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1 Executive Summary

1.1 Introduction

Women have become the face of AIDS in Africa, with 60% of all HIV positive adults being women. Women’s lower socio-economic, political and cultural status inhibits them from making informed sexual and reproductive health choices to prevent HIV infection. Women’s positions also place them at greater risk of earlier infection, placing them in the position of being unfairly blamed for the transmission of the disease, whilst also inhibiting them from accessing resources and services to cope with the impact of HIV. Women also bear the greater burden of the HIV and AIDS epidemic, both as people living with the virus, and as the primary caregivers for others who are infected.

Two studies, conducted in Namibia and Mozambique in April and May 2006 respectively focused on examining the inter-linkages between cultural practices and beliefs, customary and general (statutory) laws, vulnerability to HIV and the impact of AIDS on women and girls. The findings from the Namibian study were expected to enrich the knowledge base on the reasons for women’s the greater vulnerability to HIV. The aim of the study was to facilitate and pave the way for the design and implementation of meaningful prevention and intervention strategies crucial to slowing the increasing prevalence of the disease amongst young women, particularly those in 15-24 year old age group, where the greatest increase in HIV had been reported (UNICEF Report 2005). The Mozambican case study aimed to explore and document the dynamic relationship of factors that contribute to reversing the present trend of the epidemic which is seeing girls and women more infected and affected.

In both countries, the following are some harmful traditional and cultural practices that were identified as increasing the vulnerability of women to both gender based violence and HIV and other STIs:

- Patriarchy, men’s abuse of power and the accepted male dominance and women’s subordinate positions
- Polygamy (whether formal or informal) and the acceptance of male promiscuity as ‘manly’
- Multiple concurrent partnerships
- Widow inheritance and widow cleansing
- The desire for children at all costs which leads women and men to engage in unprotected sex, even when their partner is known to be HIV positive
- Culture of silence which makes it taboo for men and women, parents and children and husbands and wives to speak about sex
- Reluctance by men to use condoms, and women’s failure to control condom (and other birth control) use, especially in marriage

1.2 Namibia

According to the 2004 HIV sentinel sero-survey conducted by the Ministry of Health and Social Services, 19.8 % of all women attending antenatal care were found to be HIV positive, with prevalence varying by region from 9% to 43%, with an overall estimated 20 percent crude prevalence rate for sexually active adults. As a result, Namibia was one of the top five HIV-affected countries in the world.
Qualitative data was gathered from a variety of people living with HIV and HIV and AIDS activists in two geographical locations in the Omusati (high prevalence) and Karas regions (low prevalence). Although the general themes that emerged from the research were the same for both cultural groups, the data indicated four overarching central themes that impact on the rates of HIV transmission and women’s greater vulnerability to HIV in Namibia. The strongest emerging theme was that of male dominance - men are regarded as the heads of the family, decision-makers and controllers of resources. The other themes were the importance of marriage - marriage is taken very seriously and agreements made during marriage negotiations are traditionally binding; the value of children - there is high value attached to having children to the extent it appeared not to matter if the children were born HIV positive; and the separation of men’s and women’s rights - women had very few rights, especially in relation to property and inheritance.

Although the study findings were explicitly on cultural issues, the main problems reported for women were of a structural nature i.e. poverty and unemployment, which could lead to women engaging in transactional sex as a means of survival. Although poverty was universally regarded as the primary underlying factor in the spread of HIV; rape, violence against women and alcohol were perceived as the other major problems.

### 1.3 Mozambique

The Ministry of Health in Mozambique (MISAU, 1999) indentified behavioural factors, among others, as being influential to the increasing incidence of HIV and STIs. The rise in HIV infection was also found to be related to levels of knowledge of HIV and AIDS and other STIs and to the efficiency of the different prevention and risk reduction methods being promoted, as well as to weak inter-personal communication. A study by Barreto et al. (2004) in Mozambique indicated that 14.9 % of people aged 15 to 49 were living with HIV. In the same age group, 500 new HIV infections occurred daily. The highest HIV prevalence was noted in the central part of the country with 40% of new daily infections, while the north and south documented 20% each. Unprotected heterosexual sex appeared to be the major method of transmission and women were most vulnerable to contracting the HIV virus (Barreto et al, 2004).

This study examined cultural beliefs, practices, women’s rights (both customary and constitutional), gender equality, HIV and AIDS prevention and impact mitigation and the ways in which indigenous (original) knowledge in communities contributed to the direction and rate of the HIV epidemic. It also sought to understand the linkages between indigenous knowledge and the legal system in relation to women’s rights and efforts to reduce the vulnerability of Mozambican women and girls to HIV and AIDS.

This study was conducted in Chókwé, a district in Gaza province in the south of the country - HIV prevalence among pregnant women was approximately 22.09%. Study respondents included, among others, religious and community leaders, HIV and AIDS activists, youth and medical practitioners.

Study findings indicated that women were expected to respect their husbands, fulfil family and community tasks and accept polygamous relationships. The study also found that cultural practices such as circumcision (at home or in the bush) and cleansing rituals after death were closely related to the spread of HIV. In addition, power relations linked to patriarchy and gender roles also appeared to be linked to unsafe sexual behaviour. Financial security and employment opportunities were some of the particular problems women faced. Study respondents suggested that women must have access to education and employment and that both the husband and wife must ensure gender equity in their relationship. Amongst the youth, the study revealed knowledge about sexuality from both the cultural and the modern points of view. This group also recognised that safe sexual behaviour was key in avoiding infection with HIV.
2 Methodology

2.1 Namibia

In order to obtain the most relevant cross-section of respondents allowed given the time available for the study, sample populations from two geographic locations in Namibia were identified; one with high HIV prevalence and the other with low HIV prevalence. These areas were the Omusati region in the northern part of the country (high prevalence) which is predominantly inhabited by the Owambo cultural group, and the Karas region in the south (low prevalence), which is predominantly inhabited by the Nama/Damara cultural group. HIV prevalence could be low in the Karas region because the population is less dense and migrations lower than in other regions in Namibia.

This study employed structured individual questionnaires and focus group discussions which followed a format similar to that in the questionnaires to collect data. Two Interviewers, both educators; one an educational psychologist and the other involved in educational management conducted the interviews. In the Omusati region, the interviewers spoke exclusively in Oshiwambo and spoke Afrikaans (the lingua franca in Namibia) with the respondents in the Karas region.

The study population included traditional leaders (community elders, headmen, tribal council members, midwives, and government officials), groups of women, groups of men, groups of HIV activists, a group of HIV positive women working in a community project, and other persons living with HIV and AIDS.

A total of 43 respondents, 22 in Omusati, 19 in Karas, and 2 in Khomas (Windhoek) were interviewed. Omusati participants included senior traditional leaders, a senior headman, a school principal, school teachers, a nurse/midwife, a member of an OVC committee, government officers, community women, HIV activists and women employed outside of the home. Karas participants included traditional leaders, community elders, women living with HIV, a social worker for OVCs and community women. The Khomas (Windhoek) participants were a married couple who were both HIV positive and were well-known HIV activists.

The interview questionnaires employed were identical in each region. The questionnaires were developed by the consultants in collaboration with SAfAIDS staff members. The interview process consisted of three parts, Part A involved interviews conducted with traditional leaders either individually or in small groups, Part B involved focus group discussions with community members, and Part C consisted of interviews with people living with HIV, HIV activists and educators, individually and in focus groups. After the focus group discussions, individual interviews were conducted with community leaders and with selected members of the focus groups. Data was analysed by the researchers using a data matrix and descriptive analysis.

2.2 Mozambique

The research took the form of a case study which allowed researchers to undertake in-depth exploration of a small sample of individuals. This design allowed detailed descriptions of linkages between cultural beliefs, practices, women’s rights, gender relations and HIV and AIDS. A non-probability sampling design permitted the researcher to obtain a convenience sample (N= 53) drawn from the community in a rural area with high HIV prevalence.
Participants were drawn from the population of the rural area of the district of Chôwé by means of a non-probability sampling procedure (Judd, Smith & Kidder, 1991). A convenience sample, of any individuals who volunteered to take part, was used. Some participants were selected to complete the written questionnaire (N = 10), one in-depth interview was carried out with one participant, and 40 participants split into four groups, participated in Focus Group Discussions (FGDs). Each participant took part in the study only once. Respondents who left out more than two questions on the written questionnaire were excluded (N = 3). Activists for counselling and voluntary testing (N = 3) and people living with HIV (N = 3) did not want to take part in the study after completing the written questionnaire. Other key participants (N = 6) gave basic information that enriched the understanding of the social context in which the fieldwork took place.

The main methods of data collection in this study were the questionnaire, individual interviews and focus group discussions (FGD). The questionnaire was the main research instrument selected to capture the desired information. Two types of questionnaires were developed: one was administered to key informants, traditional leaders, religious leaders and midwives, and the second was administered to HIV and AIDS community activists and persons living with HIV. The other tool used for data collection was a Focus Group Discussion guide.

Thematic analysis was the technique employed in the analysis of data. The content of the responses were considered in their social context of use and meaning (Krippendorff, 2004).
3 Study Findings

3.1 Namibia

The study findings indicated four overarching central themes: male dominance, importance of marriage, value of children and the separation of men’s and women’s rights.

3.1.1 Theme Summary

Male dominance:

This was deemed a major theme universally accepted by both men and women i.e. men were head of the family, decision-makers and resource controllers. Women were expected to be submissive, not to make decisions or explicitly and overtly negotiate a position. Christianity was revealed to be the dominant religion (practiced by 90+% of people in the country) and religious beliefs were employed to support the strongly patriarchal stance of men in the regions. This assertion is supported by some Christian respondents who maintained that:

"According to Apostle Paul, women should be submissive as it is wise in the eyes of the Lord. Men should be the heads of household."

This was also the case in the rural areas where 67-70% of the population resided.

Men generally had decision-making power about whether or not condoms would be used in a relationship. Most women were not allowed to use contraceptives, nor could they decide how many children they were willing to have. Respondents from a women’s focus group stated that one could never suggest condom usage in a marriage as the man would not accept it.

Younger male respondents indicated that some of cultural beliefs and practices needed to change in order to protect the more vulnerable groups (women). These included:

• "shyness of women to request condom use";
• "the silent approval of men who have more than one partner"; and
• "men still do not seem to understand that multiple partners play a role in the whole HIV issue."

Research findings indicated that women were expected to engage in domestic chores including farming, tending to cattle and goats. There continued to be a strong view that biological differences influenced the type of work that men and women were expected to do and that the weak socio-economic and cultural status of women seemed to inhibit them from making informed sexual reproductive health choices (as evidenced by women from the northern region who spoke about not having the right to refuse to have sex). As one female respondent made clear:

"Owambo men don’t like a condom. Even a man whose wife died of HIV, on going to a woman whose husband died, he may still not want to use a condom. If you tell him, he may not accept. You are my wife, why use a condom?"
**Importance of marriage:**

In both the northern and southern regions, cultural traditions were arranged in such a manner that marriage was highly valued and taken very seriously and agreements reached during marriage negotiations were traditionally binding. Within the cultural traditions of the northern region, marriage is so highly valued and that a woman will marry even if the man is known to be HIV positive. If a woman is unmarried, it is assumed that something is wrong with her (and by extension, her family/clan). Divorce has a very detrimental connotation, and often women will remain in a bad marriage.

According to the elders, adultery is unacceptable and men were not to have more than one wife. However, a female social worker and study respondent stated, “Men have the right to have as many children as they wish with as many partners as they wish. Taking care of their children seems to be voluntary.” Thus, there seemed to be an apparent discrepancy between cultural norms and actual practices. Respondents cited official and “unofficial” polygamy as common practices. “Unofficial polygamy” refers to a man who is married and also has a number of other ‘girlfriends’. Having girlfriends is such an accepted cultural practice that men say, “what is the point of being monogamous if we all have girlfriends anyway”.

Notwithstanding men’s polygamous tendencies and practices, certain views emerged from the Focus Group Discussions which reflected the view that HIV was caused by women having sex with men other than their husbands. These comments did not acknowledge the role of men as transmitters of the disease. As one man observed:

> “Polygamy should be officialised. This will help us reduce HIV. The husband would get a young girl who was never sexually active, be engaged to her while she is still a child and when she is old enough, she becomes your wife. In that way, no HIV.”

**Value of having children:**

Cultural norms, for example the Owambo culture lays great emphasis and importance on the fathering of children. The more children a man fathered, the more prestige he had in the society. When Namibia’s former President bemoaned Namibia’s small population by saying “Men should stop wasting time drinking in bars and spend more time making babies...we need to produce more (babies)...each one of us (men) must have a duty to perform, making babies.” (The Namibian, 20 April, 2001), it was generally perceived/interpreted to be mean that men were being given the license to have as much sex as possible, with as many partners as possible, to make babies and in the process enhance their status and prestige and assist the nation.

The value attached to having children was of such primary importance that it appeared not to matter if the children were born HIV positive. As a result, women with many children held in higher esteem and had higher standing in the community than those who had fewer children. In the case of a childless union, blame was placed on the woman alone, unless it was otherwise proved that her husband had a medical impairment that prevented procreation.

The inherent cultural contradiction herein was that if a boy or man impregnated a girl outside of marriage, his family would celebrate that he had produced a child, while her family was shamed; the boy would not marry her because of this shame.
The negative stigma associated with childlessness could be eliminated within some cultures, at the risk of contracting HIV, through the practice of third-party sexual intervention. In this practice, the brother or close friend of the man, who may or may not have been selected by the wife would have sexual relations with the woman for the purpose of procreation. Offspring conceived from such a union was considered the husband’s. The biological father would never discuss this because it was perceived to be a secret practice between the wife and him.

There were differing perceptions about the role of fathers. Respondents from the south generally indicated that children were the responsibility of the mother, who carried the burden of care. However, a high level of alcohol usage among single mothers in the south often led to neglect of the children. In the North however, men were perceived to be more involved with their children, as was the extended family. It was noted that the extended family was not as closely knit as it once was and thus children were more vulnerable to sexual abused and increased risk of contracting HIV.

**Separation of men’s and women’s rights:**

Respondents universally indicated that women had very few rights especially in as much as they involved property and inheritance. Women were more likely to state that women have a right to equality, generally viewed in 1) economic terms: women can own property - a cow given to the wife to feed her children belongs to her clan and not to the husband and in 2) inheritance terms: upon death, the cow reverts to her clan. Although these rights were not universal, they pointed to positive practices in the arena of women’s rights.

Women had rights (traditional Nama ways) within the family and community and these included respect from her husband, inheritance of land when the husband died, consultation and planning about the number of children the couple would have and the right to refuse sex. This response differed greatly from most other responses (both from the northern and southern regions) which indicated that inheritance of land and the right to refuse sex were ambiguous rights at best, and non-existent at worst. This indicated the existence of a dichotomy between perceived rights and cultural practices, wherein these perceived rights may not have been exercised. The question which then arose was whether or not both men and women perceived these traditional rights in the same manner, or indeed, if they were perceived at all.

In both the northern and southern cultures wife inheritance (if a husband or boyfriend died, she may be inherited by a brother, cousin, or other close male family member of the late husband or boyfriend) was practiced. This practice was to ensure that the family wealth was retained by the family and to ensure that the children would be cared for with the necessary love by their father’s brother. At the time of the study, this practice was no longer as prevalent as it was in the past, but it still existed. This practice could be harmful if HIV related illness had caused the husband’s (or boyfriend’s) death there was the very real possibility that the wife could also be infected, and would in turn infect her new husband with HIV.

Although women appeared to understand that economic resources provided empowerment, when they worked outside the home and earned an income, men felt threatened. In the Northern region, a women’s focus group defined women’s rights as:

“She is in charge of the kitchen. You may be senior wife, so you supervise other wives.”
Their opinion about rights revealed the inherent ambivalence about women’s rights where culturally a man was considered to own almost everything in the household as the head of the household. Their own status as a result was derived in part from their husband’s status, reflecting the internalisation of beliefs about the cultural correctness of male dominance.

“(Women’s) rights create lots of conflicts. Culturally, a man is considered to own almost everything in the household. Women have too much respect for their husbands. Wives don’t want people to look down on their husbands; as a result they will go an extra mile to acquire property that will reflect positively on his status. We believe that a husband is the head of the household. Even if I am, the owner of the house, my husband should be the head. There is no institution without the head.”

This acceptance of male dominance is present despite other statements regarding the men’s use of power to the detriment of women and children, including in domestic violence.

Acceptance of the status-quo appeared to be a prevailing theme as only a very few respondents urged increased education about women’s rights. This was collaborated by a focus group comprised of women working outside the home who recognised that women’s rights cannot be realised in the absence of understanding and acceptance by men. The women commented:

“Some women just hear ‘equal rights’ but don’t really know what it is about. Laws should be explained to all men in villages who are not aware of these laws. Sensitised men should go from house to house and educate the men. Traditional leaders should get involved. Men should learn about topics of gender and HIV.”

Such statements however also reflected the entrenched cultural beliefs about male dominance; that is that change cannot happen without the approval and agreement of the men. The women themselves did not appear to be willing to speak up and press for their rights. This may have been because women were bargaining within the prevailing patriarchal and cultural contexts and continued to have restricted notions of their own identity, that is, that they could only express their rights and power through their roles as wives and mothers.

3.1.2 Priority issues identified by respondent groups

**Women’s concerns:**

There was clear consensus among all respondents, female and male, that women were more vulnerable to HIV infection. Some of the reasons cited included, the inability to refuse sex, the inability to insist on condom use, the risk of being injured during sexual intercourse (rough sex or rape), wife inheritance and the necessity to engage in transactional sex to alleviate the challenge of poverty and unemployment. Poverty was seen by all as the primary underlying factor in the spread of HIV. Alcohol was perceived primarily as a causal agent causing women to engage in risky behaviours and causing men to perpetrate violent acts against women, rather than as a symptom of some of the wider cultural and structural forces that increased women’s vulnerability to HIV.
Traditional leaders' concerns:

The loss of traditional ways and the breakdown of traditional values were lamented by all leaders as they viewed these as reminiscent of the orderly and well-defined past:

“Old people are not dying of AIDS. But the young people are dying in numbers. Let’s bring in traditional education for our children. It will help save our children. We believe as traditional leaders that the ways of our grandparents will save them.”

A pervasive view on the part of older traditional leaders was that if traditions were kept, then HIV and AIDS would be non-existent. Elderly people generally blamed the new (civil) laws as well as young people for the increase in HIV infection rates. According to the traditional leaders, decision-making should be left to them, and women who cited civil laws were considered trouble-makers - courts were less effective than “elder convened” dispute resolution.

Traditional leaders’ responses suggested a return to the old ways which seemed to imply that HIV and the associated problems (alcohol, violence) would diminish if people (women) only followed more traditional behavioural codes:

“The government has tabled much law without consulting the traditional authorities. Most of the laws have been modernised. The government should go with us and put some of these old laws (i.e. traditional practices and regulations) back in place.”

Concerns of HIV activists and persons living with HIV:

The stigma and fear that goes hand in hand with being HIV positive was mentioned by all respondents in this group. Stigma was so pervasive that few people were willing to inform even close family members of their HIV positive status. Even within an NGO project which supported people living with HIV, incidences of stigma were rife, as evidenced by the case of a woman who used a cup belonging to another person and the owner became so incensed that she threw the cup away.

Respondents also revealed encountering stigma from people who conducted HIV testing and provided anti-retroviral (ARV) drugs. Another key problem cited was the lack of confidentiality in HIV testing.

There appeared to be divergent ideas about the roles of cultural beliefs and women’s rights as related to HIV. Some traditional responses commend the past:

“Before independence (1990) there was respect for culture. The new culture mix has caused problems. Nowadays women go into relationships for material gain. When a woman is empowered, a man feels threatened” (Traditional Leader).

Such statements reflected the cultural belief that a woman’s place was in the home as a wife, and implied that the desire for material gain led to problems of prostitution, alcohol abuse and HIV infection.
At variance with the above were responses by an HIV positive community activist in Windhoek who stated that:

"Women in Africa were never on the same footing as men. Women are viewed more negatively. Gender roles for example insist that a woman’s place is in the kitchen. For some the male culture of having more than one partner is accepted by women as ‘how it should be’. ... We need empowerment of women and the current approach (ABC) to HIV is outdated. Women and men must be educated together in mixed groups. In trainings it’s tough because women will not speak.... There is a need to create supportive structures for vulnerable women to have round table discussions and set their agenda. Boys are behaving like men. We need to try to change the mindset of men, but we can impact on the boys now while they are still young. People should not change their culture, but we need to identify risky behaviours within the culture and address them."

A focus group of HIV positive women from the southern region indicated that women were more vulnerable as a result of:

"...the use of alcohol and guys throwing cash around. Many men do not believe we are positive and insist on sleeping with us without protection... To report rape or violence is not culturally acceptable. In the past, people (women) would just keep quiet. Women should be able to say no to sex."

These common themes reflected a general lack of empowerment and lack of power by women to say ‘no’ to sex and to insist on condom use as well as the lack of the economic resources to withstand men “throwing cash around”. These themes were also buttressed by a focus group from the northern region comprised of HIV and AIDS activists and educators who stated that biologically women were more vulnerable to HIV and that they would not report domestic violence. The women also addressed the issue of bride price, which seemed to imply that the man had bought the woman. The need for education and empowerment was acknowledged as being of paramount importance.

3.2 Mozambique

3.2.1 Priority areas for redress

Men and women’s rights

Unfortunately, in the literature reviewed for this study, no written customary law for Mozambican was found. Before the time of changes (colonisation and urbanisation) women were expected to spend more time at home and to fulfil household and community tasks, bear children and educate them, be faithful to their partners, dress appropriately and not to have extra-marital affairs. Women were expected to respect their husbands as well as to accept polygamous relationships.

According to the study findings, women were still expected to accept and follow certain cultural and traditional norms. Some of these roles and expectations had been eroded in towns and villages due to influences from a variety of sources, including from government policy and the influence of greater social interactions between people coming from various parts of the country and abroad.
Mozambique has in place modern laws and policies meant to ensure the equality of women and men. Articles enshrined in The Family Law (2003) and the Constitution of the Mozambican Republic (I.N.M., 2004) included the following entitlements:

- Women as well as men are entitled to gender equity within political, economic, social and cultural dimensions (Article 36);
- They are entitled to have a good life (Article 40), and to have honour (Article 41);
- Both women and men are entitled to work in their communities (Article 44), to join or create an organisation (Article 51, 52, 53);
- To pray (Article 54), to have a house (Article 55), to have freedom and security (Article 59);
- To be compensated for damage if necessary (Article 58), to resort to the tribunal (Article 70), to exercise freedom to participate in political activities (Article 73);
- To have properties, to inherit, to work, to be educated, and to be healthy (Articles 82, 83, 84, 85, 86, 89). They are also entitled to live in a balanced social environment, to have a house, family; and
- To be protected (Article 90, 91 and the Family Law).

These human rights entitlements were referred to by the participants in focus group discussions, interviews and questionnaire. Participants highlighted differences between social norms then and now: “before changes in social norms, things were that way but now things are this way”.

Given that women’s rights were enshrined in the Mozambican Constitution, there is evidence that the Government of Mozambican had made some progress in developing policies and laws that protect women. Educators were working in order to reduce the drop-out rate for girls in primary and secondary schools. After completion of high school some girls were enrolled in a programme that prepared them for courses in traditionally male fields such as engineering and mathematics.

Other institutions were also making efforts to reduce the trend towards feminisation of the HIV epidemic. More people with authority in the communities were involved in tasks such as skills training and counselling. These people included community and religious leaders, former freedom fighters, agrarian activists, people living with HIV, teachers and traditional doctors (herbalists) together with specialist staff.

For example, in consonance with civil law, the religious leaders and nurses categorically stated that a man must have one wife only in contrast to other participants who tolerated polygamy. The religious leaders and nurses explained that couples (wife and husband) must agree on issues such as the number of children to have, the frequency of sexual intercourse as well as condom use. In this way, decision-making was shared between husband and wife. Participants were aware of their cultural and civil rights as the constitutional rights enshrined in constitutional law were translated into government policies that protected the citizens (both women and men), although some problematic cultural practices were still in existence.

**Cultural beliefs, practices, traditions and customs:**

Cultural beliefs, practices, traditions and customs in Mozambique were still influenced and enshrined in customary law and a patriarchal system in which men had supremacy. People put beliefs into practice and behaved and acted in consonance with those beliefs.

Before changes in the customary law, one participant states, ‘... people were doing menstruation rituals, wedding rituals, feasts for the name of the baby and death cleansing ceremonies’. While one participant

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1 Imprensa Nacional de Moçambique
argues that, “in the present day practice, some families do not do the menstruation ritual as well as virginity checks in the wedding process’.

Both the menstruation ritual and the death rituals mentioned above are each linked to sexuality. It was believed that the menstruation ritual had a positive effect on the behaviour of young people in protecting their sexuality, as expressed by elders in the two focus group discussion held. The menstruation ritual was intimately related to the expectations for girls to remain virgins and to the pride attached to the marriage of a daughter.

The death ceremony is a process that aims to cleanse a wife following the death of her husband and to ‘replace’ the deceased person with another. The death ceremony is called ‘kutxinga tindzaka’ which literally means replacement (‘kutxinga’) of the waste (‘tindzaka’). Most research participants stated that the death cleansing ceremony was an ongoing cultural practice.

Some participants, in support of culture and traditional practices maintained that HIV in Mozambique was driven by people who did not observe culture practices. They noted that, “… many people do not follow cultural instructions concerning sexual behaviour. That is why some people are semi-dressed … they fall in casual sex, get disease and get ill’. This comment suggests the need for people to return to the practicing of traditional and social morals governing sexual behaviour. Under customary law, elders were responsible for counselling young adults on sexual matters.

In the study sites of Chôkwé and Hôkwé, despite claims by some religious leaders interviewed that: ‘... each man is entitled to have one wife only’, the focus group discussions as well as the interviews revealed that polygamy had been practiced in this community for a long time.

One participant argued that:

“... polygamy itself is not a problem. The most important thing is mutual respect. Men must be prudent and keep harmony among their wives”.

The problem with polygamy identified here arises when men in polygamous unions find themselves unable to offer their women as much affection and financial support as they were expected to. Families where polygamy was practiced, it was admitted, also experienced more strain on financial resources required for the upkeep and education of the children.

Participants however also made the link between multiple concurrent relationships and the spread of HIV by mentioning that HIV is more readily spread through polygamous relationships, meaning that there was a greater likelihood that both the wives and the children in polygamous families would be more at risk of becoming infected and affected by HIV and AIDS than those in monogamous faithful relationships.

“Mutual respect” seemed to include acceptance of myths and taboos meant to control sexuality (especially that of women) under customary law. There were numerous taboos placed on sex and sexual matters within a family. Topics such as sexually transmitted illnesses, including HIV, dying and death were also as taboo as was communication between married couples on issues related to adultery, STIs HIV and AIDS or STIs it was taboo for a wife to talk face-to-face to her husband.

The traditional midwives and the elder women in the community were expected to counsel young women on family planning and procedures to avoid sexually transmitted infections. The women were expected to be faithful to their husbands, even in their absence, as adultery by women was culturally condemned. On the other hand men, who were sometimes away from their homes for more than one year, were entitled to have other wives.

Further, under customary law, only husbands were entitled to request divorce, while the constitutional law makes provisions for women to file for divorce if they are unhappy in marriage. Culture therefore played
a critical role in the interpretation of women’s and men’s relationships. Children belonged to the father and this continued to be recognised even after the parents had divorced. Divorcing couples split belongings such as household effects.

In contrast, some participants complained of the absence of myths, taboos and strong beliefs relating to sexuality. The argument advanced was that in the present day there were no prohibitions placed on talking about sex and sexual intercourse with young men and women.

**Gender relations:**

Under customary law, the balance of power and the organisation of society was such that men held all the power and men were considered more important in the community. Men made all the decisions and had control of everything, including their wives and children.

3.2.2 Various dimensions to deal with HIV:

In Chôwé there was a mobile counselling and voluntary testing office, although it was revealed by a respondent that the office was not very effective and did not achieve all of its objectives. Further, HIV activist groups consisting of both young and older people had been disseminating knowledge about the disease and safer sex practices and how to counter stigma and discrimination.

As part of dealing with people living with HIV, specialised staff, institutions and the community made great strides in providing care, support and treatment to mitigate the impact of the epidemic although levels of stigma, discrimination and denial by those living with HIV were still high. This was probably the reason why those providing counselling and voluntary testing services, as well as people living with HIV, did not want to participate in the study.

As noted, the issues around HIV in Chôkwé and Hôkwé was of such concern that the government took action by implementing policies such as support for school health activities and a joint approach by many institutions (Barreto et al, 2004) to deal with STIs, HIV and AIDS and to prevent new infections.

3.3 Similarities and differences in the Studies

Several common factors, as well as some differences, were identified during the course of the two studies, these included:

- Both studies focused on examining the inter-relationships among cultural practices and beliefs, customary and general (statutory) laws and HIV vulnerability, and the impact of HIV on women and girls in rural areas in Namibia and Mozambique respectively.
- The methods employed for the collection of data collection took the form of structured interviews using questionnaires and focus group discussions in both countries; although for Namibia the focus group discussion followed the same format as the questionnaire for interviews, while in Mozambique a focus group discussion guide was used for collecting data.
- Forty three respondents participated in the Namibian study while Mozambique collected information from 56 respondents. Nine respondents in Mozambique were excluded - three had left out more than two questions on the written questionnaire (N= 3); activists for counselling and voluntary testing (N = 3) and people living with HIV (N= 3) did not want to take part in the study after receiving the written questionnaire.
- Namibia did not outline any study limitations, while Mozambique mainly cited inadequate time allocated for field work and challenges faced in persuading some people living with HIV to take
part in the study. This could be the reason for some respondents refusing to take part. The study in Mozambique was undertaken in two areas, Chókwé town and Hôkwé village with participants constituting a convenience sample (which is non-probability sample). Because of this, the findings cannot be generalised.

- Both studies questioned traditional leaders, midwives, HIV and AIDS community activists, persons living with HIV and groups of women and men as the study population. Namibia also included government officials.
- Most respondents in both studies acknowledge that women were more vulnerable to HIV infection, with the exception of nurses and midwives in Mozambique who argued that both men and women were vulnerable.
- Polygamy was seen as a cultural practice still existing in communities under study for both countries irrespective of HIV/AIDS problem.
- Male dominance was evident in both studies as men were viewed as the decision makers in the home and women’s responsibility were to take care of food production and the rearing of children. Women’s rights in both studies were compromised for example; women in Namibia were viewed as having very few rights. Women’s rights were enshrined in the Mozambican Constitution and the government had made great strides in developing corresponding policies that protected women. In practice, the study found that the girl child was valued in Mozambique in terms of completing school and embarking on courses such as engineering and maths, which was not the same in Namibia. Women’s rights in Namibia were evident on paper and not understood nor practiced accordingly. Hence even domestic violence was viewed as normal practice and the feeling was that women were not allowed to report cases of domestic violence because this would damage the husband’s image. Acceptance of the status-quo on women’s rights appeared to be a prevailing theme in Namibia.
- In Mozambique, the respondents seemed to be aware of cultural and civil rights unlike in Namibia where there was evidence that there was need for awareness-raising on women’s rights.
- Cultural practices and beliefs seemed to be observed by some in both countries as some respondents reiterated that cultural norms and practices determined the behaviour of some people, especially women, girls and boys in terms of their ability to discuss and negotiate for safer sexual behaviours. While some people blamed harmful cultural practices for the HIV prevalence levels, in Namibia the traditional leaders expressed the belief that the loss of traditional ways and the breakdown of traditional values was the cause for the HIV prevalence levels and AIDS related deaths. The traditional leaders expressed the belief that if traditional education was taught to children, it would save them.
- Both studies showed that wife inheritance was still practiced in some cultures after the death of the husband, potentially exposing women, and men, to sexually transmitted infections as the community leaders conducting the ritual did not consider the cause of death of the spouse.
- Women experienced some problems linked to financial security and employment opportunities. In both studies, poverty, mainly attributable to the unemployment of women seemed to be the cause of women’s heightened vulnerability to domestic violence, sexual abuse and male dominance leading to the spread of HIV.
- Both studies showed that children were so valued in marriages that both men and would go to great lengths, including extra marital sex, in order to ensure procreation. Women from Omusati region in Namibia for example, would get pregnant in spite of their HIV positive status in an effort to have more children and to consolidate their position in the family and the society.
- Both studies realised the importance of empowering women especially on their rights and ensuring gender equity.
4 Discussion, Conclusions and Recommendations

4.1 Namibia

4.1.1 Discussion

The findings indicate that, culturally, discourses of ‘rights’ do not occur within a universal notion of rights, but rather a sex-disaggregated understanding of who can access which rights. When rights were discussed, they were discussed in terms of women’s and men’s rights to property and inheritance, as well as differing rights within marriage. This sex-disaggregated notion of rights is gendered, in the sense that it is embedded within gender relations that promote male dominance.

Despite laws and common talk of equality and women’s rights, male power continues to be reinforced. Both men and women know what the rights of women are, yet the expectation of the subordination of women is more salient than the application of their rights. The practice is totally different from the laws. All interviews and focus group discussions seem to confirm the dominance and power of men, especially regarding sex-related issues. As a result, this study provides information that confirms that it is simply not enough to empower the female sector of society. An Africa-centric gender perspective (Preece and Ntseyane, 2004) should be employed in HIV education programmes, despite the fact that women have little power to take the initiative in preventing HIV.

Nationally, Namibia has committed to a notion of ‘human’ rights, which means that all citizens (members) should be able to exercise and enjoy their rights by virtue of being ‘human’. Because the current situation in Namibia does not uphold this ideal, as the ability to exercise of ones’ rights is determined by ones gender, it is possible to argue that women in Namibia are currently, de facto, less ‘human’ than men. The dual legal systems in both countries mean that often women’s rights fall by the wayside because in instances where customary and constitutional laws are in contradiction, customary law takes precedence. In Namibia and Mozambique, the study findings show that customary law around issues of marriage, divorce and inheritance denies women their rights.

Government commitment and action is critical in coming up with ways to bridge the contradictions between community customary and national constitutional laws in order to ensure that women’s rights are respected. The research findings do however indicate that given the manner in which some respondents, particularly those who are older and custodians of culture “romanticised” tradition and cultural practices, there would be some resistance to such a move.

The research findings also show that it may be easier for the Government of Namibia to fulfil its legal obligation of ensuring women’s rights if it approaches change from a gender perspective. This perspective, with its emphasis on gender as a relational concept, highlights that the legitimacy of women’s rights can be more easily ensured if cultural and structural alternatives are provided not only to women, but also to men. Because in the fight for women’s rights is viewed as necessarily involving the disempowerment of men and because men are not provided with alternative ways to re-define and exercise their masculinities they feel threatened and offer up some resistance as a means of clinging to power.

This in turn causes culture to appear to be static rather than dynamic as men respond negatively to the necessity of social change and social adaptation. Thus the study findings indicate that sustained change demands investment in women and men.
The UNDP indicates that in Namibia, women’s annual incomes are almost half that of men (UNDP, 2001). Further, young women in urban areas are more likely to be unemployed than men, which increases the possibility of their turning to and engaging in transactional sex and unsafe sex, in the process increasing their risk of contracting HIV. Ultimately, the evidence indicates that economic status determines equality, but that the situation where women occupy subordinate position in the surveyed societies does not have to remain the same.

The complimentary benefits of equality imply shared rights as well as shared responsibilities. Any interventions need to ensure that communities understand that equality does not mean disempowerment for men, but rather a societal adaptation and acceptance of the ‘humanity’ of women. Both men and women need to be considered as instrumental to the change process. It is important that men be capacitated to understand the importance of, and benefits that can be reaped from avoiding the practice of having multiple sexual partners because it would no longer be important for them to prove their maleness in this way. Further, men need to understand that practising sex safe not only serves to protect them from STIs and HIV but that it also protects them, their partners and their offspring. Women in turn need to empowered and capacitated to have the strength to assert and own their rights and employ strategies to protect themselves from harmful cultural practices, gender based violence and STI and HIV infection.

Empowerment has to do with a willingness to abandon some aspects of customary law and to expand structural and identity choices for both women and men. In the most pragmatic sense, empowerment for women means ensuring their access to resources and control over assets and property. Embedded within this control of assets and property is the issue of access to information. Access to information and communication technologies is essential for women to make informed choices regarding HIV. Without such access, knowledge about HIV prevention is implicitly restricted for women.

4.1.2 Conclusion

*In summary the study found that:*

1. The accepted practice and belief in male dominance/patriarchy is the primary and most basic cultural issue affecting women’s ability to access rights that would reduce their vulnerability to HIV infection.

2. Secondary to this belief are:
   - The support and acceptance of men’s polygamous relationships (formal and informal);
   - The acceptance of male promiscuity (multiple sex partners); and
   - The evidence that condom use, and prevention of pregnancy and sexually transmitted infections in general, is male controlled.

3. Female sexuality is not a matter of individual choice; rather it is set in the structural and cultural relationships within which women exist. Women appear to accept the health risks inherent in their male partner’s practice of having multiple sexual partners. They seem to be hesitant to demand that men exhibit less risky behaviour, in part because women remain economically dependent on men.

4. Structural factors which place women at a disadvantage and at higher risk of HIV infection include poverty, unemployment, limited access to resources and lack of control over assets and property. These structural factors, combined with the cultural practices regarding divorce and inheritance, can leave a woman helpless in the face of impending poverty.
5. There are contradictions between women’s rights as articulated under customary law and under civil law in the areas of marriage, divorce and inheritance. The limited rights afforded to women under customary law may ultimately place women at risk of HIV infection because of the threat of loss of all economic support should they choose to exercise ‘unpopular’ rights. It appears that a little financial support from a husband, even if he has multiple sexual partners and places all the women at risk, is preferable to no support at all.

6. Empowerment of women remains part of the ‘culture of noise’, where there is much talk about educating women about their rights, but little genuine attention to the factors that will provide actual empowerment; economic opportunity in the form of education, access to resources and control over assets and property, social and political advancement, and HIV prevention methods that women can control.

7. The stigma attached to being HIV positive is so great that many Namibians still would rather not know their status than be confronted an HIV positive result.

4.1.3 Recommendations

The following key recommendations were generated from this study analysis:

- **Break the silence and get past the noise:** Namibia has good laws and policies that only exist on paper. Women and men must start "walking the talk" of women’s equality. Without knowledge of their rights, and without active protection of rights, these remain useless in the fight against the epidemic for the people who really need them. It is imperative that the laws and policies which are articulated on paper be enforced; and be enforced in a fair and sensitive manner which is not prejudiced against women. It also includes strengthening women and child protection units, providing police protection and safe places for women to seek shelter, and ensuring the availability of PEP for victims of rape.

- **Keep good cultural practices; change the bad ones:** Traditional leaders are in a strong position to help break the silence. Cultural practices and beliefs that discriminate against women and cause them to be vulnerable to HIV can, and should, be changed. Therefore, high-level workshops with traditional, religious, and political leaders, especially if held at the local and regional level, can be held to reinforce the best in local culture, as well as to identify and promote a change in those harmful cultural practices and beliefs that currently discriminate against women. Meaningful prevention programming for women requires a new strategy, one that has at its heart the concept of empowerment: creating programmes that help women gain control over their economic, social and sexual lives. For HIV prevention, empowerment should take the forms of economic opportunity to lessen women’s dependence, social and political advancement to allow women the capacity for self-determination as well as HIV prevention methods that women can control.

- **Give women HIV prevention methods that they can control:** It is imperative that adolescent girls and women have the knowledge and means to prevent HIV infection. Women must have a stronger voice in terms of deciding when, where, and with whom they want to engage in sex (meaning, more training is needed in communication skills, and more respect and understanding that “no” means “NO”), as well as improved and accessible barrier methods - contraception - that protects against HIV and other sexually transmitted diseases. Female condoms should also be more widely available.

- **Mainstream gender - but also give gender issues special attention:** Gender mainstreaming is based on the recognition that the organisations implementing policies and programmes in response to HIV and the communities where these programmes and policies are being implemented are themselves gender-affected structures. The way power and resources are shared between men and women in a community is implicitly or explicitly prescribed by the gender structure of the community and its organisations.
• **Conduct further research:** Broaden and replicate the present study to include other major geographic regions and cultural groups, and an additional study regarding prevention and intervention with more male respondents so as to gather baseline data for the preparation of an intervention program targeted at men.

4.2 Mozambique

4.2.1 Discussion

The analysis of the data shows that the meaning of being a woman or a man is derived from both customary and constitutional law and that the interplay of the two laws creates a challenge. The patriarchal system, power relations between women and men, some customary beliefs, practice and behaviour are still influential in terms of people’s sexual behaviour. These aspects are also discussed in Miles (1997) as cited in Gergen & Davis (1997). The study found that the achievement of universal practice of safer sexual behaviour is problematic because of the power dynamics which mean that often, men alone control the use of condoms in a relationship. For this reason, a participant in a focus group (of elders) with the agreement of others, stated ‘...women must be trained in order to insist on condom use with their partner, always’. Similar ideas were also stated in Miles (1997) cited in Gergen & Davis (1997).

Use of condoms must be the individual choice of every woman. While cultural factors inevitably play a part in this, Mozambique’s constitutional law guarantees gender equity. According to symbolic interactionist theory, in the processes of interaction with others and in thought, a person has the opportunity to reconstruct his or her safer behaviour. Individuals must reconstruct their behaviour in a creative and innovative way and in this context; every woman and man, is required to make an earnest individual choice to be responsible in protecting her/himself through practising safer sex and behaviour. If women in particular, because they have been shown not to have the power in the two case studies, are encouraged to make this choice, this is likely to help reverse the trend of the HIV epidemic by reducing the number of new infections.

4.2.2 Conclusions

The status of women’s and men’s rights, as well as the cultural factors that determine these rights, have been changing in Mozambique. In a fast changing environment, it is useful to shed light on these changes by illuminating them through relevant research undertaken within various theories and with the use of appropriate research tools. These may help provide ways of uncovering, understanding and dealing with the psychological aspects of change such as attitudes, beliefs and subjective norms (based on social norms) connected with important life events such as death, marriage, divorce and child birth. It is possible to replace damaging rituals such as the ‘kutxinga tindzaka’ practiced in Mozambique by applying a psychological understanding and providing counselling to deal with the periods that follow.

4.2.3 Recommendations

Greater opportunities should be created to allow the custodians of culture and young people to talk about culture in detail, taking into account the present contexts of modern life and new technologies. Therefore, it is suggested that a cross-cultural survey be conducted, in which focus group discussions are employed to clarify the relevance of certain concepts and redefine them within the common vernacular. This can help participants to bring practical information about practices that may still be influencing sexual behaviour.
out into the open, whether or not they have knowledge about HIV. Focus group discussions can also aid in the interpretation of survey findings by exploring in-depth, the implications of relationships and quantitative patterns revealed by the survey technique.