

Chapter 13

Reproductive health and the condom dilemma: identifying situational barriers to HIV protection in South Africa

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Abstract

This chapter explores common social and cultural barriers to condom use, and in general to adopting protective behaviour against HIV infection. The social situations touched by HIV are many and complex, and each may require different and often apparently conflicting behavioural decisions. Situations and choices may change with time and affect individuals differently as they move through life. Health care workers should recognize and be sympathetic to the above, and design intervention programs which are situationally and culturally appropriate, and respond directly to the expressed needs of particular groups and to the cultural dynamics characteristic of their local environment. Although the points made have universal applicability, the illustrative context is that of KwaZulu Natal in South Africa.

The problem of identifying barriers to behaviour change

Surveying the growing literature on condom use, or non-use, in South Africa leaves one with a growing sense of discontinuity and contradiction. Conflicting evidence is reported for the same region; single studies show little consistency, either in attitudes to condoms, or in reported protective behaviour; and attempts to map change on a broader scale have so far failed to provide a coherent picture of trends in risk avoidance. Cautious reports of increased condom use tend, unfortunately, to be restricted to highly motivated and often relatively educated and atypical sections of wider populations and success in condom intervention programs has, by and large, only followed extensive peer group support and, often, resource-intensive group counselling (Hadden 1997a, b). Even where there is evidence that attitudinal resistance to condoms is decreasing significantly, this is invariably weakened by the observation that actual use tends to be inconsistent and decreases with time.

A number of the contributions to this volume illustrate the above points only too well. Varga (this volume Chapter 2), for instance, while noting signs of a growing willingness of some young black South Africans to acknowledge the importance, and even the acceptability, of condom use, is uncertain of the extent to which this change is translated into action. Her data, furthermore, illustrate a point which is beginning to cause concern among health care providers: this is the possibility that advocating (and even carrying) condoms may be taken as evidence, not only of having a number of sexual partners, but of being HIV-positive. The latter point is reiterated by Meursing (this volume Chapter 3) who makes an otherwise positive assessment of

condom acceptance by a sample of people diagnosed HIV-positive in Zimbabwe. She reports, however, an unwillingness to advocate condom use on the part of those of her respondents who had not revealed their HIV status to their partners, or to the other significant people in their immediate social environment. This they explained as due to fear that such advocacy would be interpreted as evidence that they were HIV-infected.

Similar fears, personal insecurities and also cultural expectations are explored in this chapter. The objective is to develop a nuanced understanding of the many barriers, both social and cultural, which prevent individuals from adopting protective behaviour against HIV infection; and, in particular, to understand their resistance to condom use. Much of the recent social science literature makes the same point. Here, however, I draw attention to three interrelated perspectives which I believe are still often either neglected, or not fully explored.

1. The complexity and multiplicity of the social situations which HIV touches, and how each may require of the individual different, and often apparently conflicting, behavioural decisions;
2. The importance of recognizing that the parameters and constraints on decision making change as people move through life and the various life stages which characterize any society;
3. As a corollary of both the above, the need for health care workers to recognize and accommodate the imperatives and internal rationality of the choices currently made with respect to HIV protection by many people. Although this general point holds true across a wide range of cultural contexts and social situations related to HIV, here discussion is confined to the high value placed by both women and men on fertility, and their consequent dilemmas in adopting protective measures against HIV transmission for much of their reproductive lives.

This discussion leads to an endorsement of the call for HIV intervention programs (including those involving condom distribution) to be designed around locally specific needs and concerns, and for the people targeted to participate in the formative research, and in the subsequent design and implementation of such programs. Imported and inappropriate intervention programs may be, in themselves, barriers to behavioural change, in that by their very irrelevance to local concerns, they may promote negative reactions to the intended prevention message.

The material drawn upon comes largely from research in KwaZulu Natal, South Africa, where the HIV epidemic is essentially heterosexual, but where transmission from mother to child before or at birth and through breastfeeding is of grave concern. The risks consequent upon the desire for fertility are compounded by the fact that the majority of African women in the region breastfeed from birth, and at least intermittently for long periods after this. The use of AZT therapy to prevent the transmission of infection from HIV-positive women to their babies before or at birth increases the risk of the same infants being infected by breastmilk. Breastfeeding, however, provides the best and, in poor South African communities, the only, protection against malnutrition and infection leading to early deaths (Pillay 1996; Coovadia 1998; Richter and Griesel 1999). The dilemmas raised for already pregnant women, for women wishing to have children, and for their medical and health attendants and advisors, are abundantly clear.

This broader context of HIV transmission from mother to child makes clear the importance of seeing women not only in the moment of sexual negotiation, but as mothers and would-be mothers: that is, in the context of their highly valued reproductive capacity. Similar dilemmas face men as fathers and prospective procreators. The situations over which HIV looms are, indeed, varied and far-reaching. In the last resort they bring women and men, and their children, face to face not only with death, but with its aftermath: the continued life of the orphaned, the bereaved and the sick. This chapter focuses on the changing contexts of sexual and

reproductive behaviour in the face of HIV and AIDS, with emphasis on the variation and flexibility of the factors affecting HIV decisions in response to changes in the life cycle and social circumstances of individuals, and of the domestic groups in which they live.

Behavioural choices around condom use

The starting point for this discussion is the importance of the immediate social and cultural environment in decision making about the risk of HIV infection. The focus is on the people who are influential in this environment, but behaviour itself, and the decisions guiding action, are intensely situation-specific. Individuals may behave in what appear to be contradictory and inconsistent ways in different situations, as well as over time. Because condoms are used in one instance does not ensure their continued use even by the same people in other situations. This general perspective, which has elsewhere been referred to as situational selection (Gluckman 1965), has proved useful in explaining apparent inconsistencies (often described as 'irrational behaviour') in situations of rapid and progressive change and social challenge in southern Africa. The AIDS epidemic has begun a process of change which will eventually match that of any colonial encounter, or even the effects of contemporary globalization. It may well be seen as part of globalization.

Intervening to change behaviour

Even a cursory review of the international literature, both specialist and popular, confirms that condoms are, with the exception of celibacy and monogamy between uninfected partners, the only secure form of protection against HIV transmission (Whiteside and Franssen 1999). However, as already noted, both scientific opinion and conventional wisdom are less than optimistic about the behaviour change necessary to increase the efficiency of condom use itself. There is a clear emphasis in current literature on exploring the potential of community-based peer support to back up condom distribution, and on changing behaviour on broader fronts than that of health promotion narrowly defined. The view advocated here seeks to introduce another element into these debates, to alter the level of analysis and, consequently, the nature of discussions around intervention. Its primary focus is on the varied and constantly changing situations in which people find themselves and which determine the form which behaviour takes. Evidence to support this view is not hard to find. It abounds in the small print of most descriptive ethnographies, and specifically in the words of informants which are often quoted from both in-depth interviews and focus groups. Here I draw specifically on the work done in KwaZulu Natal over the last two decades, both by myself and by close colleagues at the University of Natal and the local Medical Research Council. Discussion is confined to insights around the use or non-use of condoms and the values associated with fertility. Together they constitute the 'condom dilemma' and, as in Varga (1997a), the 'fertility conundrum'.

The condom dilemma

Striking examples of local ethnography go to the heart of the condom dilemma: while this form of protection is reportedly gaining acceptance in casual relationships, very little headway has been reported in introducing condom use in heterosexual, conjugal and longer-term 'love' relationships. As elsewhere in the world, the issue of trust is paramount. The negative associations of condoms with casual and multi-partner sex are not easily dislodged from people's perceptions. These may be even more resistant to change than the traditional objections based on the perceived diminution of sexual sensation when using a condom (Abdool Karim *et al.* 1992). We need to explore the complex interaction of these issues to appreciate the nuances of the condom dilemma.

The negative stereotypes of condoms are summed up in such statements as 'It's like eating sweets with their paper on / with plastic around / bathing in a raincoat'. New versions of the same idea surface, but the objection is much the same. In the face of the urgency of the HIV message the conventional wisdom is still that people would rather not use a condom. There is growing evidence, particularly in the case of modern South African youth, perhaps largely those living in urban and peri-urban settings (Campbell 1995; Varga, this volume Chapter 2), that condoms are becoming more acceptable, at least in theory. The following remarks made to us by a young man, who styled himself 'modern', indicate the possible complexity of thought processes on the issue. Asked if he would ever use a condom he replied in the affirmative and explained under what circumstances, '...to avoid an infection or, worse, perhaps, an early pregnancy that can not be reversed, I would go along with it...'. After a moment he added however: 'but why should I use one with my real girlfriend? She is clean and I love her...'. So the cycle continues and is not easily broken – and condoms are not used consistently, and not used in many situations as potentially dangerous as those in which they are used.

Negative attitudes to condoms tend to be reinforced at many turns and in surprising places. In a study in the early 1990s of the reactions of staff of family planning clinics in Durban to requests for condoms, it became clear that the nurses themselves not only held negative attitudes to condoms, but often conveyed such attitudes in their abrasive reactions to requests for condoms. Some simply refused to provide young girls with this form of protection (Abdool Karim, Abdool Karim and Preston-Whyte 1992a, b). Other nurses were embarrassed in dealing with requests from young men for condoms, and left security guards at the clinics to supply them. The association of condoms with the treatment of sexually transmitted diseases has further contributed to their negative image. In summary, while men sometimes use condoms with casual partners, they do not carry this over into other more meaningful relationships. Another classic case in this respect, but with women as the active advocates for condom use, is that of sex workers who acknowledge the wisdom of 'using a condom on the job' but not with their own lovers (Campbell 1991). Here also it is the appropriateness of the situation, and not so much the instrument itself, that influences behaviour.

The answer to situations such as the above may be to attempt to change the definition of the situation, and by implication, the barriers to adopting protective strategies. Innovative intervention programs, such as one established by Hadden (1997a, b) in KwaZulu Natal recently, attempt this when they provide both men and women, sometimes in mixed-sex groups, with routines designed to develop new cognitive definitions of all sexual encounters, including close ones. Hadden's study reported small but statistically significant changes in the use of both male and female condoms after the administration of a culturally sensitive intervention program

administered by specially trained local facilitators. She attempted, in addition, to engender clarity and objectivity in the perception of risk facing all sexual encounters that occur outside strict monogamy with a proven HIV-negative partner. In contrast to her success in persuading some participants to use condoms, the program failed to persuade men to limit the number of their sexual partners. Clearly more intensive group work directed to changing gendered assumptions of male rights and needs in this respect would be appropriate. Hadden's failure in this respect is by no means unique to KwaZulu Natal and touches on the near-universality of ingrained gender stereotypes and stereotyping.

As with similar intervention strategies elsewhere, even the limited success of Hadden's study was won at great expense of both valuable time and capacity. She and her specially trained field assistants devoted enormous energy to the program, and taking the pilot project to scale would be very demanding, and expensive. Herein is a vast practical barrier to successful wide-scale HIV intervention and behaviour change in many developing countries where both human and financial resources are already thinly stretched. However, resources *per se* may not be the critical issue: it may not be either culturally or politically acceptable to change the definition of the risk situation, or to give this priority in terms of the public purse.

I turn now to a classic example of a cultural barrier to HIV protection and to some suggestion of how to mediate it.

The fertility conundrum

The case of women seeking to become pregnant is, perhaps, the fundamental conundrum facing condom use. While this may affect all or most married women the world over who do not have children, it is well established that women in most African societies are particularly vulnerable because of the paramount importance placed on both fertility and relatively speedy procreation after marriage. Even single women in long-term relationships feel pressure to get pregnant, and this affects younger women and girls, and also older women. My work with teenagers, undertaken two decades ago, demonstrated the fear of being branded 'barren'. More recent studies confirm that this is still a major consideration in their failure to use contraceptives, however easily available these are made by the contemporary health services. In their turn, older single women and married women with no children, and even some with one or two children, seek to become pregnant in order to ensure support in old age. Being unmarried is no bar to the desire for children in KwaZulu Natal, as argued in some detail in Preston-Whyte and Zondi (1992).

The conflict between consistent condom use and the desire, even the need, to bear children invariably surfaces with both men and women in discussions of the drawbacks of condom use. Men often remark that 'children are what we give *iLobolo* (bridewealth) for', while women state simply that they cannot and will not advocate using condoms if it means not conceiving. Single as well as married women agree on this point, and single women stress that in the absence of marriage, the birth of children and establishment of a home in which to rear them bring social maturity and respect. 'I cannot always live in my father's home like a girl without children', one thirty-year-old woman put it many years ago. I return to this point in a later section. It is sufficient here to register the 'fertility conundrum' as perhaps the single most critical dilemma facing the promotion, not to mention the popularization, of both the male and female condoms in southern Africa. It is invariably raised in focus and support groups aimed at teaching women, and men also, about safer sex practices. Hadden (1997b) makes a point of this in reporting the results of her study and comments as follows:

Interventions need to address the conflict condom use poses, given women's and men's desires to have children and the high value placed on fertility in many Africa countries. Condom use strategies that are more 'reproduction sensitive' could include a component that assists women and men to understand women's peak ovulation days in order to decrease the time over which condom use is abandoned when pregnancy is desired (Hadden 1997b: 8).

This is sensible advice which seeks to take into account both cultural imperatives and HIV risk in seeking an optimal solution to what at first sight appears an insurmountable barrier to behaviour change. It is innovative thinking of this nature that will solve such apparent conundrums, though it may not, of course, be appropriate to all situations. Again the message is that changing behaviour is a complex learning process on all sides.

Structural commonalities and universals

The discussion so far has emphasized variability and situational specificity. There are, in addition, common and what may even be universal features setting up barriers to behavioural change. Most have been well explicated in the literature, and are reiterated briefly.

High on the list of commonalities in southern Africa, as elsewhere, are issues of gender in all heterosexual encounters, matched, significantly, by the ideal of mutual trust and hence the non-use of condoms in close relationships. The difficulties and even the inability of most women to negotiate 'safe sex', and their dependence on providing sex in return for basic economic benefits and personal protection, are amply documented. These are especially pressing in situations of abject poverty, social instability and unrest. The vulnerability of younger women, and increasingly, those in their very early teens, as well as in their early twenties, is another recurrent feature of the specifically African AIDS epidemic. There are, furthermore, significant differences in the cultural expectation of what constitutes 'good' or 'appropriate' sex across societies, and this never includes the use of condoms in African societies; there is also invariably a disjunction between men and women with respect to these perceptions.

Increasingly noted in the literature and not to be ignored are the changing influences of fast-developing urban and rural myths around the causes and spread of HIV. Concerned with the symbolic meanings attached to HIV and AIDS that clearly undergo rapid change and elaboration, these studies¹ provide valuable insights into the broader social and cultural context which influences heterosexual behaviour. Although relatively new in KwaZulu Natal, similar work is under way with serious comment being made on one of the first manifestations of local myths very similar to those reported from elsewhere in Africa. This is the belief that sex with a virgin is a cure for HIV and leads, as shown by Leclerc-Madlala (1997), to the rape and harassment of younger and younger girls. Important and disturbing research by the same author is now documenting the emergence of a new phenomenon involving the victimization of Zulu women in much the same manner as has been reported from Tanzania (Haram 1996,1997). Leclerc-Madlala draws attention to conceptual continuities between this and the original work on AIDS as a metaphor for illness and death by Susan Sontag (1988). In Southern Africa the victimization of women accompanies growing evidence of rape and violence against women both inside and outside the home. A local woman, Gugu Dlamini, who was a member of the South African

¹ See Ingstadt 1990; Treichler 1992; Morgensen 1995; Haram 1996,1997; Weiss 1997.

National Association of People Living with HIV/AIDS, publicly disclosed her HIV status; she was attacked and subsequently died from her injuries. This is symptomatic of the possible tragic trajectory of such conceptual victimization (McNeil 1998).

Age categories versus developmental cycles

Given the above discussion it is not surprising to find that to be a young woman, black and sexually active, is to be at extremely high risk of infection by HIV in South Africa today. This is evident from the results of the annual national HIV surveys of women attending antenatal clinics across the country (*Surveillance Bulletin* 1998; National HIV Survey 1998). Most of the clients at these clinics are black. It is also clear that the proportion of HIV-positive women is rising. While the 1997 figure stood at 17 per cent, by October-November 1998 it had risen to 22.8 per cent. It is of great concern that the figures for KwaZulu Natal are considerably higher than the national average, being 26.9 per cent for 1997 and 32.5 per cent for 1998. While the reasons for this difference cannot be explored here, much of what follows provides the context of both the national and provincial figures, and suggests some perspectives which need to be combined with those already in use in planning interventions to reduce the barriers to behavioural change.

The overall estimates of seroprevalence, while shocking in themselves, take on new meaning in the light of the accompanying Figure. Based on the 1998 data, it indicates the extreme vulnerability of adolescents and women in their twenties, with growing rates of infection beginning in early adolescence and reaching dramatic heights in the early to late twenties. Even

the post-twenty-years category is not beyond concern. These are the ages, of course, when women become sexually active and establish families. Apart from the effect of HIV infection and lingering illness, their eventual deaths will have major repercussions for their families and the communities in which they live. While the implications of these trends are much commented upon, it is not always understood fully that it is not chronological age which is important. It is what may be referred to as sociological age, with all its associated expectations and responsibilities, which is critical. The stage reached in both the personal and domestic situations of each individual affects not only their risk of HIV infection, but their own perception of alternative responses open to them.

This general insight, like that of 'situational selection', is by no means new to social science. It takes its cue from the work of the anthropologist Jack Goody (1962) who traced the influence of 'the developmental cycle of domestic groups' on both individual behaviour and the development of these groups themselves. His insight has been essential to many social and cultural anthropologists working in Africa over the last few decades and it is sobering to find that it is absent from the work of many the HIV/AIDS researchers in the same region. This may be because of the dominance of a largely biomedical model, both in research and in the design of many intervention programs. This needs to be replaced by more nuanced and socially, and also psychologically, informed thinking (Campbell 1997; Preston-Whyte 1993a). Some of the material in this chapter is now amplified according to a cyclical and developmental view of the changing demands made on women, and by implication their partners, as they move through life. Space permits a focus on only two major points in the life cycle: adolescence, the point at which fertility begins, and later reproductive maturity, which sees its flowering.

Awakening sexuality: the irrelevance of contraception

Reference has already been made to work by Zondi and myself in the early 1990s on adolescent decision making about sex. The burden of this work, which is confirmed by recent fieldwork reported in this volume by Varga, is that sexual activity occurs early in South Africa and there is little discussion or negotiation before a girl's first sexual encounter. Her male partner calls the tune, and by and large, continues to do so (Varga and Makubalo 1996; Varga 1997b; MacPhail 1999). In most sexual situations, discussion of condoms not only is irrelevant, but, as Varga shows, may be dangerous for the girl by leading to violent response from her partner and to the suspicion that she has other lovers.

The teenagers we interviewed nearly ten years ago had, indeed, seldom if ever considered using contraception. In the case of condoms, one girl remarked 'they are for prostitutes and bad girls'. Another said: 'We don't know about them...they are for boys to use and I hear they are dangerous, too...they can come off and get caught inside you...No, I won't agree to use a thing like that'. Mothers, even if they acknowledged (which most did not) that their young daughters were sexually active, were against 'taking them to the clinic..it is not right for young girls to be going there, and using contraception...it is bad for them ...you never know if they will get their periods back'. Even clinic staff were, as we have seen, negative to requests from schoolgirls for 'family planning' (contraception). For many years local clinic staff would not prescribe contraceptives without the permission of the girl's mother who had to accompany her to the clinic (Abdool Karim, Abdool Karim and Preston-Whyte, 1992a, b). Condoms were almost by definition

not given to women and girls. Although this has changed and teenage clinics have been set up where youngsters are welcomed and dealt with confidentially, monitoring still detects a reluctance to provide condoms to very young girls. Certainly in the early to mid-nineties some clinic staff, having been well schooled in the tenets of family planning, opposed condom use because of its supposed high failure rate in pregnancy protection. It has taken time for the spectre of HIV to penetrate the consciousness of many nurses who were trained to see their mission as, first and foremost, to prevent unwanted pregnancies. Girls themselves voiced their embarrassment at being seen at family planning clinics. 'Sometimes the sister is your neighbour and scolds you, or someone in the queue tells your mother...'. Though attitudes are changing, the old stereotypes and barriers remain remarkably difficult to dislodge.

At another level positive attitudes to childbearing and fertility, and the lack of long-term sanctions against births outside marriage, served to render contraception relatively unimportant for teenagers (Preston-Whyte and Zondi 1992). In many societies fear of the consequences of premarital pregnancy is a potent factor in either the maintenance of virginity or the use of contraception. In the world of the teenagers we studied there were few lasting repercussions for early unwed pregnancy. Parents were, it is true, extremely angry when the pregnancy was discovered, but most eventually accepted the birth philosophically. The pervasive value placed on children and on evidence of fertility eased the acceptance of the new baby into the home of the young mother's parents. In many cases the father of the child was known and publicly acknowledged, and after contributing to the costs of the confinement, might be a regular visitor to the home. The possibility of marriage was, of course, often present and negotiations to this end were begun, thus legitimating the relationship (Preston-Whyte and Miller 1987).

It was the norm rather than the exception for the young girl's mother to accept the major responsibility for rearing the baby. In cases where the family could afford to keep the daughter at school, the value placed on education, which almost matches that of fertility, made it likely that the young mother would return to school while her mother or grandmother cared for the baby during the day. At least one school in outer Durban was known for its high number of schoolgirl mothers. Girls discussing the situation made the following points:

Well, you see schoolgirl mothers everywhere in the township...at home they have a lovely baby but in the day they give it to their mum and put on their school dress and shoes. Most of my friends have babies or their older sisters had them – it is lonely not to have one too and even most of the school leavers have a baby. In fact the biggest women in the town are 'Miss' and not 'Mrs'. It didn't stop them.

Even after the birth of one child, young women did not, and many still do not, seek sustained protection from pregnancy.

When I have a boyfriend and I do not get a baby he asks why – even if I have had one by another man already...he asks if I am still able to ... he won't marry me if he thinks I can't...what would I want with family planning? That's just for older people who have enough children. Even then the women have the injection...its too simple and it's a secret. These condoms are nasty ...I've never even seen one close up.

Here the particularities of the local situation set the parameters for a lack of contraceptive interest and knowledge among teenagers; indeed, condoms were irrelevant and were continuously reinforced as such by mothers, teachers and clinic sisters who refused to discuss sex and contraception with youngsters. The church mainly spoke of sex as sin, and chastity before

marriage as the only option. In contrast, peers, the really critical 'significant others' in their lives, encouraged sexual exploration and ridiculed the girl or boy without a lover. This attitude was carried over into the era of HIV/AIDS, with disastrous effect.

To summarize, the culture when HIV became a reality was neither one of contraception nor of abstinence for young people. Even those who thought about family planning saw it through the eyes of older women and clinic sisters and its technologies did not include condoms. This culture was, in itself, a strong barrier to condom use in the face of HIV and this had, and still has, to be changed. The fact that Varga found some teenagers beginning to internalize condom use suggests that this barrier is diminishing. That there are countervailing forces making actual and sustained condom use unlikely, is the challenge which, however, still faces us. Interventions focused on adolescents and the complexities of their cultural environment are clearly of the utmost importance. As recent reviews of the South African literature suggest, this will require ingenuity in both future research and in how this is used and evaluated (MacPhail 1999; Campbell and Williams 1999).

Moving to reproductive maturity: fertility in domestic groups

Adolescence passes and with it the carelessness of youth. As the young informant quoted immediately above recognized, fertility and contraception take on a different meaning as women grow older. More important, their reproductive potential takes on a new meaning as well, both for them and for their families and sexual partners. It is important to reiterate that in many African societies, women, and in fact men also, grow in substance and social stature with age and marriage, and also with the birth of children to them (Caldwell *et al.* 1993; Caldwell, Orubuloye and Caldwell, this volume Chapter 10). The value placed on children and fertility is to a large extent manifest, therefore, in the size of the family or household that comes to surround a woman as she moves through life. The major keys to this progress are first, childbirth, and second the survival into adulthood of children. Tragically, HIV and protective measures against infection strike at the roots of both processes. We need now to explore the domestic groups in which these dramas are played out, and the imperatives of domestic life which determine decision making around HIV protection.

The high rate of births to adolescents in KwaZulu Natal translates into a high rate of births outside marriage. This in turn has led to a number of variations in the nature of household groups and families, particularly in urban and peri-urban areas (Preston-Whyte 1978, 1993b). Of particular importance here are the households and families which develop around single women. However, similar constraints operate in both marital and non-marital households. The 'condom dilemma' is much the same, and it is important when planning intervention programs to recognize that the pressures on unmarried women are possibly in some cases even greater than are those on married women. It is equally important to realize that unmarried women may well need to continue childbearing for as long as they need to attract new male protectors.

Marital households

As in most societies, marriage in KwaZulu Natal is a significant rite of passage. The likelihood of a young couple living for some time in extended-family households is still strong in many rural areas although it is less common in town. Whichever is the case, one of the expectations of a 'bride', if not the major expectation, is that she will soon become pregnant. In rural areas this

begins the process by which a 'house' or new reproductive node will develop around her. In the traditional polygynous patrilineal system this would have eventually led to the development of a new lineage segment (Preston-Whyte 1974). The birth of children to a monogamous nuclear family is no less valued today in both urban and rural areas in KwaZulu Natal. Fertility is thus not only approved: it is expected, eagerly anticipated and, if it does not materialize within what is regarded as a reasonable time, concern is publicly expressed on all sides. Both Western and traditional healers may be consulted, medicines prescribed and, if it is deemed appropriate, various religious ceremonies are performed to set the situation to rights (Ngubane 1977). If there is still no result the woman is eventually branded as barren. In the past, and still in some families today, steps are taken to ask her family for a surrogate. More often in the modern context, however, a divorce will ensue. The personal histories of women who are or have been in this position suggest that they perceive themselves to have been heartlessly 'chased away' from their marital homes. Indeed, during such times the psychological pressures on the woman concerned are often extreme, and possible barrenness regarded with trepidation. Conversely, a woman who bears a number of children, including sons, is approved even in the most modern of families.

The fact that a woman's husband may have been diagnosed HIV-positive will weigh little against the expectation that she should bear children. Furthermore, should she wish to use condoms if she suspects her husband to be HIV-positive, it is unlikely that he will concur. The evidence we have from actual cases and reliable testimonies is that women may well be forced into accepting unprotected sex by anger and violence from spouses or partners. At best they are 'chased away'; at worst they are beaten into submission. The level of violence in many conjugal relationships is now being revealed by much of the continuing in-depth research into domestic and sexual interactions in the region (Campbell 1992, 1997; Hadden 1997a, b; McNeil 1998), and the AIDS situation makes it worse. Even when a married woman has borne children she is expected, until menopause, to take her lead in sexual behaviour from her husband and the use of a visible contraceptive is provocative in the extreme. For this reason black women in South Africa who have wished to cease childbearing or who have sought to space their children have, for decades, welcomed the protection provided by 'the injection'. We have yet to develop the equivalent secret protection against HIV.

For women who are diagnosed HIV-positive another situation arises, one that has an equally tragic potential to that of barrenness if they reveal their HIV status to their husbands. Then they too may be 'chased away' or merely abandoned, often to care both for themselves and possibly for ailing children. Imagining such a situation produced the following declaration from one informant.

No, I could not tell my husband ... he would say I had been with other men even if he really infected me. Men never believe they are the cause. Nor would his family. They would just chase me away. It might be better just to go ... but I would rather not tell.

Non-marital households

From the life histories of unmarried girls who bear children, it is clear that, while some do marry and establish conjugal domestic groups with their husbands, the majority do not. Instead, as their parents age and die, they establish their own households. It might be more accurate to say that domestic groups form around them. The nucleus is present in the children they bear in

adolescence, and whose numbers are increased with time and often a succession of lovers. In many cases it is with their mothers that single women continue to share the support of a common household. These older married women have often survived the death of their husbands, or having been divorced or abandoned, they look to their unmarried daughters for support. Such households are thus 'woman-headed' and 'woman-linked' and have come to represent between 25 and 30 per cent of all black households in many urban and peri-urban areas. Once initiated, these households, like their conjugal counterparts, grow with the birth of more children and later grandchildren to them. They are also often joined by relatives with no alternative place to settle. Many eventually grow to encompass three and four generations and are the functional equivalent of male-headed extended households. The critical point is that the head (along with a co-operating core of related women) is responsible for the welfare and the economic survival of the unit.

Seen in the above terms, children are the social and eventually the economic capital of households made up largely of women. For her part, to have established such a unit, an unmarried or divorced woman has demonstrated her ability both to have children and to support them. Although she may not be married, she has achieved the other indicators of social maturity and achievement. In ensuring support for the household, however, women are often rendered most vulnerable. Woman-headed households the world over are recognized as being economically at risk and, while some of the women in them find intermittent employment, they are often poorly paid relative to the salaries men can command. Alternatively women earn money in a variety of informal ways, but most look also to one or a number and, in practice, a succession of lovers for additional income and assistance in kind (Varga 1997a; Preston-Whyte *et al.* in press). In these relationships, on which they and their dependants come to rely, such women may be subjected to the same abuse as married women if they try to insist on condom use. As noted already, new lovers invariably look for the birth of a child even from women to whom they are not married, while women, especially as they grow older, may still hope for marriage or believe that a child will bind their lover to them and make him more generous.

In some cases single women have to accept male violence as the price not only of economic support, but also, paradoxically, of physical protection against criminal and random violence which is endemic in many areas of the region. In the perception of many such women, it makes little difference if they are married or not: they need men for support and protection. It is only as they age and reach menopause that this may lessen. One contributory factor in their release is perceived as being able to 'relax and let our daughters take over...She must earn now'. That this seldom materializes fully in practice is not the point, and it is certainly no incentive to stop childbearing until menopause. Condom use is still, therefore, inappropriate.

To summarize, the desire of all women, not merely those living within conventional marriage relationships, for the status of a mother and, increasingly that of a matriarch, goes together with ensuring the continuity and reproduction of many contemporary South African households. The fertility conundrum is thus as great for single as for married women, and it increases as single women age and also as their households grow with them and mature.

The dilemmas of breastfeeding

It is a cruel twist of fate that HIV/AIDS now poses a major threat to many of the children who are so highly valued and longed for by South African women and men. Transmission of HIV during birth and as a result of breastfeeding has added immeasurably to the dilemmas facing pregnant women, both married and single, who have been diagnosed HIV-positive (Bobat *et al.* 1997; Coovadia 1998). It is also a hidden threat for women who do not know their HIV status. So new and complex is the situation that the majority of black women are not fully aware of the general issues at stake. Little local research has been done specifically on breastfeeding and HIV and we have, therefore, to extrapolate from more general work to imagine the shape of the dilemmas that will face them.

Assuming that AZT therapy is either affordable or made available by the national health system, which is not the case at present, the first dilemma to be faced by many women is the choice whether or not to use it. AZT therapy may reduce the likelihood of their transmitting HIV to their babies at birth, but will increase the likelihood of the infection being passed on in their breastmilk. The exact chances and the relationship between these possibilities are, in themselves, open to considerable medical debate. It is clear in the South African context that not being breastfed poses a major threat to babies whose mothers cannot afford suitable bottle feeds and do not have ready access to clean water to mix the feed. Since breastfeeding provides both protection against nutritional deprivation and immunity to major infant illnesses, it has been extensively and successfully promoted for a number of years. Reversing this will, in itself, be no easy matter. In addition, it is feared that the use of bottle-feeding will be taken as an indication of a woman being HIV-positive, with similar tragic repercussions to the revelation of her HIV status by Gugu Dlamini mentioned previously. It will hardly be surprising if women ignore the advice offered by health care workers about breastfeeding in the era of HIV. Unfortunately it is very likely that the medical profession will respond to non-compliance with comments about the intractability and irrationality of the mothers concerned.

Another set of difficulties ahead is illustrated by Richter and Griesel (1999), in a timely and thought-provoking review of the available research on breastfeeding in South Africa. They raise a number of possible situations which will present both women and their care-givers with difficult choices and also with possibilities of severe misunderstanding. They stress that we know little about the effect of HIV on the cultural and emotional meanings of breastfeeding for black mothers. A simple example will illustrate the general point. Black mothers use the breast as much to nurture and comfort crying babies as they do as a source of food at fixed times. Advising women not to breastfeed may thus be unrealistic unless local wisdom in relation to dealing with infant irritability and frequent crying is recognized, and other forms of comfort are suggested at the same time as a move to bottle feeding.

The interventions that currently are being suggested to allow breastfeeding and yet avoid HIV infection, depend on the extent to which breastmilk is used exclusively or combined with other substances in the infant's diet. Richter and Griesel (1999) question how much what the medical profession understands about breastfeeding accords with what mothers actually do. They note, in a recent study of mothers in Soweto, that only eight per cent of babies whose mothers were studied were exclusively breastfed. In all other cases mothers combined breastmilk both with other liquids and also with gruels. Because they used the breast as a comforter when their baby cried, unlike many white mothers, they found it difficult to give details of the number of times

they gave the baby the breast in one day. This surprised the researchers who, from a purely Western medical model, had assumed, first that the breast was offered largely at set feeding times and secondly, that women either breastfed or they did not. The researchers found furthermore that the nurses in the clinics asked routine questions in such a manner that they excluded the possibility of recording a more complex interactive pattern between mother and baby. Here the local reality was silenced in favour of the medically acceptable norm based on the current Western view of breastfeeding.

The Soweto research also found that mothers did not always follow the advice of the clinic nurses about a wide range of treatments; in practice many follow local knowledge. The words of one informant in relation to the use of enemas sum up the situation.

One nursing sister said that I must not do that because I will kill the baby. But I won't stop because when the baby is constipated he won't eat nor sleep, and the nursing sister won't be there. I will be alone with the baby (Richter and Griesel 1999:51).

The same will be true of the position of HIV-positive women. Whatever the advice of health care workers the mothers will, in the last resort, be alone with their babies much as they are with their husbands and lovers when the decision whether or not to use condoms is made. It will be their understanding of their situation which will determine their actions.

Conclusion: intervention and the rationality of apparently contradictory behaviour

This chapter has revealed the real personal dilemmas that HIV imposes and must continue to raise for women in the era of HIV. The rationality of the choices made in relation to HIV are intensely specific to persons and situations, and are influenced by their cultural meanings for the persons concerned and for those in their immediate social universe. The decisions women make may well, from the outside observers' point of view, demonstrate highly inconsistent or even apparently 'irrational' behaviour, but from the point of view of the woman, the behaviour is completely rational because it is appropriate to its situation.

Failure to appreciate such subtleties hinders an understanding of the full mechanics producing or constraining protective behaviour. This is only too likely where the 'observer' (or the planner) and 'observed' (the subjects of the intervention) do not share a common understanding of the constraints and complex nuances of each other's social worlds. The 'commonsense' assumptions of each do not coincide, and may be worlds apart. This can only detract from mutual communication and must impede the design of intervention strategies. These end up by drawing on inadequate understanding of both the cultural context and the wide variation in situational contexts.

Other social scientists have attempted to encapsulate the immediacy of local influences on behaviour. They have called for a local model from which to develop interventions that are in tune with African, rather than the currently dominant Western, 'sexual ecologies'. A similar rationale lies behind the repeated call for HIV interventions to be based on community and particularly peer support (Schoepf *et al.* 1992; Jewkes and Murcott 1998). Such mechanisms seek, after all, to provide a social and interactional context for the support of protective behaviour, radically different from that often adopted at a geographical and social distance from the

recipients of the intervention. A further elaboration of the same principle leads to the use of participatory methods to elicit locally derived 'commonsense' in the development and execution of intervention programs. Such work has come far, indeed, from the earlier biomedically-oriented paradigm which, with its emphasis limited to 'education' in Western-based 'scientific knowledge', often disregarded the value of indigenous cultural systems and the practices which make sense to the majority of African people.

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