http://socialwork.journals.ac.za/
http://dx.doi.org/10.15270/40-1-351

Ackermann L

THE DANGER OF HIV INFECTION FOR GIRLFRIENDS AND WIVES

Ms L Ackermann is a Lecturer at the Department of Sociology, Faculty of Humanities, University of the Free State.

AIM OF THIS STUDY

Any social scientist hopes to make a contribution, albeit small, to the improvement of the lives of people in society. In the light of the fact that, to date, no cure for HIV has been discovered, prevention remains crucial and strategies to prevent the disease are urgently sought. Studies that help uncover the social dynamics that underlie HIV transmission are valuable to the social sciences – social work in particular.

The aim of this study was to explore the underlying social dynamics that make women vulnerable to HIV infection. Issues such as the reasons for engaging in (unsafe) sex and the types of relationships that these women were involved in were also investigated.

METHODOLOGY

This study was conducted in Bloemfontein[1] with a sample of HIV-positive women who reside in this area. The participants were selected by means of purposive (non-probability) sampling. A qualitative approach was followed and in-depth semi-structured interviews were used to gather information. These interviews were tape-recorded and later transcribed and translated into English. The transcriptions were then studied by the researcher. The researcher analysed the data by organising them into categories on the basis of themes, concepts or similar features.

ETHICAL CONSIDERATIONS

It is every social scientist's ethical responsibility to ensure that the participants in his/her study are not harmed in any way. This is particularly true in research involving HIV-positive people. Apart from being stigmatised within the community, many HIV-positive people have expressed the sentiment that they are regarded as nothing more than guinea pigs that are researched and discarded. In order to protect the participants in this study, the researcher used the Human Sciences Research Council's (HSRC) code of ethics as a guideline when conducting the research. The following principles of the HSRC (1997) were adhered to:

- *Informed consent* - Although the HSRC recommends getting the participants' consent in writing, many participants were not prepared to sign their names in order to protect their identity. The participants were, however, fully informed about the nature and purpose of the study and what the value of their contribution would be. Participants were welcomed and encouraged to contact the researcher if they had any queries or misgivings about the study;
- *The participants' right to refuse to participate* in the study and their right to withdraw their participation at any stage was respected at all times. No respondent was forced to take part in the study. Participants were repeatedly made aware of their right to refuse to take part and

[1] A city in the Free State Province of South Africa.

http://socialwork.journals.ac.za/

http://dx.doi.org/10.15270/40-1-351

were also informed that they were free to stop the interview at any stage if they did not wish to continue (with no effect on their remuneration). This was also communicated in a covering letter to each participant;

- *Confidentiality* - The interviewer pledged to hold the identity of all participants in the strictest confidence, never to repeat it to anyone but the researcher, who is also bound by a pledge of confidentiality. The researcher was convinced that the interviewer, being a qualified nurse and an individual who is sensitive to the needs of HIV-positive people, is absolutely trustworthy in this regard. Relating to the aforementioned, respondents' names were never mentioned and they cannot be identified by outsiders in the research report.
- The HSRC also recommends that no financial or other inducement should be offered to participants to ensure a particular research result. However, they state that participants may be rewarded, on condition that all participants are offered similar rewards and that such rewards are related to the sacrifices required of them to make their contribution, e.g. transport costs, meals and token of appreciation. In this regard participants were paid R100 each as a token of appreciation for their participation and to cover all costs the interview may have incurred.

Because of the nature of the sample and the focus, generalisations to the broader population cannot be made. The information does, however, reveal something about the particular group of wives and girlfriends that were studied and gives an in-depth glimpse into the total picture and forms the basis for future research.

PROFILE OF PARTICIPANTS

The ages of the participants ranged from 19 to 46. The home languages of the participants were one of the following: Sesotho, isiXhosa, Setswana and English[2]. Two of the participants were married, one was divorced and the rest were single or cohabiting. Only two of the participants were employed by a business, one was self-employed and the rest described themselves as unemployed.

FINDINGS

Lack of information about HIV

The women's lack of specific knowledge before they acquired HIV became evident from the interviews. The message that HIV is a dangerous disease seems to have filtered through to the community and is reflected in statements such as: *"I did not know much about HIV, I only used to hear people saying HIV kills people, especially when they are drunk talking about HIV." "I had little information, what I knew was that it kills." "I knew it was fatal and incurable".* The way to prevent it or the actual details regarding the virus, however, seems to be unclear: *"I only knew there was such a virus from other people but I didn't know its effects on a person's body." "No [I didn't know about the virus]. I always heard people talking ... they said HIV was infectious when you sleep with a person."*

Although it is important to stress the serious consequences of the disease, the specific actions that cause transmission need more exposure. Another perception held by some of the women was the

[2] *One* woman came from Zambia, but did not specify what her home language was - she participated in English.

http://socialwork.journals.ac.za/
http://dx.doi.org/10.15270/40-1-351

stereotypical view that HIV only affects promiscuous people and that being in a stable relationship somehow protects one against HIV infection.

"I had knowledge, but I believed I would not have it. I thought only people who do bad things will contract the virus. I even used to point fingers and say 'so and so does this and he has this'… I never thought I would be affected because I told myself that I don't do those things…I thought it only affected promiscuous persons."

"I knew that when you have many boyfriends/men, it could affect you and that when you have a man living with you, you wouldn't be affected. I trusted the man I lived with. I knew he loved me and that he would never do that to me. I didn't even worry about using a condom because I trusted him."

This corresponds with the Demographic and Health Survey which found that 87,4% of respondents believed that staying faithful to one partner would protect them against AIDS (Department of Health, 1998). Mutual monogamy is important and it is misleading to encourage monogamy without emphasising that *both* partners must be monogamous.

Type of relationships

The type of relationship that the women were involved in revealed the following four aspects: firstly, their relationship with the person they acquired the disease from was a stable relationship in terms of duration; secondly, the majority of relationships were loving relationships (with two exceptions); thirdly, almost all of the relationships were characterised by infidelity; and fourthly, there was a lack of open communication regarding sexual matters within the relationships.

- **Stability of relationships**

All the women in the study reported that they acquired the disease from their intimate partners (boyfriends/husbands). The shortest time of sexual involvement was 3 years and the longest 9 years. This corresponds with the assumption that people are engaging in sexual intercourse at an early age, marriage is being postponed and stable pre-marital relationships do exist. This corresponds with global trends, where marriages are being delayed and cohabitation is increasing (Gelles, 1995; Benokraitis, 1996). The relationships in the study were not one-night stands and it is inevitable that after a certain time a measure of trust (or rather the expectation of trust) develops in the relationships, which ultimately puts the partners at risk. Le Beau, Fox, Becker & Mufune (2001) assert that for many people the length of the relationship seems to function as a guarantee against contracting STDs, including HIV. Two women acquired HIV from their husbands to whom they had been married for 7 and 13 years respectively. Trust also characterised these relationships, perhaps more so than in the case of those in a dating relationship.

- **Nature of relationships**

When asked about the nature of the relationship, most of the women indicated they were involved in positive relationships. The overwhelming sentiment expressed by the women was that they were involved in loving relationships where the men showed their affection.

"He used to phone me because he was working at Klerksdorp and whenever he was home he would visit me first and he was loving and doing everything for me I needed."

"... he was supportive, whenever I had problems he would help me."

http://socialwork.journals.ac.za/

http://dx.doi.org/10.15270/40-1-351

"It was filled with warmth. He cared a lot and I said, 'this person loves me'. So I also didn't want to hurt him with anything… He didn't want to do things that might hurt me. That is why I think it was hard for him to tell me that he had the virus."

"I have good memories, I feel like we could be together again and continue with our love."

"It was wonderful because there was love. I think he knew that I loved and trusted him even though he gave me the virus. He did all the bad things [infidelity] knowing that I would forgive him, because love overshadows many things."

"He never beat me. Whenever there was a mistake, we talked about it and we both begged for forgiveness."

"He loved me. His actions also showed his love."

What is disturbing is that a natural, loving relationship held the danger of infection. These men were not monsters or rapists; they were the husbands and boyfriends of these women. It is within loving relationships where people do not anticipate a threat and are therefore unlikely to protect themselves. Most people regard sex as a natural, satisfying part of an intimate relationship. In this lies the greatest potential for the spread of HIV. It is difficult for people to change behaviour at the best of times, but even more so when the behaviour does not seem threatening or when people do not perceive themselves to be at risk.

Another interesting aspect is that two women equated their love with the presence of children: *"We loved each other a lot to the extent that I had his child…". "We share a child together."* Because of the importance placed on fertility and the idea that to share a child somehow connects one to another person, it is not surprising that these women believe that having a child expressed love and commitment.

Apart from the more positive aspects of the relationships, the following negative aspects were present. Some of the relationships involved physical and emotional violence. The men in these relationships clearly have more power than the women, even to the extent of engaging in assault and the removal of a child (which surely has legal implications).

"...he used to hit me with his fist or throw me with stones...he still comes to me and tells me that he has changed and that I should go back to him, he says everything will change...I've realised he would never change…".

"His people wanted to make things bad between us. They wanted to bring conflict between us. At some moments when we had a disagreement, he would take our child to his parents, knowing that I would go after him."

Another negative aspect was the family interference on behalf of the husband. The quotation above expresses this as well as the one that follows. These were the words of a woman who said she was in a customary (lobola) marriage with her husband:

"I thought of how my husband was like before he died. His parents didn't even want to inform me of what was happening...I wasn't allowed to go with him to the clinic/hospital. But finally his brother told me that the parents think I bewitched their son, but that he is actually HIV positive. I started to worry...especially when I lost weight because he also started losing weight. I thought it might be TB, but unfortunately the nurse at the clinic said I was HIV positive..."

His parents had such power that they could even refuse her access to her dying husband. This woman also did not feel that she had enough power to go against their wishes and see him anyway. This is typical of a patriarchal society, where the wishes of the husband's family take precedence

http://socialwork.journals.ac.za/
http://dx.doi.org/10.15270/40-1-351

over those of his wife. What was also revealed was that somehow it was the woman's fault that their son fell ill and that she "bewitched" him. This confirms findings by LeClerc-Madlala (2001) that HIV/AIDS can lead to the increasing marginalisation of women because they are blamed for the spread of the disease.

However, despite these negative aspects, the impression was that for this particular group a loving relationship was dominant.

- **Reasons for engaging in sex**

An important aspect of the study involved investigating the reasons for the women engaging in sexual intercourse with their partners, keeping in mind the many coercive factors that may directly or indirectly force women to have sex. The overwhelming response was simply that they loved their partner. This corresponds with findings that young women usually engage in sex in order to please their partners and for the sake of love (Brannon, 1996; Mbananga, 1994). The whole idea of love and a loving relationship was also emphasised in the discussion about what type of relationship the women had with their partners.

" I felt like sleeping with him because I loved him. He never forced me into it."

"Its because he asked me to sleep with him…I loved him dearly."

"I believed it was something that… it was something that must happen between a man and a woman."

"I got it from someone I trusted, I loved him and respected him. I never thought he would love someone else besides me."

"He told me how much he loved me and that he was going to marry me and I also loved him."

"It was because of love."

"We trusted each other and he was a nice person."

Some of the women did, however, indicate that coercion was involved in the sexual relationship. Indirect coercion such as threatening to find someone else and direct coercion or rape occurred. What was not pursued in the interviews was whether or not these women actually considered what happened to them as rape (seeing that the rape was committed by an intimate partner).

"He said if I didn't sleep with him, then I don't love him and so he will sleep with other girls…so, I loved him... It was difficult because some people didn't like him. I was the only one who loved him. They had their reasons...but I always protected and defended him because I loved him...I feared him. He used to play tricks on me, like he would say to me 'lets go to my house to get my shoes'. We could not leave before we had sex."

"He worked outside away from me and he would come back with his problems and complaints [STDs]. When I asked him to go to the doctor, he refused. I saw he was taking pills...I started to have my doubts about him. I refused to sleep with him after that, but he forced me to have intercourse with him without a condom."

Once again the politics of interaction come into play, where a powerful or strong person can impose his/her decision or will on the less powerful. The overwhelming response, however, was that love was the overriding reason (forced sex being the exception). Coercive sex exists and is not denied, but HIV awareness must be extended to include those in stable, loving relationships as these women are also at risk.

http://socialwork.journals.ac.za/
http://dx.doi.org/10.15270/40-1-351

- **Trust and infidelity**[1]

Trust was another central idea in this study. This is especially true when the issue of condoms was raised. Several studies have already highlighted the fact that "condomless sex" is seen as a demonstration of trust in one's sexual partner (LeClerc-Madlala, 2001). In this study the women stated that they trusted their partners and therefore did not use condoms.

Most women, however, mentioned infidelity in their relationships. This was often the only thing that marred what appeared to be good relationships. Unfaithfulness was found to occur particularly when men worked out of town, which is in line with the theory that migratory labour has contributed to the spread of HIV (DeCosas, 1998; Hunt, 1989). LeClerc-Madlala (2001) points out that women continue to accept that men have numerous partners and the men seem to regard numerous partners as part of a cultural norm; this was also true in this study where the indiscretions of the husbands and boyfriends were forgiven.

- **Lack of openness when talking about sex**

There was a general lack of openness when communicating about sex. Harrison, Xaba, Kunene & Ntuli (2001) refer to several studies that emphasise this lack of openness and that this is a modern outcome rooted in a tradition where children and parents do not discuss sexual matters. In this regard Paterson (1996:89) states that "… the saddest thing of all is this: that with all the paper, screen and celluloid sex that goes on in the media, there is considerable evidence that for the majority of families, in all parts of the world … talk about the *reality* of sex is virtually taboo". What is interesting is that while girls do not appear embarrassed about discussing sex with each other (Harrison *et al*., 2001) and men will discuss sex with men, a transgender and trans-generational embarrassment appears to exist. As a result young women and men are ill-informed, subject to peer pressure and cannot communicate their needs and wishes to their partners.

Communicating with men about sex was particularly difficult for the women in this study. The women indicated that they were embarrassed to talk about sex and they could not communicate with men because they are unapproachable (the same men whom they had described as being loving and caring). The women did not feel that they could speak openly with their partners and used words such as "afraid" and "scared". This may be because it would be breaking a norm that suggests that it is inappropriate to discuss sexual matters with someone of the opposite sex.

"No, we don't [talk to men about sex]. Especially black women. We just do what the men tell us to do…we think that a man is the only one who has the right to decide and to guide the marriage. The only one who can think. We were taught that a man is a man. Even when you want to tell him that you love him, you are afraid to do so because of what he might say."

"No, it's not easy…It's because women are scared of sitting down with men and discussing these things."

"It is not easy because we are ashamed of talking about those kind of things."

"No it is difficult. Look, now I am afraid to tell my boyfriend … today I want this, not that. "

"Men never talk about those things with their wives or girlfriends. Yes, they will discuss things like 'I don't find sexual satisfaction in my relationship with others, but never with you'."

This lack of communication also extended to the issue of death and the stigma of HIV. In the following case a dying man could not bring himself to tell his partner what was wrong with him

1 This is discussed in more detail in another article.

even though their relationship was good. At the same time she did not feel that she could pursue the issue, even though she really wanted to know what was wrong with him, and in this case had a right to know.

"Before he died he got sick and during this period of sickness he must have realised something or they might have told him at the hospital since he was admitted. He said there was something he wanted to tell me. He said " I will tell you what's wrong with me." Then I said "What is wrong with you anyway." He said he would tell me all about it when he come home, because he was still at the hospital in Kimberley. When he came, he talked about other things and didn't want to tell me anything. So we never spoke about it."

MAIN FINDINGS

The main factors that contribute to the spread of the disease among this specific group of women are summarised below.

- A lack of information regarding the spread of HIV. Although *the women* knew that the disease was fatal, they were unaware of the detail concerning transmission routes.
- Misconceptions regarding one-sided monogamy. The idea exists that if you are faithful you are safe.
- The misconception that being in a stable relationship protects one from HIV infection (regardless of previous histories and current infidelity). The fact that all of these women were in stable relationships when they acquired the disease emphasises the vulnerability of women as wives and girlfriends.
- The sense of safety experienced in stable relationships puts women at risk as trust evolves and the value of trust translates into the norm of non-condom usage.
- A lack of openness when communicating about sexual matters.

RECOMMENDATIONS AND CONCLUDING COMMENTS

When protecting women and making recommendations in this regard, the model of Ajzen (as explained in Van Dyk, 2001) is relevant. Ajzen asserts that before behavioural change can be brought about, it is necessary to understand (and change) the cognitive structures that govern behaviour. Barring rape or coerced sex, the individual remains the final decision-maker regarding sex. This model states that individuals will only change their behaviour if they: realise the need for change; know what behaviour to change; have the intention to change; have a positive attitude; a support structure; belief in their ability and know how to perform the modified behaviour; perceive more benefits; and have the necessary skills to perform the modified behaviour.

- ### Realise the need to change

In the HIV context this involves the person perceiving themselves as a member of a high-risk group. While sex-workers and people with multiple partners know that they are at risk and have been portrayed as such, the message that HIV threatens all women should be propagated. Many people cling to the stereotypical views that only promiscuous people get HIV/AIDS and that having only one partner somehow protects one against infection. Women must be made aware of the fact that their monogamy does not protect them and that the infidelity and past histories of their partners threatens them directly (no matter how loving and stable the relationship is).

http://dx.doi.org/10.15270/40-1-351

- **Know what behaviour to change**

Talking about safe sex in general rarely affects behaviour and "…the concept 'safer sex practices' is vague and refers to a whole category of behaviours instead of specific behaviour" (Van Dyk, 2001:84). This was true of the women in this study, who had some vague notion that HIV was fatal, but were not equipped with the specific information about transmission and how to prevent it. More specific information dissemination is needed. Many women indicated that one could learn a lot about HIV from the media. In this regard more specific and detailed information could be included in the safe-sex campaign.

Another specific behaviour that should be encouraged is abstinence in girls and boys who are becoming sexually active at a very young age. Although abstinence is often propagated from a religious/moral point of view, the researcher views the encouragement of abstinence purely from a health point of view – particularly in cases where women are being pressured by peers into early sexual relations they do not want. However, the researcher acknowledges the trend of postponing marriages and that in these cases abstinence is an unrealistic expectation for older individuals - hopefully older women would have developed the skills to negotiate and demand safe sex.

- **The intention to change**

Intention refers to all the motivational factors that influence behaviour. This is connected to how hard people are prepared to try and how much effort and planning they are prepared to put into changing their behaviour. Here it is important that women and young girls should be motivated to protect themselves and to carry out certain preventative behaviour. This can be achieved by regular talks at schools and messages from people who are role models. It is important to keep reinforcing the motivation to prevent HIV transmission. In addition to this, it is necessary to reinforce the intention that directly corresponds to the specific behaviour. So although general motivations are important, specific behavioural patterns (such as the advantages of staying healthy) must also be encouraged.

- **Positive attitude**

The attitude of the individual towards the behaviour (be it condom use, abstinence or remaining faithful) must be positive to increase the likelihood that the behaviour will be carried out. Often the attitude towards a certain behaviour is influenced by group norms and expectations. Thus condom use will be negatively perceived if it is associated with infidelity or abstinence will also be negatively viewed if the group norm of sexual prowess prevails. Attitudes are directly related to the subjective norms surrounding the behaviour. The importance of reference groups or individuals in a person's life and the desire to fulfil expectations are relevant, because it is reference groups that maintain certain norms that in turn influence the behaviour of individuals. Recognising this is a crucial aspect in preventing transmission. Peer pressure to engage in sexual behaviour is well known and the study of Harrison *et al.* (2001) reveals that girls encourage each other to become sexually active. In addition to this, pressure to please a partner also leads women to engage in sex or unsafe sex against their better judgement.

- **Support structure**

Peer pressure and the desire to fit in or please others is a part of social life. However, other significant groups can act as opposition to the pressure to have sex or unsafe sex. Firstly, parents should be educated to speak more openly about sex and the dangers of unsafe sex. Secondly, religious groups should inform their adherent about sexuality and how it could be handled. In this regard then, one at least has counter-pressure groups.

http://dx.doi.org/10.15270/40-1-351

- **Belief in ability and knowledge on how to perform modified behaviour**

Having the intention to change behaviour, however, is not enough. People should also believe that they have the ability to perform the desired behaviour. Efficacy refers to a person's belief in his/her ability to control behaviour (Van Dyk, 2001). This is something that is strongly influenced by macro social forces. If a woman does not believe that she has the right to ask her boyfriend to use a condom, or that she has to accept her boyfriend's infidelity, she is unlikely to change her behaviour simply because she does not think she has the power to do so.

Practical ways (e.g. female condom) of increasing the choices women have should be investigated. Studies have shown that use of the female condom has lowered STD infections and that, once tried, women like it (UNAIDS, 2000). The greatest barrier remains the price, as it is more expensive than the male condom.

- **Perceived benefits**

All individuals weigh up rewards and costs when considering behaviour. A woman may find that the costs of insisting on condom usage (arguments, threats of violence) may outweigh the rewards. Or that the costs of abstinence (being rejected by partner and perhaps ridiculed by friends) might outweigh the rewards of abstinence. Individuals must constantly be made aware of the rewards, particularly long-term rewards, of avoiding HIV infection. However, this can only be achieved if women have something to look forward to, such as employment and better quality of life. This relates to the macro level of analysis, where improving the economic status of women should be a priority in South Africa.

- **Skills**

"For an individual to change his or her sexual behaviour may require complex negotiation with sexual partners who may not have the same degree of commitment towards change" (Van Dyk, 2001:90). For girls this means the promotion of life skills by schools and parents teaching their daughters and sons how to refuse sex or what to say to an insistent partner. For women it may mean re-education and role modelling in order to give them the courage to say what they feel without fear of reprisal. On a macro level, the economic empowerment of women will give them the power of financial and personal independence and ultimately more control over their sexual lives.

ACKNOWLEDGEMENTS

Prof GW de Klerk is acknowledged as the supervisor of this study. The author wishes to thank all the HIV-positive women who participated in the research project as well as Ms M Mohapi for conducting the interviews. The NRF is also acknowledged for financial assistance.

REFERENCES

BENOKRAITIS, N.V. 1996**. Marriages and families: changes, choices and constraints**. Englewood Cliffs, New Jersey: Prentice-Hall.

BRANNON, L. 1996. **Gender: psychological perspectives**. Boston: Allyn and Bacon.

DECOSAS, J. 1998. Labour migration and HIV epidemics in Africa**. AIDS Analysis Africa (Southern Africa Edition**), 9(2):10-11.

DEPARTMENT OF HEALTH 1998**. South Africa demographic and health survey 1998 (preliminary report**). RSA: DOH.

http://dx.doi.org/10.15270/40-1-351

GELLES, R.J. 1995. **Contemporary families: a sociological view**. London: Sage.

HARRISON, A.; XABA, N.; KUNENE, P. & NTULI, N. 2001. Understanding young women's risk for HIV/AIDS: adolescent sexuality and vulnerability in rural Kwazulu/Natal. **Society in Transition**, 32(1):69-78.

HSRC. 1997. **HSRC code of research ethics**. Pretoria: HSRC.

HUNT, C.W. 1989. Migrant labor and sexually transmitted disease: AIDS in Africa. **Journal of Health and Social Behaviour**, 30(December):353-373.

LE BEAU, C.L.; FOX, T.; BECKER, H. & MUFUNE, P. 2001. Agencies and structures facilitating the transmission of HIV/AIDS in Northern Namibia**. Society in Transition**, 32(1):56-68.

LECLERC-MADLALA, S. 2001. Demonising women in the era of AIDS: on the relationship between cultural constructions of both HIV/AIDS and femininity. **Society in Transition**, 32(1):38-46.

MBANANGA, N.D. 1994. The social epidemiology of sexually transmitted diseases among adolescents and young adults in Transkei. Bloemfontein: University of the Orange Free State. (Unpublished MA thesis)

PATERSON, G. 1996. **Love in a time of AIDS: women health and the challenge of HIV**. Geneva: WCC.

VAN DYK, A.C. 2001. **HIV/AIDS care and counselling: a multidimensional approach**. (2nd ed) Cape Town: Maskew Miller & Longman.

UNAIDS 2000. **Report on the global HIV/AIDS epidemic**: June 2000 (UNAIDS/00.13E). Geneva: UNAIDS.