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Perceptions of risk and level of precaution used to prevent HIV/AIDS infection : A study of Zimbabwean migrant women living in Johannesburg

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University of the Witwatersrand

The Graduate School for the Humanities and Social Sciences

Forced Migration Studies Programme

MA Research Report

Research Title: Perceptions of risk and level of precaution used to prevent HIV/AIDS infection. A study of Zimbabwean migrant women living in Johannesburg.

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Date: 15 February 2006

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STATEMENT OF ORIGINALITY

I declare that this is my own unaided work. It is being submitted in partial fulfillment for the Degree in Master of Arts Forced Migration Studies at the University of the Witwatersrand, Johannesburg. It has not been submitted before any degree or examination in any other University.

_____

Pascalia Ozida Munyewende

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ABSTRACT

Perception of risk was used as an independent variable and behaviour as the dependent variable in the research with the assumption that level of precaution used during sexual practices to safeguard against HIV infection will be positively related to the perception of risk to HIV. The conclusiveness of this approach was dependent on evidence that participants know what risky behaviour can contribute to contracting HIV/AIDS and on their willingness to report their risk perception honestly. A snowball sample consisting of 15 Zimbabwean women living in and around Johannesburg was employed. Research objectives were addressed through semi-structured interviews. For all participants, perception of risk was qualified by a number of factors. Common precautionary strategies identified by women were to remain faithful to one partner and being more contemplative when choosing bed partners and using condoms. High risk perception was marked by having had various sexual partners, inconsistently using condoms, fear of sexual violence, mistrust of partners, feeling of fear of vulnerability to HIV whenever they had sex and survival concerns. Migrant women's adoption of safe sex was limited by their circumstances and strategies of risk management and in particular their biases in assumptions about their partners' sexual histories. This exposes them to the vulnerabilities of HIV/AIDS. Thematic analysis was used to interpret the data.

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DEDICATION

For my dear little niece, Tadiwanashe Munyewende, orphaned by AIDS. I hope the almighty God continues to give you life.

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ACKNOWLEDGEMENTS

This work would not have been made possible without the love and assistance of various people. My appreciation goes out to:

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To all the Zimbabwean Migrant women who chose to participate in this research and their supporting organizations ZIPOVA and SAWIMA.

To the good Lord, for all the hope and successes in my life. I am thankful.

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Chapter 1

1.1 Background and Introduction

The economic meltdown in Zimbabwe has prompted citizen migration both overseas and regionally. Previously, the majority of migrants have been male but recently women have been increasingly migrating alone or with their partners to flee persecution or for economic opportunities. Alongside other married couples, single parents and widows are now major breadwinners as well as household heads to their families in Zimbabwe. This new development of women as breadwinners or of migration has been termed the feminization of migration streams which is broader than Zimbabwe, has been observed regionally and internationally Akileswaran (2004). She argues that female workers are now relocating as principal wage earners instead of just accompanying partners. There is a trend indicating that in Southern Africa, as well as other areas of the world, women are increasingly migrating as labourers. A UN (2006) state of the world population report writes that half of the world's international migrants are reported to be women and girls and that currently they are about 95 million who are on the move.

Meanwhile, it has become common in Zimbabwe to find an entire family being headed and sustained by a woman. It is important to consider the migration of women in this research as it gives insight into some of the dynamics of perceptions of risk and level of precaution used to prevent HIV infection in the lives of foreign migrant women. They are a population that is regarded as vulnerable and discriminated against.

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Women leave Zimbabwe expecting to find a better life, employment and look forward to remitting money back home to their families. On their arrival in South Africa, some find that accommodation is very expensive and that good jobs are very hard to come by; basically they are faced with the reality of poverty. It is argued that migration is gradually progressing towards an unsavory course hewed on the negative side of globalization, and exacerbating existing inequalities, discriminatory barriers and inadequate human and labour rights protections (UNFPA 2006).

The majority of Zimbabwean migrant women live around the Hillbrow and Yeoville areas in Johannesburg, where living conditions in most places are known to be appalling. Working conditions are often precarious, difficult, and very uncertain such that having a regular income is very doubtful for most migrant women. The idea of going back home without fulfilling one's expectations as well as the expectations of family, relatives and friends becomes unthinkable. The International Organization of Migration (IOM 2003) report says that migrant women in host countries occupy the lowest and most exploited strata in the global division of labour, which is evidenced by their heavy employment in menial jobs that are lowly-skilled and lowly-paid. Migrant women once in the host country get engaged in such work as domestic work, hairdressing, hawking or trading and cross border trading or being waitresses in restaurants. Life in a foreign country becomes a very challenging prospect. Firstly, food is expensive and secondly, access to information about HIV/AIDS and health care is difficult, given that most are undocumented migrants it may reduce their ability to be proactive where their health needs are concerned.

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A telephonic interview with the International Organisation of Migration, (IOM), Regional Office in Pretoria in 2005 revealed that many Zimbabwean migrant women in South Africa are undocumented because they do not have legal permits. The disadvantage of this situation is that where migrant women may experience problems be it health or security, it can be difficult to report to the authorities for fear of deportation. Hundreds of Zimbabweans amongst them women are deported on a daily basis for various reasons but mainly for being without legal papers. The South African Migration Project (SAMP 2005) says that an average of 200 Zimbabweans are deported daily and dumped at the Beitbridge Police Station. This may limit their inclinations to seek medical help immediately. This prompted the observation that;

> It is not always possible for a Zimbabwean, or any other foreigner, to walk into a clinic and be given health care. Potential patients are invariably asked for ID of some kind, and many asylum seekers do not have an ID, and at this point, some have reported being denied health care …Others have reported failing to access health care because they cannot afford to pay for it, especially for specialist treatment (www.zimbabwesituation.com).

The above quotation highlights that migrants, especially Zimbabwean migrant women may not be comfortable with accessing health services in South Africa. There is a general feeling amongst migrants from different countries that accessing health services is a daunting task (Brockerhoff and Biddlecom 1999). The possibility of having to pay cash upfront at points where they do not have the money when they need medical assistance is also another concern. Financial constraints become an

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important factor in determining health seeking behaviour. These views reveal that for women the lack of finances presents a double jeopardy; as "female poverty often brings with it an increased risk of HIV infection through restricted access not only to health information, but also to health services such as STD treatment and condom supplies" (The Dossier 1990:35).

It is assumed that even in a foreign environment, women have to balance their socio economic lives (Zulu *et al* 2002). Inevitably, they interact with their male counterparts and in these interactions intimate relationships can develop. Zimbabwean migrant women are no different as they also interact with men. Intimate relationships between men and women may not always be equal especially if the woman is impoverished. While it cannot be generalized that all migrant women sometimes engage in survival sex (where women may have sex for money or goods), cases have been recorded where women virtually had no other choice but to resort to it. "Women on low incomes cannot afford certain basic necessities such as housing, food and having to take care of their families back home thus their negotiating position for safe sex with sexual partners can be undermined by economic dependence. It is argued that when people spend too much time on survival issues, they may ignore a disease that may take years to come," (The Dossier 1990:35). For many women it can be a choice between survival and risking HIV infection.

The IOM (2003) has further observed that some migrant women from Zimbabwe faced with the possibility of long periods of unemployment and ungainful livelihood

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find themselves being forced to resort to sexual networking partnerships[1] which expose them to risk of becoming infected with HIV/AIDS (IOM 2003). The Solidarity Peace Trust (2003) also mentions that young female school leavers who are leaving Zimbabwe each year are faced with the same conditions when they arrive in South Africa. They argue that in the absence of familiar social norms, cultural sanctions, community taboos and familial guidance in their lives some Zimbabwean migrant women end up engaging in casual or transactional sex which they might not normally be involved in when they are at home. This disadvantage, coupled with the hardships they encounter in their everyday life greatly diminishes their negotiating power as in most instances; they may end up appreciating any financial compensation they get for having sex with unknown partners. The question is, presented with this scenario are women able to make rational choices with respect to HIV/AIDS risk perception and precautionary behaviour in their day to day living existence?

Given this background, this study assesses the perceptions of risk and level of precaution used by Zimbabwean women living in Johannesburg against HIV/AIDS infection. It was noted that women's particular perceptions of HIV/AIDS changed as they found themselves in different situations. At times it would remain constant if a woman was adopting precautionary behaviour through protected sex or abstinence and at other times it would not based on risky sexual behaviour. It is important to analyze this state of affairs because migrant women's inferior economic and social status may alter their perceptions and increase their vulnerability to HIV. It is possible that with financial independence, women can control their sexual and social lives as

[1] According to Webb (2000 see also Brockerhoff and Biddlecom 1999, Worjicki and Malala 2000) sexual networking is when an impoverished woman engages in sex with multiple sex partners for material goods or money. Such a woman may not view herself as a sex worker. Transactional sex also has a similar definition. These acts may be done intermittently when a woman feels she is desperate. These terms will be used interchangeably in the research report.

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well as against HIV/AIDS. Further, there is limited understanding and research on the social factors that lead women to engage in risky sexual behaviour. Barnett *et al* (2002) write that the rate of infection has, to some extent, been influenced by perception and individual behaviour. It is vital to understand the factors impacting upon the perceptions individuals have of their risk to HIV/AIDS so that strategies to curb the epidemic can be successfully implemented. Undertaking this research was important in revealing that the relationship between perception of risk to HIV infection and precautionary sexual behaviour is a very complex relationship that is sometimes not guided by rational choices depending on circumstances. Therefore, a step towards understanding perception and behaviour can provide inroads to behavioural change away from risk taking to safer behaviour as well as provide answers to HIV prevention. This is because, what is unknown is the fact that the choices that women or other individuals in general may not always be rational.

"Sociological and anthropological studies have shown that perception and acceptance of risk have their roots in social and cultural factors" Slovic (1987:236). Hence, it is important to point out that while individual sexual relationships are personal they are built on and reflect society's fundamental norms. In African societies and indeed in Zimbabwe, sexual relations are power relations between men and women. From time immemorial, the desire to control has always been coveted by men. This has been viewed by society as normal until gender and feminist studies began to question this state of affairs. In addition, it is important to undertake this study because women are said to have greater chances of being infected than men because of their social status as well as their physiology as UNAIDS (2004) report on the Global AIDS Epidemic noted. Despite high levels of knowledge and awareness about the disease, the prevalence of HIV/AIDS in women is still on the rise. UNAIDS Global Report (2003)

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on Southern Africa also points out that the main mode of transmission is through heterosexual contacts.

The study is motivated by the criticism of authors, Poppen and Reisen (1997), who argue that in as much as there have been numerous studies on perception of the risk of transmission of sexually transmitted diseases, including HIV/AIDS, that encourage persons to take on or continue self-protective behaviours, the research literature has by and large failed to demonstrate the association effectively. This research report will argue that there are other reasons that hinder the effective association between perception of risk and self protective behaviour against HIV infection. It is common knowledge and widely accepted that people will not endanger themselves unnecessarily before taking action.

According to Pligt (1996) it is common for people to approximate the gravity of a risk in most health-related behaviours. People base their assumptions, measure the costs and benefits of an action, and then choose a course of action that will make the most of their anticipated result. Akwara *et al* (2003) found it impossible to tell from their study of 'Perception of Risk of HIV/AIDS and Sexual behaviour in Kenya' whether the perception results were based on past risky behaviour or whether behaviour was based on perception. The present study seeks to build on and to fill a gap in exploring the association between perception of risk and self reported level of precaution used to prevent HIV/AIDS infection among migrant women from Zimbabwe. Results obtained indicated that it is very complex to assume a relationship between perception of risk and precautionary behaviour. In real life, this relationship is much more complex and is not easy to comprehend.

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1.2 Aim of the Study:

The present study seeks to answer the question:

How does the perception of risk to HIV/AIDS among Zimbabwean migrant women living in Johannesburg affect the levels of precaution used to prevent infection?

1.3 Objectives:

1. To determine Zimbabwean migrant women's knowledge, attitudes and beliefs about HIV/AIDS.
2. To measure their perception of risk to HIV/AIDS.
3. To note the self reported level of precaution used by respondents based on the information they provide.
4. To test the hypotheses and develop, based on data analysis and literature review, probable rationalization of the findings among Zimbabwean migrant women living in Johannesburg.

1.4 Hypothesis:

Level of precaution used during sexual practices to safeguard against HIV infection is positively related to the perception of risk to HIV.

1.5 Rationale:

The research is important in a South African context in that it will provide insights as to how migrant women perceive HIV/AIDS in relation to themselves. It is important to study migrant women in the context of HIV because of their perceived

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vulnerability and exposure to potential sex partners in a foreign environment. How they think they can protect themselves in a foreign country realizing that South Africa has become the centre of attraction for many African migrants from the region.

The research literature on perceptions and precautionary behaviour pertaining to migrants in general, and foreign migrant women in particular is limited. The study will produce useful descriptive data and will address a gap in behavioural literature, migration and HIV/AIDS. It will demonstrate the link or absence thereof of the association between perception of the risk and level of self reported precaution used against HIV infection by Zimbabwean migrant women.

The study will further test the hypothesis on a sample population of Zimbabwean migrant women by using a qualitative research method. The study is limited to a specific geographical area; inner city Johannesburg including areas like Berea, Betrams, Hillbrow and Braamfontein. It will focus on the complexities arising from the assumption that perception of risk should be associated with safe sexual behaviour. It should raise awareness about the HIV/AIDS prevention strategies which must be remodelled to focus on perceptions and behavioural attitudes if HIV/AIDS prevention strategies are to work. It will inform policy through the recommendations that will be offered in Chapter five. It will argue that migrant women should be recognized in programs that are to do with reproductive health in South Africa.

The study will fill a gap in literature about the problematic nature of assuming positive perceptive associations in the area of HIV/AIDS, it should serve as a pointer to program providers and that more research needs to be done in this area. Further, what role does perception play if any at all or are there other factors at play in the adoption of safer sexual behaviour?

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1.6 Chapter layout

The research report starts with Chapter one which provides the background and context of the study followed by a review of literature in chapter two. The methods employed for the research to gather data on perceptions of risk and level of precaution used to prevent HIV/AIDS and the challenges encountered during the research process are explained in chapter three. Chapter four presents an analysis and discussion of the findings based on evidence presented by participants that they know what risky behaviour can contribute to contracting HIV/AIDS and on their willingness to report their risk perception honestly. Some of the themes found were reasons for choosing Johannesburg as a settling point and perceptions of risk, sexual decision making and health seeking behaviour. The discourse of gender and vulnerability as well as preventive measures against HIV/AIDS. Chapter five presents conclusions of the research findings and offers some recommendations.

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Chapter 2

Literature Review

2.1 Introduction

This chapter will engage with several interdisciplinary arguments that support and inform this research on perception of risk and level of precaution used to prevent HIV/AIDS. The strength of the study is that it is not wholly grounded in one academic tradition or the other. By drawing scholarly opinions from the fields of psychology, sociology, and anthropological theoretical conceptions, it will highlight agreeing and opposing trends that concern sexuality and HIV/AIDS. Research findings of similar studies on perception of risk and prevention measures will also be highlighted. It is argued that for HIV intervention programs to succeed they have to be based on a firm grounding in behavioral science principles and established models of health behavior.

A person's belief to susceptibility to disease is an important consideration in models of preventive health behavior (Pinkerton and Abramson 1992). As the literature review will highlight, this is a subject of great contestation. There is a gap and conclusive answers that explain the various motivations for people's perceptions and sexual behavior need to be examined. Accurate predictions of patterns of sexual behaviour and its relationship to HIV infection need more thorough work (Gillies 1996: 136). Gillies points out that, "the psychological approach, the most dominant conceptual approach, focused on beliefs, perceptions, attitudes, and intentions with an emphasis on individual determinants of sexual behaviour as rational" (ibid). Some of

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the main theorists on perceptions, beliefs and intentions are presented in this literature review with the arguments that they make. Unraveling the importance of beliefs, values, gendered ideologies, cultural constructions and social expressions of sexual behaviour will assist in understanding the perceptions and precautionary measures in relation to Zimbabwean migrant women against HIV/AIDS infection.

2.2. Perception of Risk and Level of Precaution

According to Rosenstock (1990), the Health Belief Model asserts that the extent to which an individual perceives vulnerability to contracting HIV should influence self protective behaviour or minimizing their risk. Studies about HIV risk taking relevant to this study have been conducted by Pinkerton and Abramson (1993, 1995) evaluating the risks: a Bernoulli process model of HIV infection, risk reduction, decision making and personality factors in sexual risk-taking for HIV/AIDS: a theoretical integration. Their studies highlight that perceived personal susceptibility is an important predictor of preventive health behaviors in homosexuals, prostitutes and the general public. The studies on perception of risk have failed to support the finding that perceived vulnerability to succumbing to a terrible disease like Aids warrants precautionary behaviour. For instance, when people think that they are not at risk by having a monogamous relationship, they will not use precaution.

Other scholars like Cohen and Bruce (1997) point out that the association between perception of risk and risk behaviour is always changing such that it can hide the influence of perceived risk on behavior. A question in relation to Cohen and Bruce's study is whether there is an association between these two variables. For example, the perception that one is at low risk may lead to indulgence in risky sexual behaviors,

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where a heterosexual may think that receptive anal intercourse is less risky than receptive vaginal intercourse. This may subsequently lead to an altered view of one's risk (Pinkerton *et al* 2000). These studies present competing view points that are both pertinent and significant to the topic under investigation as will be highlighted in the analysis section. This research questioned whether there were instances in migrant women's lives where their perception of risk was influenced by their circumstances.

Arguments in the debate on perceptions and self protective behaviour have been provided by Poppen and Reisen (1997) on whom this research is based. They point out that there have been a number of studies on perception of the risk of transmission of sexually transmitted diseases including HIV/AIDS but many have been inconclusive. According to them, the research literatures have failed to show an association between self protective behaviors and perception of risk; the research literature shows a limited understanding of this association.

Researchers have developed several methods of measuring study participants' perceptions of their own HIV risk (Poppen and Reisen 1997). Common methods cited involving asking participants to compare their own risk of contracting HIV with that of people who are more or less similar to themselves. The problem with this method is that it is stereotypical. It allows people to remove themselves from the problem and focus on the "other" whom they think is more at risk than them. The problem is that the "other" may be consistently adopting self-protective behaviour. Classifying participants as either high risk or low risk to HIV infection based on self-reported risk behavior and then comparing these questions with the participants' own perceptions of their level of risk is a more accurate and possibly conclusive approach

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that was adopted by this study. The high and low risk questions are typically based on qualitative assumptions about high risk activities. The presence or absence of particular risk factors, for example, engaging in unprotected sexual intercourse or having multiple sex partners are factors that will also be employed in this study.

Slovic (1987) argues that the ability to sense and avoid harmful environmental conditions is necessary for the survival of all living organisms. According to him "survival is aided by an ability to codify and learn from past experience. Humans have an additional capacity that allows them to alter their environment as well as respond to it. This capacity both creates and reduces risk" (Slovic 1987:236). The study defines perception as a way of understanding issues that an individual has about certain phenomenon, in this case HIV/AIDS, and the strategies an individual employs to avoid getting infected. I argue that perception of risk must be positively related to precautionary behaviour against HIV/AIDS.

Brunswik (1959) argues that perceptions may be based on stereotypes and insufficient information or evidence where a person thinks that in certain interactions, positive rather than negative situations can happen to them. "Perception is a cognitive and emotive process which has been described as sense of vulnerability or susceptibility to a perceived threat and is assumed to be a principal feature that influences motivation to avoid risky behaviour or adopt self protective behaviour" (Poppen and Reisen 1997:375). This fits in with this research where for instance a person's perceptual level of risk about something can be high or low and ideally that should influence the extent of avoidance of risky behaviour. The challenge is that perception itself is a social and psychological construct appearing at different times and depends on the environment that people find themselves in. It is the goal of the study to seek to

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understand the extent to which perception of risk directly impacts the protective behaviour undertaken, or whether there are other intervening factors that impact this straightforward relationship. The indicators that were used to measure the perception of risk were asking participants to approximate their risk as high or low based on the assumption that they know what dangerous sexual behaviour is. Fear of sexual violence, mistrust of partners, feeling fearful or vulnerable to HIV and whether this vulnerability is influenced by being in South Africa or not were considered. Key words such as views, thoughts, feelings and worry about individual risk were used to measure perception of risk.

According to Poppen and Reisen (1997) the other most commonly used approach in measuring risk perception and sexual behaviour is usually marked by asking respondents the likelihood of them contracting the virus in some estimated time period. However, since such questions require cognitive appraisal of one's own risk status and focuses on emotional concern about behaviour or risk status conclusive results may be difficult to establish. Poppen and Reisen (1997) worry that this may end up affecting validity and reliability especially when considering that questions on peoples sexual behaviour can produce a lot of discomfort. The study asked questions on individual risk perception and behaviour risk perception/level of precaution used as a more appropriate definition of the construct of perception of risk to HIV. This will most likely be related to self protective behaviour as suggested by Poppen and Reisen's argument that perception of risk is determined by an individual's motivation for self preservation. The results of the study will contribute towards literature about perception of risk to HIV/AIDS. The results will produce a probable connection between sexual behaviors undertaken and the vulnerabilities faced by migrant women in the context of increasing feminisation of migration especially Zimbabwean migrant

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women living in Johannesburg. This is buttressed by Poppen and Reisen's argument that;

> "characteristics of a relationship, such as duration, exclusivity, levels of commitment or trust, and the distribution of power between partners, affect risk perception and the probability of engaging in self protective behaviour," (1997:386).

Poppen and Reisen (1997) write that an individual's demand for protected sex determines behaviour in spite of an individual's perception of risk. In this regard, attitude towards self preservation through using condoms becomes very important when considering risk perception. In the context of this study it maybe that migrant women's demand for sex in general may determine whether or not they use protection seeing as there are different reasons why women have sex. Seeing as some literature posits that migrant women facing hardships may be forced to get involved in transactional sex, (Adepoju 1993) it is vital to take this into consideration as well as the fact that not all migrant women may be involved in survival sex. Against this background it would be important to analyse Zimbabwean migrant women's sexual negotiating skills, understanding of HIV and the power they have to insist on condom use with their sexual partners.

2.3. Varying perceptions of risk and level of precaution used depending on circumstances

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According to Ellen *et al* (1996) perceptions of risk may vary amongst individuals as well as the circumstances they find themselves in. The population of adolescents they studied showed that "owing to the differing rates of exposure to negative outcomes such as STDs adolescents had different perceptions of risk" (1996:417). Drawing from their work, migrant women's perceptions of risk to HIV/AIDS, their level of knowledge about sexually transmitted diseases and their level of exposure to precautionary measures related to HIV/AIDS may vary. The kind of cultural environment or migration experienced by Zimbabwean women may have an influence on perception of risk and preventive behaviour among individuals.

Cultural beliefs and attitudes have an important role in determining the level of precaution (Vance 1991). In the context of the study, it will be necessary to analyse whether migrant women may argue that they can never have sex whilst menstruating. There is a cultural belief in Zimbabwe that having sex with a man while menstruating can kill or make a man ill. Migrant women can believe that careful administration of traditional herbs can convey HIV immunity. For some, influence of perception of risk can come from having had a friend or colleague who succumbed to the disease. In their study on factors associated with adolescents' perceived level of risk for contracting sexually transmitted diseases or HIV/AIDS, Ellen *et al* noted that anxiety appears to be the most likely factor related to adolescents' perceived level of risk. "Higher levels of anxiety are associated with perceptions of higher relative risk" (1996:417). Depending on the individual, a higher level of anxiety may mean higher risk. This is possible when an individual considers their past sexual history. Subsequently, thoughts about a disease that will affect them negatively later in life

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will follow. As has been highlighted, competing factors of survival may overtake anxiety.

To link the above points to the current research, extreme levels of worry or anxiety in Zimbabwean migrant women can be related to a higher perception of risk as it did in the adolescents they studied. Their study also aimed to show that perception of risk can vary by the age of respondents. Therefore, these points are important to the study, to see whether they also apply to some Zimbabwean migrant women in perceiving themselves to be at higher risk and being anxious about it. This may be due to factors like the high number of sexual partners they have had or lacking trust in their partners and reporting that they do not consistently use condoms. Perception of risk can be low for those migrant women who may think that their partners can be trusted to be sexually inactive while they are away. The environment that migrant women are living in while in South Africa can also influence the way they perceive the concept of risk. When tied to the reasons why women migrated and the current situation that they are in, this may have an impact on their perceptive associations of risk.

In the past, African women used to migrate as accompanying partners to their husbands or relatives. However, with the disintegration of patriarchal values and the family, women have to stand on their own and this is part of the reasons that women are migrating IOM (2004). There are now more unattached women than ever before and this has compelled women to be mobile so that they can take care of their children and extended families. Akileswaran (2004) argues that this feminisation of migration streams is a recent trend indicating that in southern Africa as well as other areas of the world, there is an increasing mobility of women as labourers. Migrant populations,

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especially foreign women, generally tend to be marginalized where jobs and social services are concerned (Adepoju 2004). The author argues that women have become active in migration as a family or individual survival strategy. According to him, "there is an overall trend away from labour migrants from Africa and towards commercial migrants, that is, entrepreneurs who are self-employed, especially in the informal sector. The post-apartheid wave of immigrants from Zimbabwe are mostly street vendors and traders seeking to capitalize on the relatively affluent market of South Africa to provide for additional income desperately needed at home" (Adepoju 2004:2). An assertion like this makes it vital to investigate the social conditions of Zimbabwean migrant women and to ascertain whether social conditions have a bearing on perceptions of risk and precautionary actions. These jobs do not guarantee a stable income all the time and it becomes a source of stress for not making ends meet monthly.

Brockerhoff and Biddlecom discovered that "riskier sexual behaviours among migrant groups have been attributed to three factors. Firstly, predisposing individual characteristics. Secondly changes in individual attributes due to migration, notably separation from spouse or partner and thirdly exposure to a new social environment, featuring different sexual norms, opportunities and constraints that result in behaviour modification," (1999:835) These authors suggest that the act of voluntary movement over long distances, between radically different socio cultural environments and with uncertain consequences and support networks at destination defines migrants, to a greater or lesser degree as innovators or 'risk takers.' This can present a challenging situation to migrant women inducing feelings of vulnerability, not knowing what to do, a resigned attitude or resistance itself. For uneducated migrants especially and

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those who lack specialized skills for income earning opportunities, it becomes quite challenging to repatriate money to the home country.

Risky sexual behaviour has been linked to socio economic status, unemployment and idleness among women by Zulu *et al* (2002). In a study that was conducted in Nairobi, Kenya, Zulu *et al* discovered that "women were driven by poverty and deprivation to engage in risky behaviours that include multiple sexual partnerships" (2002:312). Coupled with irregular income is the issue of not having the legal right to be in South Africa. This places great emotional stress on them and it is argued that these concerns may bring about a lack of self esteem, and inability to control the course of one's life. "As other economic options run out, economic desperation pushes women to rely on sexual relations to obtain sufficient money for rent, children's schooling and other basic necessities and many of them maximise the number of sexual partners they have in order to increase their economic security," (Zulu *et al* 2002:313). Campbell (1997) argues that it is believed that if people feel that they cannot control their lives through taking care of themselves, they often assume a resigned approach where they take anything that comes their way as their inevitable fate.

Barnett and Parkhurst (2005), Worjcicki and Malala (2001) point out that survival sex or sexual networking may end up being an option for women who are faced with the occupations that yield low financial returns over having sex with many partners. They argue that when a woman is presented with the choice of getting money or a food basket on a weekly basis from a sexual partner or the prospect of domestic work for a month for the same; she may take the most rational choice. "Women working outside

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the home, such as market vending, may exchange sex for money intermittently or on the side…," Brockerhoff and Biddlecom (1999). The important question they ask is whether the woman will be able to make a rational choice of protecting herself when engaging in survival sex. The point being made here is that psychological studies such as the Dossier (1990) noted that when people spend too much time focusing on survival issues, they may ignore a disease that may take long to manifest itself. For many women, it may be a choice between survival and risk HIV infection. The Dossier argues that sexual decision making in poor women can sometimes be undermined by economic dependence.

There have been other explanations given by Mc Grath *et al* (1993) as to why women adopt risky or precautionary behaviour. McGrath *et al* suggest that women engage in unsafe sex as a survival strategy as well as for socio-cultural reasons, "so as to maintain a monogamy narrative which is contradictory to condom usage, not to be associated with promiscuity and to secure an economic livelihood" (1993:431). They argue that looking at sex viz-a-viz HIV/AIDS from an economic perspective provides explanation as to why risky behaviour is continuing; that the act is considered mutually beneficial by the people engaging in it. These factors psychologically affect women's ability to negotiate condom use even when they can perceive it to be risky. Risk therefore, is arguably linked to the possibility of loss and is normally perceived to contain two mechanisms: the likelihood and the severity of negative outcomes. Migrant women may feel that they are obliged to give a man unprotected sex as a way of conveying gratitude to them for having taken care of them. Mc Grath *et al's* (1993) study makes it evident that the migrant women they interviewed were surviving from hand to mouth. Any gifts women received from men warranted a lot of gratitude and

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as a result made them unable to approximate the gravity of risk brought about by having unprotected sex. Benefits of having unprotected sex were chosen over long time negative consequences of HIV/AIDS. Psychological and sociological conceptual frameworks will assist with the understanding women's behaviour when faced with such situations such that realistic intentions become impossible to apply at the right moment, as research reveals. Zimbabwean migrant women's sentiments concerning condoms and how they can affect their perceived risk to HIV infection will be discussed in view of this. Findings from studies by others such as Gupta (2000) conducted in South Africa conclude that condom use in personal situations may be a violation of trust and intimacy. It brings an element of disequilibrium to the sexual relationship for both sex workers and for women not engaged in commercial sex.

For the purposes of this study, level of precaution is defined as the self reported measures that a woman takes to prevent herself from getting infected by the HIV/AIDS virus in a sexual partnership. The Dossier (1990) argues that women's adoption of safe sex may be limited by their risk perceptions and strategies of risk management and in particular their biases in assumptions about their partners' sexual histories. Because of the perceptions they may have, women may think that it is important to size up men or weigh them up on the basis of their appearance and their behaviour. Those that would not force them into unprotected sex and assumed to be capable of taking care of their financial needs may be deemed as safe. This may be in contrast to those that can display signs of violence and it is for these men that Zimbabwean migrant women may assume that there is need to use precaution. The Dossier (1990) further asserts that sociological perceptions of risk may be decreased by the creation of a sense of trust and sexual safety which can be established very

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quickly, even over the course of a single night. Thus, the fact of having sex can itself create trust, and trust can mean sex without condoms. Migrant women may reveal that they would not use condoms on partners whom they have been going out with for a long time arguing that in that case condoms would be tiresome. For some, it may be the case that the concept of using the condom itself highlights a lack of trust and destroys intimacy or that it is not culturally appropriate for a proper woman to be found carrying condoms in case they may be mistaken for prostitutes (Flood 2003). Thus, the behaviour of a male partner towards a woman may end up playing a very important factor in determining whether they can be trusted or not where condoms are concerned.

2.4 Studies on perceptions of risk

Pinkerton *et al* (2000) used a quantitative study to examine the accuracy of college students' HIV lifetime risk using a mathematical model. They used a variety of examples like the number of sex partners, sexual acts per partner, and the use or non use of condoms. They discovered that Asian American students perceived their risk to be low compared to other college students. The study highlighted that students overestimated the transmissibility of the disease through only one sexual act and this has been reported in several perception of risk studies. Their results were also supported by Pinkerton *et al* (2000) over two studies using a mathematical probabilistic model of HIV transmission to quantitatively evaluate risk accurately. Linville *et al* (1998), asked college students to estimate the probability of HIV transmission for either a single act or multiple acts of heterosexual intercourse and compared these with the current scientific estimates. Given the relatively low rates of transmission estimated by the medical community, (less than .001 for male to female

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transmission), the data found highlighted that college students tended to overestimate the risk of HIV transmission through one sexual contact (Linville *et al* 1998*)*.

While college students overestimated the single act transmission probabilities, they were reasonably accurate in estimating the cumulative risk from multiple sex acts. Another relevant study to this topic was done by Cohen and Bruce (1997) who used a mathematical model of HIV transmission to compare college students' estimates with the actual probability of contracting HIV from one or more acts of unprotected vaginal intercourse within three types of relationship strategies casual encounters, serial monogamy, and extended relationship. Pinkerton *et al* (2000) noted that in both studies, it was found that participants greatly overestimated the risk of contracting HIV for all types of relationship strategies. The limitation of these studies was asking students to estimate using probable numbers. The problem is that this is similar to guessing. In fact the researchers report that they had to exclude some of the samples because they felt that the students were not taking the research seriously enough or because they had failed to understand the questions. Researching migrant women's individual vulnerability to HIV infection using a qualitative method and not a quantitative one is of critical importance to this study as this will assist in thematically concluding whether perception of risk is associated with the level of precaution used in Zimbabwean migrant women. Further, the studies listed above did not acknowledge the presence of specific socio-cultural sexual practices that may influence individual's perceptions and precautionary strategies. This research argues that there are certain specific sexual practices that may influence individual positions on the subject of risk to HIV infection. We shall look at some of them here.

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2.5 Specific sexual practices in selected African contexts with particular focus on Zimbabwe.

The HIV/AIDS epidemic has influenced the demand for behavioral scientific analysis of HIV sexual transmission. Anthropological methods of analyzing sexual behaviour have helped identify socio-cultural, political, economic, and historical factors that influence sexual behaviour and contribute to increased HIV transmission. Furthermore, these analyses are helpful in the development of more culturally appropriate models for HIV prevention (Vance 1991). Exploring the value system and social infrastructure shaping models of sexual behaviour in a given context is necessary to unpack information that may not be widely known about HIV infection. Anthropological research gives an insight on this important subject.

Information has been provided by anthropology about the prevalence of specific cultural sexual practices which contribute to HIV infection (McGrath *et al* 1993). Dry sexual practices have been identified as common negative practices. A variety of intravaginal practices that are common elsewhere in Africa have also been identified in Zimbabwe and have been well documented by Wijgert *et al* (2000). Intravaginal practices were defined as the acts that women do as their normal daily routine such as finger cleansing with water or using a variety of other substances. These authors investigated intravaginal practices among 169 Zimbabwean women. They studied the extent of such practices and how they affect STD/HIV transmission. Their results showed that a greater percentage of the Zimbabwean women they studied start having sex at a mean age of 18 and that the behaviour of adopting intravaginal practices using various liquids and herbs starts at the mean age of 21. The majority of the

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Zimbabwean women they studied, reported that they finger cleanse themselves an average of once or twice per day with a variety of liquids. These include water and soap, Dettol or Betadine liquid, germicidal soaps, salt solution, lemon juice, or vinegar. Almost all users reported drying the vagina by inserting cloth, paper, or cotton wool after finger cleansing and after sex. Some of them reported inserting traditional substances derived from herbs, trees, stones, and soil a few times per month to dry or tighten the vagina (Wijgert *et al* 2000).

Anthropology has also added to the knowledge and understanding of cultural meanings of sexuality and sex in the lives of women (Standing 1992). According to Kun (1998), drying agents are used when there is a cultural preference for a dry, rather than a lubricated vagina and that there are many motivations for this in different African countries. South African men allegedly view vaginal lubrication as a sign of prostitution and too much sexual activity. They connect it to having sexually transmitted infections or using contraceptive pills (Kun 1998). She further reveals that in Zaire, a wet or large vagina is often thought to represent a curse or bad luck while in Senegal, drying agents are used by the community with the belief that the vagina is simply not a natural part of the body, but must bear the mark of artistic work (Kun 1998). In her work, Kun observed that it was agreed by both male and females that the practise increases satisfaction for both partners. In Zimbabwe, the practise is evident in all types of women, educated or uneducated, with some using herbs believed to heat up the body (Wijgert *et al* 2000). This practise as highlighted is somehow very popular in Africa. Kun notes that the literature does not uniformly support the assertion that vaginal drying practices are linked to increased HIV risk.

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The social and economic contexts which influence the continued practices of risky sexual behaviors have also been critically examined by authors such as Gupta and Weiss (1993) and Ankrah *et al* (1994). In particular, anthropologists have examined those socioeconomic and political gender constraints and inequalities that force women to pursue risky sexual behaviors, making them vulnerable to HIV infection. Anthropological research has also examined the effects of particular occupations such as migrant labour, long distance truck driving on the transmission of HIV virus in rural and urban areas (Farmer *et al* 1993, Orubuloye *et al*. 1993). Their studies found that long-distance truck drivers in Africa have temporary or long term sexual relationships with poor women who reside close to or along the major routes they used. They revealed that many women had sex for goods or money and practiced the habit of using herbs in their private parts.

It is also possible as was found in studies by Campbell (1997) and others that migrant women may be placing herbal portions in their vaginas to make them tight and dry and drinking herbal portions and believing that these would protect them from HIV/AIDS. Since respondents in their studies reported no personal negative consequences but advantages from these practices, they believed themselves to be safe. Some research has alleged these practices to have the negative impact of fuelling the epidemic (Wijgert *et al* 2000). It is highlighted by Campbell (1997) that women felt that in order to remain more competitive and desirable, they had to resort to such practices. These assertions find support in sociological and anthropological literature and highlights that women place the pleasure and satisfaction of men over theirs. Accordingly, the initial pain experienced when having sex after inserting herbs to constrict the vaginal walls is nothing when compared to satisfaction expressed to them

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by their male partners. Thus, cultural practices highlight competing factors that influence a particular perception of risk. It is important to question some of the cultural practices as they provide a context within which to situate this study. The concern here is specific sexual practices that are deemed to be necessary by society and their contribution to women's pursuance of risky sexual behaviour. This brings on the concept of unequal power relations between men and women when it comes to sexual matters and is discussed in the following section.

2.6 Unequal power and sexual matters in Zimbabwe

According to Chinouya *et al* (2001), there are varied ways in which societies make sense of the biological difference between men and women. Culture is a key concept in understanding the ways in which women negotiate safe sex. Thus, the meaning of being a man or woman varies between African groups, reflecting particular lived realities. Chinouya writes that in Zimbabwe, there are gendered spaces for learning about sexual matters. Paternal aunts reinforced myths of masculinity to boys and girls, consequently, sexual control and knowledge were constructed as male, as well as men's insatiable appetite for it, while girls were expected to assume innocence and be submissive. The limited literature on Zimbabwean women suggests that as girls they also went through these gendered spaces of learning. Paternal aunts taught them as young women about methods perceived to enhance the enjoyment of sex in men particularly vaginal drying agents. The negative effect of not adhering to this sort of advice would become evident when a woman was "returned to be advised" or was rejected for not having followed the specific cultural norms Chinouya *et al* (2001). Meanwhile, divergent research has noted that the dry sex resulting from the use of

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foreign substances into the vagina has been known to cause abrasions on the vaginal walls that construct opportunity for the HIV to enter the body (Jackson 1992).

Within the context of studying perceptions of risk and level of precaution used in HIV prevention, gender, sex and sexuality assume particular importance. The ways in which men and women negotiate heterosexual relations is shaped by the distribution of power between men and women. Flood (2003) notes that power is implicated in the negotiation of safer sex strategies and more often it is the men who wield this power. The unequal power balance in gender relations that favours men, translates into unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control than women over when, where, and how sex takes place. This 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. The culture of silence that surrounds sex in Zimbabwe makes accessing treatment services for sexually transmitted diseases highly stigmatizing for women. The majority of women interviewed by Meursing and Sibindi (1995) in Bulawayo, Zimbabwe, revealed that if married women or single women with boyfriends experienced a sexually transmitted infection, they would not tell their partners. They would seek for help in secret mentioning that broaching the subject with a male partner in the house will bring about violence. Further, they revealed that Zimbabwean women perceived sexually transmitted infections to be the hazards of married life thus discussing it would lead to one being cut off financially or otherwise.

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Meursing and Sibindi (1995) cogently point out that in the socio-cultural context of Zimbabwe, where men have both sexual freedom and power over women in relationships, the use of condoms and family planning remains subject to a men's willingness. Traditionally, men have always been allowed considerable sexual freedom, but this freedom used to be limited to having more than one marriage partner. Over the years, this had been changing due to the HIV/AIDS pandemic and monogamy is becoming the practice. Meursing and Sibindi argue that the superiority of men over women remains undisputed due to cultural perceptions. They further point out that the use of condoms in Zimbabwe remains subject to the husband's moods and may have to be re-negotiated at every sexual act, thus having an impact on the risk of HIV transmission. Their studies have indicated that such women, despite low economic status and resultant dependence on men can have knowledge about the health effects of unsafe sexual behaviour but have no power to negotiate. Therefore, it can be argued that the Zimbabwean migrant women's sexual behaviour may in part be influenced by perceptions and the level of precaution which have their roots in social and cultural factors. Underlying the relationship between migration and high risk behaviour are substantial gender differences in sexual behaviour, that men have a stronger cultural prerogative over women in initiating and negotiating sexual relationships (Brockerhoff and Biddlecom1999).

2.7 Conclusion

Literature from various academic disciplines on perception of risk has been presented and as well as the importance of exploring beliefs, values and gendered ideologies. Women are the weaker sex and this may inform the social expressions of sexual behaviour used by Zimbabwean women against HIV/AIDS infection. It is clear from

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the literature review that women are informed by their socio-environment about whom, why, where, how and what kind of sex they will have with their partners. The literature highlighted above evidences that women's coping strategies, cultural background and practices have an effect on their ability to perceive risk and or negotiate safer sex. Poverty may compel migrant women into situations in which they have to exchange sex for material benefits making them vulnerable to unprotected sex. The work presented in this literature review provides the context of the association of various factors that contribute to the understanding of perception of risk and level of precaution used to prevent HIV infection. We will discuss the methodology that was adopted to unravel this in the next chapter.

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Chapter 3

Methodology

3.1 Introduction

This chapter discusses the methods employed in the research study. Snowball sampling and a semi structured interview guide was used to gather qualitative data to test the hypothesis that safe sexual practices or precautionary behaviour should be positively related to perception of risk. This qualitative research method was used to gather data on how migrant women from Zimbabwe show a defined perception of risk through knowledge, attitude and practice through precautionary behaviour against HIV/AIDS. Participants were asked to report their self protective sexual behaviour. The independent and dependent variables used in the research were outlined and defined in the previous chapter. The background, procedures and limitations of the study and the method of data analysis are discussed in this chapter.

Most of the Zimbabwean migrants in South Africa were compelled to leave Zimbabwe owing to the deterioration of the rule of law, the economy and loss of economic livelihoods. In South Africa they have been termed economic migrants because of the difficulties resulting from having to distinguish them from the 'real' asylum seekers. Among them are also victims of political persecution who deserve asylum seeker permits. The study did not seek to distinguish between these two groups but sought to interview women who were Zimbabwean. With many being undocumented, information gathering becomes a challenging task as a result of their mobility, lack of fixed addresses, uncertainty of livelihood and mistrust of strangers. The Solidarity Peace Trust in 2004 noted that it is difficult to access people who

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spend much of their time trying to avoid detection from anyone they suspect can cause their deportation. They concluded that working with a hidden community limits the nature of the investigations that are possible. It becomes almost impossible to arrive at statistically reliable conclusions on scattered samples of people using structured questionnaires with whom randomized sampling techniques are largely unsuccessful.

Follow up interviews are often difficult as the living conditions of these migrants are constantly changing. This observation has been true for most migrant populations as observed by Jacobsen and Landau (2003). They experienced similar difficulties in their study of foreign migrants living in inner city Johannesburg. Zimbabweans in South Africa are no different as they have an unknown demographic profile and are of an unknown number. Getting estimates of the accurate figure about Zimbabweans has been a contentious and unreliable given the overestimation or underestimations by the media and the South African Police Service (SAPS). “Musina’s taxi rank is full of Zimbabweans”, “Zimbabweans arrested in suspect heist…” (*Sowetan and Business Day, August 2006, reports.* Issues of confidentiality and ethics assume particular importance when dealing with people who feel threatened with the risk of deportation looming. This highlights the importance of the methods employed when working with migrant populations.

3.2. Justification of the methodology

Several methods of investigation were explored before undertaking the study. I decided not to make Zimbabwean migrant women a case study because the time in which to conduct and compare other different cases in South Africa was limited. “Locating a case study requires time and experience. There is need to determine and

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identify the most critical of cases for either the most likely or the least likely, that is cases that are likely either to confirm or irrefutably falsify propositions and hypotheses" (Flyvberg, 2004:426). Further, no other studies of perception of risk and level of precaution used have been done as a case study in South Africa or for migrant women from other countries who reside in South Africa. The other limitation of a case study is that there is a tendency to generalize from a single case which may not be representative. This study is different in that although it will also generalize it will not do so from the comparing different case study which in this case are unavailable. The study could not have attempted to do that since it is limited in terms of the geographical space. It does not claim that the results found are representative of all Zimbabwean migrant women resident in Johannesburg.

A qualitative method of enquiry as opposed to a quantitative one was chosen for the study on perceptions of risk and level of precaution used by Zimbabwean migrant women for various reasons. Firstly, this method was chosen because it explored the rationalistic models that attempt to explain or predict people's sexual risk taking behavior as interactions between the social, cultural and economic environments in which Zimbabwean migrant women found themselves in. Sexuality consists not only of isolated items of behaviour, but of a complex set of actions, emotions and relationships, whereby living bodies are incorporated into social relations and which are too complex to be apprehended using quantitative research alone (Campbell 1997:275). Secondly, there was the realisation that such studies on risk perception and precautionary behaviour, outcome expectancies, and outcome valuations have not yielded results due to the quantitative methodology that is normally employed and have been unfruitful in providing a conclusive approach (Poppen and Reisen, 1997,

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Pinkerton *et al*, 2000, Akwara *et al*, 2003). The study attempted to use a model of qualitative enquiry to unravel the implications of social self reported intimate relationships between migrant women and their partners, the environment where they live and gain their livelihood as well as their personal characteristics. It sought to unpack how these points influence and interact with or serve in determining risky sexual activity and precautionary behaviors. It assumed that a qualitative study would be more user friendly than a quantitative mathematical model that asked people about the odds of an event occurring which can lead to poorer accuracy than other risk perception elicitation methods (Pinkerton *et al* 2000).

Thirdly, research questions of a sexual nature concerning HIV/AIDS are very sensitive such that the environment has to be considered. Rapley (2004:18) writes that "when interviewing someone in a coffee shop and we turned to the subject of his sexuality he began to speak in hushed tones. So the actual space where you interview someone can actually make a difference". Given the sensitive nature of the subject of sexuality and HIV/AIDS the environment in which people were to be interviewed was considered. At the Methodist shelter in Braamfontein, I was given access to use the office of the Director of the Zimbabwe Political Victims Association, (ZIPOVA) for some of the interviews. The atmosphere was quiet and private which was conducive for interviews to be carried out. This implies limitations of interview based research in this area. Such research necessarily focuses on finding people prepared to talk about their sexuality in an interview in a certain private environment. However, it can say nothing about how talk about sexuality is organized in naturally occurring environments such as talk between partners or indeed talk about sexuality in the context of real time counseling interviews (Silverman 2005:117).

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This approach was better compared to the one that was taken by Pinkerton *et al* (1993) which could have affected the results of their study. They went to a school and handed out questionnaires to students in a classroom. The situation was one where individuals were not guaranteed privacy in answering the questions. It may account for the reason why they had to discard some of the interview transcripts because their participants did not take the research seriously.

The other reason why a qualitative method was chosen over a quantitative one is because of the limitations of quantitative studies. Quantitative studies tend to focus on the attributes of individuals at the detriment of linguistic and sociological issues such as language use and social context. For instance, it may be helpful to have a one-on-one talk with a participant where questions and responses are clarified and probed on. For questions that needed more probing I would offer my ideas. There was an instance where one of the participants (Paulina, businesswoman aged 29, single) was alleging that condoms do not work which is the reason why people were getting infected. I offered my views on the matter and asked her whether she was aware that people could be getting infected because they were not using condoms consistently. She replied impatiently that then it must mean that the condoms themselves contained the virus. The point here is that there are certain responses that can be given by participants that may need to be probed on in order to understand their world view; this is an advantage that is provided by the qualitative interview.

Qualitative studies give voice to the previously silenced. It is through their rich descriptions of their social world that meaning is derived. This is quite impossible in a

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quantitative study. For instance as audiences, how do we know that self-protective behaviour alone is directly related to perception of risk or how do we know that perception of risk is not related to self protective behaviour if one cannot be present to ask this from a particular individual? Further it may be difficult to conduct follow up interviews with participants as the answers tend to remain structured and no facial ques can be observed. There are also other intervening variables that need to be considered and merged with others. Pinkerton *et al* (2000), in their study employed a mathematical model of HIV transmission to calculate the cumulative probability of transmission for more complex scenarios. They used this quantitative method to get probabilities which they used as the standard to compare respondents' risk estimates.

According to them, the Bernoulli-process model treats each act of intercourse as a probabilistically independent trial. Like the flip of a coin or the roll of a dice it takes into account factors such as the number of acts of intercourse, the number of partners, the type of acts like insertive vaginal or receptive anal intercourse, the prevalence of HIV infection among potential partners, and the frequency with which condoms are used. What it does not do is to relate these factors to the lived experiences of individuals. A much better conclusion can be obtained by possibly merging the two research methodologies.

However, this is not to say that mathematical models have completely failed to shed light on the relationship between perception of risk and preventive behaviour against HIV/AIDS infection. There have been mathematical models that have translated sexual behavior patterns into HIV risk estimates that have been quite helpful, notably by Pinkerton and Abramson in 1993. Their study evaluating the risks a Bernoulli

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process model of HIV infection and risk reduction is an example that was used which had its own limitations. The qualitative method employed for this study attempted to reveal the association or lack thereof between perception of risk and level of precaution used. The results represent the responses of a small snowball sample of 15 Zimbabwean migrant women living in Johannesburg and should not be used to generalize the entire population of Zimbabweans resident in South Africa or other similar migrant populations. It is recommended that both qualitative and quantitative methods be used to further explore perceptions of risk and level of precaution used to prevent HIV infection. For instance, qualitative data can be used to better understand social processes while quantitative data can be used to examine associations and their statistical generalisability for populations (Brannen 2004:314).

Pinkerton *et al* (2000) for example argue that that people who normally perceive themselves to be at low risk because of their subjective perceptions will also believe that they are considerably less vulnerable to HIV infection than their peers. Using a qualitative method can help to explain why such results are obtainable. Of importance, would be to find out what makes people assess their risk perception by comparing themselves to other people when they do not know how those people behave in their private sexual lives. For instance, a domestic worker may choose to perceive herself to be at low risk together with her other colleagues who are in the same work stream but what we need to know is how does she come to such a conclusion. Such questions are left unanswered in quantitative studies. For instance, Pinkerton *et al* (2000) were left with puzzling results in their study of sexually active heterosexual college students. They found that students thought they were at low risk of contracting HIV than any of their peers and even those who were very similar to

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themselves in engaging of highly risky sexual behaviour. I argue that there was no ground for this comparison as it failed to answer the question of specific individual risk.

The question raised by these studies is; when is a low risk appraisal unrealistically optimistic and when is it an accurate reflection of the risks faced by respondents? (Weinstein, 1984). Hansen *et al* (1990) for instance, examined the relationship between risk perception and actual behavior among a convenience sample of 18 to 25 year olds. Participants who reported a high number of sexual activity and numerous partners in the last 12 months believed themselves to be vulnerable to HIV infection just the same as individuals who were not involved in risky sexual behaviour. It follows that persons perceived to be involved in high risk behaviour are perceived as being at higher risk of infection, but then, this situation does not point out whether participant's responses of their risk perceptions were accurate. Qualitative methodologies can be used to bring out some of the nuances involved in behaviours relating to sexual attitudes.

Cohen and Bruce (1997) likewise used a mathematical model of HIV transmission to contrast college students' approximations with the definite likelihood of contracting HIV from one or several acts of heterosexual intercourse from three types of relationship strategies, that is, casual encounters, serial monogamy, and extended relationships. They too, discovered that respondents greatly overestimated the risk of contracting HIV for all types of relationship strategies. Their participants also failed to recognise that in the three relationship strategies, there was one where the likelihood of getting infected was lesser than the others. The students simply placed

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all the relationship types on the same risky level. Another limitation again was that they failed to examine the individual perceptions of participant's risk to HIV infection.

The research by Pinkerton *et al* (2000) consequently suggests that people may overestimate HIV risk in general but what is not clear is whether they also overestimate their own risk or whether a sense of unique invulnerability causes them to underestimate their risk. However, through the use of a qualitative research method, this was not the case with Zimbabwean migrant women where some appeared to have a firm grasp of what their perception of risk was in conjunction with the level of their self reported behaviour discussed in detail in Chapter four. Sometimes, it is possible that people may underestimate their risk perceptions due to misunderstandings as was found in the research on Zimbabwean migrant women.

The conceptual framework adopted in the study was to identify the two outcome variables, that is, the independent variable perception of risk and the dependent variable level of precaution used. Both try to explain each other but it was found that the relationship can occur either way. This was due to intervening variables like post-migration factors, age, occupation, marital status and so forth. Measures of Zimbabwean migrant women's social demographic characteristics were included in the analysis to predict their attitudes towards perception of risk and level of precaution used to prevent HIV infection. These included women's current work status such as unemployed, hawker/trader, manual and skilled labour such as hairdressing or domestic work and sex work. Professional work such as teaching or being students and clerical work were found to be the qualifications of some of the participants. Women's highest level of education obtained was also considered being

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none, primary, secondary or university education. Measures of a woman's relative status were also included in the analyses to ascertain whether there was a connection between poverty and sexual behaviour as alluded in some studies (Zulu *et al* 1998). A key socio-economic factor such as where women resided was examined. Although one Ndebele woman who could speak Shona was included in the study, no substantial difference was found between her and the other Shona participants. It was thought during the study, that since she spoke a different language she might perceive the HIV/AIDS risk and precautionary behaviour in an entirely different manner. This conceptual framework supposed that these factors would have an influence on the subject under study. I chose to study Shona women despite the fact that there are more Ndebele women living in Johannesburg because I can speak Shona and not Ndebele. I thought it would make the interviews easier say if participants could not understand some questions and they could not speak Shona it would have made it difficult for me.

Researching migrant women's sexual behaviour and in researching sexual behaviour in general is not an easy task. I found myself having to explain at great length that I was a student and that I would not pose any threat to the migrant women. Despite the fact that I explained this to Zimbabwean migrant women, some were not satisfied. There was an HIV/AIDS workshop which I attended at the Southern African Women's Institute for Migration Affairs, (SAWIMA), hoping to be able to interview a few migrant women but I was not successful. I only managed to make contact with one woman. I overhead the reason why women were reluctant to get involved that questionnaires involving Zimbabweans had a way of getting one deported. I tried to explain to them with the help of the onsite nurse Ms Duduzile Tshuma that I was no threat, but most were scared and adamant to get involved. I needed Ms Tshuma's help so that since they were already accustomed to her presumably they would understand

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that I would not jeopardize their safety. Social networking in the sense that women consulted each other first before taking a decision was observed to have been a major influence on the refusal of Zimbabwean migrant women to be a part of the research process. The situation was different at the Zimbabwe Political Victims Association (ZIPOVA) where the Director simply informed the women who I was and what I had come to do. The women here did not seem to have a problem with being interviewed because according to the director they were always being interviewed by journalists looking for stories. This situation was observed by Rapley (2004) in his study where he noted that there are multiple possible influences on the interaction and the trajectory of the talk that makes interviews. He mentions what he terms recruitment conversation, the physical space, the introduction, status of the researcher as well as the gender and many other factors that have to be considered when preparing to interview prospective participants.

Data on sexual activity, particularly risky sexual behaviour typically suffer from under reporting and this specifically relates to the sexual activity of women. To ensure that I would be accepted, I dressed in a manner that Zimbabwean women would be able to identify with. I observed that a significant number of Zimbabwean migrant women normally wear skirts and t-shirts or loose fitting jeans with a t-shirt covering their bottoms. I found that their dress sense is quiet conservative compared to South Africans. South African women will more often than not be found in tight fitting jeans and small tops that sometimes expose their navels. These observations are not meant as a representation for the population groups mentioned, but are meant to shed light on the type of women the research study was dealing with. I also took into account the social location Zimbabwean migrant women would be found. I did not want to dress

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in a manner that would bring attention to myself but I wanted to fit in. I tried to make the respondents comfortable by building rapport through asking them the welfare of their children as well as how they were getting along.

People use a variety of situations to measure their perception of risk. In this study, people were asked to consider their past sexual behaviour with the assumption that perception of risk may be based on how a respondent was handling their past sexual life. In this case, perception of risk could be expected to be high if a participant was involved in a multi partnered relationship in the absence of condoms or had suffered a sexually transmitted infection which is believed to predispose individuals to higher chances of HIV/AIDS infection. Related to this aspect was also the need to find out whether women were aware that physiologically they are more likely to get infected with STDs including HIV through unprotected sex with an infected partner. It was necessary to elicit this kind of information to determine whether current perception of risk was influenced by past behaviour or not. Accordingly, a low perception of risk may be because somebody has stopped risky behaviour but still this does not remove the possibility that one may already be infected. Where a person was adopting precautionary behaviour through the consistent use of condoms or abstinence, it is assumed that their perception of risk will be low or passive.

Another pointer to the conceptual framework was the idea of the environment that Zimbabwean migrant women were living in. For instance, does the fact that one is in South Africa lower or increase risk perception? A person's ideas of the prevalence of the disease should influence their thoughts about the disease as well as beliefs about men and women in general. "Perception is a cognitive and emotive process which has

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been described as sense of vulnerability or susceptibility to a perceived threat and is assumed to be a principal feature that influences motivation to avoid risky behaviour or adopt self protective behaviour" (Poppen and Reisen 1997:375). This means that a person's perceptual level of risk about HIV/AIDS can be high or low and that should influence the extent of avoidance of risky behaviour. But a particular perception itself may be a social and psychological construct appearing at different times and depends on the environment that people find themselves in.

The conceptual framework of the study was also based on questioning the assumption that knowledge about HIV/AIDS and how it is transmitted is important in determining people's sexual behaviour. More importantly was to question whether women were aware that in its asymptomatic phase HIV can not be detected by a physical eye screening diagnosis of a potential sex partner. This was considered because women are guided by social and cultural norms in their behaviour of partner screening. Campbell (2000) noted that women may feel pressured to conform to cultural beliefs that make them downplay concerns about HIV infection such as dry sex and other methods (Chinouya *et al* 2000, Wijgert *et al* 2001). Meursing and Sibindi (1995) writing on Zimbabwean sexual culture also posit that women may feel that if they insist on a condom, they may endanger their relationships which give them emotional or financial support. The age of women was also considered to unravel the assumption that it is predominantly young women in their teens who engage in risky unprotected sex (Ellen *et al* 1993).

This study will therefore seek to understand the extent to which perception of risk directly impacts the protective behaviour undertaken, or whether there are other intervening factors that impact this straightforward relationship between perception of

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risk and level of precaution used. The indicators that were used to measure perception of risk were asking participants to approximate their risk as high or low based on the assumption that they know what risky sexual behaviour is. Fear of sexual violence, mistrust of partners, and fear of vulnerability to HIV and whether this vulnerability is influenced by being in South Africa or not were considered. Key words such as views, thoughts, feelings and worry about individual risk were used to measure perception.

For the purposes of this study, level of precaution was defined as the self reported measures that a woman takes to prevent herself from getting infected by the HIV/AIDS virus in a sexual partnership. The important indicators of self reported level of precautionary behaviour were taken as: the consistent use of condoms with every partner, seeking early treatment of STI's or any other such preventative behaviour or visiting Voluntary Counseling and Testing (VCT) centres to seek information. Knowledge of HIV/AIDS was tested to see if it is reflected by the consistent use of various levels of precaution.

Before this particular study, no studies on perception of risk and level of precaution used by Zimbabwean women have been carried out in Johannesburg. Therefore, the research will serve to better understand Zimbabwean migrant women's thoughts on the subject of this study. Research objectives were addressed through semi structured interviews. Ordinary people's perceptions of risk present a more complete picture of the factors that influence perception of risk and methods used to prevent infection, "lay people's basic conceptualization of risk is much richer than that of experts and reflects legitimate concerns that are typically omitted from risk assessments" (Slovic *et al* 1987:295). This method was effective in that since the concept was explained to

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participants, they were able to give their open views on their perception of risk thus giving rich descriptive data. This does not necessarily mean that the results that were obtained were ideal or where expected. On the whole, it showed contradictions and other complexities. It just goes on to give a pointer on the potentiality of methodologies used. Thematic qualitative analysis was used on the raw data.

3.3 Thematic Analysis

Participants' responses are organized thematically into five categories which reflect participant's perceptions of risk and level of precaution used to prevent HIV/AIDS infection. Pseudonyms have been used for all the participants while quoting from interviews in this document to avoid treating them simply as 'research subjects' and thus giving them the human face they have. An example is Paulina, single, business woman aged 29.

Thematic analysis was chosen because it is more explanatory than content analysis and also because it aims to understand rather than know the data. Data is explained through key themes that arose in the course of the study and that are related to the research question and hypothesis. Thematic analysis is dependable in that it provides a good assessment trail. For instance, key points of the raw interview data are taken to emphasise some of the points in the themes. According to Marks and Yardley (2004) the criteria for good thematic analysis are its ability for introspection where the researcher thinks about their own experiences in relation to the research question and looking at power relations in a particular set of circumstances.

Boyatzis (1998) argues that developing a theory driven approach is necessary as it has the advantage of building onto knowledge. A theory driven approach will have a

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higher consistency of judgment being sensitive to the context of the raw data. Further, as he argues, there is a great momentum towards the use of theory driven methods in social science research. Insight can be derived from previous themes to a set of information and this can be done either through hypothesis testing or through searching for consistencies or anomalies (Boyatzis 1998). Thematic analysis was used in this study where the theme was given a label and a brief definition of what that particular theme concerns. Information of how to know when the theme occurs, especially through the use of catch words or elements of the theory is given. The titles of the themes are an example of this. Anomalies and consistencies found in the theme are also mentioned.

Marks and Yardley (2004) point out that thematic analysis has its own advantages and disadvantages such as providing a meaningful and organised structure of the research work. Because of its richness, insightfulness and complexity, thematic analysis can also be used for theory construction. However, they note that this approach can be time consuming, its reliability can be difficult to demonstrate and that data may be little or too superficial to allow full thematic analysis.

3.4 Participants

The sample consisted of 15 Zimbabwean women living in and around Johannesburg. These participants met the following criteria: Zimbabwean nationality and their age group ranged from 18-45 years. These women came from various backgrounds of domestic work, sex work, waitressing, hairdressing, trading, teaching, a university student, correspondence student, a book keeper and a political activist and two were

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unemployed. Snowball sampling method was employed when recruiting the participants. By interviewing one woman it was possible to access some of her friends and colleagues. 14 Shona women and one Ndebele woman were interviewed. That one Ndebele woman was interviewed is just an honest observation. Her inclusion in the research is not going to have any qualitative impact on the results. This is because when analysing the results this distinction did not appear to have any particular effect. Further it would have been unwarranted to make generalizations about Ndebele women based on an interview with one person. All were consenting individuals.

Paulina was interviewed on 28/11/05 was aged 29 and had two dependents. She regarded herself as a business woman and had been living in South Africa since 2003. Her reasons for coming to South Africa and staying in Johannesburg were that the city provided her an opportunity for making more profit than Zimbabwe. She regularly trades in small items like sweets, cigarettes, cosmetics and occasionally some fruits depending on the market. Paulina said that she ran short of money but never totally and she said she coped with this situation by suspending the buying and eating of nice food. She mentioned that she got involved in transactional sex intermittently when she was desperate. Paulina hated doing this. She was vague about her exact thoughts on condom use as will be highlighted later in the next chapter. Her standard of education was up to the junior level certificate (Form 2). She said her risk to HIV was high.

Sarah aged 43, was interviewed on 29/12/05, a domestic worker, she had 3 dependents and had been living in Johannesburg from 2003. She came to Johannesburg because her work as a cook at a college in Bulawayo was terminated suddenly and coupled with her widowhood, she decided to come and look for work so

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that she would be able to take care of her children. Sarah complained that she always ran short of money as a domestic worker and complained that the working conditions were not favourable for her to do any other money making tasks like selling small items. She said she continued to work where she was because of the accommodation that came with the job. As a result she did nothing to supplement her income. She reported her perception of risk as high and pointed out that she was scared of getting intimately involved with a man because of this.

Bridgett, aged 33 interviewed 30/12/05 had three dependents and had been living in South Africa since 2003. She came to South Africa because she was being harassed in Zimbabwe by government officials for her political activities. She said she used to stay in Pretoria and had to come to stay at the Methodist shelter because she had no where else to go. She described herself as a part time student doing a secretarial course. On whether she ever ran short of money, Bridgett reported that she occasionally goes to different churches asking for donations. She mentioned that sometimes transactional sex was an option because of the hardships “you are forced to go with a man because you have no money and surviving is just hard but I haven’t done this many times. It is not easy to do it especially if you have no experience.” She described herself as being at low risk to HIV.

Prisca, aged 21 was interviewed 1/12/05 married and had one dependent. She had been living in South Africa for only a year. Her reasons for coming to South Africa and wanting to stay in Johannesburg were to further her education. She said she had been at a university in Zimbabwe doing her first year when her aunt enticed her with good education prospects in South Africa. She was shocked to realize when she came

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that her aunt was in fact a prostitute and was in the process of making her one. She ran away and came to the Methodist shelter. She grumbled that they were always hungry at the shelter and that there was much competition when it came to food with some being able to afford more than others. “I have lost a lot of weight and what hurts me most is that my husband and the rest of the family think I am here and I am going to be doing my studies they don’t even know that I am suffering. The Methodist Bishop promised to get me a place to study nursing so that I can study and make money at the same time so that’s why I am still here.” She said at the moment she was doing nothing and had no occupation but was just surviving on hand outs. She said her risk to HIV infection was low as long as her partner remained faithful.

Sekai, aged 32 interviewed on 2/12/05, had four dependents and had been living in South Africa since 2001. Employment seeking was her major reason for coming to Johannesburg. She thought it would be easy to find a job because it is heavily populated. In the beginning, she stayed with a distant relative for about three months and then the relative had started complaining that she was just eating and doing nothing in her house. “…to make matters worse I couldn’t get a job quickly so she started becoming moody every morning before she left for work and in the evenings when she came back from work.” She did not find the job she wanted and was tricked into prostitution by another Zimbabwean migrant woman who told her she could be paid handsomely for escorting business executives to their evening dinners. She discovered that the “escorting” was a once off thing. Sekai said she ran short of money especially when her regular customers stopped coming. It was difficult because she had to start making new contacts and new relationships where sometimes she would meet men who would refuse to pay her afterwards.” Sekai thought that she

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could prevent herself from getting infected if she religiously drank and used her herbal portions all the time before sex. She said her risk was high.

Rumbidzai, aged 19 interviewed on 3/12/05 was unemployed. She would occasionally plait hair and play with children at a nursery school nearby. She had one child and started living in Johannesburg about six months ago. Previously she had been staying in Pretoria for approximately six months where she had met her boyfriend. Frustrations in Zimbabwe had forced her to come to look for a job but she ended up staying in the Methodist shelter in Braamfontein because she had no where to stay. Her boyfriend had disappeared when she told him that she had missed her period. When she ran short of money, Rumbidzai said she can have sex with men and sometimes get paid as little as five Rands due to desperation and the absence of food for her and her baby. Rumbidzai had started having sex at the age of nine and had never used a condom during the encounters. She started using condoms last year (2005) when she realised that there were too many diseases out there and not necessarily in her. Rumbidzai reported that she would tell her mother if she suffered from a sexually transmitted infection. She said she was at low risk because she was now consistently using condoms.

Tendai, interviewed on 3/12/05 was aged 22, had one child and had been in South Africa since 2004. Her reasons for coming to South Africa and staying in Johannesburg were the need to achieve a good life and improve herself by getting “a nice job” so that in the end she could support her child and the rest of her family. She was unemployed and explained how she came to be on her own when her brother went back to Zimbabwe. The father of her baby had “tricked” her into pregnancy

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saying he would marry her. When she runs short of money she sleeps with men and hopes to gather enough money to go back home so that she can go and leave her child with her parents. She said sometimes she would sleep with men to get money and mentioned that some men would be reluctant to give her money. This produced depressing feelings in her afterwards. She said she was "at low risk for now." Tendai thought that Aids was a hard disease and that it can be cured.

Wandi, interviewed 4/12/05 was aged 20 had two dependents and had been in South Africa since 2003. Her reasons for coming to South Africa, particularly Johannesburg were to get a job and to further her education. She described herself as a student. She said she was still dependent on her uncle and aunt for any money she might require and that if they didn't have money she would just have to wait until it was available. Wandi described her risk perception as low and said she was faithful to the father of her children.

Ruth, interviewed on 4/12/05 was aged 28, had two dependents and had been living in South Africa from 2000. After her husband had replaced her with a younger wife she felt depressed, left her children with her mother and came to Johannesburg where she had heard that it was easier to find work. She described herself as a hairdresser. Ruth supplemented her income by diverting customers from the saloon she worked from to her home. Occasionally, her male partner chips in with financial support. She described her risk perception as low but believed that Aids could be treated by people who know African medicine.

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Eunice, was interviewed on 6/12/05 aged 25 years old had one dependent and described herself as a correspondent student with UNISA. She was unemployed and said that she did run short of money but had friends who helped her to get around. She said her perception of risk was low. She used the leaves of a certain flower to make her vagina tight so that her male partners would not leave her.

Victoria, interviewed 6/12/05 was 24 years old, had no dependents and had been living in South Africa since 2004, she described her usual occupation as a book keeper and had come to Johannesburg specifically to look for a job. In addition to her job she has two sexual partners who take care of her financial needs and are not known to each other. She described her risk as low.

Rutendo, was interviewed 7/12/05 was 24 years old, a hairdresser with one dependent and had been in South Africa since 2000. She decided to leave Zimbabwe for want of independence and leaving a husband who had taken on another wife. Johannesburg seemed a popular city and was closer to home. She gets her income by plaiting people's hair in the street. She said she was at low risk.

Nomalanga, a Ndebele, was interviewed on 7/12/05. She was aged 22, had no dependents and had been in South Africa since 2002. She described herself as a sex worker. She started off as a housemaid and realized that the money she was earning was 'not making sense;' prostitution was better. "I came here looking for my uncle who said he had found me a job. I didn't find him because at first I called him he agreed to come and pick me up at Park Station where I was and he didn't turn up I slept at the station and then another Zimbabwean took pity on me and took me in for a

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few days…I then got a job as a housemaid but the money was never enough so that's when I decided to become a full time prostitute. I got more money in a week than what I was working for during the whole month." Nomalanga mentioned that she never runs out of money now. She said she was at high risk to HIV because she had slept with too many men.

Loreen, aged 24 was interviewed on 7/12/05 had one dependent and started living in South Africa since 2004. She is a domestic worker who reported that she wanted to have a better future. "I wanted to come here and work and save a lot of money to be able to start my own business selling clothes when I eventually go back home. I thought I would just work here for about five years and then go back home but now I am not sure if I will be able to do that. I am struggling to make ends meet." She ran short of money but there was nothing that she could do to supplement my income. Loreen was grateful for the free accommodation and food from where she works as a domestic worker. It enabled her to send all the money she got to Zimbabwe arguing that it made a difference when converted to Zimbabwean dollars. She was afraid of Aids. Loreen described her risk to Aids as low.

Thabitha, a teacher aged 26 was interviewed on 8/12/05 had one dependent and had been living in South Africa since 2003. She sometimes brings small items to sell at the private college where she teaches so that the students can buy them from her. She was afraid of HIV and she thought that she is at low risk. She said she has been faithful to her husband and that if he too remained faithful then both of them would be safe.

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3.5 Instruments.

A semi-structured interview guide which included demographic details and a consent form were used throughout the study. It had open ended questions that were used to obtain the life experiences of these women in their own words. The advantage of open ended questions is that it does not force the participant to adapt to pre-conceived answers but to respond spontaneously. According to Nachmias and Nachmias (1976) the researcher approaches a sample of individuals presumed to have undergone certain experiences. The obtained responses constitute the data upon which the research hypotheses will be evaluated. Thus face-to-face interviews were necessary to elicit this information from participants.

Demographic details included questions regarding participant's occupation, age and their reasons for choosing Johannesburg as a destination and area of residence. Some of the interviews were conducted at a shelter for women, some at participants' residence, in a back room of a hair saloon and one at the researcher's residence. There was no missing data on all the variables employed in the research instrument. Conversation took place in English in most cases with only a few questions having to be explained in Shona.

Since the concept of perception of risk may have been unknown to participants due to its academic nature, questions on perception were phrased in a way that described the construct using key words such as views, thoughts and feelings about contracting HIV/AIDS. These questions were "what are your feelings and perceptions about HIV/AIDS in South Africa; do you think you are safe from HIV/AIDS in South Africa or as compared to Zimbabwe?" "Are you afraid of getting HIV/AIDS?" "Do

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you consider yourself to be at low or high risk to HIV/AIDS?" "Do you think condoms are effective in preventing HIV/AIDS? Why or why not?" A strategy like this was very instrumental in testing the hypothesis in that psychological processes like fear and worry are more likely to provide a conclusive response.

The research instrument was administered by the author and lasted for about 45 minutes. Confidentiality was assured by the use of pseudonyms for all participants through out the study. Participants were asked to verbally agree and to sign a consent form that informed them of the objectives of the study, their guaranteed confidentiality and the duration of the interview and the not so direct benefits of the research. Their choice of terminating their involvement anytime without being castigated was assured. I informed participants even though they did not ask for it that they could be given a copy of a summary of the completed study if they wished. The semi-structured interview guide was composed of a list of 34 questions most of which were open ended. These questions addressed several subjects; perception of risk, level of precaution used, STD and health issues. However, since the instrument was a guide some questions were asked in addition to those appearing on the questionnaire and in some instances a woman would start by focusing on subjects that were to appear later in the questionnaire. Hence, it was necessary to employ a flexible approach so as to make participants as comfortable as possible without losing track of the subject matter.

3.6 Procedures

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The study's procedures and consent form were submitted for evaluation to the University of the Witwatersrand, Human Research Ethics Committee (non-medical) for clearance of research involving human subjects.

The semi-structured interview guide was pilot tested on two university students who presented views to the phrasing of some of the questions and on restructuring them. It was evident that there was need to explain some of the questions to participants to ensure no misunderstandings.

In selecting cases for inclusion in the study, snowball sampling was used. This is because migrants tend to be a hidden and discriminated population hence are difficult to access. The starting point was to contact organisations that work with Zimbabwean migrant women namely ZIPOVA and SAWIMA and thereafter references made by participants were followed to widen the sample. Participants were asked to first obtain permission of other potential participants before giving the names to the researcher. It was hoped that this approach would protect the privacy and freedom of participants.

Participants were asked to be honest in the interests of assisting the research and assured of strict confidentiality. The researcher tried her best not to assume a judgmental attitude and politely probed for detailed information on some of the questions.

3.7 Limitations of the Study

Only 15 women were interviewed and this may not be representative of all Zimbabwean migrant women in South Africa. However, women's varied experiences

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that were captured do assist in qualitatively enhancing the understanding on this subject. The study is limited to those only living in Johannesburg (Braamfontein, Hillbrow, Betrams and Berea). The time and space was limited to conduct a more representative study. It was costly in terms of time, as respondents were difficult to get at times they would have stipulated due to their personal commitments and jobs they had.

Some participants refused to participate in the study if they were not given money first. Others demanded money as a condition to be included in the research. This had the potential of providing bias in that participants would have ended up giving the researcher the "socially correct answers" to the detriment of the research process. They said that the questions were too personal and private things that they would be reluctant to talk about. These participants were not included in the research sample due to direct refusal on their behalf or due to the voluntary, unpaid nature of participants set out in the study. For some the interview process helped them an opportunity to show their alternative strategies and for some their vulnerability and sense of helplessness that they might be forced to have unprotected sex for fear of being cut off financially by their male partners.

It is possible that the extent of survival sex may have been under reported in the study because of time constraints and also the method that was used to get the sample. Snow ball sampling was used to identify and pick out Zimbabwean women. Despite not having divulged interview proceedings with any of the participants, some women would ask me soon after I finished interviewing one and say what did she say to you? They would intimate that "this woman should have told you more. She is the one who

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does these things and knows so much more than any of us." It was part of the research's procedure not to discuss any of the participant's responses with others.

Some researchers have questioned the assumption contained in studies of perception of risk on whether people are able to approximate their level of risk accurately. A study in rural Uganda found that patterns of HIV risk perception by age and gender mirrored actual sero-prevalence patterns, suggesting that respondents had a reasonably accurate sense of their true risk of infection (Smith and Watkins 2005). In as much as this study lacks data about sero-prevalence which wasn't the aim, it however provides evidence that participants were knowledgeable about their personal risk as will be discussed in chapter four. Participants displayed a high level of knowledge and awareness of HIV/AIDS and of risk factors such as not having sex when menstruating or having sex when one has a sexually transmitted infection. The results do offer debate and insights on the subject of perception of risk and level of precaution used against HIV/AIDS.

3.8 Conclusion

Snowball sampling and administering of the semi structured interview guide described in this work were used to try to explain perception of risk and level of precaution used to prevent HIV/AIDS. Snowball sampling enabled the selection of participants who fitted the requirements of the research. But it had the disadvantage of leading the researcher to people of the same group known to each other and who might not have wanted to reveal more of their sexual behaviour. Perhaps given more time, they might have revealed more information on their private sexual life.

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The semi structured interview guide was successful in managing to provide detailed biographical information about participants but some participants were embarrassed when it came to questions concerning sexuality and it is suspected that there could have been under reporting.

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Chapter 4

Findings and Discussion

4.1 Introduction

This research was based on the premise that perception of risk or vulnerability to HIV/AIDS infection should be connected to the underlying assumption that people will engage in safe behaviour that does not predispose them to infection. Indeed, education preventive programs also support this notion; the idea that teaching people about the ways HIV is transmitted and how to avoid infection will result in positive behaviour change. Evidence to date made obvious by the escalating HIV infections in sub Saharan Africa reveal that these methods are not working as expected (Vance 1997). People either fail to assess their risk perception, continue to engage in high risky behaviour and get infected even when they have all the information or they assess it accurately and adopt preventive behaviour. This is not to disregard the fact

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that some may be getting infected because of ignorance or misconceptions. The fact of the matter is that even the health belief model which argues that perceived risk results in behavioral change does not account for origin or variation in the understanding of risk (Rosenstock 1974). Evidently there are individual methods that people use to gauge their perceptions. These are many and varied.

Those that were seemingly consistent with the hypothesis through perception of risk and self reported precaution in the study were seven women: Thabitha; married teacher aged 26; Sarah, widowed domestic worker aged 43; Prisca, married university student aged 21; Victoria a book keeper aged 24; even in the presence of sexual networking with two partners, Eunice, student corresponding with UNISA aged 20; Loreen, married domestic worker aged 24; Ruth, who is single, a waitress aged 28; her self reported behaviour was consistent with the hypothesis but she felt that the disease can be 'treated by people who know African medicine.' The hairdresser, Rutendo, aged 24 gave conflicting responses (as did other respondents). She felt that it was necessary to use condoms all the time when having sex except to get married or to get pregnant but failed to mention that it is on condition of having a negative blood test for both partners. Further she tried to disassociate herself from the problem (which was a general occurrence with most of the respondents) saying that "I can't really say but I feel that eventually everyone will get the disease no matter how hard we try to use protection. But I am at low risk to Aids because I have only had two men in my life" (Rutendo, hairdresser aged 24).

It was also found that there were some for whom perception of risk or self reported behaviour was not linked at all. These were convinced that traditional medicine,

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herbal portions for instance and generally indulged in risky unprotected sexual behaviour. The full time prostitute (her own description) Nomalanga, aged 22, Bridget, the political activist aged 33, reported risky sexual behaviour at times, but mentioned that her perception of risk was low. Also Paulina, the 29 year old business woman, Rumbidzai, the 19 year old unemployed young mother, Sekai, the 32 year old sex worker (her own description) and Tendai, the 22 year old woman who used to do computers, were participants whose reports reflected high risk behaviour through unprotected sex. Most of their thinking and reasons will be highlighted in the key themes that were found in the key themes that were found.

Perceptions of risk can result from cultural understandings and other such positions that can be found in any society. The research findings revealed that assessing risk perception is a very complicated exercise as there are diverse factors such as the unique migration experience, level of education, occupation, social environment, age, understanding and exposure to disease. As the research can reveal, observation was made that these variables have an impact on how women rationalize their actions and view themselves against HIV/AIDS. These characteristics influenced women when measuring their personal risk. Based on women's self reported behaviour these aspects contributed to overestimation/underestimation of risk. The results show that there is a complex association between perception of risk and precautionary behaviour. Importantly that some women do not protect themselves sufficiently against the disease and those who do so do not protect themselves consistently. This chapter discusses the results of perception of risk and level of precaution used to prevent HIV/AIDS among Zimbabwean migrant women using thematic analysis. This approach is prior research driven in that other researchers have found similar themes

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thus it aims to build on current literature. The five themes that appear immediately after this introduction which are women's perception of risk, perception of risk by level of precaution used, perception of risk as influenced by the environment and vulnerability thereof, the phenomenon of migration and sexual decision making, all confirm ideas that have been researched on by various scholars.

4.2 Women's perception of HIV risk

The point here was to get an accurate estimation of personal risk/knowledge of HIV/AIDS. Precautionary behaviour was considered as the willingness to avoid risky sexual behaviour. The number of sexual partners and personal worry about acquiring the disease were measures that were employed to look at this variable. Health seeking behaviour for Zimbabwean migrant women was viewed in terms of seeking medical attention and knowing where to get their blood tested for HIV infection. The question of whether Zimbabwean migrant women had ever heard of someone who had died of the disease was meant to assess whether it would be a deterrent and a motivating factor to adopt precautionary behaviour as suggested in the literature by Ellen *et al (2003)*. The Health Belief Model (Rosenstock 1974) supports this argument that knowing someone who has or had Aids is supposed to raise awareness as well as prompt behaviour change. Responses from women revealed that all participants had known or heard about someone who had the disease but for some women, this was not related to precautionary behaviour. Knowing someone who had the disease may have heard an influence on perception of risk but there was no reciprocal relation with precautionary behaviour on some of the participants.

> Yes a very close of mine died of Aids. It made me feel very afraid and I ask myself whether I will also die suffering like she did. She had cancer in her

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> private parts and when she died it looked terrible. I think that this disease has no boundary, its just everywhere like this air we breathe (Sekai, sex worker aged 32, single).

It appears that Sekai's comments are vague and varied. She thinks clearly about the effects of getting infected but sees this as something separated from her. Or at least, something that she should not be worrying about at the moment, "it's everywhere this disease just like the air we breathe." This is supposed to highlight the fact that it's widespread and it is a world view that should be shared by any reasonable person. Sekai buttresses her point by saying that the disease can be caught by everyone. She uses many voices to bring out this point. 'We' is used once to refer to other people and 'I think' symbolizes that she is actually worried and concerned about the disease. But what she said in other parts of the interview turns out to be controversial and worrying. Let us see what else women said about their knowledge of people known to them who had succumbed to HIV/AIDS.

> A lot of my relatives have died of Aids. I always felt very angry about it and I know that most of the time they went looking for it and that it was their fault that they got Aids (Prisca, university student aged 21, married).

> Yes my father's sister died of Aids. But I always felt like it was not my own problem. I just looked at her and thought that she went looking for it, most of the time I didn't even want to talk to her (Paulina single, business woman aged 29).

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> My cousin who was a soldier died of Aids and it made me very sad because he was very young. I don't get to see many people with Aids here since I am always in the yard where I work (Sarah, widow, domestic worker aged 43).

These women confirm their beliefs about HIV but more so, they add value to the discussion by providing real life situations about risk perceptions and HIV preventive behaviour. It was also realised that people categorise threatening events in their physical world according to moral values that is deriving their risk perception from belief systems that justify and reinforce socially sanctioned behaviour (Slovic 1997). The dying or suffering from Aids of the relatives of some migrant women was associated with as being some sort of punishment. 'I always thought it was their own fault they went looking for it' (Prisca, university student aged 21) 'sometimes I didn't even want to talk to her' (Paulina, business woman aged 33).

In addition to knowledge about people who had suffered and died from Aids, Zimbabwean women were also cognizant of HIV prevention methods, how it is spread as well as risky behaviour. The hypothesis assumed that these factors are likely to influence positive behaviour change for greater condom use or abstinence but from the responses given by women on other questions; this association became mixed up in the way it was juxtaposed with certain scenarios in migrant women's lives:

> Abstaining from sex and using condoms is the only way to prevent HIV. I am afraid and I think that I am at low risk because I have only slept with 3 men in my life I know that it is spread mainly through sexual contact and that it can take time to come out and that it still can't be cured but that there are drugs

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that can make someone better (Bridget, political activist, aged 33, unemployed).

Practicing safe sex and being faithful to one partner or the partners that one is sleeping with prevents HIV infection. I am afraid of HIV/AIDS and I think that I am at low risk. I am married and have been faithful to my husband so if he remains faithful then both of us are safe (Thabitha, teacher aged 26, married).

I know that the virus which causes Aids can be transmitted via sexual contact or through flesh to flesh sex with an infected partner. The disease cannot be cured but I don't understand why they are failing to cure it. I am very much afraid of HIV/AIDS. I think I am at high risk and I have already given you my reasons (Paulina, single, business woman aged 29).

I can say that I am at low risk to HIV because I am sexually active with my partner and one day he may be tempted to have sex with someone without a condom. I know that it's a virus that causes AIDS and that research has proven that it can't be cured, (Prisca, university student aged 21 married).

I know that it is spread though unprotected sex with an infected person and through careless use of sharp objects with infected people. It cannot be cured but its infectiousness can be controlled by ARVs if they are taken accordingly and at the right time. I am afraid and I think that I am at low risk. I am married and have been faithful to my husband. So if he remains faithful then both of us

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> are safe. Yes, there is a chance although there are some articles that it's a 1 in 800 chance especially if there are no other infections present but being a woman it's tricky because you have someone's sperms running inside your body for about 2 days. For me it's not because I use contraceptives and we are both HIV/AIDS negative (Thabitha, teacher aged 26, married).

It was noted that the teacher as did other respondents here had knowledge about how HIV is spread. This influence could have come about because of her high education. Thabitha had answers that were consistent with the hypothesis that if one is worried about HIV risk they will adopt behaviour that does not make them prone to infection. Her responses show that she has got a clear and straight forward understanding of how HIV is spread how it can be mitigated by Anti Retro Viral therapy taken consistently. She also believes in blood tests shown by the confirmation that she and her partner are both HIV negative. Her knowledge is further heightened by the statement she makes about the transmissibility of the disease. Her attitude is one of being vigilant where approximating the gravity of risk is concerned.

This view is also asserted by Pligt (1996). People base their assumptions, measure the costs and benefits of an action, and then choose a course of action that will make the most of their anticipated result. In this case, Thabitha shows that she will not risk having unprotected sex. Thabitha argues that HIV can be transmitted through one unprotected sexual contact because of women's physiology that "being a woman, its tricky because you have someone's sperms running inside your body for about 2 days". This can be the time that one gets infected. This in fact is true to some extent as medical reports do say there is a chance although it is minimal. She also goes to point

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out that condoms are effective and that the reason why people continue to be infected is because either they do not use them consistently or correctly. It can therefore be said that virtually all the participants were familiar with the ABC approach (Abstinence, Be faithful and Condomise) message but some had misconceptions about whether it can be cured or not and this tended to confuse their perception of risk.

In general, women professed ignorance about where Voluntary and Counselling Testing Centres could be found in Johannesburg. Zimbabwean migrant women identified places where VCT centres could be found mentioning Esselen clinic in Hillbrow and other places. It was noted that while some women may have been deeply worried about Aids infection, it nonetheless did not increase their inclinations to want to find out whether they were infected or not. Women appeared to be cognizant of how the disease is spread, prevented and how painful an Aids related death is. Most conjured up images of their relatives who had been victims of the disease. About 11 women said they would not go for HIV testing for fear of being diagnosed HIV positive. Zimbabwean migrant women were terrified of being tested. There was extreme fear of being confirmed to be positive for a disease that had no cure and had the effect of making them even more vulnerable in the face of expensive medical costs.

> Yes I know that there is a VCT Centre in Braamfontein (Prisca, university student, age 21, married).

> Yes I know where VCT's can be found but I haven't been tested yet. I am still healthy so I think I am ok (Nomalanga, sex worker aged 22, single).

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> Yes I know where to go and get tested but I don't think there will come a time when I will be ready to be tested, maybe when I really become sick or if I get tested against my will. I don't want to be told that I have HIV. Its better not to know because if I do I will start to get worried and then the disease will eat my body (Sekai sex worker aged 32, single).

> No I never looked for them (Tendai, unemployed aged 22, single).

> There are many if you walk around here in Hillbrow, you will see that even private doctors do these tests (Victoria, book keeper aged 24 single).

When asking questions about whether a migrant woman had experienced a sexually transmitted infection, the assumption was that an individual would take into consideration their prior precautionary sexual behaviour to influence their perception of risk. It was assumed that having had a sexually transmitted infection would be a predisposing element to greater HIV infection as HIV/AIDS studies have suggested. This was also employed as a method to gauge a more accurate perception of personal risk. It was found that women were not entirely comfortable with the subject of being asked about having had a sexually transmitted infection. It is possible that they may have been cases of under reporting on this subject. Responses suggested that women disliked having to suffer the shame of a sexually transmitted disease such as HIV. For them, it was like being exposed in public for an act that had been done in private. Meursing and Sibindi (1995) also reported the same behaviour from the women they

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studied in Bulawayo, Zimbabwe. Women were embarrassed about suffering from STDs and disclosed that it would make them feel uncomfortable so much that they would not tell their partners about it. As a consequence it would become difficult to seek medical attention because of high stigmatization. This was made evident by the reports that women gave on the question of what they would do if they experienced a sexually transmitted disease. Most said they would wait to see if it will go away on its own. If it did not, they would use herbal remedies and if this failed to work, then they would go to the clinic and take medication without their partner/s knowledge. The question was meant to establish whether women were cognisant of the fact that untreated STD's, genital lesions etc made women more vulnerable to contracting the virus that causes AIDS. By taking medication in secret and not informing a sexual partner means that there is risk of the woman getting reinfected with the same STD possibly by the same sexual partner or infecting somebody else which in turn may cause drug resistance thus fuelling the epidemic.

> I would seek help immediately because if I don't, I know that it can destroy some parts inside. First I will take a herbal remedy and if it doesn't go away quickly then I will go to the hospital…No! I would not tell any one about it. I don't want people going behind my back saying that look at that one she once had "siki" (Shona word for any STD). Firstly, I don't want to be labeled a prostitute because it's only prostitutes who suffer from those diseases, and secondly, I wouldn't want to lose my partner and financial security because the moment he finds out I will be divorced. And besides I don't have sex everyday (Paulina, single, business woman aged 29).

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> No, I wouldn't tell a man that I have an STD, I would just make sure that I don't pass it on to him, It means I have to be extra clean and take my medication in secret (Bridget, political activist, aged 33,single and unemployed).

Fourteen women said they had never experienced an STD. The question itself produced a large degree of discomfort amongst participants made evident by some of the responses. Most said they would wait to see if the STI would first go away by itself or through herbal portions before enlisting professional medical attention without the knowledge of the sexual partner. When asked how she (Paulina) would take her treatment without the partner finding out, she said she could give him various excuses of why they can't have sex until she is totally healed.

Another aspect that seemed to influence Zimbabwean migrant women's perception of risk and thereby affecting their precautionary behaviour was their perceived ability to 'screen' out potentially HIV infected men from their sexual lives. Many respondents did not associate the absence of visible symptoms with the fact that in its asymptomatic level, HIV infection may not be so obvious. The worry though is that there is medical information (Linville *et al* 1998) which argues that when one is in the early stages of infection, the asymptomatic stage, they are likely to infect other people because it is at this time that they have elevated infectious virus load. In the absence of a test, people may not be aware of this and it is argued that it is this situation that has largely contributed to fuelling the epidemic. There was a study about HIV/AIDS, knowledge in Zimbabwe by the Central Statistical Office and Macro International in 1995 which observed that while both men and women had heard about HIVAIDS

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there were some amongst them who did not believe that a healthy looking person could carry the virus. Zimbabwean migrant women assessed their sexual partners on the basis that they did not fit with the popular images of people who had Aids 'its obvious it always shows when one is infected'. It seemed that there was the tendency to believe that people with HIV can be easily identified through self diagnoses of potential sexual partners. Because of such limitations, it was found that Zimbabwean migrant women "rely on mental images and intuitive devices that supplement or replace such knowledge ideas that were also confirmed by (Slovic 1997). Similarly as Slovic further argues, stereotypes function as categorical devices that permit easy cataloging of cases or events. Apparently, according to some women, the absence of visible symptoms through a subtle partner screening process rendered one safe and not infected as these quotations tell;

> They can look perfectly healthy and it makes it difficult to see who is infected and who is not. For these reasons it is necessary for me to make sure that before accepting any proposal from a man, I always look for tell tale signs. These days, they are so many even in someone who looks very healthy if you look behind their ears you can see two little bumps which are very small. You can think that they are pimples. These are now like small glands and they are a sure sign that someone has got something. If you look at their skin you check if they have pimples you should also see how those pimples are healing. If they look very very black, then just know that something is wrong. And in general, there are some with tiny but frequent coughs those are also very questionable so I look at these things before accepting someone. Yes one can get infected (Bridget, political activist, aged 33, single and unemployed).

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This false security can prove to be dangerous as Sekai herself noted;

> I know that using condoms or practicing safe sex is the only way to prevent infection but sometimes these things do not apply to us who have sex with different men and you just want to make some money to send some food to Zimbabwe. Some of these men are unfair because they can increase money for unsafe sex and then because you want money you have to make a quick calculation of his health. Does he look like he has glands? How about his penis? Is it ok? No pimples pus or anything? And pray that I am doing the right thing that I won't cry about this tomorrow. But as women in this industry we drink herbal remedies so that they can fight any germs in our bodies or you can insert the roots of the "umkomo" tree (Baobab) inside the vagina so that it just cleans everything out. I occasionally drink African potato to clean my blood. Some say that if a person doesn't have any STD, it's very rare, so sometimes I think of this when I am not using a condom that I hope I don't get infected but it's something that I am constantly hoping for. People with HIV can look perfectly healthy and that's the worrying thing especially nowadays where you can stay for a long time without becoming sick of you are eating good food and these herbal remedies (Sekai, sex worker aged 32, single).

Sekai, the sex worker was clear about how HIV is transmitted and this encouraged her to be strict with her herbal portions which were supposed to convey HIV/AIDS immunity to her. Here her, statement shows elements of both resignation and fear. She believes that she may not be the only one doing this. See the way she says "sometimes

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these things do not apply to us who have sex with different men" the statement suggests that she sees herself as a representative of all the other women who should have been interviewed. She feels that she and others who do sex work are in a catch 22 situation where the results are the same: "the more I sleep with someone the more vulnerable I become." There was a participant who actually mentioned that in some cases. A person with HIV may not display any symptoms. This in fact may be true for HIV/AIDS in its asymptomatic stage, a person may not show signs of infection at all.

This quote reveals that Sekai's perception of risk and level of precaution is based on the mental image of her potential partner. If he looks healthy, then it follows that he can be safe but as she points out it can turn out to be a fallacy since infected people can look healthy. Sekai dilutes her fears about the possibility of getting infected by regularly drinking African potato and inserting the roots of the baobab tree in her vagina in an effort to convey immunity against the disease. This in a way influences her sexual decisions and particular level of precaution.

Married women were more likely to believe that their husbands would not risk them by engaging in extramarital affairs as highlighted in some of the quotes above. This influenced their perception risk enough to hope that their partners would use protection if they are not with them. Married women said they were in sexual unions where they could comfortably talk to their partners and would manage to dissuade them from forced sex. The single women expressed vulnerability and said that there was nothing they could do to protect themselves if their partners forced them into unprotected sex, especially realizing that they depended on these men for their

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livelihood. Reported sexual behaviour by migrant women highlighted that condom use among married couples or 'regular partners' is low and pointed to the idea of 'trust.' While it is useful to promote condom use, it will be in line also to promote blood tests for migrants who are separated from their partners. It is recommended that when designing prevention programs, the issue of perceptions over the complete and consistent condom use should be addressed.

Results also showed that age was a factor that influenced perception. The mean age of the participants in the study was 26. Women who were older that is between 21 and 45 years had better understanding of the disease and knew somebody who had succumbed to the disease. They were more likely to report that one could get infected through one sexual contact and that sexual promiscuity was risky. Given the relatively low rates of transmission estimated by the medical community, (less than .001 for male to female transmission). The data collected highlighted that women tended to overestimate the risk of HIV transmission through one sexual contact. This may have been to do with the fact that older women (mostly married) were resolute about avoiding infection and did not want to take any chances trying to find out if it was true. For these particular women who fit in the hypothesis, it can be assumed that they weighed the negative consequences of getting involved in an unprotected multi partnered sexual relationship over remaining safe in the absence of risky behaviour. Rumbidzai, the 19-year-old mother had her own misconceptions about the disease. She was very young to comprehend the complexity of the HIV/AIDS virus and her attitude showed that she lacked the familiar social norms, cultural sanctions, community taboos and familial guidance in her life. It is possible that if she was staying with her mother whom she made reference to, she would not have ended up in

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multiple sexual partnerships. It is such an example, coupled with other hardships that migrant women encounter in their everyday life that greatly diminishes their negotiating power in sexual relationships as in most instances, they may end up appreciating any financial compensation they get for having sex with unknown partners. Rumbidzai's sexual behaviour provides some interesting elements that have an impact on the hypothesis. Firstly she revealed that her first sexual debut was at nine years.

Ellen *et al* (1990) associated risky sexual behaviour to early age of first sexual intercourse arguing that this exposes an individual to multiple sexual partners. Rumbidzai mentioned that she sometimes had to have sex for five Rands just so she could get a meal. This means that she has been exposed to many multiple sexual partners in the absence of marriage and precautionary behaviour considering that she started using condoms in 2005. She however mentioned that she had never had a sexually transmitted disease which may have had an influence on her perception of risk. She described her perception of risk as low and this reveals that the association between perception of risk and level of precaution to prevent HIV may operate in an interesting way. For instance, Rumbidzai perceived her HIV risk to be low because she was considering her current sexual behaviour precautionary. But she revealed that it was appropriate to do so now as "she realised that there were too many diseases" actually influenced her perception of risk.

Another example that provides an interesting pointer to the relationship between perception of risk and level of precaution used is the one of Victoria the book keeper. It can be said that her perception of risk was actually low or somewhat passive based

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on her negative HIV tests. Victoria (24 year old book keeper) intimated that she had been using condoms ever since she started having sex at the age of 19 and had been using them ever since. She believed in their efficacy and the idea of being tested for the virus all the time.

Occupation as well as education gave light as to how women perceived the phenomenon of HIV in relation to themselves. It was noticed that Thabitha, the teacher, Victoria the book keeper, Bridget, political activist, the two domestic workers, Sarah and Loreeen, correspondent student, Eunice and Prisca, the university student were very careful in their approach to precautionary behaviour. Insistence on condom use and or abstinence was regarded as the best way to avoid infection. The hypothesis was true for these individuals. Prisca, the university student possibly because of her high education was very knowledgeable about the disease believing that getting infected was a matter of choice. She said she was only at risk if her husband decided to take on another partner and engage in risky behaviour. In her present relationship with her husband she was not using condoms. She did not mention whether this was out of the fact that they were both negative but she emphasised that if she were in another relationship with a different man she would use protection. Women who had more education knew more about HIV and though they were inclined to believe that there was a small chance that HIV could be transmissible in the presence of an STD. Unfortunately, some Zimbabwean migrant women with the least education were more likely to underestimate the transmissibility of the disease, (sex worker, unemployed young mother and others).

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It depends on what kind of an infection it is. Some people don't easily get infected (Sekai sex worker aged 32, single).

Yes that's obvious; one can get it (Paulina, single, business woman aged 29).

It just shows, it will be obvious when one is infected (Sarah, widow, domestic worker aged 43).

I think that an infected person can always show signs and symptoms but then some people say that it's not true (Paulina, single, business woman aged 29).

Some can look perfectly healthy but some you can tell just by looking at their skin. Yes but some research says that in the absence of an STI the chances of getting infected are very low so I guess it depends (Prisca, university student, age 21, married).

It depends sometimes it (STI) doesn't get passed on (Rutendo, hairdresser aged 34 separated from husband).

If you are lucky you might not get it (Nomalanga, sex worker aged 22 single).

It is assumed that a perception of already having the disease also has influence on whether one is willing to modify their behaviour or not. Avoidance of HIV testing while discontinuing high risk behaviour is an excuse but continuing high risk

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behaviour in the absence of an HIV test is something that was found to be quite common in some migrant women. The way Zimbabwean migrant women reflected anxiety or worry about HIV showed that it does not automatically mean that they will avail themselves for testing. It is assumed that when one is HIV positive they should assume more precautionary behaviour for fear of infecting others and getting reinfected themselves.

> Yes I am at high risk to HIV but I don't think there will come a time when I will be ready to be tested. Maybe when I really become sick or if I was tested against my will. I don't want to be told that I have HIV. Its better not to know because if I do I will start getting worried and then the disease will start to eat my body. To be honest to myself I think that I am at high risk to Aids because I have slept with a lot of people and sometimes without condoms. I think I am at high risk I wouldn't be surprised if I am positive but I don't want to think about it now, because many people at home depend on me to send groceries and money for fees. Everyday I have sex and every time I do it I am vulnerable the more I do it the more vulnerable I become (sex worker aged 32, single).

Some women showed that they considered their past behaviour when assessing their risk. See quote "everyday I have sex and every time I do it I am vulnerable the more I do it the more vulnerable I become" (Sekai, sex worker aged 32, single). This quotation suggests that the sex worker is presumably already having suspicious perceptions of carrying the disease. If this is true, then there is reason to believe that

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she should already be adopting self protective behaviour but her statements reveal that she is faced by the demand for money for her own upkeep as well as for her family in Zimbabwe. In the interview, Sekai mentioned that she had four dependants, as well as other members from her extended family in Zimbabwe who needed finances regularly from her at the end of the month. People at home wanted money from her and that is what she would provide even if it meant she had to sleep with a lot of men. This is part of the reasons she did not want to entertain thoughts of getting tested and then getting worried about it. Sekai has a perception that she is in a high risk group which may mean that she feels that no situation can change the particular high risk she is facing. Perhaps this is part of what is influencing her continuous risky behaviour. Pinkerton and Abramson (1997) argued that individuals sometimes rationalize risk sexual behaviour based on certain socially constructed criteria that could explain the apparent mismatch between objective risk and perceived risk so this may explain the attitude that Sekai had adopted.

In general, these findings point to the fact that perception of one's own HIV status is not strongly related to precautionary behaviour in migrant women's lives at some points. The decisions are influenced by other variables. Findings also suggest that the majority of Zimbabwean migrant women do not really understand the characteristics of how HIV develops. This makes them unable to comprehend that a false attitude about protection that may actually work against them and get them infected. For instance, the idea that a herbal portion can suck out infections and partner screening diagnosis is false. It is important to know what causes migrant women to behave the way they do as this can have important implications for health prevention. For instance, if perceptions are rational, they can contribute to a willingness to avoid risky

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sexual behaviour but as has been noted before, in real life situations, this is a very complicated exercise. These kinds of attitudes influence the level of precaution that a woman will use when having sex something which will be explored in the next theme.

4.3 Perception of risk by level of precaution used

Under this theme, adoption of safer sexual practices was looked at. The main one being consistent condom use, both the female and male. This was also tied to the assumption that if women were really worried about their protection from the disease, they would take the initiative to buy, get and keep condoms on their person, abstinence and avoidance of sex when one is menstruating or in the presence of an STD were issues that were considered. It is also assumed in the Health Belief Model (Rosenstock, 1974) that if one is HIV positive or if they suspect themselves to be, then they should adopt safer behaviour. Women believed themselves to be at low risk if they were not having sex. This is actually true. One is safe from the disease if one refrains from having sex with an infected partner or becomes completely celibate. Frequency of intercourse or discontinuation of intercourse is expected when someone believes themselves to be at risk. For instance one participant, Sarah, revealed that she had stopped having sex.

> I have totally stopped having sex. I think it's better to suffer alone because if I decide to get a boyfriend here most likely he will be a South African and he can end up abusing me and might not even help me. And most likely they will be married so that can end up creating more problems. What if the wife came

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> to beat me up? I can't take that chance. I think I am at low risk, (Sarah, widow, domestic worker aged 43).

The use of condoms is also recommended. Most respondents would say that they are at low risk because they were being faithful to their partners. But, they would reveal that they were worried about their partners. Straying and one day bringing them infection as has been highlighted above. Therefore, they perceived themselves to be at risk based on the behaviour of their husbands or their sexual partners. Many women reported that they do not use condoms on their regular partners which in itself is a risk, especially in the absence of a negative blood test. The question on whether condoms were effective or not was meant to gauge how women seriously looked at preventive measures against HIV infection. Valid and contradictory responses from Zimbabwean migrant women were recorded. The university student who for instance said;

> They are to a certain extent, if one has no experience of putting on the condom it can burst and cause problems. If one wants to get pregnant it may not be necessary (Prisca, university student, age 21, married).

> I know that both offer protection. The female condom makes noise and men complain that the ring inside makes them feel pain when they rub against it. I often use the male one because I don't want to make my customers unhappy and end up losing them. It is effective but sometimes people might want to have children and get married so it can end up messing up your plans (Sekai, sex worker aged 32, single).

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I have never used a condom before my husband died and ever since I have never had sex. If I was having sex I think it would be necessary to use them all the time to prevent infection. They say they are effective but then people are dying of this Aids so it's not clear what is happening. I think men are all the same. It would be best to use condoms with everyone especially nowadays where there are so many diseases I don't have a partner so I think I am safe and I don't want to have a partner because then I think I can end up getting Aids. I think it is very high in this country because I heard about it on TV, (Sarah, widow, domestic worker aged 43).

Abstinence is the best, that's the only thing actually. I was reading a magazine that if you take a doctor and ask them to have sex with an HIV positive person using a condom they will refuse. Why do they refuse? It can only mean that these condoms they also don't trust them. So they don't work? (Paulina, single, business woman aged 29).

Yes I take the initiative to get condoms. I don't think that they are hundred percent effective. Sometimes I get customers with big penises and the condoms are too small and sometimes they burst when having sex and you only discover that afterwards. So its not that you can really trust them. On some occasions they have slipped off and remained inside me that's when I decided I would go looking for the female ones but after the complains I had to just resort to the male one Generally I use condoms with casuals. When I come to trust someone I don't think it's necessary to use condoms. I wouldn't

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have sex while menstruating because I don't like people to see my blood. I had an injection Deprovera which prevents me from menstruating. So when my time comes its just drops so it isn't that bad. The need for money messes me up most of the time. I do however worry about getting the disease but I make sure that before I have sex I drink medicinal herbs and insert some in my vagina with the hope that I don't get infected (Sekai, sex worker aged 32, single).

They are not safe. If they really protected people from Aids, I don't think people will be suffering the way there are suffering now. I would use it with a casual partner because I don't know that person and I wouldn't trust him. Sometimes, I feel it's not necessary what if I want to have a child or to get married. All those things are all lies and they can make you sick actually. I know that the male condom can prevent the transmission of STDs/HIV/AIDS and pregnancy. I don't know anything about the female condom. I have never seen it before in my life but I think I would like to see it (Paulina, single, business woman aged 29).

Traditionally I wouldn't do that but it can depend with the partner that I have at the time. I once had a white boyfriend who did not mind having sex when I was having my period (Paulina, single, business woman aged 29).

Paulina, the 29 year old business woman seemed to have a negative perception about condoms. She argued for sometime how she thought condoms are not safe. When I queried that it is because people don't use condoms that's why they get infected, she

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just kept on insisting that they don't work and ended up suggesting that then it must be because the condoms themselves have the virus. She refused to elaborate on what she meant that they can make you sick. It is not easy to conclude whether she was really convinced about what she was saying because she said she would use condoms with casual partners. But why use condoms at all if they are not effective? It seems that she was leaving everything to chance here. In asking women if they would have sex whilst menstruating, it was assumed that socio cultural beliefs and practices known to Zimbabwean women would dissuade them from behaviour that is likely to elevate the chances of getting infected. The kind of society where one comes from or their ethnicity can contribute to their sexual behaviour through cultural beliefs and practices. For example, three women in the study mentioned that they regularly used herbs in their vaginas to make them tight for their male partner's pleasure. These kinds of assertions are not strange considering that women come from a background where they went through gendered spaces of learning through paternal aunts who emphasised the pleasure of men over the pleasure of a woman. This influences women's weaknesses when it comes to adopting safe sexual practices.

> When I have had a long relationship with someone and I know and trust that person it won't be necessary to use any condoms even if you are not tested. Sometimes when you are happy with your partner or you are celebrating about something that has happened and condoms can be boring. And I think if I want to have a baby I will stop using condoms (Bridget, political activist, aged 33, unemployed and single).

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> I think that Aids is everyone's disease and that all of us should take measures to make sure that we don't infect each other and to always test for HIV so that one can get help with ARVs before it gets bad… I use protection with everyone I don't take exceptions unless we both go for testing and we are both negative (Victoria, book keeper aged 24 single).

Again, we see the question of relationship status coming into play. The differences in the responses are apparent. For the first quoted one can gather that if a relationship has been going on for a long time, the outward appearance of a man is 'good' then having a blood test is not necessary. The issue of whether one is "safe" was an emotive one based on how a sexual partner made a woman feel. Zimbabwean migrant women's adoption of safe sex was limited by their circumstances and strategies of risk management and in particular, their biases in assumptions about their partner's sexual histories. However, the book keeper is clear about her prevention strategy, "no protection no sex" seems to be the point she is making here. For most migrant women who downplayed the issue of protection the Dossier (1990) made the observation that when women spend too much time on survival issues, their ability to adopt rational choices at the appropriate time may be compromised.

There was also the perception that condoms are unnatural when having sexual intercourse and the idea that when one is a regular partner, it follows that they are not having sex with someone else therefore condoms may not be necessary. Extraneous factors demonstrate that they have a capacity to surpass the level of precaution and

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may overshadow perception of risk. Campbell (2000) made a similar observation in her study of sexual workers at a mine area in Carletonville. In her study, she reflected that women felt that men had a duty to take care of them in the presence of a sexual relationship that had no restrictions. In a context where condoms are highly stigmatized, it strengthens the perception that condom use indicates a lack of trust and infidelity (Varga 1997). Similarly the Dossier (1990) pointed out that sociological perceptions of risk may be lessened by the creation of a sense of trust and sexual safety which can be established quickly, even over the course of a single night. It was clear in some instances who a regular partner was for certain women especially those that were married but for some women it was not clear who a regular partner was or how long it took for a man to hold such a title. What was clear was that sex itself can create trust, and trust could mean having unprotected sexual intercourse (The Dossier 1990). Thus relationship status was an important component in determining women's precautionary behaviour. Campbell (1997: 126), Walker *et al*, (2004:41) and Berger (2004:61) affirm that there is a strong psychological perception that only unhealthy people use condoms as well as associating condoms with disease which was found to be a common belief among Zimbabwean migrant women.

These results show that popular global prevention strategies do not usually concur with what most individuals perceive as effective measures to prevent themselves from getting infected (United Nations 2002). For some participants a particular perception may be reality especially when people base their decisions on unreliable unscientific diagnoses. It is important to keep these points in mind as we try to see whether the particular perceptions that women may have can be influenced by the kind of environment they are live in the next theme.

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4.4 Perception of risk as influenced by environment and the vulnerability thereof.

Brockerhoff and Biddlecom (1999) observed that the link between Aids and migration in sub Saharan Africa, though well documented, does not examine the underlying social and behavioral mechanisms in this relationship. According to them, migrants have distinct personal characteristics and sexual behaviours such as high numbers of sexual partners and low condom use that are conducive to contracting HIV. The research assumed that being in a foreign country may to some extent influence the way women perceptions of risk and their behaviour in terms of precautionary behaviour. As mentioned before, riskier sexual behaviours among migrants were attributed to three things by Brockerhoff and Biddlecom; being the predisposing individual characteristics of migrants themselves, changes in individual attributes such as separation from a spouse or partner and the exposure to a new social environment, with new sexual customs, opportunities and constraints that may encourage or force behaviour change. To this end, questions about what Zimbabwean migrant women thought about HIV in South Africa as compared to Zimbabwe were posed to them. In essence what are their feelings about this situation in a foreign country? A lot of interesting views were brought on that were similar to the findings made by Brockerhoff and Biddlecom;

> It's hard for me to answer that question. I feel that everyone can catch this disease anywhere it doesn't matter whether you are in South Africa or you are in Zimbabwe. It's all the same. I don't think that I am safe because I am still young and one day I can say this is the one and then off I go. I am very

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worried because I feel that on my own I can prevent HIV but then I have to interact with men who may lie to me about their sexual history or tempt me with their money into having unprotected sex (Paulina, single, business woman aged 29).

I think South Africa is much worse than Zimbabwe and I don't feel safe here. There are a lot of rape statistics which scares me. I am thankful that I wasn't raped when I walked from Pretoria to here on foot (Prisca aged 21, married, university student).

I think there is more Aids here than in Zimbabwe judging from what UNAIDS is saying. I don't feel safe here because there is a lot of crime and the rape statistics are very scary. I could get raped and most disturbing is that most men have a lot of sexual histories that one may not know about. They can make you feel like you are their only partner yet they are sleeping with another or two more women. No wonder people say that sex is a dirty business because can you imagine what you are getting if someone sleeps with you without a condom? It could be several things from all the other women he has been sleeping with and the boring thing is you just never know. But yes, I am scared here because it looks like South Africans have not yet accepted that there is this disease. (Bridgett, Political activist, aged 33, unemployed).

Yes there is a lot of Aids here in South Africa and I think I am vulnerable. I may get raped in this country (Prisca, University student, age 21, married).

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> I don't think I am safe in this country because of its crime rates and HIV/AIDS statistics. Its better to seek help immediately because if you let it grow inside it can end up not treatable like what happened to my friend she waited and waited thinking she would grow better but she ended up dying. I once had one but it was a long time ago and I was treated for it. It's not ok to sleep with someone with an infection. It depends on what kind of an infection it is some people do not easily get infected (Sekai, sex worker aged 32, single).

> I think both countries have got a lot of Aids and it wouldn't be wise for anyone to say that it's better in this country or that country because the risk is the same. I don't think I am safe at all especially if I start sleeping around (Thabitha, teacher aged 26, married).

Most of the responses given by women here show that they think that South Africa is heavily affected by the HIV situation compared to Zimbabwe. A UN (2005) report stated that South Africa had emerged as the leading African countries with the highest HIV/AIDS prevalence rates. When the report was released last year it received a lot of media attention and it may have been the reason why women thought that South Africa was affected more by the disease compared to Zimbabwe. Going back to the Health Belief Model we can observe that women's perceptions and their behavioral styles where sex is concerned were to some extent influenced by their prior experiences and the current environment that they were living in Johannesburg. The 43 year old domestic worker for instance was sticking to abstinence because of the potential hazards that could be brought on by taking a boyfriend. It is interesting to

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note that the majority of women were scared of being raped in South Africa and being taken advantage of by South African men. It is not clear whether these fears had fact in them. “Men have a stronger cultural prerogative over women in initiating and negotiating sexual relationships. Reasons given for men’s multiple partnering are typically biological their pursuit of sexual pleasure or their drive for sex whereas an economic rational is applied to women” (Brockerhoff and Biddlecom 1999:839). Women mostly reported using sex when they were desperate for sustenance, to get pregnant or to keep a partner for material benefits as highlighted below. This makes it particularly difficult for women to insist on condom use where transactions are involved:

> Only when I have become really desperate for money and I have nothing at all is when I can exchange sex for money. Although I myself do not like to do this because it feels like I am degrading myself sometimes I have no choice and sometimes you can’t tell the man that you need a lot of money you just tell him to give you whatever he can so that he doesn’t think that I am a prostitute. But I end up feeling like a prostitute when he gives me something like 20 rand or just goes after buying both of us some food to eat there and there (Paulina, single, business woman aged 29).

> I can do anything as long as I thing that the guy is ok and also because I will want the money you see. for me who doesn’t get a regular salary, any opportunity that presents money I have to go for it because it doesn’t make sense. For me to refuse when I know that I need the money I just have to hope that this guy is ok, (Sekai, sex worker aged 32, single).

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I always run out of money. I don't get paid well and the working conditions are bad I just keep working there because I get accommodation and there was a time when I wanted to start selling sweets and cigarettes and the madam got mad saying I wanted to embarrass her so I just sit when I am off because they don't want to pay me overtime (Sarah, widow, domestic worker aged 43).

Yes sometimes I go to different churches asking for donations. Sometimes you are forced to go with a man because you have no money and surviving is just hard but I haven't done this many times. It is not easy to do it especially if you have no experience. I have a family to support back home and at the same time have to find food to eat here in Johannesburg. At least I just want my eldest daughter to get somewhere with her education so that if I die she can take care of the others. I would just go back home especially if it's HIV/AIDS. Home is best. Violence, threats and the possibility of getting raped makes me feel vulnerable (Sarah, political activist, aged 33, unemployed).

I do run short of money especially if I can't get my regular customers then I will have to start making new contacts and new relationships. I hate to do this because with regulars you don't think that what you are doing is work it gets to a point where it just becomes part of your life that today I meet John, Peter and Andrew and then even space them out nicely to give myself room to be nice to all of them. And sometimes I can have men who refuse to pay me afterwards (Sekai, sex worker aged 32, single).

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Nothing can stop me! I am powerful enough to protect myself especially if I have the money I am the one who calls the shots. You see it is easy to control someone when you can take care of yourself (Paulina, single, business woman aged 29).

Yes, I am vulnerable because sometimes I may not be able to insist on a condom no matter how forceful I may try. Say if my partner insists that he can give me more money to get myself groceries or to buy things for my business it can look very attractive especially if he had given me some money before we had sex. So this makes me feel scared at times that why does he insist on condomless sex when both of us have never gone to those centres (Paulina, single, business woman aged 29).

I wouldn't do that. It would be better for my partner to kill me than to do sex without a condom. (Single, business woman aged 29).

Yes anything can happen to me especially if its matters to do with sex. Men can appear to be very understanding when it comes to using condoms but then end up tricking you by wanting to give you more money for sex without a condom. They can put you in a tight position especially when they know you are vulnerable and without money (Bridget, political activist aged 33, unemployed).

The other thing is that I don't want my partner or my other regular partners to leave me so I have this little plant that I know it has purple flowers and if you

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> take the green leaves and crush them into a paste you can put it into the vagina and after about thirty minutes it tightens the muscles and then you can take a shower and afterwards have sex. It has amazing results and my partner and other men I have tried it on love it. It makes them very happy and they tell me that they want to be close to me because they say its feels good when they are inside they say like I am just a virgin. I want them to feel happy but it makes me feel pain especially when they begin penetration like I am being torn apart and then later it will be ok (Tendai aged 22 unemployed).

Some of the views offered by Zimbabwean migrant women in these quotes for instance that Tendai, Sekai and Nomalanga are placing men's sexual satisfaction over theirs lend credence to arguments that are found in sociological and anthropological literature. Mainly that perception and acceptance of risk have their roots in social and cultural factors (Slovic 1987) and that when it comes to sex a man's view point has to be considered first otherwise one risks losing the relationship altogether especially where the woman is poor. This shows that while it is vital to point out that individual sexual relationships are personal they are also built on and reflect society's fundamental norms. In African society and indeed in Zimbabwe, sexual relations are power relations between men and women. From time immemorial the desire to control has always been coveted by men and this has been viewed by society as normal until gender and feminist studies began to question this state of affairs.

These assertions find support in sociological and anthropological literature and highlights that women place the pleasure and satisfaction of men over theirs. Accordingly the initial pain experienced when having sex after inserting herbs to

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constrict the vaginal walls is nothing when compared to satisfaction expressed to them by their male partners. Thus cultural practices highlight competing factors that influence a particular perception of risk.

As has been noted in the literature review it was women migrate for family or individual survival strategy Adepoju (2004). The reports by some Zimbabwean migrant women revealed that they are commercial migrants that is, entrepreneurs who are self employed, especially in the informal sector. As the author noted, women sought to make a living by selling as street vendors and traders seeking to capitalize on the relatively affluent market of South Africa to provide for additional income desperately needed at home. The social conditions of Zimbabwean migrant women were very difficult because of the nature of work they involved themselves and it is being argued in this research report that certain social conditions have a bearing on perceptions of risk and precautionary actions. These jobs like street trading, hairdressing where one is paid on the basis of a commission or waitressing do not guarantee a stable income all the time and it becomes a source of stress for women when they are not able to make ends meet at the end of the month.

4.5 The phenomenon of migration

According to Brockerhoff and Biddlecom (1999) the act of voluntary movement especially the socio economic aspects of it and with uncertain consequences and support networks at destination defines migrants to a greater or lesser extent as innovators and risk takers. Zimbabwean migrant women viewed South Africa as a threatening and different environment when it came to HIV/AIDS.

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Firstly, there was a general perception among migrant women from Zimbabwe that HIV prevalence was high in South Africa and that seeking medical help in South Africa is easier here than in Zimbabwe. The only problem that hindered them was money which made it difficult for them to seek medical attention. Only one migrant woman mentioned that one might be asked for ID papers by medical staff. Most women found it easier to say that if they fell ill in this country they would go to the clinic. The only worry is that most said they would wait to see if their problem would go away on its own first before getting medical attention. To use the words of one migrant woman "the body can heal itself sometimes."

Secondly, expectations women bring with them from the home country may also influence perception. Most migrant women that were interviewed revealed that they came to South Africa after having been promised a good life by their relatives and were later let down. This made them resort to what they had not planned for. The university graduate, for instance, came to South Africa after her aunt had told her that she would help her to find a job but she realised too late that her aunt was involved in prostitution and trafficking of unsuspecting young women. There is the other case of the domestic worker who when she phoned her uncle to come and fetch her from the Park station switched off his cell phone. The post-migration experience had been a disappointing one for almost all the respondents. Women explained how they were disappointed in not getting the necessary support from their relatives who were resident in the country. They explained how difficult it was to make ends meet as money was not easy to come by.

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> I was being harassed in Zimbabwe for political activities. I used to stay in Pretoria and had to come to stay at the Methodist shelter because I had no where else to go (Bridget, Political activist aged 33 unemployed but a part time student doing a secretarial course).

> I am a sex worker. When I came here I was leaving with a distant relative. I stayed with her for about three months and then she started complaining that I was just eating and doing nothing in her house and to make matters worse I couldn't get a job quickly so she started becoming moody every morning before she left for work and in the evenings when she came back from work (Sekai, sex worker aged 32).

Sekai drifted into sex work as a result, others resorted to survival sex when they realised that either their incomes were too meager to support them or that they had no income at all. Some did neither of these and decided not to involve themselves with risky behaviour for fear of the consequences. The IOM also noted this about migrant women behaviour; threatened with the possibility of long periods of unemployment and ungainful livelihood, women may find themselves being forced to resort to sexual networking partnerships which expose them to risk of becoming infected with HIV/AIDS (IOM 2003).

This seemed possible for some but the worry was Prisca, the 21 year old university student. I wondered how long she would be able to manage, considering that she had no job or money of her own. She seemed particularly vulnerable and she complained of hunger all the time. The women who were staying at the Methodist shelter were

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living in very poor conditions. From observation, the place was dumb and humid. A site of abject poverty greets any visitor; it is dingy and crowded with adults and children as well as people's belongings saddled in corners. Bedding lines the floors only leaving narrow gaps for people to pass. It is here that I found the political activist, the university student, the correspondence student and the young unemployed mother for inclusion in the research. Occupants had to fend for themselves at times. Food was a concern particularly heightened by the fact that the church had no money at the time. It was a situation of survival of the fittest in the sense that those who had their own food would cook and eat alone in the presence of other occupants. Such an environment can prompt one into transactional or survival sex based on the social setting that one is living in.

It can be said that the migration experience itself may have an influence in the high risk taking behaviour of migrants in a post-migration setting. Adejopu (2003) argues that for other women who migrate to economic centres without an education, marketable skills or knowledge of available income earning opportunities, informal and formal prostitution is one of the means immediately available to earn sufficient money for self support and to send remittances to relatives. This was found true in some of the accounts that women reported especially by two sex workers, Sekai and Nomalanga. Orubuloye *et al* (1992) also observed that in the past, resorting to commercial sex has been common among divorced, single or separated migrant women. Female migration arguably exposes women to potential sex partners as well as removing behavioral concerns. Movement from kin reduces women's leverage in sexual negotiation. For some, mobility can result in reduced awareness of and access to family planning including condoms at destination. This point may not be relevant at

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this time 2006 as condoms are available free of charge in South Africa. Oliver Kubikwa, who manages the Zimbabwe Political Victims Association situated at the Methodist church shelter in Braamfontein were some Zimbabwean migrant women where staying confirmed that condoms were easily accessible and available to women resident there. Women can access them for free in toilets and clinics, doctor's private rooms and indeed anywhere else.

> I came here to find employment. I don't have much of an education I failed my Ordinary level but I have a good form 2 certificate. But even though, I couldn't find a job in Zimbabwe. So I decided to come here to Johannesburg because I here it's very easy to meet a lot of people and to make a lot of money (Sekai, sex worker aged 32, single)

> I am a sex worker. When I came here I was leaving with a distant relative. I stayed with her for about three months and then she started complaining that I was just eating and doing nothing in her house and to make matters worse I couldn't get a job quickly so she started becoming moody every morning before she left for work and in the evenings when she came back from work. So one day when I was out to buy some bread I met a woman who was speaking Shona so I started talking to her and then she told me that jobs are not easy to come by here in this country and then she looked me up and down and told me that with the way I looked I could make a lot of money. So I asked her what she meant and she said here men pay a lot of money to be with a woman who looks good. I asked her if she was referring to prostitution and

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she said no but if I was interested she said I should leave my relative and come and live with her while I got trained. So we arranged to go to her flat later in the day for she said she also stayed in Hillbrow. Later, when I went there I realized that she was leaving a good life style she had everything and even bought some take aways for us while she told me that you can get paid for escorting business executives to their evening dinners. I found it quite interesting and told her of my interest. So that very same day I told my relative that I had found a job and she was surprised when I told her what it was. She was very suspicious and said it sounded like prostitution and said she hoped it wasn't and wished me well. She didn't tell me that I could come back if anything went wrong. I think she was relieved to see me go. So, anyway, I discovered that I had to have sex with these men in addition to escorting them to the dinner parties which was just a once off thing (Sekai, sex worker aged 32, single).

I was at the University of Zimbabwe in my first year studying Psychology and then my aunt who lives here invited me here saying that she would be able to get me a place at UNISA and that I would be staying at her house. When I came here, I was shocked to realize that my aunt leaves in a shack she used to bring us pictures of her house and she would always be driving different nice cars. But when I came that very evening a big nice car with 2 Nigerians arrived and they were welcomed into the house by my aunt who started telling them that she had brought someone who is fresh and if they wanted to find out she would bring her out. I was sitting in the other side of the shack and I just

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got suspicious when she called me and said she wanted me to meet some good friends of hers and that I was supposed to be nice to them otherwise she might have to send me back to Zimbabwe. The Nigerians started asking me what styles of sex I was good in. I was so embarrassed and said I needed to be excused to go and wee in the bush since they had no toilets in the shack. Thank God because I didn't trust my aunt's shack I always carried my passport in my breast I just walked out of the shack into the bush and never came back. That's how I came to be staying in this shelter. Here we are always hungry because sometimes there is no money for food and some people here who have money buy their own food and eat by themselves. I have lost a lot of weight and what hurts me most is that my husband and the rest of the family think I am here and I am going to be doing my studies they don't even know that I am suffering. The Methodist Bishop promised to get me a place to study nursing so that I can study and make money at the same time so that's why I am still here(Prisca, University student, age 21, married).

I came here because I had been working in Zimbabwe as a trader and I had stopped making profit from the fruits and vegetables I was selling. So I thought that since Johannesburg is well known for being commercial I decided to come here and do the same. But here I don't sell vegetables I sell various sweets cigarettes, maybe some nail polish and occasionally some fruits if I can tell that they can go fast because I don't want them to get spoiled and end up throwing them away(Paulina, single, business woman aged 29).

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> I was working as a cook at a teachers college in Bulawayo and then I was suddenly told that my job was finished. So I decided to come here so that I can work and support my children back home. My husband died a few months after I stopped working so I had to do something to save my children from poverty (Sarah widow, domestic worker aged 43)

> Here it is easy to get medical care but they don't give you much medical attention. They just listen to what you are saying without giving you a proper examination. They don't like foreigners. In Zimbabwe it's good but no drugs (Sarah, political activist, aged 33,single and unemployed)

Another mechanism that was noted that had an influence on sexual behaviour was the issue of the absence of support networks from the family. This was observed in migrants who were of a young age. It was noted that migrants who were between the ages of 19-26 were the most misinformed about HIV in terms of whether there was a cure for the disease or not and basically providing conflictual information about their perception of risk and their precautionary behaviour. Women who get initiated into sex at an early age are more likely to be engaged in high risk behaviour. This is noteworthy for the unemployed 19 year old Zimbabwean woman. She reported that she had started having sex at the age of nine and that she had only started using condoms the previous year 2005 after realizing that "there were too many diseases." She described her perception of risk because she reported that she was using condoms consistently to prevent diseases. She based her perception of risk on her present behaviour to mean that since she was no longer indulging in unprotected sex then she

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is now safe from the disease. What Rumbidzai did not consider was the fact that her past behaviour may have already exposed her to infection especially as she had not gone for a blood test. In contrast to Victoria the book keeper who is a little older than Rumbidzai being 24. She reported that she was involved in a multi partnered sexual relationship but was consistently using condoms all the time differences in their cases can be noted. Firstly Victoria is right that her perception of risk is low because she has never had unprotected sex before. She mentioned that she had been suing condoms all the time ever since she started having sex at the age of 19 and she really believed in their efficacy because she had tested negative for HIV. This shows that in an environment where a young woman may not have access to familial norms for guidance or access to information they can end up making the wrong choices in their sexual lives. This can be seen when one has an unwanted pregnancy which resulted in a baby. Rumbidzai fervently wished to raise money so that she could go to Zimbabwe to leave the baby with her mother. She revealed that she sometimes slept with men who gave her only five Rands. A situation where migrant women are presented with challenging choices where sexual matters are concerned is raised here. What informs women to have the kind of sex they have? We shall try to explore this in the next theme concerning sexual decision making.

4.6 Sexual decision making.

Without financial independence it is quite difficult for women to make confident decisions about the use of protection in sexual relations, an inferiority complex resulting in an inability to control their lives. This is so especially when a woman is poor and needs money and material things for basic sustenance, studies argue that they risk losing financial security Meursing and Sibindi (1995). Women with some

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degree of financial security were confident about taking appropriate preventive sexual behaviour; Sarah, Prisca, Wandi, Victoria, Thabitha, Ruth and Eunice. These participants were involved in stable partnerships, which points out that for others it may be complicated for a woman to insist safe sex from a man she hardly knows. Some Zimbabwean migrant women in the study revealed that at some points not using precautionary behaviour lay in the belief that that submission is the only way to guarantee financial security. The fear of her losing partners is justified because men have been known to desert or reject their partners when a woman enforces sexual behaviour that they do not like. Men have been reported to go ahead and seek sexual satisfaction from other women; Meursing and Sibindi (1995).

Wandi, aged 20, a student, was confident that her partner would never force her to have unprotected sex as he was well aware of her goals in life and she also reported that she did not have anything standing in her way where precaution was concerned. This participant a unique one in the sample, considering that she was a dependent here in South Africa. She said she was a student staying with her uncle and aunt whom she was dependent on for her stay in this country. Wandi said if she ran out of money she would just wait until her guardians made it available to her. Wandi, despite her young age, was knowledgeable about the way HIV is transmitted and mentioned that "sleeping around was dangerous." More importantly was the fact that she was still leaving with guardians which would be a constant reminder that she should not misbehave especially as they were taking care of all her needs. She seemed quiet content with her status and did not wish to supplement her income by doing anything else. Her example shows that her beliefs and knowledge about perception of risk and level of precaution were in line with the assumption of the hypothesis. Being content

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for the respondent in this case meant that she felt safe and secure having weighed the negative consequences of getting involved in a multiple partnered sexual relationship which would predispose her to HIV infection. It also revealed that she has the power to make sexual decisions.

Migrant women experience many obstacles when negotiating safe sex which exposes them to the vulnerabilities of HIV/AIDS. Some women mentioned that their inability to dictate what they wanted in a sexual relationship was influenced by financial constraints. Migrant women's priorities were noted to be economic, recognizing that most of them migrate primarily for economic reasons and a better livelihood. Women reported having sex for as little as five Rands when they were desperate or having sex for a meal. Eleven of the participants said that when they had money they could confidently tell a man to put on a condom and refuse sex when he declined to put on one. Some resignedly noted that if they were forced into unprotected sex by their partners for fear of being denied economic livelihood then they would have to accept because they would have no other choice, especially when there was the hope of eventually getting married to one's sexual partner. Findings presented in the research indicate that it is very challenging and difficult for migrant women to insist on condom. South African men were identified as tending to take advantage of migrant women's desperate position and their being foreigners.

As mentioned before, the African epidemic is understood as one in which women especially poor women are significantly more vulnerable to HIV infection than men. The vulnerability has been based both on biology and the lower social status of women (Berger 2004, *Walker et al* 2004). When women have sexual partnerships, it

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emerged that their behaviour is largely not “shaped by the conscious decisions of rational individuals” (Campbell, 1997:7) with knowledge about long term negative consequences of risk playing only a minor role in sexual behaviour change. Expectations that Zimbabwean migrant women had coupled with the prevailing socio-economic circumstances was an explanation to their risky sexual practices.

Where a partner is chosen or whether self protective behaviour will be adopted, in this case, condoms, was based on perceived cultural and social factors as well as understandings of the disease. Women sometimes left men to make this decision for them if they had no pressing worries like the need for money for immediate survival. Women engaged with these beliefs that a man maybe a low risk partner to rationalize their anxiety about HIV/AIDS while continuing behaviour they found challenging to manage. It can also be assumed that women may be employing this strategy in order to avoid contact with someone who is infected, that they are safe by doing this and that their own risk is will not be compromised during the sexual encounter. For others, it was a sincere belief that their partners are ‘clean’ and it is the argument of this research that more engagement with misconceptions is necessary if potential impact resulting from factual information is to be achieved.

Selectivity based on mood about the “condomise message” was rampant among Zimbabwean migrant women and the type of partner they were in a relationship with at the time. When migrant women were generally, in a happy frame of mind with their partners after having been provided with groceries or celebration of some occasion condoms were not used. Fluctuating perceptions of risk could be noticed when women were faced with strong emotions like happiness, possibility of getting married

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or getting pregnant. A situation like this implies that one cannot contract the virus when one is in a happy mood. This signifies that it is at such points that participants engage in high risk sexual behaviour and lower their perception of risk. In future it may be interesting to see how consistency of condom use or other precautionary behaviour can decrease perception of risk, considering that it was not the hypothesis of the study.

The other reason I am saying this, is that, there seemed to be a resistance in some of the women to buying and keeping condoms. There was the belief that keeping condoms is a sign of prostitution and engaging in too much sex/prostitution rather than for protective reasons for both partners. It cannot be entirely concluded that the decision to use protection is left to the men entirely; sometimes women mentioned that they can resist the use of condoms for sexual pleasure or reasons to have children and to get married as highlighted above. This heightens women's risk to infection. So again, in the end, the onus of weighing the risk of contracting HIV and or the benefits of having unprotected sex at the time lies with the Zimbabwean migrant woman herself. See the quote below:

> No. I wouldn't that you see I am a good African woman and I should be seen to have good manners. Now if I am seen with condoms or buying condoms, what would people think? What about my partner? He would start to think that I do prostitution (Paulina, single, business woman aged 29).

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However what stands out from these statements is that power relations, cultural beliefs, expectations from the sexual relationship and mental images of the appearance of potential sex partners determine the extent to which women are able or unable to protect themselves against sexually transmitted diseases, pregnancy and unwelcome sexual acts as asserted by Wood and Jewkes (1997). These factors then go on to influence women's perceptions of risk.

4.7 Discussion

Zimbabwean migrant women who reported that there was no chance of infection through one sexual contact with an infected man were more likely to believe that they were not infected and not at risk. Migrant women's perceptions of risk in both Zimbabwe and South Africa were associated with their personal anxiety of HIV/AIDS infection. Perceptions about HIV transmission speeds and the possibility of infection appears to have many different effects on Zimbabwean migrant women's perceptions of their own personal risk and on their methods of precautionary behaviour.

The association propounded by the hypothesis that perception of risk should be positively related to precautionary behaviour was not proved in the expected direction. Aspects of personal assessment of HIV risk, worrying about HIV, health seeking behaviour of migrant women including getting tested for HIV and their behaviour were not related. It may be assumed that women are more concerned at avoiding a male partner with HIV to protect themselves from this disease than to prevent themselves from the actual reality that a partner is HIV positive. It's not conclusive whether this 'prevention' strategy comes because women think that they

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are safe when they avoid 'HIV positive men.' Or because they really believe that their personal risk to infection is not associated to sexual transmission either because they drink herbal portions that suck out infections if any or their infrequent sexual acts.

While the health belief model asserts that individuals are normally motivated to adopt preventive behaviour when they know and understand infection routes. It further points out that, because of this motivation, people can create a relationship between personal behaviour and the perceived risk of acquiring HIV. By this, we take it to mean that those who believe that they are not infected will take the necessary steps to keep it that way and that those who believe they are infected will take the necessary steps to avoid their re-infection and worsening their condition and also to protect the health of their partners. Findings for some indeed revealed this connection. Could there be denial or misconception on the part of the other women? Whatever the case, it is such examples that are spreading HIV/AIDS infection and this needs to be corrected.

When examining the perceptions of migrant women by their social demographic qualities, it was found that older women were more likely to think that acquiring HIV was a deadly consequence. Most reported how they had had relatives who had suffered and died because of the disease. They were more likely to believe that HIV was not that transmissible as well as that it had no cure and that HIV was much higher in South Africa. They thought that their perception of risk was high only because of the rape statistics in South Africa, but in actual fact, their risk was low as they reportedly did not indulge in high risk behaviour. Respondents who had a higher education in this case the political activist, accountant, teacher and university student

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were more likely not to overestimate the transmissibility of HIV and to confirm that condoms and fidelity were effective. This points out to the fact that these individuals had greater access and understanding of the scientific knowledge that revolves around the subject of HIV/AIDS. One was even quoting the UN Aids report and recent news and making some agreeable country comparisons between South Africa and Zimbabwe. Younger women appeared to be quiet misguided about the disease. Single women were also more anxious about the disease. Perceptions about HIV risk and level of precaution used by Zimbabwean migrant women in this study were on occasion influenced by other things and not strictly the hypothetical relationship that was expected.

These results indicate that there is a complex relationship with this assertion, simply knowing and understanding risk does not necessarily mean that one will not adopt risky behaviour. Even knowing that the disease results in a slow deterioration of the body seems not to count. If it does the concern is not immediate. In real life, people do not necessarily behave in a manner that is expected. I suggest that for further studies on this complex subject both quantitative and qualitative models need to be employed to unpack the nuances involved in perceptions of risk and levels of precaution used. I suggest that there is need when designing HIV prevention programs to take into account how people make sense about the information and knowledge they have about getting infected.

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Chapter 5

Conclusion and recommendations

5.1 Introduction

This chapter presents the conclusions of the research on perception of risk and level of precaution used to prevent HIV/AIDS among Zimbabwean migrant women living in Johannesburg. It also offers suggestions and recommendations for further academic research and policies.

5.2 Conclusions

When conducting analysis of the raw interview data from participants using thematic analysis, it was observed that the relationship between perception of risk and precautionary behaviour was difficult to understand. When asked the question whether they thought they were at high or low risk most (13) participants tended to identify their risk perception as low but when other factors they mentioned were taken into account, their perception of risk emerged as high. However, their statements were qualified with their worry over survival issues which contributed to unprotected sex or their male partner unfaithfulness. Participants tended to identify their own perception of risk as being low yet their precautionary behaviour did not indicate consistency with this belief. This behaviour of perceiving oneself to be at low risk yet practicing high risk sexual behaviour was also observed by Campbell (2000) and Varga (1997), Walker *et al* (2004), Berger (2004), Sandala *et al* (1995) and Wood and Jewkes (1997).

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Poppen and Reisen (1997) and Pinkerton *et al* (2000) have pointed out that the association between perception of risk and risk behaviour as one that is always changing such that it can overshadow the influence of perceived risk on behavior. For example, the hypothesis assumed that the perception that one is at risk may lead to a reduction in risky behaviors, which should lead to an altered view of one's risk.

The study of perceptions of risk and level of precaution used among Zimbabwean migrant women leaving in Johannesburg revealed that there were three types of relationship strategies against HIV/AIDS mostly used by women, that is, casual encounters, serial monogamy, and extended relationships. It was revealed that migrant women at times greatly overestimated/underestimated their risk of contracting HIV for these types of relationship strategies. At some points Zimbabwe migrant Three women did not realise that in the these relationship strategies, there was one where if both partners remained faithful and HIV negative the likelihood of getting infected is significantly reduced. Again, migrant women in the absence of condoms placed most relationship types on the same risky level arguing that men can never be trusted and that it is better to remain single or to take herbal concoctions. This is according to individual perceptions of migrant women's risk to HIV infection discussed above.

However, some Zimbabwean migrant women appeared to have a firm grasp of what their perception of risk was in conjunction with the level of their self reported behaviour discussed in detail in Chapter four. Sometimes, it is possible that people may underestimate their risk perceptions due to misunderstandings as was found in the research on Zimbabwean migrant women. Persons perceived to be involved in high risk behaviour like Sekai and Paulina to mention for example and to conclude are perceived as being at higher risk of infection, but then, this situation highlighted that

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in some cases participant's responses of their risk perceptions may be accurate or inaccurate. A situation like this presented a challenge of when is a low risk judgment unrealistically optimistic and when is it an accurate reflection of the risks faced by respondents?

The independent variable that is perception of risk and the dependent variable, level of precaution used highlighted that while both variables were trying to explain each other, it was found that the relationship occurs either way. This was because of intervening variables like post-migration factors, age, occupation, marital status to predict their attitudes towards perception of risk and level of precaution used to prevent HIV infection.

However, the research revealed that migrant women's perception of risk was at times overshadowed by their feelings, where, if they were happy, wanted to have a baby or just to enjoy sex and certain survival concerns. Their risk perception appeared to become inactive where they thought they had to fulfill certain concerns in their lives even in the absence of an HIV test. It raises the questions whether migrant women's perceptions of risk at these times is due to misunderstanding of how HIV is transmitted. It is likely that competing priorities may have had an influence on their perceptions as well. Or did their frame of minds at the time that prevent them from acting rationally as individuals who are susceptible to the disease at all times especially if both partners are not tested?

All women, except one, mentioned that HIV could be transmitted through only one unprotected sexual intercourse with an infected partner signifying high perception of risk. It is possible that women's decisions to have unprotected sex with their partners

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when they were happy about something may have been overshadowed by the fact that they judged their partners status simply by assessing whether they looked healthy or not. Trust also emerged to be an important factor when arriving at the decision of whether or not to use precaution. It is possible that their ability to perceive their risk yet not act on it covers the potential association between perceived risk and actual behavior.

This has an impact on the hypothesis in that, the results show that migrant women's adoption of safe sex was limited by their circumstances and strategies of risk management and in particular their biases in assumptions about their partners' sexual histories. Two things seemed to be occurring; firstly, other factors that influence perception of risk had the effect of decreasing it at certain points, for instance happiness, trust, wanting to have children or getting married. Secondly, the perception may be high but in the face of poverty and survival concerns, Zimbabwean migrant the women were choosing to downplay or ignore it. As highlighted, there are several competing variables which influence women to use or not use precaution when they have sex and this influences their perception of risk.

The author agrees that there are factors that affect the association between precautionary behaviour and perception of risk and these factors overshadow perception of risk. The association in hypothesis, which is propounded by various studies is too simplistic in that they fail to consider that poor women think of their survival first when it come to precautionary sex and getting Aids much later. Models of protective behavior, for instance, the Health Belief Model argues that one's psychological capability of sensing risks associated with sex is a very significant

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requirement for one to adopt self precautionary risk reducing behavior. A better explanatory model would be that perception of risk is influenced by sexual behaviour whether it is precautionary or not. Nevertheless, the results should not be interpreted as conclusive and unquestionable truths but it does offer debates and insights on the subject of HIV/AIDS and how it is perceived by some migrant women.

5.3 Recommendations

Implications of this study on perceptions of risk and level of precaution were complicated and not easy to discern. In accordance with the results the following suggestions are recommended

1. Given the high numbers of migrant women in South Africa and the severe impact HIV/AIDS has in this sub-region, there is need for better understanding of Zimbabwean migrant women's socio-economic positions and need to improve these with empowerment programmes so that there is discontinuation of unsafe sexual practices as a basis for economic survival and possibility of HIV infection.

2. Further, research is needed into the specific cultural practices that make migrant women adopt risky sexual behaviour and the unequal power relations that exist between men and women. Research into migrant women's

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personality and its relatedness to risk and vulnerability towards HIV are also important.

3. There is need to use both qualitative and quantitative methodologies to shed light on perceptions of risk and level of precaution used. For example, qualitative data can be used to understand social processes while quantitative data can be used to examine associations and their statistical generalisability for general populations.

4. Despite displaying a high level of knowledge and awareness about how HIV is transmitted and means of protection, their knowledge about whether the disease can be cured remained unclear. Migrant women should be provided with educational programs that dispel myths about the cure of HIV/AIDS.

5. Migrant women face the greatest exposure to HIV infection because they are absent from their homes for long periods of time. This gives them access to potential sex partners, sometimes with many people. A workable intervention is needed so that they can be protected together with their partners, as well as for the promotion of migrant workers to be encouraged to live together with their families.

6. The areas where migrant populations live (Hillbrow, Yeoville, Berea and others) would benefit well if they are renovated and improved. This is because there is an understood connection between social and living conditions and the spread of HIV.

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7. Psychological, sociological and anthropological theories as highlighted above have sort to explain these discrepancies but it is clear that there are other societal complexes that compel women to adopt unsafe sexual practices. These need to be examined.

8. Lastly, the methods used for data collection could be improved. Instead of using semi structured individual interviews, focus group discussions could be used to elicit more interaction and more open responses from participants as the method employed in this research was restricted by its sensitive nature on a one to one basis with the researcher.

9. Therefore a step towards understanding perception and behaviour can provide inroads to massive behavioral change away from risk taking to safer behaviour where condom use is promoted as an answer to HIV prevention. This is because what is unknown is the fact that the choices that women or other individuals in general may not always be rational. Results obtained indicated that it is very complex to accept and engage with text book definitions of perception and behaviour. In real life this relationship is much more complex and is not easy to comprehend.

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Appendix:

Questionnaire[2] **Questionnaire No…….**

Date of Interview:----------
Start Time:----------
End Time:----------
Respondent Code:----------

Perceptions of risk and level of precaution used to prevent HIV/AIDS infection. A study of Zimbabwean migrant women living in Johannesburg.

To be read to all before the beginning of the interview.

How are you? My name is Pascalia O Munyewende from the Department Of Forced Migration Studies at the University of the Witwatersrand, Johannesburg. I am inviting you to participate this study that seeks to understand perceptions of risk and the precautions that are used to prevent HIV/AIDS infection by Zimbabwean migrant women who live in Johannesburg. I need to know what you think or whether you are concerned about risk to HIV/AIDS and what you are doing to prevent infection. I do not work for the government or any aid organization; this study is **mainly** for academic purposes.

Please note that apart from my appreciation, I do not promise any compensation for your participation. Participation is voluntary you do not have to take part if you do not want and no harm will come to you by choosing not to be involved. You can refuse to answer any question at any time and can stop the interview if you feel you would not like to continue. The information you give me and your identity will be kept strictly confidential. I will not write down your name or contact details unless you want me to contact you at another time. Even in that case, it will not become a part of the research documents. The interview will take about 45 minutes to complete. I will give you useful addresses of organisations that work with migrant women in the areas of health and HIV/AIDS We can cover any issue or questions you are concerned about at the end of the interview.

Do you give verbal consent to participate in this study? Yes□ No □
Signature of Investigator _____

1Questions are drawn from Smith P.K and Watkins C S, (2004) Perceptions of risk and strategies for prevention: responses to HIV/AIDS in rural Malawi, the Southern African Migration Project (SAMP) and other similar researches.

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Background Information

1. What is your age? --------
2. How many dependents do you have?
3. When did you start living in South Africa?
4. What were your reasons for coming to South Africa and wanting to stay in? Johannesburg?

5. What is your usual occupation?

6. Do you ever run short of money? If yes, how do you supplement your income?

Perception of risk

7. Have you ever taken care of a lived with someone infected with AIDS or has any relative friend or colleague of yours ever died of AIDS?

8. What are your feelings and perceptions about HIV/AIDS in South Africa, do you think you are safe from HIV/AIDS in South Africa or as compared to Zimbabwe?

9. Do you know of any Voluntary Counseling and Testing (VCT) centers?

10. How do you think you can protect yourself from HIV/AIDS?

11. Would you have unprotected sex when you didn't want to because you were afraid of what your partner might do to you either denying you money or

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threatening violence?

12. Are you afraid of getting HIV/AIDS? Do you consider yourself to be at low or high risk to HIV/AIDS?

Condom use

13. What do you know about HIV/AIDS, do you think it can now be cured?

14. Do you think a person infected with HIV always shows symptoms or can such a person look perfectly healthy?

15. Do you think you could become infected through only one unprotected sexual contact with an HIV infected man?

16. Would you say you are vulnerable to or at risk to HIV/AIDS?

17. What do you know about the male condom/ female condom?

18. Which one do you use regularly?

19. Do you think it is necessary to use condoms every time you have sex?

20. Do you usually take the initiative to get condoms?

21. Do you think condoms are effective in preventing HIV/AIDS? Why or why not?

22. Would you use a condom with your regular partner or with a casual partner?

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23. Are there times you feel it is necessary not to use a condom?

24. Do you think contraceptives can prevent you from getting HIV/AIDS, would you use them?

25. Would you have sex during menstruation?

26. Do you think that there is anything that prevents you from using precaution against HIV/AIDS?

STDs and Health Issues

27. If you fell ill in this country what would you do?

28. Do you think it is easy to seek medical attention in general or here in South Africa than in Zimbabwe?

29. If you experienced any sexually transmitted infection do you think it will be necessary to seek help immediately or to wait and see if the infection will go away on its own?

30. Would you tell your partner/s about it?

31. Has a doctor or clinic nurse ever told you that you had an STD?

32. Do you think that it's ok to sleep with someone with an infection?

33. Do you think the infection can be passed on to someone during sex?

34. Are there any questions you would like to ask me?

Thank You for Your Time.