Research brief: A case study on rights, values and services in Pietermaritzburg, South Africa

Author: Mzikazi Nduna (Wits University)
Editors: Deborah Ewing, Jane Argall

AIDS Foundation of South Africa July 2017
ACKNOWLEDGEMENTS

I would like to thank Thulile Louisa Mbhele and Moeti Lesuthu of the AIDS Foundation of South Africa (AFSA) for supporting the implementation of this study. Thanks are also due to research coordinator Maxwell Magobolo and his team of field workers, and to all the research participants who provided valuable information and gave freely of their time.

I would also like to thank colleagues from Department of Psychology at the University of the Witwatersrand: Dr Peace Kiguwa; Lesego Ndhlouv; Nosipho Mxoli; Matamela Makongoza, Oncemore Mbeve and Andile Mthombeni, for their contributions to the report and their participation in the member-checking meeting in Pietermaritzburg. The researchers’ writing of this series of reports was made possible by support from the National Research Foundation Centre of Excellence (COE-HUMAN), the Faculty of Humanities at WITS and AIDS Accountability International, through a Ford Foundation grant.

AFSA’s Sexual and Reproductive Health Rights (SRHR) Programme, for which this study was undertaken, is supported by the Embassy of Sweden and the Norwegian Aid Agency Norad.

Photos: GLN
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1. INTRODUCTION

The case study presented here is the second in a series of reports from a study undertaken as part of an ongoing research programme to explore the alignment of traditional belief systems with sexual and reproductive health and rights (SRHR) in South Africa. The purpose of this research is to provide evidence of the positive and negative influences of culture, religion and traditional practices on men and women’s access to SRHR, and to inform effective community interventions, particularly with women, young people and sexual minorities.

Culture is the way of life of a group of people, and is seen in the way people behave, dress, how they relate to those within and outside of their group, and their values and belief systems. Another definition refers to culture as a set of dynamic beliefs and practices introduced with internal ambiguities and contradictions, albeit often reduced to static traditions that were practised in the past (Shope, 2006).

Cultural beliefs and systems are transferable from generation to generation, but are not static because cultures change over time in response to altered circumstances and environments. African cultures are known to be mostly collectivist, with language being the core indicator of cultural identity and cultural interdependence (Eaton & Louw, 2000).

In different ways, sexual and reproductive health outcomes are influenced by, among other variables, culture. Traditional and conservative beliefs attributed to certain groups of people are reported to influence access and utilisation of health prevention messages (Nduna & Mendes, 2010).

In South Africa, there are various traditions practised in line with the diversity of cultures. According to the Oxford dictionary (2015), tradition is defined as "... the transmission of customs or beliefs from generation to generation, or the fact of being passed on in this way". Among African communities, tradition can also be
regarded as a cultural practice that refers to the way of honouring the elders and the community, and which needs to be adhered to by members of a particular community (Heeren, Jemmott, Tyler, Tshabe, & Ngwane, 2011). Traditions are regularly linked to SRHR outcomes in research (George, 2008).

Culture and religion have particular values and rituals. Religion is defined by characteristics that include a strong belief in a supreme being, a belief in spirits and divinities, and a sense of community among those who follow a particular religious path (Beyers, 2010). A religious practice expresses the deepest values that a particular person chooses to be guided by. It refers to one’s faith and faith-based practice. Faith can be an intensely political act (Welty, 2005). It can be an individualised practice that shapes action and is intended to bring the world into accordance with a more private version of what is right and good (Welty, 2005).

Both religion and culture are found to have a huge influence on SRHR: they affect the views, decisions and actions of policy makers, intervention implementers, service providers, researchers and service users alike. Culture and religion shape views on sex (Jozkowski et al., 2013), sexual orientation, gender identity and expression (Mkhize, Bennett, Reddy & Moletsane, 2010), gender and gender-based violence (Dartnall & Jewkes, 2013) and contraceptive use (Mathenjwa & Maharaj, 2012; Moodley, Naidoo, Wand & Ramjee, 2015).

In this study we were interested in examining the role that religion and culture plays in facilitating or hindering SRHR access. The views of the four participating Pietermaritzburg communities aim to provide valuable baseline data needed to assess the influence of SRHR outreach interventions that are delivered by the Gay and Lesbian Network, an AFSA-supported non-government organisation in the greater Pietermaritzburg area.

Shortly after the data were collected, KwaZulu-Natal, and Pietermaritzburg in particular, made headlines because a woman tried to sell a baby on the Gumtree website. Mothers abandoning babies is reported in the media to be a ‘huge problem’. The response is usually condemnation of the woman concerned. However, cases like these also reflect the fact that services and support are urgently needed to prevent unwanted pregnancy, whether it is the result of rape or the lack or failure of contraceptives. The study made clear that the roots of gender-based violence need to be dealt with, that women need better access to contraceptives, including the morning-after pill, and that the legal right to safe abortion needs to be realised.

The intersectionality of cultural and religious values and their influence on SRHR requires integrated intervention strategies. Research to better understand the sexual and reproductive needs of men and women in the study sites is crucial. Whilst research does not lack in studies that link culture to SHR, these are not uncontested, owing to various research positions and negative and racial stereotypes that some of this knowledge can foster (Nduna & Mendes, 2010).
2. STUDY DESIGN

This study was carried out by a team of researchers from the Department of Psychology at the University of the Witwatersrand, Johannesburg. This Pietermaritzburg study is a component of a wider programme of research and community-based development supported by AFSA to advance SRHR in the Southern African region.

This broader study was conducted in the Eastern Cape, KwaZulu-Natal and Mpumalanga in South Africa. The study, which received ethical clearance from the University of the Witwatersrand, is nested within an AFSA Southern Africa (SADC) regional SRHR programme aimed at aligning sexual and reproductive health with culture and religion.

Data for this study were collected from black African women of varying ages, residing in low to low-middle income townships outside Pietermaritzburg, namely Imbali, Caluza, Mpophomeni and Maswazini. The entry point for recruitment was the Gay and Lesbian Network (GLN), an organisation that works on Lesbian Gay Bisexual Transgender Intersex Queer (LGBTIQ+) rights.

Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), following an open-ended format, were used to collect data. FGDs are a good way of collecting data as they also present an opportunity for sharing of new information by fellow participants, unlearning of old knowledge and re-learning. It is possible therefore that these discussions provided opportunities in themselves to create attitude shifts.

The main findings are summarised under the following themes: relationship dynamics, family planning and pregnancy, condom use, sexually transmitted infections (STIs), access to health services, communication between parents and children, sexual orientation and gender identity.

The report also presents a set of recommendations based on these findings and on feedback received by the research team from a member-checking meeting held with community stakeholders on the 29 September 2015.

Pseudonyms are used in reference to all research participants.
3. FINDINGS

Relationship dynamics
Coercion and violence
The findings on relationship dynamics reflect normative constructions of relationships as heterosexual and violent, with different forms of violence alluded to by the participants. Hegemonic notions of masculinities and femininities seemed to influence relationship expectations and sexual behaviours within and outside of relationships. To locate sexual and reproductive health and rights within the relationship context, studies of sexuality need to focus beyond sex. In this study constant reference was made to relationship character by the participants, in particular when describing heterosexual relationships. Men and women’s investment in romantic relationships was viewed as being different and unequal. In a dissatisfied tone of voice, a young woman in the Mpophomeni FGD said “… the way things are going most men just love sex. [It’s] not that they love us as women”. This was supported by data about pressure on women from male partners to have sex even when the woman did not want sex.

Related to the belief that some men were less invested in their relationships was a lack of trust. Some women held the view that men could not be trusted to be honest about their HIV-positive test results and could deceive their partners into believing that they were HIV-negative. The Maswazini participants were agreed that “… a man will not agree to go with you [to the clinic]. They are stubborn: they go alone and when he comes back he never shows his results, but he can change them (participants talked simultaneously, agreeing).” (FGD, young women, Maswazini)

Men were presented as always wanting to do things their own way, an indication of gender-relationship power inequity. Women reported that they could not get their partners to co-operate and listen to them, a finding that indicates how the participants felt about women’s status in relationships. Couple counselling is available in some clinics in South Africa (Desgrées-du-Loû & Orne-Gliemann, 2008) and yet men were described as not interested in this.

The suspicion of deceit held by women in Pietermaritzburg was echoed in the findings from Flagstaff (Case study 1 in this series). Young men themselves disclosed possible ways of lying about their HIV-negative test results in order to deceive a partner and keep a relationship going (Nduna, 2016a).

Men here were also not trusted with their partner’s HIV-positive test results. Women living with HIV reported that disclosure was risky for them because, upon learning the truth, a man could end the relationship, leaving the woman feeling dumped for having HIV. As a result, as one participant said, men sometimes “… just carry on spreading [HIV] from one partner to another one wherever you run to …” (Andile, FGD, young women, Mpophomeni).

This suggested that serial monogamy was a phenomenon for some women living with HIV as a result of desertion by partners upon learning about their status. Serial monogamy needs to be discouraged as a public health risk in high HIV-prevalence settings with low condom use.

Dishonesty about HIV-positive results was noted for both men and women. For women, concealed HIV-positive status was motivated by lack of trust and a fear that their disinvested partners would terminate the relationship upon learning about their HIV-positive status. For men, an HIV-positive status was reportedly concealed, although it was unclear why some men would deceive their sexual partners and present fraudulent HIV-negative results. These findings suggest that there is a need to enhance relationship communication skills about SRHR and fight stigma against HIV to facilitate disclosure where it is necessary. Relationship communication should emphasise the importance of honesty and trust in stable unions.

One of the limitations of this study was possible recruitment bias. The FGD facilitators were responsible for recruiting potential study participants. This may have resulted in the attraction of people who were in abusive relationships and knew the facilitators as volunteers within the health sector. Hence, there was a predominantly negative view of relationships.
"Due to romantic or emotional attachment and social norms that support male dominance in relationships, sexual violence was not always readily identified as violence by those affected."

There are various ways in which sexual violence manifests in intimate relationships. Due to romantic or emotional attachment and social norms that support male dominance in relationships, sexual violence was not always readily identified as violence by those affected. Experiences that could be described as violent were presented as pressure to engage in sex. Participants appeared to believe that failure to respond immediately to a partner’s sexual request could ‘justifiably’ result in physical violence. A woman’s freedom to agree or disagree to have sex was constrained by her male partner’s reaction, including blackmail and the use of physical violence to get her to concede to his sexual demands. Intimidation was reported to be used by male partners who demanded sex because if a woman “refuses, he goes somewhere else—he has a lady on the side” (FGD, young women, Maswazini).

This inherent relationship pressure was linked to undesirable outcomes. One young woman said:

“I think most people, especially girls, they fall pregnant because of the pressure that when your partner wants to sleep with you, when you are not ready he might say he will go somewhere else. In that way you try to keep him and end up pregnant unwillingly.” (Nu, FGD, young women, Imbali)

The reason given for men’s reported tendency to demand sex and seek it outside the relationship if refused was “… that’s how they [men] are” (FGD, young women, Maswazini). The essentialisation and naturalisation of men’s sexual demands in relationships may result in women staying in relationships, accepting that were inevitably disrespectful. Moreover, it takes away men’s individual agency by hiding their actions behind a culture that generalises their behaviour as the norm.

Common sense might suggest that relationship dynamics improve with age, and yet young adult women from the Maswazini FGD thought contrary to this. They suggested that:

“When you are younger there is not that much pressure because it is your choice; when you decide to have sex you have sex, and the male asks nicely.”

This implied that although young women may act out of pressure from their boyfriends, it is pressure that they can get away from as there is no commitment in these relationships. However, for older women, relationship investments may tie them into unhealthy unions. For some, this could be a result of having a child with a man or matrimony. One woman said that “men really pressurise us because you have to dish up for him and if you refuse he will beat you up” (Thembeka, FGD, young woman). The term ‘dish up’, a metaphor derived from the domestic chore of preparing and serving food, referred to giving sex on demand. Others concurred.

“It is true he will beat you up.”
“… and you have to do it fast because you will get beaten.” (FGD, young women, Maswazini)

In these data sexual and physical violence were referred to constantly. Other research also reports forced-sex encounters for women (Mulumodherwa & Harris, 2013). Hence, it is important to educate people about Intimate Partner Violence (IPV) early on in adolescence. SRHR interventions should promote mutual respect and offer women real options should they wish to terminate a relationship. However, the sense that men needed to be educated and that their attitudes were a stumbling block to women’s realisation of SRHR prevailed in these findings.

One young woman said:

“mostly … boys need to be taught because all women are equal and they know that but men don’t take that.” (Mbali, FGD, young women, Mpophomeni)

Another said:

“Family planning is only for women. Men are not included when in fact they are the ones impregnating girls in this community. There are no actions taken in fighting that.” (Nu, FGD, young women, Imbali)
Participants suggested that SRHR education was delivered through workshops and yet these data indicated that face-to-face workshops were limited in these communities. Perhaps to avoid the logistical challenges and the higher costs of face-to-face interventions, mass media in the form of print (newspapers, magazines, and pamphlets), radio, television, online media, such as internet and social media, could be used more.

**Alcohol abuse**

There is significant evidence from South African studies of the problematic relationship between binge drinking and unsafe sexual practices, such as unprotected and transactional sex. Taverns in Pietermaritzburg and in other study sites were characterised by participants as places of unsafe sexual practices between strangers and drinking associates. Men and women were positioned differently in relation to these practices:

“…if he is at the tavern and gets turned on, he grabs any girl and sleeps with her. What do girls say at taverns? She will sleep with any boy who brushes her thighs all night just so she gets a quart of beer, and then she passes on the disease, and then the husband comes home with that disease, whereas if men had workshops that they attended, this kind of situation wouldn’t occur …” (Mbali, FGD, young women, Mpophomeni)

In this scenario, men who drank in taverns were reported to behave in a predatory manner while women looked out for transactional sex opportunities. The assumption here is that the man is married and the girl a disease vector.

This discourse feeds into a historical myth that men cannot control their sexual desires, that if a man feels horny, he should have sex. ‘Grabbing’ any girl suggests that the girl does not have agency. This constructs taverns as sites of sexual violence and indiscriminate sex. The girl at the tavern is further represented as a vector of HIV transmission. The ‘grabber’ is now the victim of this malicious behaviour. The man, who started by feeling aroused and acted on this by grabbing any girl, is assumed to be HIV-negative until the girl passes HIV on to him. Women whose husbands drink in taverns are presented as, unbeknown to them, involved in a sexual network with the girls at the tavern, through their husband’s behaviour. Wives were pitied here as innocent victims of HIV risk through their mischievous husbands’ sexual behaviour.

At the same time, sex work, for instance, was viewed as a compelling choice for women from poorer townships, where economic constraints presented limited livelihood opportunities. In this way socio-economic conditions were understood as shaping sexuality and sexual expressions, and thus influenced socio-sexual practices. These findings reflect the persistence of women’s gendered passive positions: women in taverns are observed to be passive in relation to predatory men but at the same time responsible for spreading disease. The passive wife waiting at home is seen as a victim of sexually transmitted infections because of her husband’s behaviour. Interventions are needed to activate women’s agency, especially their ability to protect themselves from victimisation, blame and diseases.

**Family planning, pregnancy and abortion**

**Counselling on contraceptives**

Family planning is an important aspect of SRHR and services for both men and women. Increasing access to and promoting consistent use of contraceptives require education and a trusted family planning clinic that provides a full range of services. Participants reported a lack of information, education and counselling about the contraceptives they accessed at their local clinics. Some participants complained that nurses did not take the time to explain contraceptive measures. Instead “they shove you with an injection” (Zandi, FGD, young women, Mpophomeni).

Others reported more positive experiences.

“[They] … have to check if you are not pregnant so that they don’t inject whilst you are already pregnant. You must explain that it is your first time and you have never done it before. Then they will check all of that. They don’t just inject you if it is your first time, never.” (Sane, FGD, young women, Maswazini)

“Well, they check your urine first and sometimes they tell you that you will go on your periods—it might make you go on
While experiences at family planning clinic services were varied, participants agreed unanimously that there was little choice available to them. There was also the sense that not much was known about the contraceptive implant. According to one young woman, doctors themselves “are not sure if it’s a hundred per cent guaranteed” (Qando, FGD, young women, Mpophomeni). This uncertainty has resulted in a loss of trust of the method. The implant was consistently mentioned here, as in other sites. It appeared to have overtaken the three-month Nur-Isterate injection, which used to be the more popular and commonly available prevention method among young people (Moodley et al., 2015). Not all participants knew about the implant. Stereotypes, myths, negative attitudes and misinformation around contraceptive use were shared in the discussions and these might serve as a barrier to effective contraceptive use. Some participants believed the implant caused weight gain and flabbiness while others held the misconception that women’s bodies changed as a result of their promiscuity, a view also expressed among Flagstaff participants.

“"I know someone who had an injection and her body was fine before the injection. Her body suddenly got fatter and she was wobbly and she turned into something you don’t know—her body turned into jelly. (Nkuli)

“"That was caused by the partners she changed every day.” (Phili)"

“"No, she is married and lives with one person.” (Nkuli) (FGD, young women, Imbali)"

Participants in the different sites seemed to acknowledge the limited protection offered by hormonal contraceptives. At the Maswazini FGD, women understood that hormonal contraceptives were limited to pregnancy prevention and did not protect against STIs like HIV. One young woman from Mpophomeni said:

“I think that … we all know that now there are sicknesses, you know, that you might contract a sickness or fall pregnant. Even if you went for an injection, you must use a condom. Do not rely on that injection because you don’t know what you might get in the end, because if you don’t use a condom you get a virus or a child.” (Thembi, FGD, young women, Mpophomeni)"

Participants in the FGDs suggested that youth SRHR centres were needed in their communities. This need was expressed in the Flagstaff site as well. SRHR services are sometimes rendered by NGOs but these intervention programmes are not usually sustainable since they are reliant on volunteers with a stipend and do not have a wide reach (Nduna, 2016a).

Pregnancy: ‘Phuthaliyenzeka, Nhloso, Delela’abazali’

Phuthaliyenzeka, Nhloso and Delela’abazali’ are some of the jocular children’s names that participants used during a member-checking meeting in Pietermaritzburg to refer to children born out-of-wedlock. If it was the first pregnancy it was regarded as a mistake because mistakes happen (iPhuthaliyenzeka). The person could be forgiven. However, in the second incident the pregnancy was considered to be deliberate and probably wished for. Nhloso (aim or motive) means that the second
pregnancy was intentional. A third pregnancy was regarded as a sign of disrespect. The name ‘Delel’abazali’ (disrespect the parents) suggests the pregnant woman’s intention to provoke her parents. These names clearly suggest that a child born out-of-wedlock was undesirable.

The right to choose when to have a child is a fundamental reproductive right, recognised and protected in international law in declarations ratified by most countries. This right is easier to realise for some than for others. Self-monitoring was evident in the data for young women.

“The rule is we should not fall pregnant at all. We are supposed to sit at home and wait for marriage. But then modern times and olden days are different—we could not wait, we fell pregnant, had the first child and had another one.” (Woman 5, FGD, young women, Maswazini)

In these data there was a sense that having a child was a necessary burden for heterosexual-identifying women. It was expected that a woman would have at least one child and the timing and circumstances for the pregnancy were somehow prescribed by social norms.

“You know this thing of not having a child by the age of thirty-something … bones get stiff and you cannot give birth on your own … so we are rushing to avoid that (they all laugh).” (Mbali, FGD, young women, Mpophomeni)

At the same time, women were judged for having a child ‘too early’ or without being married and this was perceived as rushing for maturity against parental advice. In cultural and financial terms, participants reasoned that having a child pre-marriage reduced the value of ilobolo (bride wealth traditionally paid in cattle) for the woman when it was time to get married. Childbirth out-of-wedlock is common in South Africa (Ardington, Menendez & Mutevedzi, 2015). However, an intersection of tradition and political economy around this cultural practice may affect the realisation of women’s SRHR by undermining their value and dignity.

“You are not accepted rightly because you had a child at an early stage. Having a child at home is not a right thing. You must have them when you are married because it is so wrong. Even when that person [man] pays ilobolo, the amount of cows has to be reduced, you see? Because now you had taken mom’s cow and given it to the boys [others laugh].” (Mbali, FGD, young women, Mpophomeni)

This ‘cow’ refers to the cow that would have been paid to parents as part of ilobolo if the girl was a virgin.

When a woman gets married in this community, she moves out of her natal home to stay with her husband and his family. The couple eventually move out of the family home to start their own home. Raising a child in one’s birth home was reported to be a burden. Participants further viewed it as irresponsible and a financial burden to have more than one child.

“It is not right to have babies these days because children end up poor. Even us, their mothers, we are struggling; we do not have jobs.” (Khethiwe)

“She who has babies should stay with the ones she has and not have more.” (unidentified woman) FGD, young women, Maswazini)

Participants’ thinking seemed to be confined by the realities of their everyday lives in South African townships. When poverty and economic deprivation become central to decision making, it limits women’s realisation of their reproductive rights.

Participants not only expressed a concern about a woman’s current financial status but predicted that poverty would continue into the next generation, hence the caution that: “these children grow up hungry and they steal, they break into people’s houses” and “it becomes your burden and the world is cruel now” (FGD, young women, Maswazini).

This worry suggests the commodification of reproductive rights: only those who can purchase them can afford to enjoy them (see also Eshowe report, Nduna, 2016b). This suggests a phenomenon
that reproductive rights may be infringed by the expansion of a neo-liberal global economy and an emphasis on individuality and free will. Hence, women in this study were worried about the impact of poverty and deprivation on their offspring. They were mindful that they would carry the burden as parents for the undesirable consequences of raising children in what they termed a 'cruel' world. The world was viewed as cruel on the basis of economic constraints and, additionally for girls, because of their vulnerability to different sorts of human rights violations, chiefly sexual violence. As one young woman said: “… a stranger may just come and rape your child and leave her with a disease” (FGD, young women, Maswazini).

This worry is not misplaced as levels of sexual violence against women are high in South Africa (Dartnall & Jewkes, 2013). Parents, and mothers in particular, worry constantly about crime against girls and women because of their gender. This indicates high levels of social injustice resulting from the normalisation of Gender Based Violence (GBV) and the failure to provide support and redress for victims and survivors of sexual violence. In spite of the challenges associated with having children, participants believed that it was important to “have at least one child” (FGD, young women, Maswazini). Having no children was viewed negatively due to a woman's gendered identity, which was seen as primarily maternal. Having many children was also viewed negatively as demonstrating lack of insight and wisdom on the woman's side for not learning from 'her mistake'.

Having a child was also seen as affecting a woman's prospects of getting married. Ironically, the effects were constructed in both positive and negative ways. On a positive note, having a child was viewed as good because, as some participants argued, men were suspicious of a woman with no child at all.

“Now most boys don't want a girl with no kids … like me, if I were to come up now and say I don't have a child, he will look at me in another way and ask where do I take these kids to?” (Qando, FGD, young women, Mpophomeni)

This questioning insinuates that the woman has either aborted a pregnancy or is hiding the fact that she has a child or children. ‘Having a child’ for the participants meant having been pregnant which equated to bearing a child. Previous abortions and secondary infertility were also seen as a burden. For participants whose frame of reference could be self-induced or backstreet abortion, the possibilities of having a future pregnancy were viewed as slim to none. As one young woman said:

“I think that once you perform an abortion, it is possible that you might never have kids again.” (Thembi, FGD, young women, Mpophomeni)

Discussing the causes of secondary infertility in women, a participant explained what she believed was a traditional view of abortion:

“If you had an abortion … well, to others it happens that they have a miscarriage and then will never be able to have kids again. It starts deep from the traditions because they say that it freezes the womb. The previous child needs traditional ceremonies like Iladi (a ceremony where there is a lighting of candles and gifts for the person for whom the ceremony is being performed) and you need to do all of that and buy what you are told to buy for you to be able to have kids again.” (Andile, FGD, young women, Maswazini)

The 'previous child' here refers to the embryo or foetus. This example further demonstrates the link between culture, traditional beliefs, rituals and reproductive health outcomes.

On a negative note, a child born pre-marriage with another man was viewed as a burden and a liability. It was observed that wisdom, following cultural norms, dictated that women should leave their children at their parents' homes when they got married.

There is anecdotal evidence that a section of the South African population is opposed to the child support grant (CSG), which is one of the social benefits available for vulnerable children in South Africa. In this study, as in others (Nduna & Bujela, unpublished work), the CSG was blamed for high rates of pregnancy among young people.

“It is very hard on sex issues and then
they fall pregnant and say they want grant money even. That money is nothing. That money does not do anything. What can you do with R300?” (Women 7, FGD, older women, Caluza)

Pregnancy for closeted lesbian and bisexual women was also contested. Where bisexuality was recognised, it seemed to be infused with a ‘progressive’ homophobia, under the guise of concern for the children. One older woman asked:

“How was she sleeping with men and even having a child? We are not against her if she had been in the closet. If she had known of her feelings she should have used a condom or used contraceptives or taken pills. But then now the problem arises when she has children—that is our problem: these children that she has brought to the world. What will they say then? Will they say ‘dad-mom’?” (Woman 7, FGD, older women, Caluza)

Children were used to evoke disapproval against same-sex couples. For participants, it was unclear how a bisexual person could consider having children and it was deemed an unacceptable situation for the child. The message was that the sexual orientation of the mother would create confusion in the child. It would seem that this argument is consistent with that expressed by people who oppose homosexuality. The reproductive rights of bisexual women are questioned: they are expected to live their lives but to make sure that they do not get pregnant. Participants argued that bisexual women should use contraceptives. If they get pregnant and have a child it becomes a ‘problem’.

“It means that the person is selfish; they only think of themselves and no other people or the community. What will the children that you brought into this world think? Will they call you ‘father’ and call their father ‘father’ as well? What happened to mother? She did not mean to have children, no … why did she open her legs? No they will not call her ‘mom’ but she will date women.” (Zama, FGD, older women, Caluza)

Others also reinforced this view. The fluidity of sexual orientation and the gender identity continuum seemed to confuse people. Though bisexuality was acknowledged, bisexual people were not granted the freedom to live their lives. Community members demanded an explanation and justification for gender non-conforming behaviour. This was demonstrated in the discussion below with multiple participants interrupting each other:

“No, no, no (‘No, Zama, it is what it is!’). I am not against what you are saying. Listen to me: that is why there are people who are bisexual, transgender and so on (‘We know their categories.’) That person, I would say, they are selfish. They want to do it all. The reason they had children is because they wanted to know how it feels like. Then they decide they are not generous towards children. In fact, it is not because they are selfish but they are transgender…” (Zama, FGD, older women, Caluza)

Disapproving attitudes towards pregnancy out-of-wedlock, the child social grant and pregnancy and childbirth for bisexual women were not the only problems facing women. The genitor’s response to the pregnancy also had negative consequences.

Paternal acknowledgement

The genitor’s reaction to a pregnancy varies—in particular to early unplanned pregnancy. Where the alleged father acknowledges responsibility and there is no misattribution, there is no problem, although this does not necessarily guarantee consistent child support. However, some young women experience their partners’ responses to the news about an unplanned pregnancy as contesting and temporising. Qando in Mpophomeni painted a miserable scenario:

“As women, at times we fall pregnant and men love to have sex with you [but] he will leave you and your tummy just like that … and you do not even want that baby.” (Qando)

“Men have rights. If he says the baby is not his, it is not his, and if you go and
have blood tests, [men] now have this habit of drinking traditional herbs and if they drink that the results will reveal that the child is not his, even though it is his, and that will hurt you." (Qando, FGD, young women, Mpophomeni)

The genitor’s failure to acknowledge paternity negatively impacted a woman’s ability to cope financially.

“A child ends up fatherless these days and you as the woman end up struggling on your own not knowing how you are even going to feed the baby and maybe you are not even working ... For now, as you know, we do not have jobs and we have children. Their fathers just leave us.” (Woman 1, FGD, Maswazini)

Sometimes a man’s positive response to an unplanned pregnancy was viewed as him simply tolerating the situation. The woman was then expected to show appreciation for his tolerance by preventing a future ‘mistake’ from happening, otherwise he would be justified in leaving her. But a woman’s ability to provide for her child was still negatively impacted.

“Fine, I had the first one and he stayed and he was patient … but comes the second one, he hits the road and then I am left with two babies, struggling, and I have to chase after him looking for him and not even find him.” (Woman 4, FGD, young women, Maswazini)

The use of the word ‘patient’ was deployed instrumentally as if to suggest that the alleged father had an option to leave. Paternal acknowledgement and connections with a biological father are highly valued in South African communities (Nduna, 2014). Yet, there is very little research on paternal acknowledgement in South Africa. This phenomenon needs to be given adequate research attention as it affects men, women and children in dire ways.

Some people who grew up without knowing their paternal identity are believed not to be protected by the correct ancestors. As most South African groups are patrilineal, the ‘correct’ ancestors are considered to be from the paternal side of one’s family (Nduna, 2014). Children in some families are thus stigmatised and any problems experienced with them in extended family formations could be attributed to the fact that the child “stays with traditionally acknowledged children whereas he is not [acknowledged]” (FGD, older women, Caluza).

**Choice of termination of pregnancy (cToP)**

In the event that unprotected sex results in an unplanned pregnancy, a woman has, in theory, several options: to carry the pregnancy to term and keep the baby; to give the baby up for adoption, if she is older than 18 years; or to terminate the pregnancy. Throughout the Pietermaritzburg sites, abortion was understood as an option that women had and various reasons for some women to choose this option were spelt out. These reasons included relationship break-ups, fear of a parent’s reaction, financial constraints, contraceptive failure and parents forcing the child to have an abortion. The following exchange addresses the situations, in which a woman might choose an abortion:

“Abortion happens if a person cannot identify the child’s father. That is a first reason. Secondly, it is because a person is scared of her parents. She does not know what they will say about the trouble that she is in so she cannot carry that child. Another person thinks the child will set them back. Life goes on so they cannot sit and care for a child whilst they want to live their life, so they cannot have a child.” (Andile)

“When a person has an abortion, I think it is because when she told her partner he may have run away because he does not know how he will report at home that he has impregnated a girl ... so because the boy distanced himself from a girl she ends up having an abortion.” (Zandi, FGD, young women, Mpophomeni)

An unplanned pregnancy is not always unwanted. However, it may threaten a relationship.

“Sometimes you have an abortion with this reason: maybe I have eight kids ... how am I going to have a ninth child?
Maybe that child was not even planned, so the best way is to have an abortion because I cannot have nine children without having a job. How will I care for them? And sometimes you tell the father of the child, and he says he does not want a child and that if you carry on with that child, then it is the end of your relationship, and then you end up aborting to make your love last?” (Mbali, FGD, young women, Mpophomeni)

Contraceptive-use failure resulting in an unplanned pregnancy was another reason why women choose abortion.

“[You] had this injection that lasts for three years, because they say you cannot fall pregnant if you have it. So when you go to the clinic and find out that you are pregnant but you are still on this injection, so then you make a decision to have an abortion because you did not plan that.” (FGD, young women, Mpophomeni)

For some of the young women, abortion was seen as an option to help them reach their goals and to honour their parents’ aspirations, or because they found themselves stranded.

“Sometimes we have an abortion because of the parents. You find that maybe you are still at school, you haven’t finished yet and then you fall pregnant. Maybe you are doing your matric or in standard nine and you fall pregnant. Maybe your parents had their hopes on you. Maybe they are not even working and now you have to drop out of school but you would still like to carry on with school and they throw you out … so then you resort to abortion.” (Thembi, FGD, young women, Mpophomeni)

These findings suggest that there is a need to conduct research to better understand the link between unacknowledged and denied paternity and teenage abortion. This link is implicated in a qualitative study from the Eastern Cape on young women in distress (Nduna & Jewkes, 2012). These data also suggest that certain practices that include virginity testing, such as ukuhlowlwa/Inkcyio, could lead to clandestine abortions due to fear and shame of having had sex whilst being a member of a virginity movement. Inkcyio (ukuhlowlwa) is a movement of maidens among some ethnic groups in South Africa, predominantly in the Zulu, Swati and to some extent the Pondo communities. A concern was raised by participants here that parents’ experiences of shame, stigma and disappointment, and a harsh reaction to the pregnancy may make them force their daughters to undergo a clandestine abortion.

“Sometimes our parents have a problem about what will the neighbours think whereas the child was undergoing umhlolo [and is now pregnant]. What will they say now? So now the option is that a child has an abortion so that the child stays in position whereas the truth is she has been off-position long ago, you see.” (Mbali, FGD, young women, Mpophomeni)

In this site, there was a degree of acceptance of abortion as an option for women. This was in stark contrast to the complete rejection expressed in findings from Flagstaff, a Pondo community only 258 kms from Pietermaritzburg, and in Eshowe, a Zulu community 213 kms from Pietermaritzburg. Religion and culture were not emphasised as reasons against abortion. The only problem identified that was linked to tradition was the non-performance of iladi, a ritual associated with childbirth. This could be because Pietermaritzburg has an urban influence, is less conservative and more accepting of abortion as a medical procedure.

Women’s reproductive choices in the context of poverty are constrained. Unemployed and poorer women are increasingly finding it difficult to choose when and how many children to have. This is dictated by money and so women’s right to choose cannot be realised in this context. Women themselves constructed unplanned and or out-of-wedlock pregnancies in negative ways, similar to those in Shefer et al. (2013).

**Safer sex/condom use**

Condoms, predominately male condoms, continue to be promoted as an effective HIV-prevention, public-health intervention method.
for safer sex. Using a condom correctly and consistently remains one of the most reliable ways to prevent pregnancy and STIs, including HIV, for men and women. Availability of condoms is important if this method of prevention is to be encouraged. Further to availability, access to condoms for everyone who needs them is critical. Utilisation is key to making sure that STI/HIV and pregnancy prevention is achieved. This section explores these three sub-themes that emerged in the discussion about condoms: availability, access and utilisation of condoms.

Availability of condoms
Availability of condoms at clinics and at taverns was confirmed across the nine research sites in the three provinces. However, there were different perceptions of availability of condoms within and across communities. This suggests that there is not consistent availability and so participants could have different experiences with obtaining condoms at different times. In these data, as with the other sites, availability of freely distributed government ‘Choice’-branded condoms was commended by participants. However, there were challenges with availability of other protective products, as reflected in this exchange:

“We were at a workshop where they talked about condoms for gay people, so I do not know if they have them in our clinic. There is one for the tongue and one for hands and so forth. Where do those come from?” (Woman 9)

“No, we have not heard about them.” (Women 7, 3)

“We only know the femidom, for women. Oh, that is better. There are now condoms for fingers as well.” (Woman 7) (FGD, older women, Caluza)

This discussion referred to lubricants and dental dams. The reference to ‘condoms for gay people’ suggested a belief that gay people engaged in sexual activities that heterosexual people did not. Whilst lubricants and dental dams are mainly used by gay and lesbian couples, people who identify as straight also engage in anal and oral sex so these products would be useful for all groups. This idea of exclusivity contributes to the stereotyping and stigmatisation of gay and gender-variant people. Where such binary views are shared by health service providers, it means that heterosexual and LGBTI people may not be offered the services or products they require equally. Restricted or selective access to condoms, which does not respond to actual needs, undermines prevention efforts across society.

“The reason I say there is lack of knowledge is … well, I am going to make an example. You know when I go for blood tests, they ask me where is my boyfriend. And they ask if we use a condom, even though they know of my sexuality. Also [there is a need for] the distribution of lubricants to the LGBTIs and to heterosexuals as well, and in the clinics there are no condoms for homosexual people.” (Phill, FGD, young women, Imbali)

Access to condoms
Clinics seemed to be the main sites of reported condom distribution and participants felt that this was not enough. Sometimes condoms were reported to be distributed in taverns, but participants argued that more could be done to make them accessible privately where they were needed. The following challenges with access were brought up:

“I wouldn’t say that condoms are not there. The issue is that most people are scared of taking condoms in the presence of other people, especially in taverns or in public spaces.” (Ayanda)

“Some people fear taking condoms in front of other people because of the comments that people make when they see you taking a condom; they just assume you are going to have sex on that particular day, so next time when you know for sure that you are going to have sex you fear taking a condom in the presence of other people.” (Thuli)

“Well, I think that … how can I put this? … sometimes you look at it this way: having sex is a private thing so now taking a condom in public just shows people what you are going to do (laughter).” (Nu) (FGD, young women, Imbali)
Sex is a subject that excites and yet embarrasses people. Inappropriate and untimed comments about sex could be experienced as embarrassing or harassing for some, and thus could dissuade some people from acting responsibility in relation to their health, for example, in picking up condoms in front of others. Participants were concerned about ignorance regarding condom use and suggested that condom distribution should be accompanied by education for the users. One young woman said that people should be taught about family planning in taverns “because many girls that fall pregnant are from taverns”, (Zandi, FGD, young women, Mpophomeni).

Other participants suggested that condoms should be issued in churches and schools.

“A lot happens during goodwill church conferences. I saw it this year people having sex at night. And in schools as well, they should be put in the toilets because we have sex at school too (laughter).” (Nkuli, FGD, young women, Imbali)

There were conflicting ideas about the distribution of condoms at schools. All participants across the different FGDs agreed that it was logical to have condoms at a place where most young people have access. The aim of extending condoms distribution to schools is not to encourage or enable children to have sex but to make condoms accessible to young people who are becoming sexually active and might not have access to a youth-friendly clinic. There was contestation around the young age of school-goers and the expectation that learners should not be having sex yet. However, there was recognition from some of the older participants who, as parents, supported the distribution of condoms distribution at schools.

“This issue of distribution of condoms at schools ... we as parents think the government is corrupting our children and encouraging them to engage into sexual activities at school. The government is saying they do it anyway no matter what, so they are trying to solve problems and they are saying since you are ready to do it then here is a condom—use it.” (Woman 7, FGD, older women, Caluza)

**Utilisation of condoms**

Consistent and correct condom use is important for optimum protection against STIs and pregnancy for sexually active persons. Where condom distribution enables access, the next important step is that condoms should be used. Even where condoms were available in different places, apart from clinics, the likelihood of them being used was questionable. Participants spoke of circumstances that did not support condom use.

“Most people drink and when they are drunk the chances of them contracting infectious diseases are high because when you are drunk you do not think straight, you see. Short-term pleasure does not pay out, because they say skin-to-skin sex is more enjoyable (laughs) than sex with a condom (everyone looks at her and she responds to the nonverbal communication). Seriously, that’s what they say. And another thing, people get drunk in this area so when everyone is drunk people grab whoever they want to grab to do their business.” (Nu, FGD, young women, Imbali)

The focus on places where reckless sexual behaviour occurs was not misplaced. At the same time it should be borne in mind that unsafe sex also happens in encounters between regular and intimate partners, which could be as risky as well where there is infidelity, unknown HIV status and no condom use. The importance of safer practices, including use of condoms, in what seems to be a stable relationship should also be communicated continuously and consistently in HIV-prevention messages.

Despite admission that access to (male) condoms was not a problem, consistent use of condoms remained a challenge for some women.

“As women we face challenges that sometimes you find that a man doesn’t want to use a condom because men want flesh against flesh and now you will end up, since you love your partner, you end up offering him flesh against flesh, whereas if there were female condoms distributed accordingly, you will take them and if he wants flesh against flesh you give it to him and feel comfortable in
that way.” (Zandile, FGD, young women, Mpophomeni)

“Men do not want to use condoms and we need to just agree with them on that.” (Woman 4)

“Men say, ‘If you want to use a condom, then we would rather not do it.’” (Woman 7 FGD, young women, Maswazini)

“You see, even when you are married he will just say ‘… since I married you I won’t be able to have sex with you with a condom on’. Meanwhile he knows that he is cheating on the side, so you might enter a marriage with both of you having negative results but as soon as you are married he goes out and cheats and comes back to pass it on to you.” (Mbali, FGD, young women, Mpophomeni)

Coercion through intimidation and manipulation was commonly reported by women as preceding encounters of unprotected sex with their partners. Love, relationship commitment, conjugal ties and fear of losing a relationship all contributed to women giving in to sex without a condom. However, participants recognised the importance of women being able to exercise agency because they have to deal with the consequences, and be blamed for them. So they cautioned against non-use.

“What we need to be careful about, if you were to be sick now with a discharge and have to go to a clinic, at the clinic these days, they ask you where do you come from with a sexual infection these days? Two: if you have sex without a condom, you are expecting to have a virus and a baby …” (Qando, FGD, young women, Mpophomeni)

In terms of condoms, people are looking for variety to encourage use. In the Pietermaritzburg site, as in Flagstaff, research participants found the routinely distributed, standard Choice condoms boring for a variety of reasons. They expressed preferences for flavoured, textured and attractively packaged condoms that an NGO once provided in this locality.

“They (unnamed) condoms were different and people liked them. Maybe if they could come back again … They weren’t Choice. It was the ones with flavours.” (Mzet)

“… and fancy, so that you know when your partner is visiting, you take the fancy ones. You know with the red package (everyone laughs) … and even their female condoms. They were the ones with the sponge, not the ones with a rubber band.” (Phil)

“They have a sponge?” (Thuli)

“(Uses hands to demonstrate) It is like this (horizontal position). It has rubber on both ends, so instead of rubber bands, the ones that were supplied had sponges.” (Phil)

“Oh, so the sponge goes inside?” (Thuli)

“Yes, and it sucks dirt in, well, not dirt but the offspring of the person you would have slept with.” (Phil)

“It is hot, hey?” (Sma) (FGD, young women, Imbali)

‘Sucks dirt’ here referred to absorbing the semen. It is a common understanding in some of these communities that semen (and vaginal fluids including menstruation) is dirty. The ‘dirt’ referred to potential infections that could be contained by such fluids. At this point in the discussion, a facilitator distributed female condoms so everyone in the group could see what was being referred to.

This discussion indicated a strong interest among participants in incorporating barrier methods of HIV and pregnancy prevention into what should be pleasurable sexual activities. This suggests a motivation to overcome resistance among partners to condom use and a desire to exercise agency. These aspects are very important in addressing the attitudinal and practical obstacles to condom use, as freely distributed government condoms are rejected across board by young people (Nduna & Mendes, 2010). Colour and flavour were suggested as factors in choice and acceptance of condoms. Since April 2015, the South African Department of Health (DoH) has started distributing a variety of condoms in pilot sites, mainly institutions of higher learning, aimed at overcoming the challenge of young people’s lack of interest in Choice condoms. These
flavoured and coloured condoms are fondly known as ‘Max’, for maximum protection.

**Education about condom use**

There was a sense that the female condom was easier to use and an answer to men’s refusal to use the male condom because, with the femidom, a woman has control. Research reports that even though the women insert the femidom it does require communication about use with the partner (Maharaj & Mahlalela, 2015; Mathenjwa & Maharaj, 2012). It is not entirely secret, but it has evolved and improved to address some of the complaints about its discomfort. The following comments reflect both that the improved femidom was more user-friendly but also that there are problems of availability.

“Sometimes you would not find condoms at the clinic whereas they should have all kinds of condoms. Mostly there are male condoms; female condoms are rare and sometimes you find that they are there. As women we like to use condoms, and as women we look at it as … in our clinics we are not important, men are more important than women because you only find that the condom boxes are filled with male condoms, you will not find female condoms.” (Zandile, FGD, young women, Mpophomeni)

“You can wear it and go. It does not have a problem. My sister, it can stay for six hours in your private parts—it gives no problem. And I think it is very good for people who like to jam because when they taught us about it … and I thought it was good because at the jams, even if you are not raped … sometimes there is no asking each other. If you are with your boyfriend but you see someone else and see that they have money, he will just wink at you and then you go outside and do your business and come back. So, in that way it is safe because when you are done you take that condom out and fold it and put on another one (others nod at this description and exclaim softly in agreement). So, I thought it was good for us who jam …” (Woman 7, FGD, older women, Caluza)

A ‘jam’ is local slang used to describe small gatherings similar to parties where people gather and bring alcoholic drinks to share. The participant implied that in these drinking spaces opportunities presented for casual sex, sometimes forced, and, at times, transactional and consensual.

**STIs and HIV/AIDS**

There were knowledge gaps concerning STIs including HIV. Myths around the ‘shower effect’ (the false idea that showering after sex could reduce HIV risk) (Nduna & Mendes, 2010) were voiced and partially correct knowledge was infused with misinformation.

“Firstly, you do not contract sicknesses easily if you are circumcised, you see. You do not easily contract an STI because if you have just finished getting naughty as a woman or a man you have to wash yourself afterwards. Both of you should bath. Even if you do it the whole night, you must have bathing water for when you are done. They must have a Dettol and soap so that you do not contract sicknesses easily.” (Andile, FGD, Mpophomeni)

Participants attempted to convince the group that some people might look like they had AIDS and yet their HIV test might prove otherwise. They might be sero-discordant, whilst others might have undetectable viral loads.

“You see, someone may be positive and reflects positive on you, but his blood may reflect negative and he comes to you and shows his results and says I do not have anything.” (Woman3)

“Yes, men are strong. Some even die without it reflecting and some just carry it and spread it.” (Woman7)

“Can I just say that not only in male species where the reflection is low, even in female species sometimes, it hides. It may not reflect but it’s there (They mumble an agreement).” (Woman4)

“Listen, even if he does have it, he comes back and says he is negative and he goes somewhere else, it does not reflect immediately; it reflects after
a certain period of time. It depends on a person’s blood type … and sometimes you may even die without reflecting and sometimes it depends on your CD4. A woman’s CD4 is facing upwards and it receives immediately, and a man’s CD4 is facing downwards.” (Woman1) (FGD, young women, Maswazini)

These statements demonstrate a misunderstanding of HIV infection dynamics, including (mis)reading of viral load information, sero-discordance and the window period in relationships. This discussion also proved that some people still judged other’s HIV status by looking at them, despite education to dispel this ‘slender disease’ myth.

One of the simple ways to explain increased biological risk for HIV infection for women is to explain that the vagina receives and retains semen. It would seem from this example that this lay explanation was completely misunderstood. A similar situation was evident with the understanding of the immune system.

“There is a CD8 and a CD4; if you have a CD8 it means your immune system is in one direction, your immune system fights illnesses. When you have a CD4 it means your immune system is not in the same direction so when you get illnesses your immune system cannot fight because the illness finds a part where it hides and you end up HIV positive and have AIDS, whereas if you have a CD8, your immune system is in one direction and it can fight illnesses because they are in one place as soon as the virus comes in, they fight because they are in one place and not scattered. You may even die negative.” (Woman 2, FGD, older women, Caluza)

There seems to be an urgent need to address the Information Education and Communication (IEC) gaps about HIV. Some research reports that people are AIDS-fatigued (Shefer, Strebel, & Jacobs, 2012) and yet this data reflects the need for consistent and continued education to disseminate correct information. More important here is the need to develop local language materials to communicate scientific information correctly for better understanding.

Strengthening knowledge about various aspects of SRHR remains a challenge. This ranges from understanding of consent, the right to information and quality services, to basic information about the female body and sexual pleasure. This lack of education and the resultant ignorance was reflected in the discussion at Maswazini about Choice condoms versus commercial condoms. Young women here seemed to agree that freely distributed male condoms caused vaginal dryness, itching and a rash.

“When you have this itch it is like a small rash, but yet you cannot see it … you only feel the pain.” (Khethiwe)

“Maybe it is this oil they put in them.” (Thembeka)

“Yes, it’s exactly like that—it feels like a rash but it’s very painful.” (Gugu) (FGD young women, Maswazini)

Notwithstanding a possibility that some people may experience allergic reaction to latex, by and large these are signs of sexually transmitted and other infections. Some participants incorrectly believed that lubrication was used on condoms in order to prevent STIs. There seemed to be a problem experienced with condoms when the lubrication was considered to be excessive as the condom would get slippery and come off during use. On the other side, too little lubrication was reported to result in dry and painful sex.

Either way this could inhibit condom use. The participants here, and elsewhere, did not seem to consider or know that other factors could affect sexual pleasure, with or without Choice condoms. A woman’s vaginal lubrication differs across her lifespan and at different times in the menstrual cycle. Readiness for sex, romantic mood, stressors, treatment side-effects, contraceptive side-effects, etc. could potentially affect vaginal lubrication and sexual pleasure (Jozkowski et al., 2013). Sometimes, vaginal problems such as itching and rash are an indication of sexually transmitted infections (Mlisana, Naicker, Werner, Roberts, Loggerenberg, Baxter, Passmore, Grobler, Sturm, Williamson, Ronacher, Walzl & Karim, 2012). Correct recognition and labelling of conditions is important in health-seeking (Jozkosk et al., 2012) and this comes with knowing about the signs and
symptoms of STIs. However, participants attributed their negative sexual experiences to the Choice condom. Partly, this could be a reflection of lack of education about STI signs and symptoms and it could mean that these STIs are left untreated.

**Access to health services**

Participants reported positive and negative experiences with healthcare services, particularly in primary healthcare clinics. On a positive note, participants who were living with HIV and were on antiretroviral (ARV) treatment reported that there were good changes in the way that ARVs were delivered. This was an example of progressive and improved services that made the service accessible and easier for them, thus improving adherence.

“There is a medi-post when you go to the clinic. You do not have to stand in line like before where you stood in long lines with many people and it would take time. I think the government has reduced our problems for us that have to go and collect our medication.” (Woman 7)

“Now it has changed; if you book an appointment for a certain day, when you get there you find the doctor [is present].” (Woman 3) (FGD, older women, Caluza)

Improved antiretroviral treatment (ART) clinic service was also reported in Flagstaff at the member-checking meeting a year after baseline data were collected.

Participants from sites outside of Pietermaritzburg spoke about distance as a geographical barrier to access the clinics and availability of all services. For those in closer proximity to town, such as Imbali and Mpophomeni, access was not a problem. Further out of towns and cities access to sexuality education was reduced. Living on the outskirts of the town was also reported here, and elsewhere, to limit access to services as well as education and information about SRHR (Nduna & Mendes, 2010). Mobile clinics were available, albeit not accessible to all in remote places. Some progress to increase services had been made, yet it was not enough. The timing of health education provision was also questioned as it excluded working members of the community because it was usually either door-to-door during the day (no weekend and no public holiday work), or at clinics, also during the workday. A sense that men were a bigger part of the problems experienced by women in relationships prevailed, with calls to teach men about SRHR made. As one participant put it:

“[Men] are stone-hearted; they do not want to understand and they do not believe that this sickness exists. And the way they do things, they do not like the clinic. They never think of going to the clinic.” (Sbongile)

“I think that there should be more workshops for men and there must be more people who will be trained and educate men. (There is a short argument.) Others are educated but they don’t like to visit the clinic.” (Mbali) (FGD, young women, Mpophomeni)

If the African community generally is conservative, men were viewed as more so. Women viewed themselves as liberal and thus more responsive to SRHR education than their male counterparts. Instead of listening to the ‘SRHR gospel’, men were reported to pose a challenge for educators.

“When we conduct a door-to-door, sometimes you come across men and those men will not take you seriously and they just think they have scooped a girlfriend.” (Zandile)

“I think the way she explains it is that they do not take your work seriously. While you explain about your work/task, they step over the line and tell you that they love you.” (Mbali) (FGD, young women, Mpophomeni)

This insinuation of sexual harassment can potentially create a gender-hostile environment for female community workers. In addition to the distance to the clinics, which is a structural barrier, and the resistance of men, some health workers’ attitudes were also said to remain a barrier to improved sexual and reproductive health outcomes.

“What I see is that teenage pregnancy is high, reason being they are scared...
to go to clinics because nurses have an attitude … (there is a murmur of agreement). A nurse does not have a right to tell that you should not take an injection because you are still young. It might happen that you may fall pregnant and maybe you even have many boyfriends and if you fall pregnant you would not be able to tell who the father is. So her job is to advise you then give you the medication that you need and not give you an attitude.” (Mbali)

“Another thing, on the point of teenage pregnancy, it happened when I was at the clinic recently, when a girl came in for an injection … there was a comment that ‘Now here comes the matric ball gang’. So when they say that, how is that child supposed to feel? When they say the ‘matric ball gang’, [it means] now it is the time for the school kids to go to a matric ball. When girls come for an injection they are saying that they are doing it for a matric ball.” (Zandi)

“Well, if you go to a clinic and find someone with no care, even if the medication is available, she would not offer you because she has no care. She has her business that she is thinking about, whereas if they hire people with care they would not give up work to focus on their things.” (Mbali) (FGD, young women, Mpophomeni)

It would seem that the persistent problem with nurses’ attitudes prevails nationwide as it was reported in all seven sites and it is discussed in recent publications (Meehan et al., 2015). This dissatisfaction was coupled with lack of trust of duty bearers to whom challenges with the service providers were reported. Community members did not always trust that their concerns were escalated to the higher offices to be addressed.

**Parenting and SRHR**

Across all the FGDs most of the participants had children. Some had children when they were younger and reflected on this during the interviews. In the main, parenting was seen as a difficult role in contemporary society. Single maternal parenting is common in South Africa and results from unmarried, separated, widowed and divorced couples (Roman, 2011). Single parenting resulting from divorce is higher amongst the African section of the population. Talking to children about SRHR seemed to be experienced with difficulty by parents. The next section explores this.

**Communication about SRHR**

Here, as in other sites, respondents saw a need for open and honest communication between children and their parents about sexuality. Phill suggested that “there is a need for you to sit down with your child and talk to her” (FGD, young women, Imbali). Data analysis uncovered particular ways of communication that parents employed, one that was dominated by reprimanding but came from a place of love and fear amongst parents. This was mainly expressed as fear that a teenage daughter would have an unplanned pregnancy, a position expressed vehemently in Eshowe (Nduna, 2016b). It is this fear that leads to parents giving their children the ‘Don’t’s rather than the ‘Do’s. One woman expressed it this way: “Hey, girly, never get a boyfriend do you hear me?” (Woman 3, FGD, older women, Caluza). Parents found themselves communicating in these ways because of their ‘heartache’. Similar to findings from Flagstaff, this admonishing approach was recognised as ineffective by the participants, including those who were parents (see Nduna & Vilanculos, accepted for publication). There were suggestions in all the FGDs about the importance of effective communication based on clear information and free of shouting, and yet there was evidently hesitation to do this.

“I hear what the lady is saying but it is hard. It is hard talking to a child telling her how to, what can I say … well, they are girls right? You cannot allow yourself, because you love your child, you cannot tell her how to wear a condom. So I do not know how it could be possible that we talk about this issue because you wish to talk to your child but still think they are too young whereas, on the other part, they are grown so us parents we are in trouble.” (Woman 3, FGD, older women, Caluza)

The main obstacle seemed to be a perception of what was culturally appropriate to do from a
perspective of an African Zulu community. The next section explores this dilemma.

**Black racial identity culture and parent-child communication (PCC)**

The need for parent-child communication and education around sexuality was not contested at any point. However, participants struggle to conceive of a way of doing it. Some suggested that children should be allowed to bring their romantic partners home and introduce them to the parents.

"It would be easier for parents to talk to their children because if you sit Mpilo and her partner down and tell them of the consequences they will face if they ever start to do anything, they might listen better and I am sure they would not do things they are not supposed to do, it will be alright." (Phil)

"Even if he starts troubling you it will be easier to tell your mother that your boyfriend is doing things you do not agree to." (Mpilo)

Participants reverted to their identity as (black) Zulu parents in a way that made it sound natural and essential that children are dealt with firmly.

"The problem with black parents is that I do not know whether they are shy or what in talking about these things with their children, even about love. I do not want to lie, a person will tell you that they love you only when they are shouting (imitates a shouting parent and everyone laughs in agreement). You see she tells you that she loves you while shouting." (Nu, FGD, young women, Imbali)

The participant added that "our culture does not allow … this thing of sitting down and having a talk with an elder". Participants examined the challenge of African values in relation to age and etiquette, and the respect that should be paid to women. One suggestion made about overcoming the communication barriers was to share the parenting role with other women.

"It is better if you tell your child to go to someone else (Others utter 'mmm...' in agreement). It is hard teaching your child. We are Zulus from olden days, like she has said (pointing at a fellow participant). It is not easy to talk to your child about condoms. How do you even start? Rather have someone else talk to your children for you or their peers (Woman 3, FGD, older women, Caluza)

The extract below suggests that the discomfort was shared by both parents and children:

"X knows my daughter ... she is old but she can never talk to me about her boyfriend. But I know she has one, but she cannot tell me: ‘Mom, me and my boyfriend went and did this’. No, it is hard even if I hint and tell her to go to the clinic to get tested. But I would not tell her straight. I will hint and she also would not tell me straight that she uses a condom, she will just say: ‘Ey mom’, and she gets up and leaves me and I would not chase after her either. We Zulus, our children fear us even if you have not said anything because it is in our blood as Zulus ... respect comes naturally. You can never tell us of such things … tell me about sex, never! Even in the olden day we had amaqhikiza (people who guide women who have chosen boyfriends) that will tell you that: ‘Now, young lady, since you have chosen this you will have to do thigh sex (called soma in isiZulu) and when you soma you sleep with your thighs closed, but even in thigh sex if a mistake happens and it goes inside you fall pregnant.’" (Woman 2, FGD, older women, Caluza)

Parents had fears and anxiety about seeming to be leading their children to have sex. They even considered asking other women to talk to the young woman and take her to the clinic. This would ensure that the young woman maintains respect for the parent. Some participants agreed that being strict with the child did not help.

"Sometimes being too strict does not help ... I am not saying that you should be too friendly towards the child, but you should set boundaries. A child
will stay in a hot situation because she is scared of her parent. I stayed in a hot situation for fourteen years in my marriage because I was scared of my parent. I could not talk to her and tell her I was burning [could not take it].” (FGD, older women, Caluza)

At the member-checking meeting in Pietermaritzburg, parents also discussed the strategy of finding another woman to talk to one’s daughter as a way to deal with the need for parent-child communication on SRHR matters. A similar suggestion was put forward at the Flagstaff and Pietermaritzburg member-checking meetings. Some of the participants acknowledged that times have changed. One said: “There is no fear now; children must be told.” (Phill, FGD, young women, Imbali).

If not opting to use amaqhikiza, some participants suggested that a language that toned down the taboo could be used.

“Like my mother, she does not mention the word love. She says: ‘Who are you involved with?’ even when watching [the TV soap opera] Generations. She refers to love the same way. She says: ‘Oh, Karabo is now involved with Tau’. She never says they are in love, so where would she start with me?” (Mpilo, FGD, young women, Imbali)

Lack of information about SRHR was reported to be behind some of the attitudes that parents held towards SRHR rights and services. Ignorance breeds ignorance and the view was expressed that black people “are not knowledgeable” (Woman 3, FGD, Caluza). This claim to inferior knowledge amongst black people has stood the test of time (Nduna & Mendes, 2010). These findings also communicated a sense that family discord in black communities was rife. Black families suffer the detached and uninvolved men phenomenon resulting in a high prevalence of single maternal-parented families (Makiwane, Makoae, Botsis, & Vawda, 2012). One participant compared black and white families thus:

“The problem is that white people try to commit themselves. Like if there is both
parents, they involve themselves in their children’s lives, but with us black people, the men are just sperm donors so it’s not easy just bringing a partner home. I do not know how I can put this, but a father is a male person, so he will understand that the boy has come with intentions that are … eeish … I do not know how to put this … but our families as black people are not the same as white people’s. The thing is we were raised by our mothers so we do not have any relationship with a father, unlike a white child. Like I am referring to the unity of your family … it is not like white people’s because even when white people are divorced, when they fight for a child’s custody, they plan how the visitations of a father will go, unlike with us black people. It is a woman who stands for everything.” (Nu, FGD, young women, Imbali)

The challenge here is that biological mothers do not always raise children; the grandmothers, who were reported to parent the ‘old way’—meaning that they were reportedly conservative—commonly raised children. The collective experience of single mothers evoked views against early and out-of-wedlock sex if they themselves fell pregnant under these conditions. Participants seemed motivated to change the situation for their own children so that they do not raise children with absent fathers. A similar view explains findings from a recent multi-country teen pregnancy study (Odimegwu & Mkwananzi, 2016). Participants’ strategy, as parents, to change this was to discourage youth sexual relationships.

It is not always the case that mothers in two-parent families deal better in parenting. Research from South Africa records positive attributes and evaluations of single mothers (Roman, 2011). Single mothers need support in raising children, both material and social support. Of course, these self-fulfilling prophecies and ideas about black parents as unable to communicate with their children due to age-respect-culture were contested also.

“Don’t say ‘black people’; don’t include all of them because there are some who are knowledgeable.” (Nkuli)

“What do you mean when you say that black men are sperm donors? Because even white people sometimes they impregnate someone and then leave. Are you saying white people are better?” (Nkuli)

“Most, most, they have a balance; most white children are raised right.” (Nu)

“I do not know why we black people cannot do the same.” (Mpilo)

“Black people do not like to be at the top of the game.” (Nkuli) (FGD, young women, Imbali)

This was a conversation among young women. Sometimes the basis for the disagreement and arguments to deconstruct this image of black people was hypothetical.

“Us black people are not the same. There are black people who do as white people do, but there are some who do not do that, like me, I can bring my chikita … [referring to girlfriend] home and introduce her as my partner.” (Nkuli)

“Have you ever introduced your partner to your family? (They all laugh.) (Mpilo)

“Oh please, I am making an example.” (Nkuli)

“Yes, but have you introduced her?” (Mpilo)

“They know her.”(Nkuli)

“And they accepted her?”(Mpilo)

“Yes, but she is scared of them, but she has been home, but she is scared of them.” (Nkuli)

“Now you are telling us a tale.” (They all laugh.) (Nu) (FGD, young women, Imbali)

Participants here, as elsewhere, discussed the right time to start giving sexuality education to children.

“It should start when they are still young. They should not wait for them to be eighteen years old because you cannot start that conversation at eighteen.” (Phil)

“They should start at ten when they are still young.” (Nkuli)
"Not just with girls, boys as well." (Ayanda)

"Yes, because they start dating in grade five." (Nkulii) (FGD, young women, Imbali)

The women at the Mpophomeni FGD, who were young parents themselves, disagreed on the influence that they should have on their children. Some participants had their children when they were teenagers and held a view that parent-child communication was good to prevent experiences similar to theirs.

"Sometimes a parent and a child talk and the parent would advise the child and tell her wrong and right things, so actually if you are a child, whether girl or boy, you should talk to your parent ... be open with your parent and she should also tell you a wrong and right thing ... “ (Sisi)

"No, for me, I grew up living with my grandmother and she would never say anything. Now I am talking on the note that these kids that we have. We must be able to talk to them so that they would not fall pregnant at an early stage like us.” (Sisi)

"Like me, you see, I have got two children. Maybe if my mother was able to talk to me about things, maybe all of this would not have occurred, maybe I would not have had kids, but my mother hid things from me... I asked her why is it that my friends go on their periods and I do not? I had my first period when I was 22 years ... and my mother was scared to talk to me about the periods issue. She never told me that to go on your periods you will undergo such stages like growing breasts, but I had to look at my friends and I wondered why do they have their periods? Why do they have boyfriends? Is there something wrong with me? Do I need to go on my periods to have a partner? Even when I had a partner I did not know that I had to prevent and condomise, no. All I knew was that if I go to a man he has to touch me and then I have to open my vagina and we have sex, you see? Mistakes occur like that, it starts with parents.” (Mbali) (FGD, young women, Mpophomeni)

Preference for styles of communication was for authoritative rather than authoritarian communication as the latter was viewed as ineffective.

"And you should not shout at the child but rather talk nicely and she will do what you want her to do, and she will be open with you and even tell you about other things.” (Sisi, FGD, young women, Mpophomeni)

"Then that means there should also be a workshop that will focus on parents to create that relationship with their children.” (Nu, FGD, young women, Imbali)

"That is why there should be workshops for women or forums so that they can talk about these things, you see?” (Phill, FGD, young women, Imbali)

Whilst there are challenges with parent-child communication in South Africa, to frame this as a race issue inadvertently creates problems. There are other coinciding social and political factors that distinguish black and white people in South Africa, chief amongst these is class. Hence, the difference maybe at a latent level and manifest as a cultural problem for a group of people racially categorised as black.

Parents' role in SRHR realisation

Parents have a bigger role to play in terms of assisting their children to realise their SRHR. This role was understood as to protect the child and this was conveyed as potentially possible through instilling discipline. One young woman suggested that parents needed workshops on the rights of children. “The way that they act shows that they are not educated. We are in a mess because of our parents.” (Mbali, FGD, young women, Mpophomeni). Some said that some parents had already started to do this.

"Other parents take their daughters to the clinic for family planning and sometimes you find that there is a circumcision programme and parents
come in to sign agreement forms for their sons to undergo the process. You see that sort of thing.” (Sisi, FGD, young women, Mpophomeni)

In other contexts, when parents take the child to the clinic this takes over the child’s decision-making power and autonomy and it could be interpreted as bordering of parental psychological control. This approach is not recommended for its negative impact on children’s healthy adjustment to young adulthood (Roman, Anja, & Donavon, 2012). However, given the challenges that young people sometimes faced with service providers, perhaps this might help in this context to enable better access and young people might feel confident to access these services when supported by their parents.

There were contradictory views on the principle and the extent of involvement of parents in their children’s decision-making and use of SRH services. This was linked to parents being permissive and thereby driving their children to have sex. Of course, participants’ views on this conflicted as well.

“I would like to ask on the point where parents accompany their kids … does that not encourage kids to take advantage and do as they please since they do family planning? Does that not encourage the child to go out there and have sex, because now mom has granted me the right? She tells others that she has been taken to the clinic so now she is free to do it?” (Zandile, FGD, young women, Mpophomeni)

Others objected in defence of those parents.

“It is not because they mean to encourage, but it is because they notice the signs. Maybe a child has started on disappearing acts around evenings, maybe they even go to bed without knowing where the child is and when she returns and asked where she has been, she claims to have been playing at a friend’s house, and when they confirm at that friend’s house they point another friend’s house. So parents do that to protect their child from such situations. At least she should not have a baby. But another person may look at it in a way that maybe we are encouraging them.” (Andile, FGD, young women, Mpophomeni)

Those who held contradictory views believed that parental involvement to this extent might inadvertently encourage early sexual activity. However, this was dismissed by some who advocated for parental involvement.

“I also think that the correct way is that if you go to the clinic, nurses should not tell the child what the injection is for … (they talk simultaneously). She should just think of something else to tell the child as a nurse.” (Mbali, FGD, young women, Mpophomeni)

A discussion about child discipline here, and in all the other sites, evoked a discussion about children’s rights as an unwanted interference in parenting. The main right that parents seemed to be in disagreement with was the right to protection and dignity for children. It is against this right that corporal punishment is deemed undesirable in South Africa and child abuse is criminalised under the Corporal Punishment Act 33 of 1997, Section 10 of the South African Schools Act 84 of 1996. However, one participant said that “these rights are what’s killing us” (Sbongile), to which another asked: “How do rights kill you?” (FGD, Mpophomeni)

At the same time parents in another FGD reported feeling helpless.

“We have too much pressure because if you hit the child government will send you to jail, whereas I am the one who feeds and pays for school fees and everything, but if I get angry and raise my hand, I’m the one who ends up in prison and my child has rights in my house. I do not know what is what these days … we cannot do anything!” (Woman 2, FGD, older women, Caluza)

This discussion was focused on corporal punishment. There was no agreement on this as some participants were in favour of the legal ban
on corporal punishment whilst others felt that it took away parents’ effective tools to discipline.

Media exposure, role-modelling and overcrowded living conditions were identified as challenges and factors that influenced early sexual debut in children. Participants who were parents also saw their responsibility for controlling media exposure.

“These movies that we play, they watch them while we are at work. Sometimes you play a movie that you are not supposed to watch with a six-year and a seven-year-old child, all these [soap operas] Generations, Bold and so forth. We as parents should not allow small children to watch movies. They shouldn’t watch because movies have age restrictions. They write at the bottom according to age stages, sixteen and thirteen. So we as parents must try a way, I don’t know how … (all exclaim ‘mmm…’ silently).” (Women 1, FGD, older women, Caluza).

“It was not only exposure to sexual content in the media that worried parents but also exposure to adult’s sexual activities.

“And since we live in one-bedroom houses and we have naughty habits. Maybe you share the same bed with your child and her father or maybe she sleeps on the floor. You might think she is snoring and then start having sex with her father. She will be watching peeking beneath the blankets and she watches everything that you do, and the way we talk … you speak vulgar language in front of her she hears you … (and the phones!) … and these phones we buy them (yes, the phones, my sister).” (Women 7, FGD, older women, Caluza)

A similar concern was raised in the findings from the Flagstaff site. It is true that most children in South Africa tend to be raised by single parents, and single parents are predominantly reported to be mothers (Roman et al., 2012). Despite the challenges with space and not being married to the father of one’s child(ren), there was a sense that parents should be responsible with their own sexual expressions so as to afford their children good role-modelling.

“Yes, foods like cheese, eggs, foods we were told not to eat when we were growing up as young girls. A young girl was not supposed to eat eggs and chicken. It is because our parents knew what it does to a young girl, it makes you hot. Things like Knorrox that the children eat, it is very hard, only God can help us ….” (Women 7, FGD, older women, Caluza)
The myths around nutritious diet and sexual initiation are reported in similar studies from the same provinces (Ewing, Nduna, Rolston, & Khunou, 2013).

With all the difficulties that women believe themselves to go through, when their daughters are married off, they felt that they were short-changed.

“From the beginning the father will blame me and say I am the cause of the situation. Then that’s when the problem starts because when there are ilobolo negotiations he will get more cows and I get only one (all agree). I don’t know how we can change this because I am the one who carries the foetus for nine months and brings her up. I take care of her, I pay for school fees, look after her health as she grows, and I do everything. And as soon as she engages to sex and gets pregnant I am the one who receives bad words that I am the one who corrupted her. But comes a time for negotiations, he gets more cows than me. When children have ilobolo negotiations coming up they tell you straight in the face that they want their fathers and there is nothing you can do about that.” (Women 7, FGD, older women, Caluza)

Parents’ negative influence on their children, as well as their deliberate obliviousness to their children’s risky behaviours, was condemned. Some parents were reported to act in ways that encouraged risky behaviours.

“If she has got the sugar daddy who gives her money instead of the five rands you give her, you cannot tell her to leave him, but at least try. There are parents like that, who do not approve of relationships of their daughters and their partners if a boy does not work, and they choose partners for them even if it means an older person, as long as he has money.” (Phill)

“Some parents are just happy they get plastics (referring to groceries).” (Thuli)

“I have a friend who is a gelempisi (meaning she doesn’t have morals) Enhle knows her, every time when she returned home her mother would say: ‘Do you have umgezaqolo?’ (meaning do you have a cleansing gift) (laughter). And what will you learn if every time you return from a boyfriend, she is asked about umgezaqolo? Yes, because you were not homed you need cleansing (laughter) … We went to her home and as we were approaching the gate, we saw her standing by the door and shouted: ‘As you are coming to my house, do you have umgezaqolo?’ And I just laughed …” (Nkulida) (FGD, young women, Imbali)

“… which means you have to bring back a grocery pack. (Phill cuts in.) This thing goes like this.” (Nu) (FGD, young women, Imbali)

This section highlights an important aspect of the challenges that parents experience with communication about sexuality. The self-fulfilling prophecy of black ignorance is alleged in a study whereas white participants lamented this (Nduna & Mendes, 2010). In this case all the participants were black and their understanding of the challenges faced by their communities was also framed within a similar discourse. This requires concerted interventions to dispel the stereotypes.

Sexual orientation and gender identity (SOGI)
The discussion about sexual orientation (SO) and gender identity (GI) arose spontaneously in most interviews. With regards to same-sex relationships and sexual orientation, here, as in Flagstaff, there was an acknowledgement that it was difficult for parents to know how to respond when one of their children came out about their homosexual sexual orientation. Participants expressed their concerns about this.

“It is still unusual, I would not lie. At times it is hard to accept the orientation of your child. We do not how we can make it possible for us to accept or how we can teach our children in the community to understand different sexual orientations, because you find that at times the children get confused about these things and sometimes they stare and laugh if they see a gay person. We do not know how we can sit them down and talk to them and tell them that
we are not different at all. It is just our choices of lifestyles that are different.” (Woman 1, FGD, older women, Caluza)

“Maybe if there could be things like workshops and awareness programmes to teach us parents about these things, because it is us parents that have a problem. If we see that our children are not like others we hide them.” (Woman 2, FGD, older women, Caluza)

Another participant concurred that great knowledge built understanding and tolerance.

“Actually what has opened our minds in this ward … because as parents we did not understand this thing … at times when you saw a boy walking funny you would say: ‘Ah! there is a faggot!’ But then due to workshops that were held here in this ward by gay people, in time we got to understand how this gay thing comes about. So actually it is the workshops about LGBTIs that helped us because we could not understand when you saw a child walking funny you would use all these unsuitable names. So now we see them at a very young age … how they conduct themselves. You can tell as a parent what they will become. But if my child has a baby then later decides to change her sexuality, she would rather leave my house, leave! I cannot wash panties whereas I knew her previous sexuality. Now in this ward we have learned how it works, with sangomas [Zulu traditional healers/diviners], blah blah blah. We have knowledge now like I even have friends who are gay in my neighbourhood and sometimes when people see me walking with them they would say: ‘What is that walking with mawi?’ That is because they do not have the knowledge that I have. Because of my knowledge, I treat them as my own children.” (Woman 3, FGD, older women, Caluza)

These debates from the participants suggest that there was willingness to learn and embrace diversity. The GLN (Gay and Lesbian Network) could take this opportunity and strengthen its awareness-raising and education projects to the heterosexual and cisgender community. Interventions need to go beyond raising awareness and education to empowering parents with the skills needed to deal with their child who comes out and the society’s reactions to that.

“As parents we need to be taught about these things … to understand and maybe for us to know about their feelings and we could also teach them, because actually this matter is still hard to understand. We should be the first ones as parents to understand their feelings. When a girl child explains that she is a girl but loves other girls, you shouldn’t shout or hit her but sit her down and have a talk about it.” (Woman 1, FGD, older women, Caluza)

In this study, sexual orientation was problematised by some participants and seen as needing a solution in the form of divine intervention. Zama impressed on her fellow participants that divine intervention would not help.

There ensued some confusion about sexual orientation and intersex. Participants from Caluza questioned whether a lesbian could have periods. Since she is seen to be acting like a boy, perhaps she did not have her periods, they said.

One woman asked if “they place it [the pad] in both private parts” (Woman 1, FGD, older women, Caluza). This led to a discussion and argument about whether there were people born with both male and female reproductive organs. Some believed yes and others no. Zama herself, who was knowledgeable about lesbianism, denied that intersex persons existed.

Homosexual relationships were partly accepted. There were misunderstandings of bisexuality as a legitimate form of sexual orientation. On the theme of relationships, lack of understanding of fluidity and variations in sexual orientation and gender identity seemed to create confusion and misunderstanding. Notably, there was a strong negative reaction to what some participants saw as ‘switching’ of sexual orientation, from straight to gay. People who have had heterosexual
relationships and were later in homosexual relationships were misunderstood and dismissed. In one FGD an unidentified voice shouted, “It’s a very bad thing [when] you know someone as a boy and then suddenly he is a girl!” Another said: “First you have a child then suddenly you become a lesbian, how?” (Woman 6, FGD, older women, Maswazini). Another woman in the Caluza FGD spoke the difficulties people have with people who ‘change’ their sexual orientation.

“Here at ward 20, we live with them and we accept them and we take them as our own children. When we call them, they respond ‘Ma’. However, the ones that we do not like are the ones that have children and then suddenly decide to be homosexual. We do not like those. We want the ones that grew up not hiding their sexuality because as parents they grow right before our eyes. We see the way they act and the way they do things. It is obvious to see. When boys play, you can tell when a boy child does not want to play with them but would rather play with girls and play with dolls. We welcome them with our open arms a hundred per cent.

Here in our ward no one can say they have experienced ill treatment or abuse because they are misunderstood. We do not like people who change after having a child. We do not like people like that, who decide to change their identity (someone who has children and then comes out as gay) … She is hurting herself and her children as well, because the child will become a joke amongst other children at school. They knew a child’s mother as a woman and then suddenly she is a guy and loves another woman?” (Woman 7, FGD, older women, Caluza)

This discourse, that assumes that people ‘suddenly decide to be homosexual’, ignores the fact that for a long time sexualities that are not heterosexual have been marginalised. In South Africa, homosexuality was decriminalised only in 1996 (Croucher, 2002). Despite the decriminalisation there is still a lot of intolerance and abuse towards lesbians and gay people. Hence, some choose to hide their real sexual identities, suppress their attraction to same-sex persons until they feel safe to disclose it, and thus risk being seen as living ‘bisexual’ lives or changed lifestyles.

There were different sets of information and beliefs held by different participants. These went hand in hand with multiple hypotheses about sexual identity and sexual orientation. Among these was the view that people are socialised into being gay and that their sexual orientation can change.

“I have a gay brother … and I told him to drop this thing and he agreed to but he hasn’t stopped. He acts as if he has wings when he walks down the street. You should see him! (Participants all laugh and some mumble inaudible words).” (Andile, FGD, young women, Maswazini)

This belief that one can ‘drop’ being gay can dangerously fuel the misconception that people are ‘recruited’ or choose to be gay. This discussion created opportunities for unlearning of old knowledge and learning new information, based on evidence that could lead to attitude shifts. This is one advantage of the FGD as a data-collection method. References to the bible and a curse were also made here, as in Flagstaff. However, there was less gay-bashing and no reference to homosexuality as being un-African at all.

“We will not judge them much because when another person grows up, sometimes they have this thing that you know you are a woman but sometimes wish to associate with men. They get that feeling that you just wish to act like a man.” (Woman 12, FGD, young women, Maswazini)

Explanations of why people ‘turned lesbian’ were used to justified the ‘deviance’. It was reported that women’s disappointment in relationships with men resulted in lack of interest in men. In an attempt to make sense of this some participants said:

“A woman has much more love to give than a man. They sometimes seek love from other women because of suffering too much from men or maybe she is tired of men.” (Balungile)
“Listen, you know what causes women to change their sexuality? (Others agree, eager to know.) It is the treatment they get from men. When people decide to be gay they do not hide that they are in love, unlike you when you love a man you show him that you really love him but at some stage he will retract and goes and dates someone else. But gays have no problem when they are in love. They show each other that they are in love (some of them laugh).” (Woman12)

“She is right, gays have no problem, and they do not have any troubles.” (Woman6)

(FGD, young women, Emaswazini)

There was also recognition that lack of social acceptance might force others to live in the closet and subject themselves to family pressures.

“Maybe that is not the kind of life he wants to lead. Maybe he is gay but he lives that other life because he wants to please the family. They pressure him into getting married, so he is looking for a hideaway (interjection: no, he also wants to be with a woman). That is why there are people called after-nines: at night they date men and during the day they date women (interjection: there are after nines? No, they are just selfish there is no such thing. This sort of thing exists). It’s wrong if they tell children to call them fathers. They are feeding children wrong things, but other than that this sort of thing exists. People who do it all, they have sex in every way. No, that is wrong. It is just being bitchy. No, they are generous. They never say no to anyone. They are generous.” (Zama, FGD, older women, Caluza)

One of the participants shared proudly that she had twice dated a woman. Asked if her sexuality was “mixed”, she said:

“No, that is never the case at all (they all laugh and exclaim ‘Ha!’). You take it as a joke but your partner … you can see that they are serious because even when I bump into her in town I can see that she is still a boy, but then my feelings are more focused on men because I am a woman and I did not carry on.”(Khetiwe, FGD, young women, Maswazini)

Societal expectations of men and women based on sex, gender and one’s gender identities and roles informed some of these discussions.

“In Greytown there is a person who is a lesbian. She is a woman. She has breasts and everything … so she moved to Pietermaritzburg to work. She worked with us in Richmond and she dated women but when you looked at her, there was nothing manly about her. She even had a soft voice. No, she was a woman trying to be a man. She has breasts like yours. She even has her periods.” (Gugu)

“So would we say that is natural or she changed?” (Slindile)

“Some fake it. I would say she was a fake because where she grew up, she was treated as a female. They even called Sis’Yenzo, but when she got this side, she is a male (chuckle). She grabs women and dates women, does all sorts of things.” (Gugu) (FGD, young women, Emaswazini)

The focus in this example is on one person dating women and takes away the involvement of her female partners as lesbian as well, and thus proving the existence of a lesbian community rather than exceptionalising ‘her’. In this view, only a male-bodied person should date a woman. The idea of a woman dating another woman destabilises this heteronormative order. As such, that female is seen to be ‘trying to be a man’.

Even normative dating activities, such as sharing gifts, were questioned in lesbian relationships, as if these should not be happening. Gugu expressed shock that “in a workplace they will even buy each other gifts” (FGD, young women, Maswazini). This statement seemed to suggest that there are different expectations of people in same-sex relationships: they are not entitled to the heterosexual ways of courting.

A discussion of positive aspects of being gay ensued and some of these were contested.
These were about safety against pregnancy, safety against HIV (for lesbians) and abuse-free relationships. One participant said: "It is good a man dates another man and a woman dates another woman. They lead a good life and they have each other unlike us ... we get abused" (Women 13, FGD, young women, Maswazini).

It was evident in these findings that homophobic attitudes from clinic staff interfered with access to reproductive health.

“Yes, say you are a [butch] lesbian, you cannot go the clinic and say you want contraceptives because nurses are getting a picture of a boy. They can see that it is a girl, but leading a boy lifestyle, and if you go there looking for contraceptives they get confused: that how does it happen? What do you need it for? Then that leads to people being scared to go to clinics because of judgements they face, and in gay people as well. If they have piles they fear going to clinics and have to show nurses, because in the clinics they don’t have homosexual nurses who are supposed to attend to homosexuals only. A nurse … you would [explain] that you want to sleep with your partner but you have piles. Since a nurse has to see the problem first before treating you, you see that you cannot just walk in the nurses’ room and show your bottoms and your piles. You try other means first … maybe lower certain foods or apply an ointment, maybe try the help of someone who has had that same problem before. Maybe if clinics and hospitals could appoint an individual to look out for gays and lesbians, someone with an understanding of homosexual lifestyle … maybe they can take a look at you first, maybe even take pictures and then go to show them to a nurse so that the nurse can see what kind of sickness you are contracting. She may even tell if you do not have piles … maybe you went rough on the sex … that would be better.” (Zama, FGD, older women, Caluza)

In this example the client could be bisexual, and we learnt how bisexuality is frowned upon and the least understood in this community. Clinic staff attitudes need to be changed through consistent and repeated training to encourage health-service use by affected and especially minority communities.
4. CONCLUSIONS

This study aimed at exploring the views, perceptions and experiences of the community with regards to SRHR. These views and experiences are assumed to influence access to SRHR services. These findings confirm that views and experiences reported by the participants are greatly shaped by and intertwined with cultural and religious beliefs. Inequity in terms of access and experience was related to lack of uniform access to sexuality education and differences in application of service norms and standards. While the basic education Life Orientation school subject offers some lessons on SRHR, the delivery is sub-optimum, leaving many young people who pass through the school system ill-equipped in the attainment of these rights.

Across the greater Pietermaritzburg sites, there were challenges related to pregnancy and paternal acknowledgement. There was an assumption that people who drank in taverns were more at risk of sexually transmitted HIV infection. Whilst there is a grain of truth in this, it should not create a sense of invincibility for women who do not visit taverns regularly, or fuel stigma and a ‘deserving victim’ label for women who drink alcohol.

The need for a variety of condoms to be publicly available, the demand for flavoured condoms and for female condoms should be addressed. This research proves that contextual factors are important in facilitating more education on condom use with the aim of increasing condom-use efficacy. Marriage and intimate partner violence seemed to be the main barriers to condom use.

There was subtle homophobia expressed by nurses, as reported by the participants. For instance, it was deemed homophobic for nurses to ask a lesbian client about her male partner when it is known in the community and the clinic that she is a lesbian. This was experienced by those affected as rude and insensitive. There was also evidence of ‘progressive’ homophobia from the general community, for instance, the conditional acceptance of gay people.

Longstanding worries about body-shape changes as a result of use of hormonal contraceptive were also expressed here. This means that more education about this is needed so that people come to know the effects of pubertal changes versus side-effects of contraceptives, two phenomena usually experienced at the same time. The popularity of the ‘barcode’, referring to implants, as well as the concerns about its side-effects, cannot be ignored.

Gender-power inequality meant that women could not express their concerns in fear of infuriating men or ‘causing him to be violent’. Chief amongst causes of relationship conflict was that women should not make men wait to have sex if they do not want to lose them, otherwise they will go somewhere else to get sex. A perception that relationships should be transactional was harboured by parents as well, who found it appropriate for their children to date a partner who would provide them with money.

A different take on race relations is needed in the media, as media tends to portray white families as being able to deal better with communicating about relationships with children. The perceptions that black people do not know how to deal with these was juxtaposed with ‘perfect’ white families, where there is a mother and a father. Where there was recognition of challenges with absent fathers in the black community, this was regarded as part of the reason why parent-child communication about sexuality was lacking. Black parents were said to express love through shouting, while white people were reported to employ open and effective communication. Even when black parents wanted to talk, they did not know when to start conversations with their children. This was coupled with the perception that black people were not knowledgeable, attributing ignorance to being black or African, rather than to a lack of access to IEC about SRHR.
5. RECOMMENDATIONS

SRHR education
The interventions should focus on educating the community about STIs, including dispelling myths about condom lubrication being a prophylaxis against STIs.

Advocacy for the female condom, dentals dams, lubricants and other commodities needed for safer sex for LGBT-identifying persons is needed. Information needs to be made available in local languages, hence, the need to develop local language competency in translating scientific jargon to simple indigenous languages for education purposes.

Given that most South Africans, despite of the rural/urban divide, have access to radio and television, it is worth advocating for more appealing programmes on SRHR to be aired, especially during prime time.

Parent-child communication (PCC)
Socialisation, in particular role-modelling and communication, was reported to have an influence on young people.

Adults need to be supported in these and communication should be directed at both males and females.

Parents will need additional support with addressing aspects such as Choice of Termination of Pregnancy (cToP), homosexuality and condom use, as these seemed to be rather difficult subjects for them.

Challenging stigma, stereotypes and social behaviour
Stigma and discrimination against HIV appeared to influence status non-disclosure and these need to be addressed. Alcohol was identified as a driver of HIV and GBV.

Interventions aimed at responsible drinking, as well as debunking gender stereotypes around alcohol drinking, would be useful. The same may go a long way in addressing HIV stigma, especially for women who drink alcohol as they seem to be subjected to multiple forms of stigma.

Access to contraceptives
Access to SRH services and in particular the choice of contraceptives needs to be increased through youth-friendly clinics that are adequately stocked.

Autonomy and agency, especially for young people, needs to be fostered.

Intersections of cultural norms and socio-economic realities should be addressed in SRHR interventions.
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