Research brief: A case study on rights, values and services

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We would like to dedicate this study to the late Mercy Manci, founder and director of Nyangazezizwe in the Eastern Cape and long-time partner of AFSA.
INTRODUCTION

The case study presented here is the first of a series undertaken as part of an ongoing programme of research to explore the alignment of traditional belief systems with sexual and reproductive health and rights (SRHR).

The purpose of the research is to provide evidence of the positive and negative influences of culture, religion and traditional practices on SRHR, in order to inform effective community interventions particularly with women, young people and sexual minorities.

This study by a team at the Department of Psychology University of the Witwatersrand, Johannesburg, is a component of a wider programme of research and community-based development supported by the AIDS Foundation of South Africa (AFSA) to advance SRHR in the Southern African region.

STUDY DESIGN

The study was a community-based qualitative evaluation. This choice of design was informed by the fact that every community produces its own social reality when it comes to sexuality. Research was conducted in nine sites in three South African provinces. The study was approved by the University of the Witwatersrand’s ethics committee for research with Human subjects.

This case study focuses on the SRHR project of Nyangazezizwe (healer of the nations) a traditional healer-led NGO working in the community of Flagstaff, Eastern Cape.

Nyangazezizwe was established in 1989 to support traditional healers with health information and education. Its aim is to empower healers to function in a modern society alongside other players in the field of health and well-being. The organisation is involved in HIV/AIDS advocacy and strives to educate traditional healers with up to date health information.

One of its objectives is to create a platform for traditional healers to collaborate with biomedical practitioners. Nyangazezizwe promotes an understanding of the interactions between cultural beliefs and practices and health needs, and the importance of finding a balance between the two.

The report below addresses themes related to SRHR that emerged from focused group discussions (FDGs) and key informant interviews (KIIs) conducted with participants, beneficiaries, service providers and community leaders in the Nyangazezizwe area of operation. The findings of the research were shared and verified with the target populations through community meetings, and the recommendations used in project planning and advocacy by the organisation.

Parenting for better SRHR outcomes

Data suggests that older men were aware and sometimes concerned about their role as parents in influencing their children’s sexual and reproductive health outcomes. Analysis revealed sub-themes of parent-child communication, an authoritarian parenting style and role modelling. These are discussed below. All names used are pseudonyms chosen by respondents.

Parent-child Communication

There is a need for parent-child communications around sexuality, as one of the participants puts it:

“…it’s the right thing to sit down with your child and tell them about everything related to sex and teach them about all that so that when they start they know that if they do so-and-so the results will be A and B not like us; we were so blinded and had no direction…” (Mapitsela, female, FGD, Flagstaff)

In that way a parent will openly tell their child about how children are brought into the world and also talk about the consequences of engaging in sexual intercourse without using a condom; such as pregnancy or being at risk of contracting HIV or any other sexually transmitted diseases.

As Ntuthu added: “…you need to tell your children at the age of eight and seven that ‘…I slept with so-and-so and got you. I did not buy you, you [can] get pregnant as soon as you start menstruation …and once you sleep with a man you will become pregnant. You need to explain to your child and say that ‘Can you see? You either get pregnant or there is HIV and if you get AIDS you die’.” (Female, FGD, Flagstaff).

It should be noted that the tone is authoritarian, admonishing, threatening and solely focused on the negative consequences of sex.
The fact that it is not so easy for some parents to talk with their children about issues relating to sexuality was reflected in the focus groups. Zuziwe (female, FGD, Flagstaff) said that:

“...What Lwethu said about oral sex is true but our parents are shy to communicate it, but they educate us in riddles; even when you get pregnant it’s hard to tell your parents...” Ntuthu supported this by saying that: “...I agree with Lwethu; that it is not easy for our parents to talk to us about sex, especially in the olden days...” (Female, FGD, Flagstaff).

It was found that some parents, instead of sitting down the children to talk to them and advise them, they would shout at them. This happens especially when a mother sees her daughter walking around with a boy in the streets.

Mapitsela mentioned that her mother could not teach her about sex but would just shout at her and insult her severely. Some parents were so strict or authoritarian that it made it difficult for children to open up to them in matters relating to sexual and reproductive health. Children may prefer to speak to someone else or even to a relative instead and this was illustrated when Mapitsela (female, FGD, Flagstaff) said:

“...it is not easy at all to communicate with our old parents. At least it was better back then when we were playing soccer with sis Bongi. As old as she was, it was possible to communicate with her about anything and she would advise you; and I even remember my other aunt, she would sit you with your boyfriend and try to advise and fix your differences”. (Female, FGD, Flagstaff).

It has been shown that if parents speak to their children about sex and reproduction it can help prevent unplanned and early pregnancy, and also the risks of children being infected with HIV (Hutchinson, Jemmott III, Sweet Jemmott, Braverman, & Fong, 2003; Teitelman, Ratcliffe & Cederbaum, 2008). Parents’ inability to talk to their children about sex-related issues derives from their own backgrounds; they themselves did not communicate to their parents about sex or the use of condoms.

As Mapitsana said: “...we were a condom-free generation and they did not have freedom of speech. Sleeping out was a disgust and it was treated as a secret. We would go late and come back in the early hours in the morning. Unlike these days, we go on Monday and come back on Friday” (Female, FGD, Flagstaff).

Some parents reported speaking to their children about cultural practices associated with delaying sex, like virginity testing. As Lwethu said: “…I was inkcinyo [going for virginity testing] and my mother used to talk to me about relationships...” Another factor in this is that in previous generations premarital sex was prohibited, more so when it involved a teenager; hence the prevalence of premarital sex was new to parents.

As Lwethu said: “…Our parents could not educate us about sex; they had less complications than us. They engaged in sex after they got married unlike us. We, on the other hand, engage in sex while still in our teens. Our generation must educate our children about sex.”

Some participants mentioned a lack of formal education as a hindrance. Mjwentu said: “Even here there are those whom their parents don’t teach about these things, because even when they are talking about these things they can’t even call them by their name. I don’t know maybe because my parents are uneducated or what...” (female, FGD, Flagstaff).

Men, as fathers, preferred to talk to their sons and deferred sexual socialisation of a girl to the mother - perpetuating gendered patterns of communication. An example given was of a son receiving threats that should he make a girlfriend pregnant he would be forced to work for and marry her. When referring to their parental role, the men spoke in an authoritarian manner that suggested that there was little space for open, two-way communication with their children.

Authoritarian Parenting
Respondents believed that in the past parents were more strict and authoritative, unlike modern day parents. As an example, Zuziwe said: “…You see at home we were staying with our grandfather in our great-grandfather’s home (ekhayakhulu). He was very strict and you would not just wander around; he would make sure that if you went to the river he wanted you to be back home in hardly 30 minutes, and when you come back from the
river he expected you to sit down. The only time you would go outside the yard is when you are going to the shop. Wandering around the streets was a rare experience, until he passed on and then we had to stay with our mother…” (Female, FGD, Flagstaff).

Authoritarian parents tell, leaving no room for negotiation. As Mafohlela emphasised: “My son Tsodoyi knows. I always tell him that sex results in pregnancy and that he will have to marry the girl; even if she has one eye, I’m telling you. As for my daughter, I tell her mother to talk to her because I don’t know how to approach her…” (FGD, older men, Flagstaff)

It was observed that when they could not enforce authoritarian parenting, the older men felt upset, surrendered and prepared for the worst outcome. As Magembe stated: “I would go to a [funeral] parlour and start paying for her funeral arrangements so that when she comes back home dead I can be able to bury her…” (FGD, older men, Flagstaff)

Role-modelling
Despite their own views, which were sometimes at odds with the younger generation, older men were adamant that they had a role to play in educating their children about relationships and sex: “The right way of doing things will come from us because in the streets [children] will learn wrong ways of doing things. That forces us as parent to educate our kids ourselves; being a good example to them will also help us…” (Siya, FGD, older men, Flagstaff)

Some participants admitted that in reality adult behaviour did not always show good role-modelling. For instance, they noted that adults could expose children to sex. This typically happened when a man visited his mistress’s house and the couple engaged in sex in the presence of her child as acknowledged in the statement below: “[We] wait until we think she’s asleep, then we start our thing; the poor kid is listening and watching us. It’s not my kid. It’s hers - mine are home, safe and protected from all this. What is going to happen to this young kid? I corrupt his or her mind. Government must do something about that too … for men so that they can stick to one woman…” (Sam, FGD, older men, Flagstaff)

As indicated in this example, participants frequently shifted their responsibility for sexual and reproductive health outcomes to the government, even while expressing discontent with government’s ‘interference’ in terms of SRHR. For instance, the child support grant, the choice of termination of pregnancy and LGBTI rights are areas where State intervention was contested.

Exposure to media and its sexual content was also noted as a possible influence of irresponsible sexual behaviour. The power of the media was seen as interfering negatively with parenting and good family values. Sam made this example: “The other thing that makes it even more difficult for us as parents is Beyoncé. She is forever half-naked and my daughter sees that as a good thing - even myself sometimes, I will approach a girl because I see her legs; only to find out later that she’s a baby…” (FGD, older men, Flagstaff)

This failure to accept responsibility was dismissed by another male participant, Magembe, who said: “…that is against the law, you can go to jail for sleeping with her, so it’s important to ask even if you see her breast are very firm and beautiful; for your sake…” (FGD, older men, Flagstaff)

In this FGD a discussion ensued about older men dating girls and much younger women, in which Magembe declared that “he will have to pay because he is eating my eggs” - a statement that is loaded with expressions of how girls are viewed their father’s property.

When the ‘eggs’ are ‘eaten’, referring to the somewhat secret relationship between the older man and one’s daughter, participants agreed that the person responsible can be fined under customary law.

Asking for financial compensation or a settlement for the father is however counter to the constitutional rights of the girl child and might create leeway for perpetuating practices such as Ukuthwala, where a man traditionally marries a girl he has abducted by sending money for ilobolo to her father/family.

Engaging in undisclosed multiple sexual relationships, having unprotected sex that results in children being born, as well as having sex
in the presence of children, heightens the risk of HIV transmission and compromises positive role-modelling. Some participants admitted to such behaviour although they were critical of extra-marital sex and early sexual debut. Exposure to a highly sexualised environment and intergenerational transmission of condescending attitudes towards women are known to influence young people in negative ways. In a study by Linda Naidoo these experiences were also found to be reported by young sexual offenders (Naidoo & Sewpaul, 2014).

**Sexual socialisation**

Sexual socialisation is the process through which young people learn and internalise sexual knowledge, attitudes, skills, norms and expectations (L’Engle & Jackson, 2008). Sexual socialisation agents include parents, school, peers and the media (L’Engle & Jackson, 2008). Age and gender also intersect to determine sexual and reproductive health-seeking behaviours at community level. For instance Mafohlela emphasised that cultural norms inhibited him from testing for HIV: “… going for a test is a big problem because I’m a man and I’m old. The whole thing is very scary for me … makes me nervous…” (FGD, older men, Flagstaff)

**Sex education programmes**

In recognition of the urgency around preventing HIV/AIDS and unplanned teenage pregnancies, participants seemed to be in support of school-based educational programmes. It is noteworthy that these interventions were viewed as relevant and necessary for ‘others’, invariably young people and mostly females.

Participants indicated that educational programmes around sex, reproduction and the use of condoms were needed at schools and Zuziwe said: “It is right because the teenage pregnancy begins at school. Children that fall pregnant are teenagers, they start having sex at a junior secondary or high school…”

Mjwentu added that she believed that: “School-based sex education will help us because you find out that these kids start at a very young age to fall pregnant…” (Female, FGD, Flagstaff).

This language also places responsibility for early and unprotected sex on girls, as those who ‘fall pregnant’.

Another point raised was that educational programmes would help provide a platform for children who have been or are sexually abused at home or in their residing areas. It was felt that they could speak to a professional person if they could not relate the matter to their parents or guardians at home. This was reflected in Mtwenju’s observation that: “…if an elder brother or your father’s brother or uncle harasses you sexually with his penis you may not be free to talk about it at home but you can easily talk about it to someone at school or a social worker or to the nurses.” (Female, FGD, Flagstaff).

As participants indicated, some learners start to engage in sexual activities and become pregnant at a very young age. One response to this has been advocacy for the supply of condoms at schools. Participants observed however that condoms were supplied at some schools and said some learners played with them instead. Others were more concerned about supply and demand of condoms and limited access.

“At schools they are taught about condoms and give out those condom packages but only to a few people; only six people and the peer educator. They only take a few people and lecture them in the office not the whole school…” (Zuziwe, female, FGD, Flagstaff)

There is a national programme of life orientation in schools. Peer educators are tasked to roll-out the HIV-prevention and sex education so that it cascades to the broader school population. The quality and effectiveness of this peer education approach is unknown as there is no authoritative evidence of its success in South African schools. Evaluation researchers (Ngidi & Moletsane, 2015) and civil society organisations have assessed interventions but this is often not sustained.

**Supply of condoms at schools**

Though there seemed to be unanimous agreement that sex education in schools is necessary, providing condoms in schools was contested.
Some participants were against as they believed learners would no longer be hindered from having sex by the fear of unwanted pregnancy and STDs. Amanda argued this point by saying: “When I am at school I do not expect to sleep with any man but it seems like this availability of condoms gives us the option to engage in sex. Sex will never end…” (Female, FGD, Flagstaff).

In colonial times, schooling in South Africa was often introduced through Christian (missionary) projects, which adopted a regulatory approach towards sexuality, especially of learners (Shefer, Bhana & Morrell, 2013). When the State rolled out education as a civic right, some of the ideological elements of religious schools were kept. It is against this backdrop that a moralistic, blaming discourse continues to prevail, as found in research on SRHR in schools. This contributes to tension between the official policy of the Department of Basic Education on sex-education, service guidelines, cultural and religious norms and actual practices (Shefer et al., 2013).

**Supply of condoms at taverns**

Participants in several studies have identified taverns as places where people under the influence of alcohol engage in risky sexual activities (Chersich & Rees, 2010; Dunkle et al., 2004; Kaufman et al., 2014). Examples were made of people ending up having sex with a total stranger or even being raped (Jewkes, Sikweyiya, Morrell, & Dunkle, 2010). This study supported this perception, with Zethu saying: “… in these places we spend our time in, especially the taverns, you find that sex is a common thing when people are drunk and you always see that drunk people in these places easily drop their panties behind the toilets… just everywhere… they don’t care who says what.” (female, FGD, Flagstaff)

According to participants, people who initiated sexual intercourse when they were drunk rarely used condoms, even though they were often supplied in taverns and people did take them.

Amanda said: “…for real we find these condoms available in the taverns not knowing how did they get there, you would just find people grabbing a lot of them, for example here at [name of tavern].” (female, FGD, Flagstaff)

Participants expressed a concern that condoms were distributed to these places but people were not educated on how to use them. Ntotho said: “…I cannot remember them educating people about the condoms as much as I do not even know whether it is the nurses or not who distribute them to the taverns.” (female, FGD, Flagstaff)

At the same time, some participants seemed to be against the supply of condoms in taverns, especially if they did not come with education on how to use them. Amanda suggested that when people saw condoms in the taverns, they were motivated to engage in sex: “We will always sleep with men everywhere because we are provided with condoms, equipped with weapons to sleep with me. We go for booze to the taverns but now there are condoms.” (female, FGD, Flagstaff)

**RISKY SEXUAL BEHAVIOURS**

**Acceptability and use of barrier methods**

In a FGD with older men at Flagstaff, participants identified trust in a relationship as a factor that influenced condom use. Sam explained his view of use of condoms in marital unions: “… it’s because we are not trusted and also not trusting; our wives are having affairs while we’re in Jo’burg working, you come back home she is pregnant and yet you didn’t sleep with her [but] they are having sex [laughs] …and when you are talking to her she’s busy with social network (WhatsApp) but I am right here next to her… You just came back but you can’t even get sex and yet I was not around for a long time [and] sending money day by day …you end up making a choice of being safe at all times because you will die.” (older man, FGD Flagstaff)

Sipho supported that, saying “it’s very important for two people that are in a relationship to trust one another. That is the best way…” In addition, he stated that this is “because we don’t know much about these condoms. We hear about them in these cities so a person must be honest to his partner.” (older men, FGD Flagstaff)

Xoli, in the same group, supported the narrative of lack of trust saying that “… it’s not right to have sex without a condom; it’s not safe at all. These girls sleep around so it is hard to trust…”
Even though there seemed to be consensus about the importance of using a condom, other participants expressed resistance to its use: “…the condom thing is not nice because the condom will go first and I was the one who approached you not the condom; and though people are using these condoms they are still getting pregnant so I just don’t understand it. But we have to use them because they say it is for safety…” (Bra Eddie, FGD, older men, Flagstaff)

Lizo was ambivalent in his support, citing lack of education about condoms as a reason for his non-use and suggesting it was the government’s responsibility to come to his area and teach people about condoms: “I don’t know what a condom is so I go straight in my woman and do what I’m supposed to do when I’m in. I’m from the rural area and the government has never come to tell or show us a condom. It may be better if the government may do so because now I can’t say anything about something I don’t know and we only hear about this on radios…I don’t have a TV because we don’t even have electricity where I live. I live deep in the rural areas where cars don’t even go so the government doesn’t come to our places…” (older men FGD, Flagstaff)

Women participants spoke about both the male and the female condom (femidom). Female condoms were said to be rarely available and hence most women either did not know them, or how to use them. Ntonto was one of the women who only knew about male condoms because she asked, “…anyone who has ever experienced how these female condoms work amongst us…? Who can say that they know how to use them? … Because we [don’t] know anything about it…”

Zethu added that “it would be better if there is someone who knows how to use it because men are taking advantage of us.” Some participants in the female FGD were familiar with femidoms and had received information on how to use them. Siphe, for example, said: “…they show us that this one is for females and you make an eight-shape out of it and insert it in the vagina, then wait for an hour before you can use it”. Zine added that “…the rubber of the women’s condoms is bigger so that it won’t fall inside like the one for males.”

Some participants said female condoms were needed but one of the reasons given was a perception of reliability rather than female control. Okunene said “…I want them to be many because they are very scarce, you see the ones for males they usually break…” (Female, FGD, Flagstaff)

**Discourse around (non) condom use**

Men’s ability to use a condom was associated with access and information, with rural villages presented as marginalised from education. However, the procreation narrative was evoked by some in the older men’s FGD, such as Jomo, who stated: “…families will not grow with us using condoms whereas we get married so that we can extend our families…I’m against condoms.”

Mageba supported the pro-creation thesis and linked it to his ideology of a family saying that “…I have never used it and I don’t see myself using it. I’m a family man. When you use a condom you won’t be able to reproduce so this condom destroys reproduction so I don’t use a condom…”

Mafohlalela also supported the notion of marriage as intended for pro-creation, using his own situation as an example: “…I will speak the truth. I don’t use a condom. I’m old so the condom thing is a no. I’m married. Unless I’m cheating - that’s the truth - on my wife, no I don’t; because we got married to have kids. When having sex with a condom in the morning I don’t feel like I had sex because I ejaculated in a plastic; I feel good when I do it directly inside …that is why I try to have my wife and one mistress, so that I will know when I am sick where I got the sickness. My wife and I, we don’t use a condom at all because we need to have kids and now the mistress also complains that I don’t trust her when I want to use a condom, then I end up removing it…I grew up that way, there were no condoms, people were having sex freely…and if I use it, she [the wife] will think I don’t trust her or I am cheating…I am only telling the truth now. I end up trying not to have a lot of mistresses …” (older men FGD, Flagstaff)

Mafohlalela justified his non-use of condoms with his mistresses by saying “It’s not fair to do something that the person you’re with is not happy with it…so I end up having sex with her without a condom because I don’t want to be funny.”
Research with men of similar age from a similar rural background in Mpumalanga reports similar motivations for men’s failure to use a condom (Mfecane, 2012). Our findings with female FGD participants also supported the men’s assertion that their partners preferred having sex without condoms. They cited instances where their partners wore a condom which then caused them some vaginal pain, or slipped off and got stuck. Amanda said: “There are the ones called ‘rough riders’ and those are really tough; those feel good and they stay on, not the ones called ‘Choice’; those ones don’t feel really good, you can see them accidentally falling inside.”

Okunene said: “... I just decided to stop using the condom, this condom thing. No...No...No! I got injured.” (female, FGD, Flagstaff). Some women cited such reasons for not using condoms at all. Some complained of condoms breaking but Ntotho said that “a condom is not meant to break because it is not like a bread plastic [wrapper]; it is made up of a thick elastic because the manufactures understands the roughness of men, it can only break when one deliberately punctures it with a pin or when it is old but that is rare” (female, FGD, Flagstaff). She implied that men can also deliberately puncture condoms so the partners end up having unprotected sex.

Zethu added: “That would not happen if we may have more access to femidoms; these guys are tricking us”.

Several statements indicated that commercial condoms, unlike the free Choice brand, were perceived to be stronger and less likely to break or slip off. Participants went on to say that condoms that had expired were more likely to break or slip.

There findings also suggested a preference for flavoured and slightly more interesting condoms. Another study, from a township outside Cape Town, also found that flavoured condoms, followed closely by extra-large condoms, and regular condoms in bright packaging were far more popular than the free brand Choice; only 6% of condoms taken from the youth clinic being Choice condoms (Ashmore & Henwood, 2015).

A discourse around pregnancy
A double standard was communicated around pregnancy. When a man made his partner pregnant that was construed as the purpose of sex, whilst evidently pregnant women observed in town were seen as a problem. They were a reminder of HIV/AIDS, careless and risky sexual behaviour in women.

This double standard, and the reluctance of men to take responsibility for unplanned pregnancy, can be noted in the exchange below from and FGD with older men in Flagstaff:

Bra Eddie: “It’s our government that made us behave this way. In town you see a young girl having a big tummy walking along the street with her mother who is also pregnant. They don’t see anything wrong because on the first of each month they get money. HIV and AIDS is something that they are not scared of and I don’t think they even think about it because we wouldn’t see so many pregnant women everyday if women really cared or were scared of it. The only thing in their minds is money.”

Luvuyo: “In all Siya, you are saying this increase in pregnancy is also caused by the money that they get from the government grant.”

Siya: “As I have said before, our government has failed us. if you listen to Khada he will do anything for money because he doesn’t have [any]; the same applies to the young girl who falls pregnant 4 times with different men... because government will give her money for being a mom and it will be R300 x 4 = R1200; and these babies are from different men. That means she has not been using a condom... Government must come to us and educate people about how to have and live a good life. It must be done in rural areas too, not only in towns.”

Men did not only appear to shift responsibility for pregnancy to women but also suggested women should take the responsibility for birth control. For instance Mafohlela, suggested some women did take control by using contraceptives and this relieved men of the responsibility to prevent pregnancy from their side. The question of prevention of HIV and other STIs was not mentioned in this context.

“These mistresses we are having have a problem with condoms. Even if I try to practise this condom
thing some girl will tell you straight that she wants you directly... because sex is not nice with a condom and it is also painful with a condom. When you ask about her falling pregnant the answer will be that she is on birth control so what is stopping you from having sex without condom?... (FGD, older men, Flagstaff)

**LGBTI SEXUALITIES**

There was strongly expressed hostility towards homosuxuality and intolerance generally of lesbian, gay, bisexual, transgender and intersex people. Male participants evoked popular religious, cultural and mental ill-health ideologies that are commonly cited as grounds for rejecting same-sex practices. Lizo stated: “Sodom and Gomorrah! ...God has never created us to do that. He created Adam then made Eve for him. The animals are better than us; have you ever see same sex animals having sex? What is wrong with people? How are we going to be fruitful and multiply and fill the earth as God made intended for us? “

Essentialising child-bearing within marriages, leaving no consideration for choice about reproduction, feeds into discriminatory heteronormative ideas around marriage. The government, Whites and countries faraway (overseas) were blamed for homosexuality.

Acceptance of homosexuality was put side by side with the loss of African culture, which was presented as completely heteronormative. Sam’s sentiments are evidence of this: “Government is going in the wrong direction ...and the world ...because this freedom came with people from the West, they are the reason we lost ourselves in almost everything that we believed in as black people (UBUNTU BETHU). I don’t know if it’s English or what, but it has cost us ourselves...” (FGD, older men, Flagstaff)

In an attempt to naturalise that which people were familiar with and demonise that which they felt threatened by, normative, negative labelling was used in the FGDs. Homosexual orientation was represented as ‘crazy’, questioned and vilified. Bra Eddie: “...it’s crazy ... How do you start? What causes you to do that and what is it that makes you have feelings for another man...?”

Unidentified participant: “...It’s fine because they don’t get pregnant and these diseases are not as much as they are in normal people...?”

Sam: “They are rotten in their behinds and they are sick, very sick most of them...”

Lizo: “They have all these diseases, believe me, they also don’t want to use condoms, and their behinds are rotten.”

This discourse that gay men are disease-carriers was evoked despite significant evidence, over many years, demonstrating that it is in fact young heterosexual women who are at greatest risk of HIV infection, from heterosexual men, in this community (Jewkes et al., 2006; Shisana et al., 2014). It would appear that the imagination of the sexual act contributed to the negative perception of gays and to a lesser extent lesbians. Penetrative vaginal sex was viewed as ‘normal’ and hence same-sex women relationships where the vagina could be penetrated by a sex toy were viewed as better than anal sex between men.

Magebhe said: it’s very wrong for men. At least women do it with their fingers, they don’t do it in the anus. (FGD, older men, Flagstaff)

This view goes against evidence that heterosexual couples may prefer or enjoy anal sex. It is therefore unclear whether it is anal sex that is frowned upon, only anal sex between two men, or if the community finds comfort in that anal sex in heterosexual relationships is usually kept secret. One participant equated anal sex with crime, regardless of age or consent. “…it’s wrong of all of them. God did not create us to do that. He made us to be fruitful to fill the earth. It is wrong. Even in South African Law it’s called INDECENT ASSAULT. In South Africa, it’s against the law...” (FGD, older men, Flagstaff)

This hostility was also linked to patriarchy and the desire to maintain unequal gender relations. Authoritarian men desire a partner who is submissive. Another man may resist and challenge authoritarianism resulting in a physical fight.

“I cannot call another man my wife, never. Sometimes, when your woman does something wrong and keeps repeating it, you as a man have
your own way of punishing her, so how can you punish another man? It will be a fight because he is a man and cannot take orders from another man.” (FGD, older men, Flagstaff)

The above quotation demonstrates how the men’s rejection of homosexuality was based on insecurities about men’s effectiveness in making their partner obey them, and their use of violence to affect the desired outcomes. When men meet their match - in terms of physical strength - the use of violence will not be possible or effective. Retaliation (from a male partner) would undermine the man’s authority to ‘discipline’. Authoritarian men feel challenged, dispossessed, and destabilised by homosexuality when imagining that it challenges the gender-power structure that permits the use of violence in heterosexual relationships.

Luvo: “I don’t understand it; I see it on TV - a woman kissing another woman or two men kissing. Now…my worry is: if my son can come to me and tells me that he has feelings only for men, I don’t know how I would handle it and to think about it scares me to death…” (FGD, older men, Flagstaff)

When relationships are viewed as existing for sex and sex as penile-vaginal-penetrative and existing for the purpose of procreation, same sex relationships challenge this order.

Kata: “No I don’t support it, never, because women complain about a guy’s penis being small, is not satisfying them; now in this case how is using fingers good for them? No, I just don’t buy it. In this side of being a guy who is going to allow another man my anus - to put his penis in my anus: never! I would never.” (FGD, older men, Flagstaff)

Information, education and discussion are needed in communities so that people differentiate between sexual orientation, sexual preferences and sexual relationships. For example, if a woman is not interested in sex with a man, the size of a man’s penis is not an issue. It is evident from these data that perceptions of acceptability or inappropriateness of homosexuality are grounded in ignorance and also fear among parents that they will not know how to handle something that is counter to their beliefs or upbringing.

STRUCTURAL OBSTACLES TO REALISING SRHR

Religious influences

Religion was seen to have both a negative and a positive influence on issues of sexual and reproductive health. The issue of hypocrisy was also raised. Mapitsela said: “Church has a good influence and at the same time churches do not have any positive influence…” (Female, FGD, Flagstaff). But Ntotho said that “…I don’t think church does any good because believers are the first to behave in shameful and disgusting ways…There’s nothing that the churches can do to influence youth in a good way.” (female, FGD, Flagstaff).

On one hand, Lwethu suggested that the fear of embarrassing one’s parent(s) as a child, especially if the parents hold a high profile in a particular church, seemed to inhibit sex and thus prevent unplanned pregnancies amongst the youth: “Sometimes it is a shame to a parent because of their position in church when you get pregnant. It is also good motivation [for being responsible for one’s sexual health] if you are a believer…” (Female, FGD, Flagstaff).

On the other hand Mapitsela suggested: “It starts with embarrassment that arises when the child of a high-profile parent in church becomes pregnant and then they start to do dirty things [referring to termination of pregnancy] so that they can look pure in the eyes of the community -therefore they advise their children to go for abortions.”

It is significant that a termination of pregnancy is viewed as ‘dirty’ by some in this community. The statement also implies that not observing pregnancies among church-goers may not necessarily mean that sexual activities and pregnancy do not occur. Instead it may be occurring but concealed, as some parents, protecting their positions at church, may advise or force their children to terminate their pregnancy because they do not want their child’s pregnancy to ruin their reputation.

Another issue raised about churches was that they are generally run by older people, and hence
are regarded as authoritative by young people, so that open communication is impeded:
Mapitsela: “We cannot speak to Mr Zawuka about sexual life. You will not be able to speak to Mr Zawuka about your boyfriends and to ask him to give you advice when you want to leave your boyfriend. You will feel that it is a disgrace…” (female, FGD, Flagstaff)

In churches, the youth said they were uncomfortable and ashamed to ask questions about sex and condoms. So some participants suggested that it would have been better to have churches run by youth, because they would easily be able to relate with them about matters concerning sexual and reproductive health. Some, including Ntotho, disagreed with this notion, expressing scepticism about having youth leaders running a church instead of the old people, whom she perceived to be wiser and more experienced.: “No, I do not think that it would be wise for a church that would be formed to be under youth leadership. That will never work because if it would be only young men and women, that is where they can start engaging in sex during the times of discussing the Bible.”

Cultural influences: Inkciyo or Ukuhlolwa
Inkciyo or ukuhlolwa is loosely translated to mean virginity testing in English. Inkciyo is a movement that involves hundreds and thousands of girls and young women who are motivated to keep themselves virgins until marriage (Swaartbooi-Xabadiya, 2010). In Flagstaff “…Inkciyo is still there even today…” and was practised in some areas according to Zuziwe (female, FGD, Flagstaff).

Under normal circumstances, no child should be forced by their parent to go through the process but it is found that there are still some parents who force their children to join the movement and remain in Inkciyo. Amanda supported this statement when she said: “It depends on the child who is going to go through the process; no parent can force a child to go for it without her interest because it is something that has to come deep down from the child’s heart… There are some households that are still forcing children to go for Inkciyo.” (female, FGD, Flagstaff)

Aside from scientific evidence that virginity testing is not effective, there is controversy around the necessity and purpose of the practice. Some participants said that it was not a worthy practice because it sometimes created conflicts between the participating girl’s mother and the women who conduct the virginity tests. These conflicts were said to arise when the mother refused to accept that her daughter is no longer a virgin and therefore tended to accuse the testers of lying.

As Zuziwe said: “The problem with our parents is that they force their children to go for ukuhlolwa knowing well that their children are not virgins and therefore blame those people who are doing the process only just because they want to start a conflict with them” (female, FGD, Flagstaff).

Another problem that was identified was that some girls who were not virgins were alleged to take part to spite the organisers. Some also said that the oils that the women applied on their hands when they inspected the teenage girls were suspect. There were accusations that girls who came from this process of ukuhlolwa had a strong desire to have sex and ended up engaging in promiscuous behaviours. Zethu supported this by saying: “when she says that there is something applied by these women before they do the inspection, for sure there is, because I have experienced that too. It happened to me I became a slut and loved men so much in an awkward way…” This also implies a need to externalise responsibility for behaviour (eg multiple sexual partnering among girls) that is considered unacceptable in the community.

Some girls didn’t want to go through virginity inspection because they said the women who conducted this ritual were judgmental. Some participants said that this process has become corrupt because girls were given false results (eg declaring a girl is a virgin when she is not) either due to bribery or because the woman who did the inspection feared telling the truth because of the parent’s anticipated response. As an example, Lwethu said “I was once on Inkciyo and I was having sex but I’d go to Inkciyo and they would give me false results, telling me that I was still a virgin…” (Female, FGD, Flagstaff)

Some participants regarded Inkciyo as a good
practice; Mjwentu said that she believed that “it can help us fight this HIV thing and youth pregnancy.” (Female, FGD, Flagstaff) but others did not support it, arguing that it led to some girls becoming victims of rape.

Mapitsana said: “To practise Inkciyo is a good thing if you commit yourself; there are girls who are twenty five and thirty years who are still virgins. Being Inkciyo is more like being a Christian but the problem is that you would be a victim or a target for rape in this area. It is good maybe in KZN, where they still respect and observe the practice fairly. It’s not practical locally to be Inkciyo; at least in KZN you get the support when you are Inkciyo whereas you are a laughing stock in the Eastern Cape.” (female, FGD, Flagstaff).

These concerns are similar to those reported in previous studies (see Swaartbooi-Xabadiya & Nduna, 2014).

**CONTEXT FOR PROMOTING ALIGNMENT OF SRHR AND SERVICES**

**Family planning services**

Participants were concerned about how nurses refused to give them birth control pills but instead gave them injections, despite the fact that some of the women were experiencing side effects. These women said that they were told that the reasons nurses gave them injections was because they would forget to take the pill anyway, or that there were no pills available.

The female participants were aware of various contraceptive options including the newer implant. They were of the view that the implant “is the same as the injection, it only prevents pregnancy, but you can be sick.” (Amanda, female, FGD, Flagstaff). Nurses were accused of planting an implant immediately after child birth without getting the patient’s consent, especially if the patient was a young woman. Most sexual health services rendered in these villages were provided by NGOs. These services were said to mostly only educate people about HIV and AIDS, but not to offer education on sexual and reproductive health rights. This was clearly pointed out by Mapitsela when she said: “Just like what Zine talked about with [NGO], for sure they were talking about health issues and living with HIV, TB and so forth, but we have not been taught about the rights and pregnancy - but we are always educated about HIV and AIDS.”

Participants alleged that there were instances whereby patients who went to do pregnancy tests were given false results. As an example, Ntotho said: “They tested that child and said that she was not pregnant but she was pregnant”.

Ncumisa added: “I want to agree with what Ntotho just said, because she was going with me the time she went there. It is because the tins that we pee in for a urine sample are not clean; they don’t sterilise them so she peed in someone else’s urine, someone who was pregnant.” (Female, FGD, Flagstaff).

Educational campaigns offered in these villages were regarded by participants as unsustainable since they are conducted on a ‘once-off’ basis. As an example, Mapitsela said: “Last time the nurses came with the forms to be filled by the parents to consent to the check-ups and diagnosis of all child diseases the child may be get…We signed them; they never continued we last saw them that day.”

**Nurses’ work ethic, values and principles**

Participants complained about the treatment that they received in clinics or at the hospital. Siphe said: “…the nurses… are very abusive. They can be so abusive during the time of labour, when in birth pains they hit you in the thighs, shout at you sending you up and down and asking you what you want from them.”

Mapitsela added: “That is what makes most people prefer to give birth at home or on the wayside; you can be abused in the hospital and they really don’t care for people.” (Female, FGD, Flagstaff).

Patients were reported to suffer from physical and emotional abuse in clinics and hospitals. Unethical behaviour and corruption of health professionals and government officials was also reported in the men’s FGDs. Khada (FGD, Flagstaff) said: “It may happen that I’m already infected… I will go bribe the doctor because I know I have the sickness that I have, and then my results will be negative.” (FGD, older men, Flagstaff)
Health facilities in this district are far from the villages, so when patients are maltreated at their local clinic and they would like to go to other services, they become constrained by lack of transport fare.

Hence Mjwentu said: “You find out that now that they are busy shouting you, their families are badly sick but they don’t know. And you are likely to default because you are trying to hide from these loose people and prefer to go to another clinic to collect your treatment; that will also cost you financially as you will need twenty eight rand to travel to and from Flagstaff…” (Female, FGD, Flagstaff)

Lack of confidentiality
Another problem was that nurses were accused of breaching confidentiality. Mapitsela said: “…these nurses do not treat patients’ status confidentially” meaning that patients were exposed if diagnosed HIV-positive. The nurses involved were even said to disclose patients’ status via social networks. Amanda said: “You see what they do in [hospital] is not right because they tell people who are not even nearby the family and they post it on Facebook…”

This is a serious violation of SRHR. Research shows that women, in particular, prefer disclosing their status to close family members (Abdool Karim et al., 2015) and this may take time as they themselves need to get comfortable first. There can be severe negative consequences of forced disclosure.

Another issue raised was that the way clinics were administered led to disclosure: “They separate people who are negative from those who are positive and that is not right, they must put us in one room, all for high blood pressure, for positive, why do they separate us? People are not the same and we don’t accept sicknesses the same way, some people don’t feel comfortable” (Mjwentu, female FGD, Flagstaff).

This segregation divulged their status because other people came to know where HIV positive people queued for their treatment.

Negligence and carelessness
Nurses were also alleged to be neglectful and rude to pregnant women, especially if they were young. They were said to leave them waiting and unattended while their time of giving birth was close or due. Mapitsela related the following incident: “The nurses told the girl that the baby was not close she had to wait. So she almost died due to negligence; her mother said her child would rather give birth onto her hands because she was deserted in absence of the nurses.”

This was supported by a traumatic experience that Zethu related: “I was giving birth and I felt the baby coming so I called the nurse screaming, and she came and hit me and said there was no baby. After I gave birth I was not on her mind…I was walked room to room not even sure if the baby was mine. I was bleeding vaginally, constantly, and then I collapsed and I took a big cloth and placed it there to prevent infection when I pulled it out, it was so big. So I went home and then on Monday I had a very bad odour even though I was bathing every day. I didn’t know anything about stitches; I saw a green rope which they put to prevent the bleeding and I thought that I was going to die. So I told them to take my baby and I went to the kitchen and took the scissor and cut it out. I noticed that it was white, but it had turned green. No wonder I don’t fall pregnant anymore…me and my boyfriend we don’t even use a condom.” (Female, FGD, Flagstaff)

Antiretroviral therapy (ART) preparedness session
Participants complained about the ART preparedness programme. Mapitsela complained that “…when you are sick (HIV positive) the nurses will tell you that you have to attend their school, maybe it takes four days or more and there is nothing important in this school, they teach you something like: you are going to like sleeping, it is just something you can summarise and assess it only in one day…” (Female, FGD, Flagstaff).

Female participants perceived the programme as gate-keeping for HIV positive patients. They felt that the lessons given were boring and that they were wasting their time because it is something that can be taught in a one day session but took four days or even more. Mjwentu said: “Let’s say you test positive now, there is a school that educates you about HIV and AIDS. It’s one most frustrating session.”
PROPOSED SOLUTIONS TO THE PROBLEMS

Current solutions

Community support of government interventions is a necessary facilitator of acceptance and success of interventions. In the Flagstaff FGD with older men, the involvement of government in promoting safe initiation circumcisions was most welcomed and supported. Participants denounced sending under age boys to initiation school. They denounced the participation of young men as traditional nurses or initiators.

Participants knew about the availability of suggestion boxes which were placed in hospitals and in clinics. They knew that they could write about any complaint that they have and put it in the boxes so that their problems could be attended to. The problem, however, was that the clinic staff were believed to be corrupt; participants said the nurses themselves opened the suggestion boxes to filter out any complaints written down by a patient against them. This also places patients in danger of being further ill-treated by the same nurses if they write a complaint and the nurse is able to recognise the person based on the description of the incident. Participants said some nurses confronted patients who placed a complaint against them.

The clinic manager was alerted of these allegations but the problem was not resolved but was brushed off instead.

Recommendations

With regards to the ill-treatment that the patients received in hospitals and in clinics, participants suggested protests against poor health service delivery. But there seemed to be some fear of doing this. Mapitsela said that her community was scared of the youth: “Even if when we had a meeting they said that we are planning to protest and that was so strange because we were only seven [people].”

Concerning churches in the communities, participants suggested that it would be better if they had youth involved in leadership. Mapitsela said: “There has to be something, so like the pastors must be open and talk about anything, so that they may not be afraid to share anything with them - preferably young pastors whom you can sit down with and be free to tell your problem whenever you have a misunderstanding with your partner.”

Since others, such as Ntotho, did not think that it would be wise for a church to be run by youth it was felt that older people still needed to be there to enforce order. At the same time young people would be able to speak freely to youth leaders about matters of sexual and reproductive health. In this way, it was argued, the levels of teenage pregnancy, non-use of condoms and sexually transmitted diseases would decrease.

The women also proposed that it would be better if there were community projects or peer education programmes that would teach people how to use condoms and inform them about SRHR. Participants perceived that this might lower the rate of multiple concurrent partnering (MCP) and casual sex, unwanted pregnancy and the levels of HIV and AIDS. Zuziwe even asserted: “Maybe, if there would be educational sessions like these weekly in rural areas as well, that would prevent our younger siblings from getting pregnant at such an enormous pace. The rate of pregnancy in schools would decrease.”

Zethu agreed with this and added “If they [health educators] can visit schools, clinics, even go to the places we gather at for recreational events [it will help]; because in most cases sex stuff affects the places where there’s alcohol involved.”

Alcohol use was highlighted as a problem in these communities by both young men and women. With alcohol use came risky sexual behaviours, unprotected sex, sex with older partners, MCP.

Siphe said: “Maybe the better way is to just stop selling alcohol because we drink too much and we cannot stop because it is still there, because of the person who brought it, we still are going to drink” (female, FGD, Flagstaff). Some suggested that it would be better if there were youth rehabilitation centres that helped people to stop drinking alcohol. As Pitsi said: “Unless in these youth centres there will be something or a remedy to help people stop drinking alcohol, for example, I’ll go to [a tavern] after hours so I don’t think they will help us to stop drinking.” (Female, FGD, Flagstaff)
Access to material possessions, such as cars and clothes, were presented as attractions for both young men and young women dating older partners. Financial transactions were discussed as a feature of age-disparate intimate relationships. The pursuit of money by those involved in transactional sex was presented as undermining health imperatives.

For men, ‘flashing’ a car was seen as a gateway to accessing women for sex. According to Khada “…now that I will be driving a nice car they will be interested, unlike before - they used to tease me...so it will be my time to get whoever I want.” (FGD, older men, Flagstaff).

CONCLUSIONS

The findings indicate that most respondents are acutely aware of the risks of unprotected sex and the negative consequences of unplanned pregnancy. The focus group participants were able to debate and propose solutions to the numerous challenges of promoting sexual and reproductive health. However, there was a tendency to externalise responsibility for safer sexual practices and particularly to blame women for the negative consequences of risky behaviour, such as early pregnancy. There was recognition of the importance of using condoms but, again, shifting of responsibility. It is interesting to note that there was no mention of the female condom or other contraceptives in the men’s FGD. Reasons for condom non-use were different for men and women. There were many complaints and serious allegations of unprofessional and unethical behaviour by health professionals among the female participants. The fact that the male participants expressed fewer frustrations with the clinics may be due to men’s less frequent use of such facilities.

For SRHR to be fully realised in the communities studied, interventions should recognise, mobilise and support groups within the community that are clearly engaged with these problems and have practical suggestions for how they can be addressed.
RECOMMENDATIONS FOR INTERVENTIONS TO ALIGN TRADITIONAL AND RELIGIOUS SYSTEMS WITH SRHR

1. EDUCATION

The need for increased and sustained education on SRHR was evident in these findings. The findings of this study refute the claim made by some that communities are experiencing AIDS fatigue. In fact, communities such as that of Flagstaff are eager for more information and knowledge. However, this needs to be integrated into comprehensive SRHR education, support and advocacy.

2. ENFORCE THE LAW

To align SRHR with traditional and religious systems, one of the tools that can be used is the law. Enforcing the law can be a deterrent to some behaviour such as engaging in sex with an underage child, a feature of the practice of child-bride abductions.

3. GOVERNMENT INTERVENTIONS

There is a need to mobilise support from communities for government interventions so that they are accepted and not treated with suspicion.

4. LGBTI

There is a need to educate communities about gender power, relationship control and violence in intimate relationships. It appeared that to some extent men are socialised to date partners that they can dominate (women). Sensitisation is needed about respectful relationships of equals as ideal in heterosexual relationships. Gay relationships threaten this typical gender power dynamic and men do not accept that. Normalising LGBTI sexualities, challenging and destabilising heterosexuality should be at the forefront of interventions, for LGBTI rights and for broader gender equality.

5. SEX IN RELATIONSHIPS

It was evident from these findings that traditional views of sexual intercourse as ultimately for the purpose of procreation were informed by narrow religious and social constructions of families. Though a lot of risky sex involves MCPs and extra marital relationships (where procreation is not intended) the view that sex is ultimately for procreation prevailed. Interventions that include workshop tools such as the ‘Boxes and Binaries’ and ‘the heterosexual questionnaire’ are recommended. Such approaches include a focus on sexual pleasure, differentiate gender identity and sexual orientation, and get participants to think ‘outside the box’.
REFERENCES