

Preface and acknowledgements



This supplement to *Health Transition Review* consists of original papers and research reports prepared for a Workshop on Multi-Partnered Sexuality and Sexual Networking in Southern and Eastern Africa held at the University of Natal, Durban, 7-8 February 1997. The goal of this workshop was to bring together young researchers, particularly those from Eastern and Southern Africa, who are actively engaged in contextual studies relevant to sexual risk and the spread of the HIV/AIDS pandemic. The publication of these papers represents an extension of the Health Transition Centre's series of books and papers on AIDS in the Third World.

The workshop formed a smaller, complementary meeting to the International Union for the Scientific Study of Population (IUSSP) Conference on the Socio-Demographic Impact of AIDS in Africa. The Health Transition Centre at the National Centre for Epidemiology and Population Health, Australian National University co-ordinated the funding of the workshop with a grant from the Rockefeller Foundation. In South Africa, the Health Transition Centre co-organized the workshop with the University of Natal, Durban, especially the office of the Deputy Vice-Chancellor for Research and Development and the Economic Research Unit. The efforts of all those responsible for funding and organizing the workshop are gratefully acknowledged. In particular, we wish to thank Dr Seth Berkley (Rockefeller Foundation), Professor John C. Caldwell (Australian National University), Dr Alan Whiteside, Ms Deborah Jack, Mr John Devlin, Ms Pam Dow, and Ms Madeline Freeman (University of Natal, Durban).

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Introduction. Sexual networking, knowledge, and risk: contextual social research for confronting AIDS and STDs in Eastern and Southern Africa



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The Workshop on Multi-Partnered Sexuality and Sexual Networking in Southern and Eastern Africa, from which this selection of papers originated, took place at the University of Natal, Durban, on 7-8 February 1997. The workshop was primarily a gathering of young scholars, mostly from Eastern and Southern Africa, engaged in behavioural and cultural studies related to the spread of HIV/AIDS. In the context of the workshop, the organizers acknowledged that while a great deal of social research on AIDS in Africa has been done, it is not enough.

While demographers and epidemiologists may chart the epidemic, the answers to stemming the tide of AIDS remain with those who can assess the cultural and behavioural dimensions of this disease, and provide a meaningful basis for designing and evaluating interventions that focus on behavioural and cultural change. That Africans conducting such grassroots social science do not receive enough support is not a new insight, yet only marginal progress has been made in promoting such capacity in the decade and a half of the AIDS epidemic in Africa. Despite the enormous challenges for social research on AIDS, training opportunities for Africans in anthropology, sociology and qualitative research have lagged far behind those in epidemiology, demography, and international health. On the ground, AIDS research and intervention projects that have allocated multiple senior staff and teams of assistants necessary for demographic surveillance and epidemiologic monitoring often operate with a single expatriate social scientist and a junior African colleague for research assistance. Much of what is known has been produced by outside researchers and European and American graduate students, few of whom have the time or resources to properly aid in the development of the capacity of African colleagues to carry on research. Those African scholars who have received training often lack opportunities for professional development, research funding, and access to forums for publication.

By bringing the participants of the Durban workshop together, we sought to begin the task of drawing together those who are beginning their careers in this important field, and those who are moving toward it in mid-career. The participants were provided a platform in which they could engage one another in order to assess the state of current research on multi-partnered sexuality and sexual networking in the countries of the region; discuss the significance of regional dynamics of multi-partnered sexuality and sexual networking in relation to HIV/AIDS, sexual and reproductive health, fertility, and gender; and consider ways forward in co-ordinating a regional program of research and support for junior African scholars working on these topics.

In all, 22 researchers from nine countries in Eastern and Southern Africa participated. There were also several participants from outside the region, including three from West Africa. A few senior scholars attended, but most were Masters degree holders or graduate students in the disciplines of anthropology, demography, public health, history, education, and social medicine or psychiatry. The workshop culminated in the formation of 'SafeSexNet',

which is to serve as a facilitating body, keeping links alive in a regional network for scholars conducting behavioural and cultural studies on sexuality and risk in the context of AIDS.

Many of the papers and research reports published here represent work in progress. They all deal with issues that remain a focus of concern in addressing sexual networking, knowledge, and risk in Africa. These include young people entering sexual and reproductive life; the sexual activity of mobile and migrant men; and the role of qualitative methods and ethics in relation to AIDS research. Contributions by Leshebari and Kaaya, Kalunda, Nnko and Pool, and Varga explore issues of communication, knowledge, negotiation, and gender among adolescents and young adults in Tanzania, Zambia, and South Africa. Chirwa, and Lurie et al., take up the complex topic of men, migration and mobility with regard to risk of HIV/AIDS in Malawi and South Africa, respectively. Contributions from Harrison et al., and Letamo and Bainame examine the use of qualitative studies of sexual networking for improving STD services in South Africa, and cultural values about multi-partnered sexuality in Botswana, respectively. Some of the ethical challenges of qualitative cross-cultural research on sexuality (much of it, by necessity, conducted with people considered by fellow community members to be 'too young' to be involved in sex) are addressed in Bond's paper from Zambia.

Migrant labour, sexual networking and multi-partnered sex in Malawi



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Abstract

This paper shows the possible connections between migrant labour, multi-partnered sexual activity, sexual networking and the spread of AIDS in Malawi. It focuses on the economic, social, cultural and mobility factors, and their effect on the spread of the disease. Migrant labourers, like truck drivers, itinerant traders, and prostitutes, are a high-risk group both at the place of their work, and especially in their areas of origin. The paper also looks at the difficulties of research on HIV and AIDS among the returned migrants. The sensitivity of the topic, and the political nature in which it is often understood in Malawi, are factors that limit its objective and effective analysis. Another limiting factor is the consideration of human rights issues when interviewing actual or potential HIV patients. The information on which the paper is based comes mostly from field interviews with returned Malawian migrant mine workers to South Africa.

The first AIDS case in Malawi was documented in 1985 (see Cheesbrough 1986a,b). Since then, there has been a growing body of literature on the status of the disease in the country. Much of it is unpublished, focusing primarily on how HIV is, or is not transmitted, prevention measures, counselling, high-risk behaviour, condom use, misconceptions of the disease, and the effects on the country's economic and social structures (Kalilani 1989; Kishindo 1990; Carr 1992; Hubley 1993; Cuddington and Hancock 1994; Brown 1994; Chimtengo 1995; Kakhongwe and Kornfield 1996). There are also a few studies that deal with the demographic and geographical patterns of the disease (Ministry of Health 1991a; Becon 1991; L'Herminez, Hofs and Chiwaya 1993); policy implications and guidelines (Broadhead and Moorhouse 1992) and the public awareness campaign mounted by the government and other institutions (Ministry of Health 1991b; AIDS Secretariat 1994).

One major deficiency in this literature is that there are only a few studies that deal with the high-risk groups such as prostitutes, school students, drug users, truck drivers, itinerant traders and tourists (e.g. Chilowa, Dallabetta and Wangel 1991; Kishindo 1993, 1995a,b; Liner, McAuliffe and Chilowa 1993; McAuliffe 1994; Chirwa 1995; Chimtengo 1995). Though it has been noted that the fast spread of HIV infection in Malawi is predominantly due to the prevalence of multi-partnered sexual relations in the 18-45 age group, there are no comprehensive studies on this topic. The sexual networking of the high-risk occupational groups also remains insufficiently studied. The only exceptions are the prostitutes (bar girls) who have been adequately studied by Kishindo (1993, 1995a,b), Chimtengo (1995) and Cammack (1996).

The purpose of this paper is to show the possible connections between migrant labour, multi-partnered sexuality, sexual networking and the spread of AIDS. Economic, social, cultural and mobility factors affect the pattern of the disease. Migrant labourers, like truck drivers, itinerant traders, and prostitutes, need to be treated as a high-risk group both at their place of work and in their areas of origin. At the place of work the migrant workers live as single men and often have sexual relations with local women, mostly in pubs, canteens, and

such places; and also with men. At home, the earnings from migration play an important role in sexual and marital relations. Young men migrate to earn money and accumulate domestic goods for use in their families. Returning migrants engage in conspicuous spending, and since their incomes are generally higher than those of the average peasants at home, they become a major attraction to the rural women. As a result, the returned migrants often tend to have more than one sexual partner. These intrinsic relationships between, on the one hand, migration and multi-partnered sex, and, on the other, migration and material comfort, facilitate the spread of HIV infection.

There are difficulties in research on HIV/AIDS among the returned migrants, caused by the sensitivity of the topic, and its politicization in Malawi. It should also be noted that migrant labour is neither the only, nor the major avenue for the spread of HIV/AIDS in Malawi. Long-distance road haulage, tourism, prostitution, cross-border itinerant trade and the movement of refugees may play a more significant role in spreading the disease (Chirwa 1995:127).

The migrant workers study

The information on which this paper is based comes mostly from interviews with Malawian migrant mine workers returned from South Africa. The interviews were conducted in two separate studies in 1989-1990 and 1993-1994 (Chirwa 1992, 1996a,b, 1997). Neither of the studies had anything to do with the relationship between migration and AIDS. The aim was to find out how the returned migrants integrated in the socio-economic structures at home: their personal experiences as migrants, economic activities at home, and ambitions for the future. Issues of HIV/AIDS arose out of responses to questions relating to their repatriation from South Africa between 1988 and 1992. The emotional responses from the informants influenced the course of the research. The migrants wanted to have their story told. It thus became necessary to dwell on the issues of HIV/AIDS in detail.

For almost a hundred years, the South African mining companies recruited migrant workers from Malawi. In 1986, the Chamber of Mines introduced HIV screening for its recruits (Crush, Jeeves and Yudelman 1991: 120; Chirwa 1995, 1996a, 1997). By mid-1988, about 200 Malawians had tested positive. The Chamber of Mines requested the Malawi government to screen all potential recruits at home before they left for employment in South Africa. The Malawi government, on legal and moral grounds, refused to screen them. The Chamber responded by banning further recruiting of Malawian mine workers by its agent, the Employment Bureau of Africa (TEBA); and repatriating over 13,000 of those already at work in South Africa regardless of whether they were HIV-positive or not. The repatriation was due to the introduction, in 1987, of legislation prohibiting HIV carriers and AIDS sufferers from migrating to the Republic. It became an offence for an individual or an institution to knowingly help a person with HIV or AIDS to enter, work, or stay in the Republic. Those entering the country for purposes of work or study had to produce an HIV-free certificate issued not more than two weeks before their entry (Chirwa 1995:120; 1996b).

The above events provided the context for the investigation on the links between migration, sexual networking and the spread of AIDS discussed here. Questions were asked on the migrants' marital history, health record, social life at home and at the place of work, awareness of HIV/AIDS, and knowledge of anyone with the disease among friends, colleagues and relatives. The interviews were open-ended; no structured questionnaires were used, and the informants were given the chance to describe their migrant experience in detail. The role of the researcher was to probe with questions aimed at obtaining more details relating to the main themes of the study. Some informants were interviewed more than once, and on different aspects of the migrant experience. Since the intention was to gather qualitative information, the numbers of both the interviews and the informants were less

important than the quality of the information gathered. Some informants interviewed only once gave better information than some who were interviewed several times.

Most of the interviews were tape-recorded and transcribed verbatim. The informants had the right to refuse to be interviewed or tape-recorded. They were also free to put restrictions on public access to the recorded material as well as on the way the information generated could be used. In total, 163 returned migrants were interviewed in four districts in the three regions of the country. More than three-quarters talked freely about HIV/AIDS, but requested confidentiality when it came to information relating to personal health and sexual life. Marital relations were freely discussed: almost all the informants gave full details of their individual histories. Some names of colleagues with HIV or AIDS were mentioned with a request for confidentiality of the source of the information. In not less than 25 cases, these colleagues were located and carefully interviewed; all of them put restrictions on the publication of the information.

Migration, manhood and sexual maturity

The information from these interviews suggests a close connection between migration and the social construction of manhood and masculinity. Inherent in the last two are elements of male sexuality. In Malawi, as in southern Africa in general, migration is more than an economic phenomenon. It is also a cultural phenomenon, undertaken more or less as a rite of passage. Young men migrate to express their social and cultural growth. According to George Kapote Phiri of Chia in Nkhota-Kota district (interview 29 September 1989):

I decided to contract with TEBA and go to South Africa because everybody was doing it... every young man of my age.... Our fathers and grandfathers did the same. Through migrating we showed the world that we were men... after that we married... we had wives and children to show that we were grown-ups... we were mature.

These statements point to two important connections: between migration and the social construction of manhood; and between migration, manhood and sexuality, expressed in social terms, 'to have a wife and children to demonstrate to the world that we were grown-ups, we were mature'. The social construction of male sexuality is thus part of the construction of manhood and masculinity. Sexual relations are expressed in terms of social maturity, to grow up and marry, and migration is seen as a measurement of these factors.

The other link is between marriage and the rewards of migration. In those communities where *lobola*, bridewealth, is paid before marriage is consummated, young men migrate in order to obtain money or cattle for this purpose. Domestic goods accumulated through migration also play an important role in the maintenance of family life. It has been observed that the money and the domestic goods the migrants bring home make them 'a big attraction to women in the village' (Kishindo 1993:5; Chirwa 1992: Chapter 10). As a result, migrants maintain multiple sexual partners.

It is important to understand how material objects such as domestic goods and money enter the sphere of sexual and marital negotiations. A man courting a woman for sex or marriage is expected to make gifts to her, or her relatives. The acceptance of these by the woman symbolizes the acceptance of the man's sexual or marital advances. In cultural terms, the gifts carry the spirit of love and friendship. In Malawian culture, a man courting a woman for marriage affirms his commitment to her by giving her or her parents or guardians a material gift called *chikole*, from the word *kukola* meaning 'to get hold' or 'capture' or 'take control'. The *chikole* gift thus symbolizes the man's access and claim to the woman's sexual territory, and the exclusion of other men from her. A woman expects and receives the *chikole*

because it signifies the man's affirmation of his sexual and affectional commitment to her. Thus, *chikole* is a very good example of how material objects enter the circle of sexual or marital negotiations.

However, to give *chikole* to a woman does not mean to buy her sexual rights and favours; and it does not mean that the woman then becomes a man's sex object. Its value is that it symbolizes commitment, it is a seal of the sexual and social contract between the man and the woman. What migration does is to put the material items used as gifts into the hands of men, who are traditionally the initiators of the sexual negotiations. Thus, the material rewards of migration create opportunities for the migrant labourers for sexual networking in the communities where they live. For this reason there is an intrinsic relationship between migration, sexual networking, and multi-partnered sexual activity.

Sex has many dimensions. It is the means of procreation; but can also be used to express the emotional side of love and friendship, just as a material gift would do. Sex and material gifts can therefore be exchanged in a non-commercial transaction when they have the same emotional values. The exchange can occur in both marital and non-marital sexual negotiations because it is inherent in them. This raises a serious question when considering the dividing lines between commercial and affectional sex. In the former, sex is commoditized, sold and bought: there is a fixed or negotiated price attached to the sexual act. In the latter, sex is meant to express the emotional sides of love and friendship; or it is determined by religious, cultural and procreational morality. Affectional sex is thus linked to both the individual character and the societal moral attributes. The two categories are not mutually exclusive, and they both involve the circulation of material objects in their negotiations.

The individual and societal moral attributes which determine people's sexual behaviour may change with mobility, education, economic growth, and exposure to exogenous factors. Migrant labour affects societal moral attributes by exposing people to exogenous values. It also changes the material base of society, which in turn affects the moral values. Thus, most migrant workers engage in multi-partnered sexual life as a symbol of economic and social success; and as a form of entertainment. It is not necessary to show that they are in love, but that they belong to a socio-economic class that is different from the rest of society. They have the material resources, the knowledge of the social world outside their local communities, and the prestige associated with these. Their multi-partnered sexual behaviour is not interpreted as an indication of social irresponsibility and immorality, but as a symbol of economic and social success acquired through their migration to the mines. Society tacitly expects it. The rewards of migration enter this social sphere of success, status and economic power; and thus provide the opportunity to enter the sphere of sexual and marital negotiations.

Evidence from oral interviews suggests that it is usually during the first six to eighteen months of their return from work that the migrants tend to have multiple sexual partners. Thereafter, they are jokingly referred to as *woguga* or *wotchujuka*, meaning 'rusted', 'faded', or 'lost value', because after some time these people will have spent their money and items brought home through their conspicuous expenditure and consumption. They did this because, as career migrant miners, they were assured of going back to the mines and accumulating more (Chirwa 1996a, 1997). Out of the 163 informants interviewed, 84 or 51.5 per cent said that they had more than five 'regular' sexual partners during the first twelve months after their return from South Africa. Another 28.8 per cent said that they had between three and five partners during the same period; 14.1 per cent reported having between two and three sexual partners. The remaining 4.9 per cent refused to comment on the issue.

The 'regular' partners were defined as those with whom there were more than one or two non-commercial sexual contacts. There was some form of friendship that involved the exchange of gifts, provision of physical and emotional comfort and 'maintenance' of home. The popular phrase used is *chibwenzi* in the Chichewa language or *mubulu* in Tonga or

Tumbuka, which means 'love affair'. It involves a man 'taking care' of a woman by providing her with some of the necessities of life such as soap, food, money, and other domestic items. In return, the woman provides emotional and physical comfort to the man. She may also provide subsistence on a regular basis. The above figures suggest that 94.5 per cent of the informants had this type of relationship during the first twelve months after their return from the mines. If these men or their partners were infected with HIV the disease would rapidly spread in their local communities.

Migration and high risk

The relationship between migration and high risk can also be assessed by focusing on the sexual behaviour of these people in the process of migrating and at the place of work. Once recruited, the migrant workers were transported by bus to two transit centres in Blantyre and Lilongwe before being flown to South Africa. These centres were located outside town, but surrounded by facilities for night entertainment where prostitutes and local village women sold sex. One informant, Lloyd Chilewe, of Misanjo Village in Mulanje district (interview 4 April 1994), recalled the activities at Ngumbi near Chileka airport in Blantyre where the migrants were housed on their way to and from the mines:

The place was full of women, selling and buying... They drank with men and at night slept with them. It was a dangerous place... anything could happen there. There were also bars and bar girls in the vicinity. I am sure a few guys picked up some diseases, including AIDS, from that place.

His opinion was shared by almost all the migrants who had passed through the place to the mines and back. They told how one could buy sex with a blanket or a set of bedsheets from South Africa, or a pair of women's shoes or earrings. The concentration of these 'wild and tired' (meaning sexually deprived) men at these centres gave full-time and part-time prostitutes a ready market for their services. The transit points were thus among the places where HIV could be easily contracted by both the migrants and the women who provided sexual services.

In addition to the dispatch points the migrants could also contract the disease at the place of work. Historical studies have shown that there is a direct connection between prostitution, homosexuality, beer drinking, and the social reproduction of the mining labour force on a daily basis (van Onselen 1976, 1982). Malawian migrant workers interviewed for this study confirm this:

...there were beautiful women in shebeens, bars and canteens. They were easy-going women and they did not care if you slept with one of them today and her friend tomorrow. They said whoever had a man, it was her luck, tomorrow would be another one's luck... We had them at will... (Confidential interview, 9 April 1989).

The informants also made constant reference to *mathanyula*, homosexuality, in the compounds at the place of work. Because of these sexual networks, these informants argued, the chances of contracting AIDS within South Africa were very high (Mwazeni Mtira, 29 September 1989).

Most migrants interviewed were aware of their position as a high-risk group. Binford Mhone of Dindano village, Nkhata Bay, observed that despite the awareness of the risk of contracting HIV, there was a tendency for the majority of these men to engage in multiple sexual relations. This, he argued, was partly due to the fact that the majority of them migrated

as single men; and partly also because, with money in their pockets, they took the purchase of sex as a form of easy and cheap entertainment.

At this juncture there is a link between migration, alcohol consumption, and commercial sex. In Malawi, as in many African countries, bars, restaurants and canteens are places where prostitutes operate. Studies in Zimbabwe have shown that commercial sex is 'largely based out of bars... 98 per cent of commercial sex acts [are] preceded by alcohol consumption' (*World Bank* 1997:2). This is true of Malawi and other eastern and southern African countries. The evidence on which the present paper is based shows that before the ban on recruiting, returned migrant labourers were regular patrons of bars, and thus potential customers for prostitutes. Some of them invested their pay in bar, restaurant and canteen businesses (Chirwa 1997).

Though most migrants have a multi-partnered sexual life, they do not openly show it. Sexual issues are regarded as private. Similarly, issues of HIV/ AIDS among them are kept confidential. The identities of those who had tested positive in South Africa are not publicly revealed. Family members are not told, unless by the victims themselves. 'I knew that my "friend" had tested positive', said one informant, 'but I cannot tell anyone because it is not something I should tell everybody'. The reason given for this attitude is that the migrants do not want to cause some kind of AIDS scare in the villages. In addition, it is felt that revealing the information is like passing judgement on the victims' morality, and condemning them to death 'given that everybody is aware that the disease has no cure' (Confidential interview, 12 April 1994).

Neither the Malawi government nor the Chamber of Mines publicized the results of the HIV screening in South Africa (Chirwa 1995, 1996b). The danger here is that some, if not all, of those who had tested positive had sexual partners at home. Some of them are now dead and their widows have remarried or have had several other sexual relationships. In a recent study in the Kapichira area in Chikwawa district, south of the country, Cammack (1996:11) observed:

Old men in Njereza report that those TEBA men in their village and in nearby Bwalo especially, are now dead, leaving widows (some of whom remarried locally) and orphans. Whether the Kapichira villagers have made the connection between AIDS and the premature deaths of these men is unclear. In any event the premature death of younger men has been noted elsewhere.... where there are reportedly more orphans than in previous years.

This could be the case in many other areas to which the repatriated HIV-positive migrants returned. The Malawi government made the mistake of not testing the repatriated workers; and no effort was made to educate them on the risk of passing the virus to their partners at home. It would have also helped if the government had kept a record of these people and where they went for follow-up and counselling purposes. The lack of information on these people has made it difficult for social researchers and medical personnel to conduct investigations on them. The degree of the risk they pose to their local communities and to the Malawi society in general thus remains unknown.

Research difficulties

In addition to the lack of records on the repatriated migrants with HIV and AIDS, there are other challenges to research on the subject. First, 'many of the behaviours thought to transmit HIV are private and hence difficult to investigate' (Boulton 1992: 1; see also Jayasuriya 1988; Miller and Rockwell 1988; Orubuloye et al. 1994; VanLandingham et al. 1994). Asking about individuals' sexual behaviour, beliefs or preferences, marital stability or instability,

extramarital relations and other forms of multi-partnered sexual activity entails 'treading on very personal ground and involves a high risk of offending and alienating respondents' (VanLandingham et al. 1994:85). Though the informants for this study were ready to talk, they could not avoid being sensitive to some of the questions put to them. They were concerned about the stigma attached to the disease, and would certainly not like to see their names appear in official documents as carriers or patients, or even as people who have been tested (personal communications I. Nyirenda, 16 December 1993; J. Kaunda, 18 December 1993; G. Mulile, 8 December 1994). The reason for this is that HIV infection is widely associated with loose sexual behaviour. As a result, the identification of a person as an HIV carrier or AIDS patient is often taken as an indication of promiscuity, despite the general awareness in the country that the disease can be transmitted in other ways (National Statistical Office 1994: Chapter 10).

The second difficulty, and related to the above, is the accessibility of certain stocks of information. Though the informants may be physically and readily accessible, the wider stocks of the information they possess may not. This is especially so with people infected or likely to be infected. Many of them may not want to face the realities of their predicament or to talk about it. Awareness of their infection often gives them a negative attitude towards researchers. Their view is: 'You know I am dying and you are here to assess how soon that will be'. The result is that such informants will give only partial information.

Related to both the social sensitivity and the inaccessibility of the information are issues of human rights. How do the social researchers working on HIV and AIDS protect the rights of their informants? In the course of this study, two cases of rights violations were observed. The first was the case of medical professionals who conducted a study at an urban hospital in Malawi without giving their research subjects the right to agree or refuse to be part of the sample. The aim of the study was to examine the relationship between STD and HIV-1 infection in urban pregnant women. Some 5376 pregnant women presenting for prenatal care were interviewed about their demographic, medical and sexual history. They were given a physical pelvic examination and were tested for syphilis and HIV-1 (Dallabetta et al. 1988). Those in the sample maintain that they were not informed of the purposes of the inquiry and the tests, and were not given the right to agree or refuse to be party to the exercise. In addition, they did not have access to the results and were not informed of how these were to be used.

The other case was that of the migrants screened in South Africa. They too were not informed of the purposes of the exercise and the way the results were to be used. They also feel that taking blood samples for HIV screening without their informed consent was an insult. After the screening, they were stigmatized as a 'high-risk group'. 'This attitude', complained Mwazeni Mtira, 'brought a lot of psychological torture to us...In the compounds and at work we were taunted and heckled by our colleagues from the other countries... they called us dying people...'

The fourth challenge in dealing with these informants is that the researcher has to guard against both the social seclusion and the exploitation of the subjects. Once the informants have been singled out as a target sample group, there is the danger of developing in them a sense of the putative vectors of the disease which in turn leads to social seclusion (Scambler and Graham-Smith 1992). They become the people to be monitored and to be consistently researched. As the research becomes more and more focused on them, it becomes 'a form of surveillance in its own right' (Scambler and Graham-Smith 1992:68). In the process, the dangers of violating the informants' right to privacy become enhanced. There is also a danger of over-exploiting the informants as a source of information. As victims, or potential victims, the informants are likely to feel powerless *vis-à-vis* the researcher in a research situation. This

imbalance of power is among the factors that lead to exploitation and objectification of the informants in the research process (Holland et al. 1992:228-229).

Finally, as regards the connections between migration and the spread of HIV/AIDS in Malawi, there are enormous conceptual and political challenges. The most important are those relating to the politics of the disease. After its first diagnosis in 1985, there was a lot of official resistance to reporting and researching it. Even the medical officials in the country were not willing to be objective and open about it. In fact, they resisted and condemned any external attempts to report and research on the disease:

It is difficult not to respond angrily to so called 'expert estimates' of the incidence of AIDS in one's country. The correct approach, however, is to acknowledge that AIDS cases have been seen in our hospitals... and to state our present ignorance of the magnitude of HIV-III infections in the community. We should challenge such expert opinions on the incidence of AIDS in Malawi as have been published in *Africa Health* or in the sensational *Zimbabwe Sunday Mail* by carrying out our own epidemiological studies and publishing the data (*Medical Quarterly* 1986).

The medical officials further claimed a monopoly of knowledge on the issue and gave themselves 'the duty... to accurately inform the lay public' about the disease in Malawi. They even denied that HIV/AIDS was a major health problem, instead calling it 'a diminutive community health problem'. However, it did not take them long to realize that 'there was a high incidence of HIV infection' among Malawian prostitutes, male hospital staff and male prisoners hospitalized with other diseases.

The reason for the defensive attitude is that until very recently, Malawi was a closed society with a political leadership that was not willing to acknowledge the existence of crises, endemic poverty, hunger and disease. The efforts of researchers to work on HIV/AIDS were curtailed by a political regime ardent in its assertion that the country was a 'star performer', a model of economic growth and political success where everybody was healthy and lived in peace. This was coupled with the assertion that this was a Christian country with strong moral values. Since AIDS is widely associated with promiscuity, use of drugs, homosexuality, and other forms of 'immoral' behaviour, Malawi, as a Christian country, would not be the place to look for it. Sheltering under the umbrella of Christian morality, the Malawi government could not publicize the prevalence of HIV/AIDS among its repatriated migrant workers.

The manner in which the migrant workers were repatriated has added to the challenges of research on HIV/AIDS in Malawi. The issue has become extremely politicized (Chirwa 1996a,b; 1997) to the extent that any mention of HIV/AIDS to the repatriated migrants immediately arouses ill-feeling against TEBA, and both the South African and Malawi governments. The migrants are still seeking explanations for the events of 1986-1992: why they were screened, hurriedly repatriated (most of them without compensation), dumped at home, and not told anything about future prospects of employment in the mines. They feel betrayed by their home government for not fighting for their cause.

Conclusion

The above challenges call for a major reassessment of the research methods for investigating the AIDS pandemic in Malawi. The scope of contemporary enquiry is limited to perceptions of risk and risk-taking behaviour, condom use, and public awareness campaigns. The methodological advances in social research on AIDS achieved elsewhere in the world (Boulton 1992; Aggleton et al. 1992) have not reached Malawi, and much of southern Africa in general. There is need to employ different models for studying cohort groups, and for the designing of field studies and counselling strategies.

The case of the Malawi migrant labourers is important because it highlights some of the areas and challenges of social research on HIV/AIDS in their country. Given that the whole of the southern Africa region is affected by the system of oscillating labour migration, there is need for comparative studies on the relationship between this and HIV/AIDS infection patterns. The movement of refugees, the return of exiled political groups and liberation forces, and the massive retrenchment of migrant workers from the mines, will have effects on the pattern of the disease in the region (see *Southern Africa Economist* 1992). These groups need to be placed in the high-risk categories. It is therefore important to draw the connections between the constellations of cultural, social, economic and political factors and the pattern of HIV/AIDS in the region.

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Circular migration and sexual networking in rural KwaZulu/Natal: implications for the spread of HIV and other sexually transmitted diseases*



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Abstract

Patterns of migration do not simply arise out of chance. In South Africa, for example, migration patterns are a result of decades of legislation aimed at restricting the movements of the majority of the population and providing a steady flow of cheap black labour to the gold mines and other industries. In the new democratic South Africa, restrictive laws have been lifted, but circular migration remains a way of life for several million black South Africans.

This paper examines the social and epidemiological implications of widespread circular migration from the perspective of a rural South African Health District. In particular, we report our findings on the patterns and prevalence of migration into and out of the Hlabisa Health District in rural KwaZulu/Natal, and the patterns of sexual networking of migrants and their rural partners. We conclude by examining the implications of these patterns of migration and sexual networking for the spread of HIV and other STDs.

The prevalence of HIV in KwaZulu/Natal, South Africa, is nearly double the national average, and is increasing rapidly. In 1995, the prevalence of HIV among women attending antenatal clinics was 18.2 per cent, up from 4.5 per cent in 1992 (Swanavelder 1996). Throughout South Africa, black people suffer much higher infection rates than any other group, and women aged 20-24 are most affected.

HIV in South Africa is not strictly an urban problem. In Hlabisa, a rural district of about 210,000 people in Northern KwaZulu/Natal where this study takes place, HIV prevalence in women attending antenatal clinics increased from 4.2 per cent in 1992 to 25.9 per cent in the first four months of 1997 (unpublished data). In addition, HIV prevalence in a small household sample of one defined geographical area was measured at 12 per cent (Wilkinson et al. 1997).

Importantly, all of the HIV cases detected in this pilot study were either migrants or partners of migrants. This highlights the fact that many of the people, males in particular, are extremely mobile and are therefore probably at increased risk for HIV and other STDs. More than 2.5 million black South Africans were registered as migrant labourers in 1986, although

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the number is probably much higher (Jochelson, Mothibeli and Leger 1991:158). Migrant labour was a central tenet of apartheid, which sought to create a steady flow of cheap black labour to South Africa's mines, industries and farms. A myriad of laws prohibited black South Africans from settling permanently in 'whites only' areas, and as a result, migration patterns in South Africa tend to be circular, with men maintaining close links with their rural homesteads.

This paper explores the social and epidemiological implications of widespread circular migration from the perspective of a rural South African Health District.

Migration and sexually transmitted disease

In several parts of the world, geographic mobility, migration and widespread population displacement have been identified as significant risk factors in the transmission of HIV, and 'migration has become a central theme in the discussion of AIDS' (Decosas et al. 1995:826). Migrants are particularly susceptible to HIV and other STDs, both in South Africa (Zwi and Bachmayer 1990; Jochelson et al. 1991; Department of Health 1995) and outside (Hunt 1989; Quinn 1994; Decosas et al. 1995; Nunn et al. 1995; Lurie, Hintzen and Lowe 1995; Decosas 1996). The argument that migration is a risk factor for HIV and other STDs rests on the assumption that migrants are more likely than non-migrants to have additional sexual partners.

Despite this growing body of work, there are still major limitations in the available literature. This section reviews some of the key findings about the relationship between migration and STD including HIV and concludes with a brief discussion highlighting the shortcomings of the studies that have been done.

Table 1
Summary of major migration and HIV/STD research

Location, year (authors)	Population	Main findings
Uganda, 1995 (Nunn et al.)	Rural Ugandan residents and migrants	People who moved within last 3 years were 3 times more likely to be infected with HIV than those who had stable residence for 10 years.
Senegal, 1993 (Pison et al.)	Seasonal migrants in rural areas	HIV spread mostly first to men who became infected during seasonal migration, then to their rural partners when they returned.
Zimbabwe, 1990 (Bassett et al.)	Urban male factory workers	HIV+ men more likely to live apart from their wives and to have multiple sex partners.
South Africa, 1991 (Jochelson, Mothibeli and Leger)	Urban male mine workers	Migration disrupts family life and creates a market for prostitution in mining towns.
South Africa, 1992 (Abdool Karim et al.)	Rural KwaZulu/Natal residents and migrants	HIV 3 times more likely among those who had recently changed their place of residence.

A recent study on HIV and migration in Uganda showed a strong correlation between HIV infection and migration status (Nunn et al. 1995). The lowest rates of HIV were found in those people whose place of residence was more permanent. People who had moved within the last five years, for example, were three times more likely to be infected with HIV than

those whose residence had been stable for more than ten years. The lowest infection rates were among those who had been living for the longest time in the same place. The study also documents that people who migrate have more sexual partners than non-migrants. However, since this study deals with one-way, long-term migration, it may have only limited applicability to South Africa's pattern of circular migration and its implications for potential repeated exposures.

In rural Senegal, a study of seasonal migration and HIV reported that HIV was 'mainly transmitted first to adult men through sexual contacts with infected women met during their seasonal migration and second to their wives or regular partners once they are back home' (Pison et al. 1993:196). Since this study concentrates on seasonal migration, in which men spend on average half a year or more away from their rural homes (Pison et al. 1993), the implications for South Africa may be important as the migration patterns in Senegal are somewhat similar to those of South Africa.

In a study of male factory workers in Zimbabwe, HIV-positive men were more likely to live apart from their wives and to have multiple sexual partners than HIV-negative men (Bassett et al. 1992). In Ghana, Anarfi has argued that migration 'acts to increase the extent of sexual networking' (Anarfi 1993:45).

In South Africa, high rates of STDs have been found in gold miners, although there have been no studies on prevalence of HIV or other STDs among returning migrants. Some estimate that the prevalence of HIV infection among migrants is 50 per cent higher than among non-migrants (Evian 1995). In a study of the seroprevalence of HIV in a rural KwaZulu/Natal community, people who had recently changed their place of residence were three times as likely to be HIV-infected (Abdool Karim et al. 1992).

While the argument that the migrant labour system encourages high-risk sexual behaviour in South Africa has not been proved in a statistical sense, it is clear that migrants' frequent and lengthy absences from home can 'disrupt their familial and stable sexual relationships' (Jochelson et al. 1991:157). Quinn argues that the migrant labour system created a market for prostitution in mining towns (Quinn 1994), and this is borne out in other research (Roets et al. 1996). This argument is not new. In 1949 Kark argued that the widespread prevalence of gonorrhoea and syphilis in both urban and rural areas of South Africa was due to the migrant labour system and that prostitution resulted from the separation of husbands from their wives and families (Kark 1949).

There are several limitations to the current literature, and this study is a modest attempt to begin to fill those gaps. First, most studies on migration tend to focus on migrants at their place of work. Consequently, they fail to document the effects of migrants' return to rural areas. The circular pattern of migration in South Africa may put people at risk of HIV and other STDs at both ends of the migratory movement. However, in part because of the emphasis of migration theory on the determinants of migration, and in part because most work in South Africa on migration has occurred on the gold mines, little if any work has been done to document the effects of circular migration in South Africa's rural areas.

More specifically, while there is some rudimentary understanding of the relationship between a person's migration pattern and susceptibility to HIV, little is known about that person's rural partner's susceptibility to HIV or other STDs. Studies that examine the social and epidemiological implications of migration at both ends of the migration spectrum are therefore needed.

A further limitation of the available literature is that it tends to classify 'migration status' as a dichotomous variable: one is considered either a migrant or a non-migrant. Relatedly, many studies look only at one-way, long-term migration. In reality, however, the situation is considerably more complex and fluid. For example, migration status can change several times within the course of a lifetime. Furthermore, there are many different types of migration, and

each may carry with it a different risk of sexually transmitted infection. A contextualized approach that seeks to refine our understanding of different types of migration is therefore urgently needed.

Finally, most work on the relationship between migration and HIV and other STDs has tended to ignore the implications for interventions. If indeed migrants are at increased risk for STDs, then it is imperative to develop appropriate targeted interventions.

Research questions and methods

The formative phase of this rural-based research which we report here aimed to answer the questions: what are the patterns of migration into and out of the Hlabisa Health District? What are the patterns of sexual networking for migrants and their rural partners?

The majority of data were collected through repeat visits to 20 case-study households which were selected because they contain a male migrant. Permission was initially sought from the local Tribal Authority who identified several community health workers to work more closely with us and to facilitate entry into the selected households.

Each household has been visited an average of eight times over the course of the year. Data collection methods included both qualitative and quantitative techniques, which ranged from open-ended interviews to more structured monthly household censuses. The topics in open-ended interviews have ranged from the pros and cons of one's partner being a migrant, to health beliefs and health-seeking behaviour. Male migrants attached to the 20 case-study households have also been interviewed in Hlabisa where possible. Many of the interviews were conducted around Christmas time, when many male migrants return home.

Unfortunately, most censuses are inadequate for estimating the prevalence of migration since they tend not to ask specific questions about migration. Indeed, most temporary migrants in South Africa maintain close links with their rural homesteads. Therefore the census question 'Where do you live?' tends to be interpreted as 'Where is your permanent home?' since most migrants view their migration destination as only a temporary location. Without further probing, important information about migration does not get reported.

Therefore, in order to measure the prevalence and patterns of migration, we worked in five local schools situated in different parts of the District. There, Standard 5 students kept daily household composition logs over the course of one calendar month. Each morning they recorded who slept in their house on the previous night.

It should be acknowledged from the outset that the students themselves do not come from a random sample of households. Indeed, it could be argued that fathers of Standard 5 students are in the age group most likely to be migrants. However, given the wide range of ages over which men father children, as well as the wide range of ages of Standard 5 students themselves (ages 11-20 in this sample), we feel that this sample is adequate to make a reasonable estimate of both the prevalence of migration and the major migration destinations.

Furthermore, the school data have been supplemented with other data in an attempt to safeguard against the possible sampling bias mentioned above. In a recent community-based study on contraceptive practices among women in the district, we asked questions about the number of migrants in each household and their destinations. The findings were consistent with those of the school-based research, suggesting that there are no major biases in the school data.

Finally, we conducted structured observations at the local taxi rank in an effort to document patterns of movement into and out of the District.

Findings

Prevalence of migration and main migration destinations

From the rural perspective of Hlabisa, we are clearly unable to measure and detect one-way, permanent migration to urban areas in which people essentially leave the district for ever. However, it is clear that the predominant mode of migration in the district is that of circular or oscillating migration undertaken by men between the ages of 20 and 50.

We estimate that approximately 60 per cent of households have a male who is a migrant. People in Hlabisa, particularly those in the more rural parts of the District, live in kraals which are essentially a collection of households located on the same property and inhabited by members of the same family. We estimate that 50 per cent of kraals have one male migrant¹, and an additional 30 per cent have more than one male migrant. One-third of kraals had a female migrant, and another 15 per cent had two or more female migrants.

Table 2
Prevalence of migration in Hlabisa: school and household surveys

Measurement	School-based data	Household study
Sample size	120 Standard 5 children	112 kraals; 138 women aged 16-49
Prevalence of male migration	62.5 per cent Std 5 students had a father who is a migrant	55 per cent women had partners who are migrants, 50 per cent of kraals had 1 male migrant; 30 per cent of kraals had 2 or more male migrants
Prevalence of female migration	Not measured	33 per cent of kraals had a female migrant; 15 per cent of kraals had 2 or more female migrants

The main migration destinations for males from Hlabisa are shown in Figure 1 (Map with arrows out of Hlabisa). The three most common destinations are Johannesburg (32%), Durban (20%) and Empangeni (20%). Most of the rest of the male migrants from Hlabisa are scattered along the coastline between Hlabisa and Durban.

The main migration destinations for female migrants from Hlabisa District are shown in Figure 2. Female migrants live and work much closer to home than male migrants. One third of female migrants from Hlabisa were in Nongoma, which at 50 km is essentially the closest town; 22 per cent were in Durban, and all of the rest, 45 per cent, spread out along the coastline between Durban and Hlabisa, no more than a two-hour drive away. Interestingly, no women migrated to Johannesburg or its environs, despite the fact that the Johannesburg area is the most common migration destination for males from Hlabisa.

Number and duration of migrants' visits home

Not surprisingly, there is a relationship between the distance a migrant travels from Hlabisa and the number of nights he or she is able to return home each month. Since women migrate much shorter distances than do their male counterparts, they are able to return home more

¹ A migrant is defined here simply as someone who spends most nights away.

often and maintain closer links to their families. Some women are able to return home every weekend, others less often; but the majority of female migrants return to Hlabisa at least a few times a month.

Johannesburg, being about the furthest recorded migration destination from Hlabisa, and the most common destination for men, is about 600 km away, 100 km being on dirt roads. It takes between six and seven hours to travel there in a taxi. Most Hlabisa migrants working in the Johannesburg area are able to return home every 2-4 months for a long weekend, and somewhat longer over the Christmas holidays, depending on the nature of their work contracts. However, given the cost and time it takes to travel back to Hlabisa, more frequent visits are generally not feasible.

By contrast, Hlabisa migrants in Durban can and do come home at least once a month for a weekend. With the new road the journey can take as little as three hours and costs R50 (about US \$11.25 at current exchange rates). Empangeni is about an hour and a half from Hlabisa and costs R20. Many Hlabisa migrants in Empangeni return home several times a month. Several of the large companies there have special buses that travel on Fridays and Sunday evenings between Empangeni and Hlabisa.

Changing patterns of migration

The most significant change in migration patterns reported by informants is the fact that those migrants who live far away are able to return home much more often. For example, a decade ago, a Hlabisa migrant working in Johannesburg was able to return home only once a year over the Christmas holidays. Now, however, with the lifting of laws restricting the movement of the majority of South Africa's population, more flexible work contracts and improved transport systems, including a significantly developed taxi network, these same migrants can return home much more often: up to five or six times a year.

Another indication of the change in migration patterns is the fact that increasingly female partners of male migrants visit their husbands at their work places. A decade ago, with strict 'influx control' laws, such visits were strictly prohibited: all black South Africans carried with them 'passbooks' which stipulated whether or not they could legally travel in 'whites only' areas. Obtaining the correct stamps in the passbook was difficult indeed and consequently few female partners visited migrants at their workplace. Out of the 20 case-study households eight men returned home over Christmas 1996 and another three women visited their husbands at their place of work.

Sexual networking among migrants

In his excellent ethnography of gold miners in South Africa, Moodie begins a chapter on sexual activity by stating that 'miners had three main preoccupations in the compound after work - drinking, the seduction of town women, and homosexual encounters' (Moodie and Ndatshe 1994). The availability of a wide range of prostitutes in and around the gold mines has also been well documented (Roets et al. 1996). However, it is impossible at this point to estimate the number, type and duration of miners' sexual contacts.

Female partners of male migrants clearly recognize that their partners are anything but monogamous while away. On the contrary, female partners of migrants are so certain that their partners take additional sexual partners while away that they often laugh at the idiocy of such a question. This assumption is so central to the context of migration that it is barely discussed since it is recognized by all, females as well as males, as being a truism.

This brief excerpt from an interview with a key informant serves as an illustration:

ML: What is the worst thing about your husband being away?

A: It happens that when a man is away he gets lonely and then he fails to stay alone. It happens to our husbands all the time. We can't trust them to stay alone.

ML: Do you think that your husband is staying alone while he is away?

A: NO! (Loudly) Man fails to stay alone for a long time.

ML: Why do men have other partners?

A: It is because of the distances between us.

Indeed male migrants themselves readily admit that they take additional sexual partners while away. This excerpt from a focus group with four returned male migrants in Hlabisa illustrates the point:

ML: What is the most difficult thing about being away?

A1: You don't see your wife, children, cattle or property.

A2: You think about your wife, children and your home all the time, but there is no phone, so I must write a letter and it takes a long time to reach my wife. You think about your home and your family all of the time, but if something goes wrong there, there is nothing you can do because you are so far away.

ML: Some other people have told me that if a man is away he automatically has other girlfriends. Is that true?

A1: (All laugh) Yes, it is true. You must have other girlfriends as you are a human being.

ML: What is it about being a human being?

A2: You have needs for a woman.

ML: Do you all have girlfriends where you are staying?

All: Yes (all laugh), of course!

Migrant men report a wide range of relationships while they are away. At one extreme, some men have set up 'parallel families' at their work place: they live with women they call their wives and have children with them. Many men report having lived with the same woman for 5-6 years. Sometimes their rural wives know or find out about the existence of a second, urban wife, but generally this is kept a secret. At the other end of the spectrum are prostitutes who are readily available at the mines and other employment centres. There are certainly many gradations in between.

Sexual networking among rural partners of migrants

Women are much more reluctant than men to admit that they have been involved in sexual relationships outside marriage. Some women express fear that if their husbands found out that they were in another relationship 'he would beat me'. While this may certainly be responsible for significant under-reporting of additional partners, it is also possible that in reality women are less likely than men to have additional partners in their husbands' absence. One reason for this is simply space. In a rural community it is difficult to conceal a male visitor; most neighbours know what is going on next door and consequently it is difficult to hide:

ML: Does it ever happen that a woman has partners when her husband is away?

A: It happens that a husband is away and a woman falls in love - it happens many times. But we would never tell one another if we had someone else. I have heard secretly that a woman has fallen in love with someone else, but we don't talk about it.

However, the existence of a Zulu word, *ishende* or 'man on the side', suggests that it is a common enough practice to warrant its own label. *Ishende* has also been translated as 'roll-on' because, like a deodorant, it is something that goes on under the arms and is therefore kept well hidden.

Discussion

Large-scale circular migration, predominantly among men, but among a smaller proportion of women as well, has been documented in rural KwaZulu/Natal. In addition, we have presented preliminary data on the patterns of sexual networking among migrants and their rural partners. In this section, we discuss some of the possible implications of these migration patterns and patterns of sexual networking on the further spread of STDs including HIV in this population.

We presented two potentially important changing patterns of migration that may have important implications for the spread of STD. First, long-distance migrants are now able to return home more often than they could in the past. Second, it appears that more rural-based wives of migrants are visiting their husbands at their migration destinations. Both these findings have the probable effect of increasing the frequency of visits between migrants and their rural partners. The increased frequency of contact may well mean that rural partners are more often exposed to sexually transmitted infections. It is possible that a U-shaped curve describes the relationship between frequency of contact and likelihood of HIV infection. At the extremes—when a partner is always home, and when a partner is never home—the chances of STD transmission are probably low since there are few opportunities for transmission. But in situations where migrants are coming and going with greater frequency, it is possible that the chances of transmission are greater because of the increased frequency of potential exposure. Clearly, this hypothesis needs more testing, and this will be done in the next phase of this study.

The directionality of STD spread also needs further examination. There is a common, and unproven, assumption that it is returning male migrants who infect their rural partners, and not the other way around. However, it is possible that some of the spread may be from rural partners to returning migrants. There is insufficient information at this time to warrant any conclusions. However, this is clearly an important area of research since it has clear implications for the design of targeted interventions.

A way forward

Interventions aimed at returning migrants and their rural partners may well be needed, and will be further justified by the HIV and STD incidence and prevalence data that will be collected in the next phase of the study. The possibility of selected mass treatment for some returning migrants has also been discussed, although prevalence data are urgently needed to make an informed recommendation. Other prevention efforts, like microbicides, male and female condom promotion and health education are also needed.

Interventions aimed at migrants should ideally occur both at the workplaces and at home. Concentrating interventions exclusively at one place misses important opportunities. Sweat and Denison (1995) have argued that HIV interventions can occur at several levels: individual, environmental, structural and superstructural. However, prevention efforts have been dominated by interventions aimed almost exclusively at the individual (Sweat and Denison 1995:S251).

At least two structural interventions should be considered. Employers should be encouraged to provide, instead of single-sex hostels, more family-friendly housing arrangements. The mining industry, for example, has moved at a painfully slow pace in this direction: in 1993, only 2.1 per cent of miners employed by the Anglo-American Mines lived in married quarters; the vast majority, 89 per cent, lived in single-sex hostels (Crush 1995).

A second, and perhaps more significant structural intervention is that of encouraging rural development. This has the potential to alter the conditions that force large numbers of young men to seek temporary employment in urban areas and may well be as effective an intervention as we have. Indeed, these kinds of interventions need to be discussed not only for this particular rural health district, but for all of Sub-Saharan Africa, where large-scale population movement is the norm, not the exception.

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Bridging the information gap: sexual maturity and reproductive health problems among youth in Tanzania



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Abstract

The paper presents a brief review of the available literature on exposure to premarital sexual intercourse in the youth population, then discusses youth's current and preferred sources of reproductive health information, as well as the contexts of both acquisition of such information and exposure to coital experiences; what is known regarding consequences of unprotected premarital sexual intercourse among young people; and barriers to reproductive health information and services as well as potential approaches to solutions.

Many Tanzanian young people have unprotected premarital coital experiences, and suffer from subsequent ill-effects on their health. Current reproductive health information sources for this population in Tanzania are largely informal, and young people have difficulty in access to information from responsible adults in communities; they are more exposed to information on sexual intercourse than on more basic issues related to biological maturity and its significance. The circumstances of sexual intercourse experiences appear to include cultural gender differences in the ability to negotiate relationships with the opposite sex, economic factors, and changes in the socialization roles of parents which decrease parental supervision of youth activities. Many of these factors reflect changes in society in general, presenting a challenge to current socialization structures such as families, communities, the education and health systems and religious bodies to find ways of working together to provide consistent messages to youth. There is also an urgent need to address the needs of youth in contemporary Tanzanian societies, for appropriate and healthy psychosexual development.

Background

The youth (age range 10-24 years), who constitute about a third of the population in Tanzania, face several reproductive health problems. These include exposure to unprotected sex, low levels of reproductive health knowledge, poor awareness of the potential consequences of unprotected sex and lack of counselling services on reproductive health issues. Although there are no national data on the extent of coital experience among youth, available information suggests that only about 20 per cent experience coitus through marriage (Leshabari and Kaaya 1994).

Table 1

Census data on the percentage of married youth by age and sex, 1967, 1978 and 1988

Age group	Census year	Proportion married (%)
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		Males	Females	Total
10-14	1988	0.5	1.1	0.8
	1978	0.2	0.8	0.5
	1967	0.4	3.2	1.8
15-19	1988	4.1	29.3	17.0
	1978	3.5	36.8	20.5
	1967	6.9	51.9	30.6
20-24	1988	30.9	73.8	55.0
	1978	34.3	83.7	61.9
	1967	43.1	90.5	71.1
10-24	1988	8.7	30.2	19.9
	1978	9.3	35.9	23.0
	1967	13.0	47.2	31.0

Source: Computed from 1967 *Population Census*, Vol. 3, Table 202; 1978 *Population Census: Basic Demographic and Socio Economic Characteristics*, Table 2; 1988 *Population Census: Basic Demographic and Socio-Economic Characteristics*, Table 4.

Census data, summarized in Table 1, indicate that the proportion of married youth has decreased from 31 per cent in 1967 to about 20 per cent in 1988 (Bureau of Statistics 1971, 1982, 1992). Part of this decrease is probably due to an increase in school enrolment, which was increased by implementation of the Universal Primary Education Policy from 2.2 million children in 1977, to 3.9 million in 1988 (BEST 1996). This implies that many girls who, according to tradition, would have been married soon after menarche now get married several years after completing at least their primary school education.

However, despite a decrease in the proportion of married youth over the past few generations, there is a persistent variation by sex of married youth in all age groups of the census data years, with a larger proportion of married females than males in younger age-group categories. For example in 1988, only four per cent of boys aged 15 to 19 years were married, compared to 30 per cent of girls in the same age group, suggesting that young females do not draw partners from their age category but are married to men older than themselves. This wide difference between the ages of married male and female youth is one possible explanation for the higher cumulative AIDS cases observed amongst young females, who are likely to be exposed to older and more sexually experienced partners, increasing their chances of acquiring HIV (NACP 1994).

'Sugar daddies' have often been blamed for observed coital relationships between single girls and older men, where financial or material gain for the girls is implied (Lema and Kabeberi-Macharia 1992; Lwihula, Nyamuryekung'e and Hamelmann 1996). However, the 'sugar daddy' phenomenon may be too simplistic an explanation for the dynamics of sexual relations in Africa, particularly with respect to the youth population. In a study conducted in Dar es Salaam for example, a large proportion of 200 teenagers with abortion complications, the majority of whom were single, reported their partners to be men above the age of 45 years (Mpangile, Leshabari and Kihwele 1993). Almost 40 per cent of these partners lived in the same poor neighbourhoods as the girls and were not perceived to be better-off financially. Thus financial and material benefit for the girls may not have been the only reason for their relationships with the older men. Often when the 'sugar daddy' phenomenon is discussed, a shift from established cultural rules which governed sexual morality and sexual partnership in the African context is implied.

Although the choice of sexual and marital partner is influenced by a host of socio-cultural constructions of relationships with the opposite sex and contexts governing sexual intimacy in many African cultures, Setel (1997) noted that the notion that there ever were clear-cut

universally obeyed rules and rigid social institutions governing sexual behaviour is no truer for Africa than for Europe. Cultural systems and structures in Africa have been influenced by external factors such as Christianity, Islam, colonization, capitalism and modernity. Norms governing sexual partnership and intimacy being largely cultural constructs are bound to acquire a dynamic in keeping with cultural changes. Leshabari, Kaaya et al. (1996) noted, from in-depth interviews amongst elders in Southern Tanzania, a deep resentment of what was viewed as the amoral sexual behaviour of young people, which deviated from a more puritanical morality reported to have existed about two to three decades before the study, as is illustrated by the following account:

Nowadays the secrecy governing the whole process of sexual advances between men and women has disappeared. Even taboos are no longer adhered to. What you see today is a bunch of young men and women going after each other in broad daylight, ridiculing each other in public (by doing so),Some young women use their bodies as income generating machines, sleeping with whoever is ready to pay them (Leshabari, Kaaya et al. 1996:22).

However, this account from a female elder invites the question whether the concerns expressed relate to observation of increased occurrence of premarital sexual activity *per se*, or to a change in the context of premarital sexual experiences such that they are more explicit and the cultural secrecy which surrounds sex and sexual relations in many African cultures is removed. This interpretation is supported by ethnographic studies conducted in northern Tanzania by Haram (1995) who noted the links between maintaining dignity and succumbing to sexual desire:

Whether one indulges in premarital or extramarital sex is not the real question. What seems to be crucial is how it is done..... if you want to 'steal' sex (a term referring to illicit relationships) it must be done with dignity and respect (Haram 1995:37).

Setel (1995), in a review of sexual morality and cultural convention in the late nineteenth and the twentieth century in Northern Tanzania, noted that in the 1890s, 'premarital intercourse [was allowed] and virginity was not specially valued' and that 'avoiding premarital pregnancy rather than premarital sexual activity was the main priority'. The dynamic nature of cultural sexual morality is noted in Setel's account of the twin influences of missionary activity and land pressures in the early twentieth century which resulted in increased rigidity of the more accommodating attitudes towards premarital sexual activity, with a higher premium being placed on virginity.

Traditionally, men in many African societies married relatively young brides in monogamous or polygamous relationships, and there were socially accepted procedures and various roles and obligations which had to be observed. These social controls may to a certain extent have ensured that sexual partnerships culminated in marriage. It is possible that the cultural norms governing the acceptable age gap between sexual partners have persisted in recent times, in the absence of the social controls which ensured such partnerships led to marriage. There have been several reports of the loss of cultural institutions and structures which governed sexual morality in many Tanzanian societies. These include rites of passage which have been noted to lack relevance in matriarchal societies which continue the practice, or which have declined completely in patriarchal societies of Tanzania; teachings related to sexuality and community living which were part of the initiation ceremonies have not been replaced (Ntukula 1994; Shuma 1994). Current social structures are unable to sustain early age at marriage which used to serve as a control on premarital pregnancy amongst young females, and Bledsoe and Cohen (1993) note a similar trend of later age at marriage in many

sub-Saharan African countries. There also appears to be a decrease in the authority of elders over the behaviour of male and female youth (Leshabari, Kaaya et al. 1996:74). Such weakening or lack of relevance of traditional controls which governed relationships with the opposite sex may facilitate the use of sex for recreational and material benefits among both men and women.

Socio-economic factors from a different perspective have also maintained sexual relationships between girls and older men. In many sub-Saharan countries, including Tanzania, declining material and financial resources have created a situation where few men can afford to marry when young. Although bridewealth, strictly defined, has to a large extent been abandoned, other demands have sustained the high costs of marrying in a socially acceptable manner for young men. The traditional expectation for younger people to be dependable rather than independent, and cultural norms regarding the responsibilities of a son-in-law in many groups, create a situation where as well as setting up a new home, a son-in-law is expected to contribute towards food costs, medical treatment and school fees for younger members of a wife's family. Vallenga (1986), in Ghana, noted that where child betrothal exists, an intended husband may be expected to meet the costs for educating his future bride. Older men are better established financially than younger men, and hence more attractive as potential husbands. It has been noted that in communities where bridewealth and polygamous marriages continue to exist, young girls tend to compete for husbands from a small pool of older men whose numbers are declining through mortality. The gender differences in age at marriage, noted from the above census reports in Tanzania, are therefore not surprising. However, there are health implications for young girls particularly with respect to HIV transmission, as older men are more likely than young men to have extensive experience with multiple sexual partners, increasing their risks of having contracted the infection.

There is little documented evidence to support the assumption that the age gap between young females and their husbands is also reflected in premarital sexual partners of this population subgroup. However, this age gap in premarital sexual relations can be inferred from HIV/AIDS sero-surveillance data, which demonstrated a higher cumulative AIDS case rate of 281 per 100,000 amongst females aged 20-24 years, than that of 140 per 100,000 amongst males of similar age (NACP 1994). The HIV prevalence rates among teenage male blood donors (15-19) increased from 0 per cent in 1987 to 3.3 per cent in 1990 while that among teenage girls increased from 0 to nearly 7.5 per cent in the same period. This phenomenon has already been observed in other countries in Sub-Saharan Africa where women are infected at an earlier age than men (Fleming 1994). The lower peak age of females with AIDS, compared to males, suggests that amongst other factors, sexual partners of young females may be drawn from an older and more sexually experienced population than those of young males.

Although nationwide figures are not available, data from small-scale surveys in both rural and urban Tanzania suggest that a significant proportion of teenage boys and girls engage in unprotected premarital sexual intercourse. There is however, less information on the circumstances surrounding such behaviour. Small-scale surveys involving school teenagers show that a substantial number of them are sexually active. An urban-based study conducted in Dar es Salaam covering a random selection of 657 school students revealed that 62 per cent of primary-school boys and 35 per cent of primary-school girls had coital experience by the age of 14 years (Leshabari 1988). A more recent survey in Dar es Salaam (Lwihula et al. 1996) indicates that coital experience in the youth population continues to be high despite the AIDS pandemic, as shown in Table 2.

In the sample of primary-school students, with a mean age of 14 years, by the age of 15 years 29 per cent reported having had sex at least once. Available data from other small-scale

surveys in different parts of Tanzania also suggest that many young people are sexually active (Fundikira 1985; Mbunda 1988; Kapiga, Hunter and Nachtigal 1992; Klepp et al. 1994).

Table 2
Percentage of urban primary-school students who have had coital experience, by age and sex

Age (years)	Percentage with coital exposure		
	Boys	Girls	Total
11 - 13	23.0	6.0	14.0
	78	94	172
14 - 15	43.0	16.0	29.0
	164	186	350
16 - 19	49.0	17.0	40.0
	112	46	158
All age groups	40.0	14.0	27.4
(11-19)	354	326	680

The numbers below each proportion indicate the denominators on which the percentages are based.

Source: Lwihula et al. 1996, Table 24.

A recent survey using qualitative methods in a rural district in Southern Tanzania revealed that multi-partnered sexual behaviour among youth was common (Leshabari et al. 1994). Parents in this setting appeared to be either indifferent, or unable to exert any control over young people's sexual behaviour, which they reported as associated with the settings in which petty trade activities occurred such as the *magulio* (flea markets), where the young were amongst traders who travelled from one *gulio* to another across communities in the district.

These trade environments were reported to involve alcohol use, late-night discothèques and indiscriminate sexual intercourse; activities in which young people also took part. The links between sexual behaviour and trade environments has been reported by other authors, such as O'Connor, Leshabari and Lwihula (1992), in their ethnographic account of behaviours at truck-stops, and Setel (1995) in his accounts of the links between work, desire and the social person in contemporary Chagga society. Trade environments may provide greater opportunity and increase the vulnerability of youth to unprotected sex and its consequences, and the lifestyles associated with petty trade activities amongst young people may not be conducive to maintaining the cultural integrity of many communities (Setel 1995:57) and hence become the routes of bad *tabia* (behaviour), unrestrained desire and consequent HIV infection.

It seems that significant social changes have taken place within the last generation or two affecting the socialization processes of children and young people in many communities in Tanzania. Qualitative studies conducted in the Mbeya, Arusha and Kilimanjaro regions suggest a combination of declining social-economic conditions with other social changes which have influenced the factors which defined masculinity and femininity, as well as roles and obligations of fathers and mothers in the individual household. These changes are bound to influence the socialization patterns of the young at home, and accounts from both the Mbeya and Kilimanjaro regions imply that there have been adverse effects on the growth and psychosexual development of children and youth. Many of these are related to the growth of a new cultural sexual morality which links the concepts of desire, behaviour, migration and economic productivity amongst youth (Setel 1995:50-57; Leshabari, Nyamyekung'e and Hamelmann 1996). Such changes have probably influenced the current health-risk behaviour of youth in these societies.

Sources of young people's reproductive health information

Although large numbers of youth are sexually active, there is evidence that the reported sexual behaviour is taking place in an atmosphere of ignorance and misconceptions on basic reproductive health issues. Information which revealed poor reproductive health awareness among youth dates back more than a decade. Fundikira (1985) reported that many teenage school girls believed abortion could be induced by swallowing large doses of chloroquine (used for the treatment of acute malaria). Douching with rice water or tea without milk are among methods of attempting abortion reported during a survey of 658 school students in a rural setting in Tanzania (Leshabari, Kaaya and Kawau 1996). Use of cassava leaves and sharp instruments has also been reported in certain parts of the country (Mpangile et al. 1993). Lwihula and his colleagues (1996) note from a survey of school youth in Dar es Salaam that about ten per cent of secondary-school students identified as contraceptive methods swallowing chloroquine tablets, and not wearing shoes during sexual intercourse. Many of the methods used for inducing abortions have serious consequences. Causes of mortality include chloroquine overdoses, or the complications of illegal abortion attempts.

Table 3
Primary sources of information on menstruation, wet dreams and sexual intercourse among school youth in Rombo District (Rural) and Dar es Salaam (Urban) (%)

Source of Information	Reported sources of information on...					
	Menstruation		Wet dreams		Sexual intercourse	
	Rural	Urban	Rural	Urban	Rural	Urban
Peers	29.2	21.0	28.8	44.0	24.1	21.0
Teacher	26.2	19.0	14.1	6.0	11.1	7.0
Other relative	12.0	6.0	17.1	19.0	9.8	7.0
Print media	5.2	11.0	11.8	16.0	21.8	31.0
Radio/film	3.4	2.0	10.0	1.0	17.1	17.0
Father	19.7	4.0	9.4	2.0	4.8	2.0
Mother	1.3	19.0	1.2	1.0	0.8	2.0
Health worker	0.4	10.0	4.7	5.0	6.7	8.0
Religious leaders	0.9	5.0	1.8	4.0	3.6	3.0
Missing responses	1.7	1.0	1.2	5.0	0.0	2.0
Total respondents (N)	233	271	170	200	357	459

Sources: Leshabari, Kaaya and Kawau 1996; Lwihula et al. 1996.

Although prevention of pregnancy could minimize many of the above problems, many young people appear to be ignorant about fertility control. Demographic and health surveys which have been conducted in Tanzania recently revealed that teenagers as a group were less informed about methods of preventing pregnancy than older youth and adults (TDHS 1995). Data from the study conducted amongst school youth in the rural setting of Rombo district cited above (Leshabari, Kaaya and Kawau 1996) indicated that when knowledge on biological maturity and fertility control was tested using a 22-item test, 48 per cent of males and 62 per cent of females scored below 25 per cent.

Lack of formal sources of reproductive health information and services contributes towards some of the health difficulties of young people. There is some evidence that peers and the mass media are their major sources of reproductive health information, probably because parents often communicate reproductive health information in the form of a list of prohibitions or reprimands, and are rarely able to discuss at length the sex-related concerns of their teenage children. Two surveys using similar instruments covering 657 rural school

students with a mean age of about 14.9 years (Leshabari, Kaaya and Kawau 1996), and 681 urban school youth with a mean age of 14 years (Lwihula et al. 1996), revealed an interesting pattern in the reported primary sources of information on menstruation, wet dreams and sexual intercourse, among youth who had ever heard of these reproductive health related items (Table 3).

Peers were the main primary sources of information mentioned by both rural and urban school youth. However, given the reported low levels of reproductive health knowledge among youth, it appears these young people are forced into a situation where 'the blind lead the blind'. Although parents in general were not a major primary source of such information for both urban and rural school youth, a somewhat higher proportion of rural youth reported fathers to be primary sources of information on menstruation, while mothers were more likely than fathers to be reported as a source of such information by urban youth. When the proportions were desegregated by gender, it was noted that 87 per cent of those reporting fathers as sources of information were females. Though the context within which such information was provided to girls by fathers was not explored, the findings suggested a possible change in cultural norms where the silence between fathers and their daughters on issues related to reproductive health is being broken. Of concern, however, is the continued silence of mothers as evidenced by the students' responses. The low level of reproductive health knowledge found amongst school youth in Rombo district suggests that even written literature, which featured prominently as a primary source of reproductive health information, is unlikely to be a relevant teaching guide for what youth need to know about reproductive health.

Table 4
School students' preferred sources of information on menstruation, wet dreams and sexual intercourse in Rombo District (%)

	Preferred source of information on...		
	Menstruation	Wet dreams	Sexual Intercourse
Health worker	35.2	36.6	41.4
Teachers	35.7	38.8	33.1
Parents	22.2	16.6	15.9
Mass media	1.7	2.5	3.1
Religious leaders	2.0	2.9	3.6
Peers	1.7	1.3	1.0
Others	1.4	1.3	2.1
Total respondents (N)	347	314	384

Source: Leshabari, Kaaya and Kawau 1996

When the rural school students reported above were asked about their preferred sources of information on menstruation, wet dreams and sexual intercourse, other sources featured highly in the pattern of responses which emerged. Given a choice, it appears students would prefer to be taught about various reproductive health issues by a combination of people.

The survey based in Rombo District which targeted rural school youth (Leshabari, Mwanri et al. 1996) indicated that health workers, teachers and parents were the most preferred sources of information on menstruation, menarche and sexual intercourse. Peers and the mass media were ranked very low as preferred sources of information even though in practice they were the main sources (Table 4).

Because the current sources of reproductive health information are informal, it appears that for both rural and urban areas, exposure to information on sexual intercourse is greater than exposure to more basic information related to human growth and development such as

the onset of menstruation and wet dreams, and their implications on reproductive health, as summarized in Table 5. While about half of rural and urban school students had ever heard of sexual intercourse, only about 40 per cent or less reported having heard of menstruation and an even lower proportion had information on wet dreams. There was also a considerable variation by sex in exposure to information on menstruation and wet dreams. More girls than boys had information about menstruation, more boys knew about wet dreams.

Table 5
Proportion of urban and rural youth who had been exposed to information on menstruation, wet dreams, and sexual intercourse (%)

Rural/Urban	Proportion who had ever heard of...								
	Menstruation			Wet dreams			Sexual intercourse		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Rural Youth ^a	21.0	47.2	35.3	31.8	13.9	22.0	57.3	48.5	48.5
N	286	345	631	286	345	631	279	340	619
Urban Youth ^b	30.0	51.0	40.0	42.0	15.0	29.0	75.0	60.0	67.0
N	350	325	681	357	324	681	352	325	681

Numbers below each proportion represent the denominators on which the proportions are based. Sources ^aLeshabari, Mwanri et al. 1996, Table 2; ^bLwihula et al. 1996, Tables 13,16 and 19.

Rounding percentages to the nearest unit in the source data probably accounts for the discrepancy in total scores for each reproductive health information item.

This implies that despite the reported high rates of coital experience in the school student population, exposure to information on the biological processes of the transition to adulthood is poor. Evidence from the *Ngao*¹ intervention study conducted in Northern Tanzania indicated that a community-participatory approach in the introduction of a reproductive health and AIDS education program in schools, where didactic sessions and practical skills development approaches were used, was effective in increasing restrictive subjective norms towards sexual intercourse among both boys and girls, as well as decreasing intention to engage in sexual intercourse over the next three months amongst boys (Ndeki et al. 1995). However, such pilot projects have not been replicated or translated to nationwide programs. The absence of comprehensive reproductive health education within the school system, or in the community, means that young people will physically become adults with little, and sometimes distorted, understanding of the biological processes surrounding childbirth and fertility control.

Schools could be good focal points for reproductive health education, as they serve a large proportion of youth, in a teaching and learning setting. However, the dropout rates in the final stages of primary school, as well as a recent observation that only half the children eligible for school are enrolled in schools (Leshabari, Mwanri et al. 1996), mean that policy makers must find ways of targeting out-of-school youth when thinking of reproductive health information and services for this population subgroup. It also appears that menstruating girls miss several classes each month since, amongst other problems, most schools lack an adequate water supply and the necessary privacy for girls who are menstruating during school

¹*Ngao* in Kiswahili means 'shield'.

time. Although teachers claimed this only applied to girls during their first menstrual experience, many primary schools were observed to lack conditions which would be favourable for menstruating girls to attend classes comfortably. These problems can easily be handled within schools by mobilizing communities to construct latrines and other facilities needed by menstruating girls while in school. Provision of such services will minimize problems of poor school attendance amongst girls.

Since schools and health care units are present in most Tanzanian communities, the reported preferred sources of reproductive health information present a challenge to workers in these settings to work with communities in socializing youth on reproductive health issues. As evidenced from the *Ngao* project, for schools to be an effective focal point for reproductive health information, thought needs to go into the planning of the curriculum, and how to involve the community, so that messages provided by the school system can complement those provided by parents, health workers, teachers and even religious leaders. The *Ngao* project experience also indicates a need to consider training of teachers on the most appropriate methods to use in communicating reproductive health information to young people. Such a comprehensive approach will allow young people to learn about reproductive health issues from a holistic perspective. Indeed, there are various aspects of reproductive health which can be communicated by parents, teachers, health care workers and religious leaders, each contributing towards what young people should know.

Circumstances surrounding acquisition of reproductive health information

There is very little retrievable information on the current circumstances surrounding the acquisition of reproductive health information in the youth population of Tanzania. In the Rombo rural school youth study reported above, contexts within which reproductive health information was acquired were explored in five each of 'female only' and 'male only' focus-group discussions and eight which had both male and female participants. Generally it appeared from the data that acquisition of such information varies with the age and sex of the students. Younger males (14 years and below) acquired such information by listening to conversations of older males. Many reported that in most cases older youths felt uncomfortable talking about such issues in the presence of younger ones who were asked to leave if caught listening. Girls revealed that they got some information on issues related to reproductive health through discussions with other girls about their relationships with the opposite sex. The young girls pointed out that sometimes mothers and older siblings might be consulted about these issues but this had to be done with caution, as a verbal or physical reprimand was a real risk, particularly from mothers.

Traditional sources of information for young people such as extended family members, especially aunts and grandmothers, appeared to play a rather small role, even though the upbringing of most young people in this study was predominantly rural. While participants in the younger male focus-group discussions agreed that seeking information from a father on issues related to sex would sometimes result in being ignored because the parent felt the boy was too young for such information, the focus groups with older boys agreed that when sexual issues were not well understood, clarification could be sought from an older brother or a friend. However, this involved a lot of embarrassment and shyness on the part of the youth seeking information (Leshabari, Kaaya and Kawau 1996).

The disappearance of traditional sources of reproductive health information in the Rombo study area may partly be due to the influence of Christianity. In many parts of Sub-Saharan Africa, the role of initiation rites in defining femininity and masculinity as well as strengthening cultural identity posed a threat to the spread of Christianity, and the rites of passage were discouraged by the church (Wellbourne 1961; Strayer 1978). However, such discouragement deprived young people of a source of reproductive health information,

without making adequate provision for other sources which would take into consideration cultural norms; a situation which has persisted to date in many 'Christianized' parts of Tanzania.

Contexts of school students' sexual experience

There is very little information available on the contexts within which sexual experience occurs within the school population. A qualitative rural community-based study, in which data were collected using in-depth interviews and focus groups, revealed that involvement of school students in petty trade activities, use of alcohol and lack of parental supervision during leisure were factors which exposed them to the risk of promiscuous behaviour (Leshabari, Kaaya and Kawau 1996).

In two studies there is information on the circumstances of sexual experience of urban and rural school students (Lwihula et al. 1996; Leshabari, Kaaya and Kawau 1996). Coital experiences among school youth in both these studies fell broadly into two categories, sex between male and female students and sex between female students and out-of-school youths. In the category of sex between male and female students, circumstances in which such relationships occurred amongst urban and rural youth differed. Amongst the urban youth, coital experience was associated with the need of girls to do well at school, which was exploited by boys who offered academically weak girls help with school work in return for sexual favours; gifts or money from boys in return for sex; peer pressure; and to a lesser extent cultural gender-related factors which govern power relationships with the opposite sex.

Focus-group discussion data from the rural based study revealed more cultural gender power difference factors which govern sexual relationships, though the gifts or money from boys in return for sex theme also persisted as an important factor which increased the vulnerability of youth to coital experiences. In the rural focus-group data, male students were noted to be unable to deal constructively with rejection of their sexual advances, when such rejection resulted in public embarrassment. To a certain extent, girls would sometimes give in to pressure to have sex, for fear of possible rape. In the second category mentioned of girls who had sex with out-of-school youths or adult men, it appeared from both rural and urban based focus-group data that the economic gain factors predominated in increasing girls' vulnerability to coital experiences. However, the extent of the material or financial gain achieved in return for sex was variable. In the rural sample it was reported that the payments to female students could range from a soft drink from a boy-friend, to gifts such as fashionable clothes and shoes or more expensive gifts including large sums of money. In the urban sample in addition to material and financial gain, in some cases a female student would live with an adult male partner, with the knowledge of her parents, who would not oppose such a move as long as the partner paid for her basic needs, including expenses required by the school (Haram 1995:36; Lwihula et al. 1996).

The findings suggest a difficulty in separating financial and material gain to the female students in both study samples from the symbolic nature of gift exchange. It appears, particularly from the rural focus groups, that exchange of gifts had a symbolic significance in the social construction of the negotiation of coital sexual relationships in both the rural and urban youth subculture. In the male, female and mixed rural focus-group data there was consensus that accepting a gift from an interested male committed a girl to agreeing to whatever her boyfriend requested including a coital relationship. Culturally in many parts of sub-Saharan Africa, it is the male's prerogative to determine the nature and direction of a sexual relationship, while females are expected to be compliant. However, it was noted that females do have a role in initiating a liaison, particularly when this occurred between schoolboys and girls. The initiating roles of a female were implicit rather than explicit, and interpreted as such by youths when a girl was perceived to be flirting with the boy in class.

However, the implicit nature of such overtures from girls appeared to be open to misinterpretation by boys, as evidenced by the girls' accounts of fear of rape.

Consequences of unprotected sex for young people

Unprotected sex among young people has three major undesirable outcomes. First is the psychological effect of participating in behaviour of which parents, neighbours, and the community disapprove. Unfortunately, so far, little is known about the extent of this type of problem in the youth population in Tanzania. Virtually nothing is known about the psychological problems surrounding the processes preceding the stage when young people are sexually active. Secondly, there is the problem of unwanted pregnancy and its related psychological, economic, social and health consequences. Anecdotal accounts indicate that the number of unwanted premarital pregnancies among young people in Tanzanian societies has increased, though no prevalence data are available.

Data from the Ministry of Education and Culture show that in 1992 alone, 13 per cent of 21,594 primary girls who dropped out of school gave unwanted pregnancy as a reason (BEST 1994). The true proportion is probably much higher than this as the illegal nature of school pregnancies influences the reason reported for leaving school at both the school and the Ministry of Education level. Surprisingly, some of the pregnant girls were in the second year of their primary school education (BEST 1994); an observation which raises questions about the stage at which reproductive health information and services should be introduced in the school system.

The plight of young people who are not at school largely remains unknown even though there are indications that there is more tolerance for premarital pregnancies in the current generation of parents, than was the case only a generation ago (Leshabari et al. 1994). Increasing economic hardships have forced many young people, especially girls, to resort to promiscuous behaviour to make a living. The fear of AIDS, let alone other STDs, is of less concern than the more immediate lack of basic needs such as food, clothes and shelter (O'Connor et al. 1992).

Thirdly, any sexually active young person risks infection with sexually transmitted disease. Given the large number of this population subgroup which practises unprotected sex, STDs, including HIV infection, appear to be one of their major problems. The prevalence of STDs among youth in Tanzania is generally unknown even though some small-scale studies indicate that it may be a serious problem. Data from the Arusha Region, for example, revealed that nearly 13 per cent of females aged 15 to 24 years in Arusha Urban District are infected with the AIDS virus (Klepp et al. 1994). A survey carried out in Moshi Rural District found high rates of STDs including HIV among rural youth (Kessy 1996). The summary in Table 6 shows that four per cent of youths and over six per cent of girls had gonorrhoea; nine per cent of males and 15 per cent of females in the study sample had a history of syphilis. Given that these data were collected from a random selection of youth (mainly not in school), who were recruited while going about their day-to-day activities, HIV and STD infection rates among them are a matter of serious concern. The higher rates of HIV infection in females reflect trends also noted from sero-surveillance data compiled by the National AIDS Control Programme (1994). It appears that quite a large number of young people die from AIDS and this in the long run will have serious implications for the national economy.

Table 6
Variation of STD infection (including HIV) by age and sex among youth in Moshi Rural District (%)

Type of STD	Males/age in years	Females/age in years	Total
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	15-19	20-24	Total	15-19	20-25	Total	
Gonorrhoea	2.2 (322)	7.1 (183)	4.0 (505)	3.0 (268)	9.6 (272)	6.3 (540)	7.5 (1045)
Trichomoniasis	3.7 (322)	18.6 (183)	9.1 (505)	9.7 (267)	28.3 (272)	19.1 (539)	14.3 (1044)
Genital ulcer disease	0.6 (322)	1.1 (183)	0.8 (505)	1.1 (267)	2.6 (272)	1.9 (539)	1.3 (1044)
Syphilis	5.8 (308)	13.7 (168)	8.6 (476)	13.5 (259)	14.9 (268)	14.2 (527)	14.2 (1003)
HIV	3.6 (308)	7.7 (168)	5.0 (476)	6.2 (259)	13.1 (268)	9.7 (527)	7.5 (1003)

Figures in brackets are denominators on which the proportions are based; Source: Kessy (1996)

The findings of high prevalence rates of STDs and HIV are not surprising given the information from different areas of the country of high-risk sexual activity in the youth population (O'Connor et al. 1992; Leshabari et al. 1994; Haram 1995). Anecdotal qualitative survey reports show promiscuity among the youth to be fairly high, much of it precipitated and maintained by economic hardship, and socio-cultural changes which have affected their lives.

Barriers to reproductive health information and services, and potential opportunities

Many parents, health care providers, policy makers and religious leaders may not be aware of the lack of basic reproductive health knowledge amongst the young, and the implications of such ignorance for reproductive health behaviour. Part of the difficulty arises from the assumption that providing reproductive health information and services for this population will encourage promiscuity. This argument ignores the fact that many, if not most, young people are already sexually active and their promiscuous behaviour is not related to exposure to reproductive health information. As pointed out earlier, most young people learn about reproductive health from peers and the mass media, and what they learn is not only incorrect but also dangerous as they are unable to make informed decisions regarding their sexual behaviour. It is unfortunate that available literature is sometimes misquoted in order to justify moral perceptions of reproductive health issues. For example, there have been reports from religious leaders in Tanzania that only three per cent of condoms work. This approach towards such a critical issue is counterproductive.

There is a need to identify how potential resources such as the education and health sectors, parents, and religious leaders can best be exploited to provide reproductive health information, which takes into consideration the current socio-cultural and economic realities in many Tanzanian societies. There has been a basic assumption that inclusion of reproductive health issues in the curricula of primary and secondary schools will be sufficient. But this needs to be combined with concerted efforts to address issues such as the terminology to be used in explaining reproductive health to children and young people; the special skills that

teachers need to impart such information with ease to this population; and the needs for psychological support for sexually active youth.

Apart from teachers, various responsible adults in the society have a role to play in reproductive health education for children and youth. Parents, health workers and religious leaders all have some contribution to make. Every group of responsible adults brings to the issue of reproductive health education its own perspective: religious leaders contribute a spiritual and moral perspective, parents and teachers a social perspective, health workers a more health-related perspective. However, for young people, a holistic approach is necessary, which incorporates the perspectives of all responsible adults who have the potential to contribute to their knowledge base. It is also important to take into consideration the views of young people themselves on their preferred source of information.

There is also a problem in defining the most appropriate stage at which reproductive health information should be introduced into the life of a young person. In the Tanzanian context, this raises serious challenges for two major reasons. While schools are good places for imparting this information, school enrolment has declined and drop-outs have increased to the extent that only half of school-aged children are in the education system (Leshabari, Mwanri et al. 1996). Consequently there is a need to find means of reaching youth who are not at school. Within schools there are wide variations in the composition of classes by age. Age at enrolment varies from as young as five to as old as thirteen years (BEST 1994): in any one class, there may be students at a stage where they can assimilate and comprehend information on menarche, as well as those perhaps too young to benefit from such information. There is a need to realistically confront the reproductive health problems of youth to deal appropriately with pertinent issues such as older teenagers who are sexually active or already pregnant, teenagers who already have an STD, or those who are worried about menarche or wet dreams.

An important aspect of reproductive health services which is lacking in Tanzania for both school and out-of-school youth is counselling and social skills development. Given the pressure to conform to peer norms, coupled with psychological and physical changes brought about by puberty, there is a need for services which will deal with the conflicts that the young experience with regard to their developing sexuality. There are no formal counselling services for young people, and the informal traditional support services within which sexuality was dealt with do not appear to be operational or relevant for the current life styles of many Tanzanian communities. Focus-group discussions in Rombo District, Tanzania indicated that wet dreams were interpreted as an illness arising from lack of a coital relationship (Leshabari, Kaaya and Kawau 1996). However, there is no documented information on other apprehensions young people may have regarding their sexual development. Data indicate difficulties for both boys and girls in negotiating a healthy relationship with the opposite sex (Leshabari, Kaaya and Kawau 1996). In the Rombo survey there appeared to be a very fine demarcation between verbal acknowledgment of sexual attraction and sexual intercourse; ways are needed to develop the social skills of young people to allow for healthy interactions between the sexes. There is a need for appropriate reproductive health counselling services, as well as identification and development of the necessary social skills to ensure healthy sexual behaviour.

Existing policies now allow reproductive health information and services for any sexually active person (MOH 1994). However, implementation of such policies is not possible when there has been no change in the attitudes of service providers towards provision of such services to youth, especially adolescents. Similarly, the communication skills of providers should be modified to meet the needs of youth; and the infrastructure for providing services to youth needs to be considered. It would be unrealistic to expect that a single 15-year-old girl

will approach a clinic providing contraceptive services during adult consultation times, considering that her adult relatives may be attending the clinic.

Pregnant girls are now allowed to continue school after delivery, but given the poor state of repair of most schools, this will be difficult. For school girls with babies to continue with classes, schools need childcare facilities. Given that existing schools do not have even basic facilities to cater for learning and teaching, let alone hygiene needs, it is difficult to see how girls with their babies can be accommodated.

The current move towards introducing reproductive health information as part of family life education in schools in Tanzania is encouraging. However, these measures have primarily involved the Ministry of Education. There is a strong need for a multidisciplinary approach in the planning and implementation of measures concerning young people's reproductive health. It is important for all those involved in the socialization of children and youth to realize the importance of the roles and responsibilities of each participant rather than isolation and blame of others.

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Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu-Natal, South Africa*



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'We don't talk about things like condoms, sex, or STDs. It is not that kind of relationship' (female, aged 17)

'[Sex] is a symbol of power in the affair..Once you have sex with a woman, you have a strong say in the running of the relationship' (male, aged 26)

Abstract

This paper addresses issues surrounding sexual negotiation and decision-making among black South African youth in the face of AIDS. It explores choices made by young men and women regarding sexual activity and the extent to which it is influenced by HIV/AIDS. Communication between partners was poor, and young women appeared powerless to enforce their preferences in sexual situations. AIDS was not a significant factor in any aspect of sexual decision-making. Socio-cultural factors and the state of the HIV pandemic in South Africa were offered as explanations for the findings.

This paper addresses issues surrounding sexual decision-making and negotiation among black South African youth in the face of AIDS. The objectives were to explore choices made by young people regarding when, how (i.e. protected or not), and with whom to have sex, and the extent to which HIV/AIDS influences this process. A primary aim was to examine the potential role of youths' self-perceived risk of HIV infection in the sexual negotiation process. Finally, of particular importance was focus on other aspects of sex such as the meaning attached to condoms and to the sex act itself; factors which are inextricably linked with sexual behaviour and decision-making.

Reported here are results from interviews with young black men and women in Durban, a large coastal city in KwaZulu-Natal province. The above comments by male and female participants are typical of the problems and conflicting needs of youth in this study navigating sexual relationships. For the young girl who provided the first comment, the bond with her steady boy-friend was not close enough to broach sex-related matters despite regular intercourse with him. The words of the young man reflect a clear perception of sex as a lever by which to control his partner and their relationship. The findings of this study underscore the need to focus on socio-cultural, ideological and violence-related factors in understanding the dynamics of sexual negotiation and decision-making, and ultimately of sexual behaviour itself.

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HIV/AIDS in South Africa and Kwazulu-Natal

In the mid-1990s, it appears HIV/AIDS will be an ineradicable presence for the foreseeable future. At conferences and in research circles retrospectives on the first decade of AIDS and calls for new perspectives in the second decade of AIDS have begun to emerge.¹ AIDS is frequently no longer referred to as an epidemic but a pandemic, with no cure in sight and only marginally effective treatment regimens available.

The facts are sobering and the numbers defy the imagination. HIV has infected 27.9 million individuals worldwide, 21.9 million of whom are presently living with the disease (UNAIDS 1996). In 1996, an estimated 3.1 million new infections occurred, translating into 8500 infections per day. Most newly infected adults will be those who are in the 15 - 24 year age group, who engage in unprotected heterosexual intercourse, and who live in Africa (UNAIDS 1996).

Africa holds the vast majority of the world's HIV infected population. Approximately 64 per cent (14 million people) of those living with HIV/AIDS reside in Sub-Saharan African countries (UNAIDS 1996). In South Africa, HIV infection rates are alarming. The most recent national survey revealed a countrywide seropositivity rate of 10.4 per cent.² In KwaZulu-Natal province, where this study was undertaken, the same survey revealed 18.2 per cent seropositivity. This reflects a 26 per cent increase over the previous year's figures (14.4 %) for the province (Fifth National HIV Survey, October/November 1995).

The HIV-related situation in KwaZulu-Natal is exacerbated by the youthful demographic profile and seroprevalence rates among young people. Half of KwaZulu-Natal's population is aged 19 years or less; nearly one-third is between the ages of ten and 24 years. Thus, 2.6 million individuals belong to that segment of the provincial population which has recently entered or will soon enter sexual activity (SA Population Census 1991).³ Regarding HIV infection, the seropositivity rate among persons under 20 years of age is 9.8 per cent, and it is 11.8 per cent in the 20-24 year age group. Both these figures are close to double the national average for the same cohort; and are probably an underestimate of the current status of HIV in the province (Whiteside et al. 1995). Thus, AIDS is a critical issue among youth in KwaZulu-Natal, a province which has the dubious distinction of being the epicentre of HIV/AIDS in South Africa.

Research needs

Given the current state of HIV/AIDS and the lack of viable therapeutic alternatives, changing sexual behaviour is one of the few potentially effective options in combating its spread (Ulin

¹ This was a prevalent theme at the most recent Pan African Federation for Mother and Child Health Conference, held in Midrand, South Africa, 3-6 September, 1996. See also Herdt 1992 and Lindenbaum 1992.

² National HIV statistics in South Africa are compiled through a yearly sentinel survey of antenatal clinic attenders. The figures cited here were drawn from the Sixth National Survey amongst Women Attending Antenatal Clinics in South Africa, October/November 1995. Because many African countries do not undertake national or regular HIV surveys, contextualizing South African data proves difficult. Recent small-scale antenatal clinic attender studies in neighbouring African countries have recorded varying rates of HIV infection: Swaziland 18 per cent, Botswana 29-40 per cent (urban samples), Malawi 6-11 per cent (rural samples) and 13-20 per cent (urban samples), Zimbabwe 32-38 per cent (urban samples). Figures compiled from US Bureau of the Census, October-November 1995.

³ Moreover, adolescents have a tendency toward high-risk sexual practices such as early initiation of intercourse and low rates of contraceptive use. See results of the following studies: United States Congress 1991; Boulton and Cunningham 1991; Agyei, Mukisa-Gapere and Epema 1994.

1992; Sibthorpe 1992; Orubuloye, Caldwell and Caldwell 1993; LeFranc et al. 1996). This not only entails encouraging 'safe sex' practices such as condom use or monogamy, but necessitates an emphasis on subtle aspects of sexuality which affect sexual behaviour, such as sexual negotiation and decision-making (Worth 1989; Dixon-Mueller 1993; Balmer et al. 1995). Moreover, intervention efforts must not concentrate exclusively on sexual behaviour itself but adopt a more ecological approach. This means focus on political, economic, and socio-cultural determinants of high-risk sexual practices and attention to why risky behaviour is frequently continued despite population awareness of its negative health consequences.

A growing number of social scientists has begun examining the subtleties of sexual decision-making in their exploration of sexual behaviour and factors which influence it. With this has come the recognition that for many people unsafe sex is a rational choice which is perceived to result in, and safeguard, benefits such as emotional intimacy, trust, legitimacy and even economic stability (Sibthorpe 1992; Pivnick 1993; Sobo 1993, 1994, 1995; LeFranc et al. 1996). In addition, issues such as varied perception of risk have come under examination as affecting individual decisions regarding the circumstances under which sexual intercourse occurs (Lindan et al. 1991; Ulin 1992; Kline, Kline and Oken 1992; Moore and Rosenthal 1992; Keller 1993; Gielen et al. 1994; Romero-Daza 1994; Detzer et al. 1995; Lear 1995, 1996). Particularly with conditions such as HIV/AIDS, characterized by a long incubation period and symptoms often difficult to distinguish from other illnesses, disbelief in the existence of the disease and thus of personal risk for infection is not an uncommon reaction (Farmer 1992; Keller 1993; Green 1994; Romero-Daza 1994; Whiteside et al. 1995; Varga and Makubalo 1996; Varga 1996a, 1997a). Acknowledgement of risk for HIV infection may also necessitate confrontation with matters concerning personal or partners' sexual histories; a process which may at best lead to embarrassment, and at worst to the destabilization of intimate personal relationships. Thus, many prefer to view themselves as 'safe' rather than face the psycho-social consequences of possible HIV infection (Worth 1989; McGrath 1992; Sibthorpe 1992; Keller 1993; Sobo 1993, 1995; Pivnick 1993; Varga and Makubalo 1996; Varga 1996a; Bajos et al. 1997).

Finally, there is increasing acknowledgment of the need to view sexual behaviour as embedded in socio-cultural context, and carrying symbolic meaning. Sexual matters such as unprotected sex (or conversely condom use), number of sex partners, amount of vaginal fluid present during intercourse, and perceived side-effects of female hormonal contraception may all be interpreted within a cultural framework that conditions beliefs and decision-making (Caldwell and Caldwell 1987; Taylor 1990; Ulin 1992; Preston-Whyte and Zondi 1992; Runganga, Pitts and McMaster 1992; Brown, Ayowa and Brown 1993; Pitts, Magunje and McMaster 1994; Setel 1996; Varga and Makubalo 1996; Bond and Dover 1997; Feldman et al. 1997; Varga 1997a,b). For long-term effectiveness, HIV intervention strategies targeting sexual behaviour change must be based on a thorough understanding of the higher-order influences and interpersonal dynamics shaping the practices themselves (Gupta and Weiss 1993; McGrath, Rwabukwali and Schumann 1993).

Sexual decision-making and negotiation research

Most studies have found women relatively powerless in sexual decision-making. One study (Worth 1989) found resistance to condoms among minority women in a drug rehabilitation program to be the result of a combination of personal preferences and socio-cultural factors, and partners' objections to condoms. The negative implications of condom use conflicted with values surrounding relationships, womanhood and family. Fundamental to women's enjoyment of sex was affirmation of trust and fidelity through unprotected sex. Also significant was fulfilment of family and gender roles through pregnancy and childbearing (see Pivnick 1993). Moreover, some women appeared unable to exert an influence over condom

use through fear of rejection and stigmatization by partners. Such factors led women's sexual risk-taking—unprotected sex—to be characterized as a rational means of maintaining social and economic survival (Worth 1989:304).

Other research has revealed similar matters in sexual decision-making. Several recent studies (Sibthorpe 1992; Pivnick 1993; Sobo 1993; see also Sobo 1994, 1995) focused on socio-cultural issues surrounding sexual behaviour among individuals at risk for HIV infection.⁴ A predominant theme linking these works was the powerful positive symbolism attached to unprotected sex and negative connotations of condom use. Despite awareness of HIV risk, unprotected sex with intimate personal partners was nearly always chosen over condom use. As in Worth's (1989) study, condom use carried the stigma of infidelity and lack of trust.

For many women, the nature of the social bond with a partner seems to affect sexual decision-making. Casual sexual encounters and sex for economic purposes might be considered superficial, and thus not threatened by issues such as condom use. Conversely, condom use with a steady personal partner would introduce an element of distrust and disequilibrium to an intimate relationship (Sibthorpe 1992; Kline et al. 1992; Varga 1996 a,b, 1997a). Power inequity and emotional and financial dependence of women upon their partners also seem to present significant obstacles to sexual decision-making. In one study, spousal relations were characterized as 'adult-child relationships' (Pivnick 1993:441). Women described their long-term partners as behaving more like fathers than husbands; thereby diminishing their status and decision-making authority in the relationship.

Risk perception may also heavily influence sexual decisions and practices. Sobo's work (1993, 1994, 1995) has revealed that women's self-esteem and social status may be strongly linked to involvement in what they perceive to be committed, monogamous relationships. Under such circumstances, condom use is interpreted as insulting, and suggestive of infidelity, lack of love and disrespect from partners. Thus the author described 'condomless sex' as 'an adaptive and defensive practice [which] helps women maintain desired, idealized images of partners, relationships, and selves' (Sobo 1993:478; see also Bajos et al. 1997).

Finally, Kline et al. (1992) provide a marked contrast to other works. Through interviews with African-American and Hispanic women in a drug rehabilitation clinic, the authors challenged the notion of women's powerlessness and 'culturally stereotyped characterizations of minority women' (p.447) in sexual decision-making and negotiation. Study participants demonstrated a substantial degree of power and independence in sexual decision-making, with considerable control over practices such as condom use, anal sex, and abstinence even when economically dependent upon their partners (p.450). The unusual nature of these findings was attributed to women's low self-perceived risk for HIV infection and loosening of traditional gender roles accompanying socio-economic and social upheaval (Pp. 455-456). Such research provides a reminder of the need to carefully re-evaluate acceptance of models linking women's powerlessness and gender-role stereotypes to low condom use.

Adolescent-focused research

⁴ Sibthorpe and Pivnick both worked with intravenous drug users: Sibthorpe with men and women, and Pivnick with women only. Sobo conducted research with impoverished pregnant African-American women attending an inner-city antenatal clinic.

Some research has centred upon sexual decision-making and negotiation among adolescents. Studies by Kaloff (1995), Tolman (1994), and Fullilove et al. (1990)⁵ explored sexual negotiation and gender-related power issues among American teenagers. Kaloff found that for African-American girls non-traditional gender roles (platonic or egalitarian relationships with men) were associated with less dependency and greater decision-making power in sexual situations. This contrasted with findings of other adolescent-focused research.

Elsewhere, adolescent girls have been found to express confusion and powerlessness in attempting to articulate personal sexual desires and in reconciling such needs with those of their partners (Fullilove et al. 1990; Tolman 1994). Such conflict appears to be a product of pressures imposed by conventional gender roles, the closed manner in which American society addresses sexual issues, and poor intergenerational and partner communication on sexual matters. Moreover, as in studies among adult women (Worth 1989; Dixon-Mueller 1993; Varga 1996a,b, 1997a) the symbolism of sexual relations and notions of appropriate female sexual conduct prove a powerful deterrent to safe sex practices.

Other perspectives on sexual decision-making come from work focused on adolescent girls' choices with regard to early childbearing (Hogan and Kitagawa 1985; Pete and DeSantis 1990; Jacobs 1994; Gordon 1996). While the focus is often primarily on decision-making concerning fertility, the relevance of such studies to sexual decision-making matters is obvious. The picture painted is one of the initiation of sex as a reasoned decision frequently made against a background of social destabilization, family relationships characterized by lack of affection and poor communication between parents and children, ineffective authority figures, and the need to establish acceptance, intimacy and autonomy among peers (Hogan and Kitagawa 1985; Pete and DeSantis 1990; Jacobs 1994). Thus, for some adolescents deferring to the desires of one's sex partner, avoiding contraceptive use, and even sex itself become a means of escaping social and family upheaval, and finding love and adulthood.

Few studies have addressed adolescent sexuality, self-perceived risk and sexual decision-making in the context of HIV/AIDS. Working with university students, Lear (1995, 1996) found a general absence of sexual communication between partners and misconceptions about the motivations of one's sex partner. This led to confusion in and lack of preparation for sexual situations. Again reminiscent of research among adult women (see Fullilove et al. 1990; Sibthorpe 1992; Varga 1996a,b,c, 1997a), gender and degree of intimacy in a relationship were important factors in assessment of self-risk for HIV infection. Condom use was most likely in casual sexual relationships or those in which trust had not been established; and was stopped if the relationship became long-term. Moreover, students viewed sexual experimentation as positively for males, but associated with female promiscuity. Moore and Rosenthal's (1992) work among secondary school students revealed similar results.

Africa-focused research

A few recent studies have examined HIV/AIDS-related sexual decision-making and negotiation in an African context. In West Africa, Orubuloye et al. (1993) explored sexual empowerment of Nigerian (Yoruba) women. Women's apparent success in refusing unwanted intercourse was attributed to their economic independence and strong lineage ties. In Central Africa, McGrath et al. (1993) worked with Ugandan (Baganda) women. Despite a high level of AIDS awareness, women accepted multiple sex partners from economic need or for sexual satisfaction. While willing to change their own sexual behaviour, Baganda women felt

⁵ Fullilove et al. (1990) also conducted interviews with adult women in this study. Responses of older and younger participants were very similar with regard to issues in sexual decision-making and negotiation.

themselves defenceless against HIV infection because of partners' culturally sanctioned high-risk behaviour and the belief that partners would not respond to safe-sex messages.

Schoepf (1992) has addressed HIV/AIDS-related sexual decision-making and behaviour among women in Zaire. This study was unusual in examining sexual-decision-making among both African and European women in Zaire who do not fit conventional notions of 'high-risk' individuals. Perhaps the most important finding from Schoepf's research is confirmation of 'the fact that HIV is spreading not because of exotic cultural practices but because of many people's normal responses to situations of everyday life' (Schoepf 1992:275).

Little research has been undertaken in East and Southern Africa. A study in Kenya explored sexual decision-making and negotiation between partners in stable, long-term relationships (Balmer et al. 1995). As in other Africa-focused studies, acceptance of gender-specific sexual behaviour and discomfort with the negative connotations of both condoms and female contraception figured prominently in sexual decision-making and lack of sexual negotiation over appropriate sexual comportment. Although male participants admitted that women often did make the final decision regarding timing of intercourse, initiation and rejection strategies used by both partners were indirect and rarely involved open communication. Finally, in South Africa Miles (1992) studied sexual negotiation issues among black and white women through discourse analysis.

Adolescent-focused research in Africa

Available information on sexual issues among African adolescents is limited in scope. A common approach to AIDS and sexual activity among African adolescents is knowledge, attitudes, and practices (KAP) surveys (Nichols, Woods and Gates 1987; Ajayi et al. 1991; Boohene, Tsodzai and Hardee-Cleveland 1991; Agyei and Epema 1994). Such work is critical in providing a strong descriptive foundation for understanding adolescent sexual behaviour and sexuality. Nonetheless, it reveals little about socio-cultural and interpersonal factors which determine teenagers' sexual behaviour or about AIDS-related sexual negotiation.

Qualitative work exploring various AIDS-related aspects of African adolescents' sexuality and decision-making is scarce. In South Africa, few studies have addressed these issues. LeClerc-Madlala (1997) examined black South African youths' reactions to the threat of AIDS and its potential effect on sexual behaviour and attitudes toward sexual relationships. Fear of dying alone was offered by subjects as the rationale for purposeful attempts to spread HIV by engaging in unprotected sex with multiple partners. Varga and Makubalo (1996) found AIDS to be a minor issue among teenage girls, with violence an over-riding factor in their sexual decision-making. Some research has begun investigating socio-cultural factors influencing sexual decision-making and negotiation among adolescents in Tanzania (Nnko and Poole 1997) and Zambia (Nzovu and Lwanga 1997).

Similarities and gaps in existing studies

Western and Africa-focused research on sexual decision-making and negotiation share several themes and weaknesses. Their findings suggest that a combination of socio-economic and gender-based powerlessness, poor partner communication, cultural values associated with fertility and sexuality, and need for emotional intimacy leads both girls and women to remain in risky sexual partnerships. However, while research of this kind is vital in laying the foundations for understanding sexual networking, its ramifications are limited by several factors.

Most studies investigating sexual decision-making concentrate on women who are probably not representative of women in general or of the populations of which they are members. The majority of participants in the studies reviewed here were women whose socio-

demographic characteristics predisposed them to risky sexual relationships and HIV infection and transmission. Focus on such select groups calls into question the extent to which research results can be generalized to the broader populace. Commenting about their own work, Kline et al. (1992) suggest their results be interpreted with caution given that women in the study were from a narrow age-group (early thirties) and were participants in a drug rehabilitation program. Similar questions can be raised regarding the studies, both Western and Africa-focused, reviewed here.

Moreover, the nearly exclusive focus on women presents a considerable 'gender gap' in research on sexual decision-making and negotiation. Despite repeated calls to take heterosexual men into account, the male perspective remains a largely unknown element in the sexual equation (Gilmore 1990; Vogelman 1990; Dixon-Mueller 1993; Gupta and Weiss 1993; Cornwall and Lindisfarne 1994; Gage and Njogu 1994; Harvey and Gow 1994; Romero-Daza 1994; Biddlecom, Casterline and Perez 1996; Grady et al. 1996; Wood, Maforah and Jewkes 1996) This is puzzling especially if one considers that men constitute one half of the sexually active population, and are necessary members of most sexual relationships. The need for male-focused sexuality research, both specific to HIV/AIDS and in general, is particularly acute for adolescents and African populations, for whom both unsafe sexual behaviour and risk of HIV infection appear to be especially problematic.

A final limitation of current sexual decision-making and negotiation research is the absence of a dyadic focus on sexual relations. Available research frequently considers the views and characteristics of only one partner—or gender—in isolation, not as a dynamic between two individuals. The result is an incomplete portrayal of a situation which is by definition created through the interaction between partners in a sexual relationship. Thus, most works examine sexual decision-making but neglect sexual negotiation. In demography, anthropology, and related health and social sciences, there is an increasing call for sexual and reproductive health research characterized by greater gender balance and attention to couples' sexual dynamics (Dixon-Mueller 1993; Cornwall and Lindisfarne 1994; Greenhalgh 1994; Biddlecom et al. 1996; Grady et al. 1996; Ringheim 1996; Zeidenstein and Moore 1996).

Terminology

Before proceeding, it is necessary to define several frequently used terms whose connotations are often unclear. These are: sexual behaviour, sexuality, sexual decision-making, and sexual negotiation. In this paper, 'sexual behaviour' denotes physical actions associated with the act of sexual intercourse, such as penetration, contraceptive use, intercrural sex,⁶ or ejaculation. Dixon-Mueller (1993:273) distinguishes sexual behaviour as 'actions that are empirically observable (in principle at least): what people do with others or with themselves, how they present themselves sexually'.⁷ 'Sexuality' is a broader concept including both personal feelings, desires, and beliefs, and socially accepted attitudes, norms and meaning respecting interaction with members of the same and opposite sex. Referring once again to Dixon-Mueller (1993:273), '...sexuality is a more comprehensive concept [than sexual behaviour] that encompasses physical capacity for arousal and pleasure (libido) as well as personalized and

⁶ External sex between the thighs of the female partner. In traditional Zulu culture, this practice, known as *ukusoma*, was a socially acceptable and encouraged practice in the sex socialization of Zulu youth (Krige 1936; Vilakazi 1962; Van der Vliet 1974).

⁷ Dixon-Mueller includes acts and verbal communication leading up to intercourse—what may be described as foreplay—in her definition of sexual behaviour. Here, such actions are included in 'sexual negotiation' in order to distinguish them from behaviour associated with sexual disease acquisition and transmission.

shared social meanings attached both to sexual behaviour and the formation of sexual and gender identities'. This distinction is especially significant when addressing determinants of sexual behaviour and behaviour change. Without focus on sexuality as the basis of sexual behaviour, interventions targeting sexual behaviour change are likely to be superficial, short-lived, and ineffective in the long-term.

'Sexual decision-making' and 'sexual negotiation' are phrases often employed without clarity or even used synonymously. Here, sexual decision-making is defined as decisions, preferences and resolutions made by an individual regarding the conditions, such as timing of intercourse or contraceptive use, under which sexual relations occur. In contrast, 'sexual negotiation' includes the verbal and non-verbal interaction and dynamic between partners in deciding how and when intercourse will take place. Moreover, both processes of sexual decision-making and sexual negotiation are heavily influenced by conceptual and ideological factors affecting what is perceived as appropriate gender-specific behaviour.

The distinction between these two terms is critical in understanding the determinants of sexual behaviour. Individual decisions, while significant in reflecting beliefs and intentions with regard to sexual practices, may not necessarily be enforced once one has entered a sexual partnership. Of equal, or perhaps greater, importance is focus on both partners and the dynamic between them in determining the circumstances under which sexual intercourse occurs. By definition, sex necessitates the participation of at least two people; thus it stands to reason that sexual behaviour is a product of the combination of partners' sexuality, decision-making, and negotiation (Dixon-Mueller 1993; Cornwall and Lindisfarne 1994; Gage and Njogu 1994; Greenhalgh 1994; Biddlecom et al. 1996; Grady et al. 1996; Ringheim 1996; Varga 1996c, 1997a; Zeidenstein and Moore 1996; Bajos et al. 1997).

Methods

Subjects and venues

Female study participants were black African primigravida adolescent antenatal clinic attenders aged up to 19 years. Subjects were interviewed on one occasion while waiting for antenatal examinations. In order to control for the potential effect of migration, only young women who had been living in the community for a minimum of three years were included in the study. Interviews were conducted in Zulu with the aid of a black African female fieldworker. The clinic was an urban primary health care facility in a former black township to the northwest of Durban.

Male study participants were young black African men who had been involved in sexual relationships with adolescent girls (up to 19 years old) which had resulted in pregnancy and subsequent parenthood within the previous three years. All subjects resided in Durban: in the same northwest township as female participants, and in three other neighbourhoods of the city. The same residence restrictions applied as with female subjects. Interviews took place in individuals' homes and were conducted in Zulu with a young black African male fieldworker.

Male subject selection took place through snowballing. The first male subject interviewed was a 26 year-old man who had recently finished university studies. Through him, the researcher established a network of acquaintances which led to interviews. Study aims were explained to each potential male and female participant, and verbal consent received before recruitment.

Data collection

The interview format consisted of two sections: structured questions focused on HIV/AIDS-related knowledge and attitudes⁸; and an open-ended section addressing sexual negotiation and decision-making issues between the subjects and the partners with whom they had experienced fatherhood or become pregnant. Topics in the open-ended segment included discussion of HIV/AIDS-related issues and self-perceived risk for HIV infection; the timing, role, and expectations of sex in a relationship; and condom use.

Results

Socio-demographic characteristics

Interviews were collected for 39 female and 24 male participants. Mean age was 18 years (range 15-19 years) for females, and 24 for males (range 18-26 years)⁹. Females had an average of 7.2 schooling years, and males eight years.¹⁰ All study participants were unmarried.

Among male participants, 29 per cent had been involved with multiple teenage pregnancies. Mean age at first experience of fatherhood was 21 years. Mean age of the female partner with whom male subjects had their first child was 18 years.

HIV/AIDS-related knowledge

Knowledge regarding HIV prevention, acquisition, transmission, and consequences of infection was high among female participants. All subjects had heard of AIDS, and 81.2 per cent stated that the condition is fatal. When asked to list means by which AIDS can be acquired, unprotected sex (49%), blood contact (24%) and multiple partners (13%) were the most frequent responses.

Girls were also asked about specific behaviour related to HIV transmission. Nearly all viewed sex, multiple partners, shared razors and unprotected intercourse (i.e. without a condom) as potentially effective means of disease transmission. Most agreed with the statement that AIDS can be transmitted through a single sexual encounter.

When asked to list various effective modes of AIDS prevention, girls most often noted condoms (78%), abstinence (61.2%), and external or intercrural sex (*ukusoma*) (12.5%). Finally, 32.9 per cent of female subjects felt it was not possible to carry the virus without displaying physical symptoms.

Owing to time limitations it was not possible to gather questionnaire data on HIV/AIDS awareness among male participants. However, all the young men in the study had heard of AIDS, and approximately half felt it to be a real disease which could potentially pose a threat to the communities in which they lived, though not necessarily to themselves. All were aware

⁸ The structured questionnaire was conducted only among female subjects. For males, HIV/AIDS awareness and knowledge were discussed in the course of open-ended interviews.

⁹ In South Africa, adolescent childbearing is prevalent. The adolescent pregnancy rate is 300-400 per 1000, and 40-50% of all live births are to adolescents (SA Ministry of Welfare 1995; Goosen and Klugman 1996). A recent reproductive history survey conducted in an urban township near the site of this study found that women under 20 constituted 52.6% of primigravidae (Varga 1997b). No data are available for men's average age at first fatherhood.

¹⁰ In the reproductive history survey (Varga 1997b), 88.2% of currently teenaged girls had some secondary school but had not matriculated; 11.8% had completed secondary school. Two males had university degrees.

of the connection between unprotected sexual intercourse and HIV and other sexually transmitted diseases; and all knew condoms to be an effective means of prevention. None knew or had seen anyone who was HIV-infected or had AIDS.

Sexual decision-making and negotiation themes

Discussion of HIV/AIDS-related issues and self-perceived risk for HIV infection

Among female participants, 61 per cent felt AIDS-related issues were not appropriate to discuss with a partner. Only 39 per cent had talked about any aspect of HIV with their most recent boy-friend. None of the male participants had discussed AIDS with the mothers of their children.

Several issues emerged in this regard. First, female subjects were inclined to focus on lack of intimacy in the relationship as a reason for avoiding discussion of HIV/AIDS with partners. Said one 17 year-old girl: 'I would be afraid to talk to him [boy-friend] about AIDS. He is not the kind of person I can discuss such things with. It is not that kind of relationship'.

Threat of rejection or stigmatization and fear of physical abuse or coercion were also mentioned as communication barriers. With regard to the former, girls' typical comment was that if AIDS were brought up in conversation it might suggest they suspected their partners of being infected or, even worse, that they were trying to hide their own infected status. With regard to violence, one 19-year-old girl offered the following explanation for remaining silent: 'No, we don't discuss AIDS. I'm scared of him because he used to beat me. So I don't want to talk about things that might make him upset'. This young woman also implied that such a violent response would probably be due to her partner's interpreting the subject as suggestive of her infidelity.

Male participants most frequently discussed disbelief in the existence of AIDS and the opinion that it is the female partner's responsibility to protect against HIV infection. One 21-year-old said: 'I have never seen anyone who is sick [has AIDS]..I don't believe there is such a sickness. It is a myth from the old government or maybe from overseas'. Another young man who was unemployed and living with his parents stated quite emphatically: 'if a girl wants to be mine, she must stay clean, take care of herself and avoid it [AIDS]'.

Also implicit in both male and female subjects' comments was the notion of trust in one's partner as a safeguard against contracting HIV/AIDS. This reasoning was used to create a perception of low risk. Consider the comments of two young men, both in their early twenties:

I only have sex with clean, trustworthy girls. I would know if they had AIDS.

We talked about the fact that trust and fidelity will prevent STDs and AIDS.

The concept of trust was sometimes even used as a tactic to ensure fidelity. A 17-year-old respondent in her seventh month of pregnancy noted of the father of her baby: 'he said he won't get AIDS since he only has one partner. If he does get it, he will know it is from me.' Later in the interview, this young woman noted that subsequent to her boy-friend making such a statement, she was terrified to bring up the topic of AIDS for fear of his suspecting her of having had other partners and been infected with HIV. Thus, she preferred to remain silent on the issue and maintain the stability of the relationship.

Neither male nor female participants mentioned HIV/AIDS in the context of decisions to initiate sex with a new partner or to engage in practices such as condom use or monogamy. When the topic was introduced by the interviewer, it solicited responses similar to those enumerated regarding discussion of HIV/AIDS itself. As noted, a number of respondents stated they did not believe in the existence of AIDS; thus for them it was not a relevant factor in sexual decision-making. Among those who acknowledged its existence, the predominant view was low perceived risk of HIV infection combined with other more pressing concerns, such as demonstrating masculinity and social prowess, expressing commitment and trust, or avoiding physical abuse, in relation to sexual decision-making and negotiation.

Timing, role, and expectations of sex in a relationship

Male participants were adamant that sex must take place within the first few weeks (generally the first two weeks) of a relationship in order for it to be viewed as serious and legitimate. Having a true girl-friend necessitated sexual intercourse. According to one man, 'if someone is in love with a woman and breaks up with her before they have sex, that affair is as if it never even existed'. To stress the symbolic importance of sex, a 24-year-old man noted: 'it is my procedure to have sex with the girl in the first two weeks of the affair .. to prove if [she] is really committed to me and prepared to do anything to make me happy'.

Men viewed sex as an expression of pleasure and affection; though not necessarily commitment on the part of the male partner. This was articulated very clearly by a 24-year-old father of two children from different women when he described his sexual relationships: 'Sex is something you do in order to enjoy each other... It is about love and pleasure, but you can still get pleasure without having to be deeply in love with your sex partner'.

As illustrated by the quotation at the beginning of this paper, sex was a man's means of establishing power within the relationship. Having multiple sex partners was a particular status symbol, the yardstick by which masculinity, intelligence and success were measured among one's male friends. Male participants described strategies resulting in many partners as a reflection of male intelligence, cunning, and wit. The following words from a 25-year-old participant were typical of many in the study, 'It's not enough to get her to fall in love with you...To show that you control the relationship, you must be able to show your friends that you have slept with her'.

For these young men, the socio-cultural and conceptual value of having multiple sex partners was also reflected in the Zulu terms they used to describe their sexual experience. Of utmost importance was the distinction between a man with many partners, *isoka*, and a man having only one or none, *isishimane*. The former was the ultimate compliment, while the latter was an insulting and derogatory label. One male participant noted that his family greeted news of his third illegitimate child with relief, as it demonstrated beyond a doubt his public *isoka* status.

Several men emphasized the distinction between the positive connotation of *isoka* and promiscuity, which was extremely undesirable. Participants were emphatic about the fact that the two were completely unrelated concepts. Being an *isoka* was considered a natural, laudable and traditional part of African manhood. In contrast, being promiscuous was seen as distasteful and dirty. Promiscuity was usually associated with women thought to have many sex partners; such women being known as *izifebe*, whores. The following statements portray the strong sentiments surrounding *isoka* and *isishimane*, and that achievement of *isoka* was viewed by male study participants as something of a cultural birthright.

Many girl-friends is an old culture of Africans... My own father had many wives and there was nothing wrong with that... *isoka* is not a promiscuous person. Those two words come from different contexts and they mean different things (male, 24).

I am a man... I cannot have one affair. I am not *isishimane*. For a man to have three girl-friends is very reasonable behaviour (male, 18).

Like male participants, most young women stressed the absolute necessity of sex as part of a normal relationship. Their statements also corroborated those of their male counterparts in confirming intercourse as a woman's means of demonstrating love and commitment to a relationship. This was such a powerful belief that girls frequently relied on it as justification for not refusing unwanted sex. These notions are clearly embodied in the words of an 18-year-old girl who said simply: 'I don't refuse because I know that he is the only one for me. I don't want to lose him, so I must satisfy him'.

Consequences of refusal of sex

In the course of the study, refusal of sexual advances—and the repercussions of such actions—became a major focus of discussions with female participants. Over half (55 %) reported having refused sexual advances from their most recent boy-friend. Of these women, 71 per cent admitted their attempts to avoid sex had not been successful. Refusal nearly always resulted in physical coercion, abuse or boy-friends' threats of rejection. Many female subjects chose not to refuse sex in order to avoid physical abuse and maintain the stability of the relationship. One 19-year-old described the following pattern with her steady boy-friend: 'I do refuse [sex] although I usually have to do it anyway. It doesn't end there. I know he is going to hit me if I don't... I am even scared to tell him I am tired of sex'.

Attempts to discuss female partners' refusal of sex with men frequently drew indirect responses. Several participants avoided the issue completely, and a few appeared to find the question nonsensical. One means of eliciting responses from young men was to initiate discussion of recently publicized South African rape statistics and local activists' efforts to increase public awareness of sexual violence. In this context, many men felt the statistics were exaggerated, and were uninterested in public awareness movements. They were generally of the opinion that women should and do anticipate sex as part of a relationship, and that most women want sexual satisfaction as much as men.

In a few interviews, the issue of rape and its exact definition became a topic of conversation. A common comment was that it is a man's duty to satisfy a woman sexually in order to keep her from becoming bored and finding another boy-friend. Physical coercion or abuse in participants' own relationships arose in only one interview, after the topic of rape had been debated at length. Given the context of the discussion, the young man was asked if in retrospect he considered his sexual advances potentially aggressive. After some thought, he responded, 'I do not rape anyone. All my girl-friends enjoy my company'.

Condom use

Condom use appeared to play a minor role in male participants' contraceptive practices, and was not a topic of discussion with partners. Those who had experienced sex with condoms used them only until trust had been established in the relationship. Condoms were also avoided because they made sexual intercourse an impersonal and uncontrolled experience. According to one male university student, 'Condoms take away sexual control both physically and psychologically. They take away [a man's] control of the process'.

Among men, when the issue of contraception was introduced they nearly always assumed this meant female methods, ignoring condoms in their commentaries. Partial explanation for this may be that among these young men, condoms were associated primarily with prevention of HIV and other sexually transmitted diseases (STDs), not with contraception. One participant elaborated at length upon current local social marketing strategies emphasizing the connection between condom use and AIDS or STDs, not pregnancy. This sentiment was also evident in the comment, 'If I do not trust a girl, that is the only time I make use of a condom to prevent diseases'.

Over half the female subjects said they had avoided discussion or requesting use of condoms. Reasons for such silence mirror many themes uncovered here regarding other HIV and sexuality-related issues: fear of physical abuse, rejection, or lack of intimacy in the relationship. Those who talked about it (47%) said their partners usually rejected condoms on the grounds that they made sex less pleasurable. One female subject said her boy-friend refused condoms because he wanted the sexual experience to be 'meat to meat'.

As with males, young women generally did not stress condoms as a means of contraception. Instead, condoms were connected with protection against STDs and AIDS, and suggested the moral implications of infidelity and risk of sexual diseases. The association between condom use and promiscuity led one young female participant to describe how angry she was with her boy-friend when she began to suspect him of using condoms: 'He has refused to use them [with me]. But I don't trust him, because I found some in his pocket. Maybe he uses them for other [casual] girl-friends'. Later, she said that despite her discovery she was still seeing him regularly and that she had not confronted him with the issue.

Finally, as with HIV-related discussion, a predominant justification among both young men and women for avoiding condoms was trust and fidelity. For these reasons study participants felt they did not need the discussion, or use, of condoms; and perceived themselves at low risk of STD and HIV infection. None of the male study participants said they had used condoms with any regularity, and only one female participant had experienced sex with a condom. The interplay between partners regarding condom use and the rationale used to conceive of themselves as safe from infection is illustrated in statements from three female teenagers.

[He] said he doesn't have any... diseases, so why should he use a condom?

He says if a man doesn't trust a woman, that is the only time to use [condoms].

He refused to use them. He says he is faithful to me, so why bother?

Discussion

The commentaries of these adolescents illustrate several aspects of their approach to sexual decision-making and negotiation, and the role HIV/AIDS plays in this process. Perhaps unsurprisingly, there was a general tendency to avoid direct communication with partners about the conditions under which intercourse would take place; actions were based on unspoken assumptions about the kind of behaviour considered appropriate in a dating relationship. In addition, the dynamic within the relationship was routinely guided by the preferences of male partners. For young women, this translated into decision-making

powerlessness if their desires clashed with those of their partners. Moreover, it seems that awareness of HIV/AIDS was not a factor in adolescents' sexual decision-making and communication. As in much research among minority women and adolescents in the US and Africa (Worth 1989; Sibthorpe 1992; Moore and Rosenthal 1992; Sobo 1993,1994, 1995; Pivnick 1993; McGrath et al. 1993; Romero-Daza 1994; Lear 1995, 1996), it appears that for these young South Africans sexual negotiation and decision-making were influenced, and in many cases overridden, by a complex set of social and cultural factors which far outweighed the potential threat of HIV infection.

Socio-cultural context and transition

A partial explanation for the sexual dynamics revealed among these Zulu young people lies in a socio-cultural context which has not fostered sexual negotiation skills, and in which segregated gender roles are culturally sanctioned. Both historical and contemporary factors have contributed to this situation. In traditional Zulu culture, sex play was encouraged but regulated,¹¹ and education regarding sexual matters was undertaken separately for boys and girls by their older peers. Gender roles differed substantially; women were taught to be submissive and obsequious, men to be forthright and assertive (Krige 1936; Van der Vliet 1974; Kies 1987). In the polygynous and patrilineal Zulu world view, women were recognized primarily in their role as childbearers, and once married were 'absorbed into' the ancestral lineage of their husbands. The imagery and ritual surrounding marriage clearly demonstrates the process by which a bride shed her former persona, ultimately becoming fully integrated into her husband's lineage (Krige 1936; Ngubane 1981).¹² In traditional Zulu society, a woman was clearly assumed to be part of her partner's domain.

In the midst of recent social transition and rapid urbanization in South Africa, many traditional Zulu lifeways have undergone dramatic transformations. However, traditional sexual socialization and values have not yet completely eroded. Rather, they have been adapted to a new social environment and become entangled with contemporary social sexual norms. Consequently, adolescents are left in a precarious position by receiving a combination of conflicting messages about sexuality and sexual behaviour. Teenage girls in particular frequently find themselves in untenable double-bind situations. A young Zulu woman may simultaneously be under pressure from friends and boy-friends to have early and unprotected sex, forgo birth control owing to its association with promiscuity, conceive a child and demonstrate her womanhood, *and* avoid pregnancy in order to finish school and find a job (Craig and Richter-Strydom 1983; O'Mahoney 1987; Preston-Whyte and Zondi 1992; see also Olaniyan 1992; Bledsoe and Cohen 1993 for perspectives elsewhere in Africa). Traditional support and information networks have fallen away, being replaced by limited alternatives for acquiring skills to handle new demands. Moreover, contemporary reproductive health programs have been described as having 'adopted a sanitized version of sexuality that treats intercourse as an emotionally neutral act' (Dixon-Mueller 1993:276). Thus it is sadly appropriate that Nash describes contemporary black South African adolescents as 'caught in a web of change' regarding sexual matters (Nash 1990:147).

Culturally sanctioned differences in gender roles and expectations of sexual relations may also contribute to poor sexual negotiation (see McGrath et al. 1993; Romero-Daza 1994; Balmer et al. 1995). Here, such factors were evident in both male and female participants'

¹¹ Intercultural sex was an accepted and encouraged form of sex play between young unmarried partners.

¹² Ngubane discusses the vivid and emotional mourning rituals performed by the bride's family during the wedding, symbolizing the loss or death of their daughter to the lineage of her new husband.

emphasis on women's fidelity and expression of love through sex, in sharp contrast to the powerful *isoka* imagery for men: an ideal which appears to be a well-entrenched aspect of Zulu masculinity (Vilakazi 1962).¹³ In many cases, such a divide resulted in the emotional manipulation of female partners. Many female respondents voiced considerable apprehension about proving their fidelity (through avoiding condom use), dissociating themselves as much as possible from HIV, and the potential emotional and physical consequences of refusing sex. Thus, young women's gender roles and the symbolic meaning of sex often rendered them powerless to articulate or follow their own desires (see Tolman 1994).

Even contemporary social marketing strategies may inadvertently foster confusion and lack of sexual communication. A generally held opinion among both male and female participants in this study was that the responsibility for protection against unplanned pregnancy rests entirely with the female partner; and that it was an issue not relevant for discussion between partners. As an explanation, one male respondent offered the opinion that local sex education and reproductive health programs have traditionally targeted women in connection with birth control-related matters. Thus, he said, men are unused to concerning themselves with or taking responsibility for contraception. Such a lack of gender integration in reproductive health policy has also been recognized elsewhere (Dixon-Mueller 1993; Berer 1996).

Gender-based violence and coercion

Recently, physical abuse, coercion, and domestic violence as barriers to both girls' and women's sexual decision-making freedom and reproductive health have received increasing attention (Burgess 1985; Vogelmann 1990; Harvey and Gow 1994; Koss and Heise 1994; Heise et al. 1994; Stewart et al. 1996). Such awareness has taken place in both developed (Warshaw 1994; Sanday 1996) and developing countries (Sanday 1981; Heise et al. 1994; Oppong 1995; Glantz and Halperin 1996; LeFranc et al. 1996); and has led Stewart et al. (1996:129) to describe sexual abuse as a universal problem. Here, physical abuse and coercion were distinct and sometimes graphic obstacles in sexual decision-making and negotiation for female participants.¹⁴

Three factors in particular make the often coercive and violent nature of these youths' sexual dynamics urgently deserving of attention and serve to illustrate the apparent neglect of gender-based violence in the southern Africa context. First, in stark contrast to what was observed and recorded in interviews with females, male participants did not view their sexual behaviour as violent or abusive. A second factor was the reconciled and matter-of-fact manner in which female participants described and bore such behaviour from their partners. Finally, especially distressing is the fact that for these adolescents sexual violence and coercion took place in the context of familiar personal, if not always steady or serious, relationships.

Available ethnographic information on the topic is scanty at best, but appears suggestive of sexual coercion and gender-based violence as culturally acceptable norms in both

¹³ The cultural importance of being considered an *isoka* seems to have changed little through several generations. Vilakazi's description of the status accorded to a sexually experienced man, an *isoka*, could be the words of a young male participant in this study: 'To have a girl accept you as a lover is to get the assurance that you are a normal man. That is why [being an *isoka*] is such a value among the Zulu, for it gives social and psychological poise. To fail to win a woman is to be a social failure (*isishimane*) and it is to be cursed with a social stigma which... is worse than an organic disease' (Vilakazi 1962:50).

¹⁴ In the course of the study, a female fieldworker was hospitalized for a week with head injuries inflicted by her long-standing boy-friend. It was apparently not the first time she had been admitted to hospital for this reason.

traditional and modernizing southern African societies.¹⁵ Accounts in both older and recent ethnographies indicate sexual violence and coercion as a common phenomenon. The manner in which these issues are described suggests such behaviour is viewed as a norm. Schapera (1939) chronicles physical abuse of wives by their husbands as a common reaction to refusal of sexual advances. Of sexual coercion in township life Longmore wrote: 'if the girl refuses the boy openly, he may decide to assault her, to punish her for resisting him' (1959:24). In a Queenstown (Eastern Cape Province) township Kotze notes: 'men may beat their women when they do not observe sexual fidelity or when their own infidelity is questioned by their women' (Kotze 1993:76). Ramphele (1993) paints a similar picture among hostel-dwellers in Cape Town.

That such coercion and violence took place within relationships and between familiar partners suggests that gender-based violence is much more common than conventional statistics indicate. South Africa was recently described as likely to have the highest rate of reported rape in the world (Duke 1997). However, the exact dimensions and definition of rape are unclear, both by South African legal standards and social opinion (Hunt and Milton 1990; see also Warshaw 1994; Heise, Moore and Toubia 1995; Sanday 1996). Moreover, it is becoming increasingly clear that most rape and other forms of sexual violence and coercion take place between acquaintances or in the context of a steady dating relationship (Warshaw 1994; Sanday 1996). Thus, the reported 141 rapes per 100,000 South African females—twice the rate in the United States—are certainly an underestimate; the tip of the iceberg which includes young South African women like those in this study. Ulin (1992:67) has suggested that African women's empowerment lies in 'informal associations and networking'. However, the feasibility of such an approach is questionable, particularly among adolescents, many of whom see unprotected sex and relationships as a means toward intimacy, acceptance, and womanhood.

Only recently has the potential social and reproductive health impact of sexual violence come to be explored in the southern African context (Hansson 1991; Angless 1992; Varga and Makubalo 1996; Wood et al. 1996; Duke 1997). Sanday (1981) and Heise et al. (1994) enumerate cultural, economic, legal, and political factors which sustain gender-based violence; many of these fit the situation in which the adolescents in this study found themselves. Both micro and macro-level factors in South Africa appear to have created a context conducive to gender-based violence and the sexual powerlessness of women.

HIV/AIDS in South Africa: current epidemiological and social status

Why did HIV/AIDS not figure more prominently into these adolescents' sexual negotiation and decision-making? One potential explanation lies in the fact that the pandemic has not yet reached the stage of high public visibility in South Africa. Recent projections estimate the rate of HIV infection in South Africa increasing rapidly through the end of this century, only peaking by the year 2007. HIV's long incubation period without overt physical manifestations

¹⁵ The perpetuation of men's use of African culture as justification for sexual coercion is also obvious in professional academic and university circles. Such opinions were openly voiced and vehemently upheld by male participants from various African countries in discussions at two recent conferences and at a University of Natal seminar presentation focused on gender issues (Pan African Association of Anthropologists annual conference, Pretoria, September 1996; Workshop on Multi-partnered Sexuality and Sexual Networking in East and Southern Africa, Durban, February 1997; University Forum Seminar Series, Durban, March 1997).

has been cited as a major reason for this continued increase (Whiteside et al. 1995). In this study, questionnaire responses revealed that over one-third of female respondents felt a person could not be infected without displaying physical signs ('looking sick'). Such sentiments were reinforced by similar comments made during in-depth interviews with both male and female participants. The magnitude of such barriers is apparent in the comment of one 18-year-old female participant in describing her boy-friend's reaction to HIV-related issues: '... My boy-friend said he hates to hear about it [AIDS]. He doesn't believe it is real. When he hears about it on the radio, he just switches it off'.

Another likely factor at play in adolescents' low self-perceived risk for HIV/AIDS and unwillingness to incorporate AIDS-related issues into sexual relationships is the social disapprobation attached to the disease. All too often HIV/AIDS is linked with perceived immoral segments of society such as prostitutes and homosexuals, and with inappropriate sexual behaviour such as infidelity and promiscuity (Clatts and Mutchler 1989; Bolton 1992; De Bruyn 1992; Herdt and Lindenbaum 1992; McGrath 1992; Scheper-Hughes 1994; Varga 1996b). That HIV infection is so often associated with promiscuity may provide some clarification upon why young men in this study did not view themselves as at risk, while openly acknowledging involvement with multiple sex partners to achieve the *isoka* ideal. As noted above, in the Zulu world view being *isoka* and being promiscuous are conceptually unrelated conditions. Given this reasoning, a young man's pursuit of *isoka* status, and of social success and approval, could not possibly place him at risk for a condition associated almost exclusively with 'dirty women' (Varga 1996b). This rationale might also clarify why HIV or other STD infection would be blamed upon the female partner. From the male viewpoint, his sexual behaviour is natural and normal. Thus, of necessity, infection must come from the female partner.

Risk of HIV/AIDS has potentially dire emotional and conceptual consequences for intimate personal relationships (see works by Sobo cited here). In this context, HIV/AIDS, or hint of risk, suggests that at least one partner has violated the trust, commitment and intimacy of a sexual partnership. For the adolescents in this study, HIV/AIDS may have had added insult. In its association with infidelity, HIV/AIDS infection or its suggestion would be tantamount to a violation of love. Given such a context it is not difficult to understand why HIV/AIDS was such an uncomfortable topic or why attempts to discuss it might have elicited extreme reactions from one's partner. For these young people, silence and low self-perceived risk may have been means of insulation from potential social and emotional rejection.

As with the connotations of AIDS, the negative symbolism of condoms was almost entirely responsible for their avoidance among study participants. It is a bizarre twist of the success of social marketing strategies described by one male participant that condoms were associated with sexual diseases and eschewed for that very reason. Like HIV/AIDS, condoms pose a threat to trust and intimacy, and acknowledge infidelity (Worth 1989; Sibthorpe 1992; Pivnick 1993; Sobo 1993, 1995). All these images are in direct opposition to what these young people sought from a relationship, in the case of young women, or expected from their sex partners, in the case of young men. Thus, they were forced to undergo a cost-benefit analysis: broach taboo subjects like safe sex and risk rejection and physical abuse, or remain silent and hazard HIV/AIDS. For the young men and women in this study, the 'psycho-social benefits of unsafe sex' seemed to outweigh the risks of HIV infection (Sobo 1993).

One aim of this paper was to serve as a first step in furthering exploration of sexual decision-making and negotiation, and to stimulate thought and discussion in approaching these matters from a more gender-balanced and dyadic perspective. There is a pressing need for development of innovative and ethical theory and methodology in this regard; a challenge made greater in the second decade of AIDS. Another objective was to illustrate the importance of attention to socio-cultural factors, and to demonstrate their explanatory value,

in elucidating the determinants of reproductive behaviour. Such issues must be among the first to be examined in attempts to understand sexuality, foster sexual behaviour change, and ultimately curb the spread of HIV/AIDS.

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'Between a rock and a hard place': applied anthropology and AIDS research on a commercial farm in Zambia*

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Abstract

Fieldwork on a commercial farm in southern Zambia, which was aimed at designing an HIV prevention program for farm workers, gradually exposed the nature of sexual liaisons between young girls, coming to work on the farm from the surrounding villages, and older migrant men workers. Before completing fieldwork, the anthropologist voiced her concern about the implications of these liaisons for the spread of STDs and HIV with the local rural community, farm management and farm workers. The immediate outcome of her intercessions was the decision by management to sack under-age workers. Although some members of the local community, including local research assistants, and some managers and workers welcomed this decision, others were angered by it. Caught between interest groups and conflicting guidelines, the anthropologist, it is argued, was in a no-win situation, 'between a rock and a hard place'. The paper proposes that the application of anthropological ethics in AIDS research needs some re-evaluation.

An ethical quagmire

Fieldwork has a habit of challenging the ideal behaviour of social anthropologists, be it supposed detachment, implicit commitment to affective change or explicit recognition of the nature of anthropological authority. Faced with crises of one type or another in the cultures that we study, some of us pursue our 'chronic desire to be useful' (Wallman 1985) and discover that the cloak of attachment itself is not, after all, so easy to wear. If we try to apply our research findings to alleviating a problem, what existing guidelines should we follow? How can we identify the overlap between action and reflection and work towards a balance between involvement and self-criticism? This paper argues that if we accept that we are not value-free (Weber 1947) and we also decide that we are not going to tolerate a situation that

* The research presented in this paper is a component of a wide-ranging study of the capacity of a rural community to prevent, manage and survive HIV/AIDS in Southern Zambia. This research has been funded from 1991 to 1997 by the Swedish Agency for Research Co-operation with Developing Countries (SAREC). Three institutions are involved in the research: the Department of Public Health Sciences, International Health Care Research (IHCAR), Karolinska Institutet, Sweden; the University of Hull, Britain; and the Institute for Economics and Social Research, University of Zambia. I would like to acknowledge the comments and recommendations of Sandra Wallman and Eleanor Preston-Whyte to an earlier draft of this paper, presented at the PAASA Conference in Pretoria in September 1996, and of Karen Hansen and Philip Setel to a later draft, presented at the Workshop on Qualitative Methodologies for Investigating Sexual Networking, February 1997, University of Natal. Their comments have led me to revise the emphasis, analysis and framework, though the final analysis in the paper remains my own.

appals us, we do not necessarily know what we should do to make things better. We find ourselves in a no-win situation, caught 'between a rock and a hard place'.

By focusing on an event during my own fieldwork¹ which involved sexual contact between young girls and older migrant men on a large commercial farm, the responsibilities of a social anthropologist are explored. The incident had all the elements of an ethical quagmire: a multinational company, a previously undeveloped rural area, a pool of seasonal migrants, employment of 'under-age' girls and evidence for the transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV). The part that the AIDS epidemic plays in pushing us towards trying to intervene and forcing us to re-evaluate our ethics is, I believe, crucial.

There are parallels between the focus of my own work on issues that are problematic between labour and management and that of earlier social anthropologists — Godfrey Wilson, Epstein, Clyde-Mitchell, Powdermaker, Kapferer and Burawoy (based at the Rhodes-Livingstone Institute) — who did fieldwork in the mine towns on the Copperbelt from the 1940s to the early 1970s. In the context of a commercial farm or a mine the social anthropologist is caught between the goodwill of management and the needs of labour, between the men in power and the anthropologist's knowledge of labour conditions. She cannot afford to alienate any of the parties in order for the research to proceed. Powdermaker describes how she was careful to manoeuvre between races and between the 'top ranks' and the 'under-dog' during her fieldwork in Luanshya because she could not afford to 'exclusively identify with either' (Powdermaker 1966:249-250). In my own case, there is an added dimension since the local Chiawa community is distinct from the migrant worker population on the farm and thereby yet another party to manoeuvre between. Whisson, examining the potential roles of applied anthropology, reminds those of us acting as 'men in-between' or 'interpreters' of Monica Wilson's comment that 'Where the groups between whom they interpret are in conflict they are likely to be distrusted by both sides because they are negotiators between opponents' (Wilson 1972:20 cited in Whisson 1985:145). With the AIDS epidemic I feel this mistrust can be accentuated by people's anxieties about and denial of HIV infection. Mistrust of informants could invalidate a study (Burawoy 1972:240).

Analogous to Gluckman's situational analysis of the opening of a bridge in Zululand in the mid-1930s, which has 'provided a template' for anthropological work in Zambia (Schumaker 1994), in this paper I first describe the event and then abstract the relationships between the different groups involved (Gluckman 1958:2). In the final analysis, in connection with this specific event, the expectations and ethics of anthropology are re-examined.

The setting: a rural community and the commercial farm

Chiawa, lying in the middle Zambezi valley on the border of Zimbabwe and on the banks of the Zambezi river about 200 kilometres south of Lusaka, has its boundaries shaped by three rivers and the Mwinde hills. A ferry on the Kafue river connects Chiawa with Southern Province and a main road. The resident population number about 8000 and are a small ethnic group which call themselves Goba and speak a Shona dialect. Since 1993, the population has

¹ Although the applied research study, Intervention Study of Work Camps in Chiawa, involves other research colleagues, during the period of fieldwork related in this paper, I was alone in the field, except during two introductory meetings which Bawa Yamba attended. I worked on the baseline studies with local research assistants, who had been trained by the larger research project in 1991. The fact that I was mostly working on my own as a researcher, with local research assistants, has, I think, a bearing on my response to the event described in this paper. The presence of one or more of my research colleagues might have affected my choice of intervention. The other colleagues involved in the study are Elisabeth Faxelid, Solveig Freudenthal, Phillimon Ndubani, Paul Dover and Bawa Yamba.

been boosted by an annual influx of around 2000 migrant workers coming to work seasonally on a commercial farm.

The farm, owned by a multinational company, first established in 1988, grows marigold flowers, paprika and cotton. These crops need to be picked by hand for about six months a year, April to mid-September, and the farm is unable to recruit enough seasonal labour locally. Since 1993 the farm management has recruited labour from other rural areas and from town. The majority of the seasonal labour come from the adjacent river valley, the Gwembe, where overcrowding, severe soil erosion and persistent drought makes migration a main survival strategy for the local Tonga who reside there. Seasonal migrants working on the farm are called 'camp' workers by Chiawa people, owing to their residence in the 'camps' — farm compounds. Management on the farm itself is mainly Zambian, with one expatriate farm manager and some expatriate technicians. This extensive agricultural development, coupled with other tourism and environmental developments in the last decade (including the eradication of tsetse fly), has changed the local economy, infrastructure and demography of Chiawa, intensifying contact between local people and outsiders.

There are three categories of workers on the farm: permanent, seasonal migrant, and seasonal local. Senior management have their own compound and live in block houses with asbestos roofs. Other permanent workers are mostly housed in mud brick houses in the main compound, accompanied by their families. Local seasonal workers are transported to the farm on lorries or tractor trailers which reach the villages at 5 a.m. and leave the farm to take people home around 4 p.m. During school holidays, Chiawa school children often work at the farm to earn money or raise money for the school. The migrant seasonal workers live within the confines of three compounds during their stay. They are housed in mud and wattle dormitories, concrete dormitories, mud brick houses, canvas tents or temporary hessian sack, plastic or grass shelters. A few sleep outside. Most living (sleeping) spaces are overcrowded, with between three and five people sharing about seven square metres. There are a few communal toilets and showers but most migrant workers use the bush as their toilet and erect their own washing areas from hessian sacks. Every compound has water tanks or water points and some drainage channels. There are no provisions for rubbish disposal and rats are a problem. There is no clinic on the farm and to reach a health centre, workers have to travel 16 km to a mission hospital or 25 km to a rural health centre. The farm will often provide transport to the hospital. The migrant workers complain about poor housing, shortage and siting of toilets and lack of health services. They perceive diarrhoea, dysentery, chest-pain, headache and malaria as the most serious illnesses at the farm². The main focus of leisure and commercial activities is the area around a government-owned ferry, two kilometres from the farm boundary. Around payday, markets spring up overnight and local taverns and shops do brisk trade near the ferry. Some migrants travel home for a few days, carrying goods and wages with them, whilst others wile away the time and their pay locally.

The men employed at the farm outnumber the women. In 1994, 21 per cent of all farm workers were females. Their ages ranged from 8 years to 45 years, with 67 per cent under the age of 25, and 69 per cent unmarried³. The majority were local Chiawa women and girls not living in the camp compounds and employed on a seasonal basis who, in a survey, mostly

²The event described in this paper took place in 1994 when the farm was in financial difficulty. In 1995 and 1996, the farm finances have improved considerably and improvements in housing and sanitation have been made. A clinic has been constructed and is due to be equipped and staffed in 1997. Some of the improvements in health services and environmental health could be partly attributed to the presence of the research project.

³A repeat survey in 1995 reflected an increase in the number of women employed to 28 per cent of the workforce and an increase in the number of single women workers.

cited hunger and the need to buy food as the main incentive for seeking farm work. Forty three per cent of seasonal local workers were female. There were proportionately more single women than men working at the farm. The disparity between the number of men and women living in the compounds on the farm was as much as seven men to every woman. Other Chiawa women are involved informally in the economy of the farm, selling food, vegetables, game meat, tea, wine and beer to farm workers in or around the farm. Payday attracts women traders and prostitutes from outside to the area. This work environment is similar to early urban settings in Zambia.

In this paper, a distinction is made between women and girls, the latter denoting those under about 17 years who are not married and who were working on the farm during the months of July and August 1994. This distinction is not a reflection of sexual maturity or activity. My use is based initially on my concern for Chiawa teenage girls, most of whom are poor, coming into contact with older men and a cash economy which exposes them to potential sexual contact and exchange in a situation of great power imbalance, that could lead them to contracting STDs and/or HIV. The term 'girls' for the purpose of this paper also reflects labour laws in Zambia which categorize girls aged 15 and under as 'under-age', and HIV interventions which focus on adolescents in an attempt to save them from the high HIV prevalence rates found in women aged 20 to 29 years. The use of 'girl' instead of 'young woman' in the Chiawa context is based on local gender perceptions of vulnerability, moral infraction and control. Despite the fact that ideally a girl is considered a woman and sexually mature after her first period, Chiawa people still apply the term 'girl' in certain contexts to females who have started menstruating. Local discourse on connections between Chiawa girls and the farm often blames girls for spreading STDs and HIV and for being too licentious in their sexual behaviour. This criticism comes from all directions. Young migrant men complain 'These Chiawa girls are not steady'; 'These girls move with too many men - 10 or 15'. A young Chiawa man who is a research assistant says 'There is nothing you can do to protect young local girls from AIDS...I am telling you these young girls will die anyhow'. Married women on the farm will refer to 'girls' with whom their husbands have sex. There is the notion, expressed often by older women, that such girls are naive and vulnerable, 'having sex for nothing'. The implication is that these girls are not using sex as strategically as might older women. One elderly woman relates 'If a local girl gives birth, she cannot meet with men and make money'. Older migrant men at the farm comment that it is easier to get the attention of 'young girls'. A nun at the local mission hospital laments 'Our girls will oblige in exchange for money, food or clothes because the area is very poor'. School teachers also refer to schoolgirls who are working at the farm rather than being at school or schoolgirls who flock to taverns and the market on payday. A research assistant's diary records that on payday 'There were local girls aged 17 to 28 years in the store who the young men from the camps were buying beer for'. Hence these are adolescent girls who are not behaving as ideal daughters and schoolgirls should in the eyes of the Chiawa community. At the same time the community acknowledges the lack of maturity, the vulnerability and the importance to the community of these girls and expresses a desire to protect them. There are therefore similarities between my use and the local use, particularly in our special concern for this group⁴.

At the time that this fieldwork was conducted, the research project had not actually screened any of the farm workers for STDs. A review of 1987-1991 health records at the local

⁴I am indebted to Philip Setel for pointing out to me how I used both 'local girls' and 'local women' in my text without exposing either my reason for categorizing them as such or whether I was getting caught up in local categories.

hospital and rural health centre showed that out of 369 Chiawa people tested for HIV⁵, 138 were HIV-positive, and that the majority of these were from the farm area (Bond and Ndubani 1993). STD records are unreliable because so often STDs have been treated outside the government health system. In August 1995, in collaboration with the Epidemiology and Research Unit at the National AIDS and STD Control program, the research project tried to screen one-third of the farm workers for certain STDs⁶. Women workers were only screened for syphilis. The number of workers screened was 570, of whom 210 were women. The syphilis prevalence in women aged 15-19 years was three per cent; in women aged 20-29 years eight per cent; and in those over 30 years, six per cent of women had syphilis. Elsewhere in Zambia, results in 1995 from annual sentinel-site surveys show that HIV prevalence amongst young women (aged 15 to 29 years) is at least double that of young men of the same age. In 1996, a population-based survey in an urban, a peri-urban and a rural site showed prevalence rates of women aged 15 to 19 years out of school to be 17.9, 27.7 and 10 per cent respectively, with lower rates in the same age group attending school of 4.9, 11.1 and 7.7 per cent respectively, suggesting that attending school in urban areas may have a protective effect (Fylkesnes, Sichone and Kasumba 1997). Our observations of rising AIDS-related illnesses and deaths in girls and young women in Chiawa tally with these statistics of relatively high HIV prevalence in this age group.

Methods of enquiry

The research study on the commercial farm aimed to develop and evaluate a model for STD/HIV health education especially designed for migrant workers, based on a longitudinal anthropological study of the area. The study began in June 1994, the year in which the event described in this paper took place. A variety of methods were used over a period of five months to conduct the baseline study, including mapping exercises, timed observations, a register of all camp workers followed by a quantitative random survey of ten per cent of camp workers, a selected survey of key informants, focus groups with men and women of reproductive age, individual interviews, diaries kept by research assistants and my own observations. It is necessary to present the fieldwork practices in chronological order since each method threw a different light on the subject of this paper, namely the sexual contact between young local girls and older migrant men, and thereby gives the background to the specific event under analysis.

Fieldwork

The research project had conducted a socio-economic survey on the farm in 1991, and feedback meetings in 1993, and had had a continued presence in Chiawa since 1991, so the community, farm management and farm workers were mostly familiar with our work. The objectives of this particular study on the farm were outlined to management in meetings held

⁵The testing is erratic, dependent on availability of kits and government health policy.

⁶I would like to acknowledge Doreen Mulenga, Knut Fylkesnes, Zach Ndlovu and Calvin Kasumba from the Epidemiology and Research Unit, NACP, who carried out the STD epidemiological baseline survey at the farm.

in the town and farm office and, after the meetings, in a letter. Having obtained their consent to conduct our work, we (Yamba and I) held introductory meetings in the different farm compounds and with local workers to explain our interest in health promotion within the camps and the work we planned to do. We were careful to define our role, stating clearly that we were not advocates for workers' problems and encouraging them to continue to voice any complaints through their own lines of communication with management. We explained it was in the farm's interest to have healthy workers and we would pass on information to the company about health issues.

At these meetings the large number of men and their need for women were dominant issues. So too were the anxieties and queries about sexually transmitted infections and AIDS. These ranged from requests for diagnosis and treatment to worries about being infected with HIV. Some workers came privately to us after the meetings and confided that they had sexual contact with women who have since died from HIV.

After holding introductory meetings, we carried out mapping and observation exercises of the physical and social landscape of the farm. Of particular interest was the contact that migrant camp workers had with locals, bars, the nearby border post, prostitutes, their home areas and treatment sources, both formal and informal. The findings from these exercises highlighted the disproportionate number of men to women in two of the three camp compounds. Most men were unaccompanied by wives or girlfriends⁷. Our observations also indicated the sexual contact that occurred between some local girls and migrant men usually during the early afternoon or over the weekends and usually in the bush. There were a few incidents recorded of sexual intercourse taking place in the fields during work.

'We don't want to cut off our nose to save our face'

After we had registered all the farm workers ourselves in order to conduct a random survey, the register revealed that about eight per cent of the total workforce at that time were under the age of 16 years, of whom 68 per cent were local girls working on a seasonal basis and staying in surrounding villages. Their ages ranged from eight to 15 years. These figures confirmed our earlier observations that there were a number of young local girls working as seasonal workers at the farm.

These figures, generated from a database we had created for the register, stressed the possibility that young local girls, through their daily work and contact with migrants, might be entering into sexual relations which could expose them to STDs or even HIV. I started to speak to locals about the trend. Ever since we first came to the area in 1991, we had been aware of sexual contact of local girls and young women with the migrant men at the farm. As mentioned earlier, local perceptions link the farm and young girls and women working at the farm with 'movious' women or girls, 'hit and run' sex, STDs and AIDS⁸. One of the farm compounds is called *Chitabwa* which means 'to open your legs'. The origin of this name dates back to when a company came to clear the land for the farm in 1988 and young local women apparently lived in a mud and wattle dormitory and were, according to one informant, 'available to any man'. I interviewed one of these women who had moved to the farm in 1989

⁷According to a repeat survey in 1995 and farm labour records in 1996, more men are now accompanied by their spouses.

⁸'Movious' is a derogatory euphemism for people who have many sexual contacts, who are 'moving up and down' between partners. This term is also used in town. Weiss (1993), in an article titled 'Buying her grave' explains the symbolic significance of the link between women, mobility, money and AIDS in Tanzania. He proposes that the underlying connection is of danger, speed and the breakdown of control that men have over women.

with her sister. She recalled her serial and temporary relationships and unwanted pregnancies, and the death of her sister in 1992 from AIDS. She strongly feels that local girls are cheated by the men in the camp who propose love and promise money and gifts or favours at work in exchange for sex. 'Some have five or six boyfriends at the same time and they all cheat her. They say they will give her money, *chitenge* (cloth), soap or pants and then just leave'.

Older local people and local men of all ages tended to be less sympathetic about this sexual behaviour, labelling local girls and women working at the farm as prostitutes, *chihure*, and chiding them for chasing money to the detriment of their reputation and health. They described how old people feel powerless to stop girls behaving this way. Numerous local village *dare* (traditional court) cases, local government court cases and ill-fated attempts at abortion in Chiawa testify that such behaviour sometimes tends to be overlooked until the girl is 'damaged' — impregnated.⁹ Some families nevertheless refuse to allow young girls to either work or stay at the farm because they are afraid of the pressures on young girls to have sex. Some local teenage boys and young men also complain about the exodus of young girls to the farm because it makes it difficult for them to find girlfriends or wives, professing a preference for 'steady' and 'proper' girls who stay at home and are not seen with too many boys. They concede that boys without money have a hard time attracting girls (Dover 1995).

School teachers related that after working on the farm during school holidays, some of their pupils, particularly young girls, chose to continue working instead of returning to school. The teachers felt that parents were sometimes behind their daughters' decision to do piecemeal work at the farm rather than go to school. At least one headmaster had recently raised the problem with farm management and at Parent Teacher Association meetings, and there had been a verbal agreement made with management that all children should carry a letter from school before the farm agreed to offer them employment.

During the piloting of the survey questionnaire, one woman research assistant interviewed a local 14-year-old girl, who had been working on the farm for two months and had also worked the previous year on a seasonal basis as a weeder. She had left primary school in Grade 5; her motives for leaving were unclear. Her reasons for working at the farm were to raise money to buy maize, salt and soap and she was currently earning approximately US\$22 a month. She also raised money by selling bananas and scones, baked by herself. She claimed that she had had a regular boyfriend for two years, whom she saw at least once a week. He was a migrant worker who was employed not by the farm but by the European Union Tse-Tse fly project. Over the last year she said that she had had four other boyfriends and in addition she had 'moved with' (had sex with) two other men in the last three months. The girl's knowledge of AIDS and STDs was good. She knew local names for STDs and HIV, that such diseases were transmitted through sexual intercourse, where to seek treatment if infected (citing the clinic, hospital, antenatal clinics and traditional healers — the last as a second option), and that she could protect herself from STDs and AIDS by not sleeping with men or by using condoms. The interviewer said that the girl was quietly spoken and that she cross-questioned her because she was shocked by the girl's apparent sexual activity and she doubted that her answers could be true. Despite the role of this age group in the sexual behaviour of the farm, the research assistants strongly felt it was wrong to ask young girls and boys some of the questions included in our questionnaire and after some debate, we decided to exclude all workers under the age of 16 from the random survey.

⁹Long-term research in Gwembe, Southern Province, shows that in some rural households the only injection of capital in the lifecycle of a household is through marriage payments (Scudder 1995, personal communication). In Chiawa, families stand to gain financially if their daughter is 'damaged' since this adds another three financial transactions to marriage payments.

At this stage, my research assistants (all local people) and I were beginning to feel more and more upset about the apparent sexual contact between some of these young local girls and the migrant men, as well as about the level of anxiety about STDs and HIV. The girls were after all part of the reproductive future of Chiawa. One research assistant in particular, a young local man, felt strongly that 'these children should be in school'. I mentioned the trend to one personnel manager, who is himself a local man. He shared our concern and said that the reason he allowed single migrant women to come to the farm was that he thought it would keep the migrant men away from local women. 'What can we do?', he asked, 'There is hunger in the valley and people need to raise money'. I then raised the issue with the expatriate general manager in Lusaka, when I had a lift down to the farm with him. 'I find this hard to believe', he retorted, 'Two years ago we decided not to employ anyone under 16 years unless it was sanctioned by the schools during the school holidays. Maybe this has slipped through the net. We don't want to cut off our nose to save our face. After all we have a long-term commitment to Chiawa'.

Intervening

We started the random survey of ten per cent of the workforce: 159 individuals. Halfway through we started having problems identifying the selected workers, and encountered many refusals to participate. Investigating why, we discovered there were rumours that our survey was linked to recent redundancies made by management and a few informants said there were fears that individuals interviewed would subsequently be tested for HIV. There was also some confusion as to why although everyone was registered, only relatively few workers were actually being interviewed. Some whose names did not appear in the random list actually wanted to be interviewed. We had to approach the chairmen in the farm compounds and the management once more to reiterate that we had no intention to test any individual for HIV, and explain the logic behind the random selection. We asked management to repeat to workers that the farm was having to lay off some seasonal workers because it was the end of the flowering season and there were fewer flowers to pick. The local research assistants, the camp chairmen and management proved very effective at dispelling fears and misunderstandings, and we resumed the survey.

After we finished the random survey and before holding focus-group discussions, I showed the table of the age frequency generated from our register to the farm manager and another personnel manager. At first they doubted the validity of the data, suggesting that the children were merely accompanying their parents and not actively working. I assured them that the children were actually working. The following day they went around the fields and by the end of the day had fired 81 seasonal workers who looked under-age. Most of these workers were girls.

The farm manager and one personnel manager were surprised by the high number of apparently under-age workers and said that the children had been using their parents' 'ticket' to get paid and that the field supervisors had chosen to turn a blind eye to their presence. They said that last year they had a similar problem and had to go around the fields sacking under-age workers on at least one occasion. The other two personnel managers, one a local and the other an outsider who lived within the main compound, were not so taken aback. One of them was quite angry that under-age local seasonal workers had been fired. When some workers complained directly to this personnel manager about the management's decision, he blatantly said it was because of our research that the decision had been made¹⁰.

¹⁰The particular man is renowned for giving jobs to women in exchange for sex and has on occasion sacked women who refused his advances.

The same day that the management went around the fields identifying under-age workers and telling them to stop working, I talked to a small group of teenage girls as they waited for transport home. They said their ages were 17, 15, 14 and 14, though the oldest looked younger than 17 years. They had been working at the farm for between 10 and 18 months and all came from a village in an area of Chiawa where there is no schooling above Grade 3. They said their parents had let them come to work at the farm instead of sending them to boarding school in Chiawa. Some were encouraged by their parents to come, others followed their friends. Their monthly salary was spent on soap, salt, biscuits, sweets and shoes. Buying maize was not their responsibility, they explained. It was difficult to ascertain how much of their income contributed to household living. When I asked if they were bothered by men during their work on the farm, they giggled and said no, looking coy and embarrassed. My research assistant then asked where the tin rings and bracelets they all wore came from. They admitted they were gifts from men in the farm compounds. When we left them, they went in a group into a nearby farm compound and one of them was grabbed by her arm by a young man.

Implications of my intervention

Almost immediately after hearing of the firing of the under-age workers, I regretted having disclosed our register figures and my concern to management. A weekend in Lusaka gave me a chance to reflect on my actions. I felt uneasy about the rather spontaneous reaction both by myself and by management and, with hindsight, realized I should not have reacted so quickly to my findings. It seemed I had let my distress cloud my judgement as a researcher and jumped ahead to an intervention, without finishing collecting and assimilating data. It was not clear if the intervention was appropriate or not. What were the implications for the girls, the research and the planned intervention project?

I wondered what would happen to these girls now they were not supposed to work at the farm. Maybe they would continue to visit the farm anyway, having established contact there and learnt what it is like to earn money. The very worst scenario (and the most ironic) would be that losing access to casual work on the farm would push these girls into exchanging sex for goods. What are their other options in Chiawa? The labour of a teenage girl is important in a household since they are responsible for many household chores: drawing water, sweeping, cleaning pots and pans, caring for younger children, cooking. They have to work hard at home. Reynolds, in her study of Tonga children in the Zambezi valley, records the tedium of these labour tasks for young adolescent girls (Reynolds 1991:103). The farm would be a temporary escape from this boredom. Being at the farm would also allow them more freedom of movement than they had in the village. If they had remained working at the farm, it might also have been easier for any HIV and STD education to reach them. Boarding at a local primary school can also expose them to sexual harassment from teachers and local men since girls sleep together in a classroom, away from the supervision of their parents and guardians. A number of girls have been impregnated whilst boarding at the school. There seem to be no easy answers. Two weeks later I noticed one of these girls back at work on the farm.¹¹

The implications for my research were potentially serious. The trust established over the years with the study population might be jeopardized and the relationship between the research and management was now questionable. This could affect the data not yet collected, if respondents feared to speak openly because they felt that the information would be directly

¹¹ A repeat survey in August 1995 of the farm workers revealed that out of 1570 workers, 33 were under the age of 16 years, 19 of whom were girls, and the youngest 11 years. Thus in a year there was a significant reduction in the number of children under the age of 16 employed by the farm, from eight per cent to two per cent of the total workforce.

and immediately conveyed to management. On the other hand, management might see the research as subversive for exposing the employment of under-age workers.

After the girls were fired, partly because of the comments of one personnel manager, the farm manager's wife and one research assistant, some of the workers directly challenged the research assistants, accusing us of being involved in the sacking of the young girls. I had briefed the research assistants to dissociate us from the management's decision by explaining that we were only researchers and were not involved in management policy. They understood how important this was and kept reassuring me that no one in the community was denigrating us because of this incident. They simultaneously said that some older people were pleased because they too had been troubled by the apparent liaisons between their young girls and the young men in the camps. I told them that no matter what people said about the incident, they must consistently explain that we were not linked to management decisions.

Two personnel managers fortunately told any workers who complained to them that we (the researchers) had absolutely nothing to do with the young girls and boys losing their jobs. They explained that last year they had conducted a similar exercise and that it remained management policy not to employ under-age workers except during the school holidays. Around the same time as the under-age workers were fired, three primary school headmasters had directly approached the farm management regarding pupils dropping out of school to work on the farm. These interventions helped to diminish our role in the event.

A sequel to the incident taught me another lesson about the relationship between researchers and management. Soon after the under-age workers lost their jobs, I ran into the Operations Manager in Lusaka; he asked me to bring him up to date with our research. In response, I briefed him on the methods we were using and our timetable. He started to question me more closely on our findings and I said I thought the workers were anxious about STDs and AIDS, partly because of the context in which they worked, many of them staying away from their families. 'I hear you saying that migrant labour is not good for Chiawa because it encourages AIDS', he said. There followed a rather awkward conversation about the pros and cons of migrant labour, and the present and planned living conditions for migrant labour on the farm. 'I've lived in Africa all my life', he said. He said he had received no complaints about our research from the farm but quietly warned me to be discreet about our data, after saying that he found elements of a working paper we had written about the survey of migrant workers in 1991 'judgemental'. He was in particular upset about our description of a personnel officer losing his job after a riot at the farm (Bond, Ndubani and Macwang'i 1993:6). 'Stick to your subject', he said. He requested that he see copies of all our research from the farm and that we keep in closer contact. On a more positive note he offered to give me contacts for AIDS education programs for farm labourers in Zimbabwe. After this conversation, I wrote the Operations Manager a letter in which I tried to spell out our shared interest in improving the health of workers and the broader implications of our research.

As researchers on the farm we had encountered suspicions about our role from both management and workers throughout. The relatively low response rate in the survey (65%) is evidence of this. Nevertheless we found after this incident that our relationship with the farm population was not irreparably damaged. Many workers continued to confide in us their worries about health, especially STDs and HIV. Group discussions about sexual behaviour following the incident were mostly well attended, well received and very frank. Management continues to accommodate our research. The farm management in particular remains actively supportive and understanding, though at times still a little uncertain about our motives. To date we are still involved in research and interventions on the farm.

'Between a rock and a hard place'

I felt strongly at the time that the event related in this paper required some 'useful self-reflection' (Singer 1994:339). In the process of writing and presenting my experience this feeling has been justified as the complexity of the situation and the analogous experiences of other social anthropologists, either written or related upon hearing my own story, have been recapitulated and help direct my continued presence in the same fieldsite. Analysing and questioning the research design and process and the different interest groups involved has led me to examine my relationship with each group, the multiplicity of roles I was playing, the skills I have and the timing, nature and causes of my spontaneous intervention. This analysis of the practicalities of fieldwork has pushed me towards re-evaluating the ethics and existing guidelines in our profession.

In this study we set out to use our social anthropological findings to design interventions which may help prevent the spread of HIV and other STDs. Our involvement to instigate change in an attempt to save lives was implicit in the design. The event related in this paper conveys just how knotty an issue involvement can be (Wallman 1985:15). As Singer states, anthropologists involved in AIDS prevention have to respond and 'this kind of work often necessitates taking sides in a highly controversial atmosphere' (Singer 1994:339).

There are similarities, as mentioned before, between the experiences of the group of RLI social anthropologists carrying out fieldwork in the mines between the 1940s and the 1970s and my own more recent experience. They too came across situations of which they disapproved and information which management would rather not receive. Godfrey Wilson's work, for example, showed that wage levels of migrant workers were often inadequate, and dispelled the myth that there was no urbanization of Africans in the Copperbelt (Wilson 1941, 1942). The mine companies reacted to these findings by refusing to allow him any continued access to the mine compounds (Simons 1977: 262-263). My access to farm compounds is essentially also under the control of the multinational. The clash between the interests of the mine companies and the findings of researchers has some parallels with any researcher conducting fieldwork in 'an authoritarian type of society with sharp conflicts of thought systems and material interests' (Simons 1977:260). It is a difficult climate in which to do research since all sides doubt the political alignment of the researcher (Simons 1977:267). Schumaker (1997), in her book on the history of the RLI, points out that suspicions are also stimulated by interactions between white researchers and white management as well as by particular fieldwork practices, such as sensitive questions. Both I and the RLI anthropologists in the mines faced distrust and a reluctance to co-operate in surveys (Simons 1977; Schumaker 1994). The multinational that owns the farm asked to see whatever we write up about the farm just as Powdermaker was asked by the general manager of a mine to show him raw survey data (Powdermaker 1966:249). A review article by Palmer of a doctorate thesis which exposed the poverty, violence, squalor and insecurity of compound life for mine labour in Southern Rhodesia in 1900-33, serves to remind us that even if powerful groups hate criticism, we should not be bullied into submission and draw a 'discreet veil' over conditions (1976:150).

The potential politicization of research and researcher undoubtedly permeates data collection, pervades writing up and directs interventions. In my case, I have come to realize, politicization came from the research assistants, as representatives of the Chiawa community, too. What I initially distinguished as a triangle of tensions, between management, labour and researcher, is actually more like a square, since the community is another corner. The reaction of the research assistants to the interview with the 14-year-old girl and my own compliance with their wish to exclude those under the age of 16 years from the survey, was a precursor to my confronting management with the employment of this young age group and our concern about the health of Chiawa girls. For the research assistants, it was also an issue of morality,

of young girls behaving other than they should. By falling in with their concern, I was, in a sense, both constrained by and supporting their perspective and advocating on their behalf.¹²

How could tensions be dissipated without compromising the integrity of research? This event illustrates that in applied research, timing and accurate representation of the researcher is important (Wallman 1985; Preston-Whyte 1993; Wedel 1994). My role combined conducting research, analysing data, presenting results and making recommendations, designing and implementing interventions. My decision to 'wear a variety of hats and play a diversity of roles' (Gow 1993:391) is 'sticky' (Wallman 1985; Preston-Whyte 1993). As Johannsen comments, distinguishing roles is never easy and some of these roles can be viewed as 'a sum of skills' (Johannsen 1992:73). Whisson suggests that a social anthropologist immersed in development can act as a broker, an advocate or a collaborator. He says 'Each role has its place, and the same scholar can fill all three, if not in the same transaction, then in respect of a single project or people' (Whisson 1985:145). Perhaps I should have worked conveniently within the bureaucracy of the farm without rocking the boat until data collection was completed. After analysing our data adequately we could have played the role of broker, communicating our results to management, labour and the Chiawa community outside the farm in a manner which was inoffensive without withholding information (Burawoy 1972:241), raising, after some delay, the issue of under-age employment and its possible implications for the spread of HIV and STDs. Other anthropologists would label this role as 'translator' or 'interpreter' (Preston-Whyte 1993). In this role we would need to recognize that we cannot control the use of our findings (Van Velsen 1974:520-1). A step further into the advocacy area would allow us to be personally involved in promoting HIV prevention amongst this group of young women.

However in reality timing can be disrupted by our responsibility to our subjects (Barry 1988). In this situation we felt we were caught between conducting research and trying to protect young girls from sexually transmitted infection. When urgent problems appear it is sometimes necessary to make 'serious and quick research management decisions' about intervention (Preston-Whyte 1993). Simultaneously, it would seem that we need to define the limits of our involvement (Grillo 1985:3). As this event conveys, the horror and fear of AIDS can easily cloud reason in research. Preston-Whyte (1993) alerts anthropologists to the danger that while conducting research into AIDS 'the magnitude of the perceived threat may all too easily come to dominate over the achievements of good research'. As Strathern spells out, merely being involved in research that is relevant does not automatically mean that the research is good: 'the best type of policy research is that which is backed solidly by experience in the use of research skills in general and by good basic research data' (Strathern 1985:180).

Strathern's and Preston-Whyte's emphasis on 'good' research brings us to the question of different 'goods' or guidelines existing in anthropology and how they may be in conflict with one another. In my circumstance, 'ethical good' appeared, at the time, to be in conflict with 'professional good'¹³. This is best illustrated by concentrating on the conflict in local voices demonstrated by the event in this paper. Chirwa recalls a similar experience in conducting research on tea estates in Malawi where child labour is used. Management were unwilling to change the practice despite his results which showed that children were 'suffering' and many parents also wished their children to continue working on the estates (Chirwa, personal

¹²I am indebted to Philip Setel for pointing out how this decision was affected by local process.

¹³For this idea of different 'goods', I am indebted to Sandra Wallman.

communication¹⁴). Singer and Koffi suggest there should be some notion of 'common good' when faced with a plurality of voices and that the anthropologist would be justified to act on the basis of this 'common good' (Singer 1994:339; Koffi, personal communication).

Ethics is a Pandora's box in AIDS research. Ethical guidelines are laid down internationally and nationally and revolve around four broad categories: respect, beneficence, non-maleficence ('do no harm') and justice (Barry 1988; Ringheim 1995). For this research, ethical clearance had been obtained, both from the Karolinska Institutet in Sweden and from the University of Zambia. However, as Ringheim says, 'In practice the application of ethical principles is not as straightforward as the principles themselves may imply' (Ringheim 1995:1696). For example, is using our criteria to judge other societies appropriate? (Jarvie 1972). Schoepf (1991) points out that 'ethical imperialism abounds in AIDS research' and Preston-Whyte (1992) asks '...does our commitment have its origin in our own intellectual imperialism, what we construe as part of human survival?'. My concern for the health of young girls, for example, did not correspond with the concern of some of the young girls themselves. This paper demonstrates van Willigen's belief that ethical concerns are difficult enough to specify, let alone apply consistently in a relativistic framework and that 'different ethical issues are raised in the case of the applied anthropologist's relationships with research subjects, project sponsors, or fellow anthropologists. The somewhat different requirements of these relationships are sometimes in conflict' (van Willigen 1993:42). In anthropology, unlike some other sciences, there is no formal system for regulating proper anthropological behaviour (Johannsen 1992:73) although statements about ethics are made by various anthropology associations. In the field, a code of ethics is sometimes replaced by 'on the hoof ethics as you live' (Wallman 1997, personal communication). This is reflected in my description in this paper of the research process. At the time of presenting management with figures of under-age employment, I felt it was the right thing to do with my concern. With hindsight, I realized perhaps it was not. In addition, as I have continued to conduct research and interventions with women workers on the farm, I have come to understand more about their expectations of partnership and sexual practice, including their pragmatism in pursuing men for support. Any sexual relationship between women workers and supervisors, for example, is not necessarily a clear case of sexual harassment or exploitation since some women openly like their power to negotiate a favour in exchange for sex and would see this as a 'good' thing.

Clearly what anthropologists working with HIV prevention are dealing with is a combination of a commitment and a difficult task, or as Herdt put it, 'a road filled with bumps and potholes and probably landmines' (Herdt 1987:3). I hope to have demonstrated that in this area, theory and practice appear wanting (Preston-Whyte 1993) and there is a need for us to continue to redefine professional 'good' whilst realizing there are no easy answers or simple guidelines and that we can come across 'no-win' situations where ethical problems remain unresolved. Since presenting earlier versions of this paper, I have slowly gained confidence in my belief that it is important to discuss such fieldwork problems. Only once did someone respond that I 'owed an apology to my research subjects'. The most common response was sympathy for my dilemma and stories of similar fieldwork experiences.

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Sexual discourse in the context of AIDS: dominant themes on adolescent sexuality among primary school pupils in Magu district, Tanzania



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Abstract

School pupils in Tanzania have been identified as a risk group for HIV/AIDS, so a large part of TANESA'S anthropological research is aimed at charting and understanding forms of sexual risk behaviour among adolescents with a view to influencing change. This study presents the dominant themes of sexual discourse among adolescent primary school pupils in Magu district along the south-eastern shores of Lake Victoria in Tanzania. The themes are: love and sex; sexual desire; money and rewards; and deception. The fear of pregnancy also emerges as a dominant theme. Because of the nature and extent of their sexual relationships, school pupils will be increasingly exposed to the risk of HIV and STD infection. This is exacerbated by the lack of condom availability and the proscribed nature of sex (and therefore condom use) among primary school pupils.

Methods: role play

Because it is difficult to study sexual behaviour directly, we decided to use discourse analysis. We started by recruiting two ex- primary school pupils who in collaboration with us, interviewed their fellow pupils. During the preparatory phase the two 'peer' researchers visited all 11 primary schools in Kisesa ward, Mwanza town. Pupils from six schools near the workshop venue were selected for the narrative research. During the Christmas break we arranged two workshops with 15 girls (13-15 years) and later with 16 boys (5-18 years). Each workshop lasted for two days.

The study area (Kisesa ward) had 11 primary schools. Study subjects were selected on the basis of two criteria: distance between the workshop venue and each school, for transport purposes; and the presence of higher classes: not all schools went up to the highest class. Pupils from the schools near the workshop venue were selected because they could more easily attend. The participants for the workshops were also selected on the basis of likelihood of sexual experience, literacy, and not being shy. The majority of pupils in the higher classes (standards 6-7) had their first sexual encounter at the age of 12. For effective facilitation, each workshop involved 10-14 participants. Therefore we had to recruit two pupils, one boy and one girl, from each of the six schools. The recruitment was done by the pupils themselves through voting. Besides the age limit we proposed, it became clear that the pupils had selected the brightest individuals to participate in the workshop.

During the workshops pupils were asked to develop a story line on how sexual relationships between pupils develop. This was then made into scripts which the pupils performed; these performances were recorded on video. The videos were played back to the group for discussion and comments. We stimulated the pupils to be particularly critical on the

extent to which the performances reflected how they actually experienced relationships rather than on the ideal or the socially acceptable. Interpretation of the discourse contained in the mass of transcripts was facilitated by use of the Ethnograph software program.

Although the role-plays were the central part of the research, the dialogues presented below are based on the discussions of the role-plays between the pupils and the facilitators. This is largely because these discussions are more succinct and to the point than the dialogues in the role-plays.

Findings

The dominant themes which emerge from school pupils' discourse on sexual relationships are love and sex, sexual desire, money and rewards, and deception. They are dominant not only in the sense that the pupils devoted most of the discussion to them, but also in the sense that pupils' perceptions of sexual relationships are formed and informed by them.

The ambiguity of love and sex

Quite clearly the narratives indicated that pupils initiate relationships through letters: 'A good relationship always starts with a letter', as one girl put it. The boy generally initiates contact by sending a letter to the girl he fancies; she then replies, and these letters lead on to meetings. Sometimes the letters are skipped and relationships are initiated through meetings.

Script: The boy approaches the girl.

Facilitator: How?

Girl: He starts by telling her: I love you (*nakupenda*).

Facilitator: What really makes a girl accept a boy? Is it just love (*ni kwa kuwa nampenda*) or is there something that induces her to accept?

Girl: Because she loves him (*anampenda*).

Girl: Because she is given money.

Facilitator: What really attracts her to the point of having sex? (*Ni kitu gani kinamvutia mpaka wanaamua kushiriki?*)

Girl: The boy may buy a pen and give it to the girl. If the girl accepts they go and do their thing (*wanaenda kufanya mambo yao*).

Girl: The boy loves her (*amempenda*).

Facilitator: If he loves her what is the money for?

Girl: He may give her money in order to make their relationship last longer.

Facilitator: Assume they have already met before: what does the boy do then?

Boy: They talk about love-sex (*mapenzi*).

Facilitator: What kind of love-sex?

Boy: *Mapenzi ya kukutana kimwili!* [Here the sexual meaning of *mapenzi* is made quite explicit by adding *kukutana kimwili*, which refers directly to sex.]

Boy: The boy may approach the girl by telling her: I love you, I want to have sex with you (*nakupenda natakutushiriki kimwili*).

In the initial translation (by a Kiswahili speaker) of the dialogues presented above, the terms *mapenzi* and *kupenda* were glossed simply as 'love'; the word sex did not occur in the English translation at all. The meanings of *mapenzi* and *kupenda* are, however, more problematic than would appear at first sight. On a closer examination of the use of the terms in the discourse presented above (interaction between young people of the opposite sex) the

noun *mapenzi* seems to refer exclusively to sex, and the verb *kupenda* either refers indirectly to sexual intercourse or becomes highly ambiguous.

Money and rewards?

If sexual desire emerges as the main motivating factor for boys in their relationships with girls, then for girls that factor seems to be money, or some other form of material gain. In boys' perceptions of their relationships with girls their main intention is to have sex, but they see girls as being out to get as much money as possible from the boy in exchange.

Boy: She may feel unwilling [to have sex with you] because of what you tell her. Probably you have told her the real situation [i.e. that you have no money] and that does not please her, so she will avoid you.

Facilitator: Which words, when uttered by a boy to a girl, make her willing?

Boy: The girl's first interest is money. So if you fail to give her money then she will definitely be dissatisfied and unwilling.

Even though money is central, there are clearly limits as to the person from whom it is acceptable to obtain it. When it was suggested that they could have relationships with 'old' men in their forties or fifties, men with even more money than village youths, schoolgirls tended to laugh and say that they could not have sex with a man who was as old as their own father. Girls claimed that the ideal age of a partner was two years older than themselves.

Girls claim to find youths who have left school more attractive as potential sexual partners than schoolboys because they are older and often have full-time jobs (and therefore more money to spend), and because of their superior sexual experience. Girls also think that they are more likely to keep their illicit sexual relations hidden from parents and teachers, and that they are more 'respectable' (*jiheshimu*); they are seen as potential husbands who are more likely to support girls in the case of pregnancy.

Delays and false promises: negotiation strategies

If we view sexual relationships among pupils from the perspective of exchange theory then the 'goods' traded are sex on the one hand and money or material rewards on the other. However, in a situation of scarcity, since schoolboys do not have much money and schoolgirls cannot give sex away easily for fear of being labelled prostitutes, we can expect bargaining and negotiation to be important (Ankomah 1992). Indeed, in the absence of money a boy's success depends on the extent to which he can persuade the girl that he does have money and that she will receive it later. For her part the girl delays and postpones in order to increase her chances of actually obtaining the money and, where possible, to maximize the amount. This is what Sahlins (1965) has referred to as 'negative reciprocity'.

Facilitator: How should a boy explain himself in order to be accepted or rejected?

Boy: There are various ways; some are true, others are lies. You may lie by telling her you will give her everything. You may tell her the truth that you have no money and only want to have sex with her. She may agree or she may refuse.

Facilitator: So what kind of conversation (*mazungumzo*) makes the girl agree?

Boy: The conversation of lies (*mazungumzo ya uongo*).

[all laugh]

Boy: The girl may give the boy a false promise (*ahadi ya uongo*). For instance, when she tells you to meet her somewhere in the evening and you go but she doesn't show up.

Facilitator: Why do you think that the girl makes such a promise?

Boy: She does so to see your response.

Boy: She gives false promises because she was afraid to tell you the truth that she did not like you in the first place.

Facilitator: Can boys give such false promises?

Boy: You can tell her that you will buy her a *kanga* and then not do so.

Facilitator: Why do you tell her lies?

Boy: So that she will meet my needs (*ili anitimizie shida yangu*)
[laughter].

Facilitator: What is your need?

Boy: To have sex (*kukutana mimwili*).

What emerges from the above fragments of discussion is a clear picture of deception. Boys lie to girls to win them over, girls lie to boys (by making appointments they do not intend to keep) either to get rid of them if they do not like them or to assess their character. Here 'character' (*tabia*) is indeterminate. Sometimes it may simply boil down to money as well. A boy with a good character is one who provides a girl with sufficient presents and money but on the other hand, when a girl says she is postponing having sex with a boy because she is assessing his character, she may also mean that she is looking for signs that he feels something more for her than just sexual desire. Here, then some of the indeterminacy of *kupenda* re-emerges.

Although the deception-money theme is central in adolescent relationships, the importance of pure economic exchange is often tempered somewhat by the non-instrumental and non-sexual aspects of the love-*kupenda* complex described earlier. The relationship between gifts or money and sex may not always be as direct as the texts presented above suggest, and it is also possible (though unlikely) for gifts to be given without sexual intent.

Inequality, power and seduction

After having examined the dominant themes in school pupils' discourse on sexual relationships, we now turn to a discussion of the role of gender inequality in sexual relationships: do boys use force and intimidation to seduce girls, and do girls comply because they are powerless and unable to negotiate adequately with boys, or are girls active and competent participants in the negotiation process?

Force, or the threat of force, or at least the belief in the possibility of force, does play a role in sexual encounters, and it is clear that boys do sometimes resort to bullying and intimidation in order to get girls to consent. When a girl refused to comply with a boy's request for sex in the role plays, the boy sometimes resorted to calling the girl a child or a peasant, implying immaturity and lack of sophistication. Also, when a girl refused to agree to have sex with a boy and said she was going home, the boy often took hold of her hand to prevent her leaving.

The use of force is still very ambiguous, however. Although the pushy, macho approach by the boys and the reciprocal resistance and delaying tactics by the girls may be interpreted as proof that girls are, to some extent at least, innocent victims of male sexual desire and intimidation, it seems more likely that this is all just part of the courting ritual. After all, the 'force' used by the boys could more accurately be described by the milder term 'pressure' (although the word *nguvu*, 'force', does occur, pupils more often describe boys' behaviour as *kubana* - to squeeze, to put pressure on).

As was portrayed by the pupils, relationships are most often initiated by boys. However it is not uncommon for a schoolgirl to take the initiative herself if she fancies a particular boy. More often however this will be more indirect, through prompting a boy to take more direct

initiative. The fact that most girls fear to give a blunt refusal to a boy whom they do not fancy, may however lead to forced sex. Instead of giving a blunt rejection, girls often use the tactic of giving false promises. Occasionally the delaying tactics provoke the boys to the use of force. This was clearly reflected in the role plays.

Discussion

This study suggests that sexual relationships are common among school pupils in Magu District. Adolescents start having sex at an early age and by the time they are 15 or 16 most seem to have experienced sex and many are regularly involved in sexual relationships or one-time sexual encounters. Multiple partners seem to be common and relationships short. Condoms are not readily available to primary school pupils and do not appear to be much used by them.

Relationships between schoolgirls and ex-students or young adult men seem to be common. Schoolgirls consider young men to be more attractive potential partners than schoolboys because they earn more, have more experience and are thought to be more suitable as future husbands.

Sexual relationships have an important transactional component, with girls exchanging sexual services for money or other material rewards. In the case of boys sexual desire is an important motivating factor, whereas for girls there is an ambiguous mixture of attraction, and financial gain.

The role of force is ambiguous. Although it is clear that boys do put pressure on girls to respond to their advances, it does not seem likely that this is often the main reason for girls consenting to have sex. In spite of the fact that boys are bigger, stronger and older, and that girls do appear to defer to them in practice, girls are often quite competent in negotiating sexual deals that are financially rewarding for themselves, and they are adept in avoiding boys with whom they do not want to have sex.

Although HIV and STD prevalence among school pupils is still low, the extent of sexual activity and the almost total lack of protective measures justifies considering them a potential high risk group. Relationships with adult men increase the risk factor.

Given the nature of sexual relationships as presented above, any appeal to monogamy or abstinence is likely to have little effect. The serious promotion of condom use among school pupils, and the men who have relationships with schoolgirls, appears to be the most obvious intervention. The moral acceptability of condom distribution in schools has recently been endorsed by the Tanzanian National AIDS Committee (1994). It has several advantages: it is relatively cost-effective in terms of inputs in relation to potential effects, it does not require radical behaviour change and it does not contradict any of the fundamental aspects of the culture of adolescent sexual relationships, except the belief that condoms imply distrust in a regular relationship.

Condoms are not widely used by school pupils for contraception or in preventing STDs including AIDS. Risk perception about AIDS among the pupils is lower than that about becoming pregnant. Because pupils are more concerned with pregnancy, which they see as a shorter-term problem, than with HIV/AIDS infection, condom promotion with emphasis on preventing pregnancy might be positively received by both schoolboys and girls. STD and AIDS prevention, however, must remain part of health education and condom promotion.

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HIV/AIDS and sexual behaviour among youth in Zambia

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Abstract

This study was carried out in selected urban areas in Zambia in the area along the major rail links between the urban areas of Lusaka, Kabwe, Kitwe and Ndola. The objective of the study was to ascertain the influence of socio-economic, demographic and cultural correlates on the sexual networking and activities of the youth in selected towns of Zambia: specifically to determine how sexual behaviour among young people might influence the course of the AIDS epidemic and also to suggest policy interventions. Sexual behaviour among young people both in-school and out-of-school, aged between 12 and 25, may be vital in influencing the spread of AIDS in Zambia. The results indicate that sexual matters are discussed with close friends of the same sex and peer group, or with cousins who are of the same age. Sometimes grandmothers are consulted for advice by co-resident grand-daughters. Girls and boys engaged in sex or thought about engaging in sex at quite an early age. Girls discussed their intentions about sex with their close friends, many of whom appeared poorly informed about sex themselves. The general views of both sexes about STDs should be a source of concern. The youth do not seem to take STDs seriously basically because most of them, aside from AIDS, are curable. Many young people do not regard AIDS as a threat to their lives and do not even consider it as a hindrance to sexual relationships. There should be programs to inform parents and guardians on the importance of educating their children about sex and AIDS, through radio and television as well as through seminars and workshops. There should be campaigns on condom use, not just for prevention of pregnancy, but also for the prevention of STDs. Information and discussion of condom use with partners can be given, more elaborate education on STDs and their link to AIDS. Sex education should be intensified in the schools and teachers should be encouraged to give appropriate advice.

The country of Zambia is in the region of Africa reported to be the most seriously hit by the AIDS epidemic. In Zambia, as elsewhere in the region, AIDS is predominantly transmitted through heterosexual contacts, a fact which means that prevention will depend upon the difficult task of altering sexual behaviour. There is also a significant level of vertical transmission from the mother to the unborn child in sub-Saharan Africa (Plummer 1987:7). Rosenberg and Weiner (1988) report a high incidence of sexually transmitted diseases (STDs) in West and Central Africa which contributes to the high incidence of AIDS. The high incidence of STDs is largely as a result of poor access to medical care and antibiotics (Becker 1990:1605). It is generally agreed that prior STD infections facilitate the transmission of the Human Immunodeficiency Virus (HIV) (see Caldwell, Caldwell and Quiggin 1989; Becker 1990:1605). Recent studies in the United States of America also indicate that STDs, when present, usually precede HIV. The accelerated spread may further be associated with widespread sexual networking.

According to Fylkesnes, Brunborg and Msiska (1994), between 21 and 27 per cent of the urban population, and 10-13 per cent of the rural population of Zambia were HIV-positive in 1992. There was probably an increase in AIDS-related deaths from between 40,000 and 50,000 to around 80,000 between 1993 and 1997. With no cure in sight, the disease must be counteracted by efforts to change people's behaviour, in this case the sexual behaviour of youth. However, without appropriate qualitative data, suitable intervention programs are unlikely to succeed. This study is therefore an attempt to provide such data to assist in the formulation of intervention programmes.

Methods

In this study, socio-economic, cultural and demographic factors were taken as having synergistic links in influencing sexual behaviour and in turn affecting the spread of STD and AIDS in Zambia. These factors were carefully investigated using qualitative approaches, mainly focus-group discussions.

Research was carried out in January and February, 1995 in the urban areas of Lusaka, Kabwe, Kitwe, and Ndola. In order to capture non-quantifiable socio-cultural aspects, the data collected were mainly related to descriptive socio-cultural variables. At least 10 respondents were chosen for each focus group in selected study areas in the various towns. In total, 200 focus groups were conducted with numbers of participants ranging from six to 12. School students were more easily contacted; we attempted to contact for out-of-school youth through community leaders, community health workers, and social club leaders. Participants were separated into age groups: 12 to 14, 15 to 18, and 19 to 25. The younger participants were often shy and reluctant to talk about sexual issues.

The target population consisted of boys and girls aged between 12 and 25, both in school and out of school. The choice of age groups was based on the criterion that these young people would be in the sexually active age range.

Focus group discussion guide

Facilitator:

I am a member of a Research Team conducting these discussions to hear your views about issues of the youth. Over the years we have heard, even seen people die of illnesses some of which we have no idea about. My colleague and I are here to get views about the lifestyle of the youth especially concerning sex. Please do not feel ashamed to contribute to the discussion today as we will not attribute anything you say to you as an individual. Instead the topic will help us try to suggest solutions for the problems of the youth as they relate to their sexuality.

Is sexuality discussed freely in this community? Among boys/girls? With friends/relatives? Why?

When a girl/boy decides to engage in sex who does she/he discuss with? Friend/relative/parents/guardian/grandparents? Why?

FOR GIRLS

Before she says YES, what does she consider? (PROBE, for age, wealth, job/occupation, educational level, race, religion, marriage, tribe, health, WHAT ABOUT PLACE OF FIRST MEETING? etc) ASK why and/or why not.

After she says YES, is it normal for her to initiate sex? Why/why not.

What about condom-use; would she ever think of suggesting their use? Why/why not.

FOR BOYS

Before he asks a girl out, what does he consider? (PROBE, for age, wealth, job/occupation, educational level, race, religion, marriage, tribe, health, WHAT ABOUT PLACE OF FIRST MEETING? etc) ASK why and/or why not.

What type of girl would he want to go out with? (PROBE for type of sexual relationship, e.g. long term, one-night-stand).

After sexual contact commences, do:

GIRLS or BOYS

Ever think about pregnancies? If so, what normally comes to mind?

Ever think of sexually transmitted illnesses? If so, do they talk about them and for how long? Any suggestions on how to prevent them? Treatment? Seriousness of specific illness? (Probe about to categories of illness according to severity).

When there are problems of money at home, do girls normally feel they have to do something about it? If so, what? Do girls:

Ever think of somebody other than their relative to solve the problem?

If a man, what if he asks for sex? What do they do? Would they think of suggesting condom-use? Why/why not?

When a girl comes of age who do they first think of having sex with, boys their age or somebody a little older/much older? Why/why not?

Would they go out with a secondary school/college/ university student? Why/why not?

Would they go out with a working class/businessman? If so, with whom? Why/why not?

Is HIV/AIDS normally considered as a hindrance to these sexual relationships? Why/why not?

Summary of findings

Socio-cultural beliefs and norms as well as the deteriorating economy are partly to blame for the kind of sexual behaviour patterns which can be observed amongst the youth 12 to 25 years of both sexes regardless of educational background. The overwhelming response that sex was not openly discussed with parents and other older people in society is something that has been embedded in our culture. The results indicate that sexual issues are discussed with close friends of the same sex and peer group or with cousins who are of the same age. Occasionally, co-resident grandmothers are consulted for advice.

The study results indicated that girls and boys actually engaged in sex or thought about engaging in sex at quite an early age; for example, nearly two-thirds of the girls in our surveys were sexually active by age 16. This is close to the proportion reported in the ZDHS (University of Zambia, Central Statistical Office 1992). The majority of girls said they discussed their intentions with their close friends, many of whom seem equally uninformed and uneducated about sex, and therefore may not give appropriate advice to their friends about condom use, and fidelity, for example. Boys obtained advice from older boys, most of whom advised experimentation with as many girls as possible, and usually did not advise using condoms.

It is evident that factors such as physical appearance (being a 'good looking' or 'beautiful' person), and having wealth and health are of primary importance to boys and girls of all ages and regardless of educational background. Such views have serious implications for HIV infection because a healthy-looking person can also be carrying the virus. Similarly a person with a lot of money may also be carrying HIV. It is also likely that because of his or her financial position, he or she will be in a more advantaged position to make decisions in the relationship. It is therefore of great importance to deal with what the young people's ideal of a sexual partner, as some of these may expose them to higher risk of infection.

It seems clear that condoms are not having the desired effect among young people. They are hardly considered in sexual encounters; many young people share the common belief that sex is not enjoyable when a condom is used.

The general views of STDs among both sexes should also be a source of concern. Young people do not seem to take them seriously because they believe most STDs, other than AIDS, are curable. Many young people regardless of age, sex and educational background do not regard HIV/AIDS as a threat to their lives and do not even consider it as a hindrance to sexual relationships.

Recommendations

1. Programs should be established to educate parents on the importance of teaching their children about sex and HIV/AIDS. This could be done through radio and TV as well as through seminars and workshops.
2. There should be a campaign on condom use, not just for prevention of pregnancy but also for prevention of STDs. Information on how to encourage or introduce a discussion on condom use with the partner can be given in posters, brochures, or talks.
3. Youth should be given extensive information, education, and communication on STDs in schools, and in youth clubs for those not in school. They should understand that these diseases may predispose them to HIV infection. Sex education should be intensified in the schools and teachers should be encouraged to give appropriate advice to the pupils.
4. Seminars and workshops, in addition to posters and brochures, should be targeted at boys to educate them about sex in relation to HIV/AIDS.
5. The government should introduce more community based self-help projects in which young girls who have dropped out of school can acquire simple skills like sewing or hairdressing. Where these already exist, more financial assistance should be given.
6. Traditional female educators and grandmothers should be encouraged to incorporate teachings about STDs and especially HIV/AIDS and pregnancy prevention into the lessons taught in initiation ceremonies for young girls.
7. Posters should be oriented towards encouraging girls to say 'No' to sex if a boy refuses to use a condom.

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The socio-economic and cultural context of the spread of HIV/AIDS in Botswana

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Background

The first case of AIDS in Botswana was diagnosed in 1985. Despite the fact that AIDS is a relatively new phenomenon in Botswana, the rate at which it is spreading is alarming. The 1994 Sentinel Surveillance study estimated that the number of people infected with HIV rose from 60,000 in 1992 to over 125,000 by 1994. The 1995 Sentinel Surveillance Survey stated that approximately 13 per cent of the general population was infected by HIV. The projected cumulative figures of persons infected by HIV by the year 2000 will stand at 332,000 (AIDS/STD Unit, AIDS Update 1996). Obviously the rate of HIV/AIDS infection is increasing very fast. What are the socio-economic factors and practices that promote this fast increase?

Data and methods

The data used in this study were collected qualitatively using focus-group discussions. In the reproductive health problems study, focus-group discussions were held with health-care providers working in the maternity wards. Interviews were conducted between May and July 1996 in eight hospitals in different districts which were sampled and visited for this purpose; each focus group consisted of about five people. In another study focus-group discussions were held with men and women in June and August 1996 in the two villages of Bokaa and Sikwane in the Kgatleng district. The focus groups consisted of between five and eight participants; women were interviewed separately from men to avoid the possibility of domination or intimidation. All the interviews in the two villages were conducted in Setswana. The discussions were also tape recorded, and notes were taken. All of the information was transcribed; similar statements were clustered and analysed.

Results

Separation of partners and sexual activity

The reasons why people have 'multi-partnered' sexual relations are many and complex, making it difficult to understand this phenomenon: separation of spouses for long periods has been advanced as a major contributory factor. One respondent commented: 'Splitting of married couples is one of the factors that contribute to multiple relationships'. In a focus interview of men in Bokaa one of the responses was:

A person can marry and have a wife who normally goes away on trips or goes outside the country and sometimes the wife may take a longer time wherever she may have gone. So should I just wait for this woman? You go some place, should you find *legammana o a*

iteye and if your wife too wherever she finds *legammana a iteye*. But she should be careful and take care of herself.

It is obvious from the above that separation, short or long, provides an opportunity for partners to be unfaithful to each other. *Legammana* is a term used to describe a young, good-looking person. *Go itaya* is to 'hit' or 'strike'. The respondent was saying that if a man visits a place, should he find a good-looking girl, he should sleep with her.

The respondents also compared a woman to a *Phafana* (gourd used as a drinking vessel) and they argue that she should be shared. Some risk-taking activities are endorsed while others are considered irresponsible. What is also interesting is that despite the fact that both men and women are involved in multiple sexual relationships, the responsibility for 'being careful' and 'taking care of oneself' is often placed on the woman. Although people engage in multiple relationships, they seem to be aware of the dangers of that practice. One respondent comments: 'The thing is nowadays the most feared diseases are the sexually related diseases which do not have a cure. This is why it is not advisable for men to have multiple relationships'.

There was a general feeling that men may legitimately have multiple relationships, though not everybody agreed. For those who held this view, culture was used as a justification:

In the past we found our fathers being able to marry more than one woman and a woman can't be married by many men. It is culture and it is just like that. A woman should not have many men. The way nature is, is that when you have a home with a wife it should be that all the children in the home are yours, and not find a situation whereby every child in the home has its own father.

Other researchers have found that it is not uncommon for men, both married and unmarried, to have multiple sexual partners (Schapera 1940; Colclough and McCarthy 1980; MacDonald 1996; Lesetedi 1996).

Search for a partner and sexual activity

Parents were once responsible for choosing their children's marriage partners. The selection of the mate was based on some culturally attractive attributes such as coming from a respectable family. However, over the years, this practice has almost disappeared. Nowadays most young people select their own mates with little or no contribution from parents. It seems it is an acceptable practice to have several women from which one can choose a mate. There are different views on extramarital sexual relationships for married couples but there seems to be a consensus that if couples are not married there is nothing wrong with multiple sexual partners since the parties involved are 'marketing themselves'. For instance, in an interview with men, one of the responses noted was:

If not yet married and still looking for a wife it is just like hunting for an animal. You are therefore better off if you have more than one woman so that you can compare them and see who amongst them perfectly suits your life. This is because there might be some things you do not approve of about one woman, and therefore if you have several of them you can easily get rid of her.

This may have serious implications for the spread of HIV, since it is unknown whether these couples use condoms and if they do, for how long. There is a tendency for sexual partners to use condoms for the first few days, weeks or months in their relationship after

which period a condom is not deemed necessary because the sexual partners claim to know each other. It also seems that both men and women lack trust in each other.

There is also the issue of fertility. Other studies have indicated that some women deliberately become pregnant or frequently change partners in search of a stable relationship which may result in marriage (Letamo 1993). One medical doctor commented about a number of women he knows who change partners frequently in an attempt to become pregnant; clearly this can expose them to STDs, including HIV:

She stays with one man for six months. If she can't conceive she thinks this man is useless. She looks for another man. 'He can't make me pregnant; this one is useless'; she finds another one ... So she'll continue seeking a partner who will make her pregnant because we still have a very strong belief in Africa that a woman has more substance if she has children.

The above is an indication of the existence of serial monogamy. In the pursuit of becoming pregnant, this woman is changing partners frequently. Because the aim is to become pregnant, sexual intercourse can be assumed to be unprotected. In the process of moving from one man to another, the risk of spreading HIV is increased.

One of the justifications for men having multiple sexual partners is the argument that women outnumber men and do not have the means to lead an independent life; therefore a man is serving the interests of women by having more than one partner or wife:

From the past women have always outnumbered men. Therefore men married many women so that other women are given the chance to live better as women are not as successful as men....This was meant to help them out so that if you are able and have the means, you as a man can help.

The imbalance in power relations, sex negotiations, and economic opportunities which tend to favour men could lead to the fast spread of HIV among the general population. The social, economic, cultural and historical contexts within which women find themselves make them adopt survival strategies that may carry health risks. They seek both social and economic power by risky sexual behaviour.

Condom use seems to be associated with sexual promiscuity by one or both partners. The general belief tends to be that condoms are used mainly for STD prevention and on a few occasions for pregnancy avoidance. Therefore if a condom is used with a supposedly stable partner, the message relayed seems to be that one partner does not trust the other. This is probably one reason why contraceptive pills are common in Botswana. Pills do not interfere with sexual pleasure as does the condom, and each partner is trusting and therefore does not expect to contract a disease from a stable partner; these views could be fatal.

Another factor that impedes condom use is male dominance in decision-making in general. The patriarchal nature of our society dictates that males have the absolute and final authority in decision-making. The woman, most of the time, cannot take any final decision affecting the couple without the consent of her husband. This dominance of men in almost all matters, including sexual matters, increases the risk of HIV infection in women. A study by the National AIDS Control Programme (NACP) in the Ministry of Health found that young women felt that they had little power to determine whether or not condoms should be used during sexual intercourse (NACP 1992). The same study also found that women felt that they had to accept their male partner's refusal to use condoms and that they were not allowed to make decisions regarding condom use. One health worker comments on the situation of contraceptive use: 'Most of them don't collect condoms because they find it useless when their partners refuse to use them . They find it better to have sexual intercourse without

condoms'. It seems from this that male partners are thought to have the power to decide which type of contraceptive to use, if any is used at all.

The role of parents

In the past, parents were often judged by the conduct of their children as they were primarily responsible for their upbringing and training (Schapera 1940). Pregnancy outside the socially and culturally prescribed institutions such as marriage was taken to reflect parents' failure to bring up a well-disciplined child. Parents still find it difficult if not embarrassing to discuss sexually related matters with their children and often the responsibility is left to their teachers if they are still at school. One health worker comments about the situation of these young women in one village:

They don't have anywhere to go; they can no longer get the support from their parents; they can no longer turn to anyone; they are through with school; the only thing now they can turn to is men. They will give them HIV, pregnancy.

This indicates that many young women get no support from their parents or guardians.

Discussion and conclusion

The dominant theme that emerges from all the focus-group discussions is that multi-partnered sexual activity is prevalent. This study observed that the distance between sexual partners, the search for a partner, the economic position of women, the non-use of condoms during sexual encounters, and the lack of parental control over children are likely to increase the pace of HIV spread in the country. There is need to strengthen the HIV/AIDS educational program to emphasize that this disease is not a myth but a social reality that we must live with. The numbers of people falling ill and AIDS-related deaths are increasingly becoming evident in Botswana. Again unless women's bargaining power is improved to allow them to make independent decisions, the dominance of the male figure in the decision-making, including that of sexual negotiation, means that the risk of spreading HIV and other sexually transmitted diseases is unlikely to decrease. There is also some evidence that some of the sexual encounters are forced upon women.

Despite the fact the Botswana government and the non-governmental organizations provide health services and disseminate information regarding contraception and HIV/AIDS, their efforts may be fruitless if the sexual behaviour of people does not change. It seems clear that people still engage in practices that expose them to the risk of contracting STDs, including HIV/AIDS. Unless these practices are changed, there seems to be very little hope that the spread of HIV will be halted.

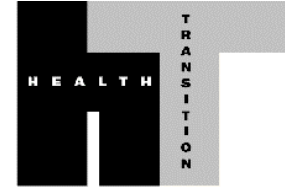
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Exploring partner communication and patterns of sexual networking: qualitative research to improve management of sexually transmitted diseases



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Abstract

This ethnographic research among rural South African men and women seeking care for STDs explores constraints to communication among partners and defines predominant patterns of sexual networking. A series of fifteen open-ended interviews explored topics related to sexual networking and partner communication. Patterns of sexual networking showed clear gender variation, with men more likely to discuss multiple partners. Both men and women believed they should tell one partner about their STD, most often a steady partner. Strong distinctions were made between regular and casual partners, with an emphasis on the role of trust in a steady relationship. Men and women expressed anxiety about telling their partners of their illness, but women more often expressed fear whereas men felt embarrassed. Multi-partnered sexuality is common and is widely accepted for men. While the importance of regular partnerships is clear for both men and women, sexual relationships appear to be highly unstable. Communication among partners could be facilitated by stronger health promotion messages, such as the importance of telling a partner about an STD. Prevailing patterns of communication and sexual networking have profound implications for the STD epidemic.

This paper reports ethnographic research conducted in the Hlabisa district of northern KwaZulu/Natal, South Africa. The district is situated in the heart of a region populated predominantly by Zulu-speaking black South Africans. The area is rural, with a high proportion of men migrating to larger cities for work. This area is also at the centre of the AIDS epidemic in South Africa, with HIV prevalence among pregnant women in Hlabisa District calculated at 26 per cent, approximately twice the national average. Sexually transmitted diseases are epidemic: a recent study of women attending family planning clinics in Hlabisa found that 52 per cent have at least one STD (Sturm et al. forthcoming).

Studies throughout Sub-Saharan Africa confirm the importance of understanding the socio-cultural factors that determine sexual behaviour, and of using such research to inform the design of feasible interventions (Standing 1992; Orubuloye, Caldwell and Caldwell 1993; Moses et al. 1994;). The purpose of this research was to inform the development of improved strategies for partner notification of patients diagnosed with an STD. In practice, many partner notification programs fail to attract a significant percentage of partners, and thus fail to achieve the goal of reduced transmission of STDs (Winfield and Latif 1985; Faxelid et al. 1994; Steen et al. 1996). A major reason for this may be failure to situate partner notification within the prevailing social and cultural framework. This includes a failure to appreciate adequately the constraints to discussing sex and sexual activity with a partner, the ways in which partners communicate about issues related to sex, the extent to which different types of

relationships exist and how partners are perceived in these relationships, and how patterns of sexual networking develop.

Methods

A series of fifteen open-ended, semi-structured interviews were conducted with men and women seeking care for STDs in the outpatient department of Hlabisa district hospital. A research nurse interviewed consecutive patients about various aspects of their illness, including their partners. Key informants were identified from among these patients for participation in in-depth interviews, which focused on various aspects of partner communication and sexual networks.

The interviews focused on the process of partner notification, and possible constraints to carrying this out. Through this, the following topics related to sexual networking were explored: numbers of partners, types of partners, type of partner most likely to be told about the STD, and factors influencing notification of a partner. Topics explored in the area of partner communication were: barriers to communication about STDs, facilitating or enabling factors in partner communication, and methods of communication.

Findings

Of the fifteen interviewed, seven were men and eight women. All but four (three women and one man) were unmarried. All women stated they were in a relationship with one primary partner, and all but two of the men were in similar relationships. The other two men stated that they had a number of different partners. Ages of the women ranged from 19 to 27, and of the men from 23 to 30.

There are several important preliminary results from these interviews, which are outlined below.

There was clear gender variation in patterns of sexual networking: men were much more likely to discuss multiple partners in the recent past (i.e. past three months); women were much more likely to discuss one partner only.

Both men and women were initially prepared to notify only one partner (usually a steady partner) of their illness. Men were more willing to notify several partners after counselling about reasons for doing this.

Both men and women drew clear distinctions between regular partners and 'casual' partners. A regular partner was often described as a 'girlfriend' or 'someone I live with'; a casual partner was often described as 'someone I just met' or 'I don't see very often', or 'someone who lives away'.

The majority of respondents placed great importance on the role of trust in promoting communication between partners; many respondents said they could tell a regular partner about their illness because they 'trust' them. Trust also implied a responsibility to 'take care of' that person (i.e. by referring the partner for STD treatment).

Personal communication was stressed by both male and female respondents as the most appropriate way of letting their partner know about their STD. Men and women made clear that communication about an STD could be difficult and embarrassing. Most respondents felt that the partner notification process, particularly with a card from the health service, facilitated communication about their illness. This type of communication was felt to be easier with regular partners who are 'well known' and 'trusted'.

Some men and women expressed fear or anxiety about telling partners of their STD. Male respondents were generally embarrassed but said they felt their partners would understand; women respondents worried that they would be viewed as 'having done something wrong' or be seen as 'unfaithful' or 'unclean'.

Discussion

Responses from both men and women indicate the prevalence of multiple partnerships in this setting. In particular, men's sexual networks appear to be quite extensive, and these patterns of sexual partnership appear to be at least tacitly accepted by both men and women. Most male respondents were unmarried, and considerable fluctuation was apparent in their 'regular' partnerships.

When asked about multiple partners, many women laughed and dismissed the subject, stating that 'it is men who do such things, not women'. Since most female respondents were married, cultural constraints to discussing additional partners are likely to have played a strong role in these statements. In fact, most married women appear to have very few additional partners. For those women who do not fit into this accepted pattern, social stigmatization can be severe. This highlights the need to understand better how women pursue multiple partnerships, particularly within marriage, and how these patterns change in cases where the husband lives away from home.

Within the context of multi-partnered sex, all of the women and almost all of the men had one regular partner to whom they felt a strong attachment. The distinction between 'regular' and 'casual' partners was drawn particularly clearly by men, most of whom felt a responsibility toward their primary, steady partner. This point is highlighted by the fact that no respondents stated they had more than one 'regular' partner at a time. The use of the term 'casual' partner by men could mean anything from someone they see regularly outside their primary relationship to a one-time sexual encounter. Some men referred to a number of 'casual' partners whom they saw regularly outside their primary relationship. More work needs to be done to understand these relationships and men's perceptions of them.

Notably, among most of the men interviewed, the idea of 'responsibility' toward a regular partner does not extend to limiting sexual relations outside that partnership. This is true even though a number of men identified the probable source of their STD as a recent 'casual' partner.

For most women, the importance of a 'regular' partner was stressed, even when a woman had several regular partnerships during the course of the last year. No women discussed having more than one partner currently. These findings strongly suggest the continuing importance of traditional social norms that prevent women from acknowledging sexual relations outside their primary partnership, and suggest that being in a steady partnership helps to conform to these norms.

At the same time, sexual networks appear to be highly unstable for both unmarried women and for men, both married and unmarried. The predominant pattern of sexual networking for women seems to be serial monogamy. Marriage appears to introduce a period of extended monogamy with one partner for most women. Thus, the number of lifetime partners and their turnover rate is probably quite small compared to men. However, it is likely that the patterns vary during different periods in life. More work needs to be done to understand women's sexual activity throughout the life cycle, particularly patterns of partnership among different age groups. In contrast, it is the norm for men to pursue multiple partnerships. As a result, even women in long-term, monogamous partnerships face a heightened risk for STDs.

Although most women did not discuss their own sexual relationships outside their primary partnerships, several did discuss quite freely the idea that their primary partners must have other sexual relationships and that this was the probable source of their STD. Most identified their primary partner as the probable source of their STD.

The prevailing theme of trust that emerged as a determinant of partner communication must be considered carefully. It is interesting that many women expressed trust in their regular partners, even though the presence of an STD suggested to many of them that their

partners were involved in other sexual relationships. On the one hand, established trust with a regular partner appeared to ease the path toward discussion of STDs. On the other hand, the perception that trust was an important ingredient in partner communication also seemed to indicate, particularly for men, that they would not be motivated to contact a casual partner, with whom they did not have such a relationship.

Although about half of the women said they would find no problem in discussing the STD with their partners, it is alarming that others did express anxiety or fear about doing so, and feared that they would be seen as 'unclean' or 'unfaithful'. Other research in similar settings has shown that women may face the risk of violence when informing a partner of their HIV status (Temmerman et al. 1995; Van der Straten et al. 1995), and that the spectre of violence permeates many sexual relationships (Varga and Makubalo 1996).

Notably, only two respondents, both women, raised the issue of HIV/AIDS during the interview. This may indicate a lack of awareness about the relationship between HIV and other STDs, although this issue was raised explicitly in each of the counselling sessions that took place before the interviews.

On the other hand, the women interviewed here were not dealing explicitly with the issue of HIV/AIDS. Although STDs are seen as shameful and embarrassing, they are common diseases that have been known for some time. Zulu medical ethnographies document categories of disease that are analogous to STDs, such as *umhlombe* (a discharge), and sores that can be caused by jealousy or stepping over something placed on the ground (Ngubane 1977). Whereas STDs are well known and understood within local explanatory models, HIV/AIDS is not. Although basic awareness is increasing, the epidemic remains at a level where relatively few people have felt its impact. This is enhanced by heavy social stigmatization which prevents open discussion about HIV/AIDS and limits educational opportunities.

These findings suggest a need to explore further the balance of power within sexual relationships, and to understand better how women negotiate and discuss issues such as a sexually transmitted disease. Expressions of fear and anxiety must be taken seriously when recommending strategies such as partner notification that confer responsibility upon a sexual partner without fully considering the relationship in which that partner exists. Women's apparent acceptance of multiple partnerships among men must be more carefully examined and understood. These issues further emphasize the need to contextualize strategies to promote sexual health within a better understanding of social processes and norms.

All of these findings have important implications for reducing the spread of sexually transmitted diseases. It is clear even from this limited research that notification of partners about an STD has far more to do with partner relations and the perceived importance of the relationship than with notions of disease transmission. This is an important consideration, particularly as these interviews were conducted after a counselling session in which basic facts about STDs and the importance of partner notification were stressed. Although some respondents did indicate that they would notify the partner from whom they thought they got the STD, the assumption was made frequently, particularly by men, that this must have been a recent 'casual' partner.

These findings have raised some important issues about patterns of partner communication. Understanding the processes of sexual networking is also important for successful prevention strategies, and these need to be further explored. It is important to understand that partner networks are fluid and changing, not static, and that communication between partners in a network depends on power dynamics within relationships and perceptions of different types of partners. In a social setting in which multi-partnered sexual activity is widely accepted, particularly for men, the success of partner notification strategies depends on incorporating these realities.

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