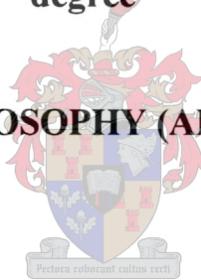


**HARMFUL SEXUAL PRACTICES AND GENDER
CONCEPTIONS IN KWAZULU-NATAL AND THEIR EFFECTS
ON THE HIV/AIDS PANDEMIC**

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree

ABSTRACT

This paper looks critically at particularly two harmful sexual practices most prevalent among the Zulu people in Kwazulu-Natal; virginity testing for girls, and the practice 'dry sex.' It is mostly the ripple effects of these practices, regarding the spread of HIV/AIDS that is most alarming to medical science, leaving them no option other than to condemn this behaviour. This treatise however endeavours throughout to proffer understanding for the needs of a culture as diverse and unique as the Zulu people. Further, this paper often looks from an overarching African perspective, since despite African peoples' differences in terms of linguistics, geography, religiosity and general differences in daily run of the mill activities, there is a dominant socio-religious philosophy shared by all Africans.

The, a, b and c of virginity testing, and the resulting moral issues revolving around this practice are addressed. The main issues regarding the repercussions of virginity testing are discussed as well as the medical controversy involved in these issues. This will prove the limited effectiveness of this practice and the potential, yet serious and harmful ramifications it has for girls who are tested.

In stark contrast to these girls, stands the girl who starts at a very tender age with the practice of 'dry sex', often encouraged and taught to her by female elders in order 'to please men'. This practice serves as a very powerful tool for commercial sex workers, venturing the streets and the truck driver stops, as it lures men into making her the preferred choice. So desperate are her socio-economic and cultural circumstances that she risks infection, and ultimate death, in order to comply with his need for unprotected and 'dry sex.' Numerous studies alert us to the fact that the drying agents used lead to lacerations of the vaginal walls, causing STD's, which in turn, exacerbate the spread of the disease.

Zulu traditions and customs regarding sexuality and sexual relationships proffer essential insight into the Zulu people's sexual behaviour. In order to strike a balance between two diverse cultural groups, the West and African, a critical assessment of the West's own sexual history guides us to understand the West's 'sober' practice of

monogamy is no less 'permissive' and 'promiscuous' than the African's practice of polygamy.

The paper also investigates the corresponding differences in relation to indigenous knowledge systems versus science. African people discern the body's physiology and anatomy metaphorically and symbolically. We cannot simply gloss over these perceptions, enforcing scientific-based knowledge in our educational programmes, without consideration and accommodation for a very unique way of interpreting one's daily experiences and one's unique self.

It is not only our biased discernment of indigenous knowledge that complicates the Aids pandemic considerably, but it is also enhanced by the burden of stereotyped gender-roles. Not only is a paradigm shift regarding the imbalance of power very much needed, we also need to understand that the inculcated anger some men in the Zulu culture fosters is a force to be reckoned with, as it displays psychological underpinnings of damage, signalling very clearly the need for therapeutic measures of healing. Conversely, the female in the Zulu culture has started to empower herself, but not always in terms of a beneficial end in itself. Similarly, it must alert us to the fine line separating the virgin-whore dichotomy, fuelled by her poverty-stricken and male-dominated existence.

It would appear that what we are fighting for is more than the preservation of life whilst engulfed by AIDS's scourge, but a global vision where the individual, or a whole community, with regard to HIV/AIDS, is "self-reproducing, pragmatically self-sustainable and logically self-contained." (Bauman 1994:188)

OPSOMMING

In die Zoeloe kultuur figureer daar veral twee tradisionele seksuele gedragpraktyke wat kommer wek by sommige Westerlinge, hier ter plaatse sowel as in die buiteland. Alhoewel hierdie praktyke as natuurlik, eksklusief en algemeen beskou word, is daar huidiglik stemme van protes wat waarsku dat die twee praktyke potensiele gevaar inhou vir die mens se gesondheid en geesteswelsyn. Die praktyke behels dat jong en weerlose meisies vanaf die ouderdom van ses jaar gereeld onderwerp word aan 'n vaginale toets om vas te stel of hulle nog 'n maagd is, en, die voorkeur van sommige mans om omgang te he met 'n vrou wat haar vagina op 'n 'onnatuurlike' wyse droog, hard en styf hou met die oog op 'n meer bevredigende seksuele ervaring vir die man. Baie vroue geniet ook hierdie ervaring. Die mediese wetenskap is veral bekommerd oor die moontlike verband tussen die nadelige repurkussies van die twee praktyke en die vinnige verspreiding van MIV/VIGS en pleit derhalwe dat daarmee weggedoen word. Die praktiseerders van eersgenoemde praktyk word byvoorbeeld gewaarsku dat dit mag lei tot gevalle van verkragting, anale seks asook kindermishandeling, terwyl laasgenoemde praktyk veral twee hoe risiko-groepe ten opsigte van die VIGS-pandemie ten prooi val; die kommersiele sekswerkers in Kwazulu-Natal wat die praktyk gebruik as wapentoeerusting, en die land se vragmotorbestuurders wat hierdeur verlei en aangemoedig word. Hierdie vorm van seksuele omgang ondermyn egter nie net kondoomgebruik nie. Studies het bewys dat die gebruik van 'n vaginale uitdrogingsmiddel daartoe kan lei dat die wande van die vagina mag skeur. Beide groepe loop derhalwe nie alleenlik die risiko om 'n seksueel oordraagbare siekte op te doen nie, maar om ook 'n VIGS-slagoffer te word.

Terwyl die beperkte effektiwiteit van die twee praktyke deurkam word, poog die verhandeling om deurgaans 'n duidelike ingeboude begrip te handhaaf vir die unieke en eiesoortige karakter van die Zoeloe kultuur. Dit redeneer dat beide groepe, Afrika-boorlinge en Westerlinge, moet probeer verhoed om te polariseer en illustreer dat diverse kultuurgroepe almal, vanuit 'n kultuurhistories perspektief, meerdere of mindere tekens van promiskuiteit en permissiwiteit ten opsigte van seksualiteit toon. Dit spreek vanself dat die twee praktyke ondersoek moet word teen die agtergrond van die Zoeloe's se inheemse kennis met inbegrip van die wyse waarop die menslike fisiologie en anatomie metafories en simbolies verklaar word. Die digotomie wat

bestaan tussen inheemse kennis en wetenskap vra dat ons boodskappe gekommunikeer moet word op 'n wyse wat beide gesigspunte konsolideer.

Uiteraard kompliseer die stereotipering van geslagsrolle in die Zoeloe bevolking die VIGS-pandemie aansienlik. Dit dra in 'n groot mate daartoe by dat die VIGS-pandemie nie suiwer as 'n biomediese probleem manifesteer nie, maar dat ander psigo-sosiale faktore in berekening gebring moet word. Dit werk byvoorbeeld 'n ongebalanseerde magsposisie in die hand wat sommige Zoeloe mans se sielkundige worsteling met hul diepgewortelde, polities geïnspireerde woede belig en dui op sommige kontemporere Zoeloe vrouens se toenemende geneigdheid om seks aan te bied in ruil vir geld. Sy doen dit om sodoende haarself van die juk van die Zoeloe man se mag oor haar en haar neerdrukkende sosio-ekonomiese omstandighede te bevry.

Die verhandeling beweeg dikwels buite sy grense en fokus nie net bloot op die gedrag van die Zoeloe bevolking nie, maar boorlinge van Afrika in die algemeen. Hierdie oorhoofse Afrika-perspektief vind regverdigingsgronde in die lig van die feit dat boorlinge van Afrika saamgesnoer word deur 'n oorheersende sosio-religieuse filosofie, desnieteenstaande die feit dat daar merkbare verskille voorkom ten opsigte van linguistiek, geografie, religieusheid en ander wat betref hul daaglikse gebruike en omgang.

To her, these words, 'seize the opportunity,' 'live your dream,' are spoken even though they have never been realised, never fully grasped, because being able to visualise them has been obstructed, not only by her physical and geographical boundaries, but an oppression that had become as natural as the dawn of her bleak tomorrows. Her eyes, tell a story of their long forgotten free will, and their fatalistic yearning saddens her tired body in anticipation of inevitable death. She is lying down like a shocked dog, waiting for the final kick, while elsewhere life has rhythm, a beat, which she can only vaguely remember, her spirit once nurtured, while she still had hope, still had faith..... she is lying down too soon.....

Rena Rauch 2002

Written after a visit to dying AIDS patients at a care facility in a rural area of Southern Kwa Zulu Natal.

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INTRODUCTION

People of Africa are confused, since the very core of meaningful existence for them, their intimate lives, and hence, their dignity and self-worth, is in disarray. AIDS, often argued to be a postmodern disease, is imposing on their most private moments and has left their daily lives in whirlpools of anger, distress and frustration as it inherently leaves complexity and uncertainty in its wake, for which there are no simple solutions. Sex, the closest, most profound and solacing, at the same time, the most delirious, sensual and physical act between any two people, has come under scrutiny and African people must now succumb to a sexual discipline that is foreign to them. Sex, in fact now, involves a virus, which forces itself mysteriously and aggressively into human bodies, through the 'exchange of fluids'. Professor Anton van Niekerk quotes from the work of Lee Grove, describing the intimate act of sex and how it has evolved as a consequence of AIDS,

“To die”, “to have sex” – that coupling has always been figurative, metaphorical, sophisticated wordplay, a literary conceit, out of those outrageous paradoxes dear to the heart of a racy divine like John Donne”. However, “Outrageous no longer. The coupling isn't figurative anymore. It's literal.” (Grove, quoted in Van Niekerk, 2002:157)

The virus, intriguingly, presents with a tantalizing masquerade, changing its identity swiftly, smoothly, invisibly and consistently, once absorbed and on its warpath against the victim's immune system. It is however showcasing more than a masked ball. It is a woeful carnage, which the victim is subjected to over the next few years. However, all the complications and contradictions as well as the daunting efforts of scientists to destroy the virus, have only remote significance in the lives of people who feel compelled to think no further than where the next plate of food will be coming from.

Hence, whilst Africa's many different cultures are still internalising modernity, they are now tormented by the tyranny of a disease, which fosters its fickleness inside homes, already suffering from conflicting values, the deconstruction of its family units, the deterioration of intimate relationships and extreme poverty. In most

instances people of Africa are still psychologically traumatised as they go about their everyday lives, picking up the scattered pieces of their socio-economic framework, which left many of their traditions, customs and beliefs fragmented and in disarray.

Against the backdrop of Westernisation, coupled with AIDS, a sexual revolution has crept up on African people, for which they were psychologically and biologically not prepared. It is however not so much a revolution accompanied and identified by a sexual liberation, but rather, a social mayhem. It started with African men, who did not only leave their homes and wives in the hinterland when they became migrant labourers, but also, their much-treasured sexual identities. Those within marriages were forced to deconstruct polygamy, which was culturally sanctioned, structured and controlled in his community, but fell out of place in a big city, tugging at his desires and tempting his self-control. And with no one in this new group directing and policing these desires, as it was commonplace in his community, he hardly spent any time, vacillating between these new sexual relations and the abuse of existing ones. It is the same lack of conscience that leads him today, to negatively contemplate prescriptions regarding faithfulness and the control of his bodily fluids by means of the use of a condom.

Thus, it leaves not only men, but also women, in a post-colonial, post-apartheid state of affairs, with no base of solidarity to ask the questions, '*what*' should *we* do, '*how*' should *we* do it and, '*why*' should *we* do it? Instead, the strong uproot of emotions and sense of morality they experience, have left men with a looming fear, which finds manifestation in violence, while already marginalized women are left with an even bigger magnitude of vulnerability, which results in their having no power regarding sexual decision-making and negotiation. In fact, the girl/child and young women have become running 'fugitives' under constant siege of the 'enemy'. Sadly it would appear, the African female has lost control over the prerogatives that prompt her sexuality, such as choosing a partner on her own terms, and staging the much enjoyed courting game, accompanied by the strict adherence to the traditional order and control of premarital sex play. Not being able to live and experience this dynamic concept anymore, as her experiences of sex and sexuality are often met with violence and abuse, the African female, as a result on the other hand, has either resorted to fatalism, or opted for the status of 'the fallen woman'. Interviewing a group of

women, ranging between 15 and 35 years of age, at the Elim Clinic in the rural area Nqabeni near Harding, Kwazulu-Natal, they displayed very overtly and dismally this fatalistic attitude, when asked the question; “How do you see your lives ten years from now?” They answered in unison that they will all probably be dead because of HIV/ AIDS. In many instances, the Zulu female currently accepts without rebelling, that she will probably not see her 30th birthday, in the same way she even accepts without questioning, the patriarchy and power imbalance vested in her culture.

It is thus clear, whilst the disease never ceases to spread its harrowing effects, women struggle to put on the attire that can protect them against its threatening power, its onslaught, not only on their human welfare, but especially on their reproductive health. They feel particularly powerless to do anything, as poverty, their lower social status and economic dependence confine them to a space in which their voices are mere whispers, carrying no authority, against a gale force wind. More importantly, women, especially those living in the deep rural areas, feel trapped, because unlike their western or westernised sisters, who are empowered by their sexuality, they live with the pressures of a culture in which their bodies are biologically and anatomically disadvantaged, and therefore, their sexuality fails them dismally in terms of empowerment. Not only are their bodies more susceptible to the disease, but they are also adding to the mortality rate, since their bodies can transfer this disease not only to the unborn child during pregnancy, but also, the newborn child during delivery or through the natural instinct to breast-feed. Ironically, while the spirit of “ubuntu” - I am I because I am for the other - is well-kept in her culture, in many instances she now lives on the periphery of acceptance in her social sphere, suffering malnutrition, stigmatisation and isolation in a once loving environment where she was part of a collective ‘we’. In short, she has become a ‘prisoner of her culture’.

In addition, the Western world is confused regarding African sexuality.” From being first diagnosed in the urban, educated, middle-class gay communities of the United States in the 1980’s” (Van der Vliet, 1996:63), current statistics prove that heterosexual transmission of HIV remains extensively and excessively the most common mode of transmission globally, a phenomenon particularly prevalent in sub-Saharan Africa. Fuelling Western frenzy even more, is the commonly held scientific notion, that AIDS crossed over from the green monkey in central Africa to the

Africans, implying thereby either a perverse and obscure kind of sexuality, unbeknownst to Westerners, or that Africans ate the monkeys. In her work, *Illness as Metaphor and AIDS and its metaphor*, Sontag (1988) also describes how Western Medicine has used 'military' metaphors, for example, of war, of conquering, in describing the behaviour of the disease, suggesting the Western World suffers paranoia, fearing that heterosexuality will be 'colonized' by AIDS via direct heterosexual contact with Africa.

Hence, in response, educational messages are often clouded by confusion, anxiety, hysteria and at times, contradiction. Westerners put enormous emphasis on the classic risk factors and identify them as the A, B, and C in the play-it-safe campaign regarding HIV/AIDS transmission; **abstain, be faithful, condomise**. This has however proved to be a mindless mantra, fuelling Africans' confusion, since it is infused with an almost unrealistic moral code. It aims to create a mirror image of idealised Western sexuality, including sexual abstinence before marriage and marital monogamy, while Western mass media, without fail, portrays the opposite. We promote the use of condoms without prying into the perilous sexual exercises, which are the root cause. We are telling people 'what' to do and 'how' they must do it, even 'where' they must go for treatment and counselling once they have contracted the disease, but we push the reasons 'why', they possibly contracted the disease to the margins, because it sits uncomfortably with us in our lounges. We express shock when we are given the statistics, or read how traditional Zulu practices have become adulterated and exploited, causing the most powerless in society, babies, children and women to suffer most, but choose not to educate people on the perils lurking at the root of the spread of the disease. Furthermore, the fact that sexual practices are subjected to a culture of silence, expected of women by males or the Church, does not serve to alleviate her vulnerability. It rather points at her undeserved and unnerving stance in society. She is not even supported by government, as the State President does not deviate from his dissident views on the disease, thereby diminishing her chances of getting amelioration of her circumstances. These are factors that thwart thorough qualitative research of sexual practices and newly found feelings regarding experiences of sexuality among African people considerably, as they cultivate a reluctance to disclose intimate pleasures and pains for fear of stigmatisation.

Taking cognisance of AIDS as a postmodern disease, brings us closer to this kind of research. However, it inevitably leads to the question: is it possible to adopt relativism, when this disease is asking for a rational, empirical and objective approach and a universal moral code of sexuality, that is applicable to everyone exposed to this atrocious health hazard? Stanley Fish, professor of Liberal Arts and Science at the University of Illinois in Chicago, writes, "Our convictions are by definition preferred; that's what make them our convictions. Relativizing it is neither an option nor a danger." (2001:3) Thus, if we are hoping to change people's behaviour we must realise that different cultures live with their own diverse convictions. This does not imply however, deeply embedded local sexual practices that prove to be harmful cannot be changed, only that efforts made in pushing forward novel ideas for positive change must curb judgements and criticism. More importantly, these efforts must proffer understanding of purposeful convictions as lived and experienced in other cultures, and be designated for social and community support, since in this way they can influence safer sex messages to a far more meaningful extent.

The revival of Virginity testing in response to the *abstinence* part in our campaigns and the practice of 'dry sex' as a local sexual tradition, had the United Nations up in arms, asking for its abandonment, since the shocking display of the infringement of human rights, the lack of anatomical, biological as well as scientific knowledge, leave the Westerner no choice other than to discard them as precarious practices in the light of the HIV/AIDS pandemic. However, to what extent can we allow the Western world's intolerance and impatience with diversity to influence another culture's convictions? This dissertation critically assesses these potentially harmful sexual practices in the Zulu culture and argues that there are no absolute, western and universal solutions for this pandemic in Africa, nor is there an independent standard for determining which one of the rival forms of experiencing sexuality can best deal with AIDS. Thus, there is no room for the adoption of rigid and staunch attitudes that reveals ignorance and a need to control peoples' emotions, intuitions and imagination. Nevertheless, our sense of humaneness coupled with the autonomous self, compel us to adhere to biomedical principles that obligate us to detect and address harm when people's health and lives are at stake. However, unless we show openness to understanding the culturally specific sexual practices, and their interaction with the

psycho-socio and economic environment, we shall not be successful in offering viable, meaningful, positive and encouraging alternatives.

This dissertation also argues that the mammoth emphasis on condom-use, controls our discernment of prevention to such an extent that we perceive it as the only method of prevention, and, should resistance prevail, we attribute that resistance to promiscuity. In the process we neglect a very crucial look into education and information efficacy levels, especially with regard to explaining the female anatomy and the existing harmful tendency to exclude gender in our messages.

Our interventions must in the first place be fashioned around the important question; are we sensitive to another culture's traditional practices, which helped to shape people's inculcated beliefs, which have been cultivated and nurtured over centuries? In other words, do we understand the origins of beliefs such as, that abstinence before marriage can only successfully been taught through the overt checking of an intact hymen, or that sexual pleasure can only derive from drying a woman's vagina? Do the foreignness of such beliefs sits uneasily with us and breeds hostility within us? If this is to be conceded then we are not ready to move forward to address the next step in our intervention. It is critical that before we are satisfied that our validations suffice beyond reasonable doubt as validations of truth and not fear, we cannot move on, for example, to ask ourselves; how we can successfully impart scientific knowledge without fostering a disrespectful imposition on indigenous knowledge?

This dissertation seeks to verify that however 'wish-fulfilling', 'magical' and meaningful practices such as virginity testing and 'dry sex' are, non-biased explorations after truth reveal them to be negative and that they should thus be discouraged as they proliferate rape, unprotected anal sex, child abuse, bleeding and tearing of the vaginal walls, all of which make women especially, more susceptible to the disease, thus encouraging a more vigorous spread of the virus. We need to educate people on the harmfulness of these practices and promote healthy alternatives, education and options to a far greater extent. More importantly, we need to drive our messages, making use of local knowledge, whilst simultaneously aiming to strike a balance with western medicine. This would imply understanding the Zulu people's very unique composition, their all-encompassing mythical conceptions and traditional

mores, their dogmatic patriarchal system and how indigenous knowledge is lived and intertwined with inculcated beliefs, customs and traditions. But perhaps, most importantly, we need to understand the person behind Western statistics and empirical data: the Zulu man's anger and the psyche of a woman who is not only economically deprived, but also suffers emotional starvation.

Thus, in conquering this mission, our challenge is not merely to identify the harm that can be inflicted on a culture's identity if it goes unprotected, but also, to start shaping and structuring our messages and education into coherent relational pillars of hope for the future. Perhaps this disease, however slow the process and devastating the consequences, is offering us the chance to move towards partnership, balanced gender-roles, political co-determination and negotiation, in a way that integrates the idea that "Human behaviours and cultural values... Have meaning and fulfil a function for those who practice them. People will change their behaviour when they understand the hazards and indignity of harmful practices and when they realise that it is possible to give up harmful practices without giving up meaningful aspects of their culture." (World Health Organization, 1997)

CHAPTER 1

VIRGINITY TESTING

INTRODUCTION

Virginity testing is an ancient custom in the Zulu culture, which has dissipated to a large extent during the era of colonisation and westernisation. The advent of AIDS prompted proponents of the practice to revive the custom *en masse* in an attempt to fight against the forces of the HIV/AIDS pandemic, “to take back what has been taken from us”, they argue, and in a fashion they can relate to. Girls must be encouraged to stay virgins until they get married, the way it used to be before the colonisers invaded their land. This, the advocates of this practice believe, is the only way mothers can prevent their daughters from falling prey to the most dreaded disease in the history of mankind and, ultimate death. It is this reasoning coupled with President Thabo Mbeki’s plea for a *African Renaissance* that could bring ‘African solutions’ to the African AIDS problem, despite his dissident views on AIDS, that could be seen as the most important rationale behind the decision to revive the custom.

Rather than attempting to change the behaviour of men, which they view as a futile and perilous exercise, women themselves must take the responsibility to abstain from sex. In the words of Mrs Xulu as reported in the Natal Witness (August, 2000),

“We are the organisation which does virginity testing of girls from 6 years old up to marriage status. Initially we started from 12 years old but by doing so we found that half of the girls tested had already lost their virginity. The reason? Because most of them have been abused by their relatives - brothers, fathers, uncles and cousins. That’s why, as Igugu Lama Africa, we stand up and fight against those evildoers. We Africans must work together to prevent sexually transmitted diseases and Aids. I don’t believe in Western civilisation and culture as they say we must use condoms and contraceptives, which promotes adultery. That is why I believe in African culture.”

But at what price is this practice making its dramatic comeback, the medical profession is asking, when figures on rape, amidst the Aids crisis, are so dramatically

on the increase? Are 'stamped' and certified virgins not sending out the powerful message, 'I am HIV-free' to those evil-hearted who are already contaminated with the virus? In fact, so disturbingly and uneasily does this practice sit with Western medicine that when video footage of this practice, compiled by a CNN reporter, was shown, the public was warned that this report might make their viewers feel 'uncomfortable'.

VIRGINITY TESTING AND ITS LINK TO THE GIRL/CHILD, YOUNG WOMEN AND ANAL SEX

"The whistles are blowing and balloons are swaying in the wind as 85 girls form a long line while grass mats are being laid in a row on the ground. With their panties scrunched up in their hands, the girls range in age 5 to 22, and appear quiet and nervous. Testing time has arrived. This particular virginity testing event was one of many weekend jamborees held at various football stadiums of local townships, writes Suzanne Leclerc-Madlala (2000) in her paper, *Virginity Testing for AIDS prevention*, presented at the XI11 International Aids Conference, held in Durban. Once the ritual is done, virgins get certificates, after their mothers paid the required five rand, and with these certificates in their hands they now join the dancing and the ululation in gregarious fashion while curious male onlookers peep through the fences. Later in the day buses and taxis arrive to take the victorious girls and their mothers home.

Another very popular setting is the village of Bulwer, a small rural town in the KwaZulu-Natal Midlands, which has become the centre of the revival of this old Zulu tradition. They start early in the morning to attend the *Nomkhubulwane* Festival. *Nomkhubulwane* was according to Zulu mythology, the Zulu goddess of rain and fertility. The festival is reserved for women only and is set up to celebrate virginity. Convinced that they are doing the right thing, and oblivious to the fact that they are participating in a highly controversial practice, the girls lie with their legs spread widely parted on *amacanzi* (traditional Zulu mats) to have their vaginas inspected. Once declared a virgin by a tester, normally female elders, nurses or educators, who use the same pair of gloves on all the girls, the girl gets a sticker or a white star on the forehead, an ochre hue painted on each cheek and she becomes the focus of attention and praise. The slaughtering of a bull and dancing competitions follow this ceremony,

which ends the next day, when all the virgins plough and plant a field. This year will mark their 8th celebration.

A private home, a school hall, a community centre or the kraal of a Zulu chief, also qualifies as settings for testing. Several festivals are held all over the province each year, some in the middle of winter, while there are also certain main centres reserved for virginity testing, such as the ones at urban KwaMashu, north of Durban and Dududu, a rural area on KwaZulu-Natal South Coast. Leclerc-Mdlala (2000) has found that amongst those who support the rural women in their eagerness to have the girls tested are officials, mainly male, in the department of education and health, academics and politicians.

While statistics on virginity testing are not officially available, the following, randomly picked from Independent Newspapers Archives, and not claiming to give a holistic overview, does give a rough indication of how rife the practice has become in the province. There are, for example, about 20 testers in the KwaMashu area and they each test between 70 and 100 girls between the ages of four to 22 every month. Two teachers in northern KwaZulu Natal proclaimed that in January 2001, thousands were tested as young as 6 years at eight different schools. One teacher alone claimed to have tested 11 000 girls in the foothills since its revival in that region 3 years ago. In the rural area Dududu, one of five testers in the area admits to testing about 460 girls on a quarterly basis. In this particular area, men line up out of curiosity outside the court buildings where these girls are getting tested. The schoolteacher involved with the testing in the Bulwer area, and reckoned to be the driving force behind the resurrection of virginity testing, proclaims she personally has inspected 60 000 girls throughout KwaZulu-Natal since 1993. In short, government officials and Zulu leaders estimate that tens of thousands are getting tested each month.

The schoolteacher in the Bulwer area encourages people to talk to the girls, as she believes no harm is done since they are not forced. They enjoy it as it makes them feel proud and special, she proclaims. She and the other testers believe they are saving these girls “from the HIV/AIDS, other sexually transmitted diseases, rape and illegitimate children.” As a traditional activist the main point she wants to bring across to these girls is to love their bodies and not to be abused by men. According to

UNICEF, infection rates are especially high among women, throughout the Sub Saharan Africa. One in four girls between the ages of 15 and 24 is HIV positive compared to 1 boy in 10. Interestingly enough, recent tests of pregnant women in Kwa-Zulu Natal, where virginity testing is most prevalent, show the HIV-infection rate in the region to be the highest in the country. In KwaZulu- Natal especially, the seroprevalence rate among pregnant women, is alarming, with 27% in 1997, 32% in 2000 and 37% in 2001. (Smith, 2001)

What exactly are these testers looking for? What they typically seek, when doing this testing, it would appear, is a visible 'white dot', also described as a 'white lacy barrier', quite high up in the vaginal canal. Some virginity testing practices even grade what they see as A, B, and C, the way a person's progress is graded at school. A, would mean that features of the genitalia meet criteria. "The colour of the labia should be a very light pink, the size of the vaginal opening should be very small, the vagina should be very dry and tight, and the white dot, or white lacy veil, should be clearly evident and intact." (Leclerc-Mdlala, 2000.) In the words of Kwa Mashu virginity tester, Nokulunga Majola, "We look for the *ihlo* (eye) it looks like a white dot. A virgin does not have a hole, only a white dot. It grows inside the vagina. If you see a damaged hole, it means the white dot has disappeared." (Pretoria News January 31, 2002:17 1st ed) In addition the experts look to see whether the 'girls' eyes are running', looking for men. They also look at the back of the legs; as with the breast and abdomen, it should be firm and taut. If an *imbobo* (indentation) is found behind the knee, it means the girl is not a virgin. If the skin is loose it means that the *ihlo* (eye) is gone.

When it is decided that a girl is a B grade, the testers proclaim the 'veil has been disturbed'. The vaginal opening appears to be slightly bigger; they sense a slight 'wetness' of the vaginal walls and the vagina itself appears not so tight. In the case of a four year old, this could mean that a father or an uncle have possibly molested the child, and it is whispered, 'someone could have been playing with the girl'. In effect this means the testers can assist with identifying the rapist and with the conviction. This fuels the proponents' arguments exponentially as this form of justification often features very strongly in debates when defending this practice.

A girl is regarded C-grade when the vagina is described as 'too wide and too wet'. The older girls are now regarded as dishonourable members of the family. Some sink into silence, for, if not overtly being told how they have ridiculed and embarrassed themselves, the grim expressions around them tacitly condemn them, for their eyes tell the testers, 'they know men'. The testers often see it as too late to help this girl, or refer her to a clinic for counselling where she can get taught how to deal with AIDS. Furthermore, she is not allowed to join the other virgins.

All over the province, ethical, medical and legal parties lambasted the proponents of the practice. Their outcries emphasise the paramount importance of emphatic and comprehensive sexual education of the youth in the face of the tempestuous wave of HIV/AIDS, spreading at an enormous pace over this country, and hence seeing, responsible health practice as a more viable alternative to virginity testing in the idiom of the modern world. However, renowned virginity tester, Nomagugu Ngobese, who holds Honours Degrees in Zulu and Drama, insists, "We are practicing sex education with an African perspective. We want action not criticism. Our children are dying, that's why we took this stand." (Agenda, 2001)

The following are regarded as the possible and potential outcomes of virginity testing and reflect unlike what traditionalists believe, not only medical outrage, but also, medical concern and compassion for the individual, incorporating the principles of autonomy, nonmaleficence, beneficence and justice within a biomedical context.

THE REPERCUSSIONS OF VIRGINITY TESTING

Come get me, I am a virgin!

With those certificates in their hands and the white stars on their foreheads, they are a shining advertisement to evil-hearted men. To these men they are sending out a very powerful and clear message, "Come get me, I am a virgin!" The most common argument against virginity testing, coming from the medical profession, social workers and The Commission of Gender Equality, is that the girls who are known to be virgins become the targets of rapists, because they are so easily identifiable. Women are not protected by this practice but exposed, as it sets them up to be used in

an area. Dr Neil McKerrow argued at a debate held at the University of Natal, “that it was a problem that men not wanting to use condoms target virgins for sex as they believe they are HIV-free.” (Agenda,2001:Issue 46)

Hence, in many cases, the celebrations after being successfully tested a virgin are regarded as only a momentary victory, because the appalling rape statistics bear testimony to the fact that she could lose this euphoria within seconds, as a girl gets raped every 26 seconds in this country. One in three women’s first experience of sex is rape. This is confirmed by Lovelife statistics showing that over 80% of first encounters experienced by girls are forced. Of all reported rapes of people under 18 years, 70% are under 12 years old. This has been publicly confirmed either via the media or during public speaking, by social workers, doctors and the Director of Childline in the province. Furthermore, studies conducted by Dr Aines Dhai, of the Department of Obstetrics and Gynaecology at the University of Natal, Durban, estimate that 40% of raped women and children who fail to receive post-exposure prophylactics will become HIV-positive. The rapist is most likely a HIV- positive male who, either knowingly, or unknowingly, passes it on to the rape victim, who is more likely not to alert authorities, since it is estimated that only one in three rapes are reported. South African Department of Justice figures show that of the 54,000 rapes reported in 1999, only 7% resulted in arrests and just 1% in convictions. Add to these statistics the fact that this province has an alarming 36% AIDS prevalence, and the picture looks pretty grim.

Targeting the local Trauma Crisis Centre in Port Shepstone Provincial Hospital for information, I was shown the record books by the counsellor, sister Thandi Langeni. In the month of May 2002, alone, there were 36 reported cases of rape in the rural area and five in the township areas. Of the 36 who were raped in the rural areas, 17 were minors (below 18) and in the township areas there were none. She alerted me to the fact that they are noticing a new tendency. Rape perpetrators seem, to a large extent, to be targeting the under 18’s, and those above their forties. In between there seems to be a huge gap. She showed me 6 such cases in May, where four out of the six were above the age of sixty. This reinforces the argument that perpetrators opt for victims who could be HIV-free. Rape also occurs at all levels of society. A report by the Medical Research Council of South Africa indicated that, “the majority of women

who reported that they had been raped, were raped between the ages of 10 and 14 years of age. Research showed schoolteachers were the perpetrators of 33% of these cases. In many of these cases the girls were bribed with threats to fail them in their exams should they not co-operate. (Beeld ,07/10/2000)

Child Abuse

In a country where child abuse figures are among the highest in the world, the concern is that virginity testing can become the means to a malevolent end, or the tool by means of which a child is abused or becomes the victim of statutory rape. Stories, such as the one told by National Youth Commission Chairman Mahlengi Bhengu, aged 30, who gave a personal account of how traumatic was her experience of virginity testing during her childhood, raises an awareness of the fact that there are many more children who suffer this kind of abuse. Assuming the abuse is restricted to indecent touching only would be a naïve, if not a dangerous and ignorant, assumption to make given the background of our statutory rape statistics. Furthermore, it would do the protection of our children against HIV/AIDS, a grave injustice.

She tells how at the age of 12, having just entered puberty, she went to live with her uncle in Eshowe. He insisted that her niece and herself were tested to ensure that they remained virgins. Her sexuality and the things she would go through during adolescence or why the test was done were never openly discussed with her. They were tested several times before she left for boarding school and a year later. Her uncle always used virginity testing punitively, saying that her friends were a bad influence. He threatened to make sure she remained a virgin. It was very scary for her and even though she has not been taught about her body, she knew instinctively that an older man looking at her and touching her private parts was wrong. (Independent on Saturday, June 17:2000)

All but one, in the group of girls I interviewed in the Umzumbe area, reported that during some stage in their lives, elder men, especially family relatives, asked whether they could look at her private parts under the pretext that they want to check their virginity status. They had however been warned by the female elders and refused to comply. According to them these men accepted their refusal and refrained from

touching them. However, having been tested a virgin and even though it makes them feel special and cared for, they reported feeling scared and paranoid for a large part of their young lives.

According to Sister Thandi Langeni, and from interviews I had with women in the rural areas, child abuse by the father often does not get reported, because the father very classically threatens to kill the mother. At the recent AIDS 2002 Conference held in Barcelona, the department of Welfare and Population Development reported that in Gauteng, South Africa's most populous and developed province, a partner murders his woman every six days. It poses a threat the average African woman cannot afford to take lightly. Neighbours are bribed into silence, which they accept at the expense of the child, since it relieves their poverty, even if only temporarily. The perpetrators, on the other hand, are petrified of the wrath and punishment of the society they live in, if exposed by the child. Quite recently, this fear culminated in two horrendous incidents in the province, resulting in two girls being beheaded by their assailants in order to avoid being reported.

In yet another recent newspaper article the superintendent of a hospital west of Durban's vast metropolis, which serves a population of about 750 000 people, proclaims, "This year we have noticed a big increase in HIV-positive children between the ages of four and 10. We suspect it is because of sexual abuse." (Sunday Tribune, October 6, 2002: 2nd section) This statement suggests that most of these children were not infected at birth, but had been abused.

More alarming is the fact that gang rape of children, is dramatically on the increase. According to Childline director, Joan van Niekerk (2002), up until June this year the organisation has dealt with 25 cases of gang rape with the ages of child victims involved, between four, and seven years. "We know of township youths who specifically target virgin girls and separate them physically from their peer groups, for instance, when walking home from school and gang rape them." Equally disturbing is the fact that the rapists were under the age of 18 years and more often than not the perpetrators were not strangers, but people well known to the child.

The virgin myth

Another danger includes the deliberate identification of girls who are virgins by many perpetrators whose HIV-positive status has been divulged to them and who believe that sleeping with a virgin can cure them of AIDS. Perpetrators use this myth in a desperate attempt to cleanse, or protect themselves. According to Sister Langeni they have dealt with a number of cases, where the father has slept with his own child because of this myth.

Studies done by the University of South Africa at Daimler Chrysler between May and July of 2001, interviewing on 498 of 4495 employees, showed that an alarming 18% of those surveyed believed that having sex with a virgin would cure the disease, few of them would change their sexual behaviour despite the disease and that generally there appeared to be a lack of faith in the efficacy of condoms. (Business Day, February 27, 2002:3)

Anal and Oral Sex

Medical and Health workers are concerned that virginity testing encourages high-risk sexual behaviour, such as anal sex among young people living in townships who, out of fear for the virginity tests, are substituting one risky sexual practice (unprotected vaginal sex) for another, more risky, sexual antic. Although anal sex is just as much a heterosexual activity as it is a homosexual activity, it is however not part of traditional sexual behaviour in the Zulu culture. In fact, historically, sex in sub Saharan Africa refers to vaginal penetration only, and not, to anal or oral sex. Hence, it was adopted from Western culture, especially since, according to the director of Childline in the province, pornography has become commonplace in our townships. By the same token homosexuality, once considered to be a big taboo among Africans in rural areas, is finding identification and signification among African youth, not only in big cities, but in the rural areas as well. Questioning a group of 19 men in the rural area near Umzumbe, who had had very little exposure to urban areas, made clear that they were ignorant about homosexuality, feel appalled by the idea and considered it to be a form of sexuality through which they would feel estranged. I was then told that a man in their community, who has become urbanised, was captured quite recently by the other men in the area and nearly beaten to death, because he 'was playing with the

young boys from behind'. Interrogation led to the confession that he had been violated by a white man for whom he had worked in the local town.

There is concern that this form of abuse can endorse a vicious circle, designed to enlist self-experience without realising its full consequences. One does not need a psychologist's perspective to realise that the abused often becomes the abuser. Childline director, Joan van Niekerk confirmed that girls are sodomized particularly where virginity checks are done in the townships. Yet, we need to realise it is not always and necessarily accompanied by bad intentions, as it could be the substitute for the old traditional 'thigh sex' during which a man could sexually release himself, if unmarried. Anal sex could also be exercised as the alternative option for vaginal penetration in instances where the boy respects the old traditions and therefore the girl's virginity status or, where he does not want to bring her or himself into discredit with the girl's family by causing impregnation, or simply for preferred pleasure's sake. Thus, in instances where proper sexual education is not received, there is concern that partners are oblivious of the risks involved, regarding HIV infections, through anal sex, whether used as a practice to mask abuse, to abuse, or, unprotected and/or for the sake of pleasure.

"Various European and US studies indicated that the chances of becoming infected with HIV after one act of unprotected receptive anal sex is approximately 20 times greater than after one act of unprotected vaginal sex. These studies also indicate that anal intercourse may account for up to half of heterosexual transmissions in some countries." (Garcia et al., 2000; Halperin, 2000; Pando et al., 2000) In yet another study carried out in the United States, Foxman, et. al. reported anal sex was associated with self-reported history of genital warts, genital herpes, hepatitis, and gonorrhoea, "Anal intercourse can transmit most STD, and receptive anal sex is associated with an increased risk, compared with oral or vaginal or insertive anal sex, of acquiring hepatitis B virus or HIV infection." (1998:91) Various studies proved that men report anal sex more frequently than women, proving that women seem to be the most vulnerable regarding this practice, since they are on the receiving end.

Albeit not a high-risk sexual behaviour in terms of HIV- transmission, oral sex on a man (fellatio) or on a woman (cunnilingus), without a condom or barrier, is

considered to have some risk involved. What percentage of the youth, living in rural areas, are aware that they should abstain from this form of sex in cases where there are open sores in their mouths, if they have a cold, a sore throat or when there are sores on the partner's genitals?

Exploitation of the practice

LeClerc-Madlala (2000) writes, "So eager are girls to pass their virginity test, that some are said to be pushing toothpaste high up into the vagina in an attempt to mimic the white lacy veil." During another interview with a social worker at our local Hospice I was also told that girls push pork meat (chosen for its light pinkish hue) up into the vagina for a similar effect. These girls are often not virgins, but sexually active young girls who may very well be infected with the virus already, yet they pass the test as virgins. In addition to being deceitful about their status, they are also putting their own health at risk as substances such as toothpaste can promote the laceration of the vaginal walls, a condition very conducive to the spread of AIDS. In the chapter on 'Dry Sex' this will be discussed at more length.

In other instances, where girls are sexually active, corruption takes place. The testers are paid in various material ways for the 'falsified' certificate, to either satisfy the parent who forced the girl to undergo the test, or to safeguard herself from possible violent behaviour from a parent for failing. Sadly however, this falsified certificate could cost her, or a well-intended partner, thinking he is dating a virgin, dearly, as she might be infected already, or is now carrying an increased risk of possible rape.

Hygiene

Doctors argue that testing 600 girls at a time with the same pair of gloves creates a condition for sexually transmitted diseases (STD's) to get passed on. This could prove to be the case especially in instances, as mentioned above, where girls act deceptively and exploit the practice, thus putting her peers at risk. In many cases testing is done with bare hands and testers seldom wash their hands between tests. In addition testers are often not trained to do the testing and incompetence can lead to damaging the child or the girl during examination. Not all STD's cause ulcers, in which case the girl

might be infected without showing it. Testing could also facilitate the transmission of HIV as in cases of manifestation of ulcers, which render girls more susceptible to HIV infection because of the openings in the mucous membranes.

The *South African Health Review* illustrates that the incidence of cases treated for sexually transmitted infections under the age of 15 years, in Kwazulu-Natal, is the highest in the country. (2001: 308) Many may not even be reported, as seeking treatment would stigmatise the girl and point to a 'polluted' state.

Violence

Cases of severe beating have been reported in instances where girls have failed the test. In the Pietermaritzburg area for example, Childline had to deal with a case, very recently, where the girl's arm was broken. While the country dealt with extreme poignancy after hearing that a KwaMashu woman was beaten and stoned to death after disclosing she was HIV-positive, it was a one-off event. Girls who fail the test, though not stoned to death, deal with severe beatings all the time.

Mental Abuse

In the worst case scenario failing the test implies a girl is 'impure', even before any disclosure of her HIV-status has been made. This is an extremely sensitive situation for the average African person, but especially women, since most fear rejection by the group. Hence, secrecy and confidentiality are of utmost importance. Not only does she get beaten, but also ostracised by the group, since she could be 'bewitched' by the disease and therefore, has seriously compromised her chances of getting married. She is tormented between having herself tested or not. Testing negative could clear her, but should she test positive her spiralling into darkness begins; poverty does not allow her body to be well-nourished to resist the onslaught of the disease, anti-retrovirals are prohibitively expensive and the stigma attached to the disease cause her to feel 'dirty' and promiscuous even though she could have been the victim of rape by a HIV-positive male. In addition to the negative presumption that she is going to die, she also becomes the scapegoat, the one who has brought the disease into the house. The only mercy she can anticipate while being isolated and debilitated by the disease, is

perhaps the kind-heartedness of her mother or her grandmother. The mere act of sitting on a bus or taxi will painfully gnaw at her self-esteem until she will finally become too tired to pick up the morsels of self-respect, one last time, as they wipe the 'polluted' seat behind her when she gets up.

THE COMMISSION FOR GENDER EQUALITY'S INTERVENTION IN VIRGINITY TESTING

All the ramifications of this practice raise a very serious question to the medical profession; does the unconcealed virginity testing safeguard an *intombi* (a virgin) against evildoers, or does it leave her with an increased sense of vulnerability? Is it in other words not setting her up for abuse and exploitation since it would appear, looking at all the evidence, that her virginity status is no longer held in reverence, the way it used to be in her culture? Hence, medical practitioners ask: Are the advocates of this practice not sorely missing something of vital importance in their quest to encourage young girls to abstain from sex before marriage, namely, the essential need to be trained in sexual matters in order to develop into responsible and independent individuals who can take care of their own destinies?

Adding their voices to the ongoing medical controversy, the Commission for Gender Equality questions women's power with regard to virginity testing. They argue that virginity testing is discriminatory as it puts a girl under enormous pressure; it places the whole responsibility of safe sex on her shoulders whilst it is also cultivating a culture of fear, since the girls become the ones solely responsible for curtailing the disease. Hence, the Commission asks, are the advocates not admitting that women are unable to change men's behaviour; that they fail in their own decision-making? Do these advocates really believe that looking at a girl's genitals can bring a solution to the HIV/AIDS problem? The Commission argues that it is a flagrant abuse and infringement of Children's rights as contained in the Constitution, even more so, a violation of Women's rights, as it is degrading and disrespectful towards the rights to the privacy of the individual. The advocates of this practice resiliently fight back in saying they are respecting their rights to revive an ancient custom they believe ensures purity and promotes morality, and could thus be the answer to avoid contracting this fatal disease. They are not abusing any rights, as these girls are not

forced. The problem, medical experts argue, is that there has been no evidence to suggest that this practice has made any difference in the incidence of HIV/AIDS or teenage pregnancies in the province since the revival of the custom about 7 years ago. Therefore, activists are lobbying the proponents of this practice for serious reflection on the severe repercussions of virginity testing.

CHAPTER 2

THE PRACTICE OF 'DRY SEX'

INTRODUCTION

Studies done all over Africa and as far as America have proved that many African men enjoy 'dry sex' and object to 'wet sex'. They would subject women to physical abuse, suffering and risk of infection in order to satisfy these urges and to make it more pleasurable for themselves, or, so it appears. Numerous studies confirm many African women seem to aspire to having just as much pleasure, thus giving preference to the practice of 'dry sex' and, to achieve this they would insert a variety of substances. "When the vagina has too much liquid, the man is not satisfied, so how can the woman be satisfied? Impossible!" one woman is reported to proclaim, and yet another, "I feel pleasure when he suffers a little, and he too feels pleasure when it's difficult to enter," Brown et. al (1993: 990) find in a study conducted in central Zaire.

However 'dry sex' is not merely a traditional sexual practice confined to the rural areas; its use has sensational appeal in the most ancient profession in the world and in KwaZulu-Natal it lures especially lonely, bored and tired long distance truck drivers, with a high HIV- infection rate and low condom use, to engage with sex workers standing waiting for them at one of the 7 truck stops in the Natal Midlands. This is the province, as Phillip Kibbukeli, President of the Herbalists and Spiritual Healers Association in the Western Cape pronounced, that does not only have the highest rate of HIV/AIDS, but also showed the highest 'dry sex' practice prevalence rate. (*The Lancet*, 1998:1292)

Hence, women who experience the practice of 'dry sex' as a powerful tool to 'please men', see the country's 'play-it-safe' campaign as a cruel cosmic joke being pulled on them, since this practice is part and parcel of their livelihood. Poverty has left them no choice. It has driven them not only to sell sex to make ends meet, but has placed the 'older' ones in steep competition with the 'younger' ones. To the 'older' one 'dry sex' has become the incentive by means of which she lures men to make her their

preferred choice, and most likely she would meet a further dangerous demand, his wish to have this kind of sex without any protection.

This makes it clear that the practice is giving Western Medicine a surplus of reasons for deep concern not only regarding the sustained injuries from unlubricated sex and the changes in vaginal pH, but also, with regard to risk-taking for both STD's and HIV/AIDS. It places not only gender inequalities under the spotlight, but begs to give attention to sexual culture, filtered through a kind of focus that does not simply condemn, but calls for a dynamic and altruistic understanding and examination of the social and cultural forces controlling it.

THE PRACTICE OF DRY SEX AND ITS LINK TO SEXUAL WORKERS

Foxman et al (1998) defines 'dry sex', in some studies also referred to as 'rough sex', as the removal of vaginal secretions before engaging in sexual intercourse by using a drying agent, or in the traditional language, "to clean the temple for creation" from undesirable vaginal secretions. (Moses & Plummer, 1994; Runganga & Kasule, 1995 as quoted in Van Dyk 2001:130) Judith Brown, et. al. (1993) reported that women distinguished three different types of vaginal secretions in the study conducted in Zaire. The first type they considered to be small amounts during certain stages of the menstrual cycle, or during sexual excitement, the second, excessive secretions that they called 'too much water' or 'too messy, dirty stuff', and the third, unusual vaginal discharges caused by infections. It was the second type of secretion that women meant when they spoke of the 'wet vagina'. Getting rid of the excess wetness was considered a routine part of personal hygiene. Men accept the first kind of secretion but are repulsed by the second type of secretion, not only because it causes too much wetness, but also because of the unpleasant noise associated with it.

Prior to the study Neetha Morar from the Medical Research Council in Durban did on vaginal insertion and douching practices among sex workers, Morar et. al. conducted a pilot study among commercial sex workers from KwaZulu Natal Midlands who offer sexual services to truck drivers travelling along the main transportation route from the port city of Durban to the commercial city of Johannesburg. The results elicited that not only would women undergo the suffering and pain of having dry sex,

but in addition, “women routinely went to traditional healers to have a small incision made close to the labia with an ordinary blade; herbal substances were rubbed into the wound. The practice, referred to as *ukugcaba*, was performed every 2 months. The women believed that if the substances entered the blood, all the impurities will be cleansed and they would attract men.” (Morar, et. al.1998:470). The pilot study found 91% of the sex workers interviewed and whose mean age was 25, insert substances into the vagina to keep it dry and tight and that the practice was taught to them by their grandmothers, relatives and peers. Not only does ‘dry sex’ suggest non-barrier sex, even in rare cases where condoms are used, women practising this kind of sex are in a no win situation since the chances are these condoms can tear, as the latex barriers are intolerant of certain substances used inside the vagina.

Questioning a group of commercial sex workers between the age of 15 – 45 years who work at truck stops in the midlands of Kwazulu-Natal, Neetha Morar’s (2000) findings show that these women and the truck-drivers like their sex ‘hot, tight and dry’. Her research also finds that the average age of the truckers is 37 and 56% of them are HIV positive, 66% have had a sexually transmitted disease in the past six months; 37% regularly stop for sex along the route; 42% practise anal sex; 29 % never use condoms with prostitutes, and 13% never use them with their regular partners, though over three quarters of them were in permanent relationships. The magazine, *Focus on Trucking and Logistics*, reports that commercial sex work has become extremely popular with as many as 30 – 40 women at the truck stop on a single night in the Harrismith area alone. These women are willing to endure pain for economic reasons, as it is paramount that men return to them. In another study, one woman explains, “Men do not like loose vaginas. If sex is wet the man thinks I have had sex with someone else and then won’t pay me.” (Baleta, et. al. 1998:1292) Thus, the truck drivers especially give preference to those who are willing to give them dry sex, whether at the back of his truck, in a room, or a communal compound. Men are also willing to pay more for a sexual experience without a condom to make it more pleasurable. Women either willingly, or in some cases, by violent means, heighten their risks and put their lives at stake not only for the sake of popularity, but more importantly, to put food in the mouths of their children, to buy them gifts or to pay their school fees. Hence, the medical profession’s concern - the rampant use of the practice of ‘dry sex’ between two extremely high-risk groups of people, the

province's sex workers and South Africa's truck drivers. The entertainment resulting from this forcefully dynamic, yet potentially perilous sexual interplay is trapped within the web of a disease that their behaviour cannot escape.

A random community study performed in Gauteng, where the two main languages spoken were Zulu (44%) and Sotho (37%), serves as a reflection of what can be anticipated in similar communities in Kwazulu-Natal, though one would suspect the figures might even prove to be higher in this province. The study conducted in Orange Farm prove that, 60% of men and 46% of women, prefer dry sex over lubricated sex. The study also showed that among younger individuals the practice of dry sex is far more common among the less educated, but there was no significant difference between education groups in the older respondents. (Beksinska et. al. 1999:178.)

Reasons for 'dry sex'

The study conducted by Judith Brown, et.al., reveals that women consider a large and a wet vagina to be the result of a curse, bad luck or numerous sexual relations and a small and a tight vagina as an indication that she was 'created right'. "My mother managed to make me a complete woman at birth. Also, the first man who knew me was so young he had no liquid to ejaculate. That's how I was spared." (Brown, et. al. 1993:990) Runganga, (1995) reports that female vaginal fluids are considered to be 'unclean' within the Shona culture, and their removal is often seen as creating a clean environment for fertilization. Some women also believe they are strengthening the body, preventing reproductive disease, and toning pelvic muscles. This would imply that women who favour this practice show immense pride in the 'right creation' of this part of her anatomy and in addition to keeping it clean, a desire to maintain an almost virgin-like status, in other words, to sustain the feeling of how it felt before marriage. This, strangely enough, appears to imply she is doing it in the first place, to please herself.

Various studies however, reflect repeatedly that women use traditional vaginal agents not only for self-treatment of vaginal symptoms, such as a discharge and itching, or for 'purity' or 'fitness' sake, but to attain, above all, the sexual enhancement and pleasure of the intercourse, thus, showing it is mostly done to satisfy the male partner.

In fact, various studies show that many women also dislike this practice, however they subject themselves to it in polygamous marriages as they see it as a weapon to keep their men faithful.

The primary reason for 'dry sex' given in the study conducted in Kwazulu-Natal, echoes the need to tighten the vagina for the sake of increased enhancement of sexual pleasure on the part of the male partner. The practice of 'dry sex' among sex workers, is in fact, used as a strategy to ensure men will return to them, thus securing their much-needed income. According to Morar (2000), 30% of the women said that they would get less money if their vaginas were wet and 17% said that if they were wet, it would serve as a reminder to the man she is with that she had sex before him and as a result he will reject her, and seek another woman.

All these findings, and the reasons found among women living in the rural areas, match an inculcated belief, commonly held since early times in the Zulu culture. The belief namely, that a lubricated vagina signifies infidelity, has been, and still is, the source of much fear and vulnerability among women. Thus among females who practise this method are those who dry their vaginas in an attempt to avoid violent punishment from their male partners. Also it is believed, once one has started using drying agents, one cannot just stop, as your partner will think "another man had you, and he will cause problems." (Brown, et. al. 1993:992) The men I interviewed in the Umzumbe area agreed that they resent finding their women wet, but it is acceptable when the vagina becomes lubricated to a certain degree as a result of the arousal they cause.

Reasons given for not using this practice, relate to strong religious underpinnings, "God created me right; all the men congratulate me on being hard and tight," or, "I don't know anything about those medicines; I'm a Christian." (Brown,et.al. 1993:993) These are highly significant assertions as it points to the role the Church could play, and its responsibility in matters regarding harmful sexual behaviour.

Substances used and beliefs for their uses

The studies conducted in various parts of Africa report use of manifold substances. According to Dallabetta, et. al. (1995), for example, the following intravaginal agents were reported to be used for both treatment and tightening, in a study conducted among Malawian women. 'Herbs', prepared in a powder form from a variety of local leaves and twigs were used by 45% of the women for treatment and by 65% for tightening. 'Stones' (pulverized pumice-like stone; silica gel crystals, or potassium permanganate crystals) were used by 56% for treatment and by 27% for tightening. Aluminium hydroxide powder was used by 12% for self-treatment and by 20% for vaginal tightening. The use of a cloth to wipe the vagina, caustic pencil, lemon juice or sugar was reported by only 1% of the women.

Others such as Runganga & Kasule (1995) find in their studies that women use antiseptic solutions (Dettol, soap, salt solutions, or Betadine), chemical and other substances (toothpaste, Surf, methylated spirits, vinegar, human urine, baboon faeces) cotton wool or newspaper to 'dry out' the vagina.

The cohort of 400 sex workers studied during the period August 1996 to May 1998 for douching and intravaginal use in the Kwazulu-Natal Midlands is as far as my knowledge goes, the first comprehensive study exploring the use of intravaginal substances among sex workers in South Africa and shows that the substances used are no different from what is used in other parts of Africa. Focus group discussions were held with 45 women to learn the substances these women use in order to produce a tightening, sometimes even numbing, and drying effect of the vagina. Neetha Morar (2000) explains that these substances can be placed into four categories; traditional remedies, household detergents, antiseptics and patent medicines. Not only the sex workers believe these remedies allow clients to enjoy sex more, but the client also ejaculated within a shorter period of time, making it more beneficial for the sex worker as she can satisfy more clients in a day, thus earning more money.

The brand names provided as traditional remedies are as follow; *alumbrown* (*ishelemgodi*), *imbiza*, *ishelenhlanhla*, *painty*, *norox*, *blue stone* and *umvubu*. They range from rocky material to powders and gels. Women believe, for instance, that

painty, a product in either a powder or jelly form, gives them psychological power and strength, thus they do not get tired during sexual intercourse. It gives them the energy and strength to satisfy anything from 4 up to the 19 clients they see during a working week. *Blue stone*, is a rock from the mines and people living on farms use it to treat animals for various diseases. It is ground and diluted in water before women drink it. "Women reported that by drinking this mixture the vagina becomes numb and swollen. Information on the effect on other organs of the body was not known." (Morar, 2000) *Uvubu*, again, is a product made up of various types of animal fat, which women believe make them 'tasty and attractive' to the men after inserting it into the vagina.

Household detergents, include *Jik*, *soap*, *Ship dip* and *Jeyes fluid*, and are used mainly to kill or remove all the germs. Morar (2000) reports that there is also a cultural belief that the detergent's distinct odour has the power to 'ward off the evil spirits'.

Sex workers reported that they use antiseptics like *Dettol* and *Savlon* largely to kill all germs entering the vagina. These products, used extensively in hospitals and other health care settings are known for the active chemical agents they contain such as, alcohol, phenols, iodine and chlorine. "I use Dettol more than three times a day to remove the dirt of the men inside my vagina" Morar et al (1998) reported one woman proclaimed.

Patent medicines include *Staaldruppels*, *Lovedrops* (also referred to as 'love potion'), *Smuff*, *SVC tablets*, *Tygerbalm* (the old Chinese balm, also called masculine ointment) Whilst *Lovedrops* are inserted primarily for a dry vagina and its pleasant aroma to attract men, *smuff*, on the other hand, which is normally used to stimulate sneezing, is used to create heat and to make them feel 'hot'. The number of women I randomly picked at my interviews to ask about the substances used, all reported *smuff* to be a very popular substance among themselves and their friends. Apart from the belief that *Tygerbalm* tightens the vagina, women also believe that it "emasculates men and rejuvenate male organs." (Morar,2000)

Morar (2000) also reported the use of other agents such as newspaper, brown paper, ice cubes/fridge water, seawater, dry cloth and sanitary pads to remove vaginal secretions and in some instances to make the vagina numb.

During one of my interviews I was also told that there were instances where women boil dagga leaves in water together with a piece of cloth. The cloth then gets pushed up into the vagina leaving the leaves inside the cloth to cause the drying effect.

The study done in Gauteng also showed a belief in drinking preparations to cause drying of the vagina. Nearly all of these women also use tissues, towels and toilet paper, with only 2% using herbal preparations or leaves for drying purposes. The remainder used disinfectants, soap, and vaginal creams.

Methods of insertion

Powders are wrapped in a soft cloth, which is then tied into a knot and inserted into the vagina. It is left in the vagina anything from 10 minutes to a few hours, depending on individual needs and serves to cause swelling of the soft tissue inside the vagina. As a result it causes the vagina to become tight. It was reported in the MRC's survey that women also use newspaper and insert it into the vagina. When liquid substances are applied, they are either inserted directly, or, with cotton wool.

The lurking dangers of 'dry sex'

Even though the majority of the women questioned during the survey held in Natal enjoyed sex when the vagina was dry and tight, a third of them reported to Morar (2000) that the practice was painful, harmful and uncomfortable, causing pain in the abdomen and burning and itching in the vagina. They also detected sores and rashes in the vagina, discharge and bleeding. One woman reported that the 'flesh came out' when she inserted the traditional remedies.

This corresponds with data collected in the various studies conducted all over Africa, which asserts that the intravaginal use of drying agents, increases the risk of seropositivity in women. Not only does the lack of lubrication cause sexual

intercourse to be a painful experience for women, but it also causes abrasive trauma, e.g. disruption of the membranes lining the vaginal and uterine wall, causing them to peel. (Brown et. al. 1993; Dallabetta et. al. 1995;) In another study, from Uganda, 'rough sex' was identified as a HIV risk factor. Hellmann (1991) and his colleagues found that "genital bruising during sexual intercourse was correlated with HIV seropositivity in both men and women." (Hellman, et.al. as quoted in Brown, et.al. 1993:994, Sandala, et. al. 1995) Also, both Dallabetta's, et. al. (1995) and Foxman's, et. al. (1998) studies support numerous demonstrations that sexually transmitted diseases (STD's), both ulcerative and non-ulcerative, are important risk factors for bi-directional transmission of HIV infection. In addition, substances used can also neutralise the use of condoms as it may cause breakage of the rubber barriers. As women also use this as a method to prevent STD's, excessive drying can have a desiccant effect, which heightens vaginal inflammation, thus putting both her and her partner at risk of infection. "Genital lesions as a result of sexually transmitted diseases (STD's) have been shown to increase the risk of HIV transmission. This would suggest that 'dry sex' practice could be a potential risk factor in the transmission of STD's or HIV. (Beksinska, 1999:178)

Brown et. al's (1993) study explains that instances where women use leaves, visible lesions in the vaginal membranes and uterine cervix could be detected. When the membranes fail to offer a protective barrier, it means their protective role is compromised. In effect these women are placing themselves and their partners at considerable risk for sexually transmitted diseases and AIDS. Some powders may have the same effect.

However, Morar (2000) warns that most of these studies show limitations and weaknesses. Brown's study for example selected women from a STD clinic, and the presence of lesions, she warns, might be related to STD's. Dallabetta's study, conducted in Malawi among 6603 pregnant women is another example. In finding a weak but statistically significant association between vaginal agents for self-treatment, does not necessarily mean it could correlate with agents used for tightening as well.

Morar (2000) concluded in her study that a well-designed randomised controlled trial is needed to determine the relationship between intravaginal substance use and HIV, since even though a majority of the women (70%) tested HIV infected during the Medical Research Council's study, their study does not significantly associate the practice of dry sex with HIV infection. What is making this kind of study an extremely difficult one, one might assess, is the fact that unlike virginity testing where the potential dangers are exposed rather overtly, the potential harm regarding dry sex has a covert characteristic, which complicates the assembling of data. However, enough data was gathered in the MRC's findings to prove that substances inserted in the vagina carry potential harm and that the chemical composition of these substances is likely to affect the vaginal environment as a whole.

A HISTORICAL ASSESSMENT OF AFRICAN PROSTITUTES AND 'AN EARLY START'

To be born on the continent of Africa, to be an African person and above all, to be a woman, essentially means that one lives a life of oppression and subordination, not only by a rigid patriarchal system, but also by political structures. Add to this the males' domination and superiority with respect to sexuality, this continent's severe conditions of famine and its effects on socio-economic and cultural life, and it is not a mystical brainteaser to discover why African women too, despite threats of evil spirits visiting them and the punishment involved, have started to challenge these circumstances and have taken to the most ancient profession in the world.

Ahlberg (1994) quotes from a number of authors to tell how the colonial system, served as the impetus for women to start changing their sexual identities within the group, since it excluded women from the labour market. Women in the rural areas, as a result of loss of access to land for subsistence production and other forms of social support, were just as much affected by the disruption of social systems. This forced women out of their protective environments, and into integrating with the urban areas for economic survival. "In the urban areas, faced with anti-women employment policies, and with low educational status, women mostly became beer brewers and prostitutes. Because of the sex imbalance, which was exacerbated by colonial laws denying male migrant workers the right to bring their wives, firm sexual relationships

could not be established. In some African societies it was the beginning of prostitution, where women in addition to sexual services also provided domestic services to the male migrants.” (Ahlberg, 1994: 221-222)

In current times, it would appear, that it is quite often the female elders who prepare their female offspring at a very tender age for their roles as prostitutes. They do this either knowingly, forced by their circumstances, or out of ignorance, not knowing that the practice of ‘dry sex’, handed down over the ages from generation to generation of women, is now a very popular, yet potentially fatal, tool in the quest for financial independence so desperately sought after by themselves and their daughters who are tired of the burdens of living in inadequate households with no electricity and water. The contact with modern living has enticed her towards the commodities and resources, which imply comfort and wealth. Being subjugated to men’s every wish, his power and anger, is perhaps the proverbial straw that pushes her to live life so narrowly on a precipice, determined to overcome the obstacles that stand in the way of her pursuit of freedom.

But what is the very young woman sacrificing when her female elders are opting for infusing teachings of promiscuity and the free display of hedonism, rather than imparting sexual education regarding her safety and health? At a very young age she learns not only that exchanging sex for material gain is right and the norm, but also how to use her body to exert power and control. She adheres to this, oblivious of its deceptive and illusory face, in that she is not safeguarded against violent abuse. Moreover, not only, is she misguided in terms of her sexuality by the people who are supposed to protect her and care for her, but she is also robbed of sufficient health education at the age when her body becomes highly alert to sexual instincts and stimuli. From this disadvantageous and underprivileged disposition, money and what it can buy, distorts all logic and reason, both for her and these female elders. The contemplation of a life/death situation hardly occurs to her, since she has found a very powerful determinant in her struggle against poverty. “Men want sex,” these young girls are saying, writes Cullinan, “and they are prepared to pay for it in cash and gifts.” And once a man has “invested” his cash, says a Durban youngster, “he will go for it, flesh to flesh.” (Sunday Independent, April,15:2001) It is this kind of premise

that is alarming and that alerts Western medicine, as it increases awareness of the low rate of condom use and the severity of women's vulnerability.

In a recent article published in a respectable South African magazine, a reporter, commenting on Durban MRC findings regarding sex workers in the province among whom the practice is rife, tells the story of Rose, one of many young girls who was groomed to please men from the tender age of 13, "My gran took me to a herbalist for muti to make me hot and tasty for men. I was also taught about the diseases men give us, and how to wash them away. I bought from the herbalist, which I powdered and put inside me to start the shrinking. I had to do this every time I'm with a man." (Copeland, 2002:38) In the questionnaire survey, held among a group of 150 women who participated in Kwazulu-Natal to establish the sexual behaviour of sex workers, Morar (2000) tells how alarming it was to see at what a young age these girls start with exchanging sex for money. One participant reported to have had her first sexual experience in exchange for money at the age of 11. The remaining 8 (5%), 27 (18%) and 30 (20%) women had their first sexual intercourse at 13, 14, 15 years of age, respectively. By the age of 15 years, 12 (8%) women had exchanged sex for money and a further 57 (38%) women did the same when they were from 16 – 19 years of age. Out of the 150 participants 69% (104) reported using condoms in less than 25% of sexual acts: 21% (31) reported condom use often and only 10% (15) reported that they used condoms almost always. None of the sex workers reported 100% condoms use with clients. Having completed screenings of these women the Medical Research Council's findings were that the prevalence of HIV infection reaches a peak in women aged 20 – 24 years and decreases as age increases, a trend, which is very similar in the general population.

Some of the key findings among researchers at the recent AIDS Conference held in Barcelona (2002), were that however much the public and police would want to intervene, much is to be learned from a law prohibiting any form of prostitution in Uganda, a country which, with the support of its community had tremendous success in changing sexual behaviour of its people in its fight against AIDS. This intervention resulted in increasing vulnerability among sex workers to HIV-AIDS, since more frequent reporting of violence, rape and other forms of sexual abuse and human rights abuse by clients and security staff occurred. There is, in fact, little that any

intervention, whether from a legal or a medical perspective, can do to deter women from engaging in this profession as it is clear, neither love, nor her strong, cultural beliefs, customs and traditions come into the equation, once she has made the decision to enter this world of mutual exchange. In fact, in a study conducted at three antenatal clinics in Soweto, it was found, that none of the 1,395 women perceived themselves as sex workers. They maintained they see themselves as leading ordinary lives, doing the best they could to survive and feed their children. However, to the outsider, whether living in an African community or from a different culture, this world appears to be chaotic, since it stands in stark contrast with her own cultural background where a woman whispers, and looks down when sexual matters are discussed, even with her peers. Unlike her 'sisters' who are led to find joy in having them tested for their virginity status, she makes the deliberate choice to abandon old-fashioned mores for the pledge of materialistic sighs. She in fact, has liberated herself to a destructive end and is in desperate need of protection and education. Julia O'Connell Davidson, in her essay *Prostitution and the Contours of Control*, published in Holland and Week's work, expresses a very radical feminist analysis of the act of prostitution, "Since no person willingly volunteers to have their human rights and dignity violated, it follows that the decision to exchange sex for money is always and necessarily forced and irrational." (1996:180)

Prostitution has over the ages, always been resisted and has always persisted. Hence, the West can still be led to understand that an African woman's choice, at a 'ripe' age, to exchange sex for money is not a free choice, but one forced by her bleak circumstances. However, considering the young age at which many African girls are forced to start prostitution, equipped with the knowledge of the practice of 'dry sex' as a 'starting kit', without protecting herself against HIV infection, the female elder and this young girl are in dire need of a *rationale* that should force them to heed to science. Since our sexual educational messages are failing us, the question remains, where is she to go?

CHAPTER 3

SEXUALITY IN THE AFRICAN CONTEXT

INTRODUCTION

The HIV/AIDS pandemic in Africa necessitates that Western medicine delve into African culture's sexual practices more deeply at a time in the history of this country when our tolerance of each other's differences and an appreciation of identity, are being severely tested. Yet, the knowledge gained is only half understood, and what we aim to achieve towards informing the Zulu people of the potential harmfulness of some of their practices can have no value if we show no respect for a culture that is interspersed with fine nuances of folklore and indigenous knowledge, and show no appreciation of the severity of their socio-economic circumstances and poverty. We need to understand the sensitive nature of our interventions, for sexuality to the Zulu people is the very core of derived pleasure, dignity and pride and as such it is protected within the boundaries of their traditional mores that they enjoy as a distinct culture. In many instances we are only scratching the surface with our investigations and therefore these practices can display a deceptive nature, luring the Western mind to dismiss them as 'practices of darkness'. It would appear that rampant violent crime often gets associated with sexual behaviour that is seen as foreign, perverse and idiosyncratic in comparison to Western sexual behaviour and, more importantly, alienated from the concept of love, as understood by the West.

There is enough evidence in literature on pre-colonial and early colonial African societies, suggesting that sexual activities were well regulated and controlled. The youth received sexual education through association and socialisation with peer groups and the practice of male and female initiation played a major role in limiting pre-marital sex and levels of sexual violence. Furthermore the practice of 'thigh sex' before marriage suggests that sexual decision-making and negotiation took place, even though it puts the emphasis on male satisfaction and entailed sacrificial offering of sexual desire on the part of the female. It is imperative and inevitable that we place these traditional practices and Western arbitrary reasoning and explanations regarding sexuality under scrutiny, in order to adopt a holistic approach that involves the diverse

nature of cultural sexuality in our educational campaigns. Furthermore, we need to see indigenous knowledge as being unique and different and recognise the potential where it could compliment science. In fact, the West should not be satisfied until it reaches a stage where it could speak of a reciprocal reflexivity on either side.

The introduction of HIV/AIDS in our lives coerces us to eradicate hostility, to bridge the gap caused by our prejudices, to accommodate complimentary levels of thought and to point, in a friendly, yet judicious way at concepts of subjective experience that hold harm for the individual. The West needs to guard against the tendency to force its 'power-knowledge' into social organisation (Foucault, 1976), whilst it pushes indigenous knowledge to the fringes. It needs to start at the very beginning and that is to become scholarly on African traditions, customs and beliefs. Moreover, it needs to contrast itself against the knowledge that is gained, in order to understand how African sexuality impacts on what is meaningful in their culture, and to understand that it suffers no more permissiveness than we, in the West, put on display.

THE ZULU TRADITIONS REGARDING SEXUALITY AND SEXUAL BEHAVIOUR

One need not seek any further, on a global scale, than the Zulu culture to find one of the most beautiful rituals on traditional courting behaviour. The courting stages possessed an unequalled charm and were manifested in the most pristine fashion through a powerful combination of sensual desire, sexual consciousness, modesty and bashfulness, intermingled with all the senses and the raw earthiness of the African person's existence. Hence, if the Western mind doubts the emotional interplay, because the physical aspect seems to it so brutal and uncivilised, then it has only its own ignorance and prejudices to blame. Various authors who did vast research on the Zulu people confirm this premise. Dr. Bryantt (1949), who came to South Africa as a missionary in 1883 and lived among the Zulu people for over 50 years, prosaically describes these feelings at play,

Could he but explain to you his present feelings, the enamoured Zulu youth would tell you that this charming creature, or some force emanating from her, has excited within

him an insuperable craving for her person. Yet no longer is it purely carnal passion that animates his breast. It is indeed, physically, still all that, but sanctified now by the infusion of something more spiritual, more sacred; something higher, nobler than anything that went before - it is the first rosy dawn of love..... (Bryant, 1949:563-564)

Hence, with these feelings the Zulu male found himself to be wholly initiated into the mysteries of love. Following this unforeseen event, a very exciting, playfully luring, and sometimes, clandestine game, has just begun amidst the cascading and lusciously green hills of Natal. Whilst the young men were educated by their elder brothers to '*Mphathise okwequanda unkosikazi*' (handle your woman with care) and instructed on the art of how to verbally trap the girls into accepting the love proposals of their suitors, he also underwent ritual purification, performed with certain medicines obtained from a traditional doctor to drive out evil spirits, as this would make him more attractive to the girls. In a similar vein the elder sisters who acted as their chaperones, would shape the acts and words of the girls, especially on how in their own defence to manage boys. For this reason boys fancied making dramatic first appearances; a boy must see the girl first before she sees him. In this way she could be 'hit by apprehension', which would cause her to be excited and she would forget all the clever words taught to combat his onslaught. Her body language would tell him when she was softening up to him, as she would drop her eyes and become soft-spoken and coy. Traditionally, the fact that a girl has started menstruation did not make her nubile and she was not regarded 'fair game' by the men. She had to curb this calf-love until she reached 16, but should a boy be attracted to a girl, he could ask her to wait for him until she was a little grown up. Vilakazi (1965) writes that although the language used and the general attitudes shown during the courting encounters seemed hostile at times, the whole affair was looked upon as a game, which involved considerable skill.

Abstaining from penetrative sex before marriage was highly valued, and so was virginity, therefore the elder girls who schooled the girl in the correct behaviour towards boys, would also tell her, *Ungazeneki izinkomo zikababa*, (do not open yourself to being deflowered'), (Vilakazi,1965:53). Bryantt (1949) wrote that incredible as it may sound, impregnation and rape were virtually unheard of until the

arrival of the White man, as the unmarried would practice *ukuHlobonga* (external sexual intercourse between the thighs). The youth had no conscience about this form of sex play and it was only practiced once free and mutual consent was gained on both sides and was proved to fall within lawful boundaries. John Mbiti (1969) reiterates this and demonstrates how vital it was to teach the girls at a pre-adolescent age, the essence of abstinence. In his work *Africans Religions and Philosophy*, Mbiti deals exclusively with traditional concepts and practices in those societies, which had not been either Christian or Muslim in any deep way, before the colonial period in Africa. He describes how 10- year old girls were obligated to sleep with boys in places known as *sikroino*. If they refused, boys had the permission to beat them with the consent of the parents. "It was meant to teach the girls how to behave towards men and how to control their sexual desires.....to prepare them for adulthood and housewifery" (Mbiti , 1969:127) No sexual intercourse was permitted when the boys and girls slept together this way. At a later stage these girls underwent virginity examination, and should anyone be found to have lost their virginity, it was considered to be a great shame for the girls. It would have angered the parents to such an extent that in some instances these 'ruthless' girls were brutally speared to death, while virgin ones would receive gifts or cows or sheep. Berglund is another author pointing to the Zulu culture, being almost obsessed with the virgin status of a girl until such time that she married. He describes how the elder women, inspecting the girls to see whether their hymens were intact, would spit in disgust in front of either the girl's mother or her female senior to show that the girl was found to be no longer a virgin. "Some informants have indicated that sometimes the inspecting woman would spit on the girl's organ to indicate to her that her condition had been discovered and that it would be made known." (Berglund, 1976: 332)

From the time a woman is considered to be a *qoma*, she is marked as a grown-up, she is an *intombi* and male relatives are no longer allowed to inflict corporal punishment on, for she is no longer a child. She could also no longer be careless or indiscreet in her actions, for this would jeopardise her chances of becoming married. Her *qoma*-status was accompanied by much publicity, "everybody in the community knew that such-and-such a girl was in love with a boy of such-and-such a kraal". (Vilakazi,1965:51) With concerted zealous anticipation people in the community would await, as in a modern day soap opera, the next unfolding episode of the

relationship. This courting game started early in the life of Zulu girls and boys, but there seemed to be no need to hasten marriage. In fact, a nubile girl who could succeed to lure and entice a boy for many years, fed his fantasies extensively and made her all the more desirable.

A wedding ceremony was normally settled upon when the moon was shining bright, as a faint moon signified bad luck. The man would have settled the *ilobola* agreement, normally 10 head of cattle, or a price agreed upon, and paid this to his 'sweetheart's father, as compensation for the loss the father's kraal was suffering. The wedding was held in the bridegroom's kraal, with the parents of the bride conspicuous by absence, as they were lamenting this loss.

In the Zulu culture, it is said both male and female regarded sex to have the same prompting as touching, eating and drinking. "In fact, it would seem that, to the Zulu mind, moral principles of right and wrong have no place or play whatever within the sphere of sex." (Bryant, 1949: 568) However, concerns about right and wrong came strongly into play where social principles were involved and any transgressions on the part of the woman, would mean an infringement of the law of property as the girl was considered to be the male's property. This said, the implications were that the amorous nature and anticipation of the courting stages would have ceased to exist for the Zulu female while the Zulu male would continue to pursue many unmarried 'sweethearts'. Bryant writes rather sceptically about the practice of polygamy, not only as it happens in the Zulu culture, but as a universal phenomenon.

It may be noted that, while the greater apes are monogamous, man himself has, at least among many primitive peoples, elected to follow the smaller monkeys, and become polygamous. The Zulus too belong to the much-wived fraternity; for the question is and always was with them, How can a normal man forbid his heart to love; how confine that love to one sole woman? However, adultery among the Zulus, was always regarded as one of the most heinous of capital crimes; 'for the lady, if caught by her husband, was liable to instant death. (1949:576).

Hence from an object to be desired outside wedlock, she loses this allure once she is married, since he loses his 'taste' for her, albeit she never loses her value as his

property and she hardly ceases to suffer his selfish whims and oppression. After all, he paid for her with hard earned money. It is like the most engrossing fairy-tale that has sadly come to an end. Although the stance is strongly opposed in Suzette Heald's (1995) work, it led authors like Caldwell(1989) and the like to speak of the 'emotional poverty of African marriage'. She writes, "I find it hard to see African marriages in the societies I know best as any better or worse than ours.....failure is deplored and put down to the personal faults of one partner or the other." (1995:500) Her statement reaffirms authors like Vilakazi's (1965) work, which strongly distinguishes between religious marriages and those among the heathens in African society which were deprived of religious values, but it is a topic to be addressed all on its own.

How do these traditional mores sit with modern living and with all the complexities and havoc caused by the HI-virus, especially since it would appear, from our statistics on rape and reported incidences of violence, that the Zulu culture has discarded the positive and decorous conventions regarding courtship and correct behaviour towards women before marriage? It seems that he is driven by what has proved to be negative and abusive, already back then, so that it features in modern society as alarming negative, destructive and harmful to an even larger extent? In contemporary society men continue to have access to young sexual partners, as their wives bear children and age. In a gender opinion survey, conducted by the Commission for Gender Equality, it was found that the majority of women in contemporary society did not support men's polygamous relationships, that it 'hurts' and that it is a 'disgrace' and 'humiliating'. Some young African women said that they would tolerate being in a polygamous relationship if it meant they knew where their husbands were. Not only does this statement imply that he might be with another unknown woman, but also that it has to be accepted, even anticipated. His need for something 'fresh', something 'new' and 'tasty', could also explain his preference for the young, as his perception of the female organ as something "dirty" and "potentially dangerous" (Leclerc-Mdlala, 2000), as 'flaccid' and 'worn out' is closely related to marriage, and not how he perceives her in her youth. In fact, the female organ was and still is, very closely associated with "pollution" as possessing a "mystical force" leading to the notion of *umnyama*, literally meaning "darkness." Moreover, it "..... diminishes resistance to disease, and creates conditions of poor luck, misfortune (*amashwa*), 'disagreeableness' and 'repulsiveness' (*isidina*)." (Ngubane,1977: 78) Menstruating

women were expected to stay away from cattle, cattle byres and all milk food, as her 'pollution' is so contagious, it will dry up the udders of the milking cows. In short, intercourse with a menstruating woman can weaken a man, as it causes 'bad blood' to rush through his head and causes delirium.

This should demonstrate the extent to which we need to heed these beliefs. It is a peril, *vis a vis* the AIDS pandemic that the African male's perception of women's anatomy suffers such a tremendous amount of ignorance, and that she, herself, is set up at a dangerous disadvantage regarding the self-perception of her anatomy, which once she enters marriage, thwarts any efforts of empowerment and the building of her self-esteem. Since HIV/AIDS relates directly to sexuality and physicality, it reinforces the way the Zulu male perceives the female sexual organ, making it possible for these beliefs to spill over into the notion that women are primarily responsible for AIDS, as her sexual organ carries all kinds of diseases and that she should therefore be controlled. It never failed to amaze Obbo (1993) during her fieldwork among Africans how consistently she came across the idea of HIV infection being conceptualised as a one-way transmission from women to men. Various authors noticed that when men are infected it points to her infidelity and when she becomes infected it indicates nothing other than that she had multiple sex partners.

In the meanwhile, back at the ranch, as the saying goes, she awaits him patiently and dares not ask about his whereabouts since she last saw him. She must instead be grateful he returns to her even though it could result in making her yet another HIV/AIDS statistic.

A WESTERN PERSPECTIVE ON AFRICAN SEXUALITY

Half a century ago, Bryant (1949) interpreted and assessed the West's bewilderment with African sexuality, in the following way, 'Quite obviously, we have here to deal with a people on a human plain altogether different from and lower than our own; whose frame of mind, whose moral ideas, whose natural instincts and feelings, whose disciplinary needs, whose whole character, economy and circumstances of life, we can hardly even yet be said to know and perfectly to understand.' He already then, begged the answer from the West with this question, 'Have we a natural or any other

right to force our social and moral views on other races who think and would have things otherwise?' (Bryant, 1949:593)

It is only natural, one might assume, that the answer to Bryant's question, would and could be met with a counter-reaction at the start of the 21st century. Hence, what kind of arrogance possesses the West; one might dare to ask, thinking it holds the key to the instincts of humanity, thinking it is not subjected to the same kind of resentment regarding its own practices? The answer is locked up in how the West perceives its options. It can either shed its colonizing-mentality, stating that a sexual value system with a single universal moral code should exist, one that sensibly and indisputably touches on all sentient beings' logic, or, it could start feeling appreciation for the fact that matters regarding a specific sexual morality, hence, moral principles that presumably apply to all human conduct, are complex and there are no simple explanations or solutions. Thus, the West can start by discarding its privileged and superior ego, assigned to its own beneficial end. This would mean it needs to cease nurturing an ideology, which still allows the Africans' 'strange' sexual 'anomalies' revolving around the songs, dances, ceremonies, customs and beliefs to have an offensive aura, the same way the colonisers allowed themselves to be affected by them back then. It can rather start, showing respect for the sexual behaviour preferences of a cultural group other than its own, in becoming equal partners in the kaleidoscopic face and character the globe displays. It implies that ideally, equal and mutual need for understanding, and not prejudice, must be shown.

What are the consequences for both Africans and Westerners, should the West choose to believe the former? History has shown us, that a resistance to acknowledging that other people do not necessarily attach equal value to an idea that is perceived as sober and rational by one group yields to recalcitrant attitudes, from adversarial schools of thought. Hence, Western arbitrariness towards African disciplines regarding sexuality and sexual behaviour can only be met with rebuttal. In saying that Western specification of sexuality can apply to African sexuality, the West is admitting that it is driven by a desire for dominance and power. And since fear acts as the determinant of dominance one may venture to say the West is haunted by a perpetuating paranoia of reverse colonization, the reason being, HIV/AIDS was considered to be commonplace among homosexuals and bisexuals in the West, but now, as it presents

itself as a heterosexual disease in Africa, it mystifies the theory. It has confused the West to such an extent that it unavoidably has to ask, how long before African sexuality affects the West to the same severe extent, where sex is a mere quantitative instead of a qualitative measure of showing affection, resulting in having multiple partners as opposed to staying faithful to one partner? To the average Westerner it re-inscribes Africa as a 'dark', mysterious and thus dangerous, continent, as this baffling behaviour displayed by Africans, compels them to ascribe to Africa a range of promiscuity, perversions and primitiveness while they conveniently choose to stay oblivious of their own sexual deviations and in fact, often act in denial of these deviations. Simon Watney explains that the presence of AIDS among black people is feared in the West, because, " it is generally perceived not as accidental but as a symbolic extension of some imagined inner essence of being, manifesting itself as disease."(1987:8) Proof of the uncivilised and perverted nature of Africa's sexuality, Westerners argue, can be found in Africa's prurient and rhetorical sexual behaviours, for example, customs and beliefs regarding polygamy, the *ilobolo*-system, sending a barren daughter's sister to provide children to the son-in-law, wife-inheritance, showing hospitality by lending one's guest your wife, and the practising of virginity testing and 'dry sex'. Hence, Westerners argue, HIV/AIDS can be the incentive that can do what colonisation could not do; it can inject Western medicine with a moral responsibility to exert its power. Henceforth, the West's moralizing mission should be aimed at educating Africans safe sex methods and towards moulding and shaping them into monogamous heterosexuality more prudent and more disciplined in nature than what one could hope to find in the West. Fuss is rightfully suspicious of this presumptuousness of Euro-American thought on African sexuality. She asserts the West itself suffers from confusion, since it tries to fit different psycho-medical categories of sexuality (homosexuality, bisexuality and heterosexuality) into universal, global formations. She asks,

Can one generalize from the particular forms of sexuality under western capitalism to sexuality as such? What kinds of colonizations do such discursive translations perform on "other" traditions of sexual differences? It is especially important, confronted by these problems, to focus on the ethnocentrism of the epistemological categories themselves - European identity categories that seem to me wholly inadequate to describe the many different consolidations, permutations, and

transformations of what the West has come to understand, itself a myriad of contradictory fashion, under the sign "sexuality." (1995:159)

This leads us to the latter option. In choosing this option, the West leans towards taking cognisance of African's own independent logic and reason. Looking back on a legacy of pride, magic, survival skills, folklore and colourful lifestyle amidst poverty, unemployment, abuse, addiction and the lack of science, it recognises and pays homage to Africans' very unique identity. It now realizes that as a previously colonized people, Africa's cultural practices suffered a plethora of misconceptions and were too eagerly discarded as they threatened the very core of what stands as acceptable for the West. It brings to the table the West's own past sexual history, admitting that Westerners themselves are victims of past societal attitudes towards sexuality and sexual behaviour, which bemused other parts of the globe in the same way. For example, in the West too, women were considered second-class citizens for millenniums and in addition, prostitution and having multiple sexual partners were practices commonplace long before Christ. Since the twelfth and thirteenth century, when the Church assumed greater power all over Europe, it went through periods of 'sex only for procreation', whilst, at the same time, 'religious houses themselves were often hotbeds of sexuality'. (Taylor, 1954:19) As with Africans, a style called 'courtly love' developed among the upper classes during this era and it was commonplace to test 'pure love', almost the same way the Zulu people did. Lovers had to prove that they could refrain from sexual intercourse by lying naked next to each other in bed.

Further, the adoption of chastity belts during medieval times, proved that the behaviour of Western men was no different, if not worse than the attitudes of Zulu men towards women, seeing them as mere 'property.' Originally designed to prevent rape, the practice was exploited, and women became 'locked up' under the pretext that they were guarded.

The belt of medieval times was usually constructed on a metal framework that stretched between the women's legs from front to back. It had two small, rigid apertures that allowed for waste elimination but effectively prevented penetration,

and once it was locked over the hips the jealous husband could take away the key.

(Tannahill, 1980:276)

Although the 16th and 17th centuries were accompanied by the loosening of sexual restrictions, premarital sex or adultery were severely punished and people had to make their transgressions public. Ironically these were also periods marked by a mother-whore dichotomy and a massive epidemic of syphilis. The late 17th century also marked the start of the Enlightenment period and the notion that women are ‘dangerous’ emerged. In fact women’s rottenness as marked by her syphilitic state runs like a thread through Shakespeare’s plays, born during this period. Tamsin Wilton quotes from Lear’s mad speeches to illustrate how vividly it was contained in some passages,

*Down from the waist they are Centaurs,
Though women all above;
But to the girdle do the Gods inherit,
Beneath is all the fiend’s; there’s hell, there’s darkness,
There is the sulphurous pit – burning, scalding,
Stench, consumption; fie, fie, fie! Pah, pah!*
(From *King Lear*, quoted in Wilton, 1997:59)

The same adverse reaction happened when America adopted the Puritan ethic in the 19th century; the ‘fallen women’ emerged and prostitution became commonplace in the cosmopolitan cities. When the prudishness and strong sexual repression of the Victorian era spilled over to America in the mid-1800s, opponents, especially men, responded with rebellious force, leaving their ‘asexual’ docile upper class Victorian lady to cover her ankles and bare neck whilst he escaped into the arms of the young prostitutes of the lower and middle classes, who were forced into these circumstances by the wretched poverty and misery. Ahlberg’s study brings to light that the Victorian era, in fact, was marked by the belief that “man’s sexual urge is biologically natural while a virtuous woman should be asexual.” (1994: 224) However, ‘unchastity’ was regarded unnatural and unforgivable in women. Does this not strike a cord with us as to Bryant’s (1949) description of the Zulu male’s polygamous adventures? Diaries prove that the Victorian woman was not exactly that innocent,

pure and content with her puritan circumstances either, and that scorching love affairs abounded. Again, we shall see that the African female has started to respond to the suppression of her sexuality along a similar vein.

History also shows us that it is not only Zulu men who believe women are polluted when in a state of menses. "In 1878, the prestigious British Medical Journal printed a series of letters in which a number of physicians offered evidence supporting the idea that the touch of a menstruating women would spoil hams" (Masters & Johnson, 1986:17) Also, sex, crime and violence grouped together so closely, towards the end of the 19th century that German psychiatrist Richard von Krafft-Ebing, undertook a detailed book of sexual disorders advocating, amongst others, sympathetic medical concern for the so called sexual perversions.

The 20th century saw the liberation of women, legalised abortion, and the establishment of 'the pill', which gave Western women more control over their sexual destinies, but it also witnessed the undesirable introduction of STD's and AIDS in the 1970's and 1980's. This introduction can, strangely and ironically enough, for the first time in the history of sexuality, act as a binding force. It asks the diverse cultures to see their sexual past as irrelevant and to join hands as, "blood and semen, as the stuff of life and the gift of death," (Small, quoted in Weeks & Holland, 1996:212) know no difference with regard to race, colour, creed, culture or class while it carries the potential to put a horrendous number of people on death row all over the world. Taking cognisance of the fact that similar perversions regarding our sexual nature prevails globally, the West must realise that in the end we are all human when it comes to the most intimate aspects of our lives and in this humaneness and vulnerability we should seek a binding force that could lead to a better understanding of our differences.

Thus, in choosing the latter option it entails that Western Medicine should be clear in its intentions and impeccable with its words. It should not merely act voyeuristically regarding the various studies concerned with harmful sexual practices, but should be showing that altruism, and not power and dominance, is invested in its interventions and that it stems from experience and the integration of diverse and different knowledge systems regarding sexuality. However, as long as the West chooses to

marginalize the victims of the disease, and does not spend the money where it is most needed, i.e., education, the vulnerable will stay vulnerable and efforts aimed at 'correcting' the disease, in finding a vaccine, will perhaps save lives, but will sadly fail to find a way into people's hearts.

Hence, African people cannot be blamed if suspicious of medical interventions, as they can hardly suffer from a frozen memory whilst they still hold so vividly a picture of a long-standing history of oppression and discrimination in every moral fibre of their bodies. In fact, African people cannot be blamed for discerning a state of hypocrisy and moralistic panic in the West, which Watney (1989) refers to as 'press hysteria.' Reactions on sexual practices and its effects on the HIV/AIDS pandemic cover a spectrum, he writes, which ranges from "stammering embarrassment to prurience, hysterical modesty, voyeurism and a wide variety of phobic responses," (Watney, 1989:41) threatening to sexually repress African people's sexuality and their sexual practices. Instead of feeling that their burdens and oppression have been physiologically, sociologically and psychologically uprooted, the media's 'hysteria' has an adverse effect, since people choose to feel even more stigmatised instead of worthy of care and support. This captures the quintessence of the required Western intervention; to act with caution and utmost sensitivity, and instead of condemnation and condescension, it should aim to strike a balance between the two very different schools of thought.

The biggest challenge for Western Medicine, in fact, is to successfully illustrate it's striving to 'rehabilitate' the sexual pleasure and power, which the outcomes of these practices have destroyed. More importantly, to show that Western Medicine's concern, often read as antagonism, arrogance or interfering, is in fact fuelled by science, human rights, care and compassion and, unlike its past, rather austere, ideology, it is deployed just as much for pleasure as for pain and is not denying people of Africa their pleasures. The MRC's research into the development of a microbicide, (addressed in Chapter 5) which will allow people to continue with the practice of 'dry sex' should they wish to do so, serves as a perfect example to illustrate the statement. In *Western sexuality: practice and precept in past and present times*, Aries et. al. assert,

Medical science has traditionally seen illness and pain as its 'raison d'être', death as the enigmatic symbol of its limits, pleasure as a sphere in which it has no control. The situation has changed in the course of this century. Death and sexual enjoyment have been progressively drawn into the field of medical skill, with a status approaching that of sickness and pain. Death is often seen as a major dysfunction whose negative effects can be limited and perhaps one day 'cured'. Deficiency in pleasure is also classed as a dysfunction which has to be treated medically. (Aries et al 1985:198)

Aries (1995) however insists that, this paradigm shift should not be misunderstood; whilst it disregards 'perverted pleasures', the focus is on 'unsatisfied desire' and 'aborted pleasure'. Practices such as virginity testing and dry sex are indeed two distinct and unique concepts but can have no benefit for reproductive health when it causes women to lose control and men to emanate a disturbing kind of male power. This clearly implies that, developing a microbicide does not diminish the need to caution and educate people against the dangers of 'dry sex', only that it would leave them with better, and informed choices to make.

Hence, the traditionalists too, have two options: they can either abandon Western medicine's conceptualisations as having its origins in an ignorant mind, thereby deciding that Western Medicine is re-inventing imperialism, or, they can investigate the merits of Western medicine's concern and attempt to meet it with mutual understanding and debate. Either way, it would be grossly unwarranted to expect Western medicine to simply gloss over these harmful practices without seeking legitimate justification and answers as it would reflect negatively as a blatant exercise of *schadenfreude*, an emotion that suggests the West is taking pleasure in Africa's suffering. As Bauman pointed out, "Moral responsibility is unconditional and infinite, and it manifests itself in the constant anguish of not manifesting itself enough." (1993:250)

SCIENCE VERSUS INDIGENOUS KNOWLEDGE

Man's natural tendency to interpret the natural and physical environment is connected to the entrenched urge to have order and structure in our lives. Somehow we align our

need for security with our need to make good sense of our surroundings and to live it with meaning and purpose. Furthermore, we define ourselves through our chosen and preferred way of living our own sexuality and not any less by the attitudes and behaviour of the society into which we were born. For instance, if born into a 'modern' society, our knowledge and information gained will be regarded as rational, based on logical principles and often as invested in highly developed technical skills. Opposed to 'modern' man, stands the person we regard as being born in a 'primitive society', someone we define as a person who uses the supernatural, metaphysical means and 'big magic' spells and/or other extraordinary measures to keep his or her world under control. What it boils down to is that practitioners of Western medicine uphold scientific beliefs in order to understand and interact with human biology, whereas traditional 'medicine' is generally based on indigenous knowledge, devoid of any empirical data, research or scientific tests, and in which health is viewed in a psychological, spiritual and social light. Science and biomedical 'correctness' are deployed in a language which allows African people to interpret the human body and human bodily processes metaphorically and symbolically.

Mquotsi explains that the more limited the knowledge, the greater is the insecurity and dangers from unknown and threatening forces to which one feels exposed. He proclaims,

Magical techniques are essentially psychological in genesis, and are dominated by the wishes of the individual or group. Wish-fulfilment and fantasy take the place of knowledge. The method of wish-fulfilment relates to projection, and this is the method adopted in magical techniques. One projects desired satisfactions and unfulfilled wishes in an attempt to control the threatening forces that surround to be their master. (Quoted in Odora Hoppers,2002: 166)

When we relate Mquotsi's assertion to the practice of virginity testing, one finds that however much it neglects instilling adequate sexual knowledge, it moves narrowly on the fringes of 'wish-fulfilment' and the 'desired satisfactions' of a cultural group, who seeks to re-appraise traditional African communitarian values and knowledge systems in an attempt to fight the 'threatening forces' of this disease. In the case of 'dry sex' among sex workers, we often find the converse. The individual has often cut ties with

traditional values, thus tending to comply with the use of condoms in the adopted libertarian approach, nevertheless they often choose to compromise knowledge in an attempt to control the 'threatening forces'. In fact, 'magic' is so deeply imbedded in the African culture that its resistance towards knowledge is often staggering to Westerners, realising that it is magic's harboured psychology that assists in controlling and mastering the unknown, and not science. However, as with any fantasy, if knowledge is not incorporated it can lead to disillusionment and dangerous outcomes. Yet, we need to understand, that to Africans, the concept of 'magic' does not denote disillusionment, but incorporates fate, thus explaining the African person's denial and fear of a disease that causes them to depart life prematurely. Bryant explains, "With them none died young; that were unnatural and inconsistent. For is man not born to live? And is not youth, and health, and vigour liberally supplied him to enjoy that life?" (1949:698) This suggests we cannot hope to achieve success in offering alternatives for harmful practices if people have not first and foremost been educated on the behaviour of the virus. Does this not tell us precisely that Westerners need to adopt a greater appreciation of indigenous knowledge systems in order to give our scientific campaign's content and meaning?

We have read what the testers are looking for when they check for an intact hymen, but how does it correspond with a Western approach? In a Western scenario virginity examinations are hardly ever done and contrary to what many may believe, doctors cannot always tell whether a female is a virgin by conducting a pelvic examination, because the presence or absence of a hymen does not render an adequate indication of prior sexual behaviour. In addition, intercourse does not always tear the hymen. Instances where a girl was seduced and not forced may only cause it to stretch. "Under most circumstances, the first intercourse experience for a girl or women is not painful or marked by a great deal of bleeding." (Masters, et. al. 1986:33) There are even instances where baby girls are born without a hymen or only a partial hymen. (Jeffcoate, 1972:25) The only instance where examination would be done is in cases of suspected indecent assault and would be performed by a qualified doctor or a gynaecologist. The presence of an intact hymen only proves non-penetration, but the proof of assault would lie in the detection of semen or evidence of fresh injury. Various studies have shown western medicine that hymen configurations vary as a result of the manifestation of different oestrogen levels present in the individual. The

hymen could also be interrupted by different activities such as digital interference or use of tampons prior to embarking on sexual intercourse.

This shows that the practice of virginity testing has merely symbolic value and that, whilst it is to be conceded that symbols and signs are necessary and meaningful in any culture, traditionalist need to establish, whether this particular and insidious symbol serves human life and dignity. In offering an alternative for this practice, the first and biggest challenge to science is to acknowledge and respect it as a symbol, before it embarks on finding creative ways to explain the anatomy.

The practice of dry sex highlights a very fundamental difference in how a man in the Zulu culture perceives sexual arousal as opposed to how it is perceived in the West. "Normally," writes Brown, et.al. "psychological and physical sexual stimulation cause glands of the cervix and vulva to produce fluids that lubricate the vagina during coitus. Without adequate lubrication, both the vagina and the penis can be traumatized." (1993:993) "Excitation", writes Masters and Johnson, "may be physical, psychological, or a combination of the two. Sexual responses are like other physiological processes that may be triggered not only by direct physical contact but by vision, smell, thought, or emotion." (1986: 60) My interview with Zulu men in the Umzumbe area led me to believe that the Zulu male is aware that vaginal lubrication happens as a result of the physical contact he shared with his woman, but not as a result of any prior thought or emotions. Finding her 'wet', not only makes the Zulu male suspicious of her fidelity, he also regards her lubricated vagina as 'not clean' and as an inference of the 'germs' and diseases she is carrying. A dry vagina on the other hand signifies erotic pleasure for the Zulu male, "a man does not want to swim in a river" as it was pointed out to me, and when she becomes excited with him, it must also not become too wet as he likes the friction and the 'roughness'. The vagina must also be tight to enhance this pleasure. Conversely, the Western male who 'only wants to slip it in', stands in stark contrast. He adheres faithfully to the tenet that, "Vaginal lubrication makes insertion of the penis into the vagina easier and smoother and prevents discomfort during intravaginal thrusting." (Masters & Johnson, 1986: 60) It compliments the Western male to find his woman sexually aroused and 'wet' on arrival, or at the onset of sexual stimulation, because it is a clear signal to him she finds him sexually attractive and that he excites her. During the excitement phase, in

fact, Masters (1986) explains other changes can be expected to occur in women; the inner two-thirds of the vagina expands, the cervix and uterus are pulled upwards and the outer lips of the vagina flatten and move apart. In addition, the inner lips of the vagina enlarge in diameter, and the clitoris increases in size as a result of vasocongestion.

Hence, the many women who practice dry sex either sacrifice or compromise a very natural physiological process occurring in the human body during foreplay. She settles instead for the superficial and painful enlargement of her vaginal tissue as the various substances she uses cause it to swell and extend. The fact that it could cause the vaginal walls to rupture which in effect makes them serve as a passage for the human immunodeficiency virus (HIV), seems to be knowledge she is either sadly unaware of or chooses to ignore. As qualitative research is not available on the most intimate and private moments between two people involved in sex play in the Zulu culture, one speculates as to whether the average Zulu male takes sufficient time to discover and appreciate the natural, biological process that takes place in the female? Should he be led to discover this 'knowledge', could it not perhaps diminish his appetite for dry sex? Is it not possible that his male power stands so rock-solid in 'wish-fulfilment' and 'desired satisfaction', that he sees that, working against nature during the most intimate moment with his female counterpart, as the only manifestation and gestation of his dominance and control over sexual pleasures, thus denying himself the discovery of the natural psychological and physiological processes during intimacy? One cannot help, by contrast, to discern the natural tendency of the Western male who, surrenders as a manifestation of his love, thus co-operating, with, the forces of nature. Briefly then, one sees the negative role gender conception plays, even in, the most intimate moment shared, of showing love and care.

Ahlberg argues the HIV/AIDS pandemic is thwarting efforts to prey into intimate relations, as the stigma and myths associated with sexual activity may distort what is reported for fear of exposure and the desire to present oneself as favourably as possible. (Marshall and Suggs, 1970; Broude and Green, 1976 as quoted in Ahlberg, 1994:225) One might add that this is particularly true in South Africa, where our notorious past has created an environment in which stigmata and prejudices, based on

race, class and gender, abound. Feeling 'dirty' or 'dangerous' because of skin colour may thus result in a situation where participants give false information to repress resistance, especially when people feel threatened because their priorities and needs are merely measured quantitatively and not viewed as real. Tangwa warns,

“the Western approach, is overly empirical, statistical and businesslike. It is a question whether all problems that face us, including HIV/AIDS can be solved by a purely analytical method where the base-line approach is to try and reduce complex systems to constituent parts, and where treatment of the parts of necessity implies salvage to the whole. This business-like statistical analyticity may, for some perspectives, appear like the epitome of rationality, but it ignores other perspectives and other aspects of being alive and being human.” (Tangwa, 2002:227)

We need to critically assess whether our questions lean towards a kind of 'social hypocrisy', thus, whether they reflect the preconceived ideas and assumptions, which are shaped by the social environment, as dictated by the West. McGeary's incisive discernment alerts us to how differently AIDS presents itself in Africa and how we should adopt our interventions accordingly, "Elsewhere," she writes, AIDS is "limited to specific high-risk groups and brought under control through intensive education, vigorous political action and expensive drug therapy," whereas by contrast in Africa, "the disease has bred a Darwinian perversion. Society's fittest, not its frailest, are the ones who die – adults spirited away, leaving the old and the children behind. You cannot define risk groups: everyone who is sexually active is at risk." (2001:45) This accurate observation strongly underscores that we cannot necessarily apply in Africa what is feasible in the West, since the scourge of AIDS has left Africa's problems with a psychological edge. Our investigations require that rather than seeing the outcomes of our problems in accordance with statistics, we should take, to a much larger extent, account of the person behind the statistics and the distinctiveness of living conditions.

Would it thus be relevant and fair, for example, to debate whether men in 'primitive societies' love their women any less, because of their preference for 'dry sex' and hardly any foreplay, or that virginity testing is inhumane and pointless according to Western standards? Although these questions smack of Western presumption and

prejudice and appear not to be honouring Africa's distinct sexuality, it also rings fair and true, that if Western medicine in its response to this pandemic does not promote and encourage scientific knowledge and information regarding potentially harmful practices, it unjustifiably disregards the autonomous-self, and the free will of the individual to choose. People are in fact entitled to access to knowledge regarding, not only their health, but also their future. It is a fine line, which one treads with respect and care, that separates being sensitive and being insensitive towards the needs of the marginalized and vulnerable in society, as these zealous efforts to 'correct' are often read as coercion. We cannot, however, afford the luxury of underestimating, and hence understating the need for intelligible information dissemination. Individuals, and whole societies are in many instances expressing a new found sexual identity as a result of cohabiting with modern society and AIDS, and thus are in desperate need of guidance in order to make informed choices regarding the risks involved.

CHAPTER 4

STEREOTYPED GENDER ROLES

INTRODUCTION

In the second half of the 19th century the father of the theory of evolution, Charles Darwin came up with the idea that men are more pugnacious, and energetic than woman, and have a more inventive genius, thus the average of mental power in man must be above that of women. In her work, *The Second Sex*, social critic and French philosopher, Simone de Beauvoir (1949), explores this superior mental power that men supposedly possess and reflects on the psychological damage the claim is causing. She proclaims that it marginalizes women, socially and intellectually, and that, “patriarchy is a thoroughgoing, multi-layered, self-perpetuating system that has comprehensively denied women the means of achieving not just equality, but ‘transcendence’.....Man is defined as a human being and a woman as a female – whenever she behaves like a human being she is said to imitate the male” (Quoted in Mautner, 1996:64) Since these words were spoken women in Western societies have, to a large extent, liberated themselves, not only through the person itself, but through structured and various ideological discourses, increased by mass media and different institutions. Sadly in Africa, the rural, dependent African woman is still deemed a minor by most African men with little if any enforceable rights. De Beauvoir words, which were applicable to most women in the West back then, indeed cannot be more apt in describing the African woman’s situation, at present.

Various studies on gender highlight in particular how the constructions of masculinity and femininity impact on violence and the violation of human rights in intimate relationships, which in turn impact directly on the HIV/AIDS pandemic. This has given rise to the identification of AIDS as a ‘gendered’ epidemic, hence, the realization that information needs to be accompanied by a fundamental understanding of the differences in power relations between men and women. These relations give answers as to why women would or would not change their sexual behaviour and how their interactions are shaped not only by poverty, but also by the social influences driven by gender inequality.

This stress the fact that AIDS has moved beyond the boundaries of being largely a biomedical dilemma, but also reflects on other dimensions such as socio-cultural, psychological, economic and political aspects. It also cautions that preconceived and predetermined ideas of gender-roles in the African culture are not only the playground for feminists' pejorative remarks, but in reality it exacerbates the morbidity and mortality rate of the disease exponentially. We involuntarily feel compelled to generalise our conceptions of the African male's and female's role in society the same way we are inclined to generalise any other culture's societal behaviour. This can easily lead us to misconstrue that *all* African men equally share a negative and a disturbing kind of power and that *all* African males regard it as crucial for their masculinity to be defined by a woman's subordination. Hence, our perceived data, either from personal experience or via the media, influences us to generally perceive and to assert that the African male is powerful, the dominant partner, the decision-maker, the provider and sexually unlimited in terms of partners, the place or time of these urges, whereas women are the passive and submissive partners, irrational, frivolous, confined to domestic chores and not empowered to negotiate safer sex, or concerned about their rights. Wherever we find deviations from these conceptions we tend to discard them as it complicates our perceived data. We choose to focus on the negative, since it involves the masses, and sorely neglect utilizing the examples of people who have risen above these conceptions, as role models for the young. It is these role models that can lead us to using a new vocabulary, a new jargon, to describe 'new' gender roles that, perhaps over time, can wash away the 'old.'

Hence, since these entrenched conceptions cannot be easily refuted because they are so deeply embedded, generalizations such as these ones have a dangerous effect in our current HIV/AIDS situation. Not only do they imply that men stand in the way of positive change, since they are not flexible and that they thus cannot play a part in the solution we are hoping to find, but it also fuels the misconception that we have reached an *impasse* stage with the average African woman, that it implies a requirement for a dishearteningly slow process to get her to act assertively in accordance with her rights, since she is powerless to resist the power of men. This view disregards the fact that AIDS is confronting men just as much as it confronts women, forcing them to face certain emotions with regard to the mortality and morbidity it leaves in its wake. The denial of the disease, which many African men

espouse, points to inner conflict and confusion as they struggle to come to terms with their own vulnerability, a trait that was previously ascribed to women as the sole bearers. In our approach we cannot afford to alienate men as demonstrated by the practice of virginity testing. It only acts to put young women under pressure to 'safeguard their reputation' and men under pressure to 'demonstrate theirs.' (Holland, et.al, quoted in Weeks & Holland,1996:239) We need to understand that the African male is just as much in need of a demonstration of the emergence of cultural behaviour change, in a way that proffers understanding for his homeless identity.

UNDERSTANDING THE AGGRESSION OF SOME ZULU MEN.

South Africa is considered to have one of the highest rates of male violence committed against women for a country not at war. It is estimated that 1 000 women in South Africa are raped daily and that one in six women are in abusive relationships. Health Review (2001) states that 2 out of 5 (39%) sexually experienced teenaged girls report having been forced to have sex. The South African Police Statistics show that in 1996, nearly 20,000 children under the age of 17 were raped and nearly 31,000 women aged 18 and over were raped countrywide. In Kwazulu-Natal where the myth about raping virgins is rife, over 4,107 children under 17 and 4,599 women over 18 were raped during that same year. In 1998 the trend continues; countrywide nearly 20,000 under 17 were raped and nearly 30,000 over 18. In Kwazulu-Natal 4,300 rapes occurred among children and 4,225 among the over 18's during the same year. These figures often leave the Westerner's mind mesmerized, as we seek to find an answer to the question, why are men so uncontrollably angry in this country? Since we are dealing with men in the Zulu culture however, we ask the question; why are some Zulu men, who once showed such immense respect for their women, lacking these skills in contemporary society?

To most on the outside, these statistics would bear testimony to the Zulu male's obsession with exercising his sexual prowess and thereby proving his manhood at all costs. How else could the domestic violence and appalling and aggressive sexual acts be explained, especially against young children? I shall point at several factors to prove the Zulu male derives his anger, by and large, from several different types of

fear originating from certain beliefs in his culture, and whilst instant gratification and entitlement play their part in these acts, his fears should not be discarded.

Seventy-year old James Rasenyalo, renowned interpreter at the Port Shepstone magistrate court, attempted during an interview to express, the Zulu man's anger in these metaphorical words, "Westernisation changed our traditional beliefs about ourselves and our sexuality. It was as if sweets were strewn onto the streets, the people were outraged with joy and ran for it, but they did not see the oncoming traffic, because they were never trained to look first to the right, then to the left and so on.....And, it was mostly the angry men, who had to deal with the struggle, who ran for the sweets. They felt frustrated at the time, disempowered, oppressed, and without homes and families, pride or dignity; they fell out of love with themselves, and these sweets, no matter how attractive they were and what they could teach these men, made them even more angry, because the power of the oncoming traffic was so strong, it started running them down without warning and this made them lose even more power, slowly and painfully. They learnt then not to trust and not to respect, but to take and to abuse, the way they were abused and the way everything was taken from them. Unfortunately it is the people who are the closest to them, but also the most defenceless, their women and children, who suffer most."

Another Zulu male (age 68) explained, "Our system worked just fine, until we were forced to migrate and become urbanised. In the cities we were lonely and we did strange things. We returned home to find our women were doing just fine without us. Nothing changed, nothing fell apart while we were gone, our houses were well kept, the cattle were fat, even the lands were ploughed. We drank and we became angry." This was a scenario that was commonplace and impacted severely on the psyche of the Zulu male. Men, in fact, mourn the fact that women can take care of themselves, a recent Durban newspaper reported. The Soul City Institute for Health has found in their research that men are raping women to punish them for their perceived independence and for dressing provocatively and speaking assertively like white women. It implicated that roles have changed, and the only way he knows how to respond is with rage.

Ngubani (1977) quotes from Leach, in his paper on the 'Nature of war, to explain the origins of the Zulu male's power and anger. It also explains why Zulu men found the uprooting of this power so disturbing. We need to understand that power in the Zulu male does not stem from persons or things, but from relations, showing dominance on the one side and submission on the other. Power itself is amoral, bringing advantage or benefits to one, yet disadvantage or disaster to another. It lies outside the individual and it is this power that joins two people. Thus it is women's place to be helpless, wailing and weeping, while men mark the end of mourning for themselves by performing an aggressive act, namely the ritual hunting (*ihlambo*). Hence it explains why it is not a woman's place to be assertive, and thus also not her place to negotiate safe sex. He, in fact, is mourning the fact that conditions are challenging his power and the only way he knows how to deal with it, is with rage. The Zulu's ritual hunting, in fact, that depicts his physical aggression, is very closely linked to sexual aggression.

"It is said, 'to clean the spears' - spears that are symbols of aggression, which stab in attack to destroy life, is in a sense comparable to the phallus which stabs to create life.What is 'cleaned' and made safe to use is not only the spear but also the phallus. It is the assertion of male virility and male power." One has to cringe at what Leach continues to say, that it is an expression of *"a health-restoring act of a magical kind"*, (Quoted in Ngubane, 1977:94) as one closely associates it with the origins of the virgin-myth.

According to Marks (2001), boys who perceived this submission on the one side and the dominance of power on the other side in the household set-up, subconsciously made one of two choices; they were either appalled and distressed by this violence, leading them to believe their mothers do not deserve this 'punishment', which resulted in feeling protective towards their mothers and disrespectful towards their fathers, or, in a few cases they lost respect for their mothers who appeared to be powerless. Male youth either desired to avenge their mother's abuse, or, accepted violence as a form of punishment and discipline, as inherently part and parcel of 'African tradition', and that it is 'an indication of concern'. Sadly, instead of making little girls angry and determined not to succumb to this brutality they conversely internalised this violence as 'something to be exerted against them, not by them',

accepting that domestic violence was ‘appropriately’ applied by their boyfriends, and later their husbands, whom they perceived as ‘custodians’ of women and children,

If the guy beats the girl , they beat you with a reason They tell you the right thing and you, the girl, go right. They do not beat you if you go right. If you go wrong, he must beat you because he has given you a right way.

(Marks,2001:25)

In modern society, this assertion acts adversely as it affirms and encourages men’s aggression. It confirms his power and puts his fears to rest, even if only temporarily, because his newly found insecurity consistently tugs at his self-esteem. What he in fact fears most is the modern, ‘new’ African woman who puts his power at risk. These are women opting for conditions to empower themselves; they have loosened the ties with traditional gender roles, and have succeeded in becoming educated. Gupta (2000) explains this situation in a non gender-biased approach and says that it leaves men feeling emasculated and results in new prevailing norms of masculinity. It expects men to be more knowledgeable and experienced about sex, yet it puts men, particularly young men, at risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and intimidates them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood. Either way men are confused, as they not only lack the certainty of what they are any more, but, more importantly, of what they are becoming. In their relations they resorts to physical abuse to relieve themselves of these perturbed feelings of anguish and frustration.

These factors are evidence that men themselves are not entirely overawed by their own power, that they in fact, subconsciously fear the power women possess. Since the woman appears to be ‘dangerous’ it strengthens the need to oppress her. Numerous studies point to the fact that women cope better with circumstances such as new crossroads and instability in their lives. In the workplace, young black men often allow their egos to interfere, as they would rather starve than suffer the humiliation of “being treated like ‘boys’ by their white male counterparts” who offer them “menial jobs”. Ramphele (2002). She further explains that the unemployment as a result, starts a vicious circle, as the man must now often look into the eyes of a woman for cash.

This is followed by “low-self-esteem, resentment, anger and abuse of the very source of your support - the woman: mother, sister, wife, lover.” (2002:160) As a patriarchal being, the superiority he possesses over her, an inferior being, sits like a micro-chip implant, making it hard for him to so readily accept she too, accommodates multiple sexual partners, and is thus challenging his domain. This is all evidence of a flourishing low self-esteem, confronting the ‘proper’ Zulu male, as he must now witness how his control over womenfolk spirals out of control.

Ngubane elucidates yet another, however subconscious, fear the Zulu male carries, regarding his power. He explains that the Zulu man is handed a paradox; his virility is dependant on the fertility of a woman. Women have no control over her shedding of blood whereas men on the other hand, have control over his reproductive fluids, and he uses this as a very powerful, psychological tool to demonstrate his potency. “While a woman menstruates involuntarily, a man ejaculates the semen when he voluntarily has sexual intercourse. In this sense he is in complete control of the situation.” (Ngubane, 1977:93) This is however where his power ends, as a woman who is ideally submissive and powerless, nevertheless exercises some power in that the continuity of the descent group depends on her fertility. “I believe that it is the realisation of this fact that makes a woman’s emissions, which are a manifestation of her reproductive powers, particularly dangerous to men’s inadequacy in entirely controlling the situation of productivity.” (1977:95) This makes her a threat to the power he is entitled to, as it touches on an *Achilles heel*, very deeply rooted, yet significantly hidden, as it is the masculine role to always be in control. However he also knows as long as he manages to keep her financially dependant, he need not fear that she would dismiss him for this reason.

All this said the Zulu male’s living experience of his sexuality is in a crisis. The continuum of violence, the brutal rape of children and women, are desperate outcries for attention. Therapy sessions, however, often reveal the contradictory: these men do not perceive themselves to have psychological or pathological disorders, “It was only the way I saw sex”, as one newspaper reported a perpetrator to have said. This statement makes the situation even more dangerous. There is desperate need to rehabilitate and restore, not only sex offenders, but also men’s views on sex in general. This is in fact sketched in the words of Marcelle Lund, director of Child

Abuse Therapeutic and Training Services, “Unless sex offenders undergo rehabilitation, they sit around with large chunks of time and nurture revenge fantasies of more deviant sexual offences. They ruminate on the erotic side of the offence and masturbate. The sexual impulse remains paired with the aggressive act and they come out compelled to repeat.” (*Mail & Guardian*, July 26 to August 2002)

Dare I say, that deep down, amidst his anger, he fosters hope that his behaviour would perhaps incite us to see his situation as just as desperate and that the word we so readily use to describe his female counterpart, could be ascribed to him as well. He is in fact, just as ‘vulnerable’. He however hopes that we would find a way of educating him without debasing what is left of his immense pride, as he has already sacrificed his spirit and identity under oppressive political powers. Like the phoenix, he is waiting to rise, yet again, from the ashes, but is severely restricted by a false sense of pride and a disease that acts as an impediment to his progress.

CHANNELLING THE ZULU MAN’S POWER

The HIV/AIDS pandemic has equipped the African male, as we have thus seen, with a nervous, yet immoral fibre regarding his power, so that his behaviour unnerves and unearths a poignancy towards the victims, yet intense loathing of the perpetrators, among people in the South African society at large. It has led to a general feeling among many authors and organizations that there ought to be a shift in focus, away from the conceptualisation that the sole solution lies in the physical and psychological empowerment of women, but rather a focus towards changing the behaviour of men, and these days it is argued, the behaviour of boys. I shall argue that in our campaigns we should target both men and women, simultaneously, since focusing on empowering only one group while we neglect the other will lead to dire consequences with regard to this pandemic.

While I concede that boys should be taught how to manage impulses such as sexual desire, anger and frustration, in order to influence the next generation of men, it would at the same time have no impact if the disturbing message he constantly receives via his own experience of gender relations, is that, “....male sexuality is wicked and men are dirty and inconsiderate. This message may also be a male

self-experience. It is a negative sexuality, which makes me a man in the eyes of other men. The wicked urge becomes something that creates identity.” (in Berer with Ray, quoted in Wilton, 1997:4) Furthermore if what he sees is that the female is “an inadequate, faulty or inherently pathological departure from the male norm”. (Homans, Ehrenreich and English, quoted in Wilton, 1997:7) In her paper presented at the X11 International AIDS conference Gupta (2000) laments the fact that many of our past, and unfortunately some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection. It is this hierarchical conceptualisation of masculinity and the perception that they possess a superior, yet negative, sexuality that, if not explained, causes more damage than good. The Zulu male cannot simply block or compartmentalise the perceived knowledge systems over which he hardly has any free will. Therefore, the vocabulary we use, instead of constructing and shaping his power positively and in accordance with gender equity, acts confrontational and destructive to the male’s perceived social stance in society. Epstein et. al. underscores how the Zulu male perceives masculinity *vis a vis* the inherited knowledge systems in his culture,

Human agents cannot stand outside culture and wield power precisely as they wish. Power is always limited and shaped by systems of knowledge which also shape the subjects and power.....power/knowledge position us as subjects of particular kinds. They put pressure on us to adopt particular identities.....in this particular sense, power and knowledge as discourse ‘constructs’ social identities.

(Epstein & Johnson, quoted in Morrell, 1998:15)

Thus, with this ‘power/knowledge’ so deeply entrenched all over Africa, is the Zulu male able to adopt new knowledge systems outside of culture? Is he ready to start imagining new ways of being a man? In order to answer that question we need to understand that many Zulu men, especially those who have not adopted any form of religion, derive their power from their sexual activities, from having multiple partners and from physically ‘feeling’ the act. Asking him to use a condom or to stay faithful to one partner, clouds the way he is experiencing his sexuality, with morbidity, since it is no longer only own errors or transgressions that can make him falter and look bad, but also, failure to comply to medical prescriptions that are foreign to him.

Sexuality now appears to be “an extremely unstable pathological field, “ a field, it seems, that, “would derive its meaning and its necessity from medical interventions”. (Foucault 1976:67) This, to him, is placing sex in the framework of disease, in fact an epidemic, and hence a territory where his power is in disarray. This is making the medical profession’s task an extremely difficult and sensitive one. Not only must it deal with the repercussions of sexual practices, but it must also focus on tendencies, instincts, images, pleasure and conduct, as manifested through the Zulu male’s sexual orientation. It would imply that we cannot shallowly single out one sex, in our campaigns, without focusing on sexual health, pleasure and rights and the, simultaneous, improvement of the ‘distribution of power’ and the ‘appropriations of knowledge’ for both sexes. Foucault writes in this regard,

We must not look for who has the power in the order of sexuality (men, adults, etc....) and who is deprived of it (women, children....); nor for who has the right to know and who is forced to remain ignorant. We must seek rather the pattern of the modifications which the relationships of force imply by the very nature of their process. (Foucault, 1976:99)

Our messages thus far have not reached him on a level he can relate to as opposed to understand but rather as words by which he is alienated. Many of our programmes are insensitive and incoherent to the different needs of individuals and are making it impossible to see whether this disease, however calamitous and callous in nature, could imminently serve as the medium through which the power imbalance could be restored. As long as we push his fears, his inculcated beliefs and conventions to the fringes in our messages, many men in the Zulu culture, especially those who find it hard to break with tradition even though they have become urbanised and those living in remote rural areas, cannot yet come to realise the full extent of the state of emergency his culture is in. It is of utmost importance that we explore ways to channel his power in order for him to see that fragments of his existing knowledge system are not cogent anymore and have become a peril to his health and his culture at large, thus, that it does not serve his good any longer. More importantly, however slow the necessary processes of transformation would *prima facie* seem to be, we should not be discouraged.

Most encouraging are the studies that were done with groups of men from a cohort of 2 500 male factory workers by the University of Zimbabwe Medical School, however much it showed that it would be naïve to presume that this paradigm-shift regarding their sexual behaviour, could occur overnight. Men want information about their risks of HIV infection, but want it directly targeted at them, in scientific formats, and from health professionals, not their wives and girlfriends. Yet, their masculinity as defined by their sexual drive, to have sex many times, often with different women, to have ‘a strong backbone’, even if they have to use herbs to achieve this, was found, to override the risk assessment when choosing a sexual partner. Condoms are discarded, as it might defeat the object: it possesses a sinister power that threatens to destroy their ‘manhood’, since it may cause loss of erection or ejaculation too fast or too slow.

The positive that came from this study however, was that men would welcome the chance to learn more about normal physiological sexual responses in men and women, if presented in scientific ways by health professionals, especially doctors. Men also showed a willingness to change their practices if they could be convinced that vaginal drying agents are harmful to women and increase their risks of HIV infection.

The powerful message emanating from this study is that men are willing to change, to become ‘new’ men, provided our educational programmes can succeed in integrating the cognitive and the conceptual. It gives clues as to why our condom messages do not succeed. Males in the Zulu culture who cling to indigenous knowledge regarding their health cannot perceive the risks, as they cannot conceptualise what harm the virus is doing, neither how their sexual practices can enhance the dangers of the spread of the disease. Unless African men understand the body’s functions and its vulnerability towards the virus, they cannot comprehend and adopt alternative sexual behaviour. Rogers proclaims, “We cannot change, we cannot move away from what we are, until we thoroughly accept what we are”. (1980:17)

This naturally hints at the role women could play in handling and channelling his anger and power. By implication Rogers suggests women of Africa have a binary task: Firstly, she must recognise who and what she is, her circumstances, poverty and the ‘lower status’ she suffers in her community, but, what she needs to accept, is far

more. She need not suffer beyond what is virtuous. In other words, she does not require humility to the extent of self-destruction. She needs to accept that the reproductive powers that have been vested in her, is nothing short of a miracle and should be revered. We cannot however equip her with the necessary emotional and intellectual powers to change the cultural and social implications of a male-dominated mindset, if we do not provide education that can explain her anatomy and the biological processes involved. She must be taught that despite the fact that she is physiologically weaker than men, the dynamic transfer of knowledge offered to her on how to govern her body with regards to the epidemiological effects of HIV-infection could become a very powerful weapon to her, not to override his power, but to guide his power. She must thus be taught to cease putting sex within the framework of 'responsibility' of her own accord, but within the framework of 'shared responsibility'.

Secondly, she must recognise the Zulu male's desperate plea; the rejection of his abusive behaviour accompanied by her love and understanding. He is in need of showing love, but in order to do that, he needs to be taught self-love, since what he sees reflected back at him through his aggressive acts are forms of abuse conducted against him at some stage in his life or the abuse against the defenceless, he witnessed as a child. In short the Zulu male has fallen out of love with himself and desperately seeks to retrieve that love. What he needs from her is not her fear, but a power that can meet his equally well, a demonstration of astute reciprocation of power within the boundaries of mutual respect. My concern is that it is this psycho-socio significance that we are dearly missing out on, should we fail to start a mind-blowing, vigorous holistic campaign, in which theory is being put to the test to extreme measures. Whilst improved access to resources, such as information, skills, methods of prevention care, and technology, (microbicides, female condom) are vital and of equal importance to both sexes, we equally need to heed to fundamental psychological differences and the basic needs of gender.

The mystical implications and paradox of HIV/AIDS is that it does not only present itself as a disease of morbidity, it also presents itself as a message of hope. Maybe, however idealistic at this point in time, we can venture from Fasteau's words of hope

as a starting point, and hope to make progress, if only halfway, towards his vision of gender balance in future,

Perhaps in the future, our lives will be shaped by a view of personality, which will not assign fixed ways of behaviour to individuals on the basis of sex. Instead, it would acknowledge that each person has the potential to be – depending on the circumstances – both assertive and yielding, independent and dependant, job and people – orientated, strong and gentle, in short both ‘masculine’ and ‘feminine’; that the most effective and happy individuals are likely to be those who have accepted and developed both these ‘sides’ of themselves; and that to deny either is to mutilate and deform; that human beings, in other words, are naturally androgenous.

(Fasteau, quoted in Singer,2000:400)

THE DIRE NEED TO EMPOWER WOMEN

The picture presenting itself when one starts breaking statistics down, from a global scale, to Africa, to South Africa and finally the situation in Kwazulu-Natal, regarding women and HIV/AIDS, emerges as follows:

According to UNAIDS (2000), women account for nearly half of all new Human Immunodeficiency Virus (HIV) infections worldwide and the number of women becoming infected is increasing each year. In effect it means, of the 34.3 million people living with HIV/AIDS, 15,7 million are women.

Four out of 5 HIV positive women in the world live in Africa. Sub-Saharan Africa in particular is singled out as it is estimated that it harbours 68% of HIV infected individuals on a global scale and that the majority would die in the next ten years. (UNAIDS, 1999) There are more HIV-infected women of childbearing age living in Africa than elsewhere and since the tendency among African women is on average to have a larger number of children than elsewhere, the risk of infecting a higher number of children becomes bigger as breastfeeding is estimated to account for between a third and half of all HIV transmission from mother to child. (UNAIDS:1999)

In 1998, South Africa contributed to more than 50% of all new infections. Community-based, HIV seroprevalence surveys conducted in the rural areas in South Africa in 1990 and 1992 demonstrated that HIV infection was not only four times more prevalent among women (1.6%) than men (0.4%) but women were also infected at an earlier age than men. (Abdool Karim et al, 1992) Morar (2000) writes that similar findings were reported by a survey conducted in 1998 in an urban population in Carletonville where the prevalence peaked at 58% among 26-year old women and 45% among 32-year old men. Data collected from these antenatal seroprevalence surveys demonstrates that HIV infection is highest among young women aged 20 – 29 years and the infection rate in women aged 20 – 24 increased from 6.9% in 1992 to 26.1% in 1998.

The province of Kwazulu-Natal, kingdom of the Zulu, does not only show, the highest HIV/AIDS prevalence, but also, the highest incidence of STD's. (South African Health Review 2001) Many reasons could be given; for example, its coastline has two major ports, making it more accessible to migrants and in addition it has two major transport routes accommodating two high-risk groups with respect to HIV/AIDS; namely sex workers and truck drivers. It has been proven that the broken family lives as a result of migrancy, lead to multiple partners, low levels of social cohesion (grouping with people outside the household and workplace) and high levels of violence and abusive sexual relations. Furthermore the Zulu culture does not favour circumcision, making their risk six times higher according to some studies. But what sits unanswered with many is the extent to which sexual behaviour, such as the overt virginity checks and high level 'dry sex' practices exacerbate the high incidence of infections, since a girl, when she reports rape or goes for counselling, is not normally asked: do you think you were raped because you underwent a virginity check, or, when visiting ante-natal clinics, do you practice dry sex, as you present with a STD? However, enough evidence has surfaced, proving that we cannot simply look at western medicine's concern as mere speculative. It in fact needs serious consideration.

To make matters worse, studies in the province show that the efficacy levels of training do not suffice. In a recent survey of 236 health workers in KZN (superintendents, doctors and nurses), it was found that 96% felt there was a need for

HIV/AIDS training in their institution. (Health Review, 2001:172) This does not only suggest that there is a problem with information distribution with a poor link between prevention and care, focusing more on the distribution of condoms while inadequately dealing with death and dying, but, more importantly, it also points to dismal failure in understanding the risky local sexual practices that ought to be an essential part of the training programme of health professionals.

This stresses a dire need for proper qualitative research into people's sexual behaviour patterns, with the first and foremost challenge to overcome, being the breaking through the barriers of enmities, prejudices and taboos regarding these interventions.

WHY ARE WOMEN SO SUSCEPTIBLE TO THE DISEASE?

Ulin argues the risk for women is two-fold: "those who remained in the rural areas are increasingly the recipients of the virus through sexual transmission by returning husbands and casual partners; women who themselves leave the village to seek wage employment in urban and peri-urban centres enter these new environments unprepared not only for the job market, but also for the grave risk of becoming HIV infected."(1992: 64) There can be a myriad of reasons for the 'riskiness' of her environment. This could be physiological, reasoning that the practice of virginity testing and the practice of 'dry sex' can increase her chances, for example, of getting raped, or receive unprotected anal sex or rough sex, all of which could cause her to tear and bleed, increasing her risk of HIV transmission. The risk could also be related to her gender, which, as verified in the foregoing, is wretchedly earmarked for depressing socio-economic circumstances, poverty, low self-esteem and lack of authority in her culture, as verified in the a foregoing. Sometimes women will go to great lengths to alleviate these problems, including the handout of sexual favours.

And, as if this fate has not handed her enough on her plate to deal with, her body is also fastidiously chosen to be biologically at least four times more susceptible to the disease than men. The thin lining or 'floor' of a woman's vagina has a larger surface area of mucosa. As the recipient of semen, she is exposed to her partner's semen for a longer period of time, as it stays with her for a few hours, whereas he, the giver, is exposed to the body fluids of a woman for only a short time. The picture becomes

even more grim-looking. Health professionals have also established that there is a higher concentration of HIV present in semen than in vaginal fluids, making transmission to women more likely. Van Dyk (2001) also reports in her work that transmission of HIV is more likely to occur just before, during or immediately after menstruation because of the large, raw area of the inner uterine lining that is exposed. (2001:20)

According to UNAIDS (2000) younger women are especially vulnerable to HIV infection because their genital tracts are not yet fully mature, thus making their vaginal secretions less copious. They are therefore more prone to vaginal mucosa lacerations.

A PSYCHO-ANALYSIS OF A WOMAN'S SPIRIT

Bryant (1949) writes that in 1862, almost a century and a half ago, Grout, in his work *Zululand*, exclaimed his astonishment over the *Lobola* custom in the Zulu tradition, compelling him to ask in disbelief: what is it in the Native female's psyche that makes her accept that she can be bought? "It is a painful experience of the South African experience," Bryant quotes from Grout's fierce denunciation, "to note the debasing effects of the custom - *ukuLobola* - on the female mind. Instead of shrinking from the idea of being bought and sold for cattle, the poor heathen girl glories in it, esteeming it as proof of her worth. Nor is the man himself willing to have a wife for nothing." (1949:593-594) Truth however spoken, that which Grout's 'superior' Western mind loathed and found difficult to understand, was in fact accepted and trusted and even enjoyed, as it was seen as a sure sign and symbol of protection. Furthermore, it enhanced her self-esteem and guaranteed attention from her father who took pride in her estimated value among young men. Within the confines of these creative ways of dealing with poverty and the customs in her society, she had a 'protective' life and self-identity. Bryant (1949) continues and speculates with the question; what then, would the West put in the place of this custom should the 'bride price' be abolished? And the answer he came up with is astonishing because of its amazing clairvoyance and foresight. Young men, he proclaims, would not have the incentive to work hard any longer and, would pick wives up for the mere asking on

every roadside and in every town, and march home with as many as they could or cared to impose upon.

Should we not, in our enthusiasm for beautiful ideals, rather succeed in making realities more deplorable than they already are, by converting, not alone those locations of so-called 'civilised' Natives adjacent to many European towns, but the whole Native territory, into one great cesspool of raging and chaotic immorality? Let sleeping lions lie; in due time they too will die a natural death due to inevitable decay. (Bryant 1949:595)

Little did Bryant however know, the 'inevitable decay' that would sweep over African people's ploughed lands, would carry the fatal seeds of the late 20th century and now, the 21st century most ruinous disease. Half a century later girls that are undergoing virginity checks in order to protect them against the scourge of HIV-infections, however, stand at risk of being raped or assaulted by the very hands who once negotiated 'thigh sex' with them before marriage, out of reverence for keeping their hymens intact. Even more alarming, girls are now picking up men by the roadside, jeopardising their lives through offering 'dry sex'. By the same token as we asked back then, how a Zulu girl can allow the traditional *Lobola* custom to corrupt her mind, we today ask, what the inhibiting factors are that cause a young educated African schoolgirl to accept a test of her virginity without considering that it could be a grave violation of her rights and privacy? The answer, however hard it would be for the 'superior' Western mind to understand, could very well be seated in the much-treasured *Lobola* custom, which made her to feel special. The feeling of safety, protection and security of the *lobola*-custom is a long-forgotten, yet an engagingly longed for feeling, since even though it is still practised in many rural areas, the feeling of not being respected has deposited itself even in those remote areas that are not in contact with modern living. Deep inside the girl knows that her virginity status is hardly a treasure, but merely a tool to protect her against the HI-virus. However, she stands incessantly at risk of an uncalled imposition, for which she is psychologically or physiologically not prepared.

On the flip side of the same coin women offer 'dry sex' by the roadside, increasing their risks of transmission. For these women the *Lobola* custom and the way it makes

them feel has become a very distant memory from their rural backgrounds. In fact, it is more a faint reminder that so little was she respected, that she could be bought, “that she was placed on a level hardly higher than his (a man’s) prized stock, or worse, a mere commercial commodity, a piece of trade-goods.” (Bryant, 1949:586 quoting Hopley, 1922) Thus, a wicked and false sense of security is retrieved in doing something with which she is familiar. In this case however, she breaks with a sense of powerlessness and takes control on a high-risk level sexual behaviour scale in order to overcome her economic confinement and to protect her children as well as herself. It is not her father that gets rewarded, but she herself, as she takes responsibility for surviving, armoured with rights as an autonomous person, but sadly her conditions are not always met on her own terms. And it is with this artificial and misguided sense of empowerment that she cuts her losses to gain only more hardship and pain.

In the interview I had with Beauty and Zanele I was told that young girls have started to a large extent to empower and liberate themselves sexually. Young girls now have more boyfriends. They would have the one they go out with and give ‘deep love’ and call him ‘Mr Sex’, but should he prove to be ‘poor’, they also have the ones they have sex with in exchange for money in order to buy ‘cosmetics’ and ‘other nice things’, or to be able to get somewhere. They refer to these boyfriends as ‘Mr Money’, ‘Mr Food’ or ‘Mr Transport’. And this they do with the blessings of the mother, who is not deterred by her eroded morals. Having no food in their homes, overrides the thought that she could fall pregnant or get infected with the HI-virus. When asked how, in their minds, the choice to have multiple sex partners is any different from prostitution, the answer was that they do not stand alongside the road. This confirms the fact that casual sex in exchange for money has become more rife and accepted in the Zulu culture than is estimated, since it is not regarded as degrading or a form of prostitution, rather, a ‘way of life’, of showing survival skills. Lovelife’s survey, conducted in 2001 among 2 200 teenagers and parents randomly picked all over South Africa showed an alarming number of teenagers that are involved in transactional sex. Nearly 15% of boys admitted to giving girlfriends money or buying them drinks or food in return for sex, and 10% of girls admitted to receiving money and goods for sex.

More alarming is the fact that mothers are themselves offering their daughters. In the Harding area, near Kokstad, a building contractor witnessed mothers bringing their daughters to the sites where young men sleep in caravans. They then leave the next morning dressed in school uniforms, after having obtained all kinds of material goods in exchange for sex, among which, cell phones and leather jackets are the most highly sought after. For this reason young women are starting to favour older, yet 'richer' men, calling them "sugar daddies", thus making it unnecessary for these men to put up a fight to get what they want while older women are starting to prefer sex with younger men, and pay them for these services. Ulin writes that adversity and social change have created a relatively acceptable climate for the exchange of sexual favours for badly needed social and economic support. "There is now ample evidence that the practice of exchanging sexual favours for subsistence is not limited to the business of commercial sex". (1992:66) And in a recent study conducted in rural Kwazulu-Natal on HIV discordance among migrant and non-migrant couples, it was found that in 40% of the discordant couples, women were infected with HIV indicating that her husband is not her only sex partner, that she indeed had other sexual partners. (Lurie, et.al. 2000)

These discrepancies are not typical in Zulu sexual behaviour patterns and show that the tables have indeed been turned on the African man's polygamous lifestyle, particularly since the 1920's as a result of the emergence of a new class of Africans called *abaqhafi*, writes Vilakazi. The Zulu man "was characterised by his absolute lack of respect for old traditions; his way of affecting Western mannerisms", and it was copied by the youth in the rural areas with whom he came in contact. (Vilakazi, 1965:76) Women felt threatened but also cheated and betrayed and gradually started to follow suit. It led authors like Caldwell and the like to reiterate Bryant's (1949) earlier premise on the Zulu's distinct sexuality in pre-colonial times, in claiming the African's sexuality is a "worldly activity like work or eating and drinking and is transacted in the same way." 1989:203) However, Bryant made it clear that despite this notion there was "no tradition of promiscuous intercourseever having prevailed among the Zulus." (1949:580) These sentiments, forty years later, are however not prevalent in Caldwell et. al's work who believe the bond between partners, is stripped of emotional considerations, making it easy for women to render services to men in return for cash and support. Suzette Heald, (1995) a proponent of

Bryant's work critically assesses and refutes Caldwell et. al.'s views, in saying, "It is because sex, whether inside or outside marriage, is seen in such terms that it is difficult to recognise prostitution in Africa in the same way as in the West. Sex in Africa always has a potentially 'commercial' aspect, so no sharp divide can be drawn between the prostitute and the 'respectable woman.'"(1995:492) Evidence of the 'respectable' woman in the Zulu culture indeed abounds, however, the current prevailing scenarios should caution us as to the extent many young girls and women do not see the 'sharp divide' in the respectable woman/whore dichotomy anymore, due to the wretchedly disturbed socio-cultural circumstances.

Given Africa's past, administered by the West's own hands, are we standing back and saying, not only are men out of control, but Africa's women have become permissive? This is the 'inevitable decay', that, Bryant almost sardonically, expressed, and that there is nothing we can do to prevent it from happening to them? Moreover, are we going to let these disparities lead us astray, and say with our tongues pressed firmly against our cheeks: do you see you traditionalists, how your customs are backfiring on you, what it has forced your women to become, without the faintest idea of African's general *en masse* striving to be 'responsible and responsive members of society'? (Heald, 1995:494) Or, are we going to proffer the understanding for the African woman's crippled spirit that has given way under the burden of one too many devastating blows, in the form of a fatal disease, that causes her body all too soon to fitter away? Do we seek time to contemplate, when we sit as a nuclear family in our cosy homes, that *her* family life is scattered, that she is a fragmented being and that this woman harbours immense desperation and darkness, regarding her future? And as she endeavours to crawl away from the shadows, away from the lush green hills and a frozen state of mind, that, what she now must face in big cities, are not only new associates and new kinds of entertainment, but also, posters and billboards, telling her she must surrender to a deadly disease and a different way and order of sexuality and thus, morality? Moreover, that she must subscribe to these paradoxes, without the support of her 'clan' and must privatise her own sexuality and morality, instinctively? When she then decides to 'sell her services', as she has no education to offer businesses, and finds no answer when she knocks on doors, and hence no money to feed her family back home, her 'evil' activities, on top of everything else, ostracise her, as she is now labelled as a 'witch' in her society. She becomes what renowned

psychologist Jung, called, one kind of polarity of the mother archetype, 'the loving and terrible mother.'

In her book, **Women who run with wolves**, Jungian psychoanalyst and storyteller Clarissa Pinkola Estes (1992) sees this witch figure as positive, as she symbolizes the wild women archetype, the instinctual inner knowing Self. However she also needs to be protected and nourished. She tells the story of The Red Shoes, which the wild woman is not supposed to wear, but clandestinely she puts them on and runs off with an exuberant feeling of desire to dance in unfamiliar places where she is not supposed to go. To her horror the red leather shoes start taking control and take her to places, which she would rather avoid. Exhausted, she dances involuntarily into a forest where the town's executioner lives, and begs of him to relieve her from this horrid fate. He cuts off the straps, but the shoes stay on her feet so that they keep dancing. She finally asks him to cut off her feet, as her life was worth nothing, which he did, whilst the red shoes with the feet in them keep on dancing until they are out of sight, leaving the poor girl behind, crippled for life. Pinkola argues that when a woman is 'starved,' she will take any substitutes that are offered, "including those that, like dead placebos, do absolutely nothing for her, as well as destructive and life-threatening ones that hideously waste her time and talents or expose her life to physical danger. It is a famine of the soul that makes a woman choose things that will cause her to dance madly out of control - then too, to near to the executioner's door." (1992:215-222) Hence, she continues, the wild women can drastically lose her way if she is distracted from her instinctual wild life, by putting on the poisonous red shoes, and whilst we should never wish these shoes upon ourselves, in its 'fiery' and 'destructive' centre there is a something that "fuses fierceness to wisdom in the woman who has danced the cursed dance, who has lost herself and her creative life.....and yet who has somehow held on to a word, a thought, an idea until she could escape her demon through a crack in time and live and tell about it." (1992:221)

Many famished rural African women are putting on these cursed shoes, as they venture out to do their nocturnal dance, so madly out of control. Yet, the problem with this story, in the South African HIV/AIDS context, is a burning question, which begs the answer from our leadership: would she be allowed, once she escapes through 'a crack in the door', and comes to it in her 'crippled', isolated and stigmatised state, to

share any words, any thoughts, any ideas, any lessons learned, with society at large? Thus, since our culture fosters denial, silence and indecisive leadership regarding the disease, will she be allowed to caution and voice her experiences and knowledge gained to the many that could follow in her wake and put on 'the red shoes'? More urgently, would our culture, in fact, recognise in time the essence of finding ways to eradicate stigmatisation, as she is perhaps the most invaluable role model that can unlock to the average young Zulu girl and woman the lurking dangers of certain practices in her culture?

These are the kind of questions that urge authors like Obbo, (1993) and the like to argue for a major rise in 'black feminism' that would address African women's oppression. This, as I have argued, can only be achieved through extensive holistic and creative education regarding women's health and the equal sharing of the burden and responsibility of AIDS. In the interview I had with sister Thandi Langeni, these sentiments were underscored, "We need more women in our culture who are strong in their character, but they must respect their bodies first. Men are scared of these women." Thus, woman's expression, strength, and autonomy, regarding her sexuality, should be encouraged and directed positively and aimed at giving these traits staying power, and hence becoming a way of life, instead of allowing female power to be viewed as a temporary aberration, manifesting when the opportunity arises in a group display of sexuality, as for example, virginity testing.

Women need to realise, without fail, that in the depth of their souls nestle both magic and medicine.

AFRICAN WOMEN'S VULNERABILITY REVISITED

We would do many women in the Zulu culture a grave injustice and in fact, insult them if we do not give credit to those who have succeeded in empowering themselves in the most positive, assertive and constructive ways through education and immense strength of character, resulting in immeasurable changes in their poverty-stricken lives. In the cities, they often hold full-time jobs, in the domestic as well as in the business and the professional work-sphere and some have even entered the political arena. In many cases they are the sole income-earners in their families.

Generally speaking however, it is to be conceded and would appear, that while much has changed for men, as they have found new living conditions in the urban areas and are exposed to western culture, “....not much has changed for women. Rural women live in much the same way as they have lived for centuries. This explains why they are often classed as ‘perpetual minors’,” writes (De La Harpe & Derwent, 1998 : 96) Yet, even amidst their remote rural circumstances, many Zulu women are not as powerless, and without influence, as many people believe: within their cultural boundaries, underpinned by male-dominance, which may seem restrictive to westerners, Zulu women have empowered themselves in their own ways, which are not understood by outsiders. Many women are the owners of goats or cattle, and furthermore they find expression and strength through informal organization, kinship ties and neighbourhood groups.

Binding all of these rural women are, amongst other beliefs, the perception of time, which acts as a strong determinant, but mostly neglected element in considering the rural women’s vulnerability. It is perceived as a two- dimensional concept, binding them to the past and the present. It is their ancestors that make the here and now meaningful and not prospects of a purposeful future. However, with no hope or desire for the future, no real spirit can emerge to redeem women from their circumstances and ignorance about the outcome of their health, with respect to the AIDS crisis. It serves as an impediment, in women’s behaviour, compelling them to adopt a rather fatalistic attitude in their relationships.

It necessitates the question: what role could Christianity play in lessening the hold of this perception? It is ironic but true that Africans correlate spirituality with medicine and that they are ‘pragmatic and utilitarian’ rather than ‘spiritual and mystical’ when it comes to religion. (Mbiti,1969: 5) God is viewed as standing outside of them and does not intervene with their suffering. “It breaks my heart,” writes the American missionary, Reverend Ted Karpf in a letter to his friends after a visit to Zululand, “when I see churchwomen who are strong and articulate in their faith communities and so weak outside of them. Yet these women, who exert powerful influence across the church, are often opposed to the liberation of women from the shackles and terror of culture and tradition. Could it be that the church blesses freedom and then tries to contain it, albeit subconsciously?”(December, 2001. www.edow.org/ministries/ted)

The Church is however not only accused of acting deceitfully regarding its exegesis of freedom from her burdens, but also of being responsible for the discarding of many of the Zulu people's customs and beliefs. In November 1999, Mr Khaba Mkhize, the then regional manager of African Broadcasting wrote, "In the olden days, when sex was X-rated in the land of honoured respect through cultural corner-stones, girls were inspected for a culture-bound lifestyle. Then came the Christian missionarisation of the Zulus, which rubbished the custom of *ukuhlola* (testing), leading to the falling apart of some decorous practices." (Daily News 20/07/2000:17) This statement coincides with a school of thought arguing that Christianity's prevailing dogmatism deprived the Zulu culture of the common knowledge that usually exists in a community about a girl's virginity status and corrupted the openness with which sexual relationships were handled. Prior and contrary to Christianity's teachings, which encourages people to succumb to secrecy and a culture of silence with regard to sex, Zulu customary practice regarded premarital sex play without coitus between men and women, as natural and the norm. Christianity however dictates, "'Good' women are expected to be ignorant about sex and passive in sexual interactions." (Gupta, 2000) This intense sexism makes it difficult for women to be informed about risk reduction or, even when informed, makes it difficult for them to be proactive in negotiating safer sex. Vilakazi himself observed, 'Among Christian young boys and girls, there is no teaching or any form of guidance about correct behaviour when people have sex relations. As a result, when Christian young people meet and have sex relations, it is usually not intercraral sex play at all, but coitus.' (Vilakazi, 1965: 55)

Another school of thought however argues that, albeit Christianity contributed tremendously towards changing the social structure of the Zulus, in giving new twists and interpretations to the old behaviour patterns, it was not always negative and was done to enlighten rather than to obscure. Yet sadly, old fears were only replaced by new fears, and somehow, and somewhere in the middle, it leaves the Zulu people to balance the equation on their own. Vilakazi comments,

"Friction abounded, but it was seen as a 'general liberalizing influence' - freeing the whole of that part of society which accepts it from all ritual observances and fears which characterized the old order, and substituting new fears - fears of sin and hell-

fire and the devil. The new definition of what is socially right and bad does not take in the old definitions. It is based on an altogether new ideology and whatever remains is modified and made to suit the new conditions and situations” (1965:44)

In fact so deep is the need of the Church to incorporate and heighten fear within the context of this epidemic, that leaders of the Church inform people that God, in his mercy, has given them AIDS as ‘punishment for their sins.’ It is this well-nurtured myth that is obstructing women’s empowerment considerably, as it reinforces men’s perception that she is to blame for the spread of the disease. Indirectly, it entails she cannot hope to find protection at the place where she worships, since so little is her worth that God uses *her* for His wrath. The Church needs to consider the confusion and contradiction this ideology is causing and how difficult it is for an outsider to handle all these contradictions.

Could the Church play a significant role in the Zulu culture regarding the HIV/AIDS pandemic? For one, Christianity is closely related to being educated, opposed to being a heathen and uneducated. It is said that Christianity and being ‘educated’ play a large part in how men perceive women, since Zulu males who have adopted Christianity, give preference to these professional women, especially teachers and nurses, “as they smell better, and are cleaner and smarter and much more enjoyable company than their sisters left behind in the rural areas,” according to Vilakazi. Christian men in the townships, however, hold prejudice against them; “they do not know how to do field work, demand too much freedom and independence, and demand from their husbands a higher standard of marital fidelity than do their less educated sisters.”(Vilakazi,1965:61) These educated women receives even more disdain from heathen men who regard these ‘educated’ women with an altogether different class distinction, seeing them largely as carriers of venereal diseases and the ones who have a lot of boyfriends. It turns out, whilst one group of men admire an ‘educated’ woman, another group fears that she might override their power and expect them to be faithful, whilst yet another group of men fear she might infect them. The Church is thus giving conceptions of women an entirely new twist among fellow Zulu people; she is valued where among people where it matters most, however the Church’s eminent striving to undermine woman’s power acts as a serious impediment in order to become a reconciliation force between the sexes.

Hence, we see that the transformation from a rural girl, into an 'educated townswoman,' handed her endless complexities and implications regarding sexual conduct in relation to status and health. This emancipation causes some of them to regard marriage with mixed feelings, "predominant amongst which is fear of losing the independence and freedom they experience as wage earners in town". (Hellmann 1974:19 quoted in Argyle & Prestone-White) This newly found power has however not come without a price; rejecting rural origins asks for uncalled strength, confidence and perseverance. It has however established a meaningful consequence; women have gradually forced their way into having access to and control of resources, which gives them power in decision-making, especially with regard to their sexual relationships, for example, abandoning the practice of 'dry sex' and insisting on monogamy as a result of the adopted Christian mores. It is however education outside of the church, that is allowing the African woman to sift through the Church's incoherent and ambivalent messages and to privatise her own morality. For example, it allows her to discard the support the Church gives to the practice of 'virginity testing,' (as telling young girls about condoms opposes its mores), and it allows her to critically assess church programmes that ban and exclude AIDS sufferers, thus using them "as objects lessons on the consequences of a fall from moral grace."(Van der Vliet, 1996:47) These are all choices she would not have been able to make if stuck to some harmful cultural mores. Hence, the Church could indeed play a powerful role regarding the empowerment of women but it needs to become cogent and consistent with its ideology and break the 'culture of silence', should it wish to reinforce its life-saving mission in which many find solace amidst the all-encompassing chaos and anguish in their lives.

Having said all this, it is sad yet true, that despite many women's apparent independence in the Zulu culture, she is regarded to be either stupid or brave when challenging the accepted norms laid down in a dominant patriarchal Zulu society.

CHAPTER 5

WHAT OUGHT WE TO DO?

INTRODUCTION

In their work, *The principles of Biomedical Ethics*, Beauchamp and Childress (2001) philosophically reflect that one cannot prevent people from getting born into unfortunate circumstances, but we can prevent harm being done to them, in fact we are obligated to prevent harm. And since AIDS unambiguously shows it is not only earmarked as a biomedical dilemma, it stresses the dire need for the social, political and cultural aspects at play to compliment the causes and the courses highlighted by bio-medical research, and to network and intermingle to a far greater extent. Ideally, all these structures should work together towards a mutually beneficial outcome in order to combat a disease destined to be merciless, especially to the marginalized. This disease is, in fact, asking for a penetrative focus on what is believed to be the root causes, namely certain local sexual practices, customs and beliefs. It is asking for re-evaluation of the negative practices that have become perils and obstacles to our human endeavours aimed at preventing people from being savaged by HIV-infection. It is thus not only asking, 'What ought I to do?', to prevent this harm, but also deals with two other, fundamental questions, adopted from Immanuel Kant's *Critique of pure reason*, 'What can I know?' and 'What can I hope for?' However, unlike Kant, who grappled with these questions on a metaphysical level, it translates back to the AIDS-pandemic as, 'What need I to understand?', 'What kind of action is necessary?' and, 'What hope can I proffer people?'

Briefly then, what people need is a tripartite culture related union, which includes education, action and hope. Yet in our campaigns, we shallowly strive to create a mere awareness, not understanding why people do not respond in accord with our wishes. We equip our messages with one-dimensional content, disregarding, that as sentient beings we function at complex and at multi-dimensional levels. In addition, our play-it-safe campaign is draped with a Western cloth, making it hard for African people to relate to its theme or its colours. It would for example appear that the virginity testers have taken the **A**, for '**abstain**' part very literally, allowing girls to take sole responsibility without exercising prudence as to the potential harmful outcomes related to their culture. On the flip side of this coin, girls who are coerced

into sex prematurely are deprived of the opportunity to reflect on the foreign idea of abstinence due to the lack of respect and education on the part of males. Both scenarios make it necessary for there to be desperate outcries for emphasis in our educational programmes on taking mutual responsibility for abstinence. The **B**, for ‘**be faithful**’ part, disregards polygamy, hence the way sexuality defines African people in this country, and the **C**, for ‘**condomise**’ part, is seeking a rapid mind shift, from indigenous knowledge regarding anatomy and sexuality, to science. And as the patriarchal African male cannot perceive these requirements as sensitive to his needs, the onus is placed on the shoulders of an already marginalized female, as it becomes *her* responsibility to sustain these precepts. She ought to see to it that it is not necessary for him to adhere to any of the above. Should it appear necessary, it clearly marks her promiscuity and infidelity. Hence the campaign presents a synopsis that seems gender-biased, opting for individual change, rather than accomplishing cohesion, ignoring the fact that African people find meaning and purpose in their lives through the spirit of ‘*ubuntu*’ - I am because I am for the other.

It would thus appear we have fired our messages before we aimed, since we feel compelled to ask: does coherent and intelligible sexual education reach rural African people? Can they relate their sexual behaviours and patterned beliefs, which have dynamically influenced them from early childhood, to these messages? According to Deputy President, Jacob Zuma, South Africa has a 97% AIDS awareness level. But, whilst influential *sangomas* believe it is not a ‘new’ disease but an ‘old’ one, for which they have a cure, and as long as African people remain gullible and fail to refute this premise, it points to a dire lack of understanding and denial of the existence of HIV/AIDS. Even more distressing, is that many men believe, “AIDS is in the condom, there was no AIDS and then came the condom, now the AIDS is everywhere.” This I was told, during an interview with women in the rural area, Nqabeni. It is thus clear that our understanding of the ways in which information is disseminated, have failed us dismally in this country, as it has thus far had no effect on sexual behaviour.

If we had aimed carefully, we would have understood that the disease makes strong demands on interpreting its epidemiological effects in a scientific way. However, Africans’ ‘magical’ ways of understanding the human body’s biological functions

also requires that we incorporate and correlate our knowledge *vis a vis* African people's unique discernment of sexuality in creative ways. Gyekye (1997) argues that in terms of development and progress made in a current culture, we should not allow ourselves to have negative features of a cultural past slip through as this could be counterproductive and harmful in that society. If proved to be dysfunctional and hampering the progress of a present generation, it should be changed or discarded. However, if we fail to consider the influence of 'magic' on African peoples' lives, our attempts and our messages can equally serve as impediments to progress, hence proving to be just as dysfunctional as the behaviour we want to address.

It points to Airhihenbuwa who put these concerns to practice (1989) in his proposal and introduction of the PEN-3 model as a strategy according to which traditional cultural health beliefs and behaviour can be categorised as positive (P), exotic (E) or negative (N) and treated accordingly. As a cultural model it is used to promote health and could be used by centres for disease control. The P for example stands for positive behaviour and singles out those behaviours that are known to be beneficial in a culture and should thus be encouraged. E stands for exotic behaviour and however unfamiliar it may be, have no harmful health consequences and therefore, need not be changed. N stands for negative behaviour that is harmful to health and which health providers should attempt to change. (1989:61) It is with this strategy in mind, that I shall deconstruct the so-called ABC, play-it-safe-campaign and simultaneously address the harmful practices, virginity testing and 'dry sex'. In each case I shall analytically categorise them and proffer healthy alternative suggestions, emphasizing the need to focus on local beliefs and customs in constructing our messages, as well as the immense importance of mutual inclusiveness of gender.

ADDRESSING POLYGAMY

Already in 1949 Bryant wrote that the practice of polygamy is suffering longstanding abuse and exploitation among the Zulu people. At the start of a new century we find ourselves face to face with a 'killing machine' that has come to change human history forever. However, despite our campaigns, the Zulu male is not deterred; he has multiple partners and picks them randomly, knowing his antics always were, and still are commonly accepted in his culture. In fact, Bryant (1949) writes, this practice was

encouraged by young women, as a man who could not succeed in proving this to a girl was considered to be an 'emasculated muff'.

AIDS-education, thus far, has not diminished the striving for *isoka* status. To be seen with as many girlfriends as possible and to engage in sexual activity with them, is still of immense importance, as it remains a symbol for the young male to prove that he is developing into a real Zulu man (a *ummuzane*). "To fail to win a woman is to be a social failure (*isishimane*) and it is to be cursed with a social stigma which...is worse than an organic disease." (Vilakazi 1962:50) It is especially his choice of main partner and his ability to 'control' his girlfriend that ensures his status and position among male peers. Conversely, as a proper Zulu-girl, the biggest compliment she could be paid, is to be described as someone who can 'hardly speak.' Dare she, whether inside or outside of wedlock, threaten his position of power, act assertively, or try to negotiate safe sex, she will in all probability be met with rage and violence, cut off from his support in monetary terms, and be regarded as 'out of control' or worse, a 'witch'. Furthermore, it is often his family that encourages and puts tremendous pressure on the young Zulu man regarding the exertion of this power and his ability to uphold his *isoka*-status. Varga (1997), in her studies among young black men at an ante-natal clinic northwest of Durban, reported one Zulu man to have disclosed to her that his family greeted news of his third illegitimate child with relief, as it demonstrated beyond a doubt his public *isoka* -status!

Varga's research especially focused the spotlight on the fact that the practice is not only rife among youth in the rural areas, but also among our well-educated youth. Views such as, "it is a man's duty to satisfy a woman sexually in order to keep her from becoming bored and finding another boyfriend," was a very common comment she found, thus explaining the high number of reports of physical coercion by a person well known to the victim. One man explained, "I do not rape anymore. All my girlfriends enjoy my company". The same research finds one male university student to comment, "Condoms take away sexual control both physically and psychologically. They take away a man's control of the process". (1997: 56-57) And well-educated girls are happily adhering to this form of intimidation. One girl commented, "We don't talk about things like condoms, sex and STD's. It is not that kind of relationship." (Varga,1997:45) These are comments, that underscore the health

professional's, not only daunting, but haunting task, in putting the consequences of exploitation of an inculcated practice such as polygamy in the right perspective. Female attitudes compel society to take drastic measures to change women's perspectives on their human rights and more importantly, to what living a healthy and quality life entails.

Does this mean that we are pleading with society to outlaw polygamy? Indeed we cannot, yet our advertising campaigns contain scare-tactics to mortify people who are practising polygamy. They typically use morbid depictions of death, for example showing how multiple partners plus no condom usage equal an ultimate future of lying in a coffin. I am not suggesting the pursuit of multiple partners is not a peril, neither am I saying the plea to use a condom is trivial in this matter. What I do suggest however, is serious contemplation of the contents of our messages as they cause anguish and rebellion, especially among those to whom polygamy is a natural part of living experience. It is asking these men to curb something as fundamental as desire, in the most morbid context, without seeing the desperate need to eroticise information about safe sex for them. Simon Watney argues that it is futile to teach immediate and total punitive monogamy. "Changes in sexual behaviour cannot be forced, they can only be achieved through consent, consent which incorporate change into the very structure of sexual fantasy." (Watney, 1987:129)

But how does Watney's view sit with the young Zulu male? In the Zulu male's mind, the two concepts, *isoka*-status and promiscuity, are two different conditions. The former is a normal and natural condition for him and fits into his framework of sexual fantasy, while the latter implies almost exclusively being involved with 'dirty women'. Given this rationale, he does not see himself at risk and therefore it might also clarify why HIV or other STD infection would be blamed upon the female partner, writes Varga (1997). It is this kind of fantasy that ought to be addressed and corrected in our campaigns.

With regard to polygamous marriages we need to accept they are as real in the Zulu culture as monogamous marriages are part and parcel of Western culture. We need to accept it as much as we need to accept that exploitation was and will always be part of it as much as monogamy has been exploited and will always be exploited in the West.

We need to take into account African people's already excess levels of vulnerability in the context of morbidity and mortality, as it is critical that we develop programmes that "recognise cultural specific beliefs, rather than simply adopt those that are developed to address multiple sexual relationships in a context where they are legally and culturally taboo." (Airhihenbuwa, 1989:62) In being classified as the poor it means that African people are more "vulnerable to the effects of flooding because their homes are more likely to be on marginal land, so they are also more vulnerable to the effects of raised levels of illness and death." (Barnett & Whiteside, 2002:71) Do we need to marginalize people living in these conditions any further with unnecessary judgements regarding sexuality? I would think not. Hence, our messages need to romanticise the safe control over this practice, for example, encouraging the sexually active not only to limit the number of sexual partners, but also to have everyone tested within the group in order to identify those with the disease. It is important to encourage young males and females to practice fidelity within this group, the way it was controlled and structured during pre-colonial times. Thus, people in polygamous situations should be encouraged and taught, once again, to cohere to these boundaries. Van Dyk (2002) in her paper, *Traditional African Beliefs and Customs*, argues, that unless Westerners gain a proper understanding of the custom of polygamy among many Africans, they will not understand the much treasured concept of personal immortality, because despite what the Western mind wants to believe, polygamy leads to reduced unfaithfulness, prostitution, STD's and HIV.

The only solution to this practice lies within the culture. As long as Zulu females, due to their socio-economic circumstances, fails, or is unable to recognise or object to the prevalent gender inequity in her culture, Western intervention should curtail its aversion to this practice, as it can only serve to stunt research on sexual behaviour in the Zulu culture. Geeta Gupta (2000) suggests that research ought to be done to identify ways and to overcome the barriers to couple or group counselling, as she believes the effectiveness of this method could create more gender-equitable relationships. However, much difficulty could be foreseen since men, it has been proved, shy away from interventions that promote gender inclusiveness. During my own research, I found it varied. In some instances men vehemently resisted and insisted on gender separation during interviews, in other instances men showed willingness without any objections. It was mostly men who cling to old traditional

mores that resisted participating with the opposite sex present. Generally speaking I found that showing a sincere understanding and interest, as well as valuing and appreciating the differences in cultures in a non-judgemental way, served as important entry ports for open and stimulating dialogue as not only did it create trust, but it revealed a surprising desire to be enlightened on the pitfalls of their behaviour.

Thus, do I argue for polygamy to be regarded as positive behaviour? I would rather argue that from a Western perspective, and if legally sanctioned, it could be regarded as exotic behaviour. However, sexual relationships with multiple partners whose behaviour cannot be controlled or influenced, not using condoms when involved in casual sex as well as prostitution, and especially at a very young age, are negative behaviour patterns that could and should never warrant an affirmative nod, however little our influence appears to be.

REVISING CONDOM EDUCATION

Condom use is a foreign concept to Africans and has added a new twist and a new conflict in Africans' sexual relationships. Holding the woman responsible for the disease implies the Zulu male is also holding her responsible for not being able or allowed to make physical contact in order to fulfil his ultimate calling, hence, to 'spread his seeds', to 'fertilize the land', or to assist with the 'ripening of the foetus'. As much as it should be encouraged at all costs, current condom-education needs serious modification, and in order to do that, Westerners firstly need to eradicate in their minds the notion that the prevailing resistance towards condom use necessarily points to "promiscuity, permissiveness and a lack of moral and religious values", (Caldwell, Caldwell & Quiggen, 1889:1890) African women, in particular, suffer this condescending and preconceived notion on two grounds; being on the receiving end, she is expected to negotiate safe sex, however, this expressed wish often leads to violence, as it signals to her partner not only infidelity on her part, but also violation of the trust that ought to be vested in him. In addition she also fears the "potential for rejection.....as it represents the decision to have unnatural or 'undesirable' sex".(Ulin,1992:68)

In fact so deep is the need for many African men to prove their immortality, that their randomly picked excuses, often used in good, but challenging spirit, for not wanting to use a condom, (e.g. 'one does not eat candy with the wrapper on,' or yet another, men want their sex 'flesh on flesh'), often have nothing to do with ignorance, but have everything to do with their fear of its contraceptive effect, it was found in a study done in Rwanda. Rwandans believe that the flow of fluids involved in sexual intercourse and reproduction, hence, the fusing of the male's semen with the woman's blood, represents the exchange of "gifts of self" (*intanga*). They see this as very important in a relationship, as it designates either the male's or female's potentiality to produce new life. Using a condom interrupts this reciprocal flow of secretions and means the male semen is turned back upon himself. As such it is blocking the flow of fertility, and causes all sorts of sickness. In fact, so strongly did Rwandans feel about blockage in the female body in pre-colonial times, that it became the king's responsibility to put girls of child-bearing age who have not developed breasts, or who have not started menstruating, to death, as it "could bring about drought or vitiate the fertility of the land." (Taylor, 1990:1025) Thus the woman carries this fear, as she knows she is not considered to be a singularity in her culture. As Taylor observed, whatever happens to a woman has a direct influence on the group, since her physiological processes are causally related to collective prosperity and fertility.

His fear is thus reciprocated, even understood, since women are scared that condoms may remain behind and that they will become "blocked beings" themselves. In a culture where health and pathology are conceived in terms of "flow" and "blockage", writes Ulin, it is understandable that women cannot imagine how a "blocking device" could also be a "healthy device." (1992:1027) It is not any different for Black women in South Africa, since they raise similar fears. They particularly express fear that the condom might move through the body, if it remains behind, and that it might cause them to suffocate at the throat. And it is not only older women who hold this fear. During the interview I had with Beauty, she confirmed that many of her friends fear blockage of some or other bodily part, especially the abdomen. In yet another study with a group of sex workers, feelings towards the female condom, femidom, were described negatively, as men were complaining about their noisiness, hence these women are willing to compromise health for the sake of something as trivial as the inconvenience of an unnatural sound effect during intercourse!

The eagerness of the Zulu woman to please men relates to how immeasurably important it is for a Zulu woman to be positively perceived by the male. Varga (1997) proclaims her studies show that insistence on condom-use is closely associated with the male partner's perception that the woman he chooses to be with is not 'clean'. Hence, in his mind she portrays negative symbolism, hinting she is 'polluted'. As a result she carries sexual diseases and should be avoided. For many girls this is the gravest insult she could be paid, since her good self-esteem and social status depend on the virtuous resolution to be committed and monogamous in her relationship, and thus, able to maintain the status quo, whilst *he* pursues polygamy. In marriage, her association with her husband is in fact, characterised by an "adult-child' relationship" (Pivnick, 1992:441). She idealises this relationship the way a child is set out to please the person who holds authority over her and accordingly, depends on his approval of her human conduct of the relationship. Sobo explains, "'condomless' sex, as an adaptive and defensive practice helps women maintain desired, idealised images of partners, relationships, and selves". (1993: 478)

Having said all this, it raises a serious question: do women fight reluctantly for condom usage because they fear violence most, or, could the real reason be that they, themselves, carry fears regarding the body's physiological processes and the loss of idealised partnerships, which outweighs jeopardising their own lives? These misconceptions also raise the issue of the dire need to come forward with innovative ways by means of which basic anatomical knowledge and the reproduction system could be explained to both males and females. Proper research into these aspects I believe could open a whole new can of worms, regarding condom education.

Another serious issue we need to address is the fact that Africans are categorically suspicious of the generosity of spirit that health care professionals put up for display in their campaign to promote condoms. Beauty proclaims, men do not trust the condoms, which are handed out free of charge, since "when one puts water inside of it, one can actually see something moving; that is the AIDS." They would rather purchase condoms from the shops and the chemists. Why should they trust the process of free handouts if adequate education has not reached them yet? There are so many other commodities they lack under the circumstances; many hope for food on the table on a daily basis, yet no-one offers them free handouts of mealiemeal (something

that has only as of late materialised in the government's budget) water or electricity. Why should, or would people whose circumstances are desperate, worry about something as superficial and dubious as a piece of rubber, when it is more important for them to get something to eat, especially when they have not as yet succumbed to the seriousness of the disease? These are the kind of questions African people are still grappling with, more than two decades since HIV/AIDS manifested in our lives. It sadly hints at our failure to create an understanding.

We need to look at countries like Uganda, where they have yielded tremendous efficacy with regard to curbing the infection rate. It has been proven that men did not really succumb to the use of condoms in that country and that it was more a community effort assigned to stimulate sexual education and behavioural change as well as the development of social support for abstinence and faithfulness that generated success. This illustrates the paramount essence of an exchangeable knowledge explosion, and for this purpose, we need to look at the root where it all starts, the very intimate and private moment any one person shares with another in the Zulu culture. A recent Lovelife study showed that 42% of parents, in contrast with 82% of teenagers, countrywide thought more open communication about sex and sexuality could help reduce the risk of HIV/AIDS. This study suggests the youth cannot expect to find this knowledge in their homes. In addition, schools refrain from touching too deeply on discussions related to sexual matters and the Church wraps its information in a culture of silence and condemnation. And since health care professionals often do not have the resources to facilitate knowledge, I believe a giant mount in community effort is needed to raise the necessary funds with regard to steering whole households, institutions and organisations into action. We need rigorous bodies of people to pursue the successes achieved regarding AIDS all over this continent, which should then be assessed in our homeland and imparted where appropriate. For example, Van Dyk (2001) reports, women in Zaire (now known as the Independent Republic of the Congo) have sought a return to traditions where high value was placed on premarital virginity. Yet unlike the Zulu people, they have not opted for virginity testing, rather, mothers had broken the taboo not to discuss sex with unmarried children in order to help them understand the need for condom protection. And although women were not in the position to negotiate sexual practices or condom use for their own safety, they had taken steps to change their children's

behaviour. Stories such as these should be part of our mission, if not the ultimate objective of community efforts, since they could serve as major sources of inspiration and motivation.

The Zulu culture, I believe, could benefit tremendously from the reinstatement of initiation schools that have been passed down through generations of Zulu people. They could serve as a necessary starting point in retrieving loss of knowledge and learning, in teaching young adolescents positive sexual conduct towards the opposite sex at the onset of puberty. However this time, it is the 21st century and it would have to present itself with a different face; my suggestion is that it incorporates the simultaneous provision and access to couple counsellors as well, teaching young boys and girls, involved in a relationship for the first time, the essence of sharing mutual responsibility for HIV/AIDS. Carefully identified, responsible and well-trained older 'brothers' and 'sisters', who are role models and beacons of hope in society, are most adequately equipped with a jargon that relates to the youth's specific frame of reference regarding thoughts on and experiences of sexuality in our current situation. Thus, I am arguing for initiation schools as a concept not only to be retrieved, but also to relate to the specific environments and trends the youth find themselves to be in, whether it be rural, township or urban. More importantly, I am also arguing for this information to be age specific and appropriate. For example it can have no relevance discussing 'dry sex' with a child, or pornography with youth living in the rural areas, just as much as it is not apt to promote 'thigh sex' among university students. This argument relates to the proposals that follow in the next section.

DOES VIRGINITY TESTING HAVE STAYING POWER?

Is virginity testing the answer? Can it empower a girl? In the light of its repercussions, I would argue, no. Paradoxical as it may sound, it rather increases her risk of infection. She is restricted in her access to information, as she is not put in a position where she can make informed choices. She is brainwashed without considerations for arbitrary feelings and judgements of the practice, and on how it could affect her future. What options does a girl of six years old have regarding giving consent for someone to watch her private parts? The passing of a virginity test allows a girl only short-lived spells of power and emancipation. There is nothing more powerful

watching a group of young Zulu-girls ululating, singing, dancing and marching together, and yet again, nothing, one can imagine, nothing more vulnerable than an African virgin girl out there on her own, facing dominant male power in its most appalling and repulsive form.

Hence, many authors believe that this disease is asking an African woman to deconstruct her sense of being part of a 'clan'. It impresses upon her individual responsibility for her health, rather than the sharing of collective responsibility. As long as she believes collective fear of the disease could lead to a higher morality for everyone, the problem exists, that she might never internalise its enormous impact, because, this way, she only becomes partially alert and knowledgeable. "A disease such as AIDS is controlled by controlling individual conduct.... The current trend in health policy is to accept this model of disease and to apply it to a myriad of other diseases, to reduce the emphasis on social or external determinants of disease and health, and to stress individual responsibility" (Brandt, quoted in Wilton, 1997:2) However, these theories show little understanding for poverty-stricken rural women who cannot afford to lose the ties they share with family, neighbours and other members in their communities when making informed choices. Their day-to-day living derives from integrated thinking and feelings thus, shared meanings and values and being dependant on a male for economic survival. Mbiti (1969) summarizes the cultural bond African people share, very eloquently;

When he suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not alone but with his kinsmen, his neighbours and his relatives whether dead or living. Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: I am, because we are; and since we are therefore I am.

(108)

Ulin (1992) believes this solidarity may be her greatest source of strength for coping with the AIDS epidemic. Looking at it *prima facie*, the revival of virginity testing at our recent *fin de siecle* has the potential to reinforce this bond, but its revival, is performed against a very different backdrop, a disease that leaves devastation in its wake. And it is not only Westerners to whom virginity testing presents with a

spurious and callous nature in the light of this disease, but also to many African people themselves. It could seemingly only be positive should it empower her, should she succeed in warding off the lurking perils. Yet it regretfully appears that, in her culture, the perils find her without her looking for them. However, can we ask for the discarding of a practice, which sits so comfortably within the Zulu's sexual identity? Indeed if it is a negative and a risky practice, not only according to our PEN-model, but also in accord with World Health Organisation's prescriptions, should health education in developing countries ask for its reduction and elimination.

Although its ramifications are proof enough of the risks involved, categorising it as a negative, is however not a simple, but complex task. The notion itself, to stay a virgin until such time that a person gets married is a noble idea and should be encouraged, as it is vital in teachings of abstinence. However, the essence of teaching incisive and comprehensive sexual behaviour and getting young couples to share equal responsibility in sexual decision-making should not be forfeited. In reality we have an HIV-situation in KwaZulu-Natal, which is exacerbated by the youthful demographic file and seroprevalence rates among young people. Half of the population in the province is aged 19 years or less; nearly one third is between the ages of 10 and 24 years. Thus 2,6 million individuals belong to that segment of the provincial population, which, has recently entered, or will soon enter sexual activity. (SA Population census 1991) Are the advocates of this practice not losing sight of natural biological processes and curiosity entrusted upon the youth when they reach puberty? Michael Foucault lucidly explains it,

“all children indulge or are prone to indulge in sexual activity; and that, being unwarranted, at the same time ‘natural’ and contrary to nature,’ this sexual activity posed physical and moral, individual and collective dangers; children were defined as ‘preliminary’ sexual beings, on this side of sex, yet within it, astride as a dangerous dividing line. Parents families, educators, doctors, and eventually psychologists would have to take charge, in a continuous way, of this precious and perilous, dangerous and endangered sexual potential.” (1976:104)

These words impress upon us that teaching our children abstinence before marriage is only part of the deployment of sexuality. They should also be informed of the pitfalls when engaged in sexual activity and we need communal effort to achieve this aim.

Virginity testers ought to rather seriously reflect on the question, as to whether it is not reinforcing the already negative image the man has of himself, and hence compelling him to abuse even more? Thus, is virginity testing not harming, instead of strengthening, gender gaps, in other words, reaffirming the expectations of the burden of responsibility the woman must take? The answer should make clear to us, that the justifications that the proponents of the practice of virginity testing advance defeat the objectives, as it does not protect young girls, but in fact, makes them more vulnerable. What this country can least afford to hear, are explanations such as, “we do not tell the girls who are virgins about condoms because if we do they will become too curious and try it. We only tell the girls who fail the test about condoms.” What we need to do instead is to get young girls to get condom-wise, as their age suggests that they inevitably will get street-wise fairly soon. “Using condoms should.....be seen as to plan for sexual intercourse rather than allowing it to happen accidentally.” (Airhihenbuwa 1989:62)

The repercussions allow me no other option than to dismiss it as negative practice, as it does not free a girl. Allowing her to privately moralise her virginity status, whilst she simultaneously becomes knowledgeable about the hazards, amongst others, that it is harmful to allow another person to look or touch your body parts, would appear to be a healthier, safer and a more self-empowering option than allotting it to a public arena. It would at the same time include a valuable lesson to men as well, who see this practice as an opportunity to abuse. Should it not rather be our mission to free girls in this society from the brunt of destructive gender and sexual norms?

Hence, what healthy alternative could replace this practice, which would simultaneously encourage abstinence, yet ascertain a balanced empowerment of gender regarding sexual decision-making? In other words, which programme could work transformatively to the extent that it promotes gender neutrality whilst at the same time, reinforcing gender inclusiveness? Whilst a number of authors argue that ‘thigh sex’ could, through clever promotion and education, come into vogue for pre-

marital couples again, thus, arguing for its revival as a method of abstinence, I personally find it debasing and disturbing. Not only does it point to gender inequity, since it is the male that gets sexual relief and pleasure out of it, and not the female, but it also bruises her between the legs, which are highly undesirable, as it so overtly puts her private life up for display. I would argue that the West's 'finger sex', in addition to the female's assistance of 'male masturbation' should rather be introduced and promoted, since not only would it guarantee equal satisfaction, but would also alert the African male to a very basic and unique physiological process that takes place in his partner. In time he could be led to appreciate and even prefer it. How would we however implement novel ideas such as these?

There is a desperate need for dynamic and vigorous sexual education that could spread just as fast, if not faster, than this pandemic. There is a need for enlightened and educated African storytellers to come to the fore, and instead of using rugby stadiums, school halls, the kraal's of chiefs, and village grounds for virginity testing, these venues can be used as platforms to dramatize (singing, dancing and storytelling) positive cultural behaviour regarding sexual relationships and the implications of AIDS in the most creative way, addressing people of the Zulu culture where it matters most, the heart. Dr Helena Sheehan, citing from a television drama, *A Society and its Stories*, proclaims, "There is every reason to believe that stories and images play a crucial, if often subliminal, role in shaping and re-shaping of personality; in the forming and re-forming of a picture of the social order in which personality is realised. (www.comms.dcu.ie/sheehan/myth.htm) In his essay, *Intimate citizenship and the culture of sexual story telling*, Ken Plummer reasons that sexual story telling is a political process and carries potential for a radical transformation of the social order and that it works its way into changing lives, communities and cultures. It is especially, "moving out of silence-stories," that help shape "a new public language, generating communities to receive and disseminate them on a global scale, ultimately creating more and more spaces for them to be heard." (Essay in Weeks & Holland, 1996:45)

This particularly rings true for Africans in this country. As the previously oppressed, they have been led into democracy and need to redefine and reshape not only their identity, but also their sexuality in relation to AIDS, which has a firm hold on their

new-found freedom. Hard cold facts have never been the average African person's forte; birth until death is lived in pictures, by myths, intuitions and superstitions, something that is hard for the average Westerner to comprehend. Our task and our biggest challenge are not to change them, but to respect them in striking a balance between a picturesque world and the facts and the figures that need to be heard. The morbidity, stigmatisation and denial need to be dissipated; people need messages of hope and not hopelessness regarding sexuality. There is a lot to be said for certain deep-rooted beliefs Africans hold in general, regarding certain cultural behaviour. These can all be used positively through integration or central themes in these stories.

Having said this, I concede one cannot dramatise intimate sexual detail from a stage, therefore health counsellors could ideally create settings at the same venues where these story-telling festivities are held, for single, couple, or group counselling.

It was intriguing to find among the girls I interviewed, the expressed desire to watch more videos on sexual education and not in a school environment, as it inhibits them. Yet, how can this kind of information reach the average Zulu girl, living in the remote rural areas where the need is dire? I believe, an emergence such as the one we are encountering calls for innovative and creative ideas that, rather than being discarded, could be considered very positively. Thus, my proposal in this regard, however speculative its nature, is formulated with this girl's haunting marginalized living circumstances in mind and involves our defence force, that has tents and media units, equipped with state-of-the-art audio-visual equipment for lecture purposes as well as electricity generators. These facilities could be utilized at minimal costs to disseminate relevant information to people living in these areas. With careful planning and structuring this could be utilized for many more purposes. This could empower women as well as men increasing knowledge about the disease, as well as the unique anatomy and physiology of each sex, exponentially. The influence and co-operation of traditional leaders could be sought in this regard and they could be appointed as supervisors at these venues. Storytelling and health and sexual counselling could be incorporated in these undertakings.

To conclude, virginity testing is not only stunting the progress of a present generation, with regard to human rights, but also that of a future generation of women. As long as

young adolescent girls and women are denied the privilege of informed consent, and as long as they do not question but accepts it, gender imbalance and its harmful consequences will prevail. If we are striving to change men's behaviour, should we not simultaneously aim to empower our women to the extent that they live up to global standards of women's rights? Do we not need to take seriously the Beijing Declaration of Women in 1995, which mark the culmination of a period of forceful international action to promote and intensify the rights and interests of women, and our own constitution characterised by its vigorous and emancipated stance on women's rights? Do we not need to recognise that times and conditions have changed and practices that were once decorous, perhaps no longer serve to reflect newly found social values and sexuality? No culture, has at some stage, not been subjected to painful change. Ancient Greek philosopher, Heraclitus (500 b.c.) expressed this truth the following way, "one cannot step into the same river a second time. If one does, one ought to realise neither you nor the river is the same."

Sleeping with parents in one room for most of ones childhood years', leaves the African child with sexual visions and knowledge at a very early age, which is intolerant of 'innocence' and 'naivety'. It calls for vigorous sexual assertiveness and correction of certain perspectives, assuring apt and topical sexual education in the face of a life-altering truth.

PROMOTING 'WET SEX'

Hardly any debate is needed to convince the medical profession that 'dry sex' is a harmful and negative sexual practice and that it should be discarded for this reason. In fact, there have been outcries from various people, amongst other, the United Nations, for its abandonment. Not only do the lesions, tearing, and bleeding of the vaginal walls act as a welcoming host for sexually transmitted diseases (STD's), men too, especially when not circumcised, are at risk to tear, which causes him to be just as susceptible. Thus, reproductive health is put tremendously at risk. And whilst no certainty can be attained regarding its correlation with HIV/AIDS, there is indeed certainty among many authors that it carries the potential to exacerbate the spread of HIV/AIDS, thus warranting regular research to explore not only the parallels between 'dry sex', sex workers and truck drivers, but more importantly between 'dry sex',

STD's and AIDS. This impresses upon us AIDS' unyielding hold over human lives and that it has added yet another dimension to African's sexuality; the practice of 'dry sex' could, in fact, be a fatal one. Studies also alert us that women of a lower economic and educational rank especially, are by far more susceptible to the diseases caused by 'dry sex' and need extra protection.

However with its strong cultural underpinnings and the strongly expressed preference from both, males and females, for 'dry sex', the medical health educationalists are going to find it extremely difficult to change male's perception, not only on the pleasures of 'dry sex', but more particularly, of the way men perceive a 'wet' vagina. His perceptions of 'pollution' and 'disease' as well as his perceptions of the way he sees the hygienic condition of a virgin's vagina as the desired utopian state, indeed correlate heavily with the practice of 'dry sex.' Hence asking an African man to dismiss this practice, is asking for a major sacrifice on his behalf, as it is important not only from a perspective that it gives them pleasure, but also from the inculcated belief that he penetrates something that is 'clean', as excess wetness would signify her passage contains 'germs'. The irony is, the lacerated and bleeding vaginal walls and cuts to his penis influence the acts of 'giving' and 'to give back' considerably more as he or she could be giving each other something by far more far-reaching: a sexually transmitted disease or ultimately, death.

The practice necessarily leads one to a psycho-socio discernment of sex play between an African man and woman, since 'dry sex' is suggestive of deprived pleasures of foreplay, or preliminary noncoital sex play, as some authors refer to it. For both, the natural secretions of vaginal fluids would defeat the object of the practice. They are both forfeiting the prolonged experience of touching and holding thus the reinforcement of the emotional entwined with the spiritual. The affirmation of emotions and a unique sense of togetherness can hardly be sealed as levels of trust and security are sacrificed; they are particularly absent among commercial sex workers and their clients. "In touching and being touched by a trusted and trusting person, one experiences not only the pleasure of being alive but also the joy of being a sensual creature." (Masters and Johnson, 1982:307) Further, since the practice essentially means the genitals are not touched for the sake of arousal, both men and women are denied the pleasures of discovering a very natural process happening

inside and outside her body. Hence the practice acts counterproductive and thwarts gender-balancing efforts considerably, since it underscores the dominant role and power emanating from the male during sexual interaction. The male is fully satisfied while the female either suffers or is satisfied partially, if she does not experience orgasm. It leaves one with the nagging question: is it not the absence of this closeness and emotional prelude that causes her to sell her body so carelessly for money, hence that allows her to give up on romance and the fine art of physical and verbal seduction?

The practice does not only highlight physical scars, but also emotional damage, which funnel into lack of knowledge and experience of her anatomy. Storytelling can yet again prove to be of immense importance, especially with regard to introducing and eroticising a healthy and safe alternative, which could be borrowed from another African culture to replace the practice of 'dry sex'. The Rwandas practice of *kunyaza* (a form of wet vaginal intercourse), for example, which is an exotic form of sexual intercourse and which focuses on heightening both partners' sexual pleasure while keeping penetration to the minimum, could be identified and encouraged. Ulin (1992) describes how the man externally stimulates the woman's clitoris by tapping his penis against it. He only penetrates her after she has begun to experience orgasm and to produce "copious vaginal secretions, called *amanyare*..... The man is supposed to make the woman urinate, i.e. cause her profuse vaginal secretion, before he himself ejaculates."(1992:1027). The ideal, to reciprocate with fluids, is fulfilled with this mode of sexual behaviour, yet it also stimulates gender equity, as they both obtain pleasure from one another. Ulin commented further that The Rwandan man values the female sexual response in the efforts to produce a common product - a child.

It is these kind of stories that need to be heard all over Africa, and not the kind of stories telling us that a country like Botswana, that is similarly shown to be worst hit by the AIDS pandemic in Africa, only recently, adopted the practice of 'dry sex' from the Zulu people!

RESEARCH ON MICROBICIDES

The Medical Research Council intervention in commercial sex work is regarded a step in the right direction, as it meets the differential needs of women and men in being more gender-sensitive. Rather than attempting to combat the solidification of her choice of this dangerous profession, the medical profession is striving towards ameliorating her chances of not becoming yet another AIDS-death statistic. The Durban branch of the Medical Research Council is currently running a research trial, which looks into the testing of vaginal microbicides. The research is one of five similar projects worldwide and for Southern Africa a first as far as the comprehensiveness of the drug trial is concerned. The microbicide is formulated in a gel, suppository, film or cream to prevent transmission of HIV/AIDS. A disposable applicator contains the 1,5ml of the bio-adhesive gel and sex workers only have to apply this once a day before intercourse for protection against HIV. However, during the initial trial it was found that the practice of 'dry sex' causes women to use the gel more often in a day, which resulted in the discovery that the first microbicide tested in South Africa caused lesions in women who used it more than three times a day. New formulations are now tested and caution has been taken so that it can be immune against frequent use in a day. Hence, it is designed in such a way that the practice of 'dry sex' needs not be compromised.

Ramjee, et. al. (1999) explains that there are three categories of microbicides and each of these consists of different types of substances. The first category consists of substances which have the potential to kill or immobilise STD pathogens; the substances in category two prevent infection after the virus has entered the body and the substances in category three forms a barrier between the vagina and the pathogens thus blocking infection. Women will have the choice to either purchase a contraceptive or a non-contraceptive microbicide, allowing her to conceive and hopefully also to prevent mother-to-child transmission. In addition researchers are hoping to make it affordable for most women. The successful outcome of these trials will not only empower women to a far greater extent as they will now not have to negotiate safe sex with a volatile male, but it will also protect a man from becoming infected.

Men from the general population and students, were also involved in the MRC's research. They wanted to establish whether men would actually support a female controlled product and also to gauge whether microbicides cause excessive lubrication. Copeland (2000) reports that of all the men interviewed 82% expressed a preference for microbicides as opposed to condoms, 74% wanted to be involved in the decision on whether or not it should be used and 63% reported that excess lubrication was unacceptable. A focus group discussion, conducted by Van de Wijgert, et. al. (1999) among men in Zimbabwe reported a similar finding; men objected to 'wet sex' and were concerned about the safety of the microbicide.

"The importance of these trials is supported by the London School of Hygiene and Tropical Medicine, which estimates that a microbicide that is only 60% effective, could prevent 2,5 million HIV infections over three years if introduced in 73 developing countries." (Copeland,2000:41)

More importantly, it will help African women in this country enormously to control their sexual experience. Gupta (2000) echoes these sentiments, "it recognises the male condom as a male-controlled technology", she observes, "and takes account of the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use." However, it is estimated that the first microbicide is not expected to reach the market before 2007, which leaves the medical profession and government with the continuous responsibility of sustained interventions with regard to sexual education. It would be highly irresponsible to discard educational programmes, because this research proffers hope, but that is estimated to only manifest in five years time. Developing microbicides and responsible sexual behaviour programmes must occur simultaneously, as it is critical that we make more options available in order to lift the burden of living with AIDS.

CONCLUDING REMARKS

We have in our country various and inspiring community AIDS projects and centres, springing up like mushrooms, almost on a weekly basis, and they are all run by caring and compassionate people, hoping, even praying, their efforts would make a significant difference in clearing the fog of confusion and changing people's harmful ways. We have Western science and Western media, even Western funding, however not enough to dissolve people's misery, attempting to do the same. We have a president who has been described by one newspaper reporter as 'seductive on an interpersonal level, frequently leaving people in awe of his brilliance' (Sunday Times, April 14,2002), yet he holds on to dissident views regarding the AIDS-pandemic and leaves the podium with responses of refutations, rather than making a much needed impact when he addresses his country's biggest impediment to progress.

In all this however, something is sorely missing - the voice of the African living with AIDS, is never heard. We speak for this person and verbalise his or her convictions on his or her behalf. Yet we hear young people's lament sweeping across our hills, whispering, 'What is the point of being careful? We're going to die anyway?' Could it be that we should be reminded of Nietzsche's philosophical truth, "Convictions are more dangerous enemies of truth than lies." In particular, one could argue, another person's convictions as expressed by us.

Sadly there is little unification to be witnessed, in our efforts to construct different truths. And the hope that we proffer does not suffice, as it does not succeed in diminishing people's fear and the anger, *en masse*. In fact, these constructions cause delays, as they lay charges of moral blame against the defenceless, holding *them* responsible for the loss of moral values and virtues. More importantly, while we dither and rebut, it costs lives. People are living with anxiety over a new found uncertainty, caused by the superfluity of living with invincible death surrounding them. Bauman describes this sense of despair very eloquently, "death means that nothing will happen any more. No miracles, no surprises - no disappointments either." (1993:100) In yet another view on risk and death, we are reminded that we should never lose sight of how people in the African culture 'march with a collective step' and that, "to be part of a collective might shape one's apparent stance in the

world, but what manifest in the reaction to risk, and evident when we encounter death or the prospect of death, is loneliness. This is the same feeling that we encounter in a world where we have to make choices.” (Small, quoted in Weeks and Holland, 1996:214) How long still before our government realises that our country’s people need certainty, in order to avoid the loneliness of choice, since they would prefer not to make these choices, but for it to be predetermined? How long, to realise that loneliness leaves African people distorted and disorientated, out in a jungle, preparing to die alone? Most importantly, how long still before it recognises the desperate and relentless hunger for knowledge? Would our government, in fact, recognise in time that a national and coherent strategy is key for a ‘new’ African to emerge, that a dynamic national strategy based on independent African decision-making could give African people hope, since as long as our government lives in denial, African people will remain confused? How much more evidence does our government need to realise the dire need for it to direct and influence, on a grand scale, whole communities, involving parents, schools, peers, the Church and health professionals as to the part they could play regarding holistic programmes in sexual education? Our government’s power and commitment, not its irresolute talks, are needed when there is no time to waste. Government is indeed fiddling while Rome is burning.

And since power can discriminate, as it is never exercised without a series of aims and objectives, it is essential that once government has decided to influence on a mammoth scale, we ascertain our educational messages meet the criteria that could make these aims and objectives clear. Government’s first priority is to look at the heart of the matter. Messages will have to explain to our youth first and foremost how to handle the conflict inside in relation to the power outside? Hence, how must they for example live with desire, yet at the same time, they must live in fear of this desire? Does it not explain to us the resistance hitherto, towards the existing power, causing our messages to become, in the Latin expression, *ex nihilo nihil fit* –nothing emerges out of nothing?

Thus, my reasoning in the abovementioned, ”What ought we to do?”, involves a paradigm shift, away from the overwhelming emphasis on condom use, however much its immense importance must be emphasised, towards an equal distribution of extensive education involving groups and couples in order to bridge the gap in gender

relations. It substitutes the **ABC**-campaign with a **GLC**-approach, which necessarily entails, **g**-for getting educated, **l**- for limiting your number of sexual partners if not in a monogamous relationship and **c**- for using condoms when involved in casual sex.

Hence **G** underlines, that education works both ways. We cannot perceive what should be taught unless we ourselves get educated on a different culture. Education in this respect will also strive to be gender-neutral and gender-sensitive in order to dissolve the imbalances with its adverse effects on the HIV/AIDS pandemic. More training ought to become available and more creative ways and venues ought to be sought to impart with knowledge and experience.

The **L** emphasises, that monogamy is the ideal to strive for, since there are fewer people in this group in whom a person's trust needs to be invested, hence making it more controllable. We cannot however allow our campaigns to ignore polygamy as if it does not exist. Thus, whether in a polygamous, or a monogamous situation, it is essential to have both tested in a couple situation, and everyone, in the group situation, to ensure safety when there is a reluctance to use condoms for whatever reason. Holding testing as a prerequisite before entering a relationship will also serve to underscore the seriousness of HIV-infection and would encourage faithfulness. We cannot hope for immediate change, only that our tiny pushes can plant the necessary seeds that could make people look at their behaviour in different ways, and even make monogamy in the long term the preferred and less risky choice. .

C requires that a person, who prefers casual sex with multiple partners, can never go without a condom and when there is doubt about the other person's HIV-status in an existing relationship, safer sex should be negotiated. African people, in particular, will have to be led to see there is no difference as far as risk is concerned, in distinguishing between 'having multiple sex partners ' and promiscuity.

Virginity testing musters gender-biasness and gender-exclusiveness, thus it is counterproductive in the **GLC**-approach. This approach argues for more sensitivity towards the needs of children, for example, it asks for respect as to her right to privacy, and would teach her that she is entitled to that privacy. This approach would teach parents to recognise she has certain instincts, tendencies, pleasures, images and

conduct that comes naturally to her at the onset of puberty and rather than to use scare-tactics and punitive actions when she fails this test, she should become educated. This approach would in fact, point critically at the tendency in Africa to foster taboos in public discourse. Anton van Niekerk critically comments on the serious limitations of such a view, especially in developing communities such as our own,

Too much of a taboo mentality towards sex for the sake of, e.g., protecting children from premature exposure to the risks and perils of adulthood, and resulting in an accompanying taboo on the public dispensing of fixtures such as condoms, can and does backfire when a sexually transmitted epidemic strikes. We ought to rethink, very carefully, the purpose and wisdom of all taboos of public discourse. However useful in context, they can become an obstacle that attains life-threatening proportions.

(2002:158)

Education has never left any person untouched and African people have a natural hunger and eagerness to get taught. Hence I believe if we invest our time, funds and energy in effective communication, in messages of hope and not morbidity, it will naturally lead to informed choices and consent regarding individual sexual needs. It is important that we call upon community leaders who are decision-makers and trendsetters in their communities to assist with the dissemination of creative educational programmes. It would also involve, that we befriend, educate and train traditional healers, whose authoritative input could yield tremendous change in society, in fact, in this country at large.

Would it not be rhetorical and sad when we as a nation, look in hindsight, a decade from now and say, look at the irony, this disease killed millions of the population, yet the man who was chosen by his own people to lead them to a better life, chose not to intervene in something as formidable and catastrophic as this pandemic? However, would it not be bliss if we would be able to say, 'yes the disease did destroy a lot of human life, yet it has proven to be advantageous to our people, since it succeeded in eradicating the negative health hazards in a culture and built on the positive?'

Quoting the simple words of beautiful Beauty, “ All I want 10 years from now is a good and honest life, a faithful husband who understands how I feel on the inside and no more than three children, because I don’t want them to suffer.” The plea is almost desperate, the striving towards this utopia almost naive. The very least we could ask ourselves is, what would it take to mitigate the suffering and bring her closer to her dream? And at the most, to try and understand, and to implement our ideas, which call for concerted zealous efforts. The call for good, strong leadership, regarding this pandemic is refrained in poet Ezra Pound’s battle cry, ‘Make it New’!

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