

COMMUNICATION ON SEXUAL ISSUES BETWEEN MIGRANT MALES AND THEIR PARTNERS: A STUDY UNDERTAKEN IN RURAL SOUTH AFRICA

Gail Hughes (DrPH), Assistant Professor

Department of Preventive Medicine-Epidemiology, University of Mississippi Medical Center, USA

Thandi Puoane (DrPH), Associate Professor

School of Public Health, University of the Western Cape, South Africa

Correspondence address:

Prof. Dr. TR Puoane

University of Western Cape, School of Public Health

Private Bag X 17, Bellville, 7535, South Africa

Email: tpuoane@uwc.ca.za

Abstract

Introduction: Women stay alone with their children in rural places while their husbands / partners work away from home for varying periods of time. Such fluctuating migration may cause difficulty in communications and may spread sexual transmittable infections (STI) and the human immunodeficiency virus (HIV).

Objective: This study explored ways in which black women in rural South Africa communicated with partners, who were migrant workers, on issues related to sexual matters.

Method: This is a qualitative study where four focus groups were utilized to allow the women to describe their experiences, and to verbalize their feelings, beliefs, and perceptions in this area.

Participants: Four focus groups consisting of six females between the ages of 16 – 48 who had partners that were employed as migrant labourers and do not live at home.

Setting: A rural area in Hlabisa jurisdiction.

Data Collection: An interview schedule with open questions were used to facilitate the focus group discussions

Findings: The women, who saw their partners infrequently, were unlikely to communicate with them about sexual matters, including STI, HIV, and contraception to prevent unintended pregnancy. Poor communication severely constrained the possibility of reducing the risk of these outcomes. Raising the subject could be interpreted as a violation of the trust attached to the monogamous relationships of these Zulu women. The women felt they owed their returning husbands sexual intimacy and refusal was not an option because it was typically countered with force.

Conclusion: The desire and need for sexual communication carried a price that was too high for women to pay. Control of their sexuality was mostly in the hands of their partners, upon whom they were economically and socially dependent. At this point in the HIV pandemic it is important to cultivate and identify the relevant social, cultural and behavioural norms that could reduce risk situations that tend to favour the spread of HIV.

Introduction

Women all over the world are being devastated by the HIV or acquired immune-deficiency syndrome (AIDS) epidemic, with most infections occurring via heterosexual activity with a primary partner (O'Leary, 2000:191). There is an urgent need to understand the social context in which heterosexual transmission of HI virus occurs in regions such as South Africa where the prevalence of HIV/AIDS infections is high (Ackerman & De Klerk, 2002:163; Middlestadt, 1993:297). In particular, we do not know how the "traditional" culture interacts with the colonial legacy, apartheid, and the present day political economy to influence relations between the sexes (Phillimon & Hojer, 2001:107; No authors listed, 2000:27).

The risk may be altered by the ability of the partners to communicate. Failure to voice concern and refusal to consider or even discuss protective measures lessens the opportunity to prevent STI's and HIV transmission (Bajos & Marquet, 2000:533; Hartung, Nash, Ngubane & Fredulund, 2002:533). Furthermore, if one partner is frequently absent, communication is by definition less than optimal (Williams, Gardos, Ortiz-Torres, Tross & Ehrhardt, 2001:133; Gavin, 2000:117; Kim & Kang, 2003:784). This is the situation among many rural women in South Africa, whose husbands work away from home for varying periods, returning periodically. Such oscillating migration may cause not only problems in communication, but also in the spread of STIs brought home by the returning male. Regrettably, initiation of dialogue suggesting condom use in stable,

ongoing relationships may be viewed as a sign of infidelity and carry consequences, such as loss of a partner and financial security (Ankomah, 1998:303; Maharaj, 2001:150; Blanc & Wolff, 2001:15).

Objectives

This objective of the study was to explore the potential of male migration to alter a couple's communication about their sexual relationship. Women in the four focus group discussions provided information about their sexual practices and sexual communication in view of their husbands' periodic absences.

Methods

A socio-behavioural survey, carried out between November 1994 and March 1995, was supplemented by four focus group discussions that allowed the women to describe their experiences in this area and to verbalise their knowledge, beliefs, and perceptions. The use of this qualitative technique enhances and explains some of the relationships and descriptive information obtained in the survey. We present the findings of the focus group discussions related to sexual communication between the partners.

Sample population

Study participation included females between the ages of 16 and 48 years, residing within the Hlabisa jurisdiction, with partner(s) (conjugal or by marriage) who were employed as migrant labourers and not living at home at that time. With the assistance of the local community health worker (CHW), the households within her jurisdiction were enumerated. A list was drawn up of potential women who met the study criteria, and the

candidates pre-screened for eligibility. From this list, women were purposely selected to include different age groups in each focus group discussion.

Setting

This study, conducted in the health district of Hlabisa, in the KwaZulu-Natal region, involved black South Africans, who populate this largely rural area. They live in widely scattered Kraals, and rely on pension remittances, migrant labour, and subsistence farming for money and food. Fifteen functioning community health workers, who resided within a 20-km radius of the Hlabisa Hospital, secured the study area. Each of these CHWs was responsible for about 100 households, working in conjunction with the local hospital to provide basic health care and public health services to those living far away from the hospital and clinics. They visited each household once a month, on the average.

Data Collection

Four focus groups with four to six participants per group were deemed appropriate and sufficient for data interpretation. Group discussions were held in the evenings (as designated by the participants), transportation provided, and refreshments served. Focus discussions were held in the local language, Zulu, and facilitated by an experienced researcher. The discussions lasted one and a half hour. An interview schedule with open ended questions was used to facilitate the focus group discussions. A question, "What does migration mean to you in terms of: communicating with your partner, decisions about when to have and not to have sex,

when to use birth control or other protective measures (condoms) and in coping with daily life activities"?

Data Analysis

The focus group transcripts were translated into English and were then checked for accuracy within the local language, followed by back translation into the source text, Zulu, by two different health workers to ensure accuracy. After each focus group, the study investigator met with the facilitator to compare notes and review group dynamics.

Analysis of the focus group discussions utilised the ethnographic transcribing technique (Maharaj, 2001:150; Blanc & Wolff, 2001:15) allowing for the identification of behavioural trends and assessment of commonalties in individual and group psychosocial and behavioural responses. The facilitator for each group prepared a summary report of the most salient themes following each focus group. After reviewing the transcripts, content analysis was performed. The analysis was conducted within the realm of the survey data, specifically considering sexual communication, as well as history of STI and concern about contracting STI or HIV.

Ethical considerations

The human subjects committee of the University of California at Berkeley, Columbia University, the sponsoring organisation in New York, University of Natal at Durban, and the Medical Research Council of South Africa approved the study. In addition, the local Zulu chief of Hlabisa and the indunas (local council men) gave verbal permission for the study. Keeping all study files and records in a locked file cabinet ensured confidentiality, while the

women only had to give their first name or initials. Each woman went through both a verbal and written consent process. Each participant received a clear explanation of the process and the objective of the study, and could refuse to continue with the study at any point. Participants continued to receive services from the hospital throughout the study, without change, regardless of their decision to continue.

Findings

Socio-demographic characteristics of the participants

Four key focus group themes had been identified. The women's ages ranged from 16 to 48, with a mean age of 32 years. All participants were in long-term monogamous relationships. The older women, over 30 years, were married to their partners in accordance with the Zulu culture and tradition. The younger women were not married to their partners; however, they considered their relationships as permanent. Most of the participants were unemployed and relied on remittances from their partners; however, women supplemented their income by selling vegetables and chickens, and sewing. The number of children these women had varied; the older ones tended to have at least five children, while the younger ones had less than three. More than 90% of their partners worked relatively long distances from home, returning with short to medium frequency (i.e. every weekend to every month).

Key themes derived from the focus groups

1. Women's view of male migration and its impact on their social status

Most of the women reported being satisfied with their existing relationship, and felt that their partner had to go away to work to earn money for the family. Therefore, living apart and not seeing their husbands daily was an acceptable situation. On the other hand, they expressed a common understanding of coping with hardships and taking care of the household while their partners were away.

The women expressed a sense of dignity and pride in being able to survive and take care of their families even with the hardship of their partners being away for extended periods. The younger women did not have much to say about the extreme hardships of surviving alone, outside of monetary dependence on their partners, because they still lived at home with their families and did not have sole responsibility for a household.

Women discussed male migration as a disruptive force in their lives, and their responses depended on several factors: the length of time the partner was away, whether the woman had employment, or whether she received a remittance regularly. In addition, responses of the older women who had been married longer, especially through customary law, tended to differ from those of the younger women who had conjugal relationships. Older women felt their independence was enhanced in freedom of thought and action, and by having increased control and participation regarding the home. Others felt that male labourer migration was a major hardship and that the independence and freedom some felt

was illusory, limited by the woman's ability to generate additional income (and thus have some economic power) and the constraints of the culture, especially in the rural area.

"The money when my husband is away is from ploughing the fields and selling vegetables, and I also sell chickens and get money to buy some food and wait until my husband gives us some money at the end of the month".

2. Women's control over their own sexuality

Most of the women reported having one lifetime sexual partner, and none had ever had casual relationships or lovers; in most cases, their present partner was their only sexual partner ever. In the traditional Zulu culture, women marry into their partner's family and live in the same household as their husband, or live nearby their partner's family. This practice makes it difficult for her to take on other partners. They also believe that they have to be faithful to one partner. They were concerned about the risk of becoming infected with STIs.

Most women mentioned that the men usually decided when to have sexual intercourse, and the women had to submit passively to their needs. They said that they could refuse sexual intimacy with their partners under two circumstances only: i) during forbidden times, such as when menstruating or postpartum; and ii) as punishment for bad behaviour, such as infidelity or being drunk. However, very few women were able to maintain their refusal for any length of time.

Although it seemed that women might be able to turn down their partner's advances at least on a single night, there are great risks in refusing for any sustained period. Women reported that the immediate response of their partner was mainly hostile, and the consensus was that they could not refuse to have sexual intercourse. In all cases when they attempted to do so, the men used force.

In summary, women submitted to their partners for various reasons, but the primary determinants were fear, marital obligation and economic dependency. In addition, men living away from home for an extended period could influence the reactions of both partners.

"Is it really unfair since we are married to have another casual partner when we know that our husbands are working for our families."

"If I suspect that he has had sex with another woman while he was away, on the first day upon his return I just refuse, then after time I agree."

"I refuse when he is drunk because I know he is not going to do it properly. So I just tell myself that I must forget until tomorrow."

3. Perceived risk of STI or HIV

There was common knowledge and agreement among the women that men in the community tended to have multiple partners, for sexual reasons, which was an acceptable norm. The older women were more opinionated about this topic, and indicated that they objected to these multiple partners because of concern about getting a STI or HIV infection. In fact, many women, even those who are monogamous, seemed to recognize that they might be exposed to STI and HIV infections in their relationship. Sixty percent

perceived themselves to be at risk for STI or HIV because of their partner, while a similar percentage perceived their partners to be at risk for STI or HIV.

Although women acknowledged their risk, they felt it was only crucial when there was proof of adultery. This attitude applies to risk of STI or HIV infection and to their partners' other sexual relationships. The health strategies of these women in the rural areas are thus often the result of rational decisions made appropriate to their circumstances. Although the women had no illusions about the possible long-term outcomes (STI or HIV infection, or unintended pregnancy), they were very realistic about the available choices and resources, and apparently were not willing to take action on supposition.

"According to my knowledge, I will know whatever sexual disease that I get it is my husband's fault because I know that he is the only one I have sex with, and I make sure I haven't got casual partners."

"What worries me is that he likes women and cannot live without women and I cannot stop him from that. I am not happy about his affairs due to the sexually transmitted disease, he told me that he couldn't be controlled by a woman."

4. Women's ability to communicate on reproductive and sexual matters

While it is important for a woman to provide sexual satisfaction, in the Zulu culture they rarely initiate the sexual act or discussions on sex with their partners. The men decide on issues related to reproduction and when

to engage in sex, while the women submit passively. Older women in particular felt that it is not their place to talk about sexual matters with their partner. Most married women and those in permanent relationships accepted that their husbands or partners had other women. Women said that if they attempted to talk with their partners about these other women, they would get angry and discontinue the conversation. In addition, the women spoke of the men's casual partners as a known fact, especially because polygamy is practiced and extramarital affairs are accepted in this culture.

In addition to sexual matters, women had difficulty discussing contraceptives with their partners. The reasons include, men wanting more children, especially boys; contraception suggests that women will have sexual freedom; and decision-making power about reproduction. This last reason is of importance, since the husband controls reproduction in the Zulu culture. Eight women disclosed they had used injections without their partner's knowledge.

Most of the women had discussed AIDS or STI with their partner, but only one woman reported condom use, which was for birth control. While none of the participants indicated that their partners had ever initiated condom use, one woman commented her husband pulled out a condom to use once, and then decided that he wanted "flesh on flesh". Reasons that were given for not using a condom were that the partner would be angry or convinced that she was unfaithful, that condoms would harm her (if the condom was accidentally left in the vagina or if they caused an increase in the production of

vaginal secretions), and that they were difficult to use. The women felt that it was important that their partners be in agreement with the use of condoms, including the female condom.

It was different with the younger women. Based on the cultural constraints and gender relations, women felt powerless to take control. By making demands that are unacceptable to the male, a woman risks loss of economic support, companionship, family ties, and social isolation. This risk of loss of her status in the society would be much greater than the possibility of acquiring a STI or HIV from their partner.

"I have asked him if I could use injections but he refused, he said in this family no one is using that. In time he agreed but he said I must rather do a tubal ligation. We have discussed about our family size. About sexually transmitted diseases, we discussed the use of condoms but he refused to use them."

Discussion

Women who saw their partners infrequently were unlikely to communicate with them about sexual matters, which included STI, HIV and contraception, according to this study. Universally, women also have difficulty with sexual discussions, especially in developing countries (Lear, 1995:1311; Crosby, DiClemente, Wingood, Cobb, Harrington, Davies, Hook & Oh, 2002:219; Exner, Dworkin, Hoffman & Ehrhardt, 2003; James, Reddy, Taylor & Jinabhai, 2004:114). Therefore, it is not surprising those women who do not live with their male

partners regularly, are also unable to communicate effectively about such matters.

Poor communication between men and women about sexual and reproductive health affairs severely constrains the adoption of risk-reducing behaviours (Keller, 1996:10; Jewkes, Levin & Penn-Kekana, 2003:125). In the context of long-term and stable relationships, opportunities for such communication may be even more remote, since partners believe that they know each other, and sexual activity is routine. Women found it difficult to raise concerns about HIV and STIs. To do so could be interpreted as an accusation or a confession of infidelity. The relationships of the women in this study have been built on premises of trust, which require partners to accept that they are safe or else admit that the relationship has failed (McQuiston & Gordon, 2000:277). Acknowledging their partner's risky behaviour for preventive purposes may be too painful or threatening, as it raises other problems perceived to be more immediate and menacing than the risk of STI or HIV (Maharaj, 2001:150; Ladebo & Tanimowo, 2002:51). The apparent inconsistency between attitudes and behaviours could be related to power and sexual negotiation. It was reported that women left behind felt incapable of refusing or negotiating any sexual favours requested by their husbands, especially since their spouses had been away for such long periods, working very hard, and had been sending money for the survival of the family. Women felt they owed it to their partners to have sexual intercourse, regardless of how much they feared the consequences, such as unwanted pregnancies, STI or AIDS (Campbell, 1998:687).

The desire and need for sexual communication has a price that may be high. Most women in rural communities are economically and socially dependent on their spouses (Mill & Anarfi, 2002:325:). Legal and customary practices regarding child custody, property ownership and inheritance deny women assets that would enable them to negotiate effectively (Ehrhardt & Exner, 2000:S53; Blair, 1997:58). Where women's sexuality is very restricted, both their risk of contracting HIV and STI from their partners and their need to negotiate safer sex is greater, yet their bargaining power is weaker (Pulerwitz, Amaro, De Jong, Gortmaker & Rudd, 2002:789; Neighbors & O'Leary, 2003:93; Dunkle, Jewkes, Brown, Gray, McIntyre, & Harlow, 2004:1415). In these circumstances, their choice may be limited to social destruction or to biological death.

Implications for research and practice

The results of the study illustrate the continued importance of oscillating male migration in the dynamic of the HIV epidemic in rural South Africa and other countries whereby work migration is prevalent. There should be more emphasis or understanding of the role migration has in relationships to sexual networking and pattern for risking disease. This would be particularly valuable in guiding the development of gender-tailored HIV prevention interventions to solve the epidemic of HIV in South Africa. Although this information was collected in a specific settlement, there is no reason to believe that the situation is different for women in other areas. Further research should focus on how to empower women to

take responsibility of their decisions regarding communications and sexual matters within a specific cultural understanding.

Acknowledgements

The authors would like to thank Ruth E. Little from International Epidemiology Services for editing. Dr. Zena Stein Columbia University School of Public Health, Department of Epidemiology Fogarty International Fellowship and Dr. Salim Abdoul Karim, Durban South Africa. Ms J. Fourie is acknowledged for the final editorial and technical revision of the document for submission.

Conflict of interest

None

References

- Ackermann, L. & De Klerk, G. (2002). Social factors that make South African women vulnerable to HIV infection. *Health Care Women International*, 23(2): 163-172.
- Ankomah, A. (1998). Condom use in sexual exchange relationships among young single adults in Ghana. *AIDS Education & Prevention: Official Publication of the International Society for AIDS Education*, 10(4): 303-316.
- Bajos, N. & Marquet, J. (2000). Research on HIV sexual risk: social relations-based approach in a cross cultural perspective. *Social Science & Medicine*, 50(11): 533-546.
- Blair, C. (1997). Communicating HIV prevention messages in sub-Saharan Africa: the role of commercial sex workers. Lessons learned. *The Journal of Development Communication*, 1(8): 58-63.
- Blanc, A.K. & Wolff, B. (2001). Gender and decision-making over condom use in two districts in Uganda. *African Journal of Reproductive Health*, 5(3): 15-28.
- Campbell, C. (1998). Representations of gender, respectability & commercial sex in the shadow of AIDS: a South African case study. *Social Science Information*, 37(4): 687-707.
- Crosby, R.A., DiClemente, R.J., Wingood, G.M., Cobb, B.K., Harrington, K., Davies, S.L., Hook, E.W. & Oh, M.K. (2002). Condom use and correlates of African

- American adolescent females' infrequent communication with sex partners about preventing sexually transmitted diseases and pregnancy. *Health Education Behavior*, 29(2): 219-231.
- Dunkle, K.L., Jewkes, R.K., Brown, H.C., Gray, G.E., McIntyre, J.A. & Harlow, S.D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363(9419): 1415-1421.
- Ehrhardt, A.A. & Exner, T.M. (2000). Prevention of sexual risk behavior for HIV infection with women. *AIDS*, 14(Suppl 2): S53-S58.
- Exner, T.M., Dworkin, S.L., Hoffman, S & Ehrhardt, A.A. (2003). Beyond the male condom: the evolution of gender specific HIV interventions for women. *Annual Review Sex Research*, 14: 114-136.
- Gavin, J. (2000). Arousing suspicion and violating trust: the lived ideology of safe sex talk. *Cultural Health Sex*, 2(2): 117-134.
- Hartung, T.K., Nash, J., Ngubane, N. & Fredlund, V.G. (2002). AIDS awareness and sexual behaviour in a high HIV prevalence area in rural northern Kwazulu-Natal, South Africa. *International Journal of STI & AIDS*, 13: 829-832.
- James, S., Reddy, S.P., Taylor, M. & Jinabhai, C.C. (2004). Young people, HIV/AIDS/STIs and sexuality in South Africa: the gap between awareness and behavior. *Acta Paediatrica*, 93(2): 264-269.
- Jewkes, R.K., Levin, J.B. & Penn-Kekana, L.A. (2003). Gender inequalities, intimate partner violence HIV prevention practices: findings of a South African cross-sectional study. *Social Science and Medicine*, 56(1): 125-134.
- Keller, S. (1996). Methods work better when couples talk. *Network*, 16(3): 10-11, 14.
- Kim, M.J. & Kang, H.S. (2003). A comparative study of consistent and inconsistent contraceptive users on partner communication, perceived contraceptive control, and sexual autonomy. *Taechan Kanho Hakhoe Chi*, 33(6): 784-791.
- Ladebo, O.J. & Tanimowo, A.G. (2002). Extension personnel's sexual behavior and attitudes toward HIV/AIDS in south-western Nigeria. *African Journal of Reproductive Health*, 6(2): 51-59.
- Lear, D. (1995). Sexual communication in the age of AIDS: the construction of risk and trust among young adults. *Social Science and Medicine*, 41(9): 1311-1323.
- Maharaj, P. (2001). Obstacles to negotiating dual protection: perspectives of men and women. *African Journal of Reproductive Health*, 5(3): 150-161.
- Mcquiston, C. & Gordon, A. (2000). The timing is never right: Mexican views of condom use. *Health Care Women International*, 21(4): 277-290.
- Middlestadt, S.E. (1993). Encouraging discussion with partners and building negotiation skills: HIV prevention strategies for women in relationships in Brazil, Tanzania and Indonesia. *Advances in consumer research. Association for Consumer Research (U.S.)*, 20:297-301.
- Mill, J.E. & Anarfi, J.K. (2002). HIV risk environment for Ghanaian women: challenges to prevention. *Social Science and Medicine*, 54(3): 325-337.
- Neighbors, C.J. & O'Leary, A. (2003). Responses of male inmates to primary partner requests for condom use: effects of message content and domestic violence history. *AIDS Education Prevention: Official Publication of the International Society for AIDS Education*, 15(1): 93-108.
- No Authors Listed. (2000). Ignorance could worsen South Africa AIDS threat. Knowledge, attitudes and behavior. *AIDS Weekly*, 13: 27-28.
- O'Leary, A. (2000). Women at risk for HIV from a primary partner: balancing risk and intimacy. *Annual Review of Sex Research*, 11: 191-234.
- Phillimon, N. & Hojer, B. (2001). Sexual behaviour and sexually transmitted diseases among young men in Zambia. *Health and Policy Planning*, 16(1): 107-112.
- Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S.L. & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS Care*, 14(6): 789-800.
- Williams, S.P., Gardos, P.S., Ortiz-Torres, B., Tross, S. & Ehrhardt, A.A. (2001). Urban women's negotiation strategies for safer sex with their male partners. *Women and Health*, 33(3-4): 133-148.