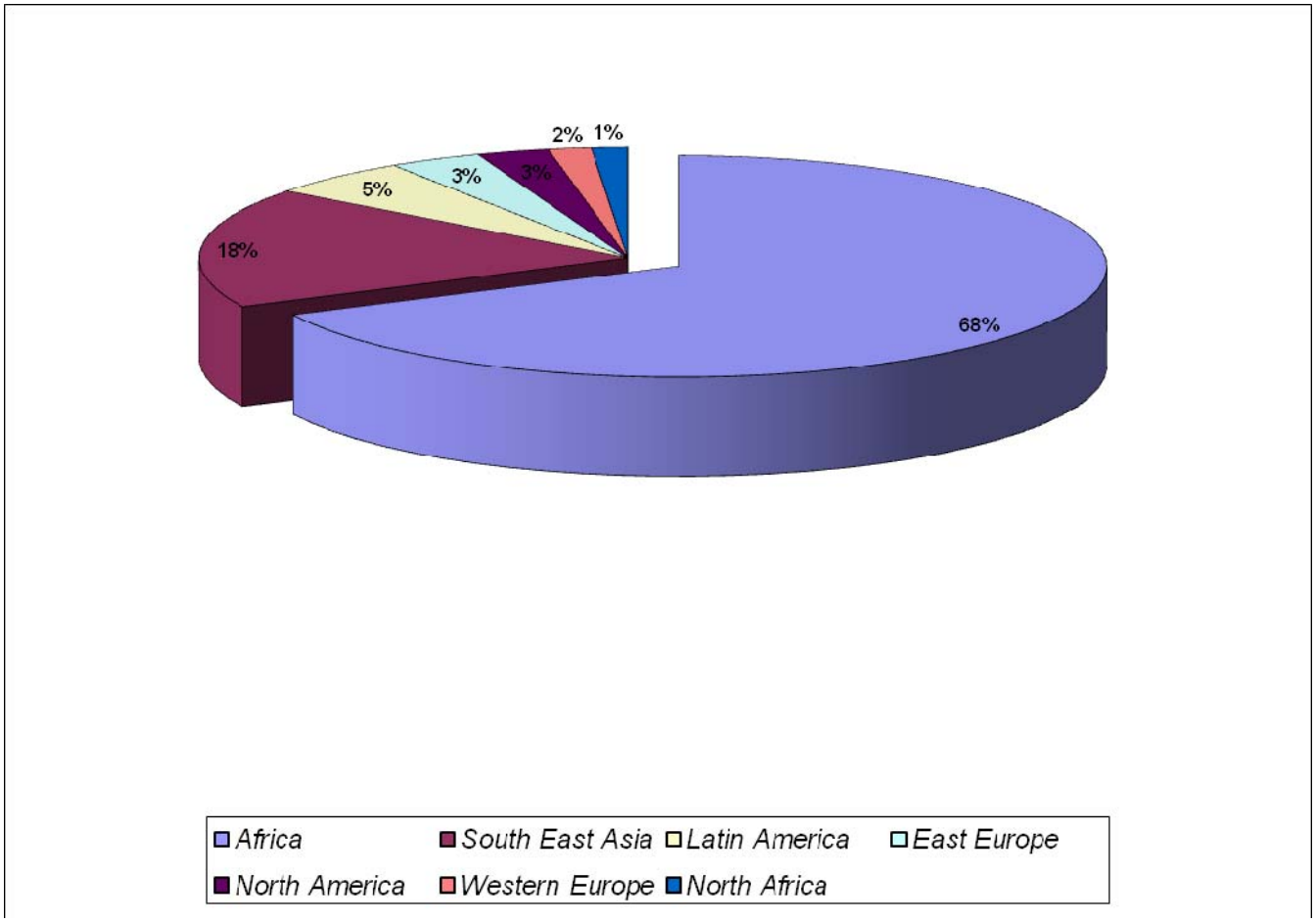
has killed more than ten times the number of people claimed by the armed struggle over the same period. The writer further notes that HIV/AIDS has not attracted enough world public attention through daily news headlines in the world and points out strongly that future historians will have serious difficulties to explain the lack of worldwide action when a whole continent was threatened. While the disease rages on, the indecisive action and failure to prioritize the taming of HIV/AIDS at the international level is a cause for concern. Nath (2001:99) concedes that "the epidemic is constantly asking just one question, "'*are you human?*' What verdict will your descendants pass on you if you stand by silently while a whole generation of children is reduced to a biological underclass by this sexual holocaust?" The above point has been highlighted by Nelson Mandela (http://issues.takingitglobal.org) who noted that "when the history of our times is written, will we be remembered as the generation that turned our backs in a moment of global crisis or will it be recorded that we did the right thing?" Whatever explanations will be advanced future generations may never forgive humanity for its inactivity to save them. It has become "increasingly clear that an understanding of a far more complex set of social, structural and cultural factors that mediate the structure of risk in every population group is necessary" (Parker et al 2000:5), yet the world has not paid heed to this and has not done anything in this direction to save humanity especially in Sub-Saharan Africa. As the world dithers in its efforts, HIV/AIDS continues to lay claim on the women populace. What is however clear is summed in the words of the UNAIDS Zimbabwe Country Report on the UN Secretary-General Task Force on Women, Girls and HIV/AIDS in Southern Africa (2004:7) that notes that "as the HIV/AIDS crisis unfolds, it is becoming more obvious than before

that this epidemic mirrors the conditions of global disparities and simultaneously flourishing poverty, conflict and equality".

The number of people now living with HIV/AIDS has reached 39.5 million by end of 2006. Sub-Saharan Africa has by far the largest number of people living with HIV/AIDS, just over 25 million (www.avert.org/worldstats.htm) as reflected on the pie chart overleaf. Africa is in the midst of worsening crisis and all possible forces must therefore be harnessed to improve the plight of the African women. It has to be now or never.

Africa needs to act now. It cannot afford any mudslinging and inaction as the human race is being ravaged by HIV/AIDS. Across the African continent, HIV/AIDS is savagely cutting life expectancy, which is now about twenty years less than it would have been without the epidemic, and below forty years in some countries (Poku 2005:51).

Pie Chart 1: Distribution of World HIV/ AIDS Infections by region



From the pie chart, Africa's cause is heartrending. The disease has firmly established itself among the general African populace. What is even more worrying is the fact that the fifteen countries in the world with the highest HIV/AIDS prevalence rates are all from the continent of Africa (Table 2) and more specifically the majority are in Southern Africa. Africa is thus justifiably a continent under siege from HIV/AIDS. Piot (1995:4) reiterates that "AIDS is now everywhere, as part of human condition and will remain so for a very long time to come".

Table 2: HIV and AIDS Prevalence by Country and Region (2006)

Africa				Outside Africa		
Rank	Country	Percentage of Population		Rank	Country	Percentage of Population
1	Swaziland	33.4		1	Cambodia	1.6
2	Botswana	24.1		2	Honduras	1.5
3	Lesotho	23.2		3	Jamaica	1.5
4	Zimbabwe	20.1		4	Thailand	1.4
5	Namibia	19.6		5	Ukraine	1.4
6	South Africa	18.8		6	Estonia	1.3
7	Zambia	17.0		7	Mynmar	1.3
8	Mozambique	16.1		8	Dominican Republic	1.1
9	Malawi	14.1		9	Moldova	1.1
10	Central African Republic	10.7		10	Russian Federation	1.1
11	Gabon	7.9		11	El Salvador	0.9
12	Cote D' voire	7.1		12	Guatemala	0.9
13	Uganda	6.7		13	Panama	0.9
14	Tanzania	6.5		14	Latvia	0.8
15	Kenya	6.1		15	Venezuela	0.6

Source: http://www.globalhealthfacts.org

The global statistics make it clear that the burden remains in Africa, although it is only home to 11 percent of the world's population. On this continent HIV/AIDS has single-handedly reversed gains in life expectancy and reductions in child mortality (Steinbrook 2004:115-117). Further still, of the nine countries that have the most HIV infected people, eight are in Sub-Saharan Africa: South Africa (5.5 million), Nigeria (2.9 million), India (2.5 million), Mozambique (1.8 million), Zimbabwe (1.7 million), Tanzania (1.6 million) Democratic Republic of Congo, Kenya, Ethiopia and Mozambique all of them with one million people each (http://www.globalhealthfacts.org 2006).

The baffling question is when will the epidemic begin to pass, if ever it will? There have also been concerns that the HIV/AIDS epidemic in Africa is different from other epidemics in the world. Caldwell (1997:248) observes that "the African HIV/AIDS epidemic contrasts with epidemics in developed countries in that very few people know their HIV status". Further still, a great deal of the people in the worst hit Sub-Saharan region have reported not being interested in knowing their status. This makes efforts to tame HIV/AIDS difficult.

Nath (2001:93) brings yet another dimension to the world of HIV/AIDS between Africa and the general world. The writer notes that "the world of HIV/AIDS is riddled with complexities. In the industrialized world, the discovery of and reasonable access to powerful antiretroviral drugs have caused death rates due to AIDS to go down and opened up newer greener vistas for those people living with HIV/AIDS where as in the developing countries it has been antagonizing. It is like seeing food when you are starving but cannot eat it" (Nath 2001:93). As the HIV/AIDS death train navigates through Africa, one thing is certain "the epidemic is truly on track to dwarf every catastrophe. In other catastrophes the worst consequence is death, in HIV/AIDS the worst consequence is not just the dead, but also the living that are left behind" (Nath 2001:93). Whether or not Africa will come out of this sexual holocaust will depend on its will to survive and face tomorrow. The above point is highlighted by Reid (1995:1) who points out that "the human immunodeficiency virus (HIV) (epidemic) carries with it forces of destruction and healing. Whichever prevails will be the measure of ourselves and our societies". To date the scale of the HIV/AIDS crisis in Africa outstrips any other disaster known to have decimated the human population. To compound Africa's

woes on HIV/AIDS, not much progress has been made in the last few years to check the HIV/AIDS onslaught with the different regions not united on a common stand against the sexual holocaust. Bell (2002:7) concurs that “humanity has been unable to meet the challenge passed by HIV/AIDS these past 20 years. Most people working on HIV have developed an “us and them” approach, focusing notably on prevention work among groups of people who are viewed as “vulnerable groups”. This is despite the fact that “…the battle against HIV/AIDS is a battle for life. It is recognizing that every life is precious in every corner of this world” (Michaelle Jean in http://issues.takingitglobal.org). This lack of oneness in the global fight against HIV/AIDS has meant that the will power to halt the HIV/AIDS scourge may not be a priority for others.

While the war to combat HIV/AIDS rages on along geographical lines (developed versus developing world) and sometimes racial lines, another fault line in the fight for survival as a result of HIV/AIDS very difficult to ignore and seeking urgency has started to gain momentum, the gendered perspective (men versus women) in the fight against HIV/AIDS. The fault line has quoted a lot of controversy and will be explored in detail. Daulaire (2006:13) concurs and reiterates that “the faces of those newly infected with HIV/AIDS are more and more often the faces of women and girls. Women now account for nearly 60 percent of those with HIV in Sub-Saharan Africa”. With this raging new identity for women going on, one is tempted to ask if the vulnerability template that has become the women’s identification tag is a result of functional or even dysfunctional roles women are expected to play will ever be

changed. Whatever the case is, the extent to which Zimbabwe is in the grip of the epidemic is explored first.

3.4 ZIMBABWE IN THE GRIP OF HIV/AIDS

Zimbabwe is one of the worst hit countries by the HIV/AIDS pandemic. Currently, she is one of the nerve centers of HIV/AIDS (Mhloyi 2001:146). Death is now a daily, hourly and often per second occurrence. Never in the country's history has death become such a daily occurrence. The following words have become a daily cry, "Ashes to ashes, dust to dust, may his/her soul rest in peace. These words, almost clichés now, to most Zimbabweans are uttered many times a day by pastors, reverends and other senior clergy at graveyards. Yet another soul is buried under Zimbabwe's 3 800 HIV/AIDS related deaths per week" (Chaparadza-Mukumba 2003:7). This is because of the fact that HIV/AIDS prevention is not the top most priority for the southern African country. Githuku (2003:2) notes that "Zimbabwe's priority concerns include economy 74%, job creation 37% and health 18%". Even more frightening is the rapid growth of the epidemic. Muchando (1998:31) notes that "since the discovery of the first AIDS case in Zimbabwe in 1985, the number of new cases is increasing by day. In 1987, Zimbabwe reported 119 cases of AIDS to the World Health Organization but by the end of September 1993 reported cases had risen to 25332". To confirm Zimbabwe's reputation as one of the worst affected countries, the following table overleaf (3) highlights a sorry state of affairs in Zimbabwe:

Table 3: HIV/AIDS Statistics for Sub-Saharan Africa 2006

Country	People living with AIDS	Adult (15-49) rate percent	Women	Children	AIDS Deaths	Orphans due to AIDS
Botswana	270 000	24.1	140 000	14 000	18 000	120 000
Lesotho	270 000	23.2	150 000	18 000	23 000	97 000
Namibia	230 000	19.6	130 000	17 000	17 000	85 000
SouthAfrica	5 500 000	18.8	3 100 000	240 000	320 000	1 200 000
Swaziland	220 000	33.4	210 000	15 000	16 000	63 000
Zambia	1 100 000	17.0	570 000	130 000	98 000	710 000
Zimbabwe	1 700 000	20.1	890 000	160 000	180 000	1 100 000

SOURCE: UNAIDS/WHO 2006 Report on the Global AIDS Epidemic

From Table 3 given above, Zimbabwe is second to South Africa on people living with HIV/AIDS and is the fourth country with the highest HIV prevalence at 20.1 percent. Zimbabwe comes second to South Africa as the country with the highest number of women living with HIV/AIDS with 890 000 women reportedly infected. Zimbabwe once again has earned herself the unenviable reputation of having the highest number of children infected with HIV/AIDS with 160 000 children infected second to South Africa. 180 000 AIDS deaths have been reported for Zimbabwe second again to South Africa with 320 000. 1 100 000 children have been orphaned due to HIV/AIDS, second to South Africa with 1 200 000. All these facts demonstrate beyond reasonable doubt that Zimbabwe is a country heavily buttressed by HIV/AIDS. These figures cited for Zimbabwe have reportedly been underreported and indications are that the prevalence rates could be higher than projected.

Whiteside (1995:218) concedes that “the number of AIDS cases in the country has been frequently likened to the tip of an iceberg as far as the actual AIDS epidemic is concerned. This is because reported AIDS cases only reflect a few of the actual AIDS cases and a small proportion of HIV positivity”. Donk (2006:136) says of Zimbabwe’s initial efforts to tame HIV/AIDS that “for too long government denied HIV/AIDS as a reality and when they finally admitted, it was very late. The admission again is still incomplete even now because there is a tendency to distance ourselves from the disease”. Zimbabwe like most of the countries in its dilemma at the onset of HIV/AIDS chose to cover up AIDS cases. Muchando (1998:31) notes that “AIDS cases were not publicized because politicians thought it would drive away foreign investment and tourism”. In 1987, the number of HIV and AIDS reported cases were reduced on the instructions of the Ministry of Health and in 1988, the Permanent Secretary of Health announced that government policy was that the blood transfusion service would only inform doctors and not donors of the people’s HIV status, hospitals were not permitted to inform patients or employers and were told to report AIDS cases only to the AIDS Control Programme. People with AIDS were officially discouraged from announcing their illness and at one point a ministry spokesperson actually accused the medical profession of misdiagnosing cases and over reporting (Whiteside 1995:218). Feldman (1990:5) says such actions “…mobilized widespread fear, bigotry and misinformation to politicize the disease and promote their restrictive agenda”.

As earlier highlighted, the first HIV/AIDS case in Zimbabwe was diagnosed in 1985 much later than such countries as Uganda. It is mind boggling as to why Zimbabwe

and the rest of Southern Africa have failed to learn from the experiences of those countries that were hit by HIV/AIDS before them. The year 2003 was an anniversary of shame for Zimbabwe. It marked 20 years of living and dying with HIV/AIDS since the first case of what has become the single biggest threat to national, regional and international development was identified in 1983 (ZWRCN 2003:5).The above concerns have also been raised by Weinreich and Benn (2004:93) who note that "after more than 20 years of a devastating HIV/AIDS pandemic there remain some very fundamental questions. Why have not more countries been able to prevent this disease spiral out of control when the main concepts of prevention and care have been known for many years? Why have not more people adopted safer sex behaviors despite being well informed about the main ways of transmission and the best protective measures?" Had the HIV/AIDS been managed with honesty, bravery, leadership and courage that was and remains needed, it may have remained just a matter of public health (ZWRCN 2003:5). The failure by Zimbabwe to learn from those countries that were affected by HIV/AIDS before itself testifies to the fact that she was going through the first stage of the transitional model as identified by Mhloyi (1992: 44), being that of "denial and gives credence to the fact that Zimbabwe's initial response to HIV/AIDS has been chaotic and shambolic". The President of Zimbabwe, Mr. Robert Mugabe has attested to the above fact and has described Zimbabwe's response to HIV/AIDS as "…slow, weak and selective "(Zimbabwe Human Development Report 2003:123).

Zimbabwe's response has been largely driven by the biomedical response, with the screening of all donated blood for HIV. In 1986, a health committee of experts, the

Zimbabwe AIDS Health Experts Committee (ZAHEC) was formed to provide technical expertise on HIV/AIDS issues (Zimbabwe Human Development Report 2003:124-125). 1987 saw the implementation of the Short Term Plan (STP), which sought to implement prevention programs. It should be noted that during the early phase of the HIV/AIDS onslaught the response to HIV/AIDS was largely individualistic and the duration was very short thus very little progress was made if at all it was. To qualify the above observation, a national HIV/AIDS and STI machinery in the Ministry of Health and Child Welfare, the National AIDS Control Programme (NACP) was formed to monitor programs in the field. The first Medium Term Programme (MTPI) implemented in 1994, focused on behavior change communication, counseling and psycho–social support was implemented. This was followed by the Parliamentary Portfolio Committee on Health and the Cabinet Social Services Action Committee (SSACC) in 2005 and the Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 (UNGASS Report 2008:11). With these multifarious activities on HIV/AIDS going on, it is justifiable to conclude that Zimbabwe's response to the HIV/AIDS pandemic was and to a large extent is still uncoordinated and essentially "fragmented" (Zimbabwe Human Development Report 2003:127) to such an extent that not much progress has been realized. The Zimbabwe AIDS Network (ZAN) was formed in 1990 to co-ordinate non-governmental organizations (NGOs) responses, but it was noted that some NGOs did not co-operate by submitting work plans to avoid duplication of duties. The Zimbabwe Human Development Report (2003:127) concedes that "this problem has plagued Zimbabwe's HIV/AIDS response to this day". The UNICEF Country Clips Report on Zimbabwe Issue 2 (2002:3) notes that "the response against HIV/AIDS has long been dominated by seeing HIV/AIDS as an individual problem". This has led to

each player trying to keep his or her activities on HIV/AIDS to oneself but the Zimbabwe Human Development Report (2003:127) lambasts such actions and labels them "…treacherous and not in the best interest of the fight against HIV/AIDS which requires national efforts as opposed to individual organization efforts. It is not a winner takes all battle, therefore as there will be no winners if people are dying at the rate they are".

In 1999, the government of Zimbabwe finally put in place an HIV/AIDS policy. With this policy, the government criminalizes the deliberate transmission of HIV/AIDS among other things (Njanji 2001:1).The late development of the HIV/AIDS policy reveals that contrary to the urgency and the rate of spread of the pandemic, policy and program interventions have been slow to develop in this southern African country (Mhloyi 2001). The Zimbabwe Human Development Report (2003:129) says of the HIV/AIDS policy that "the document proposes that it is important to publicly debate issues of confidentiality and look into legislative ways of making HIV/AIDS notifiable". It has been noted that despite having worthwhile recommendations proposed as far back as 1999, only a few of these issues have been implemented in the current fight against HIV/AIDS. Issues which are culturally sensitive, such as informing youths and women about HIV/AIDS and STIs, as well as empowering them to protect themselves, accepting prostitution as a reality and empowering them sexually and many others are still considered too sensitive as the pandemic rages on (Zimbabwe Human Development Report 2003: 130). In 1999, the National AIDS Council (NAC) was formed through an act of parliament to co-ordinate all HIV/AIDS programs. NAC notes that its broad aim is to tape the most needed community initiatives/innovations and

utilize them in preventing HIV from further spreading and to mitigate the impact of AIDS (NAC 2002:2). Whether the espoused dream is to be realized remains to be seen as to date NAC activities have not cascaded down to reach the ordinary person in the back of beyond of rural Zimbabwe.

In 2000, the government of Zimbabwe put in place the National AIDS levy. The Zimbabwe Human Development Report (2003:130) notes that, the AIDS levy was "… pegged at 3 % of individuals' tax for people working in the formal sector in order to take action against HIV/AIDS". The levy has caused a lot of controversy with accusations of the fund being underutilized from some quarters and mismanaged from other quarters. One thing is clear though, that the resources to fight the pandemic are scarce in Zimbabwe. Lack of resources to fight the epidemic constitutes in Lewis the UN Secretary General's Special Envoy for HIV/AIDS in Africa's words, "mass murder by complacency and those who watch it unfold with the kind of pathological equanimity must be held to account". While problems continue to dog Zimbabwe's response to HIV/AIDS with the government seemingly dithering in her efforts to halt the pandemic, one thing is certain and clear in this southern African country that HIV/AIDS continues to plunder Zimbabwe's resources.

As the nemesis continues, HIV/AIDS has turned out to be unevenly aggregated on the two sexes. Women have turned out to be at the center of the HIV/AIDS pandemic. Worth (in Zeidenstein and Moore 1996:119) concurs that "currently the number of AIDS is growing fastest among women." While women today form an endangered group as a result of HIV/AIDS, intervention strategies and programs enhancing their

sexuality on the ground have not matched the risk tag they now carry. Berer and Ray (1993: 42) note that “preventing women from transmitting HIV has often had higher priority in policy and programs than preventing women from getting HIV”. The Zimbabwe government has been accused of failing to champion women’s health with regard to the strength usurping HIV/AIDS statistics. The Zimbabwe Human Development Report (2003:126) concurs and notes that “it is also interesting that when it comes to women and HIV/AIDS, it was felt the women’s organizations would take care of this”. Why Zimbabwe’s government failed to show commitment to better women’s health remains a mystery. This is an area that needs a rethink in the light of the dangers posed by HIV/AIDS to women. The lack of commitment to deal with women and HIV/AIDS on the part of the government sends the wrong message to women, namely, that the government will not dedicate time and resources to them on a life threatening disease such as HIV/AIDS (Zimbabwe Human Development Report 2003:126).

As the uproar over women and HIV/AIDS in Zimbabwe continues it is apparent that Zimbabwe cannot afford to cope with mudslinging, inactivity and sexual irresponsibility (Mhloyi 1992). The HIV/AIDS clock is ticking towards a grave disaster. It is time Zimbabwe gets its priorities right. This can only be done by establishing factors and practices that impede upon the behavioural change of women with regard to HIV/AIDS. To fold this important discussion on Zimbabwe and HIV/AIDS it is important to take note of what Urlin (2002:27) has said about HIV/AIDS and women. The writer notes that “a better understanding of how women themselves perceive and respond to current attempts to prevent the transmission of AIDS is an increasingly critical factor in

the intervention process". As long as this dearth in knowledge continues, intervention strategies and programs being put in place will never tame the cunning pandemic that threatens to wipe the women populace for Zimbabwe as the vulnerability template for women will never be understood. As the uproar over HIV/AIDS continues, the Ministry of Health and Child Welfare (2004:54) observes that "Zimbabwe is going to suffer the consequences of the HIV/AIDS epidemic for many decades into the future. In many ways, the most impacts lie in the future, not in the past". The extent to which women are buttressed by HIV/AIDS is explored next.

3.5 WOMEN'S VULNERABILITY TO HIV/AIDS

The vulnerability of Zimbabwean women to HIV/AIDS is a fact that has been identified. According to Izumi (2006:1) "it is a well-known fact that women and girls are especially vulnerable to HIV infection". The above point is reiterated by Parker et al (2000:104) who note that "there is evidence that women's vulnerability to HIV/AIDS is rapidly rising in both developed and developing countries". Earlier studies have tended to classify commercial sex workers and drug traffickers as the people at risk of contracting the deadly HIV/AIDS. Oyefara (2005:2) concedes that "most of the studies focused on vulnerable groups such as urban youth, long distance drivers, commercial sex workers and uniformed forces". The fact that "in Zimbabwe and Africa in general 99% of the HIV infection is transmitted heterosexually, considering that vertical transmission is in itself a result of sexual transmission to the mothers…" (Zimbabwe Human Development Report 2003:48), gives precedence to a study of the above nature as it is very clear that women now have the "high risk group" tag. As Crewe

(2002:40) observes “Women have moved from the periphery of the epidemic to the heart of it in the time span of a decade”.

It should be acknowledged that most, if not all intervention strategies being rolled out to date in Zimbabwe, assume homogeneity of socio-cultural norms and values among the Zimbabwean people. Van Dyk (2005:116) concurs that “HIV/AIDS education and prevention programmes have mostly been based on Western principles and no attempt has been made to understand or integrate the diverse cultural and belief systems of Africa into such programmes”. The above point is reiterated by Hunter College Women’s Studies (1995:118) that observes that research and interventions on “…human sexuality have rested on faulty assumptions. Human sexuality cannot be isolated from its social, cultural and situational context”. To date, intervention strategies that have been brought to the Zimbabwean people do not promote discussion and involvement but are top-down instructions from outside the cultural practices of Zimbabwean people.

It is an undeniable fact that Zimbabwe is ethnically diverse to warrant ethnic sensitive strategies. The Zimbabwe Human Development Report (2003) echoes the above view when saying that intervention strategies would remain incomplete if the foundation of the general vulnerability is not exposed and understood. Feldman (1990:111) adds his voice to the above point and notes that “individual behaviour choices are poorly understood because there has been a lack of interest in learning how cultural values and expectation are related to … survival skills of women”. Ogundipe-Leslie (1994:225) concurs and notes that, “I think more than ever, Africa

needs to deal with her ethnicities. The ethnic defines the individual at the most primary important and emotional level of health and historical identity. We are being asked to move into the future without our past and present by those who deny or misunderstand the value of ethnicity". If HIV/AIDS is to be curtailed, the ethnic component of the individual that defines who one is needs to be taken into consideration and a study of the above nature does exactly that.

The Zimbabwean people continue to be bombarded with "Safe Sex" messages at the expense of realistic strategies to combat HIV/AIDS. This is despite the fact that these interventions have failed drastically. Parker et al (2000:5) observe that "while the inefficacy of behavioural interventions based on information and reasoned persuasion to stimulate risk reduction became evident", these have continued to be pumped out. Mann (in Gupta and Weiss 1993:3) notes "that all situations circumvent the sensitive, complex and incomparably problematic issue of sexual behaviour is no accident. But the prevention of HIV/AIDS is and will remain inextricably linked to sexual behaviour and therefore to the circumstances that affect sexual behaviour". Van Dyk (2005:89) observes that "if education and prevention programmes are to be successful in Africa, it is important for us to understand and appreciate the traditional African world-view of sexuality". Research should feed into the design of programme interventions to facilitate the holistic approach to combating the epidemic (Zimbabwe Millennium Development Goals 2004:48). This research is therefore motivated by the realisation that current strategies have failed to harness the spread of HIV/AIDS as they continually avoid the all important issue of human sexual behaviour and the socio-cultural factors that affect behaviour. It is of great importance to explore the

vulnerability template and risk factors that underlie, fuel and sustain non-behaviour change from the socio-cultural angle.

The area of human sexuality has not been explored to untangle the intricacies involved in human sexual behaviour especially with regard to the factors that affect the sexuality of women. There is a dearth of information on the subject and the strategies that attempt to combat HIV/AIDS based on women sexuality rely on baseline studies done elsewhere in countries whose socio-cultural environments are worlds apart to the Zimbabwean set-up. This study seeks to point out Zimbabwean women's trajectories and realities that hamper negotiating for safe sexual intercourse. In doing so, it seeks to pluck the identified gaps in knowledge by unravelling socio-cultural factors that hamper behavioural change in women. Its focus is the cultural setting within which behaviour takes place and the cultural norms, values and rules that organize and influence behaviour so that a wholesome understanding of Zimbabwean women's vulnerability to HIV/AIDS is understood. Ogundipe-Leslie (1994:15) observes that, "Africa has not yet given voice to her (woman) sexuality; too many silences persist in the area of human sexuality in Africa." It is these silences that the study seeks to unravel to tame the menacing HIV/AIDS among women. Muntaz, Slaymaker and Salway (in Kishor 2005:17) concur and note that "the socio-cultural construction of gender emerges as a key factor in these processes…There has been little systematic investigation of the routes through which the socio-cultural construction of gender actually influences risk related behaviour." Almost all the studies done to date in Zimbabwe have failed to confront the issue of socio-cultural barriers that impede upon behavioural change with reference to HIV/AIDS as witnessed by the firming

percentage of women getting HIV/AIDS in Zimbabwe now at sixty percent (Daily Mirror 5, July 2005). It is the researcher's convictions that if left unresolved, the plight of women due to HIV/AIDS will worsen and women may never be blameless for being affected by their partners. This statement is, of course, controversial, but will be explained further in the study.

Further sociological relevance for an empirical study of this magnitude arises from the fact that life is changing everyday to warrant a search and a revision of the previously held notions on women sexuality on HIV/AIDS. This point is emphasized by Cutrifelli (1993:1) who observes that "…research into the conditions of life and the role of African women today does not only call for some regular revising but also for a continual and timely verification of previous analyses as well as the methods employed in the research and in the analysis."

More importantly, Zimbabwe has bunched her responses to the HIV/AIDS pandemic without necessarily looking at what works in each community and what doesn't work. Manhanga (2004:76) maintains that "one thing is clear, we can not adopt a one-size-fit all approach as what works in one community may not necessarily work in another." A study of this nature will bring to the fore the responses deemed appropriate for each ethnic group. More interestingly, Zimbabwean society has maintained a closed lid on the issues that relate to women sexuality and attempts to address them have not taken aboard the concerns from the women themselves. A better understanding of how women perceive and respond to current attempts to prevent the transmission of AIDS is an increasingly critical factor in the intervention process (Urlin 2002:27). This

is offered by a study of this nature. The importance of undertaking such a study is grounded in the observation made by a Mrs S.D. Nyoni, then permanent secretary in the Women's Bureau who observed in 1992 that "…women carry a heavy load, but more importantly they carry a heavy collective responsibility to bring change". Critical and implied in this observation is the view that women's concerns need to be taken aboard if realistic solutions to HIV/AIDS in women are to be worked out. While this realisation dates back to more than a decade ago, very little in this direction has been done to understand and change the way women view themselves. This study places women's experiences at the centre of intervention process. It seeks to sociologically examine the world and human sexuality from the point of view of women, to analyse, question and unravel factors and practices that expose women to HIV/AIDS and makes recommendations based on these. It further seeks to listen to the female voice for a lasting solution to the issue of women and HIV/AIDS in Zimbabwe and move away from "man-made" theories on women sexuality and behaviour.

3.5.1 Women and HIV/AIDS: A Gendered Perspective

It is more than twenty years since the first HIV/AIDS case in Zimbabwe was diagnosed. Since then Zimbabwe has travelled an arduous trip in its bid to grapple with the HIV/AIDS pandemic. To date, women have become the fastest growing group of people with AIDS (Benzef and Bellamy 1988). The above point is highlighted by NAC (2003: 13) that notes that "…women and men, girls and boys have experienced the HIV and AIDS epidemic very differently." The report's premise is that women and girls have borne most of the brunt of HIV/AIDS. On a global scale, the AIDS epidemic has been identified as an issue that impacts upon gender relations so much that it has

been referred to as a “gendered epidemic” (Patton 1994; Wilton 1997,Hoosen and Collins 2004). It has been noted that women account for 55% of the continent’s infections (Manhanga 2004:78). As earlier alluded to, the face of AIDS is increasingly a woman’s face. Various pointers back up the above assertion. Of the 1 820 000 total infections by 2003 for Zimbabwe (Table 4), 1 540 000 were for the adults in the age range from 15 to 49 years. 870 000 infections translating into 47.8 % of the total are for the women in the 15 to 49 years age range while infections for men totalled 670 000 and that of children accounted for 280 000 of the total. From the above information, there are pointers to the fact that women and men experience the pandemic differently as women are increasingly becoming more infected by the pandemic.

Table 4: National HIV/AIDS Estimates 2003

Total infected	(adults and children)	= 1 820 000
Adults	(15 - 49)	= 1 540 000
Women	(15 - 49)	= 870 000
Men	(15-49)	= 670 000
Children	(0 – 14)	= 280 000
Adult HIV Prevalence	(15-49)	= 84.6%

Source: Zimbabwe National HIV/AIDS Conference Report 2004

Further still, the year 2003 recorded a total of 206 000 new HIV infections for both adults and children (Table 5). Of the above, 166 000 were for the adults in the age range 15 to 49 while women in the age range 15 to 49 weighed in with 88 000 new

infections of the total translating into 47.7%. The men weighed in with 78 000 new infections (37.8%) while the children accounted for 40 000 new infections (19.4%). Tsarwe (in Tariro 2004) observes that from the year 1997, new cases of HIV/AIDS grew very high levels among adult women.

Table 5: New HIV infections 2003

Total (adults and children)	= 206 000
Adults (15 – 49)	= 166 000
Women (15 – 49)	= 88 000
Men (15 - 49)	= 78 000
Children (0 – 14)	= 40 000

Source: Zimbabwe National AIDS Conference Report 2004

It is noted from the statistics given in Tables 4 and 5 that HIV/AIDS has grown into a crisis of gargantuan proportion among the women populace. The tight grip maintained by HIV/AIDS among women continues to manifest itself with statistics on HIV/AIDS deaths for the year 2003, (Table 6) reflecting a scenario where women are heavily buttressed. Of the total 171 000 deaths listed as a result of HIV/AIDS, 135 000 were for adults. Of the above, women deaths accounted for 77 000 of the total deaths while men accounted for 58 000. The children accounted for 36 000 deaths while 761 000 children were estimated to have been orphaned (Table 6). With HIV/AIDS raging on, the commitment to confront the disease among women has been weak. The writing has been on the wall for years, yet responses within and outside Africa have been desperately inadequate (Jackson 2002:35). Estimates from current research suggest

that two thirds of women in South Africa, Zambia and Zimbabwe are thought to carry HSV2 without knowing that they are infected (Beresford 2006:12). These proportions are unacceptably high.

Table 6: HIV and AIDS Deaths in 2003

Total (adults and children)	= 171 000
Adults	= 135 000
Women	= 77 000
Men	= 58 000
Children	= 36 000
Estimated children orphaned	= 761 000

Source: Zimbabwe National HIV/AIDS conference report 2004

To date all the intervention strategies employed in Zimbabwe have not considered individual women. The social and cultural spheres which simultaneously underlie behaviour have not been assessed to gain a deeper understanding of women sexual behaviour and factors that hold them back from achieving behavioural change (Aggleton and Homans 1988; Hobfoll 1998). In the light of the above situation, HIV prevention programs should stress the simultaneous investigation of the individual, social and cultural dimensions as a result of the realization that information alone plays a limited role in changing sexual behaviour (Hoosen and Collins, 2004). The above is a major climb down from HIV prevention programmes that sought to alter sexual behaviour by providing information concerning sexual transmitted disease management and health risks and condom distribution (Campbell and Hayes 1998; MacPhail, 1998). The statistics are only the tip of the iceberg. UNICEF (2004) concurs

and notes that the numbing parade of statistics on HIV/AIDS infection in severely affected regions of the world now distressingly familiar, fail to quantify or convey the full extent of human suffering AIDS engenders in a country such as Zimbabwe.

As Zimbabwe and other countries of the world struggle to develop effective policies and programs to address the epidemic, it is clear the gendered nature of the epidemic has to be addressed lest the women folk get wiped off. Muntaz, Slaymaker and Salway in (Kishor 2005:118) allude to the above fact and note that "… there has been little systematic investigation of the routes which the socio-cultural construction of gender actually influences risk–related behaviours". It is therefore important to understand the wider socio-cultural forces as well as the patterns of interpersonal power relations that drive women's susceptibility to HIV infection. There have been no clinical trials that are geared towards learning about HIV in women – as women rather than as vectors of HIV to their offspring.

3.6 SOCIO-CULTURAL FACTORS THAT INHIBIT BEHAVIOURAL CHANGE

The subject of women and HIV/AIDS has torched a lot of controversy over why it has been neglected worldwide for a long time. Various reasons have been advanced to date for the lack of commitment by research institutes to tackle HIV/AIDS and women but none has been conclusive. Studies have been carried out in high profile countries in the modern world but nothing has been comprehensively done for Zimbabwean women today. It should be noted that Zimbabwe is not different and unusual from other African countries in the extent of sexual attitudes, practices and norms that

enhance the risk of HIV spread (Jackson 2002:81). However, because of non-availability of research in other African countries as well, the subject remains unexplored to a large extent. Of concern to the contemporary world has been the influence of culture on the behaviour of people, as it has been downplayed, yet it plays a pivotal role in determining what people do and how they do it. Misra and Chandiramani (2005:63) observes that "the issue of gender sexuality and rights run deep in our personal lives, in our relationships and in our self evaluation". According to UNICEF (1999:93) "like the majority of developing countries, Zimbabwe is a cultural society. This is to say people's instincts and thought processes are not only naturally influenced by cultural nuances, but that culture is reverted to and embraced in situations that are unfamiliar to duty bearers or where in times of crisis no contemporary solutions can be found." Therefore to understand an individual, one needs to understand the cultural forces that influence an individual's behavior. Brummelhuis and Herdt (2003:10) note that culture defines much of the world in which people situate themselves and live.

Brummelhuis and Herdt (2003:10) further observe "…culture enters and then inflates itself as a barrier they confront". It is in this light that Mahaka (2001:82) observes and reiterates that "we can not hope to combat the HIV/AIDS scourge if we ignore the socio-cultural forces that shape the behaviour of the people ". What then follows is a selection of socio-cultural factors or values that impact on the attitudes of women and inhibit their behaviour making them unable to change their behaviour regarding HIV and AIDS since they are seen as subordinate and inferior.

3.6.1 The Discourse of Perpetual Minors

Zimbabwe is largely a patriarchal, patrilineal and traditional society. The above point is emphasized by the Ministry of Health and Child Welfare (2000:7) who notes that "the Zimbabwean society is patriarchal, emanating from the socialisation process. The subservient role of women is thus reinforced. Decision making is mainly in the hands of men in this society putting women in suppressed positions". Under this system women's worth is devalued as they are considered perpetual "minors" who are supposed not to do anything for themselves. This paternalistic approach marginalizes women as individuals (Tsvere in Mahaka 2001:33). This view conferred on women negatively affects their self-concept and quality of life. A Zimbabwean woman is governed in most aspects of her life by customary law, under which she is regarded as a perpetual minor subservient to her father's authority until she marries and put under her husband's authority thereafter (Reid 1995:58). A Zimbabwean woman will thus at any point of her life be under the custody of a male authority to whom she is subordinated. As a "perpetual minor", the woman lacks negotiation and decision making skills to control among other things her sexuality hence she cannot demand the enjoyment of good reproductive health. The social environment in Zimbabwe is one, which degrades and devalues the women's social worth making them unable to seek and enjoy good health.

Under the tag of perpetual minors, women cannot introduce anything new in their sexual lives for fear of being branded unwomanlike. Zimbabwean women on the other hand have deeply conceptualised this tag of perpetual minors to such an extent that they consider themselves "second rate" citizens (Furlong 2003; Taylor 2003:2) who

should look up to the men for guidance and help. As a result of this discourse of perpetual minors, millions of women in the world and Zimbabwe in particular today do not have the right and means to decide when or whether to become pregnant (UNICEF 2001). It therefore follows that a woman's use of or intention to use condoms and other contraceptives would require the approval of her husband. The AIDS Health Promotion Exchange (1992) notes that the women's lack of autonomy to determine the circumstances of their living, in particular the circumstances under which they have intercourse, place them in grave danger of infection. The reason why women in Zimbabwe and other parts of the world go to extra lengths in maintaining the low status, which endangers them, is highlighted in the functionalist perspective developed and advanced by Durkheim, Parsons and others. They argue that women functionally have to perform tasks, roles and duties as contained in the socio-cultural scripts that define acceptable women behaviour, thus are controlled by the strength of their expressive social roles to others, especially the family and the peers. This is especially true for most of Zimbabweans because a Shona or Ndebele marriage is not only a union between the two partners concerned, but also one between the two families involved in the marriage (Gombe 1995, Bozongwana 1983). Many Zimbabwean women have thus been socialised and internalised the teaching that they are "minors" who should be led by their husbands in all respects of their lives and that they should not "**shame**" their families (kunyadzisa mhuri) by demanding that they lead, lest they will be sent back to their homes of origins – a very disgraceful experience from the women's cultural point of view.

It is crystal clear from the above views that women are coerced into patriarchal rules and that they cannot themselves champion their need for good health. Even if they are confronted by situations that expose them to ill health, contracting of HIV/AIDS included, they cannot question their husband's authority as it is deemed uncultural and uncouth. This is because of very strong social bonds and roles they would have internalised that demand them not to "shame" their families which thus hold them back. The teaching of perpetual minors is heavily entrenched in male partners to such an extent that they have difficulty in acknowledging female individuals as equal sexual beings. They instead view female sexuality as something that must be controlled and restrained. This view constrains the females from reaching out for safe reproductive health.

This discourse of perpetual minors is amazingly deep-rooted among the Zimbabwean women to such an extent that when one's husband is not around, the wife cannot make binding decisions regarding the home, she has to consult one of the husband's relatives who is around. The home (musha) is regarded as belonging to the man, this includes everything in it, the children and the wife. This low traditional or social status in society cuts across all social issues making it difficult for women to demand safe sex or abstinence (National HIV/AIDS Strategies Framework 2000–2004).

While it is a truism that to any Shona man, his wife is precious as she is the one who gives him social status (Gelfand 1981:19), it is equally a truism that she is valued in her capacity as an "owned helper" while she is not given the leverage to determine important issues in her life, the attainment of good health included. Zimbabwean men

have maintained a stronghold over their women who seem to have accepted their secondary social status to men. The women's low status and lack of independent decision-making in many respects result in women having difficulty in seeking early treatment in cases of sexually transmitted infections as they are minors. The Ministry of Health and Child Welfare (2000:67) concurs that "women might not have decision-making powers to seek medical help without consulting the significant others". Women's low status in many cases forces them to even accept the infidelities of their partners as they are not equals in marriage (National HIV/AIDS Strategies 2000-2004; World Development Report 2002). The above point is also emphasized by Gomez and Meachan (2002:2) who note that women are especially vulnerable to HIV infection because of their subordinate position and status as "second or third class citizens." The discourse of perpetual minors thus makes women unable to own and control their own sexuality. Mangazira (2004) concurs that because women have internalised the notion of perpetual minors, they cannot manage their relationship and negotiate for safe sex. The inability of women in Zimbabwe to own and control their own sexuality makes them susceptible to HIV/AIDS.

3.6.2 Discourse of Marriage as the Norm

Marriage in most of Zimbabwe's ethnic groups is held in high esteem and is generally revered. It is a union in which important heterosexual intercourse is upheld. Finterbusch (1999:136) maintains that "marriage in Zimbabwe is the socially accepted or sanctioned way of engaging in heterosexual unprotected sex for purposes of procreation." Mbiti (1980:133) concurs and notes that for African people "…marriage is the focus of existence. It is the point where all the members of a given community meet: the departed, the living and those yet to be born. All the dimensions of time

meet here and the whole drama of history is repeated, renewed and revitalised". Marriage from an African perspective and a Zimbabwean scenario in particular is a drama in which everyone becomes an actor or an actress and not just a spectator. Therefore marriage is a duty, a requirement from corporate society, and a rhythm of life in which everyone must participate. Mbiti (1980:133) further notes that we must observe that marriage and procreation in African societies are a unity: without procreation marriage is incomplete. This is a unity, which attempts to recapture, at least in part, the lost gift of immortality. It means therefore that the use of reproductive devices such as condoms in a marriage set up contravenes the African quest for fertility, which is highly reverenced. The traditional Zimbabwean culture can be best described as pronatalistic. Marriage is the accepted norm and couples are expected to have children (Tsvere in Mahaka 2001:33). Weinreich (1982:34) says of the Zimbabwe marriage that "…every person has a moral obligation to marry and to continue the social reproduction of the kinship. The most basic value, to beget or bear children, is instilled in all members of the society from early childhood onwards. Nobody is allowed to shirk this duty and social pressure ensures compliance."

The above view is further highlighted by Mahaka (2001:63) who maintains that "marriage is a socio-culturally constructed institution that has value not necessarily linked to love and devotion." Giving birth to children is considered a religious obligation by means of which the individual contributes the seeds of life towards man's struggle against the loss of original immortality. It is believed that the living-dead are reincarnated in part, so that aspects of their personalities or physical characteristics are re-born in their descendants. Failure to get married and bear children means that

the person has rejected society and society in turn rejects him or her. Such a person who does not participate in marriage and procreation is a curse to the community, a rebel and law-breaker; s/he is not only abnormal but under-human (Mbiti 1980:133). Cultural prescriptions of marriage pressurise women to do everything in their powers to marry in order to escape the societal rebuke of being a spinster. Part of the means employed to marry by women in set ups include engaging in premarital sex with the hope of falling pregnant so that they can elope to the person responsible. Mahaka (2001) concurs that many girls fear getting "too old" for marriage. As a result they will do all they can to get married and in the process exposing themselves to the risk of HIV/AIDS. The need to get married and bear children is further heightened by the African prescription that one could die in peace after seeing one's grandchildren. Women are therefore in part driven by the need to ensure that the lineage name is not lost, hence the drive to be pronatalistic. The issue of having descendants is very central to the survival of the African race as a person who does not have descendants in effect quenches the fire of life, and becomes forever dead since his line of physical continuation is blocked if s/he does not get married and bear children. This is a sacred understanding and obligation, which must neither be abused nor despised (Mbiti 1980:133).

The above way of looking at life is also contained in the Gender Schema theory by Bem (in Lindsey and Beach (2002:123). Bem contends that a child learns cultural definitions of gender, which we will term socialisation. Once these are learnt, they form the core around which all the other information is organised and they tell the children what they can and cannot do according to their gender. Lindsey and Beach

(2002:123) note that “the influence of gender socialisation may help explain why it is difficult to dislodge gender stereotypical thinking”. Once a child learns the necessary norms and values that define his or her behaviour in a given set-up the child will keep and honour the expectations as per the cultural prescriptions. Culturally, traditional African society encourages early marriages. This results in women exposing themselves to HIV/AIDS in a bid to fulfil the cultural expectations to marry early. Mays and Cochran (in Berer and Ray 1993:208) maintain that in their quest for marriage “…women may not consider their own personal risk to be high for several reasons. The key to their response to AIDS is their perception of its danger relative to the hierarchy of other risks present in their lives.” The drive to marry may be a superceding need that demands to be addressed first before one can contemplate the issue of personal health and safety. The concept of marriage is deeply entrenched among women in Zimbabwe to such an extent that they view it as unavoidable if they are to enter adulthood with their personal worth intact.

The AIDS Health Promotion Exchange (1992) observes that most of Sub-Saharan Africa is patriarchal and marriage occupies a central role in the prosperity of the lineage. Under this set-up women are expected to associate sex with fertility, thus exposing women to unsafe practices in a bid to meet societal expectations. Fertility is considered “…the life blood of its society. It is life itself (rupenyu) and therefore gives simba (strength) to each local group” (Weinreich 1982:104). In most of Zimbabwe’s ethnicities, before a woman can demand respect, she has to bear children. A woman cannot remain single without losing her self-respect. Society expects women to reproduce up to menopause. Reproduction entails unprotected sex, thus exposing

women to HIV/AIDS. It is a social duty that they cannot shirk away. To further qualify the importance of unprotected sexual intercourse in the quest to have children Mbiti (1980:110) observes that children are the buds of society, and every birth is the arrival of 'spring' when life shoots out and the community thrives.

Women in Zimbabwe have been further endangered by the cultural demand of lobola (roora) payment at marriage. As Zimbabwean women are "paid for," they feel duty bound to please their men at all costs even in ways they endanger themselves. Chung and Ngara (1985: 76) maintain that "the institution of roora, which symbolized the relationship that is established when two families are brought together by marriage, was adulterated, while the subordination of women to men was made to appear justified as the latter "paid" for his wife in both cash and kind." Weiss (1986: 104) concurs that "the system of the bride price is deeply enmeshed in traditional society. Some felt it gave their husbands the right of permanent ownership over them". Roora payment in a marked way disempowers women as it instils and inculcates a feeling of being "owned" in women. This feeling holds women back from seeking safe and adequate sexual health. Mahaka (2001) highlights that the males are supposed to own their wives' bodies, because they paid lobola (roora).

In other words a husband has the wife as his asset when it comes to sexual satisfaction. The implication drawn from the above situation is that women may not necessarily be able to establish safe sexual practices as the powers to do so are vested with their "owners", the men. Dube 1997:50) maintains that "marriage establishes a husband's exclusive right to his wife's vagina". The same cannot be

said of the man, as culture does not bind him down to his wife only, the reason why he brings her the HIV. The exclusive right would imply that the woman cannot say no to sex even in situations that expose her to ill health. Mutenga (2001:86) concurs that " in Zimbabwe, the situation is aggravated by the fact that culturally a woman would be regarded as having not been brought up well if she refused sex to her husband. Culture thus helps in Zimbabwe to make many women prisoners in their own households". Masasire (1996:44) analyses the exclusive rights available to man upon marriage and classifies those rights into uxorem and rights in genetricem. The author maintains that "the rights over a woman which are transferred to her husband and his kinsman include rights in her both as a wife (rights in uxorem) and as a mother (rights in genetricem). Into the first category fall rights of sexual access and to her labour both domestic and in the fields" (Masasire 1996: 44). Gomez and Meachan (1998:30) conclude that "many women have so internalised the idea of the man as provider, head of household and owner of their bodies as a result of bride price." This conviction and view constrains the women to adopt safe sexual practices against HIV/AIDS and inhibits change in all cultural patterns. To fold this discussion, Mbiti (1980:134) says of the marriage institution that "to die without getting married and without children is to be completely cut off from the human society, to become disconnected, to become an outcast and to lose all links with mankind".

3.6.3 The Discourse of Romantic Love

Women get exposed to HIV/AIDS because of their quest and search for romantic love which remains a powerful icon for most women. In their pursuit of love women do not consider their personal well being. Gomez and Meachan (1998:5) concede that the quest for romantic love "…paralyses and lulls women from engaging in safe sexual

acts as love and trust substitute for the very meaning of prevention". The discourse of love represses questions of fidelity that threaten the basis of relations with women expressing feelings of hopelessness such as "I love him, what can I do?' (Hoosen and Collins 2004). Feelings of trust and love paralyse women from perceiving the real risk and taking preventive measures, as well as seeking validating and demanding safer sexual relations. Willing (1999) points out that high level of trust in a relationship removes the need for precautionary measure (trust as security). This discourse exposes women to the dangers of HIV/AIDS. The notion of love and trust makes the women adopt the denial of risk syndrome with a lot of them insisting that "It can't happen to me" (Gomez and Meachan 1998:5).

Worth (in Zeidenstein and Moore 1996:119) concurs that "for some women, sexual behaviour is not necessarily driven by a need for sexual fulfilment, but rather by the need to be "loved" by a man in order to feel whole. To attract romantic love, women suppress their own sexual needs; they take sexual risks that work against their own health, against their physical survival". The search for romantic love continues to hold women back from seeking fulfilling sexual gratification endangering themselves in the process of their pursuit to be loved. The quest for romantic love is explained best by the Connection-based theory of women's development, the Self in relation theory as advanced by Miller (1986:62). According to this theory, an offshoot middle-range theory of functionalism, women's sense of personhood is grounded in the motivation to make and enhance relationships to others. Women thus from a functional perspective regard their role as necessary and functional to the well being of society. This encompasses the denial of their own needs to serve others, first men and later

children (Miller 1986:62). From a relational perspective, the great threat for women is the fear of loss stemming from a disconnection caused by conflict. As a result the women's real fear of loss is likely to undermine their intentions and attempts to reduce sexual risk.

From a relationship point of view in Zimbabwe, women have to live to please men; they have been conditioned to prevent men from feeling uncomfortable. This, women achieve in many ways that include having unprotected sexual intercourse with their male partners even in situations they themselves consider risky and dangerous. Schoepf (in Brummelhuis and Herdt 2003:29) notes that "…considered normal and natural heterosexual penetrative sex with ejaculation is invested with cosmological significance, strongly valued by many as the essence of life crucial to health, beauty and survival of an individual". These views imprison women to want to satisfy their men and keep them for and by themselves even at the expense of their own health.

According to Miller (1986:344) "… eventually, for many women the threat of disruption of connection is perceived not just as a loss of relationship, but as something close to total loss of self". The above point is further highlighted by Holland et al (in Mahaka 2001: 189) who note that "others see sex primarily as what you do to keep your boyfriend happy or more negatively what you do to keep him". The above notion means that for a greater number of women they will indulge in unsafe sex even when aware of the risk they expose themselves with the faint hope that if they deny their men the "skin to skin" intercourse someone will do that on their behalf. While some women may have some power to identify and resist the dangers posed by the sexual

encounters they find themselves in, it has been noted that they do not want to resist when love, romance and the fear of losing one's sexual partner are critical issues.

Holland et al (in Mahaka 2001:191) concur that "contradictions arise in sexual encounters because women are pulled in different directions by conflicting social pressure. Passion, romance, trust and what you should be prepared to do if you really love a man are inconsistent with mistrust of strangers, social subordination to men, fear of unprotected sex, the use of physical force and concern for reputation". Thus in a bid to demonstrate their love and trust for their men, women tend to engage in unprotected sex that disposes them to the dangers of contracting HIV/AIDS. Women view unprotected sex as signifying the seriousness of a relationship and a lasting attachment.

3.6.4 The Discourse of Male Power

Zimbabwean society is largely patriarchal hence power is vested in the males. To the majority of men, women should stay in servitude and honour the men who they believe are more powerful. Ogundipe-Leslie (1994:209) captures the feeling among African men and notes that "African men seem to be riled by the idea of equality between men and women. They are not opposed to equal opportunity, equal pay for equal work or equal education but with equality between men and women they are uncomfortable. They say how can men and women be equal? Many love the story of the five unequal fingers of the hand. They think that men and women are not equal essentially". Ankrah (2001) concurs and observes that because power is vested in males, women cannot enjoy and control their sexual lives and cannot say no to men.

It is this tyranny of gender roles in which power is vested in males, which hampers women from enjoying good health. Because men are thought to be more powerful than women, women get panic stricken and cannot demand safe sex and this extends to condom use.

Hoosen and Collins (2004) in a study of Black women in South Africa found that men are positioned as being more intelligent and superior than women, they are regarded as the “heads” of the women and as a result this makes the women respect and accept men’s decision even at the detriment of their health. Gomez and Meachan (1998:7) concur that many women have internalised the idea of man as the provider, head of household and owner of their bodies. This notion disempowers the women to adopt safe sexual practices against HIV/AIDS. Gender roles have been found to exert influence on the adoption of safe sexual behaviour among men and women. Ogundipe-Leslie (1994:209) observes that “most African men are held back by their gender roles such as a husband behaves this way towards a wife. Even in intimate relationships, there are certain things a husband does and certain things a woman does.” This notion refers to the instrumental/expressive task role differentiation in functionalism. It posits roles as complementary, or co-operative, and roles are based on the ground of consensus. This thinking could also be regarded as imprisoning a woman within domestic injustice, which prevents her from staying healthy just for the sake of having order and stability in the relationship.

Many Zimbabwean women are held back by the biblical teaching by the disciple Paul as he urges women to submit themselves to their husband as they are the heads, as

Christ is the head of the church (1 Peter 4). As a result of this, women position themselves as inferior to their men and this even extends into their sexual life. Tsvere (2001) maintains that among the majority of Zimbabwean societies, the traditional concepts of a woman are basically patricide and as a result the women and their daughters are subjected to male authority. Women's own decision-making has been subordinated to men.

According to the Ministry of Health and Child Welfare (2000), the submissive role of women disempowers and makes women unable to question issues pertaining to their health and sexuality. The inability to question pertinent issues regarding their health makes women susceptible to HIV/AIDS and STIs. Evidence of the effect of gender roles and power in sexual behaviour and risk reduction has been highlighted by Amano (1997) in a study of Latina women who were asked to discuss the barriers to HIV risk reduction. Almost 75% of the women cited the issue of power and gender roles as a central barrier to risk reduction. Women talked about the discourse of male power in many ways; for example, they referred to men's stubbornness and unwillingness to use condoms and expressed feelings of powerlessness, low self esteem, isolation, lack of voice and inability to affect risk reduction. Miller (1986:6) concurs that, "the central premise of the gender specific approach to prevention is that risk among all women and especially among poor and uneducated women, must be viewed in relation to the broader social context of women's permanent inequality in status and power." Women's permanent inequality has a powerful and pervasive impact on their life experiences including the nature of male-female relationships. One of the consequences of such permanent inequality is that subordinates are

"...described in terms of, and encouraged to develop, personal sociological characteristics that are pleasing to the dominant group. These characteristics form a familiar cluster; submissiveness, passivity, docility, dependency, lack of initiative, inability to act, to decide, to think" (Miller 1986:7). These characteristics that are encouraged to develop will in the long term become so internalised that they will become part of the women. The resultant effect will be that women will be exposed to ill health including STIs and HIV/AIDS, as they cannot demand safe sex.

The effect of the discourse of male power has further been highlighted by Chen, Amor and Segal (1991:9) who note that "the unequal status of women puts them at severe disadvantage in negotiating sexual encounters and in seeking and utilizing educational and health services." The task of negotiating for safer sex for women requires them to act in conflict with their traditional socialization as unequal and subordinates to men who are assumed to be powerful, a complex matter that they would rather let go for the sake of their status in society even when faced with HIV/AIDS difficulty. This is so, because for many women, they believe a person's self grows out of a person's interaction with others and sensitivity to the thought of others' responsiveness to their attitudes, values and judgements is the hallmark of a mature person (Cooley in Coser 1971:309). Thus, the imbalance of power in sexual negotiations coupled with social pressure on women to guard their reputation as females reduce the amount of control they have over their sexuality and practice of safer sex, thereby exposing themselves to the dangers of HIV/AIDS.

3.6.5 The Discourse of Violence.

Violence against women has been found to paralyse women against taking health steps towards good reproductive health. Mapimhidze (2006: 7) notes that "…at least one in four women in Zimbabwe was subject to some form of domestic violence but the figure could be higher at the moment". The extent of the problem is deep and its consequences have been found to be dire. According to Zeidenstein and Moore (1996:38) "gender based violence and underlying sexual repression are the primary obstacles to reaching satisfactory levels of sexual and reproductive health among women." Ankrah (2001) concurs that being afraid of a violent reaction or abandonment women cannot force or sometimes ask their male partners to use condoms so that they are protected. HIV/AIDS and direct violence against women have been found to be intimately linked. In sexual encounters characterised by coercion and violence, negotiation is not an issue. Farmer et al (1996:51) note that "male violence, whether threatened or actualised, is also all too commonly used to control women throughout their lives and increase their vulnerability to infection. In many cases, such violence is legally as well as socially sanctioned." The above issue is reiterated by Miller (1986) and Freire (1990) who have both argued that violence and the threat of violence are tools used by socially defined dominant groups to control socially subservient groups. Various studies have bolstered the view that male violence or the threat of it inhibits females from reaching out for reproductive health.

The work of Gomez and Marin (1993) suggests that fear of a partner's anger in response to request to use condoms has been cited by a significant group of Latina women as the reason why they don't raise the issue of condom use with their

partners. A study by Holland et al (in Bethel 1995) notes that informants indicated a wide range of pressures in operation and reported quite frequently being coerced by men whose objective is penetrative sex. The informants reported stresses that ranged on a continuum from wild persuasion to give way sexually, or to accept unprotected sex through varying degrees of force, assault and rape. The Ministry of Health and Child Welfare (2000) cites the Zimbabwe Women's Resource Centre survey that notes that domestic violence cases in Zimbabwe have accounted for more than 60% of all murder cases that go through the Zimbabwean courts. The magnitude of the problem in Zimbabwe is worrying and a cause of concern. A study by Word and Jenkes (in Coombe 2000) has noted that violent and coercive male behaviour combined with young women's limited understanding of their bodies and of the mechanisms of sexual intercourse directly affect the capacity of women to protect themselves. Yet still another study by Richter (1996) among urban black youths in South Africa found out that adolescent women felt unable to refuse sex or to discuss safe sex including contraception or condom use for fear of violence. Thus it has been established that fear of violence handicaps women from demanding safe and satisfactory sex.

3.6.6 The Discourse of Religion

Africans are known to be notoriously religious and each people has its own religious system with a set of beliefs and practices (Mbiti 1980:1). Religion is the strongest element in traditional background and exerts probably the greatest influence upon the thinking and living of the people concerned. Religion has been known to be a significant source of social cohesion (Lindsey and Beach 2000:433). It has however

also been used to subjugate women and in the process expose them to the deadly HIV/AIDS disease. Zimbabwe is a multi-religious society with Christianity, African Traditional Religion and Islam as the chief religions practised in this Southern African country. These religions expose the women to the deadly HIV/AIDS disease through the "teachings" and "misteachings" that are rife in their religious set-ups. From the Christian perspective, the woman is presented as a helper; one taken out of man's rib bones as contained in the Biblical book of Genesis 2, verse 23 that has Adam, the first person created as saying: "this is the bone of my bones and flesh of my flesh. This one will be called woman, because from man this one was taken". This verse is often used to argue that women are not equals with men since they were taken out of man's own bone and in a way owe their existence to man. This verse is often misinterpreted to mean that women and men are essentially unequal in everything and as a result a woman has to take man's word as law.

The Biblical verses 1 Corinthians 11 verse 3, 2 Corinthians11 verse 6, Titus 2 verse 4 and 1 Peter 3 verse 1 all emphasize that women must submit and subject themselves to their husbands, learn in silence as the husband is the head of the woman as Christ is the head of man and in turn God is the head of Christ. The extensive institutional fabric of Christianity in a way emphasizes androcentrism in which the common images are of women who are subordinate to men and that a woman's functional domestic roles define her.

From the Biblical book of 1 Corinthians 7 verse 4 comes the verse that has often been used to subjugate women. According to this verse "the wife does not exercise

authority over her own body, but her husband does". The above verse has been taken to mean that a woman cannot question anything even when threatened with ill health but should be content and give herself fully to her man as she belongs to him.

Closely attached to the above issue is the controversial issue of whether a woman can refuse to have sex with her husband as given by the Islamic religion (Arrows for Change 1999, Volume 5 Number 3). The issue is addressed by quoting the book of Sarah AL- Baqarah, verse 223, that notes that "your women are a field for you (to cultivate) so go to your field whenever you want to". The above verses as given out have been used to advance the argument that women cannot deny their men sex as they are essentially owned by them and they should ready themselves as and when need arises.

Certain religious groups have been known to resist the use of contraception and condoms which may heighten the risk of HIV/AIDS. Tsvere (2000:70) notes that "the Catholic church has been the vanguard of resistance to all forms of contraception except abstinence and the rhythm method. They condemn the use of condoms." These and other multifarious teachings expose women to the wrath of HIV/AIDS. It should be noted that from an African perspective to be human is to belong to the whole community, and to do so involves participating in the beliefs, ceremonies, rituals and festivals of that community. Mbiti (1980:2) observes that "a person cannot detach himself from the religion of his group, for to do so is to be severed from his roots, his foundation, his context of security, his kinships and the entire group of those who make him aware of his own existence. " For an African woman to belong to a religious

group is the rallying point in their existence. To be without a religion amounts to a self-excommunication from the entire life of society (Mbiti 1980:2). It should be acknowledged that through religion society maintains a tight grip on the behaviour of its people as the behaviour of the individual is understood only in terms of the behaviour of the whole social group of which s/he is a member. The above reflects the contribution of parts to the whole of the system (functionalism).

3.6.7 Notions/Beliefs about sexuality.

Female notions about sexuality which are regarded as functional for the well being of traditional society as a result of socialisation expose the women to risky sexual behaviour because women internalise the belief that they are inferior beings with no free will. The National Research Council (1996:3) observes that "the societal contexts within which people are born and raised, initiated into sexuality and lead their lives strongly affect their perceptions of sexual behaviour". As a result females born in sexually restrictive environments like the majority of Zimbabwean culture today, hold the view that sex is something done to them and they do not have control over how it's done. The Southern Africa Training (SAT) Programme (2001:5) concurs that "prevailing norms of femininity encourage women to be innocent and compliant when it comes to sex. This prevents women from acquiring the necessary knowledge and assertiveness to protect themselves from HIV infection". The above view is also maintained by United Nations Development Programme (2001) which notes that the ability of young women to protect themselves is a direct function of the perception that women hold as regards sexuality. In settings where sex is viewed as something women cannot dictate or initiate, it follows that women do not have control over the

sexual process and their sexuality hence cannot guarantee their own safety and health.

Balmer, Gikundi, Kanyotu and Waithaka (1997) cite a Kenyan study in which young women felt that they did not have control over their sexuality as they viewed sex as something that happened to them and not something they could initiate or actively participate in. The traditional values and ethos females bring to life make them feel lesser human citizens and allow men to take the reigns and determine in absolute terms what should be done in a sexual encounter and how it should be done. In a study of young women the UNDP (2002) has found that most, if not all cultures, raise girls differently from boys and treat women differently from men. As a result, women bring to daily life different qualities than men that place them at risk of infection. Women tend to be guardians of compassion rather than harming, of compassion rather than ambition, of connectedness rather than control, of healing rather than harming, of closeness rather than conquest and of mercy rather than judgement (UNDP 2002). These qualities that have been set as the standard norm for being a woman prevent women from championing safe sexual behaviour, as they may fear the label or tag of the “unwoman-like behaviour”.

The notions of female sexuality in most Zimbabwean cultures emphasize the need for women to satisfy their husbands and to bear children. In vain attempts to keep their husbands and satisfy them, women will tend not to negotiate for safe sexual practice with their partners even if they know or suspect them of having multiple sexual partners lest they drive them away. Schoepf (in Brummelhuis and Herdt 2003: 36)

observes that “women’s sexual pleasure was cultivated along the duty of wives to please husbands and to produce descendants”. This notion entraps women not to value and consider their own health and inhibits them from initiating safe sexual practices that is fundamental to enjoying good health.

For most Zimbabwean cultures, being a woman is a virtue that is cultivated and based on such qualities as being non-assertive and ignorant of sexual matters. Paiva (in Brummelhuis and Herdt 1995:19) concurs that “being a woman is to be fragile, less aggressive and to be able to control one’s sexual desire, to be ignorant about sex, to be ready for sex but also naïve and never to take the initiative while men determine the modality and rhythm of sexual intercourse”. Such gender-stereotyped teachings prevent women from health seeking behaviour and exposes them to greater risk of HIV/AIDS, all just for the tag of being a “good” woman.

The above point is also emphasized by Obbo (in Brummelhuis and Herdt 1995:86) who notes that “many women become enslaved by the social construction and demands put on “good” women and always see their sexual identity in relation to the opposite mirror image of the “bad” women. Women and girls in particular decline to seek healthy sexual behaviour to escape being branded “bad women”, “brazen faced”, “promiscuous” and “bad mothers” (Kammerer in Brummelhuis and Herdt 1995). The dominant ideology that divides women into “good” and “bad” means that most women are unable to insist that men wear condoms without risking being thought of and labelled as promiscuous.

3.7 SOCIO-CULTURAL PRACTICES THAT INHIBIT BEHAVIOURAL CHANGE

Cultural attitudes, beliefs and values about sex are of great importance in determining patterns of risky sexual behaviour (Mahaka 2001:62). A number of cultural practices have been found to pose dangers to the health of women thereby exposing them to the ills of HIV/AIDS. These include douching of the vagina to make it tight and dry, nolo yemwizana among the Venda people, Kugadza mapfihwa among the Shona, Kugara nhaka among the majority cultural groups in Zimbabwe, Kuputswa and Kuripira ngozi (appeasing of a vengeful spirit). Tsvere (2001:62) notes that while the practices are still prevalent in Zimbabwe, it is difficult to measure the extent of their prevalence as families keep them as guarded family secrets.

3.7.1 Douching of the Vagina

This is a practice in which Zimbabwean women douche their vaginas to make them tight and dry. It is based on the assumption that men do not like “wet sex” (mamvura-mvura , as it is very unpleasant. Sakala (in McFadden 1998:49) maintains that this practice is performed by the women themselves – the common procedure is insertion of herbs into the vagina or mixing herbs with meal porridge for ingestion. The rationale behind this is to dry the vaginal canal thus making the vaginal environment as dry as possible for the sexual partner to enjoy sex. The practice according to medical professionals exposes the women to HIV because of bruising and tearing due to friction. Other consequences are cancer of the cervix. Women do not do this for themselves, but for men to enjoy sex. Percival and Patel (2003:12) note that douching

of the vagina is based on the “belief that men do not like what is perceived as wet sex, it means that women could lose their partners to other women. It is considered desirable that women have dry vaginas”. To meet the standard and make the grade, women scurry their reproductive organs leaving them dry and at time with marks. As a result of this belief that men dislike wet sex, they are prepared to keep their sexual partners at any cost even at the expense of their own health. Miller (1986:56) concurs and notes that, “since women have had to live to please men, they have been conditioned to prevent men from feeling uncomfortable. Moreover, when women suspect that they have caused men to feel unhappy or angry, they have strong tendency to assume that they themselves are wrong”.

The Ministry of Health and Child Welfare (2000:79) observed that, women practise such acts as douching of the vaginas because, “sexual pleasure is perceived to be under the control of the male counterparts and women are not supposed to express enjoyment. It is believed that sex is centred on the pleasure and satisfaction of men putting themselves at the risk of carcinoma of the cervix and other infections”. Such cultural practices affect the women’s ability to negotiate for satisfying sexual health and instead subject the women to morbidity. Nath (2001:26) concludes, that “in many parts of Africa, women insert external agents into their vaginas including scouring powders and stones, to dry their vagina passages because of the belief that increased friction is sexually more satisfying to the males and this keeps men from wandering out”. The practice often leaves a woman bruised during sexual intercourse and exposes her to HIV/AIDS.

As a result of their gender socialisation, women have internalised the belief that dry sex is ideal for men making it an ethic of nobility and duty so much that pain and discomfort emanating from their sexual and reproduction roles are accepted as the very essence of womanhood and as something they should live with to demonstrate beyond reasonable doubt that they have been attested fully into the role of true and mature women.

3.7.2 Nolo yemwizana among the Venda people.

According to Mapimhidze (2006:7) the "nolo yemwizana "is a practice in Zimbabwe where a bride is expected to first be intimate with a bridegroom's father before they consummate their marriage." The practice known as nolo yemwizana among the Venda people is assumed to place the health of the women at risk of getting HIV/AIDS. A lot of women among the Venda people are culturally entrapped in this practice that exposes them to ill health.

3.7.3 Death is Pre-ordained.

Research in many set ups has demonstrated that people view death as preordained and as a result feel that they do not have the powers to "run away" from it. They acknowledge that one day death will visit every human being and no one knows when it will come. Gombe (2000:165) says of the Shona culture that, "Rufu murairo woWedenga" (Death is the Lord's law). When a person acknowledges death as preordained, that person may not have the energy and strength to do a lot to avoid death. The above view is maintained by Mann, Tarantola and Nether (in Bethel 1995:315) who observe that "when a person sees AIDS as inevitable there is little motivation to change behaviour". The view that death will come and that every human

being is mortal is rife among the different cultures of Zimbabwe. Tsvere (2000:72) maintains that for many of Zimbabwe's cultures "the human being is mortal. Human beings have tried to come to terms with this mortality; the cosmic world and the reality beyond death". The thinking that death is preordained enhances risk taking among women because to the majority of women death is inevitable and what causes the death is not important.

3.7.4 Kuputswa /Kuzvarirwa/Ukwendisela

This is a practice that involves marrying off girls to raise money for food in times of famine or indebtedness (Tsvere 2001). This view is also put forward by The Training and Research Centre (2005) that notes that the customs of Kuputswa /kuzvarirwa/ ukwendisela is when parents pledge or give their daughter to an older man for marriage without her choice usually to relieve economic burdens. The practice exposes women to the dangers of HIV/AIDS as they are married off against their will and they also enter into union disadvantaged as they may feel obliged to do everything for the man who would have helped their family in times of need. Doing everything implies even having unprotected sex, which exposes the women to HIV/AIDS.

Closely attached to the above is the idea of Kugadza mapfihwa, a practice where the girl child is given away in marriage to a widower from the family of the widow (Tsvere 2000). Weinreich and Benn (2004:27) concur that such a practice exposes women to the dangers of HIV/AIDS. The extent to which this practice is prevalent is difficult to establish and measure as families keep these as guarded family secrets.

3.7.5 Kugara nhaka/Wife Inheritance/Ritual Sexual Cleaning

In this practice, an uncle or brother of the deceased man inherits the brother's widow (Tsvere 2000). Weinrech and Benn (2004:27) observe that in several areas it is traditional that a man should marry the widow of his deceased brother (wife inheritance). Sakala (in Mc Fadden 1998:49) notes that "often a wife is given a husband against her will. This practice is believed to protect the widow so that she and her children are not destitute upon her husband's death". Apart from exposing the widow to humiliation especially if the man is younger, this practice degrades women's value and injures their self worth.

Closely attached to the above is the practice of ritual sexual cleansing. Sakala (in McFadden 1998:49) notes that "when the husband dies and immediately after burial, the widow is given to another man to have sexual intercourse with her. This man could be an uncle, brother or cousin of the deceased. It is believed that this way the widow will not go around carrying her late husband's ghost". This practice exposes the widow to sexually transmitted diseases including HIV. The Ndebele cultural belief of Iseko is modelled around the custom of sexual cleansing. According to this custom, when a man dies, he leaves bad luck for his widow (Bozongwana 1990:53). Certain herbs have to be used in a sexual cleansing ceremony with a relative of the widow's late husband to avoid the bad luck. Bozongwana (1990:53) observes that the word iseko means three - up to three people will die if the casting away of the bad luck is not done. This cultural practice exposes women to the dangers of HIV/AIDS. If the ritual of sexual cleansing is not performed there is a strong belief that often the widow could be mentally confused or if she marries the new husband he could also die. This

has been used as a weapon to frighten widows by some families (Sakala in McFadden 1998:49). These and various other practices expose women to HIV/AIDS and inhibit them from attaining safe sexual health.

3. 8 CONCLUSION

This chapter has explored women's vulnerability to the HIV/AIDS pandemic. The origin of HIV/AIDS is put into focus and an overview of the HIV/AIDS in the world and Africa at large has been given, as well as the extent to which Zimbabwe has experienced one of the highest levels of HIV infections in the world. The local value systems that allow for a number of practices making Zimbabweans vulnerable to HIV/AIDS are appraised. These include the discourses of perpetual minors, marriage as a norm, romantic love, male power, violence, religion, and notions about sexuality. The socio-cultural practices that inhibit behavioural change refer to douching of vagina, inolo yemwinizana, kuputswa/kuzvarira/ ukwendisela, wife inheritance and ritual sexual cleansing. These various practices are key drivers of the epidemic and are underlying factors for risk practices leading to new infections among Zimbabwean women. Their risky behaviours have been traced in the context of norms and values in the various traditional Zimbabwean settings. These socio-cultural factors and practices prevent Zimbabwean women to change their sexual practices and behaviour in an era of HIV/AIDS.

This chapter lends itself to the next chapter on data gathering.

CHAPTER 4

THE RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter presents and discusses the research methodology employed in this empirical research study. According to Lobit and Hagedorn (1998:9) methodology refers to the techniques utilised to gather data to resolve a problem. In this case, specific techniques utilised to gather data on the socio-cultural factors and practices that impede upon behavioural change of Zimbabwean women with regard to HIV/AIDS are discussed. The important components of the research methodology included in this study are:

- The Research Design
- Selection of Study Areas
- Focus Group Discussions and In-Depth Interviews
- Survey, Sampling
- Validity and Reliability
- Data Analysis

4.2 THE RESEARCH DESIGN

The research methodology used in this empirical study is a triangulation of different related research techniques, which refers to a combination of mainly qualitative and quantitative methods of data collection and analysis. This process involves the

"…mixing of mainly qualitative and quantitative methods of data analysis. The two styles have different complementary strengths and a study that employs both is fuller and comprehensive" The negatives of one method are negated by the positives of the other method (Neuman 2000:125).

Merrian and Simpson (1984:26) describe qualitative data as "…detailed description of solutions, events, people's interactions and observed behaviour, direct quotations from people about their experience, attitudes, beliefs and thoughts". Smith and Debus (1992) concur that qualitative research is the use of in-depth interviewing and observational techniques with target groups to investigate attitudes, beliefs and social contexts associated with human behaviour.

Data in this study was generated through:

(1) A survey using a questionnaire was administered to 1002 adult women respondents in the age range 18 to 59 years to quantify the levels and magnitude of the problem of HIV/AIDS among women.

(2) Six focus group discussions were held with 48 mature women in their areas of ethnic origin to try and understand broadly the main concepts of the study. The focus group discussions consisted of adult women of ages 18 up to 59 years. Participants were asked to fill in information sheets about themselves and to consent to participate in discussions on HIV/AIDS and women. Discussions lasted between 30 minutes and 2 hours. The participants were encouraged to reflect on the way the social and cultural aspects of their living that impede upon behavioural change of women with regard to HIV/AIDS. The discussions

were audiotape recorded and then transcribed. Themes emerging from the focus group discussions were captured.

(3) Fifty (50) in-depth interviews with key informants from the various six ethnic areas of origin were conducted, eight in each ethnic group area to assess the nature of problems that confront and hold back women in their quest to attain good and safe reproductive health.

Data collection for this empirical study lasted from October 2006 until February 2007.

4.3 SELECTION OF STUDY AREAS

Based on the Central Statistical Office's 2002 Census Preliminary Report, both rural and urban areas were purposely chosen for the study. The other condition used in coming up with study areas include National AIDS Council (NAC) 2001, prevalence rates for the different districts and provinces. In Manicaland, Mutasa District experiencing the highest HIV infection rate in the country of 26.7% was the area of study for the Manyika ethnic group. Chinhoyi district represented Mashonaland West Province, as it was the district with the highest prevalence rate among the Zezuru for the period 2001. Beitbridge District represented the ethnic group of Venda speaking component of the population who make up about 2% of the total population. Chiredzi District represented the Karanga ethnic group who constitutes about 20% of the total population, while Hwange District represented the enumeration area from which Ndebele speaking people were sampled for purposes of this study. The Korekore ethnic

group of Mashonaland Central in Mount Darwin was the last ethnic group to be studied whose enumeration areas included Shamva rural and Bindura urban. The chosen study areas are culturally diverse and this made this study essentially interesting. Findings from each study area were compared with those from other areas whose cultural practices were different.

4.4 FOCUS GROUP DISCUSSIONS

Focus Group Discussions (FGDs) among 48 adult women ranging from 18 – 59 years of age were carried out to define concepts, to assess perceptions of risk among women and to identify the factors that dispose women to risky sexual behaviour. The main purpose of the qualitative FGDs was to tap into participants' perceived normative knowledge, attitudes, beliefs and practices that expose women to risky sexual behaviour. These attitudes, feelings and beliefs may be partially independent of a group or its social setting, but are more likely to be revealed in a social gathering and interaction, which the group entails. This measure sought to establish the socio-cultural practices and factors specific to the major ethnic groups that stand in the way of behavioural change among Zimbabwean women. Focus Group Discussions for this particular study will comprise between six participants to as much as ten people. An FGD session lasted for about one hour and was held at such places as schools, clinics, council premises, halls and where people regularly hold their meeting to avoid either negative or positive associations with particular settings among the participants. Gender, age and availability were the important selection criteria for this study. Note taking and tape recording were undertaken simultaneously.

A focus group discussion is an interview context where a small group of informants (6-10) is guided by a researcher to talk freely and spontaneously on the topic for research investigation, HIV/AIDS in this case. The focus group discussion is an interview context run according to an interview schedule with open or closed ended questions where a small group in terms of purpose, size, composition and procedures is investigated (Neuman 1997:274). The author further notes that a focus group discussion can be defined as a carefully planned discussion guided by open and closed ended questions designed to obtain perceptions of a defined area of interest in a permissive, non-threatening environment.

The sessions were held in an atmosphere that was considered relaxed for the interviewees, who were drawn from a target group that shared the same social and cultural ideas, opinion and attitudes. The focus group discussion as a research tool was used to elicit information on attitudes and beliefs as it tapped into human tendencies. Since people are a product of their environment and are influenced by the people around them, it was pertinent that these beliefs and attitudes were recorded from societal representatives.

4.4.1 Advantages of focus group discussions

Focus group discussions which are qualitative offer several advantages. A focus group discussion is a socially oriented research procedure. People are social creatures who interact with others. This interaction was evident in the discussion as

colleagues; friends and peers shared their experiences and knowledge on the issue under debate. Due to the exploratory nature of the study, focus group discussions were found to be useful for research study of this nature in that even the illiterate were able to understand the issues under discussion and to articulate their thoughts well during the discussions. This way, the researcher was able to probe, and participants also were able to quiz one another as they sought clarifications among themselves. This flexibility to explore unanticipated issues is not possible within more structured survey interviews. Focus group discussions have high face validity, with the researcher being able to read facial expressions and gestures. This critical and important perspective made this tool an indispensable part of the research methodology for this specific research study. Smith and Debus (1992:10) concur that a focus group discussion is "...holistic. It provides information and insight into many aspects of a behavioural situation." The technique is easily understood and the results are believable to those using the information. The results are not presented in complicated statistical charts but rather in lay terminology embellished with quotations from focus group participants. Focus group discussions are thus inductive, context – based and narrative (Smith and Debus, 1992). Focus group discussions can provide speedy results and they also allow the researcher to increase the group size without dramatic increases in the time required of the interview. In this way, the researcher found this research tool highly handy and useful in gathering data on socio-cultural factors that impede upon the behaviour of Zimbabwean women in an era of HIV/AIDS.

4.4.2 Disadvantages

All techniques of gathering information have limitations and focus group discussions are no exception. First and foremost, the researcher for this study noted there he had less control in the group interview as compared to the individual interview. During the study, some participants would move in while others moved out thereby disrupting the flow of discussions. Group members would also interact and influence one another which lead to detours of the discussion and the raising of irrelevant issues. However, the thorough training of the researcher helped in keeping the discussion focussed.

Secondly, the technique requires carefully trained interviewers. For this study, the four research assistants recruited were drawn from mature women doing a post graduate study in Sociology at the University of Zimbabwe and were trained for this project for five working days. Thirdly, the researcher noted that the groups vary considerably, with each group displaying unique characteristics. Some groups were lethargic, boring and dull while others were exciting, energetic and invigorating. To combat boredom researchers were encouraged to put life into their work, which raised enthusiasm among the participants. The fourth disadvantage noted is that focus group discussions are difficult to assemble as they require that people take time to come to a designated place at prescribed times to share their experiences and perceptions with others. However, the liaison that took place through the chiefs and village heads made the attendance really reasonable and within the researcher's expectations. With these identified disadvantages, it was prudent that the researcher plans well ahead and lays the anticipated groundwork to ensure the smooth flow of

events during the holding of the focus group discussion sessions to discuss the different factors and practices that disempower women to change their sexual behaviour to avoid contracting HIV/AIDS.

4.5 THE SURVEY

Survey research involves using self-administered questionnaires, personal interviews or telephone interviews to collect data about a topic of interest to the researcher (Lindsey and Beach 2000:44). McNeill (1990:19) notes that the term survey is "…a method of obtaining large amounts of data, usually in a statistical form, from a large number of people in a relatively short time. It may be descriptive or exploratory or a combination of both".

In this study a survey questionnaire with both closed and open questions was used to gather data on specific socio-cultural factors and practices that prevent women from attaining safe sexual behaviour in an era of HIV/AIDS and on why the safe sexual messages have not yielded the necessary behaviour change. The administration of the survey questionnaire was done from October 2006 to January 2007. Adult women within the age range 18 up to 59 years were identified as the respondents in the study. To come up with the minimum age cut point, the median age at first marriage for women was used and this was found to be 18 years (C S O, 1995). The maximum age limit for the person included in the study was 59 years because older persons in Zimbabwe are classified as old and aged from the age of 60. The questionnaire, as highlighted earlier used both open and closed questions because of the advantages of each form over the other.

4.5.1 Advantages of Surveys

The researcher settled for this quantitative tool of data gathering for this study because of a number of advantages surveys have which have also been noted by Neuman (1997:51). These include the fact that it was easier and quicker for respondents to answer the respective questions and for the enumerator to enter the information on the questionnaire. As advanced by Leedy (1991), the researcher found the survey not restrictive to the respondents in this study, as respondents explored and broadened their spectrum of understanding in applying the use of their senses to questions given. It was noted that the use of this method gave the researcher the freedom to use a wide range of description tools and could summarise answers to questions in percentages, tables or graphs (Neuman 1997:51). Lindsay and Beach (2000:44) concur that survey research typically provides data useful for quantitative analysis – analysis that is readily translated into numbers. Furthermore, the researcher noted and realised that the response choices on the questionnaire acted as a guide to clarify questions' meaning for respondents and more likely gave leads to the respondents to answer meaningfully, even issues on sensitive topics. More importantly, it was found that there were fewer irrelevant and confusing answers to questions and even less articulate and literate respondents, it was discovered, were not at a disadvantage. Furthermore the answers were found to be easy to code and statistically analyse. Replication, it was discovered and hoped, would be easier for subsequent studies when other ethnic groups are also investigated in future.

Good (1963) notes that a survey helps to secure evidence concerning the existing situation or current situation, leads to the identification of standards or norms with which to compare the present situation or condition in order to plan for the next. Lindsey and Beach (2000:44) observe that survey data can reveal what people think about almost everything. The author further note that surveys can be used to test hypotheses. A survey was employed for this study to test such hypotheses as: Women in Zimbabwe are held back by different socio-cultural factors and practices defined in their ethnic set-up to demand and enjoy safe reproductive health, women who reside in urban centres are more informed on the deadliness of the AIDS pandemic and have a better leverage to determine circumstances under which they have sexual intercourse and women in employment have control over their own sexuality unlike those not gainfully employed. Bradshaw, Healey and Smith (2001:111) further observe that surveys are extremely useful techniques for gathering large volumes of information from large numbers of people. This was found ideal for this study as a lot of information on the different ethnic groups' perception of women sexuality and factors and practices that expose women to the dangers of HIV/AIDS was sought. Because of the above identified strengths surveys were found to be useful tools for a study of this nature.

4.5.2 Disadvantages of Surveys

Despite highlighted positions, surveys do have shortcomings as well. According to Neuman (1997:51), a questionnaire can suggest ideas that the respondent would not have otherwise thought about and as a result, respondents with no knowledge can answer anyway. To overcome the above obstacle pretesting the questionnaire in a

pilot study was done to establish the suitability of the questionnaire options. Where precoded responses are given, this may frustrate respondents when their answer does not appear on the list. In this study, the option “Other” would be given to cater for that situation. Where multiple responses to a question are expected, the open-ended questionnaire is more appropriate. Bradshaw, Healey and Smith (2001:111) also observe that, surveys tell us only what people say is true, which may be different from what is actually true. However to get over that problem, samples used in this study were designed to be representative of the populations to ensure and permit inference.

4.6 PRE-TESTING THE QUESTIONNAIRE

This is a systematic process for testing target audience reactions to specific messages, vocabulary, visual sequences and materials before they are produced in final form (Smith and Debus 1992). The research assistants for this study were trained for five working days. The training covered the purpose of study, going through each and every question for verification and clarity and pretesting the questionnaire. This is to ensure that the particulars being tracked are the real issues the respondents would give answers to. Pretesting was done in Bindura and Zvishavane rural. Pretesting, it was discovered, would improve the data collection tools, sequencing of questions, phrasing of questions and the general flow of the interview schedule.

4.7 IN-DEPTH INTERVIEWS

Fifty in-depth interviews randomly chosen were conducted from October 2006 to January 2007. The interviews were done with female key informants **purposively chosen** of ages 18 up to 59 years who are people of social standing and repute in society such as councillors, teachers and nurses. A total of 50 in-depth interviews were conducted.

4.8 SAMPLING

Sampling is a process of systematically selecting cases or respondents for inclusion in a research study (Neuman 1997:201). In this case, 1002 respondents have been **randomly** selected for the questionnaire, 50 key informants for the in-depth interviews while 48 cases were selected for the focus group discussions as these are the methods employed in this study.

4.8.1 Population

Pilot and Hungler (1987:32) define population as the entire set of individuals or objects having a common character and to whom research study will be applicable. In this social research study, the population is also referred to as the "universe" to which answers to questions can be generalised in this case to women in the age range 18-59 years of age. Thus the target population for this study is women of the reproductive age group from 18 to 59 years in different ethnicities.

4.8.2 Sample

Monelle et al (1990:15) state that a sample is drawn from a target population and is representative when it actually represents the distribution of relevant variables in the target population. Zimbabwe's ethnicities number about nine, but for this study only the six major ethnicities were investigated. The identified enumeration areas have been systematically chosen based on the HIV prevalence rates for 2001 for the different ethnic and cultural groups. The sample size was selected based on 95% level of the confidence and a level of significance of 0.1. On the basis of the above; a sample of 1002 respondents for the questionnaire, 50 key informants for the in-depth interviews and 48 respondents for the focus group discussions were drawn from the different ethnic groups.

4.8.3 Sampling Procedure

The researcher used purposive sampling procedure where cases were selected with a specific purpose in mind to draw a representative sample size of 167 respondents for each ethnic group. Respondents from the ethnic groups were randomly selected. This was done until a 1002 sample size for the questionnaire, 50 key informants for the in-depth interviews and 48 respondents for the focus group discussions were drawn.

4.9 VALIDITY AND RELIABILITY OF INSTRUMENTS

4.9.1 Validity of the Instruments

Validity according to Gay (1976) and Leedy (1980) is the degree to which an instrument measures what it is supposed to measure. Validity ultimately is concerned with measuring soundness and the effectiveness of measuring instruments or research techniques. To ensure validity the researcher in this study designed the questionnaire, focus group and interview guides or schedules. These were then given to the researcher's promoter for verification. The suggestions and additions were used to review the instruments to ensure that they would collect the necessary data.

4.9.2 Reliability of Instruments

Nachmias and Nachmias (1981) note that reliability is an indication of the extent to which a measure contains variable errors, that is errors that differ from observation and that vary from time to time for a given unit of analysis measured twice or more by the same instrument. Abrahamson (1981) contends that reliability is the stability or consistency of the information, the extent to which the same information is supplied when a measurement is performed more than once. In order to check for the stability, consistency, accuracy and dependability, the instruments or research techniques, were then pretested in Bindura and Zvishavane rural to establish the extent to which they consistently measured what they are designed to measure. Areas of concern that needed clarity were revised in line with results of the pretest.

4.10 DATA ANALYSIS OF QUESTIONNAIRES

Data analysis of the questionnaires in this study is concerned with reducing masses of quantitative collected data to meaningful information. The questionnaire schedule was coded and a data matrix form created using the SPSS computer package. An analysis framework was then developed using the SPSS package which categorises variables according to their measurements. Variables were then classified according to objectives of the study in order to address the study's objectives. Qualitative data analysis and bivariate analysis (using cross tabulations) were employed.

Underlying the analyses of all data is the overarching functionalist theoretical perspective and related theories which serve as tools of analysis and explanation of findings.

4.11 CONCLUSION

This chapter has looked at and discussed the methodology employed for this empirical study. It has described the research design, which focussed on in-depth interviews with fifty respondents, focus group discussions with forty-eight respondents and questionnaires administered to 1002 respondents. The selection of research areas for the study was stipulated and the advantages and disadvantages of data gathering techniques employed for this study have been explored.

The validity and reliability of the respective research instruments or techniques were discussed to eventually have an empirically sound and justifiable study, which can make a contribution to the prevention of the HIV/AIDS pandemic in Zimbabwe.

Data analysis of gathered data will be discussed in the next chapter of findings of the empirical study.

CHAPTER 5

FINDINGS OF DATA GATHERED

5.1 INTRODUCTION

This chapter presents the empirical findings from the focus group discussions, in-depth interviews and questionnaires as given by respondents. Based on the above data gathering techniques, the research questions and tentative hypotheses held are addressed in an attempt to provide answers to:

i) How do specific socio-cultural factors hinder and disempower women from changing sexual behaviour relating to HIV/AIDS? Are women inherently unable to change their sexual behaviour?

ii) What are the specific socio-cultural practices preventing women from attaining safe sexual behaviour in an era of the menacing HIV/AIDS pandemic?

iii) Why have the "**safe sex messages**" being propagated every time on the country's communication lines (radios, newspapers and televisions) been unable to result in sexual behavioural change of women?

In addressing the above research questions, different aspects have been categorised and put into tables to allow easy access to data to find answers to the research questions. The findings from this study reveal the complex social and

cultural settings that disempower women to demand safe sexual behaviour. The study highlights the social context that underlies women's vulnerability to HIV/AIDS in Zimbabwe which is rooted in a veritable mosaic of cultural patterns and predispositions, norms and values about acceptable male-female standard codes of behaviour and roles enshrined during socialisation in a patriarchal and patrilineal Zimbabwean society. As spelt out in these findings, Barker's (1989:130) observation that, "most women know intuitively what it is to be handicapped by their gender – from trivial everyday disadvantages imposed by sexist assumptions, to life-threatening examples when the diagnosis of disease might be overshadowed" is true. The difficulties women encountered in attaining safe sexual behaviour have been highlighted in several focus group discussions and in-depth interviews with women. The findings will be interpreted according to specific topics in the focus group discussions, questionnaires and in-depth interviews. First the focus group discussion and in-depth interview findings are collated and discussed.

5.2 FOCUS GROUP DISCUSSIONS AND IN-DEPTH INTERVIEWS

Focus group discussions (FGDs) were chosen as a data gathering technique for this research process. The open-ended nature of the FGDs was expected to aid exploration through the interaction of the participants as they debated, engaged in self-reflection and even contradicted each other regarding socio-cultural practices and factors causing HIV/AIDS. (Kruger 1998; Kitzinger and Barbour 1999). In-depth interviews on the hand were done to assess the nature of problems that confront and hold women back in their quest for safe reproductive health. The described nature of

focus group discussions and in-depth interviews made them well subscribed by mature female respondents of all age groups in Zimbabwe. The respondents chosen represented the different age groups and marital statuses satisfying what Lincoln and Gouba (1985) term the maximum variation sampling to ensure the taming of the different dimensional threads to the study issue. As highlighted earlier, the minimum cut-off point was 18 years while the maximum was 59 years. In the urban centres, the oldest female respondent was 55 years living in Makokoba, Bulawayo whilst the oldest respondent in the rural area was 59 years living in Chiredzi district of Masvingo. The youngest respondent at both rural and urban centres was 18 years. The large cross section of respondents was meant to capture all pertinent issues as viewed from the lens of different individuals of different age groups. The majority of the respondents in both rural and urban areas were married. There was a considerable number who were divorced as well as never married. The large diversity of respondents was meant to give the discussion the necessary impetus to bring out the different socio-cultural factors and practices that prevent or hinder women to change their behaviours in an era of HIV/AIDS as perceived by the different respondents of different age and ethnic groups as well as marital statuses.

5.2.1 Focus Group Discussion and In-Depth Interview Findings

The study sought to unravel the social and cultural factors and practices that expose women to HIV/AIDS and inhibit their ability to demand and lead safe sexual and reproductive health. The following themes have been highlighted from the findings of the different ethnic groups.

5.2.2 Marriage

Insert 1. Marriage is a social prescription through which a woman attains completeness and a mature identity. The assumption in most cases is that a woman is only a woman by virtue of being married and producing children. Similarly the woman in this insert has learned the lesson of motherhood as compulsory and a singular avenue to true fulfilment and meaning as a woman.

Marriage (Insert 1) has been cited as a factor that enhances women's vulnerability to HIV/AIDS among Zimbabwean women. Focus group discussions and in-depth interviews among women of all cited ethnicities in Zimbabwe reflected on a dire drive for women to marry in tandem with their social and cultural customs. The value

attached to Mhuri/Imhuli (the family) is near universal among Zimbabwean women. Marriage is viewed as sacred and is treated with respect; it is viewed as the desired destination of most women irrespective of their educational or economic status. Said respondent MaMoyo, “You can have everything, your money and cars, but if you don’t marry, you are viewed as a misfit and a woman of no integrity. No one will treat you with respect. You shame your own parents” (MaMoyo 30, Shamva). It is such social and cultural overtones that in turn push the women to want to marry at all costs to escape the social rebuke that comes with not marrying. This point has been reiterated by Chitauro-Mawema (2003:14) who observes that among Zimbabwean women “…marriage is viewed as a woman’s ultimate goal”. Obbo (1980:8) concurs that “women are constantly reminded that the pride of a proper woman is a husband”. The centrality of the institution of marriage among the Zimbabwean culture across the different ethnicities is further captured by the Bhundu Boys, a musical outfit that set the musical scene ablaze with the hit “Chipo Chiroorwa”, (Chipo it’s time you marry),a song that laments that the daughter has taken too long to marry. The importance of the marriage institution among the Zimbabwean general populace of women has been highlighted further by Sinanzeni (35), a Ndebele who observes that among the Zimbabwean women generally, one is oneself not alive unless one passes on life. The above view is reiterated by Lott (1994:137) who observes that “for most women, marriage continues to be, as it was for our mothers and grandmothers, a social statement that affirms the end of girlhood and assures us of a recognised place in the adult world”.

As a result of this prescription girls in Zimbabwe are pressured into marrying at a young age. Most of them are married to older men who are likely to have had exposure to sexually transmitted diseases and less likely to use a condom. It has been highlighted in focus group discussions and in-depth interviews from women of different ethnicities that in their pursuit of the institution of marriage, women in the process, engage in unprotected sexual intercourse with the view of falling pregnant, a condition they believe can enhance their chances of getting married. According to Sipiwe (24), a Zezuru from Chinhoyi, "Vakadzi vamwe vanosangana nevarume pabonde vasati varoorwa vaine chivimbo chekuti vakaita pamuviri vanozoroorwa", (Women engage in unprotected sexual intercourse with men with the hope of getting pregnant so that they can elope and get married). The above view is in line with views expressed by young men in a study by Chikowore (2000:38) on Gender Power Dynamics in Sexual and Reproductive Health, who observe that "… girls get pregnant deliberately in order to secure a marriage partner. Girls were therefore viewed as calculating agents whose only interest was marriage".

The concept of a family (Mhuri/Imhuli) among the different cultures of Zimbabwe has been noted to command a lot of respect to the extent that women will do anything in their power to get into this institution founded on the back of marriage. Gelfand (1981) has observed that the spiritual and cultural life of the Shona centres around the family, the mhuri and that real love and meaningful joy in life is derived from an individual's family of procreation. Lott (1994:129) concurs that "our patriarchal, heterosexual majority culture continues to tell women that it is through the love of a man that a woman achieves completeness and mature identity".

From the various discussions and interviews, it has been emphasized that marriage in Zimbabwe is a platform that leads one into a family institution that individual women await to get into with anxiety. It has been observed that if a girl does not marry when considered old, the parents get worried to the extent of consulting faith healers and traditional healers. Kambarami (2006) concurs that since marriage is a sacred institution among the Shona, it is society's expectation that every woman should marry. Furthermore parents get really worried when their daughters do not get married to the extent of consulting Sangomas to break the curse as it's believed. Because women are normally sought for in marriage, they cannot exercise their power. Cicely Hamilton (in Mackinnon 1995:9) observes that the relationship of women and men in marriage in a traditional set involves "…the exchange of her person for the means of subsistence" thereby rendering her unable to demand safe sexual intercourse. Marriage is thus a death trap to many Zimbabwean women as they seek the validation of their personhood characteristics of being good family women and as they seek social approval and recognition as advanced by the gender development theory. On the basis of this study it was found that marriage is one of the socio-cultural factors which remain truly a serious goal, exalted by all social institutions in Zimbabwe's traditional patriarchal set-up and desired by Zimbabwean women, which places them at risk of infection of HIV/AIDS. This finding answers research questions 1 and 2 on specific socio-cultural factors and practices that hinder and prevent women from changing sexual behaviour in the face of HIV/AIDS. Closely attached to the institution of marriage are duties and obligations that define acceptable wife behaviour in marriage. These have further domesticated women to the extent that they cannot

demand safe sexual behaviour. From the different ethnic groups in the focus group discussions and in-depth interviews the concept of “kutsiga/Ukuziphatha” has been identified as a weapon that undermines women’s ability to demand safe sexual behaviour as it emphasizes socially acceptable female humility that underpins male-female relations in the home and society at large. “Kutsiga chombo chinoshandiswa kudzvanyirira vakadzi kuti varambe vari pasi pevarume vachiita zvinoda vanhu nyangwe zvichiisa utano hwavo munjodzi” (Kutsiga/Ukuziphatha is a weapon that is used to undermine women to demand social space and make them do even things that endanger their wellbeing).

The above custom has also been identified and substantiated in the literature by Chitauro-Mawema (2000:30) as one of the cultural prescriptions that undermine women’s ability to seek and demand safe sexual behaviour. According to Chitauro-Mawema (2000:30) Kutsiga entails “…a system of endless duties and obligations which women are expected to adhere to. It requires social non-deviance, social uprightness, moral perfectness, voiceless and above all, submitting unquestionably to male leadership in the decision making process at both the household and community levels”. Leclerc-Madlala (2000) observes that as a result of the above prescriptions, when a husband wants sex the wife should comply because that is part of the marriage contract. This scenario has seen HIV/AIDS spreading like veld fire among women because they lack control over the sexual encounter, while men can be unfaithful and sleep around, contracting the virus from other relationships. These actions relate to gender inequality and dysfunctionality in the marital relationship.

According to respondents in the focus group discussions and in-depth interviews from various cultural setups, once lobola has been paid, men are given the licence to dominate the relationship and all that women do, has to have the blessings of men. The concept of marital rape doesn't exist as men are entitled to sex every time they think of having to do so. Spiwe (37), a Karanga has observed that once lobola has been paid, aunts sit down with the wife to be and teaches her the importance of satisfying one's husband sexually. "You are told that you cannot refuse your husband sex - the lobola that we have received signifies his right to access you in full as and when he wishes, so be ready every time" (Spiwe 37, Chiredzi). The above view point has also been highlighted by Thoko Ngwenya of Zimbabwe's Msasa Project which fights domestic violence, who explains the mindset as a result of dowry payment. "Once the man has paid "lobola" - the word for dowry in several Southern African languages, they are not forcing their wives to have sex. It's just their right". The above view has been reiterated by Lott (1994:171) writing on the issue of marriage who observes that "…marriage is a contract that gives a man the right to 'carnal knowledge' of his wife". The above point is emphasized by Parker et al (2000:107) who observe that "normatively, women were expected to submit to their husbands' requests for sex, as and when these occurred".

It was found that it is these stereotyped teachings that make women vulnerable to HIV/AIDS as they cannot refuse sex even when threatened as they are duly bound to satisfy their men and this is an obligation they cannot shirk away from as long as the marriage contract has been validated by the lobola payment. Discussions from the focus groups revealed that because marriage was not a contract between two

individuals but rather families a woman could not defy her husband's orders by insisting on safe sexual behaviour without risking being ex-communicated by her own family for having shamed them. Nontando (42), a Ndau notes that the concept of shaming one's family members is apparently the major issue on the family members' main subject to an extent that one's health is secondary. The above practices are in line with the observation by Bernard's 'shock theory of marriage' (in Wharton 2005:151) which posit that "…marriage requires women to accommodate more to men than vice versa". It is these cultural prescriptions that hold women back from seeking gratifying sexual health and from contracting HIV/AIDS. On the basis of this study's findings, marriage with its institutional pressures and rewards has been confirmed as one of the socio-cultural practices that enhances Zimbabwean women's vulnerability to HIV/AIDS, a condition Chodorow in (Lott 1994:194) terms "the reproduction of mothering". Marriage as a traditional factor and practice in patriarchal Zimbabwe is thus understood by women in the context of maintaining and upholding stability and order in society and a functional requirement for the wellbeing of humanity.

5.2.3 Fear and violence

Fear as given in focus group discussions and in-depth interviews has been found to be a common and deeply felt emotion in many Zimbabwean women's lives that inhibits greatly their capacity to live secure and happy lives. Married women cited their pervasive fear of being chased away from their marital homes as the reason that tended to make them unassertive in marriage. From the focus group discussions and in-depth interviews, women from various ethnic backgrounds noted that they did not consider their personal well being because of fear. Such fear, they noted, included

fear of rejection from the partner, fear of isolation and social stigma and excommunication from the family and society at large. As a result of fear, women cannot demand safe sexual behaviour. The above views that consider acting morally as acting in terms of collective interest (eg what will my family say if I leave this marriage as a result of advocating for condom use?), are in line with the concepts of mutual consensus and collectiveness as advocated by functionalism.

The Zimbabwe Country Report on the UN Secretary–General Task Force on Women, Girls and HIV/AIDS in Southern Africa (2004:21) notes that "levels of violence against women and girls, including emotional abuse, physical violence and sexual violence are high in Zimbabwe". This is substantiated by a study by Duffy (2005) on rural Ndau women in Zimbabwe who also reported fear as a barrier to HIV prevention. The study noted that women's existence is difficult and oppressive as a result of their socialization to become mothers and workers. This is all done within a context of limited voice, subservience, violence and fear induced action. From the focus group discussions and in-depth interviews with the Korekore, the Manyika and Karanga ethnic groups, the fear of violence emerged as the strongest reason that incapacitated women in these ethnic and patriarchal setups from demanding safe sexual behaviour that include the demand that men use condoms in sexual encounters. The focus group discussions and in-depth interviews noted that it was acceptable to hit one's wife if she disobeyed a husband's command. It has been observed that the fear of violence is not an imagined problem in Zimbabwe.

According to The Ministry of Health and Child Welfare (2004:45) “sexual violence is the worst manifestation of power imbalances that expose women/girls to HIV infection”. The Afrol Gender Profile concurs and notes that violence against women especially wife beating is common. Domestic violence accounted for more than 60 percent of murder cases tried in the Harare High Court in 1998. The above point is also highlighted by UNAIDS, UNFPA and UNIFEM (2004) who point out that violence or the threat of it limits women’s ability to protect themselves from HIV/AIDS. Because of fear of violence, women in different ethnic groups revealed that they cannot discuss or make decisions about sexuality, they cannot request, let alone insist on condom use or any form of protection. Says Chipo (38), “If one refuses sex or requests condom use, one risks being beaten, maimed or bashed”. The many forms of violence against women mean that sex is often coerced which is itself a risk factor for HIV infection”. WOZA (Women Of Zimbabwe Arise) Moya November (2006:1) concurs and notes that “…violence and fear of violence limits a woman’s ability to discuss safe sexual behaviour even in agreement and that fear of violence and shame can also discourage women from seeking information on HIV/AIDS, getting tested for HIV and disclosing their HIV status and seeking treatment and counselling”. From the Korekore and Karanga ethnic groups, violence has been cited as the most widespread and socially tolerated human rights violations. According to Virginia (45), a Karanga woman, “violence against women has been and continues to be shrouded in a culture of silence because people agree that it is good for the stability of the family. “Mukadzi asingarohwi haagari” (A woman who does not get beaten up does not stay in a relationship for long). The Zimbabwe Country Report on the UN Secretary–General Taskforce on Women, Girls and HIV/AIDS in Southern Africa (2004:22) highlights that

“gender based violence has often been understood as a private or domestic problem rather than being both a public and development concern. Ample evidence suggests that domestic violence is so normalised in Zimbabwe and the rest of Southern Africa that women believe wife beating and coerced sex is acceptable as a natural consequence of bad behaviour”. Cecilia (29), a Korekore observes that among her group violence, or the threat of it, reinforces inequalities between men and women and in the process compromises the health, dignity, security and autonomy of the individuals. The above view confirms the observations made by then former UN Secretary-General Koffi Annan (2005) who noted that a woman who lives in the shadow of daily violence is not truly free. Because of violence and fear of it, women are inculcated into a culture of sexual subservience in which they are unable to negotiate sex and must risk infection to please men. These actions relate to gender development theory and the inequality of women on the grounds of being born female.

The degree and concept of fear among Zimbabweans has also been summed up by Zimbabwe’s highly acclaimed musician, social critic and commentator Oliver Mtukudzi (2005) in a song “Tozeza Baba” (we are afraid of the father). In the song the children are depicted as questioning the father why he always beats up the mother. In the song the children present their concerns to the father that he is overdoing it (beating the mother). The actions of the man portrayed in the song are regarded as dysfunctional to the well being and to the stability of the family. What is heartrending is the sociological implication and connotation carried by the word “manyanya” (you are overdoing it), an indication that wife beating is acceptable to a certain extent.

Zimbabwean women from the focus group discussions and in-depth interviews attested to the fact that domestic violence and women's vulnerability to HIV/AIDS is so widespread in Zimbabwe that it is a cause for concern. Norah, (48) a Manyika woman concurs that violence is widespread among the women and this greatly inhibits women's control over sexual matters. She notes that "the majority of women in Zimbabwe would not dare talk about HIV/AIDS and condoms with their partners for fear of being accused of bringing the virus into the home. Many women have been badly battered and others have been chased away. We are afraid of being thrown out". The Zimbabwe Country Report on the UN Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa (2004:21) notes that "gender-based violence in the context of HIV/AIDS can be particularly lethal. Risk of infection is higher where sex is forced as this usually results in tears or abrasions, while fear of violence can prevent women from negotiating safer sex". Thulani, (42) a Ndebele woman noted that she contracted HIV/AIDS on her matrimonial bed because of fear of violent retributals from the husband. She confided that "I contracted HIV/Aids right on my matrimonial bed because of fear of my husband. In marriage women give up their physical security and sexual autonomy because of fear. Being married in Zimbabwe is surely a death sentence for Zimbabwean women". Analysing themes emerging from the focus group discussions and in-depth interviews, founding a family or being married to the majority of Zimbabwean women in these traditional and patriarchal societies means terror, segregation, deprivation, devaluation and death.

From the above cases of study of women in their various cultural and ethnic settings in Zimbabwe, it is clear that fear and violence have emerged as pronounced barriers to

women's access and ability to demand safe sexual practices in any social set up in Zimbabwe. Parker et al (2000:2) concur and observe that "the impact of structural violence in shaping HIV/AIDS vulnerability and a range of reproductive health problems has become apparent". Bunch (in Iyer 1999:i) is thus correct to observe that "If this were any group other than women being maimed or killed, it would be recognised as a gross violation of their humanity and a civil and political emergency". A candid appraisal of women sexuality above has revealed and confirmed earlier held assumptions that give violence and fear as two socio-cultural vices that disempower women and hold them back from seeking satisfying sexual relations with men thereby exposing them to the dangers of HIV/AIDS. This finding recognises fear and violence as some of the specific socio-cultural factors that prevent women from attaining safe sexual behaviour in an era of the menacing HIV/AIDS, thereby answering research questions 1 and 2. Having looked at this, the discourse of perpetual minors is tackled next.

5.2.4 The Discourse of Perpetual Minors

Women from the different ethnic groups as given in the focus group discussions and in-depth interviews were roundly in agreement that their respective societies regarded them as perpetual minors from whose mouths nothing good could come and whose views were equated to those of the minors. Said Thandi (40), a Ndebele woman, "the mere fact that you have such widely accepted idioms as "vakadzi ipwere, abafazi ngabesintwana" (women are minors), best describes the views held and portrayed about women". The above idioms in Shona and Ndebele literally mean that women are minors. A perpetual minor looks up to the leader (a husband in this case) for

salvation and guidance. Because of the tag of the perpetual minors, women cannot demand safe sex as they "don't know what is good for themselves as children" (Nyaradzo, 27, Masvingo). According to Precious (32), a Venda, decision making in her ethnic group is mainly in the hands of men as women are considered minors. She further notes that as a result of this tag of perpetual minors, women in her group lack negotiation and decision making skills to control among other things their own sexuality as they are considered "small minds". The Zimbabwe Country Report on the UN Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa (2004:23) observes and concurs that "…the status of women in Zimbabwe is compromised by the way in which customary law is applied……Women are never considered adults within the family, but only as a junior male or teenager".

Thandiwe (34), a Ndau observes that because of the tag of perpetual minors, a lot of women in Zimbabwe today do not have the right and means to control when, how and where they are going to have sex. This, Thandiwe notes, includes the ability to use contraceptives and condoms in their day to day lives. Tarisai (46), a Karanga woman observes that the issue of how, where and when to have sex is not even for open discussion, it is the man's prerogative and responsibility. Such cultural teachings and obligations inhibit a woman's ability to demand safe sex. Because of the concept of perpetual minors, Perelberg and Miller (1990:17) observe that "as a young woman, she is told she won't attract a man if she is too fat. As a wife, she is told she won't keep her man if she doesn't defer to his needs. She will be an old maid if she does not marry". Mariah (32), a Korekore observes that even when one knows that one should be better treated; one can not demand that as the cultural tag of a perpetual minor

holds one back. Nomsa (44), a Ndebele woman concurs and observes that because of the tag of perpetual minors their men have difficulty acknowledging them as equal sexual beings. She notes that they view female sexuality as something that should be controlled and restrained. Because of the tag of perpetual minors, women are viewed as sexual objects for the benefit of men. The Hunters College Women's Studies Collective (1995:32) says that "the idea of woman as sex object focuses on male gratification" The above view does not consider the well being of women as the primary motive is men's satisfaction.

Block (1994:4) observes that because of the tag of perpetual minors "…conformity becomes the mode, with respect to both rules and roles". The tag of perpetual minors which is grounded in roles societally ascribed to women in traditional and patriarchal societies such as Zimbabwe is consistent with functionalism and gender development theories which uphold role differentiation and functional worthiness of each role. Findings from this study identify the concept of perpetual minors as one of the practices which are cultural prescriptions that devalue a woman's worth making her unassertive thereby exposing her to HIV/AIDS.

Having looked at this, the value of fertility is next assessed with a view to establishing how it hinders behaviour change and exposes women in the various cultural and ethnic setups as given by women in the various ethnic and cultural setups. .

5.2.5 The Value of Fertility

Insert 2: Fertility among Zimbabweans is highly reverenced as a compulsory, symbolic avenue to true fulfilment and meaning as women. Childbearing is a duty one owes to the nation, state, lineage and deity (Kaler 2003:1).

Women from different ethnicities in Zimbabwe cited the value attached to fertility as the reason that exposes them to the dangers of HIV/AIDS. The value attached to fertility is a theme that was very pronounced among all the Zimbabwean ethnicities in

focus group discussions and in-depth interviews. Women from the various ethnicities noted that society expected them to reproduce up to menopause and viewed fertility as the life brand that gives each group its desired existence. According to Rumbidzai (27), a Shona, “a woman is not a citizen until she has produced to the satisfaction of the society. One gains respect from society by the number of children one has brought into the world. It does not have to be one, two, three or four but kusvikira nyoka dzazorora (should last up to menopause)”. The value attached to fertility has further been highlighted by Nomsa (40), a Ndebele who observes that, “fertility among the Ndebele is highly reverenced. It is a duty one can not shirk away from. To be a woman is to bear children up to menopause.” To the Ndau and Manyika ethnic groups, fertility is highly regarded and they believe that it is necessary to transmit life to another human being, not only one but up to what the Almighty has bestowed upon the individual for it is the most essential aspect of being alive. Mwaonei, (38) a Manyika concurs and notes that “giving birth to many children is regarded as laying a claim in the divine prerogative of giving life, it is an insurance that one’s memory would be cherished after death. The death of a childless woman is final, that of a woman with few children is painful but the death of a woman with numerous progeny is less feared. The children will continue to invoke memories of their ancestors and those living bring to the existence of one woman of subsistence who lived to please society by leaving all those buds of flowers to society.

From the Manyika ethnic group a woman can only shed off the tag of being naïve and minor when she ascents to fertility by having many children. Fertility is considered paramount to defining a woman so much that one is considered to have “a moral

judgment of an adult when one has given birth to a satisfactory number of children normally around eight" (Lillian, 36, a Manyika). To the Korekore and Venda ethnic groups it is the number of children that makes one a good wife. Says Sylvia (40), a Venda, "it is one child that makes one a woman, but it is many children that makes her a good wife, one held in high esteem". The above point is further bolstered by Zororai (42) a Korekore woman who observes that among her ethnic group a woman lodges her bid for acceptance and respect through the number of children one will have. "Everything hinges on one's ability to bear children. It is no wonder that a woman's fertility is very important to her. It is the basis for her survival", (Zororai 42, Mt Darwin). The value attached to fertility among Zimbabwe's ethnic groups has also been highlighted by Weinreich (1982: 104) who observes that fertility is considered "the life blood of its society. It is life itself, Rupenyu and therefore gives simba (strength to each local group)". Reproduction to meet society's demand entails unprotected sex and this way a woman is exposed to HIV/AIDS. The value of fertility is summed up in the words of the clergyman Martin Luther in Perelberg and Miller (1990:17) who notes that "if a woman dies in childbirth it matters not because it was for this that she was created by God". This notion links up with the functionality of the family where the expressive and nurturant roles are emphasized and fulfilled by women. It should be noted that the subordination of individual interests and roles such as personal health and wellbeing versus group interests that include the need to bear children exemplifies the "collectivity orientation of the role women occupy'' as they seek to enhance harmony and equilibrium of the whole as given by the functionalist perspective that emphasizes that the whole is greater than the sum of all parts.

Theron (2004:10) writing on the Ndebele concurs that fertility is very central among this group. Caroline Maposhera of the Zimbabwe Women and AIDS Support Network concurs and notes that “for women there is no sexuality, only fertility.” The view that there is no gratifying sexual life appears deeply embedded among the Karanga. From this particular ethnic group there is no time for satisfactory sexual life for the sake of it, there has to be fruits of the game tied to play. The importance of fertility among Zimbabwean women has been substantiated by Schmidt (1996:15), writing on Peasants, Traders and Wives: Shona women in the history of Zimbabwe that “…a woman without a husband or children is held openly in derision. Once a woman has given birth, she is no longer called by her name but is referred to as mother of…” Ardener (1993:53) is thus justified to conclude that “a woman’s destiny it is said is to bear children. Pregnancy is not seen as a shameful condition, but as the achievement of womanhood and a reason for pride”. Thus it can be noted that it is fertility that makes a woman acquire status thus her fertility becomes her passport to respect. In a bid to meet society’s set target and escape societal rebuke, women engage in unprotected sex which itself is a risk factor for the transmission of HIV/AIDS. Fertility is a rod whereby marriage itself is assessed. A good marriage is a fruitful one (Berguland 1995:8). Contrary to the assertion held that some women have advantages over others in terms of HIV/AIDS vulnerability, MaSithole, (28), a teacher noted that despite being knowledgeable about HIV/AIDS, women of status and social standing such as the educated succumbed to HIV/AIDS in their quest to avoid the tag that educated women are “brazen faced” (vakasvauka). The above observation on women in Zimbabwe ties in very well with the functionalist view that roles women occupy in various ethnic set-ups are functional to the wellbeing of society. Thus

women have internalised the view as posed by Berguland (1995:3) that "…the woman is essentially a receiver of male seed, her main purpose in life is motherhood. She does not primarily exist for her own sake or in her own right. Her essential duty and purpose in life is to bear children". On the basis of the above evidence, the centrality of fertility among Zimbabwe's ethnic groups is seen as a social script and factor that is culturally designed that exposes women to HIV/AIDS and explains why women are unable to change their sexual behaviour. Fathalla in Reproductive Health Biennial Report (1990 – 1991:4) is thus justified to conclude that women's ability to control their own fertility which has been called the freedom from which other freedoms flow is a pipe dream for the majority of Zimbabwe's ethnic women.

5.2.6 The Discourse of Religion

Zimbabwean society is very religious with Christianity, African Traditional Religion and Islam as the main religions practised in this country. Issues to do with life and death have been known to exert great influence upon the way individuals view life and how they react in different setups. Religion is one of the strongest elements in traditional background and exerts probably the greatest influence upon the thinking and living of the people concerned. The cited religions expose women to the risk of HIV/AIDS through various ways that are imbedded in their teaching. According to women in focus group discussions and in-depth interviews from the different ethnic set-ups, from the Christian realm the woman is presented as a husband's helper, one taken out of man's multi-farious bones as alluded to by the book of Genesis, Chapter 2 Verse 23 that has Adam the first man as saying to Eve, "This is the bone of my bones and the flesh of my flesh. This one will be called woman because from man this one was

taken". They observe that this verse has been used to subjugate women in various cultural and ethnic setups as men constantly argue that women owe their existence to men and that women are essentially extensions of the males' bodies. Daisy (26), a Korekore asks "can a root then have equal power to that of the whole plant? It's not possible". As a result of this subordinate unequal position women take, they owe their HIV/AIDS status to men. As assumed earlier, the discourse of religion has been identified and confirmed as one of the factors that expose women to HIV/AIDS and prevents them from practising safe sexual behaviour in their various cultural settings.

5.3 SOCIO-CULTURAL PRACTICES

Various practices have been identified as endangering the health of women through HIV/AIDS among the different ethnicities. Among the different cultural practices cited include Dry Sex, Virginity Testing, and Female Genital Mutilation, Inolo yemwizana, Kugara nhaka/wife inheritance and ritual cleansing. The different practices are explored in detail below:

5.3.1 Dry Sex/Vaginal Douching

Vaginal douching or dry sex is a practice among the different ethnic groups that has been identified as posing great risk to the health of the women. Respondents in focus group discussions and in-depth interviews from different ethnic set-ups have noted that dry sex is a very common practice in Zimbabwe and is socially accepted and sanctioned by the elders. It is believed that after child birth, the vaginal opening widens and muscles loosen up a lot that the husband feels small in it (vagina),

(Tendai, 38, a Korekore). According to MaDube (31), a Karanga, vaginal douching is regarded as desirable in order to produce dry, abrasive vaginas that are tight and pleasurable to our men. MaDube (31) observes that in her cultural group, women are taught that men do not desire wet sex (mamvura-mvura) as the smell stinks and is repulsive. MaMoyo (30), a Korekore notes that among her group dry sex is desired because it pleases men who feel bigger in it as the vagina is tighter. The above practice has been reported to be prevalent also among the Ndebele, the Venda and the Manyika ethnic groups who report that they practise dry sex in order to please their husbands and keep them from leaving home and having other women. Thandi (40), a Ndebele reports that men in her group dislike vaginal fluids that they regard as unclean and they believe that if not removed, these interfere with fertilization and excessive contact with these vaginal fluids is believed to cause sterility. Lydia (37), a Venda, observes that dry sex is greatly desirable in her group as the exercise makes the vagina tight and heated both desirable qualities for men. Phyllis (42), a Manyika, notes that Manyika women engage in dry sex as they report being embarrassed by the over lubricated and noise of wet sex. She further notes that they are also afraid of losing their men who regard vaginal fluids as some form of defilement. One shocking revelation came from the Zezuru ethnic group. According to Tambudzai (37), a Zezuru, men in her ethnic group often accused the women that wet sex characterized by loose, slippery vaginas was evidence of infidelity.

It is these badly held misconceived notions that endanger women and make them practise dry sex that is dangerous to their health. Dry sex has been found to promulgate HIV/AIDS in that the lack of lubricants result in lacerations in the delicate

membrane tissue making it easier for the lethal virus to enter and that the natural antiseptic lactobacilli that vaginal moisture contains aren't available to combat sexually transmitted diseases (Hyena 1999:1). Zimbabwean women report that they attain dryness in various ways that range from using tree leaves of such trees as Mugugudhu, use of Mutundo wegudo as well as the use of a crushed stone called "wankie". It is evident from the focus group discussions that women in Zimbabwe practise dry sex to please their men and to keep them from "wandering away to other women". This, women do, at the expense of their own health as women have been socialized to believe that they are unequal and need to please their men at all costs to keep them for themselves to eventually maintain order in marriage.

This view has been highlighted by Miller (1985:56), who observes that "since women have to live to please men, they have been conditioned to prevent men from feeling uncomfortable". From the way women described how they strived to keep their men from being snatched away by other women, it is apparent that they have internalised the belief that dry sex is ideal for men, making it an ethic of nobility and duty so much that pain and discomfort, (latent functions or consequences) emanating from their sexual and reproduction roles, are accepted as the very essence of womanhood. The dangers of contracting the HIV/AIDS disease are discarded with this cultural practice. This practice is, instead of being a latent function of sexual relationships, a manifest function in the ethnicities studied in Zimbabwe. Women are supposed to experience discomfort and unequal treatment while also contracting HIV. The above view ties in very well and relate to functionalist view that emphasizes the different roles and duties

undertaken in maintaining, integrating and contributing to continuity, stability and order in society.

5.3.2 Kuputswa/Kuzvarirwa/Ukwendisela

Women in focus group discussions and in-depth interviews from the Korekore, Manyika, Ndau and Venda groups reported that women in their ethnic groups were exposed to HIV/AIDS as they were often married off to enable the families to get food and to repay indebtedness. This practice has been noted to be very much alive among the Korekore of Mount Darwin, the Manyika of Mutasa, the Ndau of Chipinge and the Venda of Beitbridge. According to Nomalanga (33), a Venda, this practice involves pledging or giving one's daughter to an older man for marriage without the girl's consent. Sithabile (39), a Korekore cites the example of Perpetua (not her real name) a girl in their neighbourhood who was given to a man in their locality who was owed Z$500 because the father could not just pay back the paltry money that he owed. The story received extensive coverage in the local media. It should be noted that this practice exposes women to the dangers of HIV and AIDS as women enter the unholy union disadvantaged and unable to assert themselves making them susceptible to contracting the deadly virus. The respondents noted that women at times accepted being pledged because of their attachment to their families. This refers to the functionalist view on collective consensus where obligations to the kin group are paramount so as to enhance group interests. This practice cited confirms the earlier held hypothesis that women in Zimbabwe are hindered by the different socio-cultural factors and practices defined from their ethnic setups to demand and enjoy safe

reproductive health. Thus traditional and cultural beliefs are hindrances for women in ensuring safe sexual behaviour from HIV/AIDS.

5.3.3 Virginity Testing

This practice was reported among the VaRemba group, a Karanga offshoot as well as the Manyika of Mutasa and Makoni areas. Among the Manyika ethnic group, girls who pass the virginity test are awarded certificates of celibacy, notes Thokozile (31), a Manyika. Virginity testing is a manifest function of the above communities as it is used to order society and define identity. According to Nyaradzo (27) and Phyllis (42), this practice exposes women to HIV/AIDS because of the much heralded and misinformed notion that sex with a virgin cures HIV/AIDS. As a result, infected men from all the corners of Zimbabwe constantly invade these areas in their search for an “HIV/AIDS cure” by hunting down virgins in the cited areas noted Auxillia (45), a Manyika. The existence of the practice of virginity testing among the cited different ethnic groups has confirmed earlier held conceptions that cultural beliefs in the various ethnic set-ups expose women to HIV/AIDS.

5.3.4. Inolo Yemwizana

This is a practice reported among the Venda in the south-western side of Zimbabwe. The prevalence of this practice has not been easy to establish though, with women in this group not committing themselves to say how prevalent this practice is still today. According to Nomalanga (27), the Inolo Yemwizana practice entails that the newly married bride be intimate with the bridegroom’s father before they can consummate their marriage. On quizzed on the significance of the practice, the Venda women

noted that it occupied a special place in the custom of this particular group and were not sure if the women were powerful enough to defy this long standing tradition that has been in existence since time in memorial. This relates to the manifest function of the practice that has been at the core of the people's religion and spirituality. When further quizzed on the prevalence of this practice a lot of women could not commit themselves to say if it was still being practised as it was highly secretive. "You can never tell if it is still alive. It's a guarded family secret, a closely guarded secret but we know as women that it is a custom that exists and occupies a place in our group", says Beauty (33). Nomalanga (27), however reports of a father-in-law who divorced his wife of many years and married the daughter-in-law and chased away the son. Nomalanga (27) says the action was attributed to this heinous practice of Inolo yemwizana. Whether this practice is alive or dormant, it has been established that it exposes women to the dangers of contracting HIV/AIDS and other sexually transmitted diseases.

5.3.5 Kugara nhaka/ Wife inheritance/ Kugadza mapfihwa

This practice has been found to be still prevalent among the Zezuru, the Korekore, the Karanga and pockets of the Ndebele. This practice involves a brother or an uncle to the deceased who inherits the widow (Nancy, 38 a Korekore). According to discussions from the focus groups, this practice is meant to ensure that the widow and her children do not become destitute after the husband's death; they should continue to have a father figure in their life for guidance. This practice is closely tied to another practice Kugadza mapfihwa in which a young woman is given away in marriage in place of her deceased sister or aunt. According to MaMoyo (30), "if your sister or aunt

passes away, you are given away in marriage so that you look after your sister or aunt's children. They believe as a relative you can not ill-treat your own blood and those cases of child ill-treatment are few with this arrangement". It should be noted that in most if not all instances women are given away in marriage without consultations. They don't have a voice in the bargain package; their fate is sealed for them. As a result they enter the institution of marriage with their mouth gagged already and can not speak for their welfare as they are viewed as having no say over their own lives.

In the case of kugara nhaka, women in focus group discussions and in-depth interviews from the cited ethnic groups reported that they ended up giving in so as to protect the wealth they would have toiled for, for all their years and also the quest to maintain a warm rapport for the children with their father's line in case of problems in life, says Beauty (38). According to MaDube (31), in the case of kugadza mapfihwa, a woman is not consulted; she is just called to hear of her fate decided for her and on her behalf, and cannot refuse lest she cuts all her links and connections with the family. The fear of being ex-communicated by the family was reported as the reason why women ended up succumbing to such unjust practices that expose them to HIV/AIDS. This relates to functionalist view of fulfilling roles in the quest to maintain order and stability. It should be noted that in all cases, the idea of being ceded to cement a relationship and the quest to belong to a family, disempowers women from going against prescribed cultural practices. On how prevalent this practice was, women from different ethnic groups noted that issues that touched the nerves of families were classified as very sensitive and essentially very secretive, but generally

observations indicate that this practice is alive and well, the only exception being that ceremonies to officially declare this practice have gone underground. A study by Rurevo and Bourdillon (2003) on Girls on the Street traces a case study of Barbra, a woman and her children who were hounded out of their home on the death of her husband by the latter's relatives after turning down the proposal for wife inheritance. It is clear that the practice continues to inform people's day to day living and also enhances their chances for contracting the HIV/AIDS disease. The practice of kugara nhaka, wife inheritance, kugadza mapfihwa has thus been confirmed as one of the socio-cultural practices that expose women HIV/AIDS.

5.3.6 Ritual cleansing

This practice was reported among the Karanga and the Korekore groups. According to Sithabile (40), a Korekore, this practice involves the widow being given to another man to have sexual intercourse with her, because it is believed that she is carrying the ghost of her late husband. It is believed that the woman needs to be cleansed of the dead man's spirit. It is assumed that if not cleansed of this spirit the widow will forever be tormented and haunted by the dead man's spirit. Women in focus group discussions and in-depth interviews noted that the concept of belonging and the social bonds they had with their families made them practise ritual cleansing. These views relate to the functionalist theory on acting according to collective interest and subordinating individual interests for the sake of the group. Nancy (38) observes that this practice exposes women to HIV/AIDS as the sexual encounter is not guaranteed that it is going to be safe. Ritual cleansing has thus been identified as a socio-cultural practice that exposes women in the cited ethnic setups to HIV/AIDS.

What follows is the analysis of questionnaires that were administered to one thousand and two (1002) respondents from the different ethnicities. Distribution of respondents will be discussed in each table.

5.4 QUESTIONNAIRE ANALYSIS

5.4.1 Biographic Data

This quantitative research technique was employed to question one thousand and two (1002) women respondents of different age groups to quantify the levels and magnitude of the problem of HIV/AIDS among women in Zimbabwe's various ethnic setups. It is here intended to answer and bolster findings on research questions 1, 2 and 3 as given in the beginning of this chapter on data analysis. The biographic data analysis is given on table 7 below.

TABLE 7:

Age range(years)	**Respondents**	**Percentage %**
18-20	229	23
26-30	238	24
31-35	204	20
36-40	198	20
40+	133	13
Total	1002	100

Of the above, two hundred and twenty-nine respondents (229) (23%) who participated were in the 18-20 year age group, two hundred and thirty-eight (238) respondents (24%) were in the 26-30 year age group, two hundred and four (204) respondents (20%) were in the 31-35 year age group, one hundred and ninety-eight (198)

respondents (20%) were in the 36-40 age group while one hundred and thirty-three (133) respondents (13%) were in the 40+ year age group.

From the findings, there are no variations by age and ethnic affiliation. Of the one thousand and two (1002) respondents, seven hundred and eight (708) respondents (71%) reported that they were married; one hundred and thirteen (113) respondents (11%) said that they were widowed, while seventy-seven (77) respondents (8%) reported that they were divorced. One hundred and four (104) respondents (10%) said that they had never married. According to the findings, a total of eight hundred and ninety-eight (898) respondents (90%) were married or had either married and were now divorced or widowed. The above situation confirms the centrality and reverence of the marriage institution, which itself has been found to expose women to HIV/AIDS as defined in the focus group discussions and in-depth interviews. What is clear is the position of almost universal acceptability and mutual consensus accorded to the institution of marriage which recognises this institution as functional to the wellbeing of society. The above issue is in line with the view proffered by Mbiti (1980:1) that for African people, marriage is the focus of existence. It is the point where all members of a given community meet: the departed, the living and those yet to be born and it is a drama in which everyone becomes an actor or actress and not just a spectator.

Five hundred and thirty-six (536) respondents (53%) reported that they were Pentecostal Christians, two hundred and twenty-nine (229) respondents (23%) reported that they were mainline Christians, forty-six (46) respondents (5%) said that they did not believe in the existence of a deity (were atheists) while one hundred and

ninety-two (192) respondents (19%) noted that they belonged to the African Traditional religion. From the findings, a total of nine hundred and fifty-six (956) respondents (95%) noted that they belonged to a religion and believed in the existence of a deity lending weight to the view noted in focus group discussions and in-depth interviews that religion is focal to the existence of Zimbabweans, thus has a bearing on their exposure to life and death alike. The centrality of religion has also been substantiated by Mbiti (1980:1) who observed that Africans were notoriously religious. The functional importance of the institution of religion has been highlighted by the number of respondents who subscribe to it.

5.4.2 Distribution of Respondents by Educational Qualifications.

Seven hundred and ninety-two (792) respondents (79%) reported that they were educated up to college level while one hundred and eighty-one (181) respondents (18%) reported that they were educated up to university level. Twenty-nine (29) respondents (3%) said that they were educated up to Zimbabwe Junior Certificate level. According to findings, there are no variations in educational attainment by ethnicity as expected. Contrary to widely held perceptions that women are uneducated, evidence from findings indicates generally that women are literate. This fact makes the issue of women willingly contracting the HIV/AIDS disease even more questionable. Therefore, in the case of Zimbabwean women's contraction of the virus, this could be seen and explained as a latent, unintended consequence, but adhering to socio-cultural practices makes it a manifest consequence. It therefore remains questionable and debatable.

5.4.3 Distribution of Respondents through employment.

Four hundred and forty-two (442) respondents (44%) reported that they were doing nothing for a living while two hundred and sixty-eight (268) respondents (27%) said that they were doing menial blue collar jobs. One hundred and fifty-eight (158) respondents (16%) said that they were self-employed. One hundred and thirty-four (134) respondents (13%) noted that they were doing white collar jobs. According to findings, most women (87%) are not gainfully employed lending weight to the widely held notion that women subordination and vulnerability to HIV/AIDS is grounded in their lack of economic power. The concept of lack of economic power dovetails into the aspect of enhanced male power, the husband as head of family (musoro wemba) as revealed in the focus group discussions and in-depth interviews. Lack of economic power by women has been described by Collins and Hoosen (2004) as the "feminisation of poverty" which places women at risk of contracting HIV/AIDS. Women subordination as a result of lack of economic power has been confirmed and substantiated on by MacMillan and Ndegwa (1996) writing on Zimbabwean women, to compound women's susceptibility and social vulnerability to HIV/AIDS as women can not demand safer sex in a weak position. A study by Orubuloye et al (1993:859-872) among Nigerian women revealed that women's apparent success in refusing unwarranted intercourse was attributed to their economic independence. Economically dependent women may submit to sex with infected husbands out of fear of eviction and abandonment (www.hrw.org/campaign/women/aids/qual htm). Economically disadvantaged women would consider their expressive roles in family setups functional for the wellbeing of society.

5.4.4 Distribution of Respondents by age of spouse/sexual partner.

Nine hundred and eighty-six (986) respondents (98%) reported that they currently had sexual partners while only sixteen (16) respondents (2%) reported that they did not currently have sexual partners. Age mixing is used as an indirect way to look at relations between those older men who have multiple partners and younger women (Ministry of Health and Child Welfare 2004:16). True to the perception that women are married to older men, the distribution of the respondents by their sexual partners' age suggest that there is widespread age mixing between couples and absolute variations by age between couples. This finding is in tandem with the finding established by the Zimbabwe Youth Adult Survey (2001-2002) that found out that there was extensive age mixing among couples in Zimbabwe which itself is a major driver of HIV/AIDS (Ministry of Health and Child welfare 2004:17).

Table 8: Distribution of Respondents by Condom Use the last time they had sex

	Used a condom during last sexual encounter	
Ethnic	**Yes**	**No**
Karanga	54	111
Manyika	42	121
Korekore	48	115
Zezuru	60	104
Ndebele	37	126
Venda	35	128
Total	276	705

Two hundred and seventy-six (276) respondents (28%) reported that they used condoms the last time they had sexual intercourse while seven hundred and five (705) respondents (70%) said that they did not use condoms the last time they had sex. Twenty-one (21) respondents (2%) said that they had never had sexual intercourse. From the findings above, condom use among the ethnic groups was largely infrequent. This finding is consistent with findings established by the Ministry of Health and Child Welfare (2004:22) that noted in a study that “42 percent of women reported condom use at last sex”. Basic HIV/AIDS prevention characterised by condom use as given by Bhattacharjee (2007) who observes that condoms offer contraception and protection against HIV in one inexpensive simple to use package is not largely available to the majority of Zimbabwe’s ethnic groups of women. The low use of condoms in relationships confirms earlier views by SAfAIDS News, June 2006 which observe that condom use in primary relationships is universally low. It is interesting to note that there are slight variations in condom use by ethnicity contrary to expectation. Of the two hundred and seventy-six (276) respondents who reported condom use the last time they had sex, fifty-four (54) Karanga respondents (20%) said that they used condoms while forty-two (42) Manyika respondents (15%) reported condom use the last time they had sex. Forty-eight (48) Korekore respondents (17%) reported condom use while sixty (60) Zezuru respondents (22%) also reported condom use. Thirty-seven (37) Ndebele respondents (13%) and thirty-five (35) Venda respondents (13%) reported condom use. From the findings, women are in positions in which protecting themselves against infection from HIV/AIDS is difficult.

Reasons for condom use during the last sexual encounter were explored. Thirty-five (35) respondents (13%) said that they used condoms the last time they had sex due to

the insistence of their sexual partners. Twenty-three (23) respondents (8%) reported that they used condoms because they did not trust their partners while a further twenty-eight (28) respondents (10%) noted that they used condoms because they felt their partners had other sexual partners. Forty-seven (47) respondents (17%) reported that they used condoms to prevent HIV/AIDS. One hundred and forty-three (143) respondents (52%) reported that they used condoms the last time they had sex to avoid pregnancy. It is critical to observe that from the findings, condom use was not largely driven by the desire to avoid HIV/AIDS, but by the desire to avoid unwanted and unplanned pregnancies. The findings are in line with findings by Meursing (1999:37) on barriers to sexual behaviour change in Zimbabwe who observed that condom use was motivated by the need to avoid pregnancy. The above findings are also in tandem with findings from a study by Paiva on Brazilian students in Parker et al (2000:223) that found that “the risk of undesired pregnancy was perceived as much greater than the risk of AIDS”. These were followed by absence of pleasure among the males and the desire for pregnancy among the females. The findings are in sharp contrast to assertions by Varga (1997:45-67) who in a study on sexual decision-making and negotiation in the midst of AIDS in the KwaZulu/Natal area among young women, found that young women did not stress condom use as a means of contraception, but instead these were connected with protection against STDs and AIDS. From the findings, it is apparent that HIV/AIDS is not the most significant factor in sexual decision-making; rather it is the need to avoid pregnancy that takes centre stage.

Table 9: Respondents' reasons for non-use of condoms.

Ethnic Group	Why did you not use a condom?				
	Married	Fear	Love	Partner	Can't use
Karanga	48	61	21	13	13
Manyika	32	40	16	11	11
Korekore	38	39	17	7	4
Zezuru	55	47	22	8	6
Ndebele	31	43	18	10	5
Venda	23	36	14	9	7
Total	227	266	108	58	46

Seven hundred and five (705) respondents (70%) reported that they did not use condoms the last time they had sexual intercourse, while two hundred and seventy-six (276) respondents did use condoms. Reasons advanced for non-use of condoms include fear of partner (38%), being married (32%), love of partner (15%), partner being faithful (9%) and inability to use condoms (6%). Some of the reasons advanced are in tandem with findings advanced by Anarfi (1999:85) who found out that lack of knowledge and appreciation of the usefulness of condoms accounted for the high rate of non-use. It is interesting to note from these major groups that among the Ndebele, Venda, Korekore, Manyika and Karanga ethnic groups, the fear of the partner emerged as the deepest barrier to condom use, while for the Zezuru being married was the major barrier why women could not use condoms the last time they had sexual intercourse. These findings tally with assertions made by women in focus group discussions and in-depth interviews that fear was the stumbling block towards satisfying sexual behaviour. The above findings further confirm findings by Furlong

(2002) who observes that fear is a common and deeply felt emotion in many women's lives that inhibits greatly their capacity to live secure and happy lives. The findings are also in tandem with views expressed by women in a study by Adeokun, Twa-twa, Sseikiboob and Nalwadda (1995) who discovered that women were unable to exert an influence over condom use through fear of rejection and stigmatisation by partners. The above view has also been highlighted by Muloma (2007) who observes that many women cannot ask their husbands to use a condom because in addition to being thought of as unfaithful, they fear being beaten. Besides fear of isolation, rejection and social stigma, the threat of partner violence often discourages women from insisting on condom use (www.unifem-eseasia.org/Resources/GenderAids/genderaids). From the women's responses on not using condoms in this questionnaire, it is apparent that fear is a theme that comes out strongly and is therefore confirmed and recognised as one of the most established socio-cultural factors that inhibit behaviour change among women in Zimbabwe as given also in the in-depth interviews and focus group discussions. This tally with the functionalist view of collectivity and group consensus.

Table 10: Number of sexual partners they had had in the last three months.

	How many sexual partners have you had in the last 3 months?		
Ethnic Group	**1**	**2-3**	**4**
Karanga	133	26	6
Manyika	140	16	8
Korekore	135	17	9
Ndebele	136	16	6
Zezuru	130	28	6
Venda	139	19	8
Total	813	122	46

Eight hundred and thirteen (813) respondents (83%) reported that they had stuck to their single sexual partners during the last three months. One hundred and twenty-two (122) respondents (12%) reported that they had had between two and three sexual partners in the last three months. Forty-six (46) respondents noted that they had had four or more sexual partners in the last 3 months. Although this was a significant finding that women do have a sense of power and would like to change their behaviour, it is still not regarded as conclusive in traditional, cultural and patriarchal marriages. In a certain sense it could still be seen as only pleasing men to initiate sex. From the findings, most women respondents positioned themselves as faithful lending weight to the views given in focus group discussions and in-depth interviews that most women are faithful and contract HIV/AIDS right on their matrimonial beds as was the case with Thulani (42), a Ndebele. The relatively high number of sexual partners one hundred and sixty-eight (168) respondents reported is a cause for concern. The issue of multipartnering and partner exchange is in line with findings by Anarfi (1999:85) on initiating behaviour change among female street youth in Accra that point to a high level of partner exchange and sexual activity. The results are in line with findings by the Ministry of Health and Child Welfare (2004:17) in a Young Adult Survey that noted that “among sexually experienced women aged 15-29, 71 percent reported one life time sexual partner; 25 percent reported two to three and 11 percent reported four or more lifetime partners”. From the findings above, multipartnering and sexual networking has evolved as a practice that exposes women to the dangers of HIV/AIDS. It is interesting that there are variations in number of sexual partners by ethnic affiliation. Of the one hundred and twenty-two (122) respondents who reported having had between two and three partners, twenty-six (26) respondents (21%) were

of Karanga origin while twenty-eight (28) respondents (23%) were of the Zezuru origin. Nineteen (19) respondents (16%) were of the Venda ethnic origin while seventeen (17) respondents (14%) were of the Korekore ethnic origin.

Table 11: Respondents who obtained the condom.

	Who obtained the condom?		
Ethnicity	**Myself**	**Partner**	**Both of us**
Karanga	**6**	**42**	**6**
Manyika	**3**	**27**	**12**
Korekore	**4**	**30**	**14**
Zezuru	**6**	**47**	**7**
Ndebele	**1**	**24**	**12**
Venda	**10**	**25**	**0**
Total	**30**	**195**	**51**

Thirty (30) respondents (11%) reported that they obtained the condoms themselves the last time they had sexual intercourse while one hundred and ninety-five (195) respondents (71%) noted that their partners obtained the condoms. Fifty-one (51) respondents (18%) reported that both partners obtained the condom the last time they had sexual intercourse. From the findings, it is clear that males dominate decision making, prevention of HIV/AIDS included. It is worrisome to note that women in Zimbabwe continue to defer issues of paramount importance such as their health and wellbeing to their partners. This deferment though reflects the gender development theory that construes men as more intelligent than women. It is interesting to observe that there are slight and significant variations by ethnicity and the person who obtained condoms the last time they had sexual intercourse for the majority of ethnic groups, save for the Venda ethnic group. Of the thirty (30) respondents who reported obtaining

condoms themselves, ten (10) of the respondents (33%) are of Venda ethnic origin while the Ndebele ethnic group largely reflects a deep seated patriarchal, patrilineal culture in which only one (1) respondent (3%) reported obtaining condom herself.

Table 12: Respondents who initiate sex every time they have sex.

Who Initiates Sex every time You have it?			
Ethnicity	**Myself**	**Partner**	**Both of us**
Karanga	10	104	51
Manyika	8	89	66
Korekore	24	120	20
Zezuru	14	111	39
Ndebele	11	116	36
Venda	36	101	25
Total	103	641	237

Of the nine hundred and eighty-one respondents (981) who reported to be sexually active, one hundred and three (103) respondents (11%) reported that they initiate the sexual act, every time they have the sexual intercourse while six hundred and forty-one (641) respondents (65%) reported that their partners do. Two hundred and thirty-seven (237) respondents (24%) reported that both partners do initiate sexual intercourse every time they have sex. Although this was a significant finding that women do have a sense of power and would like to change their behaviour, it is still not regarded as conclusive in traditional, cultural and patriarchal marriages. In a certain sense it could still be seen as only pleasing men to initiate sex. The findings are consistent with the gender development theory that outlines that "...gender categories, women subordinations well as gender hierarchies are socially constructed and fixated into the minds of individuals as they are prepared for their future roles"

(Chodorow in Elliot 1988:31). From the findings, women continue to play second fiddle to men in as far as initiating sexual intercourse is concerned. From the findings, it would appear that women have internalised the view given by Lott (1994:110) that "…sex is instead something one gives to a man". Female sexuality from the findings is still in the hands of the males. This is in contrast to the assumption earlier given that women in employment have control over their own sexuality. The findings are in tandem with findings by Varga (1997:13-34) who found in a study of South African young people's sexual dynamics that generally, it was the male partner who initiated sexual advances and there was very little direct communication or negotiation on the issue before its occurrence. The finding is also in line with the view proffered by Izumi (2006:57) who says of sexual intercourse initiation process in relationships that "man the agent, acts. Woman, the other exists. Man is conceived as the subject and woman as the object". It is interesting to observe that there are distinguished differences by ethnicity and the person who initiates the sexual act. Of the one hundred and three (103) respondents who reported that they initiate sex themselves every time they have sex, thirty-six (36) respondents (35%) are of the Venda ethnic group while twenty-four (24) respondents (23%) are of the Korekore ethnic group. Fourteen (14) Zezuru respondents (13%), eleven (11) Ndebele respondents (11%), ten (10) Karanga respondents (10%) and eight (8) Manyika respondents (7%) reported that they initiate sex every time they have sexual intercourse. From the findings, it would appear that Venda and Korekore women have the better leverage to determine conditions under which they have sex than any other ethnic groups. From the findings though, it is apparent and clear that initiation of sexual intercourse continues to remain a preserve of the males. This study thus confirms the earlier held assumption that the notion of

inevitable passivity of women as a cultural prescription is rife and contributes to the vulnerability of women to HIV/AIDS.

Table 13: Respondents suffering from STIs in the last three months.

Have you suffered from STIs In the last 3 months?		
Ethnicity	**Yes**	**No**
Karanga	37	130
Manyika	14	153
Korekore	4	163
Zezuru	26	141
Ndebele	18	149
Venda	7	160
Total	106	896

Using self reported history, women respondents were asked if they had suffered from any STIs in the last three months. Eight hundred and ninety-six (896) respondents (89%) reported that they had not suffered from any STIs while one hundred and six (106) respondents (11%) said that they had suffered from STIs in the last 3 months. From the findings, there are interesting variations by having suffered from STIs in the last three months among the ethnicities. Of the one hundred and six (106) respondents who reported having suffered from STIs in the last three months, thirty-seven (37) respondents (35%) are of the Karanga ethnic group while twenty-six (26) respondents (24%) are of the Zezuru ethnic group. Eighteen (18) Ndebele respondents (17%), fourteen (14) Manyika respondents (13%), seven (7) Venda respondents (7%) and four (4) Korekore respondents (4%) reported that they suffered from STIs in the last three months. From the findings, women still bear the brunt of STIs as one hundred and six respondents (106) 11% reported having suffered from

the disease in the last three months signalling that they are not in control of their sexual activities.

Table 14: Respondents discussing issues of HIV/AIDS

	Do you and your partner discuss HIV/AIDS issues?	
Ethnicity	**Yes**	**No**
Karanga	70	97
Manyika	52	115
Korekore	86	81
Zezuru	34	133
Ndebele	77	90
Venda	26	141
Total	345	657

Communication between partners has been found to increase the likelihood of condom use (Hendriksen et al 2007). Women were asked if they and their partners discuss issues on HIV/AIDS between themselves. Three hundred and forty-five (345) respondents (34%) said that they discuss issues of sexual nature with their partners while six hundred and fifty seven (657) respondents (66%) said that they did not. From the findings, it is disturbing to note that issues of intimacy and sexuality among ethnicities in Zimbabwe continue to be overlooked lending weight to the widely acclaimed view that Africans do not have a language on sexual issues. Sayagues (2003) is thus justified to note that there is a pervasive silence surrounding HIV/AIDS issues among couples. The author further notes that husbands do not talk with their wives. Men generally feel uncomfortable discussing intimacy. The above findings are in line with findings by Varga (1997:13-34) in a study of South African young people's sexual dynamics who found out that poor communication characterised circumstances of sexual intercourse among couples as they did not talk about such matters and

usually communicated through oblique references to sexual issues rarely confronting specifics such as timing or contraceptive use by either partner. Nyathi (2006:3) cites Ncube in a study of safe sex and assertiveness who observes that Zimbabwean women's subordination remains real and gender issues are rarely discussed. Duffy (2005:7) concurs that for Zimbabwean women their existence is revealed as difficult and oppressive; hence they do not discuss issues on sex and HIV/AIDS. The author further notes that their socialisation to become workers and mothers occurs within a context of limited voice, subservience, violence and economic powerlessness which are all avenues to HIV infection. This context relates to the gender development theory. Hartley (2005:4) notes that women are socialised to yield decision-making to men. They are unable to negotiate sex and so must risk infection to please men. Kim (2007) in a study of partner communication observes that women respondents noted that communicating your needs, fears and desires to your partner may not be the easiest thing to do. From the findings, Parker et al (2000:127) is thus justified to conclude that "norms that label interpartner communication on sex taboo (especially if initiated by women) or that associate condoms with illicit sex are also part of the cultural scenario of almost every society".

There are interesting variations by discussing sexual issues and ethnicity. Of the three hundred and forty-five (345) respondents who reported that they discussed sexual issues with their partners, eighty-six (86) respondents (25%) were of the Korekore ethnicity while seventy (70) respondents (20%) were of the Karanga ethnicity. Seventy-seven (77) respondents (22%) were of the Ndebele ethnicity while fifty-two (52) respondents (15%) were of the Manyika ethnic line, while twenty-six (26)

respondents (10%) were of the Zezuru ethnic line. Contrary to expectations, there are no variations in discussing HIV/AIDS issues by the level of education. There is a wall of silence surrounding “taboo” topics such as HIV/AIDS and women across the different ethnicities confirming earlier held assumptions that cultural taboos in different social and cultural settings inhibit women from seeking safe sexual intercourse.

Table 15: Respondents interested in getting tested

Respondents were asked if they were interested in getting tested for HIV/AIDS. Responses by ethnic affiliation are given in the table underneath.

Would you be interested in getting tested for HIV/AIDS?		
Ethnicity	**Yes**	**No**
Karanga	129	38
Manyika	120	47
Korekore	131	36
Zezuru	115	52
Ndebele	105	62
Venda	130	37
Total	730	272

Seven hundred and thirty (730) respondents (73%) said that they were interested in getting tested for HIV/AIDS while two hundred and seventy-two respondents (27%) said that they were not interested in getting tested for HIV/AIDS. Contrary to the widely acclaimed notion that the majority of Africans, Zimbabweans included, do not know their status and are not interested in knowing their status (Caldwell 1997), findings suggest that Zimbabwean women respondents are interested in knowing their status. There are slight variations by ethnicity and being interested in getting tested for HIV/AIDS. One hundred and five Ndebele respondents (14%) and one hundred and

fifteen Zezuru respondents (16%) noted that they were interested in getting tested compared to other ethnic groups that range from one hundred and twenty respondents (16%) to one hundred and thirty-one respondents (18%).

Table 16: Why Respondents want to be tested for HIV/AIDS.

	Why do you want to be tested for HIV/AIDS?				
Ethnicity	**Have baby**	**Getting married**	**Peace of mind**	**Know status**	**Partner unfaithful**
Karanga	107	2	14	37	3
Manyika	78	3	17	14	5
Korekore	96	1	17	21	2
Zezuru	53	8	15	11	6
Ndebele	60	4	16	13	1
Venda	145	1	17	10	3
Total	539	17	96	106	20

Women respondents were asked why they wanted to be tested for HIV/AIDS. Of the seven hundred and thirty (730) respondents who indicated that they wanted to be tested for HIV/AIDS, five hundred and thirty-nine respondents (72%) said that they were interested in getting tested because they wanted to have babies. One hundred and six respondents (13%) noted that they wanted to be tested to know their status. Ninety-six respondents (10%) said that they wanted to be tested, so that they could have peace of mind. Twenty respondents (3%) noted that they wanted to be tested because their partners have been unfaithful. Seventeen respondents (2%) noted that they were interested in getting tested because they wanted to get married. It is interesting to observe that while the majority of the respondents wanted to be tested for HIV/AIDS, the prime reason is not driven by the desire to know one's HIV/AIDS status, but the desire to have babies. The above view defines the centrality of fertility

among Zimbabwe's ethnic groups which the women have internalised. Taylor (2001:1) observes that women have noted that "their value in society relies…more importantly on their fertility". It would appear women respondents have internalised the concept of women as vessels in procreation and they would not want to be bad vessels that contaminate the babies. This notion is in conjunction with the expressive role differentiation of women and the functionality thereof society.

5.4.5 Why respondents don't want to be tested for HIV/AIDS.

The respondents who indicated that they did not want to be tested for HIV/AIDS were further probed for the reasons why they did not want to be tested. Two hundred and seventy-two (272) respondents indicated that they did not want to be tested for HIV/AIDS. Of the above, eighty-three (83) respondents (37%) noted that they did not want to be tested because of fear of a positive result. One hundred and forty-six (146) respondents (65%) said that they were afraid of depression if found positive while twelve (12) respondents (5%) said that knowing the status (if positive) would hasten their death. Twenty-one (21) respondents (9%) noted that they did not want to know their status because if positive they feared being shunned by their family and friends. From the findings, fear of rejection by significant others and the fear of depression and of a positive result has been found to be the major pervasive block among the women to knowing their status and being tested for HIV/AIDS. The above findings are in line with findings from a study by Caldwell (1997) who confirmed that individual hesitance and refusal to undergo testing owes something to fear of being shunned and isolated.

Table 17: Respondents by having been forced to have sex by partner

Respondents were asked whether they had ever experienced forced sex from their partners against their will.

	Have you ever been forced to have sex	
Ethnicity	**Yes**	**No**
Karanga	80	87
Manyika	62	105
Korekore	70	97
Zezuru	92	75
Ndebele	60	107
Venda	95	72
Total	459	543

Four hundred and fifty-nine respondents (46%) noted that they had been forced by their partners to have sex against their will, while five hundred and forty-three respondents (54%) said that they had never been forced to have sex by their partners. From the findings, marital or date rape is quite prevalent and a cause for concern among Zimbabwe's ethnic groups. The above findings are in line with findings established by www.hrw.org/campaign/women/aids/qual/htm that noted that rape and sexual assault within marriage is not uncommon and husbands may force reluctant wives to have sex against their will even when there is a possibility of HIV infection.

The significance of physical coercion as a cultural phenomenon, as well as an obstacle in sexual negotiation is consistent with findings by Varga and Makubalo 1996's study on sexual negotiation. They observed that the orgy of violence and forced sexual intercourse was a realistic threat to women's lives. The above findings are in line with a study by the World Health Organisation involving 24 000 women from

ten countries that established that between 6% and 59% of women have been subjected to sexual violence by their partners. Bhattacharjee (2007) further confirms that physical and sexual violence are common and women have little room to negotiate the use of condoms or to refuse sex to an unfaithful partner. It is also apparent from the findings that relatively a large percentage of Zimbabwean women from different ethnicities lack power as revealed by the level of coercion reported making them vulnerable to HIV/AIDS. From the findings there are interesting variations by ethnicity and having been forced to have sex. Of the four hundred and fifty-nine (459) respondents who reported having been forced to have sex by their partners against their will, ninety-five respondents (21%) are of Venda ethnic origin while ninety-two respondents (20%) are of the Zezuru ethnic origin. Eighty Karanga respondents (17%) reported having been forced to have sex against their will while seventy Korekore respondents (15%) also reported forced sex. Sixty-two Manyika respondents (14%) and sixty Ndebele respondents (13%) reported being forced to have sex by their partners.

Table 18: Risk of contracting HIV/AIDS

		Risk of HIV/AIDS		
Ethnicity	**No risk**	**Small risk**	**Moderate risk**	**High**
Karanga	64	58	28	17
Manyika	93	46	7	21
Korekore	89	42	10	26
Zezuru	66	58	26	17
Ndebele	94	46	4	23
Venda	90	49	7	21
Total	496	299	82	125

Based on their sexual experiences, respondents were asked to define how much of a risk they were of contracting HIV/AIDS. Four hundred and ninety-six (496) respondents (50%) said that they were not at risk of contracting HIV/AIDS while two hundred and ninety–nine (299) respondents (30%) noted that they were at a small risk of contracting HIV/AIDS. Eighty-two (82) respondents (8%) said that they were at a moderate risk of contracting HIV/AIDS while one hundred and twenty-five (125) respondents (12%) noted that they were at high risk of contracting HIV/AIDS based on their sexual experiences and the experiences of their partners. The findings are generally worrisome as they reveal women's refusal to put words into the pandemic. Half the respondents do not consider themselves at risk of contracting HIV/AIDS. The findings are in line with findings by a study by Ntseane (2004) in a study of cultural dimension of sexuality, empowerment for HIV/AIDS prevention in Botswana that established that about 50% of the women respondents were aware that they were at risk. A study by Awusabo-Asare et al (2000:128) also found out that 80 percent of the respondents did not consider themselves to be at risk of HIV infection. It is interesting to observe that there are no significant variations by feeling at risk and level of education, contrary to widely held notions that career women have a better leverage to determine the circumstances under which they have sexual intercourse. It is interesting to observe that true to Bell's (2002)'s assertion that married women do not consider themselves to be at risk of contracting HIV/AIDS, risk assessment by marital status revealed a low perceived sense of risk among the married women as compared to those unmarried.

Table 19: Does partner have other sexual partners?

Respondents were asked if they thought their partners had other sexual partners.

	Any other sexual partner besides you?		
Ethnicity	**Yes**	**No**	**Don't know**
Karanga	**8**	**52**	**105**
Manyika	**11**	**41**	**112**
Korekore	**17**	**35**	**115**
Zezuru	**5**	**57**	**105**
Ndebele	**23**	**39**	**105**
Venda	**16**	**47**	**104**
Total	**80**	**271**	**646**

Eighty respondents (8%) noted that they thought that their partners had other sexual partners beside themselves while two hundred and seventy-one (271) respondents (27%) highlighted that they thought that their partners had no other sexual partners beside them. Six hundred and forty-six (646) respondents (64%) noted that they did not know if their partners had other sexual partners besides themselves. From the findings, it is critical to observe that there is a general feeling of insecurity as revealed by the high number of respondents who chose to remain on the line in terms of multipartnering by their partners. With this insecurity, it is baffling why respondents do not consider themselves to be at risk of contracting HIV/AIDS.

5.4.6 Respondents' knowledge of HIV/AIDS transmission.

Women respondents were asked to identify ways in which HIV/AIDS is passed from one person to another. From the findings, one thousand and two respondents (100%) identified unprotected sex with an infected sexual partner as the main reason, while seven hundred and fifty-two respondents (75%) identified mother to child transmission

at birth as way in which HIV/AIDS is passed. Six hundred and ninety respondents (69%) noted that HIV/AIDS could be passed through contaminated blood transfusion. One thousand and two respondents (100%) highlighted sex with infected sex workers as an avenue by which HIV/AIDS is passed from one person to another. From the findings it is clear that respondents have a generally satisfactory knowledge by which HIV/AIDS is passed from one person to another.

Table 20: Ways people employ to protect themselves from HIV/AIDS.

Ways people employ to protect themselves from HIV/AIDS				
Ethnicity	**Use condom correctly**	**Fewer partners**	**Faithfulness**	**Abstinence**
Karanga	**167**	**140**	**167**	**38**
Manyika	**167**	**85**	**167**	**41**
Korekore	**167**	**78**	**167**	**42**
Zezuru	**167**	**69**	**167**	**37**
Ndebele	**167**	**95**	**167**	**42**
Venda	**167**	**85**	**167**	**45**
Total	**1002**	**552**	**1002**	**245**

Respondents were asked to identify ways which people can employ to protect themselves from getting infected by HIV/AIDS. Respondents gave multiple answers. One thousand and two (1002) respondents (100%) reported the correct use of condoms consistently as a way of protecting themselves from HIV/AIDS as well as being faithful to one's partner.

Table 21: The view that HIV/AIDS is just one way of dying not to be avoided.

	Is HIV/AIDS one way of dying?	
Ethnicity	**Yes**	**No**
Karanga	45	122
Manyika	57	110
Korekore	58	109
Zezuru	45	126
Ndebele	60	107
Venda	75	92
Total	340	666

Death provides the greatest perceived danger and because it entails an unknown experience for every person, it is the most unmanageable threat to human well being (Cox 1993:120). Attitudes towards death are important for behavioural change in the context of high morbidity and mortality (Ayiga et al 1999:67). Respondents were asked if they subscribed to the notion that HIV/AIDS is just one way of dying and it cannot be avoided. The respondents' responses by ethnicity are tabulated as follows:

Three hundred and forty (340) respondents (34%) noted that HIV/AIDS was just one way of dying and death could not be avoided, while six hundred and sixty-two (662) respondents (66%) said that HIV/AIDS could be avoided as a cause of death. From the findings, there is bravery about death and a belief that it will come when it does. That is evidence that Zimbabwe's ethnic groups are largely fatalistic, a condition that enhances risk taking. It would appear that fear of death is very far from dominating decision making about life choices for more than one third of the women respondents. This acceptance of death and a willingness to accommodate its timing is striking and

provides an answer to lack of behavioural change. The finding that HIV/AIDS is just one cause of dying is in line with findings from studies by Orubuloye and Ogumentin (1999:101-102), Caldwell, Orubuloye and Caldwell (1997:113-124) and another one by Awusabo- Asare et al (1999:125:132) who established that people believed that death is inevitable and people will ultimately die anyway, what they die from may not matter much.

Table 22: The view that HIV/AIDS is a punishment from God.

	AIDS is punishment from God	
Ethnicity	**Yes**	**No**
Karanga	58	109
Manyika	64	103
Korekore	61	106
Zezuru	74	93
Ndebele	63	104
Venda	61	106
Total	381	621

Respondents were asked if they believed that HIV/AIDS is a punishment from God. Three hundred and eighty-one (381) respondents (38%) agreed that HIV/AIDS was indeed a punishment from God because of people's promiscuity while six hundred and twenty-one (621) respondents (62%) disagreed with the notion that HIV/AIDS was a punishment from God. The relatively high percentage mark of 38% indicates a fatalistic attitude among Zimbabwe's ethnic women, a condition that disempowers women and makes them vulnerable to HIV/AIDS. From the findings, there are interesting variations by ethnicity and the notion that HIV/AIDS is a punishment from

God. It would appear from the findings that the Zezuru ethnic group is more fatalistic than any other group with a total of seventy-four respondents (19%) of the total agreeing that HIV/AIDS is indeed a punishment from God followed by the Manyika ethnic group with a total of sixty-four (64) respondents (17%) and the Ndebele ethnic group with a total of sixty-three (63) respondents (17%) alluding to the fact that HIV/AIDS is a punishment from God.

The fatalistic attitudes portrayed by Zimbabwe's women respondents in this study are in line with earlier findings by Amunyunzu-Nyamongo et al (1997:1-12), who in a study of barriers to behaviour change in East Africa found that young people reacted with such fatalistic comments as "AIDS came for people" and "Everyone will die anyway". These fatalistic beliefs and attitudes, lack of power, the concept of marriage as the norm, fear and violence and the discourse of perpetual minors and religion as well as the value of fertility hinder people from using proper preventive and management procedures thus disposing them to HIV/AIDS and hampering the containment of the virus. These are some of the reasons why "safe sex messages" are not complied to. The notion of death as uncontrollable by humans complicates behavioural change (Amunyunzu-Nyamongo et al 1997:1-12). Furlong (2003) in study of Gender, Land and Women in Zimbabwe also found that the notion of death among the women of Zimbabwe was very strong, as they believed that human beings are mortal and will die at some point in time. It is these attitudes that create buffer zones for behaviour change and expose women to HIV/AIDS.

Table 23: The reason why women are more affected

	Why women are more affected by HIV/AIDS			
Ethnicity	**Depend on men**	**Poverty**	**Fear abandonment**	**Men do not like condoms**
Karanga	**12**	**50**	**70**	**7**
Manyika	**8**	**33**	**55**	**5**
Korekore	**7**	**37**	**38**	**11**
Zezuru	**1**	**40**	**42**	**10**
Ndebele	**2**	**35**	**16**	**9**
Venda	**2**	**39**	**19**	**6**
Total	**32**	**234**	**240**	**48**

Five hundred and fifty-four (554) respondents who indicated that women were more affected by HIV/AIDS than men were further questioned as to why that was the case. Thirty-two (32) respondents (6%) indicated that because women were dependent on men they were more affected than men while two hundred and thirty-four (234) respondents (42%) noted that poverty made women more affected by HIV/AIDS than men. Lack of economic power and inadequate resources have been found to inhibit decision making among women in Zimbabwe, referring to them as being perpetual minors with no say. Apart from this, safe sex messages are also not adhered to. This places them at risk of contracting HIV/AIDS. Two hundred and forty (240) respondents (43%) indicated that women were more affected than men because of fear of anger, violence and abandonment by the partner. Forty-eight (48) respondents (9%) noted that women were more affected than men because of the view that men do not like condoms. The discourse of fear has been found to be a recurring theme in HIV/AIDS where women position men as having power over them and have to comply or risk being beaten or abandoned. Thus the discourse of fear paralyses women and positions them as unable to insist on condom use for fear of violence and

abandonment. The above findings confirm earlier findings by Hoosen and Collins (2004) in a study of black women in South Africa that observed that, “the discourse of fear as paralysing positioned women as unable to refuse sex without a condom because they run the risk of their partner leaving them, resulting in lack of money to take care of themselves and their children”. Poverty has also been highlighted as a barrier to safe sex. Two hundred and thirty-four respondents (42%) indicated that poverty tied women down hence they could not demand safe sex. The above scenario confirms findings by Paone and Charkin (1997) in Women and HIV/AIDS Special Information Packet Number 8, March (1997:186) who in a study of men living in low income inner-city housing developments found out that the risk of HIV infection is disproportionately high among impoverished minority women in inter-cities, because they have no access to good nutrition to boost their immune system.

Table 24: Have you ever heard of a female condom?

Ethnicity	**Have you ever heard of a female condom?**	
	Yes	**No**
Karanga	**160**	**7**
Manyika	**158**	**9**
Korekore	**145**	**12**
Zezuru	**150**	**17**
Ndebele	**157**	**10**
Venda	**159**	**8**
Total	**929**	**73**

Condoms remain the most effective protection against HIV/AIDS and other sexually transmitted infections (STIs) for sexually active young adults (Hendriksen et al 2007 in the American Journal of Public Health, July 2007 Volume 97:1241-1248).The female

condom provides women with an extended choice of protection (Sayagues 2003). Alexandrora (2004) concurs that the female condom carries connotations of women's empowerment and the possibility of greater sexual autonomy for women. Respondents were asked if they had ever heard of a femidom. Nine hundred and twenty-nine (929) respondents (93%) noted that they had heard of a female condom before, while seventy-three (73) respondents (7%) said that they had never heard of a female condom before.

Table 25: Have you ever used a female condom?

Respondents were asked if they had ever used a female condom. The following results were given:

Ethnicity	Have you ever used a female condom	
	Yes	No
Karanga	12	155
Manyika	22	145
Korekore	20	147
Zezuru	14	153
Ndebele	21	146
Venda	18	149
Total	107	895
Percentage	11%	89%

One hundred and seven (107) respondents (11%) said that they had ever used a female condom before while eight hundred and ninety-five (898) respondents (89%) noted that they had never used a female condom before. From the findings, it can be drawn that condom use is not a behaviour that is under the control of women as the majority of the respondents had never used it before. The above views are in line with

findings by Hoosen and Collins (2004) who found out from their study that 80% of the participants had never used the femidom. The findings are in line with findings by Chizororo and Natshalaga (2003) in study of The Female condom: acceptability and perception among rural women in Zimbabwe who found out that very few women had used the female condom prior to the survey. Geloo (2005) observes that most women shy away from using the femidom.

5.5 CONCLUSION

This chapter has explored the social and cultural practices that expose women in their different ethnicities and make them vulnerable to HIV/AIDS. Analysis has been drawn from focus group discussions held in the different ethnic set-ups, in-depth interviews as given by women in their various cultural and social groups and questionnaires handed out to women respondents. Having looked at this, findings emanating from this research study are explored next with recommendations given as well as areas for further study.

CHAPTER 6

FINAL CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents a discussion and summary of findings and draws final conclusions and make recommendations. The overall objective of this study was to improve on an understanding of the dynamics of behavioural modification and change with respect to female sexuality for women in Zimbabwe. The specific objectives of the study were to explore, assess and investigate the different socio-cultural factors and practices specific to the major ethnic groups in Zimbabwe that inhibit behavioural change of women in the light of the devastating HIV/AIDS pandemic, and to provide relevant guidelines for behavioural transformation of Zimbabwean women.

By answering three key research questions, namely, how do specific socio-cultural factors hinder or disempower women from changing their sexual behaviour: what are these socio-cultural practices preventing them from behavioural change; and why do safe sex messages not have the resultant impact on women's sexual behaviour, the study challenged predominant wisdom regarding behavioural change of Zimbabwean women. In this qualitative study all three research questions stemming from the relevant hypotheses in the research problem have been answered. Because of this, all the tentative hypotheses underlying the three research questions are accepted too.

The overarching functionalist theoretical perspective included different related gender development and behavioural change theories. This is based on the notion that social events, like socio-cultural practices are explained in terms of functions they perform or contributions they make for traditional Zimbabwean society. It is also relevant that all societies do not function orderly. Dysfunctions do exist. This research was therefore motivated by the realisation and knowledge that current strategies had failed to harness the spread of HIV/AIDS, because the important issue of human sexual behaviour linked to socio-cultural factors and practices were avoided in previous studies. The research thus attempted to highlight the need for review of existing socio-cultural practices and factors and traditional norms and values to eventually empower Zimbabwean women to change their sexual behaviour.

With this in mind, this chapter gives the discussion and summary of findings and draws the main conclusions of the study and proffers recommendations for policy formulation and guidance. It concludes by highlighting specific possible policy recommendations and implications that can be taken aboard to better the lives of suffering Zimbabwean women.

6.2 DISCUSSIONS AND FINDINGS

The research reviewed existing literature and relevant assumptions which were applied to data gathering and findings in the field. This study on socio-cultural factors and practices that inhibit behavioural change of Zimbabwean women was carried out

in selected provinces and districts namely Mashonaland West, Manicaland, Mashonaland Central, Masvingo, Matabeleland South and North. Qualitative data was collected through the use of:

- Six (6) focus group discussions and
- Fifty (50) in-depth interviews with mature adult women whose ages ranged from 18 years to 59 years. The gathered data was complemented by data gathered through the
- Quantitative survey employing a structured questionnaire to one thousand and two (1002) women in the age ranges 18 to 59 years.

Both qualitative and quantitative methods of data analysis were utilised in this study so that the negatives of one method are negated by the positives of the other method.

Before going into the main objectives of the study, it was important to define and understand the population sub-group under study. This study centred on women whose ages ranged from 18 to 59 years and who belonged to any one of the following major ethnic groups, namely the Zezuru, Karanga, Ndebele, Manyika, Korekore and Venda. The respondents chosen represented the different age groups and marital statuses ensuring the fusing of the different dimensional threads to the study issue at hand. Women, from this study living in a traditional, patriarchal society, have been classified as weak, dependent and subordinate to men. They have been categorised as minors who thrive under the guidance of men and who cannot make functional decisions by themselves. This notion, of course does not correspond with behaviour in modern western societies.

This study has made several salient observations on women, sex and sexuality, poverty and inequality as well as gender roles and cultural expectations. It has made manifest the fact that cultural practices inhibit behavioural change among women. From this study it has emerged that marriage is key to the African communities as it allows the patrikin to grow. As such every woman is obligated to marry and found a family. No woman, from the study, can remain single without losing self-respect. Every woman therefore, according to respondents from this study, has a moral obligation to marry and take the social reproduction of her kinship to another level. Women respondents have noted that before women can demand respect they are expected to reproduce. From the study, women's respect is earned through and tied to their fertility. Marriage from this study is a virtue, an institution held in highness that almost every woman subscribes to. Tied closely to the concept of marriage is the issue of fertility and sexual availability in a relationship. To women, without sex and children marriage serves no purpose.

Socially structured gender roles that stress and impress the value of motherhood in a traditional society, are in contradiction to the adoption of safe sexual and risk free behaviour by using condoms. For Zimbabwean women childbearing shapes and defines their marriage. This fundamental and basic value of begetting or bearing children has been found to have been instilled in women who now believe it's morally good for them to bear children. From this study, it is clear childbearing is a duty one owes to the nation, state and lineage which cannot be compromised for whatever gains, including the reproductive health of an individual. Closely aligned to the concept

of marriage as a duty, is the payment of lobola, which came out strongly among the different ethnic groups. In marriage the payment of lobola has been reported by women respondents as giving men sexual rights over women. Among the women surveyed, more than eighty percent (80%) believed that men were entitled to complete control over them as they had paid lobola for them.

The problem of HIV/AIDS remains a complicated and awesome one among Zimbabwe's ethnic groups. It has continued to maintain a tight grip on the population of Zimbabwe with women being heavily buttressed. Women respondents have maintained that it has become the major cause of morbidity and mortality on their various cultural and ethnic set-ups.

This study has established that for many of Zimbabwe's traditional ethnic women, the problem of HIV/AIDS begins with a total lack of control over their sexual lives and behaviour of their husbands, especially when having extra-marital affairs. The women have noted that the majority of them stay faithful to the husbands and partners as per the cultural prescriptions and roles, while their husbands do not do the same. Women respondents have noted that cultural prescriptions in their various ethnic settings condone male infidelity but expect the women to stay faithful and true to their partners. As a result, the women respondents have noted that they contract HIV/AIDS straight on their matrimonial beds.

This study highlights that all sexual activities and relations among Zimbabwe's ethnic groups are carried out in the context of power relations. As a result, women's relative

lack of power in sexual relations has meant that they cannot make autonomous decisions about their sexual behaviour. Fertility and contraceptive use are tied to the decisions by their sexual partners. Because of lack of power, women respondents have noted that they cannot question their husband's infidelity with other women, let alone demand the use of the condom. Tied to the concept of power relations, men because they are considered powerful, are the initiators of sex and they prescribe when and how the sexual act is going to be executed.

This study further notes that men and women's socio-culturally constructed gender roles have a catastrophic and debilitating consequence for the attainment of satisfying reproductive health and contraceptive use, because of society's socio-culturally prescribed unequal gender roles, where women's sexual behaviour is subject to men's approval. Women are expected to be "naïve" and "passive" in sexual matters, both characteristics that expose women to the dangers of contracting HIV/AIDS. In their gender roles women are taught and treated as the secondary sex, a condition which enhances lack of safety in sexual relationships.

This study further highlights that gender-based violence is realistic among Zimbabwe's ethnic groups and together with underlying sexual repressions constitute some of the primary obstacles that stop women from attaining safe sexual intercourse. The study concedes that male violence has been used to control women throughout their lives and this has increased women's vulnerability to HIV/AIDS infection. Therefore calls for abstinence are meaningless to women who are coerced into sexual activity.

This study makes manifest the view that in the context of HIV/AIDS, socio-cultural factors and practices present the greatest challenges to the intervention strategies. A complex set of beliefs, values and practices such as inolo yemwinizana among the Venda, vaginal drying among the different ethnic groups in Zimbabwe, the payment of lobola, wife inheritance and ritual cleansing among other practices have been found to promote unsafe behaviours which predispose women and make them vulnerable and susceptible to HIV/AIDS infection. Other cultural practices such as ritual cleansing, wife inheritance, inolo yemwinizana, virginity testing, and kuzvarira and dry sex have been repeatedly cited by the respondents in different ethnic setups as the basis for women's discrimination and their subsequent inability to protect themselves from HIV/AIDS. These have been described as semi-autonomous social fields that command respect and obedience and define connectivity. As a result women subserviently follow these.

From the study, socio-cultural factors and practices have been found to impede upon the rights of women to determine their ability to protect themselves. Because of cultural expectations and gender roles, women do not have the right to choose when, why and with whom to have sex. This fundamental right is denied and this compromises women's ability to enjoy safe sex. Women's inability to decide when, how and with whom to have sex is a cultural issue prevalent among Zimbabwe's ethnic groups and is premised on the cultural aspects of kuzvarira/kuputswa/child pledging. As illustrated through out this thesis, the challenges facing women and girls in Zimbabwe are complex. Yet, this is not reason enough and no excuse for inaction. This thesis' rallying point to the international community is that effective HIV

prevention programs should address the realities of women's lives. The following aspects emerging from this study have to be taken into consideration when HIV prevention progams are instituted:

- Women have difficulty in negotiating safer sex with their partners because of their lower social status and fear of violence. Fear of isolation, rejection and social stigma in addition to the fear of partner violence act as stumbling blocks to women's march towards safe sexual practices.
- Women's subservience and subordination to men is realistic and they cannot shirk away from it.
- Condom use in primary partnerships has been found to be universally low. In the few instances condom use has been reported, it has not been driven by the need to protect oneself from HIV/AIDS, but by the need to prevent pregnancy.
- While Zimbabwe is not short on legislation and policy on gender and women empowerment, these remain sonorous declarations and mere statements of intent that lack practical implementation. At present, from the study it is not clear why people don't understand what constitutes the sexual culture of the people bearing the greatest risk in Zimbabwe, the adolescent girls and women, since packages for prevention (condoms) have not helped the situation. While laws have been enacted to protect women from abuse, these are largely "cosmetic" as women have failed to rely on these to seek redress. Further still, this study makes manifest the view that the policies that have been put forward to date to promote the welfare of women remain quiet and ineffective to address women's rights to say no to unprotected sex.

- The current strategy of facilitating condom availability without understanding the socio-cultural conditions affecting women's abilities for self determination in a sexual relationship is not feasible, as the power to use these is not inherent in women.
- The prescribed unequal status of women puts them at a severe disadvantage in negotiating safe, protected sexual encounters.
- Sexual behaviour is not merely a matter of individual choice, but is predicated on Zimbabwean society's values, norms and cultural traits that form the under-currents for one's behaviour.
- It has come out strongly that cultural stereotypes such as "a woman behaves like this", have been used to devalue, objectify and marginalise women from demanding control over their reproductive health.
- Women's knowledge on how to prevent HIV/AIDS is generally satisfactory. It is the practical acting out in implementing prevention that needs to be tackled as women have been found to be generally hesitant in effecting prevention strategies, especially those that fly in the face of cultural and gender prescriptions.
- Effective strategies to stop and mitigate the devastating impact of HIV/AIDS among women in Zimbabwe require a holistic situation in which attention is drawn to the different ethnicities and the cultural backgrounds of the individuals. It further posits that for Zimbabwe to root out the menacing virus, the different ethnic groups' affinities and differences as well as their divergent views and meanings in the social and economic orders, need to be harnessed and made use of based on the people's ethnic and cultural lines.

- The culture of male domination or gender inequality is one of the biggest problems confronting women's desire to protect themselves from contracting HIV/AIDS.
- Very few women had seen the female condom, let alone use it. Yet condom use is supposed to form the principal means through which women can enhance safe sexual behaviour.
- Communication between partners on sexual issues has been found to be nearly non- existent and this has been largely attributed to the lack of language discourse in sex and sexuality among the Zimbabwean populace.
- Women have been patronised to regard self-lubrication of their vaginas as dirt, unclean and unpleasant. This study has observed that traditional, ethnic women instead regard a tight and dry vagina as giving very good friction to the penis and as enhancing man's sexual pleasure. Thus women have been conditioned and patronised to please men at the expense of their own health, which refers to patriarchal domination and powerlessness of Zimbabwean women.

Contrary to the finding by Vijhuizen (2002:233) in a study of Ndau women that "women are not always the weak", this study has established that indeed women are forced to be the weak, who do not want to be labelled deviant, hence they cede power to men. However, in accordance with Vijhuizen (2002) in modern societies these practices do not exist and women have equal rights in sexual relationships and women are "not always the weak".

Further still, this study has made manifest the fact that susceptibility and vulnerability to HIV/AIDS have been predicated on the particular socio-cultural gender productive

and reproductive roles associated with women. This study has also made manifest the fact that cultural perceptions of the women's body and sexuality indicate that sexual behaviour and practices are tied to the influence of traditional beliefs which are extremely detrimental to their health. With the observations made on the above scenario, the complexity and the long-term nature of gender inequality cannot stand in the way of progress and change; nor can tradition and culture stand still.

It is important to note that in this study the three research questions, stemming from the research problem have been answered and tentative hypotheses have been confirmed. While the research does not justify women's participation in dangerous, unprotected sexual relationships, it attempts to understand some of the socio-cultural practices and meanings surrounding women that make their participation in these relationships somehow justifiable. This viewpoint is also in accordance with the functionalist perspective on which the research was based.

6.3 FINAL CONCLUSIONS, RECOMMENDATIONS AND INTERVENTIONS

In reflecting on the observations made in this study on socio-cultural factors and practices that impede upon behavioural change of Zimbabwean women with regard to HIV/AIDS, a major conclusion is that unless the social dynamics, cultural and ethnic contexts and the subsequent realities are examined and understood from the social, cultural and ethnic line of the infected and affected, initiatives for safe sex and behaviour remains largely rhetoric and unusable for Zimbabwean women. The central conclusion thus derived from this study is the view that the most effective response to

HIV/AIDS should emerge from within societies and be driven and plotted on the societies' different cultural and ethnic axis. A leadership on the gendered nature of the epidemic is necessary, as without this, many communities in Zimbabwe will not survive. The responses should emerge from people facing a backlash from the pandemic who are women in this case. Turning the tide must be the result of movements that are rooted in the experiences of women and arise from the genuine recognition by communities that the situation must change. The above view is premised on the fact that "all societies maintain within them a repertoire of different life styles, cultural forms and rationalities which members utilize in their search for order and meaning, which themselves play (wittingly or unwittingly) a part in affirming and restructuring" (Long and Van der Ploeg 1994:67).

The major finding illuminated by the study is that power dynamics, gender and cultural practices have impacted negatively on women's ability to act meaningfully in avoiding HIV/AIDS and that under current circumstances, the women's social and ethnic contexts may not bring the desired fruits. As stated, this research study has answered the three original research questions earlier posed and has identified the specific socio-cultural factors and practices rooted in the different ethnicities that hold women back from enjoying safe sexual behaviour and impede upon behavioural changes.

6.4 RECOMMENDATIONS

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

1. The construction of valid, useful and encompassing policies concerning women who are infected and affected by HIV/AIDS be undertaken by reorienting and re-educating women to be assertive in marriage .It also includes attentively listening to the views, concerns and voices of the women in their natural cultural settings. There has to be greater inclusiveness in consultation and have participatory decision-making by women and greater transparency.
2. Women to be empowered economically by giving them increasing access to community resources and allocating financial resources for women empowerment so that they can make their reproductive decisions, that they own their sexuality and have control over it. This will do away with transactional sex.
3. The institution of marriage to be redefined to enhance equal decision-making by both partners involved. Both Zimbabwean women and men need to be re-educated and reoriented to view their marriage partners as equals and the marriage institution as an institution in which both have equal power of decision making to quash vulnerability.
4. The concept of lobola payment may need to be scrapped or remodelled as it has been found to be the basis of women‘s exploitation by men. Specific risk enhancing practices like lobola payment need to be reassessed to establish

their worth. Normative changes have to be made in line with specific local responses.

5. Society remobilises and resocialises men to be responsible for their reproductive decisions and instil a new thinking that does away with the concept of manchoism and patriarchy with respect to multipartnering and that Zimbabwean society should condemn in very strong terms the idea of coercive sexual practices. This can be achieved by developing advocacy and community mobilisations at districts and community levels to promote responsible reproductive behaviour**.**
6. Retrogressive cultural systems and practices such as child pledging, inolo yemwinizana, wife inheritance and vaginal drying be banned and those who still practise these be prosecuted sternly. Risk perception on these practices need to be increased through advocacy and social mobilisation.
7. The marriage institution be reclassified and remodelled as a very risky institution through education and that legislation and policy start “talking” on women’s rights in marriages, especially the right to refuse unwanted sex when not sure of the partner’s status**.**
8. Married women to be reoriented to view themselves as vulnerable to HIV/AIDS. Increase risk perception among women in marriage through education.
9. The idea that defines a true Zimbabwean woman as one who is in union and compatible with the cultural prescription of “compulsory motherhood” be discarded as this enhances women’s vulnerability to HIV/AIDS. Increased focus on promoting and valuing oneself is of paramount importance.

10. The Zimbabwean men and women to be reoriented to distinguish between sexuality from reproduction so that women in traditional Zimbabwean society may discover their right to sexual pleasure and the right to control their fertility. Communication programs that value individuals for who they are and that promote increased utilisation of sexual reproductive health programmes need to be developed at grassroots level.
11. The current various policies on HIV/AIDS and STIs in place be synchronised and implemented so as to be sensitive and responsive to the gender dimension in the fight against HIV/AIDS to enhance robust and genuine transformation of the daily lives of Zimbabwean women. This thesis adds its voice for critical examination of today's fight against HIV/AIDS.
12. The Abstain, Be faithful and Condomise approach to HIV/AIDS management, a major strategy with a "coca cola like flavour" (applicable everywhere) be discarded or remodelled to address the ethnic and cultural concerns of individual women. Life skills, negotiation skills and relationship skills need to be provided to all women through education**.**
13. Condom use in primary relationships to be enhanced with women entitled to use contraceptives as and when they wish**.** Social marketing of condoms need to be promoted.
14. Femidoms (female condoms) be made readily available to the women at the same price or slightly below that of men's and that women be educated that it is their right to access these and that they should not leave their fate and welfare in the hands of men. Support structures that advocate for consistent and correct use of condoms should promote women to take control of their lives

need to be put in place at grass root level to enhance safe sexual behaviour among young and older women.

15. Women be taught and oriented in the use of female condoms as the majority of them to date have not, let alone used these. Training on the use of female condom needs to scaled up and remodelled to suit cultural norms so that it becomes acceptable.

16. Gender roles that objectify and enhance women's vulnerability be discarded. It further calls for humanity to discard the concept of men as bread winners and women as second rate citizens. A new approach to HIV/AIDS management that takes into account how gender roles create vulnerability in women and reinforce risk pattern should be implemented. Advocacy for gender neutral roles and equality for everyone need to be promoted**.**

17. Harness all the people's collective responses to the HIV/AIDS pandemic so that a robust, large scale multi-sector and well co-ordinated strategy that incorporates the diverse needs and concerns of the marginalized, deprived and vulnerable women in their various Zimbabwean cultural and ethnic set ups be put in place. This should be based on specific risk practices based on assessments of the local context.

18. Women be re-educated, resocialized and reoriented so that they value their health and welfare at the expense of maintaining such reputations and tags as "married women", "upright", "women of virtue" and "decent". Women need to be taught to value their worth as human beings and not as baby manufacturers, wives and attachments to men.

19. Policies that build and ensure human capacity is sustained and increased to be modelled to reduce women's vulnerability. There is need to align policies and strategies and these should be contextualised based on the local norms and values.

20. The government demonstrates political will and leadership to mount effective strategies to mitigate the impact and effects of HIV/AIDS. Leaving the management of HIV/AIDS under the National Aids Council (NAC) as is the situation currently, which is not a ministry and without adequate financial resources to deal with such a pandemic demonstrates laxity in the approach to the management of HIV/AIDS. Lack of budgetary allocation for an epidemic that threatens to wipe the Zimbabwean populace out is worrisome, even the view that the Zimbabwean government has other pressing financial obligations and challenges is not reason enough not to avail necessary resources to curb the pandemic. The political leadership at national, provincial, district and village level need to come out and spearhead behavioural change rallies by speaking out on HIV/AIDS. Management of HIV/AIDS has to be placed on the shoulders of a ministry with special funding to curb the pandemic.

21. Poverty among women to be addressed since giving women safe sex messages on what to do will not yield anything positive, as messages given to women in their poverty are often irrelevant and inoperable given the reality of the women's lives. For the poor, it's now that matters, so policies that recommend the deferment and deferral of gratification will do very little to change women's vulnerability to HIV/AIDS. There is need to institute economic programmes that enhance women participation in the national economic front

to deal with women vulnerability as a result of poverty in order for them the adhere to safe sex messages.

22. Prevention strategies that take into account women's lack of power in determining conditions under which women have sexual intercourse should be explored to reduce HIV/AIDS infection among women and girls. Legislation that enhance women's decision making powers in the family need to be put in place to protect women from abuse and inequality.

Having adhered to the three research questions in these recommendations, future areas for research are explored and highlighted for the benefit of tomorrow.

6.5 PERSPECTIVES FOR FUTURE RESEARCH

This study has not exhausted all the cultural and ethnic groups in Zimbabwe who constantly cry that they are overlooked and neglected. This is an area grey for research that still needs to be addressed.

Further still, this study has been one of the few studies tailored towards learning about HIV/AIDS in women as human beings and not as vectors to their offspring. More of these studies are needed to build a comprehensive base on which policies and legislation on the welfare and equality of women can be derived upon.

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ANNEXES

Annex 1

Questionnaire

Identification Questionnaire Number-----

My **name is -------. Iam representing Mr. C. Nyoni, a student at the University of South Africa carrying out a research on Socio-cultural factors that impede upon behavioural change of Zimbabwean women in an era of HIV/AIDS. The study is purely for educational purposes. I would like to interview you if you don't mind. Your identity will be kept anonymous. The interview will last for about 30 minutes**.

Socio-Demographic Characteristics

1. Age of Respondent
   a) 18-20
   b) 21-25
   c) 26-30
   d) 31-35
   e) 36-40
   f) 40+

2. Ethnity
   a) Karanga
   b) Manyika
   c) Korekore
   d) Zezuru
   e) Ndebele
   f) Venda
   g) Suthu
   h) Other (specify)----------

3. Marital Status
   a) Married
   b) Widowed
   c) Divorced
   d) Never Married
   e) Other (specify)----------

4. Religion
a) Mainline Christianity
b) Pentecostal Christianity
c) African Traditional Religion
d) Atheist
e) Other (specify)

5. Highest Educational Qualification attained
a) Primary
b) Z.J.C
c) O Level
d) A Level
e) College
f) University
g) Other

6. What do you do to earn a living?
a) Nothing
b) Blue collar job
c) White collar job
d) Self employed
e) Other

7. How old is your spouse or sexual partner? **Age in years ---**

B.Sexual History and Behaviour

8. Do you currently have a sexual partner?
a) Yes
b) No

9. How many sexual partners have had over the last 3 months? **Number----**

10. The last time you had sex with your partner did you use a condom?
a) Yes
b) No

11. What was the main reason why you used a condom the last time you had sex?
a) Prevent pregnancy
b) Prevent STD
c) Prevent HIV/AIDS
d) Partner insisted
e) Did not trust partner
f) Felt partner had other sexual partners
g) Other (specify) ---------

12. Why did you not use a condom the last time you had sex?
a) We are married
b) Afraid of my partner
c) I love my partner
d) Didn't know how to use the condom
e) Partner looks healthy
f) Partner did not approve the use of the condom
g) Condom not available
h) Partner is faithful
i) Other (specify)

13. Who initiated condom use the last time you had sex?
    a) Myself
    b) My partner
    c) Both of us

14. Who obtained the condom the last time you used a condom in a sexual encounter?
    a) Myself
    b) My partner
    c) Both of us

15.Every time you have sex who initiates the act?
    a) Myself
    b) My partner
    c) Both of us

16. Have you ever suffered from any STIs in the last three months?
    a) Yes
    a) No

17. Do you and your partner discuss issues of HIV/AIDS between yourselves?
    a) Yes
    b) No

18. Would you be interested in getting tested for HIV/AIDS?
    a) Yes
    b)No

19. Why would you want to be tested for HIV/AIDS?
    a)Want to get married
    b)Want to have a baby
    c)Partner is unfaithful
    d)Peace of mind
    e)Know my status
    f)Worry about my risky behaviour
    g)Other (specify)

20. Why would you not want to be tested for HIV/AIDS?
    a)Fear of positive result
    b)Depression if true
    c)Suicide if true
    d)Knowing would hasten death
    e)Shunned by family and friends
    f)Other (specify)

21. Have you ever been forced to have sex against your wish by your partner?
    a)Yes
    b)No

22. To the best of your knowledge does your partner have any sexual partner beside you?
    a) Yes
    b) No
    c) I don't know

22. Based on your sexual experiences with your spouse/sexual partner how likely would you say you are at risk of contracting HIV/AIDS?

a)No risk
b)Small risk
c)Moderate risk
d)High risk
e)Other (specify)
Explain your answer----------

C.Knowledge, Attitudes and Beliefs

23.Based on your understanding how is HIV and AIDS passed from one partner to another?

a) Unprotected sex with an infected partner.
b) Mother to child at birth
c) Contaminated (unsterilised) needles
d) Contaminated blood transfusion
e) Sex with infected sex workers
f) Witch craft
g) Other (specify)

24. What ways can people employ to protect themselves from getting infected with HIV/AIDS?

a) Use condoms correctly and consistently
b) Have fewer partners
c) Use condoms with casual partners
d) Mutual faithfulness
e) Abstinence
f) Other (specify)

25. Would you believe the view that HIV/AIDS is just one way of dying? It cannot be avoided?

a) Yes
b) No
Explain your answer----------

26. From your understanding, would you believe that HIV/AIDS is a punishment from God?

a) Yes
b) No
Explain your answer----------

27. Why would you think women are affected by HIV/AIDS?

a) Lack power to determine conditions under they have
b)Women psychologically and dependent on
c)Feminisation of poverty
d) Women's beliefs that men do not like condoms
e) Fear of anger, violence and abandonment by partner
f)Other (specify)

28.Have you heard about a female condom?

a)Yes
b)No

29.Have you ever used a female condom?

a)Yes
b)No

End of Interview Thank you for your co-operation.

Annex 2
FOCUS GROUP DISCUSSION GUIDE

Questioning Route For Focus Group Discussions

TOPICS

1. **Definition of Marriage**
2. **Rights of men and women in marriage**
3. **Relationship in a sexual union- rights and privileges of men and women**
4. **Social factors that dispose women to HIV and AIDS**
5. **Cultural factors that dispose women to HIV and AIDS**
6. **Sexual initiation and premarital sex -**

- How are women initiated into sex?
- How prevalent is premarital sex?
- Why do people get into premarital sex?

7. **Sex in marriage and risk-**

- What characterizes sex in African marriages?
- Can married women deny their husbands sex?
- What underlines conjugal rights in an African marriage?
- Can women demand that their husbands use condoms during sex?
- Can women use condoms (femidom) in marital sex?
- How risky is the institution of marriage as far as HIV and AIDS is concerned?
- How is infidelity in marriage perceived and treated?
- How would you react if you find out that your husband is having extra marital sexual affairs?

8. What is your view of the initiation ceremonies-male and female circumcision?

Annex 3

In-depth Schedule for key Informants

1.**Date of Birth (day/month/year**)
Ilanga lokuzalwa (ilanga/inyanga/umnyaka)
Zuva rokuzvarwa (zuva.mwedzi/gove)

2.**Age (completed years**)
Iminyaka yokuzalwa
Makore okuzvarwa

3. Province

4. **District**
Isigodlo
Dunhu

5. Rural/urban area
Ruwa/Guta/emaphandleni/Emadolobheni

6. **Ethnicity/Imlobo/Rudzi**
a) Zezuru
b) Karanga
c) Manyika
d) Newel
e) Venda
f) Korekore
g) Ndau
h) Other/Zvimwe/Okunye chasisa

7.**Can you read and write**? Ungenelisa ukubhala lukubala yini? Ungagona kunyora nekuverenga?
a) Yes/yebo/hongu
b) No/hatshi/kwete

8.**If yes to Qestion 7 above number of completed years of education**
Nxa usenelisa ukubala qamba okwenelisileyo
Kana uchibvuma pamusoro, doma makore awakapedza uchidzidzisa

9.**Marital status**/isimo sakho/wakaroorwa here?
a) Never married/ukungathathi kwakho
b) Married/ukwenda
c) Divorced/separate/ukwalana
d) Widowed/ukufelwa
e) Cohabiting/ukutshayi amapoto

10.**Occupation/**imisebenzi
a) Councillor/umhkokheli wesigaba

b) Teacher/umbalisi/mudzidzisi
c) Nurse/umongikozi/mukoti
d) Ward leader/omongameli weward/mutungamiri weward
e) Health promotion officer/abonangesemphilakahle
f) Other (specify) Abanye (chisa)

11 **The issue of health and disease has been problematic in most ethnicities, what is the case within your group?**
Indaba yezempilakahle lemikhuhlane iluphile ezingabeni ezinengi lina likubona njani ezingabeni zenu?
Dambudziko reutano nezvirwere inyaya dzatambudza vanhu vazhinji, handizivi kuti kurudzi rwenyu munozviona sei?

12. **Which diseases have maintained a tight grip on the population**?
Yiphi imikhutilane eyala ihlupha kuzulu?
Ndezvipi zvirwere zvanyanyouraya nekutambudza vanhu munharaunda yenyu?

13.**Which groups of people have been heavily buttressed by the cited diseases**?
Yiwaphi amaqembu eminyaka ahlaselwa kakhulu yile imikhuhlane?
Ndeapi mapoka avanhu anyanyonetswa nezvirwere izvi?

14.**Why has the cited/identified disease remained the biggest challenge among women in most ethnicities, your group included?**
Yinindaba limikhuhlane isala ihlasela abesifazane.
Sei zvirwere izvi zvanyanyotambudza varakadzi vazhinji munduzdi dzakasiyana, rudzi rwenyu ruchibatanidzwa?

15.**What specific sociocultural practices hold women back from reaching out for safe sexual reproductive health**?
Yiphi imithetho yesinhu encindezela abesifanazan ukubabale besiya emacansii okukhululekuleyo?
Ndezvipi zviri mutsika nemagariro zvinotadzisa vakadzi kuti vasazvidzivirira kubva kuzvirwere?

16.**What is the position of women in a marriage set up in your ethnic group**?
Abesifazana bakhangeleka njani esigabeni senu?
Vanhukadzi vanoonekwa sei muwanano murudzi rwenyu?

17.**What are the sexual rights of women and men in marriage**?
Yiphi amalungelo abesifazana labesilisa ekuthathaneni?
Ndedzipi kodzero dzemadzimai nevarume muwanano murudzi renyu?

18.**What rights are conferred to men and women through marriage in your ethnic group?**
Kuyini omalungelo okhangelelwe ekukwenziwe ngabobaba ngabesifazane emendweni ngesintu senu?

Ndezvipi zvinotarisirwa kuitwa nevakadzi muwanano muridzi rwenyu?

19. **What is your view regarding the belief that HIV and AIDS is just one way of dying and cannot be avoided?**
Lingathini ngemicabango yokuti iAIDS ngeyinye indlela yokufa ngayo engeneliseki ukuvikelwa?
Munoti nemafungiro okuti HIV/AIDS ndeimwe yenzira yokufa isingakwanise kudzivirirwa?

20. **What is your view as regards the idea that virginity testing should be upheld? Why?**
Lithini ngomthetho/ngesikho lokuhlolwa kwamantombazano ubuntombi babo? Kungani usitho njulo?
Munoti kudii pamusoro petsika yekuongorora umhandara hwemwanasikana asati aroorwa? Sei muchidaro?

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