INCLUSION OF DRY SEX AND POLYGYNY IN HIV AND AIDS BEHAVIOR CHANGE PROGRAMMES: CASE STUDIES FROM SELECTED NGO'S IN THE ZAMBEZI REGION, NAMIBIA

A DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENT OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN SOCIOLOGY

OF

THE UNIVERSITY OF NAMIBIA

BY

IMMACULLATE MOGOTSI

STUDENT NO: 9324380

SEPTEMBER 2022

MAIN SUPERVISOR: PROF LUCY EDWARDS-JAUCH

CO-SUPERVISOR: DR ARTWELL NHEMACHENA

UNIVERSITY OF NAMIBIA: DEPARTMENT OF SOCIOLOGY

ABSTRACT

This study explored the cultural practices of dry sex and polygyny that could potentially perpetuate HIV. The study further enquired whether the two cultural practices are included in HIV and AIDS behaviour change programmes. Dry sex refers to a phenomenon where women insert herbs into the vagina to reduce vaginal lubrication during sexual intercourse. The practice is associated with tearing and cuts of the vaginal wall and glans of the penis, and this heightens the risk of contracting HIV. Polygyny refers to a practice where one man is married to more than one wife at the same time. Such marriages are an institutionalised form of concurrent sexual partnerships which can also increase the spread of HIV by creating more connected sexual networks.

The objective was to explore dry sex and polygyny that might promote the spread of HIV among women, as well as assessing HIV and AIDS behaviour change programmes adopted culturally appropriate and sensitive prevention strategies.

A focused ethnography method which consisted of in-depth, semi-structured interviews and focused observations with field notes was employed. In total, 33 participants from non-governmental organisations, traditional leaders, traditional healers, Life Skills teachers, instructors of Sikenge (girl child initiation instructors), men, women, youth and staff members from Ministry of Health and Social Services and the Zambezi Regional Council that are responsible for HIV and AIDS Behaviour Change Programmes were interviewed. The research sites were in Windhoek, Kabbe and Katima Mulilo.

The study employed Vygotsky **Social Constructivist Theory** which views human development as a socially mediated process in which individual acquire their cultural values, beliefs and problem-solving strategies through interactions with other members of

society. Hence, practices such as polygyny and dry sex are learned through social interaction. **Connell's Theory of gender and power** was also employed to illustrate sexual inequality, gender and power imbalance perpetuate women's vulnerability to HIV.

The findings indicate that the cultural practices of dry sex and polygyny were commonly practised in Kabbe and Katima Mulilo. Despite the risk of HIV associated with these cultural practices, behaviour change programmes had responded differently to address them. For example, none of the interventions had targeted the practice of polygyny directly. Similarly, no targeted interventions had been devised to address dry sex; hence, the practice persisted. This study, **concludes** that it is imperative to devise HIV interventions that are culturally appropriate and sensitive. Cultural practices such as dry sex and polygyny should be included in HIV and AIDS behaviour change programmes.

Keywords: cultural practices, dry sex, polygyny, women, HIV and AIDS behaviour change, NGOs.

LIST OF PROCEEDINGS

Mogotsi, I. (2019). Inclusion of the cultural practice of dry sex in HIV and AIDS behaviour change programmes: A case study from the Zambezi region, Namibia. In Mlambo, N (ed). Vol 1. Page 45-59. Conference theme: "The Africa we want: Wealth creation for sustainable growth and social transformation", 3rd Multi-disciplinary Research Conference.

Mogotsi, I. (2021, 12 to 15 October). Traditional authorities and gender-based violence prevention. *Paper presented at a workshop training of trainers (TOT). Workshop for developing a strategy for engaging traditional leaders in addressing gender-based violence (GBV).* Organised by Ministry of Gender Equality Poverty Eradication and Social Welfare, Swakopmund. Namibia.

TABLE OF CONTENTS

ABSTRACT ii
LIST OF PROCEEDINGS iv
TABLE OF CONTENTS v
LIST OF TABLES ix
LIST OF FIGURES ix
LIST OF ACRONYMS x
GLOSSARY OF TERMS xii
ACKNOWLEDGEMENTS xvi
DEDICATION xviii
DECLARATION xix
CHAPTER 1: INTRODUCTION OF THE STUDY 1
1.1 National Policy on the inclusion of harmful cultural practices in HIV and AIDS behaviour programmes 1
1.2 Situating the concept of culture within the discourse of polygyny and dry sex and HIV transmission 2
1.3 Statement of the problem 4
1.4 Justification of the study 6
1.5 Objectives of the study 11
1.6 Significance of the study 11
1.7 Limitations of the study 12
1.8 Delimitation of the study 12
1.9 Outline of the dissertation 12
CHAPTER 2: LITERATURE REVIEW 14
2.1 Introduction 14
2.2 Practices that perpetuate HIV in the Zambezi region 14
2.2.1 Polygyny and the risk to HIV and AIDS 15
2.2.2 Dry sex and the implications for HIV 16
2.2.3 Lack of knowledge about HIV and AIDS 18
2.2.4 Women's economic dependence heightens their HIV vulnerability 20
2.2.5 Silencing of female sexual pleasure 21
2.3 Women in sub-Saharan Africa most vulnerable to HIV and AIDS 26
2.4 Cash transfer incentives to empower women 29
2.5 Namibian National HIV and AIDS Policy Framework 32
2.6 HIV and AIDS behaviour change programmes 34
2.7 Key populations disproportionally affected by HIV 39
2.7.1 Sodomy law and criminalising MSM inhibit health-seeking behaviours 41

2.7.2 LGBTI community continues to experience discrimination and stigma 41
2.8 Origin and history of HIV and AIDS 43
CHAPTER 3: THEORETICAL and CONCEPTUAL FRAMEWORK 48
3.1 Introduction 48
3.2 The Social Constructivist Theory 48
3.2.1 Social Constructivism and human sexuality 51
3.3 Connell's Theory on gender and power: Explaining women's vulnerability to HIV and AIDS 55
3.3.1 Unequal sexual division of labour exposes women to HIV vulnerability 56
3.3.2 Gender power imbalances heightens women's vulnerability to HIV 57
3.3.3 Condoning violence against females as a disguise of culture 59
3.4 Justification to merge Vygotsky's social constructivism and Connell's theory of gender and power 59
3.5 Biomedical theories that inform HIV and AIDS behaviour change programmes 60
3.5.1 Biomedical intervention of curbing HIV and AIDS 62
3.6 Cultural practices and the link to HIV and AIDS 64
3.7 The need for cultural sensitivity in HIV and AIDS prevention 65
3.8 Social Constructivism theory in linking polygyny and dry sex to HIV 69
3.9 Connell's theory of gender and power: linking gender norms and HIV vulnerabilities 71
3.9.1 Gender power imbalances: agency-structure 73
3.9.2 Social Structures that perpetuate women's HIV vulnerabilities 75
3.9.2.1 Gender Division of Labour 75
3.9.2.2 Gender Power imbalances 76
3.10 Limitations of Social Constructivist Theory 81
3.11 The shortcomings of gender and power theories 82
CHAPTER 4: METHODOLOGY 86
4.1 Introduction 86
4.2 Research objectives 86
4.3 Qualitative research 86
4.4 Research design 87
4.5 Philosophical Assumptions 87
4.6 Ontological assumption 88
4.7 Epistemological assumptions 91
4.8 Axiology 92
4.9 Focused Ethnography 94
4.10 Population 96
4.10.1 Selecting the research site 96
4.10.2 Sampling 97

4.11 Research methods: Instruments of data collection 98
4.11.1 Semi-structured interviews 99
4.11.2 Establishing Rapport 102
4.11.3 Recording interviews 104
4.11.4 Focused observations 106
4.11.5 Photographs and documents 108
4.11.6 Data processing and analysis 109
4.11.6.1 Data analysis 113
4.12 Procedure for gaining access 117
4.13 Methodological reflexivity: Researcher's role and identity 119
4.14 Ethical considerations 123
4.14.1 Consent, assent forms administered to research participants 123
4.14.2 Maintaining confidentiality and anonymity 124
4.14.3 Causing no harm 126
CHAPTER 5: PRESENTATION OF THE RESULTS 132
5.1 Introduction 132
5.2 Demographic characteristics of participants 132
5.3 Prevalence of cultural practices of polygyny and dry sex in the Zambezi region 135
5.3.1 Social justification for dry sex 136
5.3.2 Accessibility of the herbs 138
5.3.3 Dry sex experience for men and women 141
5.4 The purpose of polygyny 145
5.4.1 Justification for polygyny among women 147
5.4.2 Differences in experience about polygyny for men and women 148
5.4.3 Polygyny and the risk of HIV 150
5.4.4. Bunyazi is a form of multiple concurrent sexual partnerships 152
5.5 Social construction of gender norms 152
5.5.1 HIV and AIDS: A woman's problem 153
5.5.2 Intergeneration and transactional sexual relations 155
5.5.3 Cultural notion of masculinity 156
5.6 Inclusion of cultural practices in HIV and AIDS behaviour change programmes 158
5.6.1 Inclusion of dry sex in HIV and AIDS behaviour change programmes 161
5.6.2 Inclusion of polygyny in HIV and AIDS behaviour change programmes 165
5.7 Challengers designing culturally responsive HIV and AIDS behaviour change programmes 168
5.8 Perspectives on preserving cultural practices of dry sex and polygyny 176

5.8.1 Reluctance to change cultural practices of dry sex and polygyny 179
5.8.2 Backlash on advocates of cultural change 180
CHAPTER 6: DISCUSSION 182
6.1 Introduction 182
6.2 Policy frameworks guiding cultural practices that perpetuate HIV 182
6.3 Cultural practices of dry sex and polygyny counteract HIV and AIDS prevention programmes 186
6.4 Social construction of polygyny 191
6.5 Challengers within Polygyny unions 193
6.6 Dry Sex: Its Pros and Cons 197
6.7 Application of the theory of gender and power on how construction of womanhood and manhood perpetuate HIV 200
6.7.1 Conservative gender roles embedded in cultural norms and traditional beliefs 205
6.7.2 Lack of interpersonal communication as a barrier to HIV prevention 208
6.8 Dry sex and polygyny excluded in HIV and AIDS behaviour change programmes 209
6.9 Need for coordination mechanisms that is inclusive of traditional structures in the Zambezi region 210
CHAPTER 7: CONCLUSION 214
7.1 Introduction 214
7.2 The key issues from the various chapters in this dissertation. 219
7.3 The Three Main Arguments 225
7.4 Contribution to academic knowledge 226
7.4.1 Importance of behaviour change programmes that are culturally sensitive 226
7.4.1.1 The evolving nature of culture 227
7.4.2 HIV and AIDS behaviour change Policy and practice 228
7.4.3 Conducting sensitive research and presentations of findings 229
7.5 Cautionary measures when studying cultural practices 231
CHAPTER 8: RECOMMENDATIONS 233
8.1 Introduction 233
8.2 Awareness creation on policy directives regarding the inclusion of cultural practices in HIV and AIDS prevention programmes 233
8.3 Strengthen regional and constituency coordination mechanisms to address dry sex and polygyny in HIV and AIDS Prevention Programmes 234
8.4 Design cultural appropriate HIV and AIDS prevention programmes 238
8.5 Abolish socio-cultural factors that heighten women's vulnerability to HIV and AIDS 241
8.6 Positioning female sexual pleasure in HIV and AIDS prevention programme 242
8.7 Transdisciplinary studies to assess the toxicity and medicinal properties of herbs used for dry sex 243
8.8 Conduct Knowledge Attitude and Practice studies to assess prevalence of cultural practices that perpetuate HIV. 243

REFERENCES 247
APPENDICES 285
Appendix 1: List of research participants 285
Appendix 2: Ethical Clearance Certificate 287
Appendix 3: Informed Consent Forms for Adults 288
Appendix 4: Assent Form 290
Appendix 5: Research Tools: Key Informants 293
Appendix 6: Research Tools: General Population 295

LIST OF TABLES

Table 1: Six phases of thematic analysis 113

LIST OF FIGURES

Figure1: Conceptual framework of social construction, gender and power theories and their linkage to HIV and aids behaviour change programmes 68
Figure 2: Herbs used for dry sex 140
Figure 3: Herbs that are consumed in tea or porridge to heat the body 140
Figure 4: Advocacy booklet on harmful cultural practices from WLC 159
Figure 5: Training manual from SFH, covering materials on Commercial Sex Work and HIV and AIDS prevention 161
Figure 6: NANASO poster marketing a public dialogue on Challenging Gender dynamics in a cultural context to address HIV 162

LIST OF ACRONYMS

AGYW	Adolescent Girls and Young Women
ANC	Anti-natal care
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
BIG	Basic Income Grant (BIG) Coalition
CAA	Catholic AIDS Action
CACOC	Constituency AIDS Coordinating Committees
CDC	Centres for Disease Control and Prevention
CSOs	Civil Society Organisations
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
DAPP	Development Aid from People to People
DREAMS	Namibia Determined, Resilient, Empowered, AIDSFree, Mentored, and safe Namibia
HIV	Human Immuno-deficiency Virus
LAC	Legal Assistance Centre
MoHSS	Ministry of Health and Social Services
NANASO	Namibia Network of AIDS Service Organisations
NDHS	Namibia Demographic Health Survey
NSA	Namibia Statistics Agency
NGOs	Non-governmental Organisations
NANGOF	Namibian NGO Forum Trust

NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
RACOC	Regional AIDS Coordinating Committees
STIs	Sexually Transmitted Infections
SIV	Simian Immunodeficiency Virus
SFH	Society for Family Health
TCE	Total Control of the Epidemic
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency International Development
VMMC	Voluntary Medical Male Circumcision
WLC	Women Leadership Centre
WHO	World Health Organization

GLOSSARY OF TERMS

Acquired Immunodeficiency Syndrome (AIDS): AIDS is a disease, caused by HIV, characterized by severe damage to the immune system that leaves the body vulnerable to life-threatening conditions, such as infections and cancers.

Culture: is defined as a set of characteristics that includes the beliefs, practices, values, norms, and behaviours that are shared by members of a group.

Dry sex: is a phenomenon where women insert herbs into the vagina to reduce vaginal lubrication during sexual intercourse. The practice is associated with tearing and cuts of the vaginal wall and glans of the penis, and this heightens the risk of contracting HIV

Focused observation: is the process of enabling researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities.

Gender: is used to describe the characteristics of women and men that are socially constructed.

Gender power imbalance: translates into a power imbalance in sexual interactions which increases vulnerability to HIV. In many societies also, the male partner is considerably older than the female, further unbalancing the power differential.

HIV and AIDS Behaviour change programmes: are activities that help a person or individual or a community to reflect upon their risk behaviour and change them to reduce their risk and vulnerability. HIV and AIDS behaviour change programmes delay the onset of first intercourse, decrease the number of sexual partners, increase the number of sexual acts that are protected, provide counselling and testing for HIV, encourage adherence to

biomedical strategies that prevent the transmission of HIV, decrease sharing of needles and syringes and decrease substance use.

Human Immunodeficiency Virus (HIV): HIV is the virus that causes AIDS. The virus is passed from person to person through blood, semen, vaginal fluids and breast milk. HIV attacks CD4 cells in the body, causing individuals living with HIV vulnerable to illnesses that a healthy immune system would have eliminated**.**

Informed Consent: Informed consent is a legal condition whereby a person can give consent based upon a clear understanding of the facts, implications, and future consequences of an action. To give informed consent, the individual concerned must have adequate reasoning faculties and have all relevant facts at the time he or she gives consent.

Patriarchy: is the manifestation and institutionalization of male dominance over women, younger men and children in the family and the extension of male dominance over in society in general. It implies that men hold power in all the important institutions of society

Polygyny: refers to a practice where one man is married to more than one wife at the same time.

Power: power is defined in terms of 'power over' where the meaning of power is the power of one agent over another or whether the underlying account of power should be 'power to', where power is the power to attain what one aims for and 'power over' is simply a subset, a means by which some agents attain what they aim for.

Semi-structured interviews: it's an interview format in which the interviewer does not strictly follow a formalized list of questions. Instead, the interviewer asks more open-ended questions, allowing for a discussion with the interviewee rather than a straightforward question and answer format.

Sex: refers to the biological, anatomical and physiological differences between males and females. For instance, male and female genitalia, both internal and external, including the levels and types of hormones present in male and female bodies are different. Similarly, in some cases, a child is born with a mix of female and male genitalia. They are sometimes termed, intersex. Hence, sex should be considered a continuum rather than two mutually exclusive categories of male and female.

Sexuality: refers to a person's tendencies, preferences, habits and interests concerning sexual activity, typically—though by no means exclusively—in an interpersonal context, sexuality is often closely associated with one's sexual orientation. Sexuality can 'refer to a wide variety of identities and behaviours for example inter-relationships between sexuality, sexual orientation (who/what one is sexually attracted to), sexual behaviour (the types of sexual activity one engages in), and sexual identity (how one chooses to describe one's self). As such, sexuality permeates influences and is inseparable from our gendered, religious, class, ethnic and other identities.

Sexual script: describes sexual behaviour as learned from a particular cultural and social context, hence defining sexual behaviour as fundamentally social. Sexual scripts are guiding posts for socially acceptable sexual conduct within a society, thus allowing individuals to conceptualize their roles in sexual encounters. This description of sexual behaviour differs from earlier conceptualizations that emphasized sexual behaviour as purely biological.

Sexual division of labour: A term referring to the allocation of different jobs or types of work to women and men. The sexual division of labour varies radically from one cultural or historical context to another

Social constructivist: refers to the meaning, notion or connotation placed on an object or event by society and adopted by the inhabitants of that society concerning how they view or deal with the object or event. In this respect, a social construct as an idea would be widely accepted as natural by society. In a certain cultural context, particular cultural practices could be condoned as the norm and are thus not questioned.

Structure of cathexis: refers to the laws, social norms and prohibitions that shape what is 'normal' in sexual relationships.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank God Almighty for sustaining me throughout this PhD journey. Thank you, Lord, for the spirit of Understanding, Knowledge and Wisdom.

This PhD journey has been a long and dauting process, there were therefore several people supporting and encouraging me along the way, whom I would like to thank.

Firstly, I would like to thank my supervisor, Prof Lucy Edwards-Jauch, sincerely for her guidance, support, generous provision of time and feedback. Your dedication to academia has impacted me both professionally and personally. I am grateful for the role you played in my life during my PhD journey.

My heartfelt gratitude goes to my friends and colleagues at the Multi-disciplinary Research of the University of Namibia. Thank you very much for carrying my office workload during my study leave. Thank you for your words of support and encouragement during my study. Without support from the Multi-disciplinary Research, it would not have been possible to take this PhD to completion. I am also greatly thankful to the University of Namibia for financial support and ensuring that staff capacity development indeed takes place.

A big thank you goes to my hosts in both Katima Mulilo and Kabbe during the time of my fieldwork. The hospitality accorded to me made me realise that the spirit of Ubuntu is still burning in us. Luitumezi!!!!

I cannot thank the research participants in Windhoek, Katima Mulilo and Kabbe enough for sharing their perspectives so openly with me. It was such a privilege to have worked and stayed in a community that so much resembled my own. As I observed the similarities between the communities of Katima Mulilo and Kabbe and my Batswana communities in

the Omaheke Region, it dawned on me that we are ultimately but just "One". I would like to thank everyone who accepted me and always made me feel welcome.

Thank you to my close friends and family for not having written me off during my protracted silences and alienating myself from our usual social gatherings and family responsibilities. Your understanding and support have kept me going too.

I would like to thank my family, Charlotte, Desi, Phemelo, Moseki, Reaotshepa and Bogola, for always being there when I needed that cup of tea, back massage, a walking buddy to stretch my strained legs and back and to rest my eyes.

Phemelo, Moseki and Reaotshepa, you grew so fast during this period. I am looking forward to being a more engaged and available mom and grandmom, and to spending more quality time with each of you. I take comfort in knowing when I had to be awake till late working on my PhD studies, I had my mother to keep me company. I take solace in the knowledge that you have more than once said to me that you are proud of how my life turned out. Sadly, my mother, Beatrix Kgantsang Mogotsi, passed away in 2018.

A word of appreciation also goes to the research assistants, translators of the interview transcripts and also Prof Talita C. Smit who conducted valuable language editing of this dissertation. **Pula!!!!!**

DEDICATION

To my mother, Beatrix Kgantsang Mogotsi and my children, Charlotte, Desi, Phemelo, Moseki and Reaotshepa.

DECLARATION

I, Immacullate Mogotsi, hereby declare that this study is my work and a true reflection of my research and that this work, nor any part thereof, has been submitted for a degree in any other institution.

No part of this dissertation may be reproduced, stored in any retrieval system or transmitted in any form or by means (e.g. electronic, mechanical, photocopying, recording or otherwise), without the prior permission of the author, or the University of Namibia.

I, Immacullate Mogotsi, grant the University of Namibia the right to reproduce this dissertation in whole or in part, in any manner or format which the university may deem fit.

----------------------------	-----------------------------	-------------------
Name of Student	Signature	Date

CHAPTER 1: INTRODUCTION OF THE STUDY

HIV remain a major concern in the Zambezi region and several factors are implicated and several factors in the spread of the virus. In this study focus will be placed on dry sex and polygyny and the risk they pose to HIV among women (Frank, 2015; Legal Assistance Centre, 2017; Ssewanyana et al., 2018). Dry sex and polygyny are manifestations of culture because they are shared meaning to the communities of the Zambezi region. Edwards (2007, p. 234) states that "the socio-cultural construction of sexuality in Namibia remains relatively unexplored. Despite the linkages between HIV and existing sexual cultures, there is a reluctance to deal with the social and cultural dimensions of human sexuality". This study, therefore, envisaged to provide a critical reflection on polygyny and dry sex that perpetuated HIV and also assessing whether NGOs addressed cultural risk factors in their HIV and AIDS prevention programmes.

This study does not imply that African cultural practices in their totality are harmful to the well-being of women. On the contrary, numerous African cultural practices are beneficial, and such must be retained. African's uphold the Ubuntu spirit which is comprised in their sense of community, sense of respect for elders, parents-child relationships, humility and sacredness of life (Maniraj, 2019). However, where cultural practices increase women's risk to contract HIV, such needs to be interrogated. This study interrogated the cultural practices of polygyny and dry sex.

1.1 National Policy on the inclusion of harmful cultural practices in HIV and AIDS behaviour programmes

The National Strategic Framework for HIV and AIDS Response in Namibia between 2017/18 and 2021/22 state that cultural practices can potentially perpetuate the spread of

HIV (Republic of Namibia, 2017). The policy directives posit that culture and religion shape human behaviour and thus, dictate people's choices and lifestyles which can influence their sexual risk-taking. The policy, furthermore, require the state to protect its citizens against violence, such as sexual violence, forms of coerced sex, as well as traditional and religious practices that affect people's health negatively. Despite the presence of HIV and AIDS policy frameworks in Namibia that require that cultural practices that potentially perpetuate HIV, no implementation framework has been designed to guide the process of inclusion of polygyny and dry sex into the HIV and AIDS national prevention framework. In this study dry sex and polygyny in the Zambezi region are used as a case study on how to identify what is needed to change behavioral and achieve implementation at individual, societal and organizational level.

1.2 Situating the concept of culture within the discourse of polygyny and dry sex and HIV transmission

Idang (2015, p2) refers to culture as the totality of the pattern of behavior of a particular group of people (Idang, 2015, p. 2). It includes everything that makes them distinct from any other group of people, for instance, their greeting habits, dressing, social norms and taboos, food, songs and dance patterns, rites of passages from birth, through marriage to death, traditional occupations, religious as well as philosophical beliefs.

Other scholars argue that the definition of culture obscures tensions within communities as it fails to explain significant historical changes in popular understandings, minimizes intragroup differences, and belittles the significance of personal agency (Akkuş, Postmes, & Stroebe, 2017; Harrison et al., 2019). There is a variation in which individuals in a community uphold aspects of cultural practices. Other members of a group might apply a

cultural practice in its entirety, while others will only apply some aspects of cultural practice and others might distance themselves completely from a certain cultural practice. Erastus and Harosh (2020) refers to cultural hybridization as a process by which a cultural element blends into another culture by modifying the elements to fit cultural norms. For example, in Namibia, there have been practices of dental ritual mutilations among OvaHerero and OvaHimba and also the practice of body and facial markings and scarring among the San people, the Owambo and the people of the Zambezi region. However, at present time, few members of these communities, except for the OvaHimba continue to practice dental ritual mutilations. These practices played a significant role as it is done for esthetics, spirituality and group identification. Naibei, (2014) for example, emphasized that culture provides constant interaction between the individual and the group to which the individual belongs. Culture keeps the social relationship intact, by preparing individuals in the group for group life. This, therefore, creates group solidarity.

Apart from this, culture is dynamic in the sense that it is continually changing, culture is not static (Idang, 2015). Kashima (2014) also observed that culture is not fixed neither is it permanent. It changes and modifies as a result of contacts with and absorption of other peoples' cultures through a process of cultural hybridity. Naibei, (2014) further highlights that culture is learned, not inherited. It derives from one's social environment, not from one's genes. These perspectives regard culture as fluid and therefore endorse the notion that culture is always changing and responds to pressures and influences, such as the changing experiences of its members, or interaction with other cultures.

Given that culture is not fixed neither is it permanent, it is for this reason this study holds the position that positive dimensions of culture ought to be practiced and passed on to

succeeding generations. Negative dimensions of culture though should be dropped to promote a more progressive and dynamic society. Polygyny and dry sex as learned behavior can therefore be altered. The positive aspect of these cultural practices ought to be retained, however, those aspects that are harmful in terms of perpetuating HIV and gender inequality and violating human rights have to be done away with.

Legarea, (2017) noted that culture is acquired through the process of learning. Hence, the learned nature of culture serves as a reminder that since culture is mastered through the process of learning, it is possible (albeit more difficult) to unlearn aspects of culture that is harmful through effective HIV and AIDS behavior change programs that advocates for gender equality and human right. The learned nature of culture provides opportunities to reform cultural practices of polygyny and dry provided they are exposed to culturally sensitive training programs.

This study, therefore, advocates for a culture-sensitive approach to HIV prevention with the hope to provide solutions to complex development issues in an innovative and multi-sectoral manner. Miedema, (2019) argued that culturally sensitive approaches to HIV and AIDS prevention have a transformative power that is relevant to the needs of people. Miedema (2019), further argue that HIV prevention interventions that are responsive to the cultural context and the particularities of a place and community, and advance a human-centered approach to development, are most effective, and likely to yield sustainable, inclusive and equitable outcomes.

1.3 Statement of the problem

Over the years, Namibia rolled out HIV and AIDS behaviour change programmes which were consistent regarding condoms use, sexual abstinence, being faithful to one sexual

partner and the prevention of mother-to-child transmission, with a focus on individual self-efficacy (Republic of Namibia, 2016). Overall, the prevalence of HIV is showing a slight stabilisation nationally at 11.5% (14 467 actual number), with HIV positive women being 14.8% (8164 actual number) and HIV positive men being 8.0% (6303 actual number). However, the Zambezi region has the highest HIV prevalence nationally at 20.7% (421 actual number). In the Zambezi region, HIV prevalence among women was more 28.0% (247 actual number) than double HIV prevalence of men 12.1% (174 actual number) (Ministry of Health and Social Services -MoHSS) (2019, p. 53).

Cultural practices such as polygyny and dry sex are also common in the Zambezi region. These practices exacerbate the spread of HIV (/Khaxas, 2008; /Khaxas & Frank, 2010; Namibia Statistics Agency, 2014; Frank, 2015; Legal Assistance Centre, 2017). This study focused on polygyny and dry sex as cultural practices that could potentially perpetuate HIV. Polygyny is a traditional practice whereby *only* a man is allowed to marry more than one spouse (Mwambene, 2017). The introduction of new wives into the marital union and low HIV testing among couples in the polygynous union can risk the contraction of HIV. The Namibian Demographic Health Survey indicated that ten per cent or more of women in the Zambezi region are in a polygynous union. The study further indicated that HIV prevalence is higher among women in polygynous unions at 22.6% (actual number 87) than those in non-polygynous unions 17.8% (1045 actual number) and women not in union 16.1% (2685 actual number) (NSA, 2014, p. 212). According to the NSA, over 10% of women in the Zambezi, Kunene, Kavango, and Ohangwena are in polygynous marriages (2014).

There is a tendency to use the terms polygamy and polygyny interchangeably, while there are actual differences. Polygamy refers to either a man with several wives (polygyny) or a

woman with several husbands (polyandry) (Mwambene, 2017). Lawrence-Hart, (2019) also refers to polygamy as a versatile kinship system that appears worldwide, across cultures and in various religious groups. In the context of this study, the practice is referred to as polygyny. Most of the national documents refer to polygamy, whilst referring to polygyny (Republic of Namibia, 2004; NSA, 2014).

Dry sex, on the other hand, refers to a practice where women insert herbs into the vagina to reduce vaginal fluids which then tighten and dry the vagina. The dry and tight vagina heighten male sexual pleasure during sexual intercourse. However, the coarse herbs and the tight and dry vagina can lead to the tearing of the vaginal wall (Doherty et al., 2014). Furthermore, a dry, small and tight vagina during sexual penetration can result in the development of sores on the glans of the penis (Fahs, 2017). The likelihood of condom tearing during dry sex is also heightened. HIV transmission is known to be enhanced in the presence of genital lesions and ulcerations (Cohen, Council, & Chen, 2019). Despite the potential HIV risk that dry sex and polygyny pose, these practices have not been included in the HIV and AIDS behaviour change programmes in Namibia. It is important to interrogate all HIV risk factors that contribute to the spread of HIV. HIV and AIDS behaviour change programmes are critical in addressing risk factors, however, HIV prevention programmes have not been tailored to address polygyny and dry sex as possible drivers of HIV.

1.4 Justification of the study

The justifications for conducting this study are on the following basis. HIV prevalence in the Zambezi region remains high when compared to the national prevalence rate, which is 20.7% (421 actual number) and 11.5% (14 467 actual number) respectively. Women are

the most infected at 28.0% (247 actual number) whilst men are 12.1% (174 actual number) (MoHSS, 2019).

Women's high HIV prevalence needs to be introspected concerning the prevalence of heterosexual male sexual behaviour. Fleming, DiClemente and Barrington, (2016) shed light on specific aspects of masculine norms that shape men's sexual behaviours which directly perpetuate female HIV vulnerability. Three dimensions of masculine norms that shape men's sexual behaviour are uncontrollable male sex drive; capacity to perform sexually, and power over others. However, these dimensions must be viewed within the social context it occurs. As described in the foundational work of Gagnon and Simon (1973), sexual behaviours are embedded within the system of social practices and are rarely motivated by solely biologically-driven sexual desires. Men's sexual behaviours are theorized as playing an integral part in constructing their masculine identity. Furthermore, men's HIV vulnerability – and the vulnerability of their sexual partners – is primarily associated with those sexual behaviours. As Jewkes and Morrell (2010, p. 9) noted in their article on HIV and masculinity, "Understanding sexual practices as flowing from gender identities helps us to understand why they are so hard to change, as well as how change should be approached".

The masculine norm that stipulates that men have an uncontrollable sex drive propagates the idea that men are biologically programmed to constantly and relentlessly desire sex (Khumalo et al., 2020). The male sexual drive has its roots in historical notions that men need to spread their seed and are hardwired to have unprotected sex with multiple women partners to reproduce many offspring (Jewkes et al., 2015). This biological explanation is pervasive in defence of polygyny.

Furthermore, Connell (1995) writes that the dominant form of masculinity is heterosexual and sexually active. Thus, being able to perform sexually (e.g. maintaining an erection, being sexually skilful) can play an important role in achieving masculine status. This may encourage men in some settings to have a higher number of female sexual partners since research in various cultural contexts has shown that men who abstain from sex or refuse sex with a particular woman are subject to teasing that challenges their masculine status (Fleming, Andes, & DiClemente, 2013; Ganle, 2015). The dimension of power refers to men's efforts to assert their power over other men and women through their sexual behaviours, especially the number of sexual partners they keep. To have a full comprehension of masculinity and the risk it poses to HIV for both males and females it is important to consider socio-cultural contexts and the social dynamics and interactions that interpret and place value upon those behaviours (Fleming, DiClemente, & Barrington, 2016). As is the case with the context where there is a male preference for dry sex and polygyny. Thus, the high HIV prevalence among women should be viewed within the confines of how masculinity is constructed.

There is also a need to put the geographical location of the Zambezi region within perspective and to interrogate the extent to which it heightens HIV prevalence. The Zambezi region is situated in the north-eastern part of Namibia and borders four countries, namely, Angola, Zimbabwe, Zambia and Botswana, which makes it susceptible to high mobility (Namibia Statistics Agency, 2011). The region is also on the Walvis Bay-Ndola-Lubumbashi Development Corridor (Kalvelage, Revilla Diez, & Bollig, 2021). Improved road infrastructure and being a border region expose it to other mobile and related populations, such as truck drivers, uniformed government officials, informal cross-border traders and sex workers (cross border and internal). The heightened movement of people

and the proximity of the Zambezi region to neighbouring countries make the region highly vulnerable to HIV.

The Zambezi region is home to people of various language grouping, they are the BaSubiya, BaYeyi, BaLozi, HaMbukushu, Khwe, Mafwe, MaKololo, Matotela, Mafwe-MaMbalangwe and BaNyange each with their own dialect. However, SiLozi language is spoken as lingua franca by most groups in the Zambezi region (Otto & Goldbeck, 2014). It is important to note that SiLozi and Setswana are closely related dialects. Setswana being the researcher's vernacular.

The Zambezi region, like many other regions in Namibia functions under a system of legal pluralism that consist of both civil and customary law. With the adoption of the Namibian constitution in 1990, the constitution retained elements of the Roman-Dutch laws from the South African former colony including international laws that Namibia adopted at independence (Republic of Namibia, 1990; Ruppel & Ambunda, n.d.). The Namibian constitution recognises customary law under Chapter 3, however the constitution has supremacy over customary law (Republic of Namibia, 1990, Art. 66. 1). Majority of residents in the Zambezi region live according to their customary laws, norms and beliefs, in particular those who reside predominantly rural settings (Otto & Goldbeck, 2014).

The structures of traditional authorities within the Zambezi region is male dominated, with each village been headed by a senior village headmen. Village headmen advises senior head man, known as Indunas, who represents a number of villages and acts as a local representative on the traditional council (khuta). The khuta is presided over by the Ngambela (chief council) and ultimately by the chief. The khuta is the highest legislative, administrative and judicial body in the area (Harring & Odendaal, 2012). Customary laws

dictates matters such as marriages, divorce, land allocation, inheritance and due to patriarchal dominance, some of these practices perpetuate gender inequality and violate women's rights. For example, the UN Human Rights Committee-HRC (1948) and CEDAW Protocol (1992) issued restrictive positions on polygamous marriages, which is considered to be incompatible with the principle of equality of treatment and have to be seen as inadmissible discrimination against women and should be abolished wherever the practice exist.

Namibia recognised that cultural and religious practices perpetuate HIV. Religious and cultural practices vary across the regions and expose women and men differently to HIV. Despite the high HIV prevalence in the Zambezi region, Namibia continues to roll out HIV and AIDS behaviour change programmes that are homogenous across all the regions. HIV and AIDS behaviour change programmes have not included cultural and religious practices that perpetuate HIV such as dry sex and polygyny into their programmes.

A policy framework was put into place to address the risk of cultural practices such as polygyny and dry sex, that might heighten women's HIV risk. Despite the presence of HIV and AIDS policy frameworks that require that cultural practices that potentially perpetuate HIV, must be addressed, there appears to be a practical-knowledge gap on how to identify and integrate cultural practices of polygyny and dry sex in HIV and AIDS behavior change programmes. Furthermore, intervention approaches that are culturally appropriate and sensitive have not been incorporated into HIV and AIDS behavior change programmes to lessen women's vulnerability to HIV. Many studies focus on individual cognitive behavior when informing HIV and AIDS behavior change programmes (Davis et al., 2015; Williams, & Rhodes, 2016; Hinton, 2017; Goodenow, & Gaist, 2019). However, there are very few

practical studies that on the inclusion of polygyny and dry sex in HIV and AIDS behavior change programmes. This study interrogates the discrepancy between HIV prevention policy and practice regarding the inclusion of polygyny and dry sex. Because of this practical-knowledge gap in the area of HIV prevention, the latest NAMPHIA (2017) survey omitted to collect data on how cultural practices perpetuate HIV in Namibia.

1.5 Objectives of the study

The objective of the study was to explore polygyny and dry sex that might perpetuate HIV among women in the Zambezi region. The other research objective was to investigate whether NGOs working in HIV and AIDS behaviour change programmes adopted culturally appropriate prevention strategies. HIV and AIDS prevention studies focused primarily on biomedical intervention strategies and individual cognitive behaviour and pays little attention on the indigenization of the HIV and AIDS behaviour change programmes. By indigenization of HIV and AIDS behaviour change programmes, it is possible to find solutions to practices such as dry sex and polygyny that suits the local context, are culturally appropriate and acceptable.

1.6 Significance of the study

This study sheds light on polygyny and dry sex in the Zambezi region that may increase the spread of HIV among women. It, therefore, proposes culturally appropriate approaches to the prevention of HIV and AIDS. The findings of this study can contribute to the design of HIV and AIDS prevention programmes that are culturally sensitive and appropriate for HIV. This study can therefore contribute to the literature on the inclusion of cultural practices of polygyny and dry sex in HIV and AIDS behaviour change programmes. Given

the high HIV prevalence among women in the Zambezi region, by addressing cultural practices such as polygyny and dry sex, women's HIV vulnerability will be reduced.

1.7 Limitations of the study

The researcher's ability to communicate in Setswana, which is close to Silozi, diminished the insider/outsider status. Overall, the researcher could communicate fluently with participants in Silozi, despite some linguistic variations between the two languages. In Kabbe, the researcher worked with local research assistants who were familiar with Silozi and Sisubia, as well as other languages and cultures.

1.8 Delimitation of the study

Due to the relatively high levels of HIV prevalence in the region, this study focused on the Zambezi region. Consequently, findings cannot be generalised to other parts of Namibia.

1.9 Outline of the dissertation

This chapter provided background information on the cultural practices of polygyny and dry sex that may perpetuate HIV among women in the Zambezi region. The study, furthermore, investigated whether NGOs working in HIV and AIDS behaviour change programmes adopted culturally appropriate prevention strategies. The remaining chapters are organised as follows: Chapter 2 constitutes a literature review. Chapter 3 provides a theoretical and conceptual framework. Chapter 4 provides a detailed account of the research methodology. Chapter 5 presents an overview of key findings from the research study presented as themes, derived from the data. Chapter 6 comprises a discussion and the conclusions made, as well as highlights the limitations of the study. Finally, in Chapter 8 recommendations with implications for practice and suggestions for future research are given.

In conclusion, this chapter covers the introduction of the study and highlights the statement of the problem and the objective of the study. It further provides the significance of the study with a justification of who benefits from the research findings. The limitations and delimitations of the study are also provided, concluding with the outline of the dissertation.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In this chapter, the HIV prevalence in the Zambezi region will be discussed with an elaboration on dry sex and polygyny and how these practices exacerbate the virus. The chapter will provide a background on other social factors that contribute to HIV infections in the Zambezi region and Namibia at large, its national HIV and AIDS policy positions, the roles of NGOs in behaviour change programmes will also be discussed. This will be followed by a discussion on the Southern African perspectives on HIV and AIDS. The chapter will end with the contestation around the origins and history of HIV and AIDS.

2.2 Practices that perpetuate HIV in the Zambezi region

The Human Immuno-deficiency Virus (HIV) and AIDS pandemic have affected the entire world to varying degrees, with southern Africa recording the highest prevalence of HIV and AIDS globally (Kharsany & Karim, 2016; UNAIDS, 2017). The first case of HIV infection in Namibia was reported in 1986. Namibia has a generalised, mature HIV epidemic that is primarily perpetuated through heterosexual sex. According to the Namibia Population-Based HIV Impact Assessment (Namibia Statistics Agency. (2014). HIV prevalence among adults stands at 11.5% (14 467 actual number) nationally, with women continuing to bear the brunt of the virus at 14.8% (8 164 actual number) and 8.0% (actual number) among men (MoHSS, 2019). Following a peak of 22% in 2002, the prevalence of HIV appears to have slowly stabilised during the subsequent years (Republic of Namibia, 2016). The Namibia Demographic and Health Survey of 2013 indicated that the national prevalence of HIV varied depending on the sex, age, geography and socio-economic status of the individual. In the Namibia Demographic Health Survey (NDHS) of 2013, the prevalence of HIV was higher among women when compared to men and had its prevalence

peak in the 35 to 39 age group among both women (30.9%) and men (22.6%). The prevalence of HIV is slightly lower in urban areas (13.3%) than in rural areas (15.0%) (Namibia Statistics Agency, 2014). A substantial variation in the prevalence of HIV was also observed among Namibia's 14 regions, with the Zambezi region recording the highest prevalence nationally at 20.7% (421 actual number) (MoHSS, 2019).

Various cultural practices are upheld in the Zambezi region and have important cultural relevance for the inhabitants. The practices described below in one way or another undermine women's autonomy and violate their dignity, human rights to health, personal security and freedom from violence (Khosla et al., 2017). These cultural practices, place women at extremely high risk of contracting sexually transmitted diseases, including HIV and AIDS. The cultural practices of polygyny and dry sex are common in the Zambezi region and are discussed in more detail below.

2.2.1 Polygyny and the risk to HIV and AIDS

Polygyny is the practice where a man marries more than one wife, with or without the consent of the other wife/wives. This practice takes place in many countries in Africa, including Namibia, and has its roots in both tradition and religion. The Namibian Demographic and Health Survey indicates that 10% or more of the women in the Zambezi region are in a polygynous union. The most common type of polygyny in Namibia is to have two or three wives (Namibia Statistics Agency, 2014).

This practice serves several purposes. For instance, in many parts of Africa, children are valued not only for carrying the lineage, but also because people can prosper on the land if they have many children and wives. In such cultures, wives and children help to work on the land and thus contribute to growing the family wealth (Koos, & Neupert-Wentz, 2020).

It also argues that polygyny curbs infidelity since the man has more than one wife and, would see no reason to seek out other women. There is, however, the counter-argument that polygyny accelerates the spread of HIV, namely if one partner in the polygynous union is infected, he or she infects all the partners (Zungu, 2019). The Namibia Demographic and Health Survey (2014) indicates that the prevalence of HIV is higher among women in polygynous unions at 22.6% (87 actual number) than those in non-polygynous unions at 17.8% (1045), while women who are not married account for 16.1% (2685 actual number) of the prevalence of HIV.

Another practice that heightens the risk of contracting HIV is the practice of extramarital affairs which is referred to as "bunyazi" in Silozi. Extramarital relations refer to a non-formalised, but a socially acceptable form of adultery in which married men or women enter into an extramarital relationship (Ojedokun, 2015). Sometimes, the other spouse may be well aware of their spouse's extramarital relations. Extramarital relations are more condoned among men. This form of extramarital relation is considered a private affair.

2.2.2 Dry sex and the implications for HIV

Studies show that women have been inserting products, such as cotton wool, cloths, powders, roots, disinfectants, Vicks, toothpaste and saltwater, into the vagina for numerous purposes (Doherty et al., 2014; Fahs, 2017). Women are also utilising commercial products, such as vaginal douching solutions, soaps, detergents and vaginal creams (Brown et al., 2016). The practice of women inserting products to alter the vagina's natural environment is a worldwide phenomenon. This practice is aimed at cleansing, tightening and drying the vagina. These practices are particularly employed for hygiene purposes, during menstruation, during pregnancy or before or following sexual intercourse (Fahs, 2017; Van

der Helm et al., 2019). Other studies show that these products are utilised for the prevention of disease and pregnancy or to meet the sexual preference of a sexual partner. In some instances, these products are used by women to abide to notions of womanhood dictated by mothers and grandmothers' which women and girls are expected to follow (Brown et al., 2016).

A study by Van der Helm et al., (2019) identified factors likely to result in women utilising products to dry, cleanse and tighten the vagina. Women with a higher absolute number of unprotected sexual intercourse acts had higher odds of engaging in vaginal cleansing. Women with recent STI symptoms had higher odds of both cleansing and drying. Women with the high sexual frequency may feel more pressure to be "clean" for themselves and their partners, and the presence of seminal fluid following sexual intercourse may lead them to cleanse more than women who have sexual intercourse less often. Furthermore, women who believe that cleansing protects them from acquiring a disease, may also cleanse as a pre-emptive prevention measure or 'cure'. Additionally, women with STI symptoms (including bleeding, discharge, itching and pain) may be more likely to engage in more frequent vaginal cleansing and drying to relieve discomfort.

Women also indicated that they use substances to dry their vaginas to heighten the sexual pleasure of their male partners (Fahs, 2017). The substances that are inserted tightens the vaginal walls, increase blood circulation and thus provide a tight vagina which increases sexual pleasure to a male sexual partner. In countries where dry sex is practised, a wet vagina is an indication of unfaithfulness, sexual infection and lack of sexual pleasure, hence women will try by all means to reduce vaginal fluids (Loosli, 2004).

Another factor that causes vaginal dryness among women is menopause, which results in reduced secretory function of the vaginal epithelium- a thin, continuous, protective layer of

cells in the vaginal wall. The reduction of vaginal epithelium decreases vaginal blood flow, mucosal thinning, microbiome changes and inflammation (Waetjen et al., 2018). Vaginal dryness also causes pain during sexual intercourse, hence, decreases sexual libido and sexual pleasure (Simon et al., 2014).

2.2.3 Lack of knowledge about HIV and AIDS

Knowledge about HIV and AIDS prevention is key to reducing the prevalence. Although awareness and general knowledge on HIV and AIDS prevention have reached communities in both urban and rural areas, there is still little and limited discussion of HIV and AIDS issues in communities among couples and between parents and their children. A Namibia Population-based HIV Impact Assessment (NAMPHIA) 2017 assessed adolescents' knowledge of HIV prevention (Ministry of Health and Social Services (MoHSS) (2019). The assessment entailed the prevention of sexual transmission of HIV and misconceptions about contracting HIV. According to MoHSS (2019), only 11.6% of adolescent boys and girls provided correct responses. Similarly, the Namibian Demographic Health Survey indicates that overall, women are more likely than men to have comprehensive knowledge about HIV and AIDS (63% of women versus 49% of men aged 15-49 and 43% of women versus 34% of men age 50-64) (Namibia Statistics Agency, 2014). These studies show that the HIV knowledge gap is highest among adolescents and women and men over 50 years.

Marais (2019) argue that intergenerational silence, secrecy and denial still surround sex, thus affecting awareness of HIV and AIDS negatively. The Namibian culture is also infused with religious beliefs such as Christianity. In these religious contexts, sex is often associated with sin, and it is this association that seems to have permeated the Namibian

culture. Teachings on matters of sex also dictate women's sexuality and reduce it to a position of insubordination (Akinyemi, DE Wet & Odimegwu 2016).

Michel Foucault's (1978) work on repressive hypothesis elaborates on how the discourse on sexuality has been confined to marriage. As a results individual outside the institution of marriage could not talk about sex, even in the contexts where parents are educating their children. Foucault (1978) refers to social restrictions to educate about sex as a form of oppression and therefore urges couples, parents, schools and individuals, in general, to be more open about their sexuality, to talk about it, to enjoy it. To take control over the discourse on sexuality, it is needed to revolt and openly talks about sex. Whoever determines what can be known effectively determines how we think and who we are. According to Foucault, then, language and knowledge always have a political edge.

Sex is often not discussed openly since, it is argued, the discussion of sex is taboo (Conroy et al., 2016). In rural Namibia, the discussion of sexuality between children and adults is forbidden and often left to the elders during initiation ceremonies. In several cultural contexts, girls are educated about sex only during cultural initiation rituals. In the Zambezi region, Sikenge initiation rituals are conducted by aunts, grandmothers and community female figures such as female traditional healers. /Khaxas and Frank (2010) argue that sex education offered during cultural initiation rites is aimed at perpetuating female insubordination. These rituals, emphasise the role of girls and women to satisfy their sexual partners, with limited instruction in ways to prevent sexually transmitted diseases and unwanted pregnancies, exercise their agency, prevent HIV and AIDS or avert gender-based violence. Conversations about sex that disempower women and girls contribute to the lack of awareness of HIV and AIDS. Communication about HIV and AIDS is a critical

component in the prevention on HIV, as it is aimed at disseminating information that may prevent HIV-risk behaviour and spread awareness (Nelson, & Bigala, 2016).

According to Foucault's (1978) the repressive hypothesis, power has been exercised to repress the discussion of sex. More important than sex, though, is the discourse on sexuality. The institution of marriage has claimed the discourse on sexuality as its exclusive property: it has complete power over what is and is not said about sexuality. Effectively, culture bans any discourse on sexuality that occurs outside the confines of marriage. Particularly, sex for pleasure is an object of disapproval.

2.2.4 Women's economic dependence heightens their HIV vulnerability

Gender differences constitute what is appropriate feminine or masculine behaviour in heterosexual relations. The National Gender Policy (2010-2020) states that gender inequality originates from Namibian cultural, traditional and religious practices, as well as language that accords women lower status in the family, workplace, community and society at large (Republic of Namibia, 2010). Violence against women and girls is rife in Namibia, which indicates the value society places on women and girls. Matthews, Avery and Nashandi, (2018) argues that violence against women and girls is an indication of gender inequality, and it is made worse by social pressure and the inadequacy to enforce laws that prohibit violence against women and girls.

Women's financial dependence on men further perpetuates their vulnerability as they have limited say in their sexual relations. According to the NSA (2017), the percentage of employment for men is 38% compared to 30% for women. Women who are economically dependent cannot question their men should they want to take another wife or if their men are unfaithful, for fear of being divorced (Rwafa, Shamu, & Christofides, 2019). Economic

dependence prevents many women and young people from controlling their risks of HIV infection. With little negotiating power, they are often unable to insist on safe sex. Due to poverty, many women have little choice other than to barter sex for survival, hence the increasing percentage of women in the commercial sex industry (Stoebenau et al., 2016). Sinha, (2015) argued that rapidly growing levels of migration, poverty, extensive globalization and privatization turned sex work into a survival mechanism for vulnerable women with poor literacy skills and lack of family support who are unable to compete in the labor market. Economic dependence is dangerous because it results in making sex a survival strategy, especially for poor women. Economic dependence also robs women of control over their reproductive health rights; hence, sexual decision-making lies in the hands of men (Klaas,Thupayagale-Tshweneagae, & Makua, 2018). Poverty has been singled out as one of the contributing factors to illicit sex. Women, commercial sex workers, young girls sexually engaged with sugar daddies, married women unable to end HIV risky marital relationships are all a consequence of poverty. It can, therefore, be argued that extreme poverty is a contributing factor to women engaging in sexual activities that heighten their vulnerability to the contraction of HIV.

2.2.5 Silencing of female sexual pleasure

Sexual pleasure is one of the primary motivating drivers for sexual behaviour Global Advisory Board for Sexual Health and Wellbeing (GAB) (2016); (GAB, 2016) defined sexual pleasure as the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to contribute to sexual health and wellbeing. Sexual pleasure should be exercised within the context of sexual

rights, particularly the rights to equality and non-discrimination, autonomy and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people's human rights and wellbeing.

Sexual pleasure experiences differ in meaning and importance over the lifespan, in ways related to age, gender, sexual identity, sexual desires, sexual capacities, health status, and trauma experiences. Although there is no one perfect definition of pleasure, any definition used to describe sexual pleasure must recognize that the possibility (and diversity) of pleasurable experiences is based on the existence of sexual human rights that allow for heterogeneity in sexual pleasure (Ford et al., 2019).

The control of female sexual pleasure has become the domain on which women oppression is based. Feminist scholars concluded that female sexual repression emanates from (patriarchal) power and control, (Swank, & Fahs, 2017). Hence, cultural practices such as dry sex and polygyny must be seen within this context. These practices are harmful, in that they seek to maintain subordination of women. Patriarchal societies are fundamentally hierarchal, engineered to sustain sex inequality. Through patriarchal power, female submission, and social inequality. The sex difference is arguably one of power (Heise et al., 2019).

Endendijk, van Baar, and Deković, (2020) document ways that sexual pleasure serves to reproduce and maintain structures of status and power. Where sexual doubles standard continues to regulate male and female sexuality, through praising male sexual behaviours and ostracising females for the same behaviours. Traditionally, men/boys are expected to be sexually active, dominant, and the initiator of (hetero)sexual activity, whereas

women/girls are expected to be sexually reactive, submissive and passive. Moreover, traditionally men are granted more sexual freedom than women. As a consequence, men and women can be treated differently for the same sexual behaviours

Muhanguzi, (2015) stressed that women are still suppressed when it comes to their bodily explorations and pleasure. This is so because sexuality in Africa is constructed within a dominant patriarchal context. Within this context, patriarchy created and preserved a gender hierarchy that serves the interest of men as dominant and women as passive and submissive. "Such constructions marginalise female sexual aspects of pleasure and desires" (Muhanguzi, 2015, 62). Within patriarchal systems, women rarely control their bodies for their sexual pleasure. Women's bodies are controlled to serve male sexuality. McFadden, (2003) states that the portrayal of women and girls' bodies as dirty, nasty, smelly, disgusting, corrupting, imperfect, ugly and volatile harbingers of disease and immorality contributes to their submissiveness and sexuality passivity. Hence, African women's sexual bodies are therefore under constant surveillance, judgement, regulation and control by a structure that intends to only benefit men. These patriarchal paradigms give rise to gendered inequality and false ideas about sex and sexual relations. Women are unable to express their sexual needs or desires out of fear that they will be labelled negatively or that they will create suspicion and potentially be shamed for having had previous partners or sexual encounters (Hargons et al., 2018). Such constructions marginalise female sexual aspects of pleasure and desire. Studies have also shown that the practice of dry sex inhibits the use of condoms use. Particularly if safe sex practices, such as condom use, are perceived by men as reducing sexual pleasure (Kanda, & Mash, 2018). The cultural practices of dry sex heighten the risk for women and girls to contract HIV and other sexually transmitted infections.

Male control over female sexuality is very pronounced in the cultural practice of dry sex and polygyny. As the dominant group, heterosexual men construct female sexuality solely for their intended benefit and pleasure. This occurs through the process of women inserting herbs in the vagina to tighten the vaginal. The vaginal walls then swell in response to the drying agents, thus creating the impression that the vagina is smaller, and the penis consequently larger. The intention is to achieve a hot, tight and dry sexual experience greatly sought after by men (Van Der Poll, 2009). This desired result is realised with a great deal of pain and discomfort for women. Similarly, polygyny is also practised to accord men sexual pleasure. A study conducted among polygynous Turkish men indicated satisfaction of sexual desire as one of the key areas why men opt for polygynous marriages (Ekerbiçer et al., 2016). Similarly, men's desire for more children or boychildren also accord him the right to marry polygynous (Wood, 2019; Dierickx et al, 2019).

Women's sexuality is directly implicated by practices and sanctions emanating from societal sex norms. The traditional understanding of vaginal fluids, for example, is centred on 'uncleanness', and its supposedly negative impact on fertilisation. Fahs, (2017) states that vaginal lubrication or fluids are an indication of female sexual pleasure, joy and connection. It need not be argued that women lack societal power to influence core beliefs that impact their sexuality, and indeed their very identity. Moreover, the pressure to satisfy men sexually is placed on women in a sphere where men enjoy greater power and influence.

Ford et al., (2019), therefore argues that sexual pleasure is structured and influenced by gender inequality. Women still lack the information, tools, or agency to discuss and negotiate, their sexual pleasure (Ussher et al, 2017). In many areas and cultures, there remains a sexual double standard where women are judged more harshly for various sexual behaviours

and desires than men (Ford et al., 2019). Whilst, on the other hand, cultural practices such as dry sex and polygyny continues to deny women bodily integrity and personal safety.

The reasons women comply with these cultural practices, are compounded by their social, economic and political inequalities. Lack of access to education, land, financial resources, and health care, coupled with women's inequality within the family. Women's economic dependence on their sexual partners hinders sexual negotiations (Mabaso, Malope & Simbayi, 2018).

Sexual pleasure and African female sexual pleasure, in particular, is complex because of the multiple meanings assigned to them. Muzenda, (2014), highlights that sexual pleasure remains stigmatised, silenced, shamed and taboo within public discourses and private discussions. Sexual pleasure is gendered as it is perceived to be a prerogative of males, thus giving rise to sexual inequality. In response to the taboos, shame, stigma and sexual inequality embedded in sexual pleasure, African feminist scholars called for a new perspective in the manner in which African female sexual pleasure is thought about, spoken about, researched and constructed (Marais, 2019).

The work of Patricia McFadden, (2003) and Musisi, (2014) critique the colonial construct of African sexuality, patriarchal paradigms that portray sexual pleasure as the prerogative of males, cultural undertones that encourages sexual silences on female sexuality and sexual pleasures. They particularly call for a sexual viewpoint that's enlightening and empowering to women so that they can reclaim their sexual pleasure as a liberating and powerful force. Women should therefore be encouraged to engage in conversations about sex and their sexual needs and pleasures in a manner that is not stigmatizing and shaming.

Marais (2019) cautions against the limited discourses that frame African female sexuality, which tends to concentrate on sexual reproductive health and rights (SRHR) frameworks

and generally ignores erotic aspects of sexuality. The issues that tend to be highlighted are sexual and gender-based violence, female genital mutilations, child marriages, rape, incest, religious and cultural norms that normalise female sexual purity and chastity. Marais (2019) cautions that although these discourses are important and should not be underplayed, they overshadowed and diminish female sexual pleasure, eroticism and desire.

Namibia has committed to eradicate all forms of discrimination against its inhabitants irrespective of their sex; hence, the existence of such practices are inconsistent and irreconcilable with the provisions of the Namibian Constitution (1990, with specific reference to Chapter 3) and the UN General Assembly Convention on the Elimination of All Forms of Discrimination against Women Declaration (2007), which also states clearly that "States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations concerning its elimination" (Republic of Namibia, 1990). Furthermore, the National Strategic Framework for HIV and AIDS Response -2017/18 to 2021/2022 call for abolishing customary and religious practices that heighten the risk of HIV. At this juncture, there remains policy directives on the risk of cultural practices on HIV and AIDS with no implementation framework in place on how to close the practical-knowledge gap in Namibia.

2.3 Women in sub-Saharan Africa most vulnerable to HIV and AIDS

Women in sub-Saharan Africa remains the most affected by HIV and AIDS with 56% of new HIV infections among young female adults. The main transmission route of the disease in sub-Saharan Africa is unsafe, heterosexual intercourse. Young women aged 15 to 24 are particularly vulnerable and are four times more likely to be infected with HIV than young men (Ramjee & Daniels, 2013). Gender inequalities, including gender-based violence, exacerbate

women and girls' physiological vulnerability to HIV and block their access to HIV services. Young people lack the information to make free and informed decisions about their sexual health and ways to protect themselves against HIV. The impact of these barriers is strongest in high-prevalence settings, predominantly in eastern and southern Africa (UNAIDS, 2017).

In South Africa, about 10% of women attending ante-natal clinics are infected with HIV (De Vasconcelos et al., 2018). Women 20 to 30 years are the worst-affected groups in Southern Africa, with Botswana, Namibia, Lesotho and South Africa showing the highest incidences of infection among women (Vermund, Sheldon, & Sidat, 2015; Gaolathe, Wirth, & Holme, 2016). Studies around the world have shown that behaviour interventions including information, education and communication programmes, condom promotion and behaviour change initiatives that encourage people to reduce the number of their sexual partners can bring about a reduction in high-risk sexual behaviour and by extension can reduce female vulnerability to HIV. Delaying the age of sexual initiation and abstaining from sex have also met with success, specifically in young people.

Kharsany and Karim (2016) emphasize the need for young women, especially those who are unable to negotiate the current HIV prevention options of abstinence, condom use and monogamy in their relationships, to access female-controlled, HIV prevention technologies. Rwafa, Shamu, & Christofides, (2019) and Alexander et al., (2012) also warn that the possibility of an AIDS-free generation cannot be realized unless young women are in a position to prevent HIV infection. In some parts of the world, HIV and AIDS is gender issue. Women and adolescent girls are disproportionately affected because of their social, cultural, biological and economic vulnerabilities. Women's vulnerability to infection and risk-taking are increased by cultural attitudes that make it inappropriate for them to

negotiate safe sex. Factors, such as gender inequality, gendered oppressive laws and cultural norms that oppress women, as well as their low socio-economic conditions, perpetuate their vulnerability to contracting HIV (Rwafa, Shamu, & Christofides, 2019).

Overall, HIV and AIDS are prevalent in almost all sub-Saharan African countries. Factors, such as income inequality, stigma and discrimination, limited health services, risky sexual behaviour, high rates of sexually transmitted infections, drug use, high alcohol consumption, sex work and men who have sex with men, contribute to the prevalence of HIV which varies across countries and also from one country to another. Some countries have a more generalised prevalence while in others HIV is more concentrated among young women, sex workers, men who have sex with men, drug users and mobile populations. Given the large variation in the factors that perpetuate HIV globally, it is not feasible to apply a blanket approach for the prevention and treatment of HIV. Consideration needs to be paid to the way that the economic status, political will and legal frameworks of different countries shape their efforts to prevent HIV. It is, therefore, imperative to design context-specific intervention which considers cultural traditions, economic, political and legal constraints, as well as social attitudes, in specific settings.

Despite the potential of HIV and AIDS behaviour change interventions reducing HIV prevalence among women and the general population, the continuing increase in infection rates suggests that these efforts have been too limited or perhaps not effective on a broad enough scale to achieve a significant public health impact. HIV and AIDS behaviour change programmes have focused on women because of the high HIV prevalence among women. This approach has been critiqued, given that prevention strategies such as the use of condoms are controlled by men. This will require women to negotiate with men for

condom use. Women have little negotiation power because of gender inequality. Femidoms and other female-controlled HIV prevention methods have not been rolled extensively as they are considered expensive. There is a need for concerted efforts targeted at reducing women's vulnerability that needs to focus on interventions that develop negotiation and decision-making skills, address gender imbalances, and locate HIV prevention in the context of women's lives.

2.4 Cash transfer incentives to empower women

Cash transfer programmes have been rolled out in numerous parts of the world to address financial constraints, particularly among women. These initiatives of the World Bank, aims to enhance the potential of poor people to move out of poverty by investing in their capabilities, changing their behaviour, and helping them to overcome disabling/oppressive social relations (Lagarde, Haines, & Palmer, 2009; Sandberg, 2012). The cash transfer programmes also include social accountability elements such as inclusion of all voices, and considerations of people's rights and justice values (Molyneux, Jones, & Samuels, 2016).

The benefits of cash transfer programmes were seen to improve recipient's psychosocial wellbeing. Pouw & McGregor, (2014) and Ferguson, (2015) alluded to the relational dimensions of human wellbeing that improved individuals' feelings of dignity, respect, self-confidence and self-esteem; assertiveness and reductions in feelings of shame and hopelessness, and relief from worry and stress. Cash transfer recipients also experienced a degree of more financial independence and control over their lives.

Female recipients of cash transfers experiences self-confidence and thus takes control of their sexual health and negotiate with their sexual partners for safer sexual encounters. Female financial independence also hinders women from resorting to commercial sex work or to remain

in unhealthy sexual relationships as a means of financial survival for themselves and their children. Studies on cash transfer in Tanzania, South Africa and Canada (Siaplay, 2012; Kohler, & Thornton, 2012) indicated a reduction in women's sexual risk taking.

Poverty and social inequality causes women to be reliant on their sexual partners for their basic needs, through transactional sex. The nature of these sexual relations inhibits sexual negotiations and safe sex practices, they thus exposes women and their sexual partners to HIV. Siaplay, (2012) noted that by addressing cash transfers and other social protection programmes targeted to girls and women it has the potential to mitigate the impact of poverty and social inequality on HIV risk. Cash transfer programmes in South Africa, Tanzania, Malawi and Zambia showed positive results when used successfully for HIV prevention (Garcia, & Moore, 2012). These programmes led to positive health outcomes, promoted education and increased income and employment opportunities among women and young girls. Furthermore, cash transfers have influenced sexual behaviour of young women and girls, thereby decreasing sexual risk factors for HIV infection. The review of the South African and Tanzania study showed that cash transfer improved female school attendance, retention and completions and also safer sexual health among school going female learners, thus reducing the vulnerability to engage in transactional sex (Garcia & Moore, 2012). Despite the positive results of cash transfer programme in transforming gender relations and empowering women and girls, studies have shown that in several Sub Saharan African countries, few governments are supporting cash transfer programmes and the social protection programmes that are specifically targeted at women in their reproductive age and those that are at higher risk of contracting HIV as a result of their socio-economic circumstances.

In an attempt to divert the high new HIV infection rates amongst adolescent girls and young women, several cash transfer initiatives were initiated the Determined, Resilient, Empowered, AIDSFree, Mentored, and Safe (DREAMS) Namibia project has been initiated in 2018 under the auspices of Project HOPE Namibia and funded by PEPFAR(United States President's Emergency Plan for AIDS Relief) through USAID (United Stated Agency International Development). The DREAMS project contributes to Namibia's National Strategic Framework on HIV and AIDS and the National Agenda for Children, specifically focusing on strengthening programs to protect adolescent girls and young women (AGYW) from HIV infection by ensuring they are educated, healthy, economically and socially empowered, and free from violence and discrimination. During its initial phase the DREAMS project provided commodities and support to AGYW and families (i.e., transportation, stationery, school uniforms, sanitary pads, and an emergency cash fund). Out of the fourteen regions in the Namibia, the DREAMS project is rolled out only in three regions, Oshikoto region as well as Khomas and Zambezi regions (USAID, 2019).

A cash transfer initiative has also been run through the Basic Income Grant (BIG) Coalition. A coalition of churches, trade unions, NGOs and AIDS service organisations formed the Basic Income Grant Coalition with a view to advocate for the introduction of a BIG in Namibia, with funding from external donors. The BIG Coalition was formed in 2004 to quicken government's pace in addressing poverty reduction. The BIG pilot has been conducted in Otjivero, in Omaheke region, which is a cash grant of N$100.00 which is given to every resident irrespective of their sex, excluding pensioners. The grant is intended to be universally awarded, going to everyone as a right. However, the rich don't get the direct benefit, as adjustments in the tax system ensure that the better off actually pay back the cost of the grant (Marenga, & Amupanda, 2021).

Given Namibia's relatively small population and excessively high unemployment rate and poverty ratio that have persisted for several years, the BIG has been viewed by social activists as an ideal means to deal with poverty. Results from an impact assessment study found that malnutrition among children significantly reduced, income increased through self-employment activities and reduced school dropout with increased contributions to school development fund, amongst others reducing school dropout and poverty-related crimes (Marenga, & Amupanda, 2021). Most importantly, the BIG was also heralded for providing women with the means to be self-sustaining and thus did not barter sex as a survival means.

2.5 Namibian National HIV and AIDS Policy Framework

Namibia is taking aggressive steps to reduce HIV transmission. A National Policy on HIV and AIDS was adopted in 1992 and revised in 2007. The National Policy on HIV and AIDS emphasises the provision of information and education to prevent HIV. It highlights the importance of individual responsibility for adopting sexual behaviour that will reduce risks of infection, and its outlaw's discrimination based on HIV and AIDS. The policy, furthermore, recognises that social, political and economic conditions create and sustain vulnerability to the risk of HIV infection. It particularly highlights the unequal position of girls and women in society and the fact that, due to biological, social, cultural and economic factors, women are more likely to become infected and are more adversely affected by HIV than men. The policy, subsequently, identifies tradition, culture and religion as having a strong influence on people's lifestyles and choices which can heighten their sexual risk-taking. It, therefore, compels the state to protect women and girls against violence, including sexual violence, rape and other forms of coerced sex, as well as against traditional practices that affect their health negatively (Republic of Namibia, 2007).

The country also has a National Strategic Framework for HIV and AIDS Response, 2017/18 to 2021/22 (Republic of Namibia, 2017). The framework targets programmatic areas which are clustered between being population- and service-based, as well as cross-cutting, interventions. The population-based intervention comprises a sub-population that is vulnerable to HIV infection. These groups include men who have sex with other men, female sex workers, transgender people and people injecting drugs, as well as migrant and mobile populations. Among the most vulnerable groups are adolescent young women, youth in general, people with disabilities, orphans and vulnerable children (OVC). The cross-cutting intervention focuses mainly on STI prevention and management, PMTCT, condom distribution and promotion, PreP and VMMC, post-exposure prophylaxis, social behaviour change communication and HIV testing services (Republic of Namibia, p. 13, 2017).

Furthermore, HIV testing services (HTS) represent a prerequisite for access to ART care and support and most biomedical interventions, such as PMTCT and VMMC. The couple- or individual-based HTS with partner-testing can also assist in identifying sero-discordant couples and thus support the prevention of HIV transmission to HIV-negative partners. Geographical and client coverage of HTS has increased with 76% of people living with diagnosed HIV. Despite the progress made, not all people have accessed and utilised HTS. According to the NDHS 2013/14, 49% of women and 38% of men aged 15 to 49 were tested for HIV (last 12 months) and received their results. This indicates a notable increase from 2006/2007 where 29% of women and 18% of men were tested and received their results. This trend is attributed to the high uptake and increased coverage of services. However, there is low uptake of HTS by couples, men, adolescents and men having sex with men (Namibia Statistics Agency, 2014).

Condom use is one of the main strategies for combating the spread of HIV; however, according to the Namibia Demographic and Health Survey (NSA, 2014), women were less likely to report having utilised a condom during their last sexual encounter than men (68% versus 83%). New HIV infections continue to occur among young women in Namibia (Republic of Namibia, 2016). The Surveillance Report of the 2016 National HIV Sentinel Survey and the Namibia Population-Based HIV Impact Assessment (Namphia), 2017, singled out younger women as more susceptible to new infections, and recommends targeted and age-specific prevention interventions (Republic of Namibia, 2016; MoHSS, 2017).

Namibia is also one of the countries that met the goal of providing antiretroviral medicines to 90% of pregnant women living with HIV since 2012. The country has also increased coverage of programmes to prevent the mother-to-child transmission (PMTCT) of HIV and implemented Option B+ (life-long ART for all HIV-infected women regardless of CD4 cell count) in 2014. At the national level, the Ministry of Health and Social Services has a well-established National AIDS Coordination Programme which has been managed by the Directorate of Special Programmes HIV and AIDS since 2004. The Directorate is overall responsible for assisting all sectors in the development, as well as the implementation of sector-related HIV and AIDS activity plans per sectoral obligations (Republic of Namibia, 2016).

2.6 HIV and AIDS behaviour change programmes

De Vasconcelos et al., (2018) define behaviour change programming as a venture that attempts to delay the onset of first intercourse, decrease the number of sexual partners, increase the number of sexual acts that are protected, provide counselling and testing for HIV, encourage adherence to biomedical strategies that prevent the transmission of HIV, decrease sharing of needles and syringes and decrease substance use. Behaviour change

programmes have been credited for the decrease in the prevalence of HIV in several countries, such as Uganda, Namibia and Tanzania, where behaviour change programmes were rolled out extensively (UNAIDS, 2014). For example, in Uganda, the 70% decrease in the prevalence of HIV was linked to a 60% reduction in sex with non-primary partners, a 2-year delay in the onset of first intercourse and increases in condom use (Mafigiri et al., 2017). HIV and AIDS intervention needs a multilevel approach that encompasses behavioural strategies in combination with biomedical and structural approaches (De Vasconcelos et al., 2018).

Effective behaviour change programmes require an understanding of how individuals understand and relate to the risk of HIV and their ability to protect themselves from contracting HIV, as well as their knowledge of the choices available to them (Knight et al., 2016). Without addressing the social and cultural norms that shape and underpin health-seeking behaviour, opportunities for individual-level behaviour change are limited.

HIV behaviour change remains a key intervention in reversing HIV, globally. Such programmes are targeted at individuals, families, communities, entire societies, or (ideally) a combination of all these sub-sectors of society. UNAIDS, (2014) highlighted benefits that can be derived from HIV behaviour change programmes: They promote accurate individual knowledge and perception of risk and increase individual motivation to avoid risky behaviour. Prevention programs also build individual skills needed to use prevention commodities properly and, to the extent feasible, to avoid or effectively negotiate risky situations. Within households, HIV prevention programs aim to decrease the stigma associated with both HIV and sexuality, promote open discussion about sexuality and drug use, and influence gender roles and norms. At a community level, effective programs seek

to increase the value associated with safer behaviours, to support community members to reduce their risk, to build social solidarity and reciprocity, and reinforce new norms. Behavioural HIV prevention programs may also seek to achieve results at a broader social or structural level. Social or structural interventions might also be indirect, by supporting broader efforts to improve the overall protection and promotion of human rights, to reduce income inequality, and to address stigma and discrimination, gender inequities, economic and community empowerment especially for women (UNAIDS, 2017).

Effective HIV prevention addresses the specific needs and circumstances of the target population and aims to affect multiple determinants of human behaviour, including individual knowledge and motivations, interpersonal relationships, and societal norms. Community engagement and strong political support have been key ingredients of successful national efforts to change behaviour to prevent HIV infection. Behaviour change remains the primary tool for reversing national epidemics, as illustrated in Tanzania, Uganda, Zimbabwe and Namibia where population-wide changes in sexual behaviour have resulted in marked declines in HIV prevalence and incidence (UNAIDS, 2014).

The non-governmental organisations (NGOs) sector, in collaboration with the government, have been spearheading HIV and AIDS behaviour change programmes in Namibia. This sector operates under the Namibia Network of AIDS Service Organisations (NANASO), an umbrella agency for all HIV and AIDS civil society organisations (CSOs) in Namibia, which has been operating since 1991. Over the years, there has been a decline in the numbers of NGOs working in the field of HIV and AIDS prevention due to decreasing donor funding. The NGOs working in the field of HIV and AIDS are the AIDS and Rights Alliance for Southern Africa (Namibia), the Catholic AIDS Action Namibia, Namibian

Women's Health Network, Development Aid from People to People in Namibia, Namibia Planned Parenthood Association, Young Women Christian Association, AfriCare, as well as the Ombetja Yehinga Organisation and the Red Cross of Namibia (Namibia Network of AIDS Service Organisations (NANASO), 2007; Namibia Network of AIDS Service Organisations (NANASO), 2010).

Funding for the NGO sector in HIV and AIDS prevention was made possible by donor organisations and government agencies. Such funding, however, has been scaled down tremendously since Namibia was classified as an upper-middle-income country with an estimated annual GDP per capita of USD5,293 (Office of the President, 2012; Menges, 2018). Namibia continues to be a recipient of HIV donor funding from the Global Fund, PEPFAR, GIZ and UN Agencies. The Namibia government is also contributing a substantial amount to HIV prevention, signalling political commitment to reduce the prevalence of HIV (Republic of Namibia, 2015). The Namibia AIDS Response Progress Report (2015) shows that investments in HIV prevention have decreased. The total spending on HIV prevention declined by 47% from N$ 535.4 million in 2008/9 to N$ 281.8 million in 2009/10 and by a further 24.1% to N$ 213.9 million in 2010/2011. From 2009/2010, international investment for prevention declined from N$253.1 million to N$ 157.8 million in 2010/2011 and, although domestic investment increased by over 50% during this time (from N$30.2 million to N$46.8 million), the net result was a substantial drop in total investment in HIV prevention. This creates serious concerns about the sustainability of the prevention response, particularly for NGOs which rely primarily on international donor funding (Republic of Namibia, 2017).

Insufficient funding to the NGO sector leads to inadequate skills and lack of capacity in community-based organisations for activities regarding the prevention of HIV in the areas of project design and planning, reporting, monitoring and planning, community mobilisation, resource mobilisation and utilisation, as well as leadership to drive the HIV prevention agenda effectively. This poses a threat to the acceleration of HIV and AIDS interventions in Namibia. NGOs in Namibia are not only under-resourced but extremely understaffed. Staff retrenchment is common among the NGOs sector. Their funding challenge poses questions about the types of skills they can attract (Menges, 2018).

The NGO sector focuses mainly on rolling out behaviour change programmes. These programmes are dominated by individual-level interventions that aim to influence knowledge, attitudes and behaviour, such as the promotion of sexual abstinence, faithfulness to one sexual partner and consistent condom use (Republic of Namibia, 2007; Krishnaratne et al., 2016). HIV and AIDS behaviour change programmes are useful as educational tools. There is, however, a need to revise how they are implemented to deviate from individual and small group interventions to more region- and country-wide approaches, and also to incorporate region-specific vulnerabilities. Furthermore, these interventions should aim at changing socio-economic and socio-cultural factors that perpetuate HIV, such as the high consumption of alcohol, unequal gender relations and gender-based violence, HIV risk factors experienced by commercial sex workers, migrant workers, income inequality, as well as cultural practices that are implicated in the spread of HIV. To scale up prevention efforts, other intervention approaches must be studied, in particular those that can lead potentially to transforming unequal gender relations and equitable distribution of resources.

Such interventions must be informed by theories, and their practical implications must be holistic and do more than just prevent the spread of HIV. To have a long-lasting effect, behaviour change programmes must aim at working across many levels of influence, such as the political and traditional leadership, community, household and individual levels. De Vasconcelos et al., (2018) allude to the fact that HIV transmission is a dyadic event that occurs in social contexts and, thus, behavioural strategies working with social units may have greater potential than those working with individuals in isolation; hence, these calls for multi-level intervention approaches that are implemented at HIV and AIDS community-based programmes. To succeed, such programmes would need strong institutional support and the capacity for implementation and sustainability. Institutions and leadership structures that are spearheading the HIV and AIDS interventions in Namibia are the Regional AIDS Coordinating Committees (RACOC) and Constituency AIDS Coordinating Committees (CACOC). Strong HIV and AIDS programmes do not only need funding that will allow creativity to emerge and be exercised but also capacity-building and organisational stability for community-based organisations to be able to undertake such work.

2.7 Key populations disproportionally affected by HIV

UNAIDS, (2019a) indicated that more than half (54%) of the new HIV infections were from key populations and their partners in addition, according to UNAIDS, available data indicated that in 2018 the risk of acquiring HIV by men who have sex with other men (MSM) was 22 times higher than amongst all adult men, and 17% of new infections were from this group globally (2019a). Despite this, key population groups such as MSM are underserved. The concealed nature of many key populations, stigma and discrimination and criminalisation of their behaviour makes it difficult to track various steps along the HIV care continuum (UNAIDS, 2019b).

The Directorate of Special Programmes under the Ministry of Health and Social Services designed programmes targeting Men who have Sex with Men (MSM). The programme objectives were to target MSM with high impact HIV testing; prevention, treatment and care interventions necessary to fast track targets i.e. 90-90-90 with combination prevention services by 2022 (Republic of Namibia, 2017). Biological and Behavioural Surveillance (IBBS) was conducted among (MSM) in Namibia. The objective of the study was to measure the prevalence of HIV and associated risk factors, assess the uptake of prevention, care, and treatment services, and estimate the size of the MSM population in selected cities, Keetmanshoop, Oshakati, Windhoek, and Swakopmund/Walvis Bay. It is estimated that there are approximately 6500 MSM in Namibia (Republic of Namibia, 2014b).

Unprotected anal sex puts MSM at a higher risk of HIV infection. Some MSM is also known to be married or in heterosexual relationships, or are in single-sex incarceration environments or engage in transactional sex. These sexual practices have been found to serve as an epidemiological bridge for HIV transmission between different population groups. HIV transmission is often aggravated if STIs are present. According to the IBBS, HIV prevalence amongst MSM varies from 10.2% in Keetmanshoop, 7.1% in Oshakati, 10.1% in Swakopmund/Walvis Bay and 20.9% in Windhoek. Prevalence in Windhoek exceeds the national prevalence (14.3%) in adults. Each of these estimates is above the conventional 5% threshold used to define a "key population" at elevated risk for HIV. (Republic of Namibia, 2014b).

Lack of awareness of HIV serostatus appears as a major barrier to accessing services and the greatest contributor to the low proportion of HIV positive MSM receiving ART. Providing services to MSM remains a challenge, as societal attitudes, norms and values do

not affirm people of non-heterosexual identities or behaviours. The patriarchal structure of Namibian society has also contributed to the strict definition of male and female identities and roles and expected behaviours that drive men with alternative sexual behaviours and identities underground and hard to reach with health services. In Namibia, like in most Southern African countries, membership to key population groups carries with it a stigma, taboo and in some instances, criminalisation.

2.7.1 Sodomy law and criminalising MSM inhibit health-seeking behaviours

One of the main hindrances to health care is outdated laws that criminalise sodomy in Namibia. The 1920 common law on Sodomy criminalises anal sex between males. The sodomy law does not criminalise same-sex female sexual relations (Hubbard, 2000). The Legal Assistance Centre (n.d.) states that the sodomy law has been cited by prison officials in Namibia as justification for refusing to provide condoms to prisoners to prevent the spread of HIV. The argument is that since consensual sodomy is illegal, providing condoms might make prison officials accessories to the crime.

2.7.2 LGBTI community continues to experience discrimination and stigma

In Namibia despite the effective implementation and significant progress made in the prevention, treatment and care programmes and the policy directives that inclusive of MSM, MSM and gay men face discrimination and stigma when utilizing health care services (Fay et al., 2011). A study among MSM and gay men in Zimbabwe highlighted how the attitude of the medical personnel is discriminatory and thus discourages health-seeking behaviour. A negative attitude, lack of support and understanding from the health professional, deters gay men and MSM to seek medical services (Moyo, Macherera, &

Mavhandu-Mudzusi, 2021). Heteronormative counselling at health facilities makes it difficult for MSM to disclose their sexual orientation. Charurat et al., (2015), in a study conducted in Nigeria, warned that if the environment is not enabling and key populations are limited in their ability to disclose their sexual orientation, it becomes difficult to appropriately serve this population despite the high HIV incidence. However, to achieve HIV epidemic control, gay men and MSM need to access unhindered HIV care services.

Calls to repeal the punitive and discriminatory common law provision against sodomy that is silent on consensual sex between men and also silent on 'anal sex' amongst men and women' had been advocated for as it is an infringement of the rights of persons with different sexual orientation and sexual preference. A submission has been made to the legislature by the Minister of Justice to scrap the outdated and discriminatory sodomy law, however, the Namibia nations remain divided on the matter (Republic of Namibia, 2021).

Despite the pressure on the government of Namibia to repeal this outdated sodomy law, the country continues to reject the UN-Universal Periodic Review recommendations on LGBTI rights. The recommendations included, among others, the adoption of legislative measures to "decriminalize consensual sexual relations between adults of the same sex including a provision on the prohibition of discrimination based on sexual orientation" (United Nations, 2016). The report highlighted instances of discrimination and violence based on the actual or imputed sexual orientation or gender identity of victims, as well as multiple statements made by government officials which facilitate the perpetuation of an environment hostile to LGBTQ+ persons.

Civil society organizations in Namibia such as Outright Namibia, Rights not Rescue Trust Namibia, Women's Leaderships Centre continues to provide the needed support to key populations such as MSM and gay men. Findings in other countries showed peer support

played a significant adherence to ART and sustain retention in care over time and promote good clinical outcomes (Adebajo et al., 2015; Graham et al., 2018). Given the negative attitudes of health care givers, there is a need for some training that sensitises them about the specific needs of key populations and fosters an environment that does not assume heterosexuality in all patients.

2.8 Origin and history of HIV and AIDS

The origin of HIV and AIDS continues to be contested. There are, however, three main debates that predominate, namely that HIV originated among homosexuals, HIV is a virus that originated among chimpanzees and manga beys in Africa and HIV is a genetically engineered virus. In the 1980s, several homosexual men in Los Angeles and San Francisco were diagnosed with low CD-4 counts, pneumonia, Kaposi's sarcoma and other serious opportunistic infections. The prevalence of opportunistic infections among homosexual men was labelled as gay-cancer, gay-related immune deficiency and the gay plague. HIV was, therefore, assumed to have originated among homosexuals (Vance, 2019). It was, however, later established that HIV and AIDS were also prevalent among heterosexuals, with African-American heterosexuals in the USA disproportionately affected (Laurencin et al., 2018).

While the biomedical sciences were battling to unravel the prevalence of HIV and AIDS among homosexuals in the USA, a similar virus, called the Simian Immunodeficiency Virus (SIV), was discovered among chimpanzees and manga beys that were tested in Equatorial Guinea, in Africa (Mouinga-Ondémé, & Kazanji, 2013; Sousa, Muller & Vandamme, 2017). The research found that HIV was related to SIV. For example, the HIV-1 strain is closely related to a strain of SIV found in chimpanzees, and HIV-2 is closely related to a strain of SIV found in sooty manga beys (Sharp & Hahn, 2011). The SIV

infected humans through human-wildlife interaction. Some researchers argue that the SIV was introduced to humans through their consumption of the meat of chimpanzees and sooty manga beys which naturally carried SIV (Sharp & Hahn, 2011; Tebit & Arts, 2011). However, other researchers argue that chimpanzees and sooty manga beys were infected with SIV during an Oral Polio Vaccine preparation in Africa in the late 1950s. The SIV infected chimpanzees and sooty manga beys were released into communities that then consumed their meat (Vance, 2019). Counter-arguments are positing that polio vaccination did not infect chimpanzees and sooty manga beys with SIV, neither was infected chimpanzees and manga beys released into communities where their meat was consumed (Martin, 2015). In an attempt to explain how human and wildlife cross-species transfer occurred, the majority of researchers argue that it occurred under natural circumstances as a result of human exposure to infected simian blood, secretions or the consumption of their meat.

Some researchers allege that the origin of HIV is linked to the USA government who genetically engineered HIV (Heller, 2015). Once it was man-made, HIV was then introduced to homosexuals and African-Americans to exterminate them. It is claimed that the USA government deliberately injected gay men with the virus during the 1978 hepatitis-B experiments in New York, San Francisco and Los Angeles and that African-Americans were also intentionally infected with HIV (Zekeri, & Diabate, 2015). A former member of the South African Apartheid era intelligence services, admitted that HIV was used in Southern Africa by the Apartheid regime as weapons of war to exterminate African people (Baffour, 2019).

Despite numerous arguments that dispute this conspiracy theory, there are Africans who support the conspiracy. For example, former South African President, Thabo Mbeki,

publicly supported this conspiracy theory, disputing scientific claims that HIV originated in Africa and accusing the U.S. government of manufacturing the disease in military laboratories. Mbeki, furthermore, established a Presidential AIDS Advisory Panel to investigate the allegations that HIV and AIDS were man-made. Similarly, the Nobel Peace Prize winner, Kenyan ecologist, Wangari Maathai, used her international spotlight to support this conspiracy theory. She, however, later retracted her support for such theories (Presidential AIDS Advisory Panel, 2001; Hogg et al., 2017). This conspiracy theory that HIV could be genetically engineered had an adverse effect on health-seeking behaviours, particularly among people of African descent in the USA where they would either delay testing for HIV or refuse ART and PMTCT (Myers et al., 2018).

Another argument around the origin of HIV and AIDS concerns the transition from HIV to AIDS. The biomedical sciences confirmed a universal principle that HIV causes AIDS (Nattrass, 2012; Schwetz, & Fauci, 2019; Jato, & Budi, 2021). There are, however, a few AIDS denialists who argue that there is much that is not yet fully understood about the transition of HIV to AIDS and about what triggers the development of AIDS (Duesberg et al., 2011; Meylakhs et al., 2014). These uncertainties about HIV and AIDS have led to the former South African president, Thabo Mbeki, refuting the hypothesis that AIDS is the direct result of infection with HIV (Presidential AIDS Advisory Panel, 2001; Hogg et al., 2017). Mbeki had the following queries to the scientific fraternity, which remain unanswered to this day: (1) why is HIV spreading rapidly in Africa? (2) Should Africa devise a different response than the western countries to its HIV and AIDS problem? He also called for further research that would, hopefully, reveal whether there were significant factors specific to the African AIDS situation, and suggested that research needed to be conducted to investigate whether the parasitic infections that were prevalent in Africa (but

not in most developed countries) predisposed individuals to AIDS (Kim, 2015). Mbeki's hesitance to link HIV to AIDS was considered irresponsible on his side as it had implications for the South African HIV and AIDS programmes, such as delaying the rolling out of the ART and PMTCT interventions (Nattrass, 2012).

The origin and history of HIV and AIDS remain controversial and has a major impact on how communities and individuals respond to medical interventions and HIV and AIDS behaviour change programmes. In particular, communities, such as that of gay men or people of African descent in America who are perceived to have started HIV, run the risk of being stigmatised and discriminated against. Hence, HIV and AIDS intervention programmes need to be cognizant of the way communities relate to the origin and history of HIV and the way it affects their health-seeking behaviours.

To recap, this chapter sheds light on dry sex and polygyny and their social significance. The risk these practices pose to HIV is also highlighted. It is argued that to interrogate practices that promote HIV and AIDS effectively, coherent HIV and AIDS behavior change programmes is necessary. Only when cultural practices are directly addressed as part of an HIV and AIDS prevention strategy at the policy and programme level can the prevalence of HIV and AIDS in the Zambezi region and Namibia hopefully be addressed. This research adopts a holistic understanding of the HIV pandemic which impacts all areas of socio-economic life and all levels of society.

HIV and AIDS in Africa are shifting from purely medicalizing the virus to recognizing the wider socio-economic and socio-cultural factors that perpetuate the pandemic. To this day no cure or vaccine has been developed, however, several preventive strategies have been rolled out to curb the spread of the virus, varying from ARVs, PMTCT, VMMC, Prep,

consistent condom use, sexual abstinence, among others. Despite HIV being a global concern, how each country responds is determined by several factors such as cultural, political will, socio-economic status and promotion of gender inequality.

It set out that HIV remains a global concern, with sub-Saharan Africa being the epicenter and young women are mostly affected. The origin of HIV and AIDS continues to be contested, with several conspiracy theorists making claims about how it originated. This chapter particularly focuses on three debates that HIV originated among homosexuals in the USA, that it originated among monkeys and mangabeys in Africa and that it could transfer to humans through human-wildlife interactions and that it is a genetically engineered virus and by extension a weapon of warfare. The next chapter discusses the theoretical and conceptual frameworks, the intersection between socio-economic and gender inequality, as well as how practices such as dry sex and polygyny shape and structure the prevalence of HIV and AIDS.

CHAPTER 3: THEORETICAL and CONCEPTUAL FRAMEWORK

3.1 Introduction

Several theories have been employed to investigate HIV and AIDS. The majority of these theories prioritised individual cognitive variables as part of HIV and AIDS behaviour change. These theories disregard the influence of socio-cultural factors on the behaviour of the individual. This study employed Vygotsky's Social Constructivism Theory to assess the inclusion of practices in of dry sex and polygyny. It also employed Connell's Theory of gender and power to explore women's vulnerabilities to HIV and AIDS.

This study, therefore, posits that practices that perpetuate HIV and AIDS need to be explored and identified. Practices, such as polygyny and dry sex play a role in influencing the risk of contracting HIV and thus ought to be addressed (Page, 2019; Ramjee & Daniels, 2013). It is, therefore, important to comprehend how community members came to learn about these cultural practices and to devise culturally appropriate ways to address them. This study argues that the social context within which HIV and AIDS are spreading and responding to is influenced, created and interpreted by both culture and gendered relations. It aims to demonstrate the process by which HIV and AIDS, interact with culture and, by extension, gender relations. It, furthermore, advocates for the inclusion of cultural practices in HIV and AIDS behaviour change programmes.

3.2 The Social Constructivist Theory

This study employed the Social Constructivist Theory as one of the theoretical frameworks to locate this research project. The Social Constructivist Theory will be used in this study to explain the extent to which HIV and AIDS behaviour change programmes exclude socio-cultural factors that perpetuate HIV.

Social Constructivist Theory is said to have originated from the work of Vygotsky. It is also a communication theory that examines the knowledge and understanding of the world as developed jointly by individuals. This theory assumes that understanding, significance and meaning are developed in coordination with other human beings. The most important elements in this theory are (a) the assumption that human beings rationalise their experiences by creating a model of the social world and the way it functions, as well as (b) the belief in language as the most essential system through which humans construct reality (Leeds-Hurwitz, 2009). For example, practices are preserved and hence transcend from generation to generation because they are part of the social narratives. The younger generation through their observation and structured ways of learning come to learn about the social importance of preserving and practising practices such as dry sex and polygyny. Smart (2019) states that language is a very important tool through which culture is preserved. Interestingly, a cultural practice that had its social significance in a particular time and space in society, e.g. polygyny was important when families were pastoralists and horticulturalists and thus relied on the contribution of several family members for their collective sustenance. However, in an era, where HIV is prevalent in society, the health risk posed by practices of polygyny outweighs the economic benefits of such cultural practices.

Vygotsky (1978) posits that cognitive growth occurs first on a social level, after which it can occur within the individual. Social constructivists assume that reality is built through human interaction. Members of a society collaborate to develop the reality of the world in which they live (Idang, 2015). Under the social constructivist perspective, the reality is not something that can be discovered or that can exist outside of social invention.

Vygotsky holds an anti-realist position and states that the process of knowing is affected by other people and mediated by the community and its culture. Qiang and Yanru (2020) also argue that the roots of individuals' knowledge are found in their interactions with their surroundings and other people before their knowledge is internalised. According to Shah, (2019) culture and context in understanding what occurs in society and knowledge construction based on this understanding are emphasised in social constructivism. Thomas et al., (2014) point out that social constructivism is based on specific assumptions about reality, knowledge and learning. All of the mentioned assumptions are described in detail below:

Reality: The first assumption of social constructivism is that reality does not exist in advance; instead, it is constructed through human activity. Idang (2015) argues that members of a society or group together (and not an individual) invent the properties of the world or group.

Knowledge: Social constructivism represents knowledge as a human product that is socially and culturally constructed (Mohammed & Kinyo, 2020). Individuals can create meaning when they interact with one another and with the environment in which they live.

Learning: This assumption of social constructivism stresses that learning is a social process. Learning does not take place only within an individual, nor is it passively developed by external forces. Social constructivists argue that meaningful learning occurs when individuals are engaged in social activities such as interaction and collaboration.

For Vygotsky, constructivism was more concerned with understanding the influence of social environments on the learning process. Vygotsky (1978) considers cognitive development primarily as a function of external factors, such as cultural, historical and social interaction, rather than of individual construction. Vygotsky (1978), furthermore,

believes that people master their behaviour through psychological tools and he, thus, introduces language as the most important psychological tool. He also raises the importance of culture in the construction of knowledge.

3.2.1 Social Constructivism and human sexuality

Foucault, Simon and Gagnon have been credited for their major contributions to social constructivism in the area of human sexuality (Gagnon & Simon, 1973; Foucault, 1979; Simon & Gagnon, 1986). In this study, a distinction is made between sex and sexuality. Sex is defined in terms of sex organs, sex chromosomes, and sex hormones and it is biologically given (Carlson, 2016). It is a biological category with two identifiable sexes, male and female. Sex is distinguished from gender, as gender is considered a social construct. On the other hand, sexual behaviour includes a wide variety of activities individuals engage in to express their sexuality (Faini et al., 2020). According to Brown (2013), sexual behaviour can be classified as masturbation, oral-genital stimulation (oral sex), penile-vaginal intercourse (vaginal sex), and anal stimulation or anal intercourse. Sexual behaviours may also include activities to arouse the sexual interest of others or attract partners. Individuals engage in sexual behaviours for a variety of reasons, differ in their acceptability based on societal norms, and change across the lifespan.

There are other marital and or sexual practices such as polyandry and polyamory that can perpetuate HIV, due to the multiple sexual nature of these practices. Polyandry is practised where a woman marries two or more men. Fraternal polyandry (where a woman is married to two or more brothers) is found in certain areas of Tibet, Nepal, parts of China and part of northern India where it is accepted as a social practice (Gurung, 2012; Benedict, 2017). In the African context, however, Machoko, (2017) refers to what he terms non-traditional

unconventional polyandry where a woman simultaneously have more than one husband or male sexual partners both or all of them knowing, accepting and approving of the sexual relationship. Starkweather and Hames (2012) argued that non-classical informal polyandry does not involve marriage or co-residence in the same domicile but necessitates that multiple men were or are simultaneously engaged in sexual relationships with the same woman and that all men in the relationship have socially institutionalized responsibilities to care for the woman and her children. Machoko, (2017) therefore, advocates that Zimbabwean society must accord polyandry the same respect and dignity as they do to polygyny, for the reasons that it provides women with sexual independence and sovereignty. Machoko, (2017) however warns that unconventional polyandry is a practice that is socially not sanctioned in societies where it occurs, as it is condemned and rejected by traditional chiefs, diviners and the Christian churches. Polyandry has no root in any Namibian culture or tradition, despite it occurring informally.

There is however also polyamory, which refers to males or females who have multiple romantic relationships at the same time. A study conducted by Pauli (2019), in Fransfontein, North-western Namibia alludes to unmarried women who have more sexual partners throughout their lives. Pauli, (2019) indicated that married women have on average children with one or two different partners, whilst unmarried women may have up to five or six sexual partners. Pauli (2019) tied these relationships to the economic benefit that women gain from men. Many unmarried women manage to survive as a result of the social networks they were able to build through joint parenthood with the different fathers of their children. Polyamorous relations have also been reported among the OvaHimba, where a married couple can share their spouse with other people, both husband and wife can share their spouses. It should be noted that OvaHimba also practices polygyny (Scelza, Prall, & Starkweather, 2021).

Both polyandrous and polyamorous relations pose a high risk for HIV transmission because of the multiple concurrent sexual partners. This study is however not focused on either polyandry or polyamory as these practices are not occurring in the Zambezi region, if they do occur they are likely to be shunned. Musisi, (2014), note that sexuality and gender are linked in different ways in different cultures, at different times in history. Gender is a framework from which sexual scripts can be developed and internalized. Men and women take up different sexual scripts in the performance of masculinity and femininity that influence their behaviour, interactions and emotions regarding sex. (Masters et al., 2013; Rossetto, & Tollison, 2017). Gendered messages have the potential to reinforce sexual double standards that affirm male sexuality whilst female sexuality is regulated. (Masters et al., 2013). The sexual script has a great impact on one's susceptibility to HIV.

Social Constructivist Theories employ what is termed ‘scripting theory’ as the principal way of explaining how various aspects of sexuality are socially constructed. Gagnon and Simon coined the term sexual script, describing sexual behaviour as learned from a particular cultural and social context, hence defining sexual behaviour as fundamentally social (Gagnon & Simon, 1973; Ussher, 2017). According to Gagnon and Simon (1973) sexual scripts are guiding posts for socially acceptable sexual conducts within a society, thus allowing individuals to conceptualize their roles in sexual encounters. This description of sexual behaviour differs from earlier conceptualizations that emphasized sexual behaviour as purely biological.

Gagnon and Simon (1973) present a theory on sexuality that is social constructionist. They also reject the essentialist view that sexuality is not universal and the same in all historical times and cultural spaces. Stevens (2015) furthermore, argues that sexuality is created by

culture, by defining some behaviours and relationships as sexual and the learning of these definitions or scripts by members of the society. Foucault (1978) also applies social construction to human sexuality. He argues that human sexuality cannot be explained fully by theories of biological essentialism. Sexuality is not a biological quality or natural, inner drive whose character remains the same across time and space. Sexuality, therefore, is a cultural construct. Its meaning is derived from language or discourse; each institution in society has a discourse about sex, a way of thinking and talking about the broad array of aspects involved in sexual expression.

Foucault (1978) discusses the relation of sexual desire to power (power being something society wields through the beliefs and actions of its members). He, consequently, suggests that power and sexual desire are linked in a complex and primary way. He supports this by saying: Power is essentially what dictates its law to sex. This means first of all that sex is placed by the power in a binary system: licit and illicit, permitted and forbidden. Secondly, power prescribes an "order" for sex that operates at the same time as a form of intelligibility; sex is to be deciphered based on its relation to the law. And finally, power acts by laying down the rule: power's hold on sex is maintained through language, or rather through the act of discourse it creates, from the very fact, that it is articulated, a rule of law (p. 83). Foucault thus implies that society utilises its power to dictate which sex acts or desires are to be considered "permitted and forbidden". For example, practices, such as polygyny, dry sex, wife inheritance, child marriages and, to an extent, widow cleansing, have their social significance in the society where they are practised. Customary laws dictate what is permitted or forbidden sexually, for example, in societies where widow cleansing has to precede engaging in sexual relations after the death of a spouse. It thus implies that a widow or widower cannot engage in an intimate relationship or remarry

unless she or he has adhered to the practice of widow cleansing (Makoye, 2013; Lomba, 2014 & Perry et al., 2014).

The same can be said about constituting marital unions. In one society, monogamy could be the culturally accepted marital institution, while in another, polygyny can be the accepted union. However, because of the strong correlation between individual sexuality and the influence of society in shaping that sexuality, HIV and AIDS prevention programmes have to include the impact of society and the way it shapes sexual behaviour that is potentially a risk factor to contracting HIV (Olutayo, 2015).

3.3 Connell's Theory on gender and power: Explaining women's vulnerability to HIV and AIDS

Another theoretical lens utilised in this study is Connells's theory of gender and power. According to Connell (1987), the Theory of gender and power is a social, structural theory based on sexual inequality, as well as gender and power imbalances between men and women. Connell's Theory of gender and power can thus assist in explaining women's vulnerability to HIV and AIDS. The current theories that inform HIV and AIDS behaviour change programmes do not properly address the impact of power imbalances and the dyadic nature of heterosexual relationships. These theories which assume that the individual has total control over his or her behaviour, as well as those contextual factors, such as power differentials and gender roles, that may heighten women's HIV risks, are given little attention (Frew et al., 2016; Michielsen, et al., 2012).

According to the theory of gender and power, three major social structures characterise gendered relationships between men and women: the sexual division of labour, gender power imbalances and the structure of cathexis (Wingood & DiClemente, 2000). This study

applied the theory of gender and power to shed light on the way that cultural practices perpetuate women's vulnerability to contracting HIV as it explored the exposure, social/behavioural risk factors and biological properties that increased women's vulnerability to HIV (Wingood & DiClemente, 2000, p. 539).

3.3.1 Unequal sexual division of labour exposes women to HIV vulnerability

Women's lack of economic opportunities, a result of low educational opportunities resulting in under- or unemployment, prevent women from being economically independent (Austin, Choi, & Berndt, 2017). This then results in women being economically dependent, thus limiting their autonomy within their relationships. The lack of financial autonomy creates both financial and material dependence on others, including sexual partners. Hunter, (2015) warns that financial dependence on one's sexual partner may contribute to a power imbalance in a sexual relationship. It may limit sexual negotiation, particularly in the context of HIV prevention. Women, who opt for commercial sex work, do so as a means of survival. Studies have shown that women in this profession find it difficult to negotiate consistent condom use. Hence, they face the risk of STIs and/or HIV infection (Maynard & Ong, 2016; Mojola, 2014).

The theory of gender and power, furthermore, proposes that women who live in poverty tend to be coerced into sex due to their survival needs. Such women and girls would thus participate in transactional sex, with limited power to negotiate safe sex, which would heighten their HIV and AIDS risks (Maynard & Ong, 2016). Studies in sub-Saharan Africa confirm the association between women's risk of contracting HIV and poverty (McCoy et

al., 2014). Women lack power in sexual relations, which results in sexual encounters being conducted according to terms stipulated by men and for their pleasure.

3.3.2 Gender power imbalances heightens women's vulnerability to HIV

Certain behavioural risk factors predispose people to HIV and AIDS. The risk factors, as highlighted by Wingood and DiClemente (2000), are alcohol and drug abuse, lack of sexual negotiation skills, low self-efficacy to avoid HIV, poor skills in condom use and limited control over condom use. Women exposed to these factors are less likely to hold authoritative influence and control in their relationships; their power over safer-sex practices are compromised (Grangeiro et al., 2015; Armstrong et al., 2015; Costa, McIntyrec, & Ferreira, 2018; Ajayi, Ismail, & Akpan, 2019; Qin et al., 2020; Cornish et al., 2021). Similarly, the lack of skills among women regarding the use of condoms or to request for condom use has been found to decrease safer-sex practices (Peasant et al., 2017). Peasant et al. (2017) also report that women who did not feel that they had control over, or the right to insist on, using condoms did not act on their knowledge of the risk of HIV and were thus less likely to practice safer sex. Among men, reasons for not using condoms included reduced pleasure (reduction in penile sensation and interruption of 'being in the heat of the moment" (Kanda, & Mash, 2018).

In a social context where sexual autonomy rests with the male sexual partner, women may find that they have lesser self-efficacy towards condom use or decisions regarding how sexual encounters take place. Self-efficacy is defined as the belief that one can accomplish what one has set out to do (Bandura, 2012; Williams, & Rhodes, 2016). This is a particularly important characteristic during the negotiation of safe sex. Furthermore, a person's AIDS-related self-efficacy is the perceived ability to engage in protective

behaviour against HIV and AIDS, such as being knowledgeable of one's partner's sexual history. Safer-sex self-efficacy is the perceived ability that one can negotiate condom use with one's partner. It has been reported that the higher a person's AIDS-related self-efficacy, the lower the high-risk practices and the more likely one is to refuse unwanted sex (Kaaya, et al., 2020). Especially females are at risk of contracting HIV, as they are less likely than males to utilise sexual negotiation techniques (Mojola, 2014).

Sexual relations between men and women tend to be unequal, favouring men (Connell, 1987). Women and girls are powerless to protect themselves against contracting HIV. Their inability to protect themselves against HIV infection is a direct function of power relations between men and women (Rwafa, Shamu, & Christofides, 2019). According to the Theory of gender and power, three social structures of labour, power and social norms interact to create risk factors that heighten HIV and AIDS risks among women and girls (Connell, 1987). Thus, women with low relationship power have limited control over the way that sexual relations will take place and when these will take place.

Edwards (2007, p. 235), furthermore, states that despite women having high levels of knowledge about modes of HIV and AIDS transmission and prevention, they lack control over their sexuality because of economic dependency, sexual violence and patriarchal sexual ideologies and practices which diminish their ability to express their sexual preferences and desires. These include the right to say no to sex, decide when and with whom they want sex, the size of the sexual networks of which they are they are part and the right to insist on protected sex.

3.3.3 Condoning violence against females as a disguise of culture

Gender-based violence and beliefs that subordinate women are condoned in some cultural norms thus, increasing their health risks (Kalra, & Bhugra, 2013). It has been reported that women who have experienced abuse are consequently placed at higher risk of being infected with an STI and HIV (Dunkle et al., 2004; Sabri et al., 2019). Women reporting the experience of forced sex or intimate partner abuse also reported higher levels of sexual risk-taking, such as having multiple sexual partners or having high-risk partners (Sharma et al., 2020). Wood, (2019) posit that patriarchal systems tend to use cultural practices to violate and subjugate women. For example, it has been argued that cultural practices, such as female genital cutting, are a form of gender oppression and a human rights violation (Boyle, 2002; Williams-Breault, 2018).

The strength of the Theory of gender and power is its focus on gender equality and the conviction that gender equality cannot be achieved under existing ideological and institutional structures. Jacobson et al. (2018) states that this theory is situated in women's lived experiences. Its approach is to start with women's concrete experiences, integrate these experiences into theory and rely on theory for a deeper understanding of the experiences (Johnson, 2014).

3.4 Justification to merge Vygotsky's social constructivism and Connell's theory of gender and power

The two theories that underpin this study are the Social Constructivist Theory and Connell's theory of power and gender. By combining the two theories they yield a better theoretical and empirical understanding of the location of the study. Dreher (2016), furthermore, claim that the social constructivism theory tends to leave the social construction of power under-

theorised because it lacks the tools to explain how gender and power are reproduced, as well as how and why certain constructs emerge and become more influential than others. Furthermore, social constructivism is not sensitive to power as a social and gendered construct, and such negation risks epistemological inconsistencies. Social constructivism has dealt with power in various ways, but not at the level at which Connell's Theory of gender and power analyses it. For Connell, power refers to both a means to legitimate authority and a material resource. As far as feminist studies are concerned, the majority of women lack this form of power and it, thus, leads to their subordination.

Connell's Theory of gender and power had thus been employed to explain women's vulnerability to HIV and AIDS. Women's vulnerability to HIV and AIDS is heightened by cultural notions that expect women to maintain subordinate positions, which inhibits their power to negotiate safe sex (Klaas, Thupayagale-Tshweneagae, & Makua, 2018 & Rwafa, Shamu, & Christofides, 2019). Thus, the increased vulnerability of women to infection may be ascribed to socio-cultural factors which place them in difficult positions to act in ways that could protect them from becoming infected with HIV. While, on the other hand, cultural notions regarding masculinity shape men's sexual behaviours regarding perceptions that: the male sexual drive is uncontrollable, men need to prove their capacity to perform sexually and they need to exercise power over others, such as women (Fleming, DiClemente, & Barringtons, 2016). These notions about masculinity also play significant roles in the spread of HIV.

3.5 Biomedical theories that inform HIV and AIDS behaviour change programmes

Numerous theories have been designed over the years to inform the prevention of HIV and AIDS. Given the medical nature of HIV and AIDS, theoretical frameworks, such as the

Health Belief Model, the Theory of Self-regulation, Theory of Reasoned Action, Social Cognitive learning Theory, the Planned Behaviour Theory, interpersonal relations and Stages of Change Protection Motivation Theory, as well as the Self-control and the Subjective Culture theories, all aim at informing prevention programmes to focus on individual behaviour change. These theories thus place significant emphasis on individual cognition, agency and self-efficacy (Bandura, 2000; Davis et al., 2015; Williams, & Rhodes, 2016). These theories focus on influencing behaviour on an interpersonal and personal level. They prioritise cognitive variables as part of behaviour change and assume that individual attitudes and beliefs, as well as expectations of future events and outcomes, are determinants of health-related behaviour. By focussing on cognitive constructs of behaviour, the interventions explicitly or implicitly start from the assumption that cognitions influence the person's thinking and decision making and thus drive sexual behaviour (Hinton, 2017).

Cognitive behavioural theories tend to focus on altering the motives, intentions and behaviour of the individual and ignore the fact that sexual intercourse takes place between two persons, within a relationship. Several factors increase women’s vulnerability to HIV and AIDS, such as the level at which they are in a position to influence a sexual decision. For example, sexual relationships with someone much older are risky because it exposes the women, particularly young girls, to a partner who is more likely to be sexually experienced and hence more, likely to be HIV-positive. Often, intergenerational sexual relations tend to be transactional, with money or gifts given in exchange for sexual intercourse (Maher, 2020). This further inhibits the ability for sexual negotiations.

Theories that inform HIV prevention programmes must implicitly recognise that personal attitudes, and norms are influenced by behavioural and normative beliefs in the society, which is useful for tracking varying modes of sexual socialisation. Hence, there is a need to recognise the contribution of structural factors to women's vulnerability for HIV (Krishnaratne et al., 2016). These environmental aspects such as taboos cultural expectations around women's sexuality, e.g. use of herbs to dry the vagina, norms and values, policies, poverty, education as well as more proximate influences. There is a need to account for structural factors at a theoretical level that might improve the design of HIV and AIDS prevention programmes and assist in their evaluation, by understanding the possible barriers between motivation and actual behaviour change.

3.5.1 Biomedical intervention of curbing HIV and AIDS

The biomedical condition of HIV and AIDS is well understood, with transmission mainly occurring through four modes, namely blood, semen, vaginal fluids and breast milk (WHO, 2015; UNAIDS, 2017; Rwafa, Shamu, & Christofides, 2019). The most common form of transmission in sub-Saharan Africa is through any form of unprotected sex with an infected person (Rwafa, Shamu, & Christofides, 2019). Furthermore, blood transmission occurs as a result of intravenous drug use, needle-stick injury and blood transfusion. Besides, HIV can also be transmitted from mother to child during pregnancy, childbirth or breastfeeding (Blanche, 2020).

Advancement in halting the spread of HIV has been significant. Over the years an HIV combination strategy has been adopted which entails home-based HIV testing and facilitated linkage of HIV-infected persons to care through community health workers, and universal antiretroviral therapy for seropositive persons regardless of CD4+ cell count or HIV viral load (World Health Organization, 2016). It also includes voluntary medical male

circumcision, diagnosis and treatment of sexually transmitted infections, behavioural counselling, and condom distribution. HIV and AIDS behaviour change programmes are specifically credited for reducing concurrent multiple sexual partners and increased, consistent condom use (George et al., 2019). The HIV combination strategy also incorporates reduction of tuberculosis transmission, including prevention of mother to child HIV transmission (Vermund et al., 2013; Blanche, 2020). This has been shown to prevent HIV-related deaths effectively (Geldsetzer et al., 2017). Female-controlled HIV and AIDS prevention methods, such as the female condom and vaginal microbicides, have advanced but remain unaffordable and inaccessible to most poor women, thus leaving women to rely on male-controlled condoms (Bame, Wiysonge & Kongnyuy, 2018).

Possible reasons for this oversight could be that HIV and AIDS programme facilitators lack the understanding and skills to integrate cultural practices in HIV and AIDS policy and programmes. It could also be that HIV and AIDS programme facilitators are resistant, or hesitant, to interrogate cultural practices because of methodological challenges. There is also a concern that an overemphasis on the role of cultural practices can blame the afflicted communities for their high rates of infection. Particular cultural groups can also become stigmatized and ostracized on account of inappropriate claims of cultural causation (Sovran, 2013; de Vries, Landouré, & Wonkama, 2020). The field of sexuality and culture is considered a difficult and sensitive subject. This, however, should not make scientists shy away from interrogating this field of study. Shying away could be tantamount to academic irresponsibility.

In the case of Namibia, the National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22 recognise what is termed harmful cultural practices in

promoting HIV and AIDS (Republic of Namibia, 2017). These policy frameworks commit to sensitising community members regarding harmful cultural factors that may increase the risk of HIV and AIDS. Furthermore, measures are to be developed to deal with harmful cultural practices that increase the vulnerability to HIV infection. Lastly, support services and remedies are to be provided to individuals who are victimised because they have rejected harmful traditional practices. Despite these policy directives, HIV and AIDS behaviour change programmes have not integrated harmful cultural practices, neither are the measures in place for those individuals who do not want to comply with cultural practices that are potentially harmful to them.

3.6 Cultural practices and the link to HIV and AIDS

The link between cultural practices and the spread of HIV has long been established in Africa (Nkwi & Bernard, 2012; Nkosi, 2012; Sovran, 2013; Menon, 2014; Adesina, 2015). Patterson, (2014) define culture as a stable process that is collectively made, reproduced, and unevenly shared knowledge structures that are informational and meaningful, internally embodied, and externally represented and that provide predictability, continuity, and meaning in human actions and interactions. Culture is thus handing down customs, beliefs and stories from generation to generation. Uwah, (2013) emphasised the importance of investigating the relationships between the cultural object, the creators, the receivers and the context in which the cultural object is occurring.

Chigozi, & Ekechukwu, (2015) note that culture has both positive and negative influences on health behaviour and it has impacted the prevalence of HIV and AIDS in Africa. It is important to note that culture does not exist independently of individuals. Individuals give social interpretations to culture and allow a culture to shape their lives and environment,

while culture can, furthermore, also be viewed as a dynamic construct that can also be subject to change. This point is further reinforced by Idang (2015) who believe that culture is one of the many factors influencing human behaviour, value systems, beliefs and practical knowledge. Means of expression or communication, such as music, dance, theatre and art, are those creative aspects of culture that we often narrowly define as culture itself. However, culture in a broader sense also includes traditions and local practices, taboos, religious affiliations, gender roles, marriage and kinship patterns, among others (Uwah, 2013). Consequently, culture is deeply rooted in all aspects of society, including local perceptions of illness and health-seeking behaviour.

3.7 The need for cultural sensitivity in HIV and AIDS prevention

The need for a cultural approach to HIV and AIDS prevention has long been debated. Chigozi, and Ekechukwu, (2015) contend that HIV and AIDS prevention programmes should be informed by the experiences and traditions of knowledge of the audiences for whom the programmes are intended. Chigozi, and Ekechukwu, (2015) furthermore, warn that HIV and AIDS prevention programmes that overlook the cultural sensibilities of their target audience are unlikely to achieve success in their quest to change the behaviour of such a target audience.

Stubbe, (2020) refer to cultural sensitivity and cultural competence as prerequisites for health interventions. Cultural sensitivity is the extent to which the ethnic/cultural characteristics, experiences, norms, values, behavioural patterns and beliefs of a target population, as well as their relevant historical, environmental and social forces, are incorporated in the design, delivery and evaluation of targeted health promotion materials and programmes (Stubbe, 2020). Cultural competence, on the other hand, is the capacity of

individuals to exercise interpersonal cultural sensitivity (Greene-Moton, & Minkler, 2020). Thus, culturally competent refers to practitioners, whereas culturally sensitive relates more to intervention materials and messages.

Stubbe, (2020) identify the following core cultural values that should be considered when developing health programmes for an audience of African descent: communalism, religion/spiritualism, expressiveness, respect for verbal communication skills, connection to ancestors and history, commitment to family and intuition and experience versus empiricism. Stubbe, (2020) attest that incorporating these core cultural values in health intervention programmes is likely to make an impact among the intended audience.

Resnicow et al., (2000) outline cultural sensitivity as:

1. **Peripheral linguistic strategy**: It refers to the mode in which the behaviour change programmes are presented, for example, the message should be receptive and accessible. This would entail the use of native languages and culturally sensitive scripts and contexts relatable to the programme recipients.
2. **Socio-cultural strategy:** This strategy ensures that the methods employed will heighten the reception of the programme by the recipients. This would require the messages to be reflective of the context, beliefs, norms, experiences and priorities of the programme recipients.
3. **Constituent strategy:** Individuals (s) who inform the programme design must be from the targeted recipients. The active participation of the targeted recipients in the entire process of the programme design, from the initial phase to the implementation including the evaluation, should be a key priority.

Uwah (2013) warns that HIV and AIDS prevention programmes that are prepacked and prescriptive reflect neither the cultural dynamics nor the socio-economic realities of the

target audience. It is important to design HIV and AIDS behaviour change programmes that respond to the cultural dynamics and socio-economic realities of the communities.

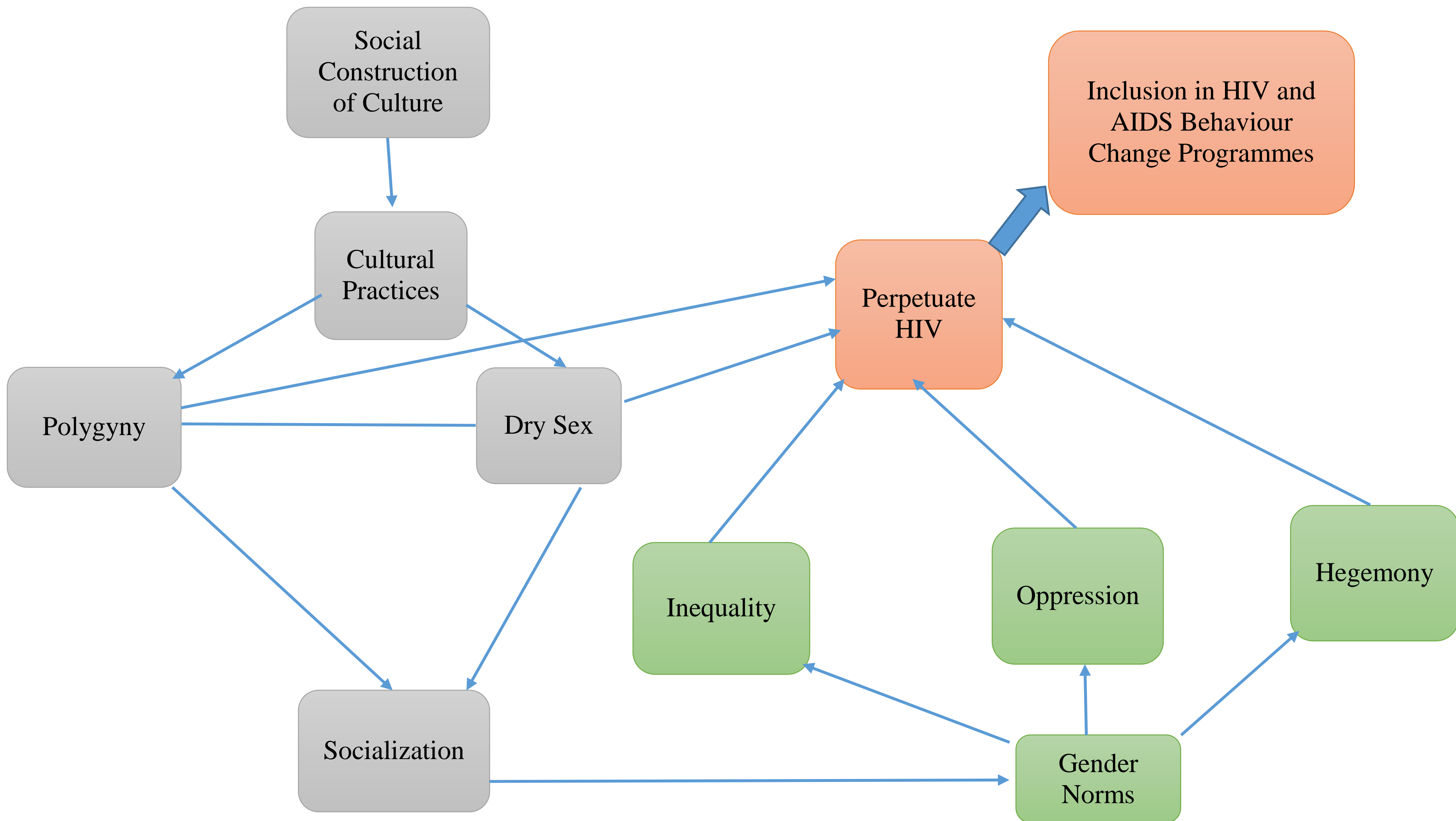


Figure1: Conceptual framework of social construction, gender and power theories and their linkage to HIV and aids behaviour change programmes

This conceptual framework provides a roadmap of how this research was explored and it is also explaining the relationship between the various constructs and variables. The conceptual framework is embedded in social constructivism and Connell's theory of gender and power. Adom, Hussein, and Adu-Agyem, (2018) refer to a conceptual framework as a system of concepts, assumptions and beliefs that support and guide the research plan. Adom, Hussein and Agyem, (2018) further, elaborates that a conceptual framework is a structure of what has been learned to best explain the natural progression of a phenomenon that is being studied. The conceptual framework, therefore, offers a logical structure of connected concepts that assist in providing a picture or visual display of how ideas in a study relate to one another within the theoretical framework. The conceptual framework also provides an opportunity to specify and define variables and constructs in the research (Mensah et al., 2020).

3.8 Social Constructivism theory in linking polygyny and dry sex to HIV

Social constructivism theory is concerned with the processes by which people describe, explain, or account for the world in which they live. They see the speech, language and communication as having the central role of the interactive process through which we understand the world and ourselves (Galbin, 2014). The theory postulates that a person's beliefs are created within the social context in which he or she lives and as such his or her knowledge, as a social phenomenon, develops within social interaction. According to the social constructivist theorist, cultural practices such as polygyny and dry sex are learnt behaviour through socialization. Internalization occurs by way of socialization when people in a society learn the objective facts of a culture and make these facts part of their everyday, or internal consciousness (Höppner, 2017; Karpov, 2016). Socialization is a combination of willed conformity and externally imposed rules, mediated by the expectations of other persons. Most people who had gone through the process of internalization,

rarely question and merely adopt these practices as a way of life. Consequently, social realities are continuously being constructed and reconstructed in a dialectic process between individuals interacting with each other and with their social world (Ba', 2021).

With this conceptual framework, it is attempted to demonstrate the process by which HIV as a biological process is perpetuated by polygyny and dry sex. This will hopefully reveal the precise nature of the social construction of HIV. The practice of polygyny which is characteristic of multiple concurrent sexual partnerships heightens the risk of HIV. On the other hand, the practice of dry sex causes skin lesions during sexual intercourse and the associated discomfort of using condoms also exposes sexual partners to HIV risk. It should be noted that something as complex as HIV cannot be understood outside the culture in which it occurs. In this context, HIV reflects both biological and cultural elements. Hence, Ajrouch, (2015) states that culture signifies a fundamental aspect of human life. To fully comprehend the drivers that perpetuate HIV all possible factors should be explored and identified, irrespective of whether they are biological or cultural. HIV lays bare every aspect of the culture in which it occurs. It is for these reasons that this study advocates that polygyny and dry sex needs to be incorporated into HIV and AIDS behaviour change programmes. By drawing the linkages between polygyny and dry sex as possible drivers of HIV, a standpoint will be created that diseases are not mere biological entities but rather socially constructed phenomena.

The use of the social constructionist approach in this study had many implications on the way core issues of the study are viewed such as cultural practices of polygyny and dry sex, gender norms, the influence of socializations patterns on HIV risk and whether all these variables and constructs are included in HIV and AIDS prevention strategies. Firstly, HIV

is constructed in many ways, one of them being biomedical construction. From the biological perspective, HIV is framed as a virus that causes infections through various transmission routes, and can ultimately cause suffering, illness and sometimes death (Becerra, Bildstein, & Gach, 2016). The aspects of the disease that is social and biological are parts of a single social reality in which disease is produced, experienced, and reproduced, and in which the cultural meanings of the experience are defined, acted upon, and struggled over (Conrad, & Barker, 2010). Similarly, HIV and AIDS prevention strategies and sexuality are also viewed as being constructed in many ways. The focus of this study will be on how social and cultural systems shape sexual experience concerning HIV and AIDS prevention strategies.

3.9 Connell's theory of gender and power: linking gender norms and HIV vulnerabilities

There is an interplay between social constructivism theory and Connell's theory of gender and power as they both explain the process of socialization. Connell's theory of gender and power highlights power imbalances in the relationship between men and women. The theory further elaborates gender norms heightens male and female vulnerabilities to HIV (Wingood, & DiClemente, 2000). The theory of gender and power is also used to delve into conservative gender and cultural norms and traditional beliefs that condone violence against women as a disguise of culture (Perrin et al., 2019). Adesina (2015) notes that traditional practices in Africa, such as polygyny and dry sex combined with forms of female insubordinations act as potential modes of HIV risks.

Adesina (2015) further recognised that cultural and religious traditions complicate reactions to HIV and AIDS and that cultural taboos around sexual talk hinder possibilities

of encouraging communication around safe sex among couples and individuals from different generations. In recognition of the extent to which culture and religion shape people's views about their sexuality, HIV and AIDS policy (2007) highlighted that forms of inequality, oppression and patriarchal hegemony must be interrogated (Republic of Namibia, 2007). Similarly, cultural constructions of gender force women to maintain subordinate positions, by disallowing the negotiation of safe sex. While cultural notions around masculinity endorse participation in polygamous relationships, these notions also play significant roles in the spread of HIV (Martins, 2015; Jansen, & Agadjanian, 2020). Thus, it becomes apparent that the social context within which HIV is spreading and responding to is both influenced, created and interpreted by culture.

Hence, culture is a significant determinant of individual perceptions and understanding of HIV and the associated risk factors. The focus of this study, therefore, is not only to identify patterns of socialization and gender norms that perpetuate HIV but also what sustains those patterns. HIV affects significant aspects of life such as human sexuality and reproduction that have cultural meaning. HIV as a sexually transmitted disease tends to be shrouded in secrecy and shame, providing opportunities for a long incubation period (Mayer, & de Vries, 2018). Practices of polygyny and dry sex are sexual and pose a particular risk to HIV. Furthermore, Greco (2013) proposes that sex is not merely an instinctive, biological behaviour but is socially constructed in complex and symbolic ways. Cense (2019) suggests that class, gender, race, age and nationality have a significant influence on how sexuality is organised. More specifically, the interplay of intersexuality influence how one chooses to engage with sexual partners and impact the agency and power that one has in terms of sexuality and sexual practices. Furthermore, their social values and interpretations, in turn, manifest in behaviour and attitudes, which may be potentially dangerous as it heightens

HIV risk. The role of traditional healers in HIV and AIDS prevention has been recognized, hence, their inclusion in HIV and AIDS behaviour change programmes (Sundararajan et al., 2021). The inclusion of traditional healing in HIV and AIDS behaviour change programmes set a precedent to argue for the inclusion of polygyny and dry sex in HIV and AIDS behaviour change programmes.

3.9.1 Gender power imbalances: agency-structure

In the case of HIV gender plays a significant role in the extent to which one is able or allowed to exercise their agency in protecting oneself against HIV infection. Most definitions of sexual agency emphasize the control of the individual over her or his own body. Cense (2019), defines sexual agency in terms of the right and ability to define and control your sexuality, free from coercion and exploitation.

The social and political context governs the options, choices and resources that are available to women, as well as the conditions under which choices are made (Carmody & Ovenden, 2013). Key components of this social and political context include cultural beliefs and customs; policies, rights and rules, the educational system; social and gender norms; and family roles and expectations.

Polygyny and dry sex are cultural practices designed for women to comply. From a feminist theoretical lens, such cultural practices are problematic because they involve female subjugation. Some women made a free choice to marry within the polygynous unions and also freely chooses to use herbs to dry the vagina (Dierickx et al., 2019). It is argued that age of maturity and ability provide women with a free choice and consent whether to participate in polygynous unions and dry sex. However, Cense, (2019) argues that choices made by women are conditioned by hegemonic cultural norms. In this conceptual

framework, the intention is to illustrate the complexity of the interplay of social constructivism theory and how women are socialized to accept polygyny and dry sex as a way of life. Gender norms reinforce this reality, through patriarchal hegemonic powers, where women are left with little to no power to exercise their agency (Sikweyiya et al., 2020).

The question of age and consent comes to play with regards to women who practice dry sex and those who are married in polygynous unions. This raises the question from what age are women participating in these cultural practices and can be considered autonomous agents capable of choosing and consenting (Dierickx et al., 2019). Can it be concluded that women choose out of their agency to enter into polygynous unions and to use the herb to dry their vagina during sexual intercourse? Or is there an alternative world view where women's behaviours are determined by a larger patriarchal system that imposes notions of womanhood? Are the HIV risks implied in these cultural practices downplayed by the desire to comply with patriarchal systems? The duality as to whether women as coerced or they are exercising agency regarding their participation in polygynous marriages and practising dry sex can only be fully comprehended in the contexts of local meanings, knowledge and power relations in the context where these practices occur.

This conceptual framework does not portray women as victims of false consciousness neither does it portray them as free agents in their quest to adhere to what is perceived as appropriate notions of womanhood within their cultural norms. Rather, the conceptual framework reveals some of the ways that women are caught up in a hegemonic culture of what is deemed an appropriate form of womanhood and how this culture heighten their risk of HIV.

3.9.2 Social Structures that perpetuate women's HIV vulnerabilities

Several social structures interplay and perpetuate women's HIV vulnerability. Connell states that the theories of gender and power are made up of three social structures, namely: labour – the sexual division of labour, power – the overall subordination of women and dominance of men, and cathexis – the practices that shape and realise desire (1995, p. 74). The structures will be discussed in detail below and how they each perpetuate HIV vulnerabilities among women and importantly how they need to be framed with HIV and AIDS behaviour change programmes.

3.9.2.1 Gender Division of Labour

The gendered division of labour operates through institutional mechanisms like the differential skilling and training of women and men, it forecloses a whole range of job options to women: it limits or constrains their economic and other social practices in significant ways (Litman et al., 2020). Skilling and training are just one of the institutional mechanisms by which the gendered division of labour is a powerful structure of social constraint. Given the unequal employment opportunities, women tend to be less paid than their male counterparts (Yearby, 2019; Litman et al., 2020). Male behaviour is shaped by local and hegemonic forms of masculinity that privileged physical dominance, emotional reticence, and patriarchal forms of power within couples, families and communities. On the other hand, female poverty and economic dependency increase risk behaviours to HIV such as intergenerational and transactional sex. Fewer opportunities for employment and education prevent the empowerment of women. On a broader, national scale, lack of finances can restrict development, educational opportunities, access to health care and employment creating a favourable setting for HIV spread. It is also widely accepted that gender inequities have fuelled, and continue to drive the epidemic, with gender-based violence, the inability to negotiate

sexual practices, and the dilemmas of transactional sex seen as key drivers of the epidemic (Colvin, 2017). The unequal power imbalance resulting from gender division of labour restrain sexual negotiations among couples and in transactional sex.

Several studies note that in most societies women are economically dependent on male family members influencing their claim to power and certain rights (Yearby, 2019; Qing, 2020; Litman et al., 2020). This dependency limits women's decision making regarding their live choices including control over their sexuality. Women's limited power and control over means of production provide them with inadequate economic opportunities. As a result of these inhibiting factors, women's increased vulnerability to HIV and AIDS may be ascribed to economic dependency which places them in a particularly difficult position to act in ways that could protect them from becoming infected with HIV.

3.9.2.2 Gender Power imbalances

The influence of gender-based dynamics within the sexual relationships of men and women on reproductive has been recognized in the literature. Gender power imbalance translates into a power imbalance in sexual interactions which increases vulnerability to HIV (Madiba, & Ngwenya, 2017). Many factors made negotiating safe sex complex for women which varies from living in a patriarchal society where women play no part in sexual decision making, the fear of possible consequences of insisting on condom use, women's inferior social position in marital relationships, cultural practices such as bride price, and gender inequality were the main barriers to practising safer sex. In societies where condom use may be associated with prostitution, promiscuity and disease, women often find it difficult to ask men to use condom use for fear of appearing promiscuous. Bond et al., (2018) described how discussions of condom use in the context of relationships that are perceived to be monogamous threaten the relationship; condoms have symbolic meanings

and are indicators of infidelity and lack of trust for some individuals. They also highlighted how condom use decreases over time within these relationships, and individuals are less likely to use condoms with primary partners than with new or casual partners. Carrying condoms by women is often construed as diseased, dishonourable, promiscuous and/or as being HIV positive (Haffejee, & Maharajh, 2019; George et al., 2019; Dlamini, & Shongwe, 2020).

The ideas of masculinity associated with risk-taking and sexual conquest, expose men to an increased risk of infection by having multiple partners, thus becoming the vectors for transmission of HIV and AIDS to their partners (Yang, & Thai, 2017). These cultural norms and expectations tend to be stumbling blocks to effective HIV prevention. It is argued that gender hierarchy and normative masculine and feminine roles prevalent in most African cultures have implications for HIV prevalence. It argues that the inflexible gender hierarchy, which is enforced through culture and the dominant position of men in society influence HIV vulnerabilities. Studies showed how masculine norms legitimize certain kinds of sexual and social practices which when combined with, cultural notions of manhood shaped men’s violence against women, children and each other (Dworkin et al., 2012; Mshweshwe, 2020). Hegemonic forms of masculinity are not only an HIV risk to women, but it is also a disservice to men, as it makes it difficult for men to practice safer sex with their partners and less likely for them to seek HIV testing, treatment and care (Bond et al., 2018). This observation of being excluded from HIV treatment and care should prompt HIV and AIDS behaviour change programmes to delve into the reasons for men’s absence and there is also the need to delve into cultural norms that precluded men from speaking about illness, vulnerability and sexuality in intimate sexual relations.

Theories on hegemonic masculinity assert that hegemonic and patriarchal beliefs often framed as cultural or traditional about manhood are pervasive and perpetuate women's vulnerability to HIV. There is evidence on how gender norms and practices structure the risk for HIV, but there is little evidence on how these norms and practices are incorporated into HIV and AIDS behaviour change programmes. There is also very little evidence on how the HIV epidemic has acted as a catalyst or a barrier (or both) to changes in gender norms and practices among men (Colvin, 2017).

3.9.2.3 The Structure of cathexis

The structure of cathexis refers to the laws, social norms and prohibitions that shape what is 'normal' in sexual relationships (Wingood and DiClemente, 2000). Cathexis is elaborated in this study as cultural practices that place women at risk of contracting HIV by restraining them from making objective sexual decisions. Despite their harmful nature and their violation of women's health, such practices persist because they are not questioned and take on an aura of morality in the eyes of those practising them (Longman & Bradley, 2015).

In this conceptual framework, it is asserted that such practices exist to benefit males. Female sexual control by men, and the economic and political subordination of women, perpetuate the inferior status of women and inhibit structural and attitudinal changes necessary to eliminate gender inequality.

Women's risk factors include limited knowledge of HIV prevention, negative beliefs that are not supportive of safer sex as well as perceived invulnerability to contracting HIV(Anokye et al., 2019). Cornish et al., (2021) alludes that women's sexual practices are very often viewed through social norms and expectations. This is, for example, the case in a social context where dry sex is the norm. Women who do not use herbs to dry the vagina

may fear divorce. Alternatively, they may be advised by their sexual partners and older women to use the herbs to save their marriages. They are also held responsible for ensuring their partner's sexual pleasure at their sexual discomfort (Higgins, & Hirsch, 2008). These restraints may limit women's decision-making power with regards to safer-sex practices.

In exploring the experience of women's sexuality, it becomes apparent that their experiences cannot be divorced from public policy, socioeconomic and socio-political constructions of HIV. González-Alcaide et al. (2020) notes that it becomes important to examine the spread and understanding of HIV within a specific social context. Consequently, HIV and sexuality research should be concerned with culturally sensitive knowledge of sexual beliefs and practices to understand the pattern of HIV transmission in different communities to come up with more effective intervention strategies. In this regard, Shepler, Johnson, and Width, (2017) opines that sexuality should be conceptualized through the discourse of sexual culture that is, the systems of meaning, knowledge, beliefs and practices that structure sexuality in different contexts. However, most researchers focusing on HIV and sexuality often overlook culture because they view it as static and thus a barrier to the adoption of biomedical strategies (Sovran, 2013; Thiabaud, 2020). Yet, culture shapes individual sexuality through roles, norms and attitudes within particular social groupings or institutions and at the same time it contributes to the reproduction of the collective or community. This implies that interaction between society and the self is responsible for educating one about sexuality and depending on the type of society; one has a different experience of sexuality. Hence, uniform HIV and AIDS behaviour change programmes that do not take into consideration, the uniqueness of how culture shapes individual sexuality tend to be superficial and does not delft into the cultural aspects that perpetuate HIV. By using both

social constructivist theory and Connell's theory of gender and power best explains how the structure of cathexis interplays to perpetuate women's vulnerability to HIV.

According to the social constructive perspective, sexuality is given meaning in social relationships. Various elements influence an individual's identity and sexuality. In other words, understanding of meaning within our world and of ourselves is mediated by social artefacts, history, culture, and interaction between people (Shabani, & Ewing, 2016). In suggesting that sexuality is socially constructed it does not deny the significance of biology either (Ussher, 2017). Biology is further complicated by the social meanings and understandings intimately connected and intertwined with gender and sex. The female anatomy and physiology make women particularly vulnerable to contracting HIV than men, hence the high HIV prevalence among women (Adesina, 2015). In this regard, Adesina (2015) notes that it is not possible to disengage gender and the erotic or to consider the politics of the sexual in isolation from sexual politics. Transactional sex is one form through which gender inequality is displayed, where safe sexual negotiation is inhibited by the unequal power relations emanating from women's low social standing.

The advantages of using the social constructivist theory and Connell's theory on gender and power provide a way of talking about the intersection of cultural practices and gender inequality and how they perpetuate HIV. In using this reflexivity, viewed through social constructivism and Connell's gender and power theory, polygyny and dry sex are fundamentally driven by patriarchal needs and desires, expressed through the medium of female sexuality (Van der Poll, 2009). Arguments supporting women's agency and the idea that women, as a group, can freely express their sexual desire within such a decidedly patriarchal social, economic and political context thus become highly suspect.

Ndebele, Ruzario, and Gutsire-Zinyama, (2013) explained how the practice of dry sex increases the risk of condom tearing and the increased probability that the vaginal wall will tear. Consequently, women are exposed to an even greater risk of contracting HIV, or STD infections. Gazimbi et al. (2020) also pointed out how polygynous marriages create a sexual network when new wives are introduced into the polygynous marital unions and where the HIV status of these wives are not known or where individuals in polygamous relationships engage in extra-marital sex. Polygyny, therefore, amplifies risky sexual behaviours such as sexual networking and concurrent sexual partnerships, all of which were found to be significantly associated with the risk of HIV transmission. This demonstrates that targeting risky sexual behaviours in a broader marital context may be more important for HIV risk reduction than banning polygyny as an institution. Hence, the importance of context within the social constructionist position helps to maintain the viewpoint that locating sexuality within a socio-cultural context may be useful in making sense of HIV and AIDS behaviour change programmes in communities.

3.10 Limitations of Social Constructivist Theory

The Social Constructivist Theory has been critiqued for assigning a passive role to the individual. With its emphasis on primary socialisation and the learning of the language, speech and communication by new members, it leaves little room for individual initiative and creativity. The Social Constructivist Theory is also critiqued for downplaying the role of biology on human thoughts and behaviour, and for solely crediting societal learning and role modelling.

Furthermore, it has also been critiqued for downplaying women's agency. Women's agency highlights the individual action versus the social structure dichotomy, in which women have been both partly formed by their society and have also, at the same time, shown the

capacity to change in part the social structures in which they live. Women have been exercising their agency by making effective choices and transforming those choices into desired outcomes (Gleadle, 2013).

Behaviour change theories that focus on individual cognitive processes, agency, self-efficacy and decisions vastly underestimate the impact of social contexts. Societal pressure and contexts do play a role in shaping human behaviour. Davis et al. (2015) in their study on behaviour change, argue that, whether or not individuals are pressured to adopt a particular behaviour, they unilaterally derive at an individual decision or a particular context; however, society does have an impact on the agency or power of individuals. This is particularly so in the HIV and AIDS debates where surveys are indicating that knowledge of HIV and AIDS and what actions to take to protect oneself from contracting HIV rate more than 90% in the general population; however, this knowledge is not always translated to appropriate action (Republic of Namibia, 2016; MoHSS, 2019).

This study, therefore, argues that society can exert pressure that would lead an individual to take any action that is not necessarily to his or her benefit. Because of the desire to comply, most individuals succumb to societal pressure. As far as this study is concerned, social factors that promote HIV and AIDS are embedded in customs and traditions where practices, such as dry sex and polygyny, facilitate the spread of HIV.

3.11 The shortcomings of gender and power theories

Several challenges are to be overcome when employing the theory of gender and power to assess women's exposure and risk to HIV and in designing HIV interventions that are culturally appropriate and context-specific. HIV and AIDS intervention programmes should interrogate the impact of cultural practices on women's vulnerability. If these cultural practices are not

identified, and the risk they pose to women evaluated, it becomes a challenge to design appropriate interventions. Furthermore, HIV and AIDS intervention programmes should define the community of women at risk of exposure to HIV and AIDS as a result of these cultural practices. For example, given the vastness of Namibia and the variety of its language groups, it becomes clear that cultural practices also vary vastly from one region or one constituency in a region to another. For example, the practice of dry sex may be occurring in the Zambezi region, but perhaps only in a certain area of the region. It may, however, also occur in other regions.

Applying the theory of gender and power to understand the risks that perpetuate women's vulnerabilities to HIV can be challenging. Social structures are often abstract, difficult to operationalise, and do not consider variations across different cultures. Moreover, when applying the theory of gender and power, it can be difficult to isolate and tedious to quantify the effect of a particular social structure on women's health. Furthermore, the social structures that perpetuate women's vulnerability to HIV are deeply rooted in culture and so often taken for granted that they go unnoticed. To a certain extent, these very situations make it difficult to identify. This is the primary contributing factor to the difficulty of constructing a cogent, empirical case that patriarchy is damaging to women's health. However, employing the theory of gender and power to understand women's health specifies a range of gender-based exposures and risk factors for examining women's risk of disease.

The issues of culture and gender cannot be explored in isolation, as they influence and shape behaviour, attitudes and beliefs. When it comes to assessing the risk of HIV, it is important to examine shared behaviour, attitudes and beliefs separately. Traditional gender and cultural norms contribute to power imbalances in heterosexual relationships by reinforcing male

dominance and female submissiveness. Sexual relationships that include a dominant man and a submissive woman have been shown to increase the risk of not using condoms (Robinson et al., 2018). In a non-egalitarian relationship, the assumption that condom use and the initiation of sex are decided by the man – which is strengthened by gender norms – places those involved at risk of contracting HIV (Ussher et al., 2017).

Despite growing awareness that the changing of inequitable gender norms is the key to realising sexual and reproductive health, including HIV prevention (Richardson et al., 2014; Sia et al., 2016; Klaas, Thupayagale-Tshweneagae, & Makua, 2018; Woolfork et al., 2020), relatively few interventions have attempted explicitly to address those norms that perpetuate HIV. Furthermore, HIV and AIDS continue to be measured by employing a purely biomedical, scientific intervention (Joe-Ikechebelu et al., 2019). It is, therefore, imperative for social science to design theoretical and conceptual frameworks and approaches, in particular with regards to gender and culture, that could measure efforts to prevent HIV infection. As much as a culturally appropriate intervention is advocated for in this study, care needs to be taken that the intended audience should not perceive the intervention as a singling out or a casting of unfavourable attention on their community (Jongen, McCalman, & Bainbridge, 2018).

In conclusion, it is recognised that studies have been conducted that investigate the cultural practices of polygyny and dry sex and the risk they post to HIV and AIDS. These studies also critiqued HIV and AIDS behaviour change programmes that are purely based on cognitive theories (Sovran, 2013; Skovdal et al., 2017). Despite Namibia recognising the effect of cultural and religious practice on the spread of HIV (Republic of Namibia, 2007). There has however not been studies that investigated the inclusion of cultural practices of polygyny and dry sex that perpetuate HIV into behaviour change programmes. It is hoped that this study can fill in

that the practice-knowledge gap. This study hopes to bring to light the importance of incorporating cultural practices that perpetuate HIV into behaviour change programmes.

CHAPTER 4: METHODOLOGY

4.1 Introduction

This chapter presents a detailed account of the research design and methodology used in this study. A section on research design introduces the reader to the ontology, axiology, epistemology and methodology on which the research is based. The chapter, furthermore, discusses the research objectives, epistemology, research population and sampling process, as well as ethical considerations when researching sensitive topics like HIV and AIDS and cultural practices.

4.2 Research objectives

The overall objectives of this research study were to explore the cultural practices that could potentially perpetuate the spread of HIV and whether NGOs working in HIV and AIDS behaviour change programmes have adopted culturally appropriate prevention strategies. The research objectives informed the research design and methods employed; these are discussed in detail below.

4.3 Qualitative research

The study employed a qualitative research approach. Mohajan (2018) holds that qualitative research aims to explore, understand and describe research participants' experiences through an inductive approach through the generation of new knowledge and theory grounded in human experience. Bazeley (2013, p. 4) also posits that "researchers engage in qualitative studies by describing, observing, interpreting and analysing people's experiences, their actions and the way they think about themselves and the world around them". This approach thus allows for exploring complex phenomena, such as the linkages

between HIV and AIDS and cultural practices, and by analysing the extent to which HIV and AIDS prevention strategies are appropriately adopted as far as a specific culture is concerned.

4.4 Research design

Mohajan (2018) notes that there are different ways of designing social research; consequently, the methodology or approach chosen depends on the objective of the research. Furthermore, how the study is designed influences the choice of method(s) which will guide the systematic and rigorous collection and analysis of data. Al-Ababneh, (2020) explains that the epistemology, theoretical perspective, methodology and methods are interconnected and inform one another, as well as the research design.

4.5 Philosophical Assumptions

The dissertation adopted the theory of social constructivism and Connell's theory of gender and power as a frame of reference to situate women's vulnerabilities to HIV, resulting from cultural practices of polygyny and dry sex. The dissertation further explored the inclusion of these cultural practices in HIV and AIDS behaviour change programmes. The section on theoretical frameworks effectively built a case on the premise that literature identified certain cultural practices that heighten women's vulnerabilities to HIV, however, HIV intervention programmes remain silent on including these practices in HIV behaviour changes programmes (Biruk, 2020).

The empirical research adopted for this study was one of phenomenological standpoint. Creswell (2013) described phenomenology as a set of philosophical principles that support the ontology and epistemology of the study. This study started as an exploratory exercise as to what the world is like (ontological) for women who practice polygyny and dry sex amid HIV transmission. It thus provided the opportunity to understand what meaning is

attached by the community members that practice dry sex and polygyny and how is that meaning shifting in the context of HIV prevalence. Furthermore, a combination of exploratory and interpretive approaches was also used to assist in establishing the reality and meaning of adhering to these cultural practices, for example, by practising polygyny and dry sex what sense of womanhood did it provide to women who adhere to the practices? Given the post-structural standpoint propagated in this study, it is argued that by identifying all factors that perpetuate women's vulnerabilities to HIV and by putting mechanisms for women's empowerment, thus allowing women to exercise their agency, individual choice and by ensuring that women regain control over their bodies. That way, factors that perpetuate women's vulnerabilities to HIV will be addressed.

This study adopted the poststructuralist principle with the intent that it might be of help to HIV prevention interventionists to be cognisant of socio-cultural factors on individual behaviour, instead of approaching HIV prevention from a purely bio-medical perspective. The study offered some important insights into the methodology and ethical considerations or value system (axiology) when studying women's HIV vulnerabilities in the context of cultural systems, thus broadening the perspective on sexuality studies.

4.6 Ontological assumption

Central to the philosophical assumption of an interpretive phenomenological study is the ontological assumption. Ontological assumptions provide the platform on how to understand the world we occupy, co-existence with other beings and also understand oneself. (Fard, 2012). The ontology of a research paradigm is the way the world is thought to be and its very nature of what is called the reality of the social phenomenon being investigated (Lincoln & Guba, 1985; Nguyen, 2019). In other words, ontology is concerned

with “what is”, in terms of the nature of reality and the nature of existence or being (Al-Ababneh, 2020). It refers to the sort of things that exist in the social world and assumptions about the form and nature of their social reality. This study, therefore, advocates that perceptions and views are shaped not only by cognitive influences but also that one’s identity is a powerful factor that influences how we view ourselves and the world.

Human holds different identities, which tends to influence views and perceptions about reality on the same matters, as a results meanings are correct from each perspective. This notion is supported by the implicit assumption in Wegerif (2008) that what provides meaning to human perceptions and views is the shared similarity rather than difference. Upholding cultural practices is highlighted as an important aspect that unities communities (Rossi, 2016). Despite the consensus in perceiving polygyny and dry sex as cultural norms, the justifications as to why these cultural practices are upheld varied depending on the perspectives and views of males and females, youth and elder research participants. The meaning and value attached to these cultural practices also varied.

Studies on women’s perspective on polygyny in Africa raised the concern that the disadvantages they experienced outweigh the benefits (Jansen & Agadjanian, 2019; Mabaso, Malope & Simbayi, 2018). Women continue to follow this cultural practice. Polygynous marriages and dry sex entail a hierarchy that supports a traditional gender ideology of male decision making and female subordination which reinforces existing gendered power structures (van der Poll, 2009; Jewkes et al., 2015; Weitzman, 2014). Ontological assumptions form one of the most important building blocks of our worldview and they are so fundamental that we rarely question them.

Cultural practices have been in existence for centuries and have been transferred from generation to generation through the process of socialization (Tam, 2015). They are therefore of central importance to the existence of communities. It is from this standpoint that the use of qualitative research methods and sociological theories set the base for studying cultural practices (Collins, & Stockton, 2018). Relativist ontology holds that the research problems have multiple realities that can be explored and meaning to be derived by the researcher through their interaction with the research participants (Fard, 2012).

Polygyny and dry sex emanate from patriarchal power and control over women. Any attempt towards the development of policy guidelines in conceptualizing cultural practices such as polygyny and dry sex as inherently harmful to women tend to be faced with backlash, opposition or such attempts are perceived as controversial. The debates then get construed into a dichotomy of African culture vs western values, which effectively derails the debates from policy guidelines that should address the marginalization of women, the interplay of sexual politics and the failure to conceptualise these practices as harmful (van der Poll, 2009; Logie, Perez-Brumer & Parker, 2021).

In this study, it is argued that to effectively address women's HIV vulnerabilities, the question of power in heterosexual relations must be addressed. Male control over female sexuality as the cause of female subordination must be contested. Furthermore, there is a need to challenge heterosexual men through patriarchal power structures that constructed female sexuality via practices of polygyny and dry sex solely for their intended benefits and pleasure. Hence, the gendered power and sexual inequality dichotomy is a significant ontological distinction that must be addressed in further research and any other systemic and policy practice.

4.7 Epistemological assumptions

According to Wilkinson et al. (2019), epistemology provides a framework for understanding knowledge and learning about the world. It relates to how we know what we know and how our experiences shape and colour what we say we know and how we know it. The epistemological underpinnings for this study rested on how research participants construed the linkages between cultural practices of polygyny and dry sex to women's HIV vulnerabilities and women's agency. Hence, in the interviews, research participants were asked to narrate how they assessed these vulnerabilities and what interventions were in place to address them. It was clear that the research participants could draw the linkages on women's heightened vulnerabilities to HIV and cultural practices of dry sex and polygyny. The research participants could also elaborate on the social significance of these practises and thus justify retaining the practices. It was also obvious that despite RACOC's knowledge on the HIV risk in these cultural practices, they were not explicitly included in HIV and AIDS behaviour change programmes.

Cultural practices that can potentially perpetuate the spread of HIV can be seen as socially constructed, created by individuals and members of the larger community. Thus, it confirms that people's experiences of their reality exist within the individual or group. Therefore, a relativist, ontological position was taken to acknowledge the multiple, constructed and holistic realities that may exist (Lincoln & Guba, 1985). As a result, influence from members of the larger community may have an adverse impact on individual behaviour. However, in the epistemological stance of constructivism, the only way to access these multiple views of reality is through interaction between the researcher and research population throughout the research process (Kivunja & Kuyini, 2017).

4.8 Axiology

According to Shokhin (2020), axiology considers the nature of value in what we find worthy, good or bad and incorporates the theory of morality. Asking what 'ought to be' is axiological. Axiology is generally understood as a value theory. The high HIV prevalence among women remains a concern among scholars and thus requires that all avenues be explored to address it. As a gender scholar with an interest in sexual and reproductive health, the high incidences of HIV among women in the Zambezi region, and Namibia at large is of particular concern. Studies indicated that women's physiology renders them particularly vulnerable to HIV. Other scholars queried socio-cultural factors that heighten women's vulnerability to HIV (Nankinga, Misinde, & Kwagala, 2016). Although these perspectives are mentioned in the broader HIV debates, few studies have delft deeper into the varieties of cultural practices in Namibia and the Zambezi region that are presumed to perpetuate HIV among women. In Namibian, advocacy to include cultural practices into HIV prevention has been the work of civil society organizations with minimal inputs from academia (/Khaxas, 2008; /Khaxas & Frank, 2010; Legal Assistance Centre, 2017).

This research topic is of special interest to the researcher, because of the cultural similarities among the communities in the Zambezi Region and the Batswana, such as the importance of upholding patriarchal structures and cultural identities. On the other hand, however, the Namibian government is advocating for gender equality and to eradicate all aspects that perpetuate women's vulnerabilities (Republic of Namibia, 1990). The Namibia constitution upholds the principles that no persons shall be subjected to torture or cruel, inhuman or degrading treatment or punishment. It further guarantees respect for human dignity. Therefore, the axiology in this dissertation is based on the constitutional values that respect the rights and dignity of women.

Furthermore, various international and regional human rights instruments seek to protect women from discriminatory and abusive practices. The African Charter on Human and Peoples' Rights (the African Charter), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the African Women's Protocol), Universal Declaration of Human Rights, Elimination of All Forms of Discrimination Against Women (CEDAW and its Optional Protocol). (African Union, 2005; African Union, 1981, CEDAW, 1992). These instruments are particularly useful in conceptualising dry sex and polygyny as a sexually based practice that is harmful to women and thus heighten their HIV vulnerability. By adopting these international instruments, the Namibian government made a solemn commitment to eliminate all forms of discrimination and harmful practices against women. The Namibian government should therefore ensure the elimination of every discrimination against women and safeguard the protection of rights of women as stipulated in international declarations and conventions.

It must be stressed that cultural practices such as dry sex and polygyny that harm the individual ultimately cause harm to the community also (le Roux, Bartelink, & Palm, 2017), Hence, harmful traditional practices cannot be used as a means to justify the subordination of women to men (Msuya, 2020; Wood et al., 2018). Van Der Poll, (2009) argues that this would, stand in direct opposition to the spirit of both the African Charter and the African Women's Protocol. The African Women's Protocol's further compels states to eradicate gender-specific violence, needless to say, that from that perspective, the practices of dry sex and polygyny cannot remain unchallenged.

Article 5 of the Women's Protocol expressly requires the government to create, through information, education and outreach programmes, public awareness regarding harmful

practices. The subsection thus envisages judicial support for women, including support in the form of health services. Government should therefore protect women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance. HIV and AIDS behaviour change programmes are therefore best placed to implement interventions that address cultural practices such as dry sex and polygyny and the risk these practices pose to HIV. Despite these commitments, the practice of dry sex and polygyny continues to victimize women.

4.9 Focused Ethnography

This study employed a focused ethnographic approach. This approach can be applied to any discipline where there is a desire to explore specific cultural perspectives held by sub-groups of people in a context-specific and problem-focused framework (Higginbottom et al., 2013). This type of ethnography is topic orientated, resulting in the researcher identifying the research topics for investigation before collecting data. Focused ethnography is appropriate for investigating societal problems in specific contexts (Wall, 2015) and research questions related to the experiences of groups or subgroups in specific cultural contexts (Higginbottom et al., 2013).

In this study, the focused ethnographic approach was useful because of its key characteristics which include: focusing on discrete communities or organisations, unstructured and semi-structured interviews; selecting episodes of participant observation and limited numbers of research participants who have been selected for their knowledge and experience of the phenomenon (Verd, Barranco, & Lozares, 2021). Intensive data collection, utilising audio-visual recording techniques, is common and compensates for short-term field visits by producing a large amount of data for analysis (Knoblauch, 2005).

However, it can be difficult without some background knowledge or familiarity with the setting (Knoblauch, 2005). The researcher was familiar with researching the Zambezi region through the United Nations Population Fund consultancy. Between 2006 and 2010, she had been tasked to evaluate feeding programmes for people living with HIV and AIDS. As a result, she was familiar with the HIV and AIDS discourse in the Zambezi region. She had also followed the work of the Women's Leadership Centre in the Zambezi region. The Women's Leadership Centre focuses on cultural practices that violate women's rights and also heighten women's risk of HIV and AIDS (/Khaxas, 2008; /Khaxas & Frank, 2010). Hence, selecting the focused ethnography method allowed the researcher to gain further insight into drawing the interrelationship between cultural practices and HIV and AIDS, as well the extent to which NGOs in HIV and AIDS behaviour change programmes were devising culturally appropriate programmes. Therefore, it was important for the researcher to establish rapport and become familiar with the setting, including the practices and language employed (Elliott, & Martin, 2013; Bergen, 2018).

The use of focused ethnography allowed the researcher to focus specifically on the NGOs working on HIV and AIDS behaviour change. Focused ethnography also shed light on community members' perspectives about those cultural practices that could potentially risk the spread of HIV. The study also sought the perspectives of traditional leaders as the custodians of culture. This method thus allowed for viewing the research topic from the different perspectives of the research participants (Lincoln, Lynham, & Guba, 2011).

4.10 Population

4.10.1 Selecting the research site

The Zambezi region was selected as a research site, due to its high prevalence of HIV and AIDS when compared to other regions in Namibia. This prevalence remains high at 22.3% in the Zambezi region when compared to the national prevalence of 12.6% (MoHSS, 2019). It is, therefore, important to interrogate all HIV risk factors that may potentially contribute to the spread of HIV. This study, therefore, focused on dry sex and polygyny and how these practices were addressed in prevention programmes. Non-governmental organisations have been at the forefront of rolling out HIV and AIDS behaviour change programmes. Namibia Network for AIDS Service Organizations (NANASO), which is the umbrella body of NGOs working in the area of HIV and AIDS, issued a Directory of AIDS Service Organization in Namibia in 2008/2009 and a Directory for Support Groups for People Living with HIV and AIDS in 2010. As a starting point, NGOs operating in the Zambezi region were identified through these two mentioned directories. A total of twelve NGOs were listed. The name of the organisation and the contact person, as well as telephone and email addresses, were also listed.

An appointment was made with NANASO, to verify and confirm whether the listed NGOs were still operating. Of the twelve NGOs listed in the NANASO directories, nine were still operating in the Zambezi region. The list of NGOs operating in the Zambezi region was further confirmed by the RACOC at Zambezi regional office and the Ministry of Health and Social Services Health Program Officer in Katima Mulilo.

4.10.2 Sampling

The sampling technique employed in this study was purposive sampling. Gentles et al. (2015) state that sampling is an important aspect of the research process, and it provides the researcher with the opportunity to explore the phenomenon being studied. Purposive sampling was useful as it ensured that only the research participants who met the criteria of the research were included in the study since they were selected according to predetermined criteria informed by the research objectives. The sample population included twenty male and female community members from Windhoek, Katima Mulilo and Kabbe, as well as thirteen key informants from RACOC, traditional leaders and representatives from NGOs working in the field of HIV and AIDS behaviour change.

Eligibility criteria specific to each group were employed to guide the selection of all research participants for the semi-structured interviews. Ultimately a total of 33 research participants were included in the study. Some of the research participants were referred to the researcher by other research participants. For example, the head of the Catholic AIDS Action referred the researcher to a research participant who was responsible for home-based care with Catholic Aids Action, but who also happened to be training young girls in the Sikenge girls' initiation rituals. The traditional healer in Katima Mulilo was referred by the research participant from DAPP/TCE. This particular traditional healer had attended training in the role of traditional healers curbing the spread of HIV and had received a certificate of attendance from DAPP/TCE. Maximum variation sampling was preferred because it allowed for documentation of the range of variation in the narratives of individuals and to determine whether common themes or patterns were present across this variation (Palinkas et al., 2015).

Data saturation determined whether there was a need to include more research participants. The concept of data saturation ensures that adequate research participants are included in the study; this also adds to the quality of the research (Fusch, & Ness, 2015). Data saturation originates from the grounded theory method which explains that, when no new data emerge to develop 'categories' further (Nelson, 2017), the amount of data gathered be sufficient to answer the research question. The concept of saturation and how this is achieved differs from one research method to the other (Fusch & Ness, 2015); consequently, there are a variety of models relating to saturation in qualitative research (Saunders et al., 2017).

Fusch and Ness (2015) and explain that in ethnographic studies data saturation is achieved utilizing multiple methods of data collection, an extended stay in the research site and a sample that is representative of the culture. Fusch and Ness (2015), furthermore, note that triangulation, which may include different research methods and different research participants, can assist in ensuring data saturation. In this study, the researcher employed different methods to collect rich, quality data, which facilitated data saturation (Fusch & Ness, 2015). The combination of semi-structured interviews, supplemented with focused participant observations, photographs of training manuals and reflective field notes contributed to the quantity and quality of data collected.

4.11 Research methods: Instruments of data collection

This section will focus on the methods and techniques employed to collect data. Data were generated mainly through in-depth, face-to-face, semi-structured, interviews, as well as focused observations, photographs, field notes and document analysis. The following section provides an overview of the data collection techniques and how they were implemented.

4.11.1 Semi-structured interviews

Semi-structured interviews are a primary method of data collection in focused ethnography (Higginbottom et al., 2013). It offers the researcher the flexibility to explore unexpected issues raised by research participants and also allows probing (Jong & Jung, 2015). The format of the semi-structured interviews was a narrative inquiry. Narrative inquiry is a form of qualitative research in which the stories themselves become the raw data. This approach has been used in disciplines that focus on the culture, historical experiences, identity, and lifestyle of the narrator (Mohajan, 2018). This approach was used in this study to collect in-depth data with thick descriptions. The approach enabled the research participants to narrate in detail their stories, thus allowing the researcher to gather in-depth meaning through this process. Narratives took place on multiple levels in this study. One is the intergenerational transferal of knowledge from one generation to the other. Where research participants learnt through storytelling and observation about cultural practices. The other is the opportunity for research participants to share their views and experiences with the researcher, and the researcher also exchanges her lived experiences with the research participants. Narrative research is also a central theme in HIV and AIDS prevention programmes. Research participants alluded to former HIV interventions programmes that had songs, drama, sketches and storytelling. Most research participants could relate to this form of HIV and AIDS information dissemination formats.

This research was framed in terms of narrative approach because it provided the opportunity for the researcher to gauge different and sometimes contradictory layers of meaning as provided by the research participants and to bring them into useful dialogue with each other, and to understand more about individual and social change (Andrews, Squire, & Tamboukou, 2013). For example, in this study men and women, young and old

expressed different views, regarding dry sex. Women spoke of dry sex as something painful, but a necessity to pleasure their sexual partners. On the other hand, men also expressed the pain experienced during dry sex, but the tight and dry vagina increased penile sexual pleasure.

This study designed two separate interview guides specific to each group. Separate interview guides were administered to key informants, such as representatives from NGOs, RACOC members, traditional leaders and life skills teachers. While a separate interview guide was designed for community members. The instruments that were employed to gather data from key informants focused mainly on the link between cultural practices and their inclusion in HIV and AIDS behaviour change programmes. A document analytical tool was also employed to assess the inclusion of cultural practices in HIV and AIDS prevention training manuals. Finally, the last interview guide was designed for community members (youth and adults), including Life Skills teachers and traditional healers. It investigated the extent to which the cultural practices that were perceived as perpetuating HIV were still followed, as well as the perception of the community regarding the HIV risks associated with these cultural practices.

Each of the interview guides contained a list of approximately ten key concepts. The concepts are: (1) demographic profile; (2) perception regarding HIV and AIDS; (3) cultural practices; (4) risks that cultural practices pose to HIV; (5) HIV and AIDS behaviour change programmes; (6) information about and decisions to engage in sexual relations; (7) construction of womanhood and manhood; gender dynamics; (8) policy intervention on HIV and AIDS behaviour change programmes and cultural practices; (9) training in HIV and AIDS behaviour change programmes and cultural practices; (10) roles of traditional leaders to mitigate in cultural practices. The interview questions were open-ended,

enabling the researcher to probe and ask follow-up questions, thus allowing for depth and detail during the interview.

The interview guides were piloted on three individuals. A colleague at the MRC who was from the Zambezi region, one staff member at NANASO and one female from the Zambezi region who reside in Windhoek went through the interview guides. These three pilot research participants each reviewed the interview guides of key informants and community members. Majid et al. (2017) stress the importance of piloting interview guides as the credibility of the researcher is recognised by posing relevant questions which are meaningful to research participants and demonstrate an understanding of the research subject. As the interviews progressed, minor changes were made to the various interview guides as informed by responses from research participants and other issues arising, such as the age and sex of the research participants and knowledge of cultural practices.

Jamshed, (2014) stress that the order in which questions are asked and topics covered will not be the same for every interview or research participant as this will depend on the way that the interview develops and what responses are given. The researcher found that research participants often moved between different topic areas and some questions were addressed before they had even been asked. However, the interview guides were very useful to keep track of what had been covered and allowed the researcher to listen carefully and focus on what research participants were saying, without the worry of forgetting to cover a specific area or ask a certain question.

Furthermore, having an interview guide to refer to ensure that the same data were collected from all research participants (Jamshed, 2014). Although two different interview guides were employed in this study, the questions and topics covered were similar. There were

only a few variations in the interview guides that focused on key informants and interview guides that focused on community members.

4.11.2 Establishing Rapport

Given the sensitive nature of the topics under discussion, it was important for the researcher to gain trust and establish rapport with research participants (Guillemin et al., 2018), thus to develop a 'trusting personal relationship' to encourage open, honest and detailed accounts (Rubin & Rubin, 2012, p. 6). This is imperative, especially when exploring people's perspectives on sensitive matters. The researcher devised different ways to facilitate trusting relationships with the research participants. She also expressed interest and was engaged during the interview; she informed the research participants that there were no right or wrong responses; she also paid particular attention to the research participant's body language and listened for clues in the tone of voice to assess whether the research participant was engaged in the interview or not; the researcher ensured that each research participant was given ample time during the interview by pacing the interview and no research participant was hurried. These techniques put the research participant at ease, which enabled an open conversation between the researcher and the research participants (Majid et al., 2017).

Jong and Jung (2015), suggest that maintaining an environment appropriate for interviewing necessitates a compromise between comfort, accessibility and level of distraction. The environment, where the interviews are conducted, plays an important role in making the research participant feel at ease. The representatives from NGOs and RACOC members were all interviewed in their respective offices which provided privacy, with minimum distraction; there was also sufficient and comfortable seating and natural light. Two of the four traditional leaders were interviewed at the palace (khuta), while the

other two were interviewed at their respective homesteads. The community members were interviewed at their homesteads. The home setting posed its challenges, depending on whether the research participants had young children who demanded their attention, and this caused occasional disruptions and interruptions of the interview process. In incidences where the interviews were disrupted, the researcher temporarily halted the interview to allow the research participant to either attend to small children, to check pots on the fire or whatever was causing the disruption. In some homesteads, the interviews were conducted outside in the courtyard or under trees. While conducting interviews at home was more suitable to most research participants, there were, however, different challenges in the rural homestead, such as clucking of chickens, dogs barking, the phone ringing, children crying and other family members being present in the homestead. The researcher had two instances where the research participant's spouse joined the interview. When the researcher informed the spouses that the interview was only with their partner, the one research participant invited the spouse to join in the interview as they had no secrets and the other one suggested that she/he would not mind that the partner heard what was said. Instead of a one-on-one interview, the researcher had a couple-interview where the main research participant would be checking for the appropriate response from the spouse during the interview.

Narrative research which is based on conversations between people the researcher and the research participants is invariably a process of the ongoing negotiation of meaning (Scheffelaar, Janssen, & Luijkx, 2021). Throughout conducting this study, as a researcher, there was a need to be sure what was understood was indeed what was meant by the research participants. For example, it was deliberate to enquire about the social justifications of the cultural practices of dry sex and polygyny in the contexts of the research participants lives. The researcher noted that both cultural practices were portrayed

to have some degree of “goodness” or relevance, while there was also some degree of badness. It dawned on the researcher, that when people uphold a particular cultural system, they don’t do it purely because they found their predecessors practising it. They also do it, because it serves a sense of meaning into their current reality.

4.11.3 Recording interviews

The researcher used a digital voice recorder to record the in-depth, face-to-face interviews. The consent of the research participants was acquired before utilising the recorder and the researcher explained to them the justification for utilising a recorder. The main justification was to ensure that all the important information was captured during the interview process. Given that the interview guide employed during this research was open-ended, the use of the digital recorder allowed the researcher to probe further for clarification. Hence the use of the recording device ensured that the researcher focused more on asking the interviewing questions and the interaction with the research participants, instead of focusing on whether the correct notes were taken, as this can at times be destructive to the interview process. This allowed for deeper interviewing engagement with the research participants by maintaining eye contact and concentrating on the interview process, in particular on their responses. Moore and Llompart, (2017) also emphasises the importance of utilising recording devices during a qualitative, in-depth interview and also stated that, before analysing the data, researchers must preserve the research participants’ words as accurately as possible by recording.

There were at least five research participants who were apprehensive about being recorded. Their queries centred mainly on why the researcher preferred recording the interview and not taking notes. They also queried what the recordings would be used for and who would

be listening to them. Once the researcher had responded to their questions, three of the research participants consented to be recorded during the interview while two of the research participants declined to be recorded, hence the researcher and the assistant took notes during these interviews.

Moore and Llompart, (2017) however, alert researchers that some research participants may not want to be recorded, and researchers must respect this in keeping with the ethical principle of respect for autonomy. Research participants have a right to refuse totally or partially to be interviewed at any point in the research process. In this study, the consent to be recorded was sought from research participants and it was also included in their consent forms. This information was read to the research participants during the introduction of the study before the commencement of the interview. Additionally, the researcher confirmed before starting each interview that the research participant was still in agreement for the interview to be recorded, with the understanding that the interview and recording could be stopped at their request without giving a reason.

Busetto, Wick and Gumbinger, (2020) highlight the importance of an undisturbed interview process. They state that the recording should be as smooth and unobtrusive as possible in order not to distract either the researcher or the interviewee. During the interview process, the recording device was placed outside the research participants' sight to avoid any distractions. After completing the interview, the digital file was saved per date. On a separate note, the name and description of the research participant, as well as the time and date of the interview, were written. The recordings were later backed up on a laptop, external drive and Google Drive.

4.11.4 Focused observations

Qualitative observation is fundamentally naturalistic and occurs in the natural context, among the actors who would naturally be participating in the interaction and follows the natural stream of everyday life (Ryan, 2019). A focused observation was undertaken as a method of data collection. The researcher observed two cultural practices. These were different herbs employed either to dry the vagina or warm the body. The sampling of observations was often opportunistic as it was not always possible to predict when such an event might happen and whether the researcher would find research participants willing to demonstrate these practices. Furthermore, numerous factors, such as when the cultural practices were taking place, the researcher acquiring informed consent and being permitted to observe, had to be considered.

The researcher enquired from the research participants who were well versed in a particular cultural practice whether she could observe some of the practices. The researcher was informed by the Life Skills teacher of a woman who sold herbs for drying the vagina and for warming the body at a junior secondary school during the morning school break. The researcher bought herbs from women in the community and also from a female and a male traditional healer. The researcher observed the texture of each of these herbs and that they looked, felt and tasted differently. On enquiring about the differences of the herbs, she was informed it was the preparation method that led to the differences in texture and taste.

The researcher would, for example, ask the research participants to show her the herbs they used and explain their purpose. Generally, the research participants were eager to share with the researcher what they knew about herbs or some of the cultural practices. This kept

the interview process very interesting and engaged as the researcher was probing and the research participants were eagerly explaining what might not have been familiar to the researcher. It also helped to build trust and developed rapport with the research participants, as well as set clear boundaries on the researcher's role. The peripheral-member-researcher role created the space for the researcher to understand the responses from the perspective of the research participants. The researcher was, however, also aware that observing an activity, interaction or illustration with the research participants could be intruding on their privacy and disregarding their spaces. This was an issue that the researcher was constantly aware of. She, therefore, made it clear to the research participants that she would discontinue her observation and leave if they wished to change their minds about the researcher being present and observing.

All the observations took place in the natural settings of the research participants which were at their homesteads in their courtyards, except for the male traditional healer in Katima Mulilo where the observation took place at his medical practice. The length of the observation was dependent on the activity. The researcher returned four times to the same research participant in connection with the preparation of herbs that are inserted in the vagina. During two of these observations, she spent more than five hours and more than one hour each during the next two sessions.

The researcher allocated sufficient time for taking notes after each observation to provide consistency and structure to the data collected. This included a description of the setting where the observation was taking place, the activity being observed, who was illustrating what was being observed and the accompanying feelings, such as discomfort or comfort, excitement or boredom, curiosity or uneasy from both the researcher and research

participants during the observation session. The researcher would take preliminary notes to highlight what she was expecting to observe prior to the observation and would also take notes after the observation. She avoided taking notes while she was with the research participants as she had noticed that it was hindering conversations between herself, her research assistant and the research participant. The notes did not include any identifiable information or information about the physical address of the research participants.

Observation as a method of data collection in the social sciences may lead to ethical concerns around an invasion of privacy (Zahle, 2017). To address these concerns, each research participant who participated in an observation activity provided written, informed consent prior to any observation taking place. Focused observations and semi-structured interviews occurred as separate data collection activities. The researcher would only decide to follow up with the research participants to conduct an observation once she had acquired the valuable knowledge and skills they had shared in the semi-structured interview. After the interview, the researcher would then ask whether they would show her a particular activity that they shared during the in-depth, face-to-face interview. Once they had agreed, the observation started or a follow-up interview date was arranged between the researcher and research participant.

4.11.5 Photographs and documents

During the design of this study, photographs were not considered as a method of possible data collection. However, during the actual fieldwork, photography was utilised to supplement and illustrate findings from the semi-structured interviews. There were instances in this study where, training manuals from NGOs and herbs that are inserted in the vagina and put in tea or porridge were photographed.

After interviewing representatives from NGOs, the researcher asked them for copies of their training manuals to assess the content and identify whether any cultural practices that could potentially be risks to contracting HIV were covered. The majority of the training manuals were only available in hard copies and could thus not be emailed to the researcher and also not put on a memory stick (USB). The only NGO that could insert the training manuals on a memory stick for the researcher was the Red Cross Society. The photocopy machines at most NGOs were either out of order or had no cartridges for printing and photocopying.

After finalising the interviews, the researcher gave a copy of a signed written letter requesting the training manuals from the research participants at the NGOs. The letter stipulated the justification for collecting the training manuals. Four NGOs immediately shared their training manuals with the researcher. However, two indicated that they needed to seek consent from their Head Office in Windhoek before they could share the training manuals with the researcher. Upon receiving the consent, NGOs would then inform the researcher. In total six shared their training manuals with the researcher. Given the voluminous content of most of the training manuals, it was impossible to photograph the entire manual. The researcher then resorted to photographing the cover page, table of contents and only those details of the training manuals that focused on cultural practices.

4.11.6 Data processing and analysis

This sub-section details the process of data analysis. It elaborates how data were generated and organised in preparation for analysis. It, furthermore, discusses the process of data transcription and also provides a brief overview of the use of the ATLAS.ti 8 programme, which was employed to manage and store qualitative data. Each audio recording was transcribed into Microsoft Word and it was saved on a separate file. The transcripts were then imported into

ATLAS.ti 8. Moore, & Llompart, (2017) refers to the process of transcribing qualitative data from interviews as one of the initial steps in preparing the data for analysis.

The study conducted 33 digital recordings. A total of 25 were conducted in English and 8 were conducted in local languages in the Zambezi region, varying from Silozi, Sifwe and SiSubia. Da Silva Nascimento & Steinbruch, (2019) assert that there are several decisions to be made around the aspect of data transcription, varying from who should transcribe, what to transcribe and how data should be presented in the text. In this study, the researcher recruited four transcribers who were familiar with the local languages and English.

The researcher and two transcribers were responsible for transcribing all the recordings that were conducted in English. The involvement of the researcher in transcribing proved to be beneficial as it helped her to become acquainted with the data. Through transcription the researcher began to immerse herself in the data, developing an intimate knowledge of the data and becoming sensitive to important issues that arose (Bazeley, 2013). The recordings that were in local languages (Silozi, Sifwe & Sisubia) were transcribed by the two transcribers. All the transcribers signed a confidentiality contract that compelled them to keep the information they transcribed confidentially and to protect the integrity of the research participants.

Busetto, Wick, and Gumbinger, (2020) advise that transcribing should take place as soon as possible after the interview. Benefits of doing this include being able to remember what was said, which can help if parts of the recording are unclear, or to return to the same research participants while in the field so they can clarify or the researcher can probe further. It also enables the identification of important issues to be addressed in future

interviews. Not all the 33 recordings were transcribed while the researcher was in the field. A total of 19 recordings were transcribed during fieldwork.

To retain the rich and full data, transcription was done verbatim (Jamshed, 2014). Furthermore, the decision was made to include all content from the interviews in the transcript to be able to explore in detail the perspectives of the research participants. Oliver et al. (2005) note that transcription practices reside between two main methods. These are the "… naturalism, in which every utterance is transcribed in as much detail as possible, and denaturalism, in which idiosyncratic elements of speech (e.g. stutters, pauses, nonverbal and involuntary vocalisations) are removed" (Oliver et al., 2005, p. 1273).

The interviews were conducted in four languages, English, Silozi, Sifwe & Sisubia. Some research participants spoke English fluently. Therefore, the researcher did not need the translation from the research assistant. Others spoke Silozi and, despite the researcher having a basic comprehension of Silozi, she preferred to make use of translations by the research assistant. Some of the research participants were, however, interviewed in Sifwe or Sisubia and, given that the researcher has no fluency in these two languages, the research assistant translated those interviews.

All the research participants interviewed in local vernaculars were given consent forms in Silozi to sign. For the Silozi, Sifwe and Sisubia transcriptions, the person was requested to type the questions as posed by the researcher during the interview, to listen to how the translator translated the same questions and to only type the response from the research participant. In the event where the question from the researcher and the translation of the translator differed, the transcriber was requested to write down both questions followed by the response of the research participant. It was important to the researcher to retain the

research participant's voice by ensuring that the essence of what was said by the research participants should not be lost through translation. The researcher, therefore, took a more naturalised approach to transcribe and even in the transcription retained the pauses, nonverbal cues, stutters and involuntary vocalisations. However, this was challenging as some recordings had background noises of children crying, dogs barking, the wind blowing and people interrupting interviews. These complications contributed to prolonged transcription time.

Each completed interview transcript was imported into ATLAS.ti 8. Using ATLAS.ti 8 enabled the storing and accessing of multiple sources of data in one place. Friese (2014) holds that qualitative data analysis with ATLAS.ti 8 can assist with querying ideas, as well as managing, visualising and reporting the data.

Additionally, other sources, such as focused observations, photographs and field notes, were employed as sources of data. This section will outline how these additional sources of data (photographs, field notes and focused observations) were managed and prepared to assist in the data analysis process. All sources of data from this study were imported into ATLAS.ti 8 and stored as Internals. Friese (2014) refers to Internals as primary source materials which are organised into the subfolders of interviews, research participants' observations, field notes and photographs.

Focused observations and field notes were transcribed as soon as possible after the event and were then imported to ATLAS.ti 8. However, they contained no identifiable data which were filtered out by the researcher at the time of creating the original source document. The field notes, recorded on a cell phone notepad, were transcribed directly into a single word document and organised in chronological order, thus, mirroring the original content

of the researcher's field diary. The field notes were captured and marked by date and place. Throughout the process of designing and conducting the research, the researcher kept reflexive notes to reflect on and share with her supervisor regarding decisions made at different stages in the research process. A file with all the photographs was then created and uploaded to the computer for safekeeping. Each of the files was labelled with the description of the photo. Once uploaded and saved to a secure, password-protected file on the computer, the digital images on the cell phone were deleted.

4.11.6.1 Data analysis

The data were analysed using a thematic approach. Braun and Clarke (2006) referred to the six phases of thematic analysis which were employed in this study. The data analysis approach was based on the outline illustrated in Table 1.

Table 1: Six phases of thematic analysis

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down ideas as they emerge
2. Generating initial codes and subcodes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code and sub-codes also generated.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story that the analysis tells, generating clear definitions and names for each theme. This is also where the findings chapter is outlined.

6. Producing the report	The final opportunity for analysis, selection of vivid, compelling extract examples, the final analysis of selected extracts, relating from the analysis to the research questions and literature, producing a scholarly report of the analysis.

Source: Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology.* 3(2). 77-101.

Braun and Clarke (2006) take the view that thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data. Thematic analysis is regarded as a foundational method for qualitative analysis, providing the researcher with key skills that apply to other types of qualitative analysis (Braun & Clarke, 2006). This method is versatile and can be applied to a variety of research questions, types of data, large or small data sets and for data-driven or theory-driven analysis (Clarke & Braun, 2013); therefore, given the variety of different data sources, it was appropriate in this study. Braun and Clarke (2006) recommend that their six phases of thematic analysis are to be taken as a guideline, recognising the need for qualitative researchers to be able to move back and forth. As with other stages in the research process and the methods employed, there are various decisions to be made around the thematic analysis approach, which should be considered before analysing the data (Braun & Clarke, 2006). The following discussion around how the researcher analysed the data will highlight and address issues relevant to this research.

Bazeley (2013) recommends taking time to become familiar with each source of data through reading and reflecting on it as it becomes available. This, along with the process of transcribing, is the first phase in conducting a thematic analysis. Richards and Morse (2007) refer to this early phase of data analysis as ‘getting inside’ the data which, they note, is easier for

researchers who have been involved in collecting the data, writing field notes and transcribing. The researcher listened to the audio recordings of the interviews on the same day that they were created. The interview and observation transcripts, as well as the field notes, were perused as soon as they had been completed after each event. This helped the researcher become familiar with the data, as suggested by Bazeley (2013), and provided an opportunity to identify further areas for follow-up during the recruitment and data collection phase.

The benefits of using ATLAS.ti 8 include: a faster and more efficient way of coding data; the ability to store a high quantity of information; categories or codes are linked to coded segments; it is easy to move from coded segments to the original context (Linneberg & Korsgaard, 2019). Coding involves the labelling of sections of the text based on an understanding of that section of text (Bazeley, 2013). Different types of codes can be employed to help focus on, and develop, ideas (Bazeley, 2013). Richards and Morse (2007) identify three types of coding employed in qualitative research, namely descriptive, topic and analytic coding. A combination of descriptive and topic coding was employed in this study and will now be outlined.

Descriptive coding allows the researcher to store ‘known’ or “factual” information, for example, information about research participants, such as age and gender. This information can be built into the way that the data are managed, with the relevant characteristics included in each data document or as a table that can be imported. In this study, descriptive coding was applied to interviews and observations as these related to research participants and the context in which the interviews took place. Keeping track of the data in this way, as it was collected, helped to guide the purposive sampling of research participants and thus inform the ongoing data collection process.

Each code created in ATLAS.ti 8 was given a description which made it possible for the researcher to review existing codes. As new ones were created, some codes were combined or became sub-codes of others. As with the overall process of analysis in qualitative research, the researcher found herself moving back and forth through the data, coding and re-coding as new categories or codes were created. Linneberg and Korsgaard (2019) note that, as coding continues and more categories are created, the process becomes more analytic. They also state that in creating categories the researcher proceeds, not just linking them to the data but also questioning the data about the new ideas developing in the new codes.

Analytic coding can assist the researcher in identifying new meanings or themes in the data, enabling the exploration and development of new ideas and comparisons (Linneberg, & Korsgaard (2019). This level of coding was performed only with the interview data set. Furthermore, the researcher created memos on ATLAS.ti 8 while coding to record her thoughts as the analysis progressed. These notes were separate from those documented in the reflexive journal as ATLAS.ti 8 made it possible to link comments directly to the codes or the source, for example, sections of an interview (Friese, 2014).

Findings are organised thematically and each theme is supported with several narrative quotes in italic and indented. Inclusion of narratives quotes allowed rich, thick descriptions of data and keeping the narratives intact ensured clarity and meaning was conveyed. By presenting the narrative quotes, it provided evidence of the study findings

The final phase relating to themes involves defining and naming the themes. Braun and Clarke (2006, p. 92) explain that this is about … identifying the 'essence' of what each theme is about (as well as the themes overall), and determining what aspect of the data each

theme captures. Furthermore, the researcher created definitions and final names for each theme in the final analysis so that the reader has a clear idea of each theme.

Exploring themes and drawing on the data set of observation transcripts, field notes and photographs enabled the researcher to illustrate and explain the themes, as well as select quotes from the face-to-face interviews. Once quotes had been selected, they were prepared for use in the dissertation. All interviews that were conducted in local languages were translated into English; consequently, all the quotes in this study are in English. Some of the concepts are, however, kept in their original, traditional names with English explanations, such as Sikenge, induna, bunyazi, etc.

4.12 Procedure for gaining access

Gaining access to a research site can be a challenge if not handled with caution. Riese, (2019) suggest that negotiating access with gatekeepers must be prioritised as early as possible. Letters seeking permission to conduct the study in the Zambezi region were written in advance to the governor's office and the Kabbe constituency office. Upon arriving in Katima Mulilo and Kabbe, the researcher contacted the governor's office and constituency counsellors to inform them of the study.

Other than to the political office bearers, a courtesy visit was also paid to the Masubia Royal Establishment to seek permission to conduct research in their area of jurisdiction. The spokesperson of the Masubia Royal Establishment accompanied the researcher and also acted as translator during the courtesy visit. During the visit, the researcher also requested permission to interview four traditional leaders from the Masubia Royal Establishment. The permission was granted and four male traditional leaders from the Masubia Royal Establishment were identified to form part of the research.

The fact that the researcher was not from the Zambezi region or that she was a woman did not inhibit access to the Masubia traditional courtyard. It should be noted that, when the researcher attended the first introductory meeting at the Masubia Royal Palace, she was received by eleven traditional councillors, as well as the Ngambela (second in charge after the Royal Chief). It also included the palace security guard. They were all men, except for the Masubia Royal Palace secretary who was a female.

The researcher discussed the proposed study with all the participants from whom consent had been sought before proceeding with the study. The proposed study was met with enthusiasm, interest and, in some instances, a degree of apprehension; however, all participants offered their support. The Masubia Royal Establishment introduced the researcher to the Induna (chief) overseeing the research site in Kabbe village. Village headmen in Kabbe village were also introduced to the researcher and were thus invited to participate in the study. Four of the village headmen in Kabbe consented to be interviewed. Hammersley and Atkinson (2007) alluded to the process of 'casing the joint' and its importance in providing the researcher with information of the study setting, which can help inform decisions around the suitability of the research site, the allocation of time needed to complete the study, the feasibility of being able to conduct the research there and the way to establish access.

The community members would also have conversations about topics related to the study. They were also seeking advice about the University of Namibia's application process for themselves and their children. The researcher's involvement in all these community activities led to more familiar and deeper relationships with community members and research participants in Kabbe. This position of the researcher was informed by Vanclay,

Baines, & Taylor, (2013) who emphasises that those who are researched should be treated like people and not as mere mines of information to be exploited by the researcher as the neutral collector of facts. The researcher thus opted to base the relationship with the research participants on empathy and mutual respect, and also decided to share whatever knowledge she possessed with the research participants.

4.13 Methodological reflexivity: Researcher's role and identity

This study required a reflexive process since it investigated cultural practices that were sacred to the cultural identity of the research participants but at the same time, shrouded in secrets. This could have posed a challenge, particularly when the researcher is considered an outsider. Reflexivity constitutes self-critical, sympathetic introspection and self-conscious, analytical scrutiny of the self as a researcher. It involves the ability to understand the ways that one's social locations and experiences of advantage or disadvantage have shaped the way one understands the world. Reflexivity is critical to the conduct of fieldwork, particularly where it concerns an anthropological study with the researcher living with the research participants for an extended period. Throughout the research process, reflexive notes around sampling and data collection were kept to record emotional responses to events and people, as well as decisions made. These notes covered aspects, such as that all the heads of NGOs in the Zambezi region, except for the Development Aid from People to People (DAPP)/Total Control of the Epidemic (TCE), were from the region. The notes also reflected on the conditions of the buildings from where most NGOs were operating, noting that some buildings were debilitated and office equipment seemed lacking. This became apparent when the researcher requested copies of training materials as the majority of the NGOs could not make copies or send emails of the training materials to the researcher. A more reflexive and flexible approach to fieldwork allowed the

researcher to be more open to any challenges to the theoretical position that fieldwork almost inevitably raises.

All the research participants were fluent in Silozi, which is very close to Setswana, the mother tongue of the researcher. This language underscored the shared, cultural values of the communities where the study was conducted, as well as those of the researcher. The researcher's ability to communicate in Setswana, which is closely related to Silozi, minimised the insider/outsider status between researcher and participants. The majority of the research participants based in Katima Mulilo were fluent in English and could express themselves with ease. It was in the villages where language barriers were more pronounced, and the assistance of a translator familiar with the SiSubia, Silozi and Sifwe languages and cultures were sought. Another aspect that required reflexivity was bunyazi, a non-formalised but socially acceptable form of adultery in which married men or women enter into extramarital relationships (Ojedokun, 2015). This is a common practice in the Zambezi region and among Batswana, although people from Zambezi and Batswana do not consider bunyazi a cultural value; on the contrary, this practice is shunned. In the past, both Silozi and Setswana customs imposed punitive measures against a partner who was in an adulterous relationship such as bunyazi.

The reflexive process required an enquiry into the role of the researcher when interacting with the research participants in the study. An understanding of one's attitudes, values and biases is a useful tool in not only gaining deeper insight into the research but also in ensuring that the focus remains on the research and its research participants. Simultaneously, by situating herself in the research process, the researcher facilitated the reader's understanding of the perspectives that had led to the analyses and findings (Patnaik, 2013). It is essentially a process of self-critique by the researcher to examine how

her own experiences might or might not have influenced the research process (Holmes, & Darwin, 2020). Thus, reflexivity is the constant awareness, assessment and reassessment of the extent to which the researcher shapes, contribute and/or influences the outcome of the research findings. In the process, Patnaik, (2013) emphasises the role of the researcher as subject to the same critical analysis and scrutiny as the research itself. From the perspective of the researcher, it was important to arrive at a clearer understanding of her position in the process of meaning-making as it allowed her to explore alternative epistemological lenses, including her philosophical leanings, biases and prejudices which could influence the research process.

Reflexivity acknowledges that the researcher's experiences, attitudes and emotions will affect engagement with the research participants and the subsequent analysis of data. Reflexivity attempts to maintain research focus by bracketing the biases and attitudes of the researcher to minimise, if not prevent, their influence on the research process. A common bracketing approach is to maintain a reflective journal. After every interview, the researcher spent substantial time noting down her immediate observations, thoughts, feelings and interpretations before she subjected the data to structured analysis. This enabled the capturing of her attitudes and responses to the research participants she had met. Dowling (2006) recommends a three-phase process of bracketing, namely as pre-action, bracketing in action and bracketing on the action. Pre-action bracketing happens during the fieldwork preparation stage when certain attitudes that are likely to influence the data are identified in advance and are dealt with. For example, from the onset, the researcher was biased towards practices, such as polygyny and dry sex because of their perceived oppressiveness towards women and girls. The researcher had to be aware of the position she was taking and thus had to deliberately seek from the research participants how these

practices could benefit women and girls. In action, bracketing is contingent upon the nature of the emergent data during the empirical work. Certain aspects might compel the researcher to examine her thoughts in manners not previously considered. Bracketing on the action is the use of this new insight in subsequent empirical work.

Another point of methodological reflexivity that occurred was a parent telling the researcher that her 16-year-old daughter did not know men, implying the daughter was a virgin and, as a result, might not be in a position to provide any insightful contribution to the research process as it was dealing with HIV and AIDS and matters of sexuality. The researcher's immediate response was to be defensive and lecture the parent about the fact that children know about issues of sexuality and HIV and AIDS even before they engage in sexual intercourse. Particularly, given that information about HIV and AIDS is taught in schools. However, in an attempt at bracketing, the researcher assured the parent that she would not pose inappropriate questions to the under-aged research participant. After the parent had granted her consent and, as the interview was progressing, the researcher reflected on the parent's concern as this issue brought in an important dimension of narrative research. The researcher was pondering whether the framing of research questions and the issues that would arise from probing in-depth explanations from the adolescent would have caused this adolescent to think about issues of sex and sexuality in a manner that was sexually arousing. For example, one of the probing questions on the practice of dry sex was whether the adolescent knew about the practice and whether adolescents were using the herbs to dry the vagina. This question implied that adolescents are sexually active. The question that arose was whether this study would have an impact on any of these seemingly very private and personal aspects of this young person's life. The researcher,

however, worked on action bracketing to frame questions around these topics in subsequent interviews where the youth were research participants.

4.14 Ethical considerations

Focused ethnography in the field of HIV and AIDS behaviour change presents certain ethical challenges, arising from the sensitivity around the topic of sex and sexuality, coupled with the extent to which the research participants would be eager to share their perspectives of the research topic under discussion. As a result of the ethical consideration embedded in this study, the researcher regarded maintaining an ethical relationship with the research participants as a critically important aspect of this research. At every step of the research process, truthful and specific information was shared with the research participants to allow them to make informed decisions about their participation in the study.

Accordingly, the researcher adopted strategies throughout the research process that enabled the maintenance of ethical relationships with the research participants. As a result, the relationship between the researcher and the research participants was characterised by principles of respect for autonomy, upholding confidentiality, the choice to participate in the study or not and justice, which entailed the right for research participants to terminate an interview halfway through the interview process if they did not feel like continuing (Beauchamp & Childress, 2013).

4.14.1 Consent, assent forms administered to research participants

Every research participant who participated in this study was invited, and a consent and assent form was administered. The ethical considerations of the research were presented to them. Separate consent forms and research participant information sheets were created for each group. The research participants were assured that their participation in the study

was voluntary and that they were not obliged to take part if they did not want to. They were also assured that there would be no repercussions for not participating in the study.

The study also targeted children between 15 to 17 years. The University of Namibia Ethical Committee requires that consent must be sought from the parents of participants in this age category and the youth must sign assent forms. The same ethical principles that were shared with the parents were also shared with the youth. The parents of the youth had to consent that their children could participate in the study.

The content of the consent and the assent forms were explained to the research participants. Consent and assent forms were translated into Silozi for research participants who were not fluent in English. Some research participants raised questions about numerous issues, such as why the interview was recorded, what the researcher would do with the recorded interviews, whether the researcher would present the research findings in a dignified manner, as well as whether the questions that were asked were appropriate for underaged research participants. The researcher thus had to take questions and queries regarding the study and provide the research participants with responses and clarifications. Once the research participants were satisfied with the responses from the researcher, only then did they agree to sign the forms as an indication that they were voluntarily participating in the study. The researcher also had to sign the consent and assent forms as an indication that she had read the forms to the research participants and that they were sure that they understood what was read to them.

4.14.2 Maintaining confidentiality and anonymity

The ages of research participants varied from 15years to 96years. From an ethical perspective, consent forms are required from all research participants. However, when

research participants are younger than 18 years assent forms are required from their parents (Flicker & Guta, 2008). This dissertation included a 15-year-old male learner, two 16 and 17-year-old females' learners. Due to their biological, social and behavioural factors, the youth are disproportionately affected by sexually transmitted infections including HIV and AIDS in Namibia. In Namibia, the highest rates and increases of HIV are in people between 15 to 24 years (Namibia Statistics Agency, 2014; Republic of Namibia, 2016; Ministry of Health and Social Services, 2019).

The national HIV prevalence is estimated from blood samples of patients who are 15 years and above, similarly, the Namibia Demographic Health survey includes research respondents from age 15 years (Republic of Namibia, 2016; Namibia Demographic Health Survey, 2014). The Namibia Population-Based HIV Assessment also draws its data from young men and women who are 15 years and above (Ministry of Health and Social Services, 2019). Furthermore, the sentinel survey indicates the high numbers of new HIV infections among adolescent girls (Republic of Namibia, 2016). In the Zambezi regions, adolescent girls as young as 14 years are coopted in the Sikenge girl initiation rituals where they are taught about female gender roles and sexuality(/Khaxas & Franks, 2010; Legal Assistance Centre, 2017). Given the above, this study resolved to include research participants from 15years, as it is in line with the national research protocols in the field of sexual reproductive health. The researcher also abided by the University of Namibia ethical requirement to seek parental consent when interviewing research participants younger than 18 years. In the research process, several measures were taken into consideration to manage the data and to protect and maintain the confidentiality and anonymity of the research participants.

To ensure the participants' confidentiality and anonymity, after the completion of the transcripts, the researcher called and emailed each of the transcribers and requested that

they delete all recordings and transcribed interviews from their computers, USBs, emails or whatever devices were utilised to save the data. All the interview recordings were uploaded to a secure, password-protected file and deleted from the digital recorder. As each interview was transcribed, identifiable information, such as names, age and workplace titles, were changed and replaced with pseudonyms to maintain confidentiality and anonymity.

4.14.3 Causing no harm

Sanjari et al. (2014) note that, while ethnography may not include the same risks as those associated with research participants involved in medical experiments, it can sometimes have consequences. These consequences can arise from participation in the research or publishing findings. They note that participation may create or worsen anxiety and, when researching stressful situations, careful consideration should be given to the effects this may have on those involved (Sanjari et al., 2014).

If the research participants experienced any form of harm or concern resulting from their participation in the study or any complaint about the ethical aspects of the research, they were urged to contact the researcher, the supervisor of the researcher and/or University of Namibia Ethics Committee. For each of the mentioned individuals, contact numbers were provided in the consent and assent forms.

One of the issues that emerged during this study was the concern raised by some research participants about the portrayal of their cultural identities. The research participants, particularly those from communities, referred to previous research that had been conducted which portrayed their culture in an unbecoming manner. This defence of their own cultural identity and critiquing scholars for the way data from communities were portrayed is warranted because cultural identities are the core of community members' existence.

Research participants are justified to feel exposed and judged if the data they have shared with a researcher is portrayed in a manner that is not dignified.

Rubin and Rubin (2012) note that part of the researcher's ethical responsibility towards the interviewee is ensuring that he or she causes no harm. They suggest that interviewees should be no worse off and, ideally, should be better off for having taken the time to participate in the study (Rubin & Rubin, 2012, p. 89). It is, therefore, the responsibility of researchers to be sensitive and to ensure that research participants are not harmed by how their stories/data are displayed. Hence researchers ought to be considerate about the tone in which data are presented and thus guard against the presentation as condescending, waning, objectifying and portraying the subjects as backward and uncivilised. Such portrayal shows academic arrogance and is condescending. African ethnographers who are researching in their African settings should avoid the pitfalls of the earlier Western anthropologists who portrayed the cultures and traditions of African nations as pagan, backward and uncivilised (Lewis,1973; Tugume, 2015).

While there was no intention to cause harm to others through undertaking this research, it was important for the researcher to consider any potential risks associated with this research project. The researcher was made aware of the backlash against one of the NGOs working on cultural practices in the Zambezi region. Those who critiqued the work of the NGO thought that the information that was shared was a distortion of what their culture was teaching and standing for.

Although it was not the intention of the researcher to harm either individual research participants or the community of the Zambezi region as a whole. The researcher was aware that some of the research participants could be potentially vulnerable when entering the

research process. Busetto, Wick, and Gumbinger, (2020) suggest avoiding interview questions that could cause harm. However, while the overall aim of this research was to gain an understanding of the different perspectives and experiences of how cultural practices could potentially increase the risk of contracting HIV, particular care had to be taken by the researcher to assess any form of vulnerability. The interview might prompt distressing thoughts or memories, given the topic under discussion.

For example, there was an incident with a 23-year-old female research participant who was married and a mother of 2 children. During the interview, she mentioned regretting being married as she was married off while she was too young at age 19 because of early pregnancy. Despite the research participant showing distress and opening up about her vulnerability, she indicated that she would like to complete the interview.

After ending the interview of the research participant who clearly showed signs of distress, the researcher enquired whether she would like to speak about her experiences to someone else other than the researcher. The researcher suggested talking to a social worker from the Ministry of Gender Equality and Child Welfare or an HIV and AIDS home-based caregiver or even a local pastor. She however declined and stated that she is fine.

Busetto, Wick, and Gumbinger, (2020) warn that for some research participants some topics will potentially stir up emotions. They advise researchers to give interviewees the option of answering a question or not, by explaining that the question might be too difficult or stressful to answer. This technique ensures that research participants do not feel under pressure to answer, in the same way, that they should not feel under pressure to participate in the research in the first place. The research participant information sheets explained this

potential risk and a section was included in the study protocol, outlining what the researcher would do if someone became distressed.

In addition to assessing potential risks to research participants, it was important to consider risks to the researcher. Busetto, Wick, and Gumbinger, (2020) acknowledge that interviewing can be emotionally and physically exhausting to the researcher, and the researcher must find ways to deal with this risk. This is particularly the case when conducting studies that require a prolonged stay in the research sites. To address the aspect of potential risk, the researcher and the assistant field researcher would share their experience after an interview and the researcher would confirm with the assistant researcher whether her observation and how she managed the distressful situation were culturally appropriate. The sharing of research experience between the researcher and the assistant field researcher provided sufficient support to both of them and thus reduced any potential risk or distress.

Bashir (2018) identifies the safety of the researcher as a key ethical concern in undertaking interviews. Bashir (2018) highlights the importance of supporting the emotional well-being of researchers when dealing with sensitive topics and putting measures in place to protect the researcher's safety when interviewing research participants in their homes. All interviews in Kabbe were conducted in the research participants' homestead. To ensure her safety, the researcher sought permission from the MaSubia Royal traditional authority to research an area that was under their jurisdiction. She, furthermore, was introduced to the headman of the villages where she was conducting the research. The traditional authority assured her of their support and that she could return to the traditional authority should she experience any challenges with the data collection process.

Furthermore, the family who hosted the researcher went out of their way to introduce the researcher to other community members. The elderly woman who hosted the researcher was a resource person in assisting to identify potential research participants who fitted the criteria of the study. For example, she knew where the village indunas lived, as well as who the local traditional healer and the home-based caregiver was.

Her grandson, on the other hand, knew school-going youth who lived close by and could be contacted to participate in the research. Whenever, the researcher went to interview a particular individual, the elderly woman and her family would be aware of the whereabouts of the researcher and the fieldwork research assistant. That provided a sense of security for the researcher in a research setting that was unfamiliar to her. It was anticipated, however, that some interviews would be conducted in research participants' homesteads; the researcher was, however, always accompanied by the fieldwork research assistant, even in cases where her services to translate were not needed. This insured the safety of both the researcher and the fieldwork research assistant.

In summary, this chapter discussed in detail the research design and methods selected for this research. The research design included an overview of the position underpinning the research, followed by an introduction to focused ethnography as a qualitative research approach about HIV and AIDS and cultural practices. The researcher's thoughts regarding how focused ethnography is the most suitable qualitative approach for this study were also deliberated.

The methods employed to conduct the research were outlined, starting with an overview of how the research setting was selected and what steps were taken to gain access, both informally and formally. Sampling strategies, including the plan to recruit research participants, were presented. The data collection techniques of semi-structured interviews,

supplemented with focused observations and photographs of training materials, were considered with attention given to how data were managed in preparation for the analysis. The process of data analysis, utilising a thematic analysis approach, was summarised at the hand of Braun and Clarke's (2006) Six Phases of Thematic Analysis, complemented by a discussion around the way that the ATLAS.ti 8 was employed as a tool to assist in this process. Ethical considerations regarding the study were framed by employing Beauchamp and Childress's (2013) moral principles of respect for autonomy, causing no harm to both the researcher and research participants. The researcher envisages that this study will contribute to the current knowledge base and discourse on the prevention of HIV and AIDS in the Zambezi region. Furthermore, this study sheds light on polygyny and dry sex cultural practices that may increase the spread of HIV. The study creates awareness of the importance of designing culturally appropriate HIV and AIDS interventions that are context-specific.

CHAPTER 5: PRESENTATION OF THE RESULTS

5.1 Introduction

This chapter presents the key findings as themes and sub-themes identified in the research study. The study presents four main thematic areas, which are cultural practices of polygyny and dry sex and the risk they pose to HIV; the inclusion of polygyny and dry sex in HIV and AIDS behaviour change programmes and challenges faced. The study further elaborates on the interplay of the cultural practice of polygyny and dry sex that heightens women's vulnerability to HIV. Finally, the study delves into the importance of preserving cultural practices in particular polygyny and dry sex and the narratives of choice regarding what aspects of culture to preserve or not to preserve.

The main findings of this study are derived from in-depth, face-to-face, semi-structured interviews with research participants. However, additional findings were derived from informal discussions with participants, focused observations, photographs and field notes. Quotes from the research participants are indented from the main paragraphs. However, field notes, which are comprised of informal conversations, focused observations, photographs will appear in black italic text indented from the main paragraph, to help the reader navigate the data. The narrative approach is useful for this study as it allows for voices and experiences to be expressed and recorded as such (Wang, & Geale, 2015; Bruce et al., 2016).

5.2 Demographic characteristics of participants

The researcher purposefully included a variety of participants, both males and females, from different age groups. The roles and responsibilities of the participants also varied. This study had a total of 33 research participants. These participants were purposefully included in the study, depending on their knowledge about polygyny and dry sex and HIV

and AIDS prevention programmes. Four of the participants were from MoHSS and one was with Zambezi Regional office. These were directly involved in the design and roll-out of HIV and AIDS prevention programmes nationally and specifically in the Zambezi region. Their roles were that of regional coordination and response to HIV and AIDS; Social behaviour Change and HIV and AIDS Communication Officers, Health Extension Officer and national coordination officers. They were all based in Windhoek and Katima Mulilo respectively. The study also included participants in the non-governmental organization sphere who work in the field of HIV and AIDS prevention and behaviour change. An NGO such as the Women's Leadership Centre was included for their advocacy in eliminating harmful cultural practices that violate women's rights. In total, six staff members from NGOs' or HIV and AIDS prevention and behaviour change programme coordinators were interviewed. The NGOs that were included in the study are NANASO, Catholic AIDS Action, Society for Family Health, DAPP/TCE, Red Cross and Women's Leadership Centre. These NGOs all run programme activities in the Zambezi region.

A spectrum of community members was included in the study, mainly because of their role in society and also for their knowledge about the cultural practices of polygyny and dry sex and HIV and AIDS programmes within the Zambezi region. The study included two traditional healers, which were male and female. They were both members of the Zambezi Traditional Healers Association and also members of RACOC. Furthermore, two life skills teachers were research participants, because of their volunteer work with the NGO sector. The female life skills teacher is an advocate against harmful cultural practices with the Women's Leadership Centre and the male life skills teacher is a volunteer at the Red Cross on HIV and AIDS behaviour change programmes. The study had four male traditional authority members, who were included as custodians of customs and traditions. The

traditional authority members are also village headmen who preside over community disputes, or whatever is of concern that is brought under their attention. Hence, they are knowledgeable about matters of culture such as polygyny, dry sex HIV and AIDS behaviour change programmes that are conducted in their jurisdiction. The practice of polygyny was traditional the prerogative of chiefs and village headmen.

The study also included three school-going youth. The two female youngsters were raised in polygynous households, hence their inclusion in the study. The male youth had an elder brother who was married in a polygynous union. Five of the research participants were in their 20s and occupied various roles in society. They, however, were knowledgeable about cultural practices of dry sex and polygyny, they also indicated the type of HIV and AIDS prevention programmes that they have been privileged to attend. Participants in their 30s and 50s were married and could share their perspectives about the use of dry sex and polygyny. Participants who are pensioners were included for their rich historical narratives about the social justification of upholding cultural practices of polygyny and dry sex. One of the female pensioners for example knew how to harvest and prepare the herbs that dry the vagina.

Each of the participants was given a pseudonym, to further conceal the identities of the participants, their ages have also been changed. Participants who work at NGO's or in government their work titles has been changed also. Furthermore, the villages that the Indunas are heading have not been mentioned also as a strategy to safeguard their identities. Of the 33 participants, 3 were from Windhoek while 30 were from Katima Mulilo and Kabbe. Thus, a total of 30 participants were knowledgeable regarding the social context of the region; similarly, they were also aware of the cultural practices discussed in this study.

The study included participants who identified with the local languages, Silozi, Sifwe, Sisubia, Mbalangwe, Yeyi, Shikwe and Nyanga.

5.3 Prevalence of cultural practices of polygyny and dry sex in the Zambezi region

The extent to which dry sex and polygyny still occurred will be elaborated. Besides, this section also assesses the degree to which cultural adaptation was occurring. Emphasis will be laid on whether polygyny and dry sex still occur as they were in the past, with minimal or no change and whether there has been any adaptation. Attention will be paid to whether these practices are declining.

The practice of dry sex is locally referred to a *kuomisa busali* in SiLozi. Women use various herbs, locally referred to as *musheshe, mulula, ka-chalo*, and *mukotokoto* to dry the vagina. The herbs drunk as tea or put in thin porridge were locally called *inswe, musatisati* and *mushekeshela*. The researcher saw at least two types of herbs that could be inserted into the vagina and two different types of herbs that could be consumed in tea or thin porridge. The herbs were finely powdered. These herbs varied in texture and colour. One of the herbs was deep reddish-brown and, when mixed with water, it had a glue-like, sticky texture. The rest of the herbs were light brown to cream in colour.

Namasiku explained that different methods were used to reduce the excretion of vaginal fluids during sexual intercourse. These methods varied between inserting finely powdered herbs in the vagina and putting the herbs in a stocking to insert in the vagina. This method was mainly to avoid inserting the granules of herbs as they sometimes were too coarse and could cause tearing of the vaginal walls. In some instances, women would dissolve the herbs in warm water and then douche the vagina. Other ways of using the herbs were to

drink them as tea or put them in thin porridge. These herbs warm up the body and also reduce the excretion of vaginal fluids during sexual intercourse. The participants, both male and female, stated that the different methods served the same purpose, namely reducing vaginal fluids during sexual intercourse.

> *The researcher, however, observed that with the two types of herbs she acquired, using the herbs in dry form had a more drying effect on the vagina. Inserting the herbs by using a stocking was most effective for the drying effect to be felt when the herbs were inserted for longer than two to three hours in the vagina. The researcher did not notice a major difference when douching with the herbs but suspected that increasing the quantity of the dissolved herbs could create the drying effect (**Focused observation on using herbs from a trusted source, Windhoek**).*

5.3.1 Social justification for dry sex

The participants, both men and women, young and old, spoke about vaginal fluid as if it was something detestable and abnormal in women. For example, Masangu stated, "it is very nice for a man to have sex with a woman whose vagina is dry". However, if a woman's vagina was found to be wet, the man might think that the woman had sex with another man. In his opinion, the woman's vagina ought to be dry because the man was the one who should ejaculate sperm into the vagina for it to be wet. The vagina was thus perceived as not having the capacity to excrete its vaginal fluids. Patrice from RACOC explained that, when the vagina was dry, it had a stronger grip on the penis and thus provided greater sexual pleasure to a male partner. This practice, she alerted mainly benefited men because women experienced dry sex as painful due to vaginal tearing.

Sibeso, the female traditional healer, and Kahundu, the sikenge instructor, mentioned that the herbs employed in tea and porridge also warmed the body since some people were cold like "deep freezers if you touch their hands or their bodies they would be cold". Werona from Kabbe also explained the importance of using herbs that warmed the body. She warned that a person who did not use these herbs might be "as cold as snakes" which might not be attractive to a sexual partner. The herbs consumed in tea and thin porridge could be employed by both men and women. The female traditional healer, furthermore, explained that sometimes a man would not be sexually stimulated when he touched a woman who felt cold to the touch unless he started to fantasise about someone else that he had sexual intercourse with, the one who had a warm body. Sibeso, the female traditional healer also alluded that the herbs are also used to treat vaginal infections. She warned that herbs that dry the vagina are used when a woman's vagina is too wet and caution needs to be taken not to use too much to a point where sexual intercourse is painful to any of the partners.

The researcher inquired about the male preference for a dry and tight vagina. Sepiso from CAA alluded that men learnt about dry sex from one another. Through intergeneration socialisation, grandfathers were also playing their role to educate male children on what to expect from their female partners. Theodor, the 86-year-old man from Kabbe, confirmed that the majority of men preferred dry sex. He also stated that, when a man had sex with a woman with a dry vagina, he would not leave her, implying that if a woman's vagina was lubricated she could be divorced by her husband. Men preferred dry vaginas because they needed to feel tightness and friction during sexual intercourse; this made them feel sexually virile.

Sibolile from the Red Cross elaborated on the extent to which men preferred dry sex as there was an acceptable level of vaginal fluids/moisture to men and a level considered too

much and unacceptable. Too much vaginal fluids were regarded by their society as a symptom of women's disease. Women who found themselves with this condition would be worried and consult someone to remedy the situation.

Nalishebo, a Life Skills teacher and an advocate against harmful cultural practices, also indicated that, when a man married a woman, he expected her to know how to dance like she had been taught by her aunts or at the sikenge girls' initiation rituals; furthermore, she must have *malebe* (elongated labia), as well as use herbs to dry her vagina. A woman not meeting these societal standards was considered abnormal and the husband would report her to the elders; the elders would, consequently, advise him to leave her as she was "abnormal".

Simataa's wife narrated an experience where she was once advised by her boyfriend to drink the herb that warmed the body because he found her body not hot enough. She then found the herb and drank it, to the satisfaction of her boyfriend. Sibolile also confirmed that men did advise their women to use herbs to dry the vagina if they found the wetness "abnormal". He said,

> Us men we advise women … You sleep with your girlfriend or your wife, you can see how abnormally wet she is then you start talking to her that this is not good. Men also do not want that wetness … at least a woman should be wet but in a normal way.

5.3.2 Accessibility of the herbs

The herbs for drying the vagina could be acquired by different means. They were sold by traditional healers and salespeople in open markets. The researcher obtained herbs from one of the research participants in Kabbe who were willing to share hers. She also bought from the female traditional healer in Kabbe at the cost of N$10.00 for three tablespoons. In Katima Mulilo, the researcher bought the herbs at a junior secondary school after Nalishebo, the female Life Skills teacher, alerted her of the saleslady who usually came to

the school. When the researcher was at the school to buy the herbs, female teachers and cleaners were also lining up. A tablespoonful of both herbs that could be inserted into the vagina and those that were for drinking was measured and sold at N$10.00. Some female learners from the junior secondary school met with the sales lady after school and bought herbs.

> *It came as a surprise to the researcher to see school-going girls, buying herbs that dry the vagina, right outside the school gate, without any reprimanding from the school teachers. (**Schoolgirls buying herbs that dry the vagina, without being reprimanded by the teachers who are onlookers, Katima Mulilo**)*

Masangu, the male traditional healer in Katima Mulilo, also indicated that he sold herbs for drying the vagina at N$150.00.

The researcher observed that these herbs were easily accessible at street markets. They could be purchased from female elders and traditional healers in the community. Both urban and rural participants knew where to find these herbs. It was, however, clear that the majority of the participants bought the herbs from someone else. An elderly female participant in Kabbe, who had promised the researcher that she would provide her with herbs, indicated that she had to go to the forests to collect the herbs and prepare them. Hence, those with knowledge of the plant species from which the herbs were harvested, collected them from the forest and prepared them.

> *The researcher acquired the herbs that are inserted in the vagina and those that are consumed by various people. She noted that although all the participants indicated that the functions of the herbs were the same. Some of the herbs varied in texture, from finely powdered to coarse and colour, varying from deep red to light brown. She also smelled and noticed that the reddish herb had a sour smell, while the other was were bland. The*

researcher was informally told by the female and male traditional healers that the difference in appearance is a result of the plant species and the processing of the products.

Musheshe *Mulula*

Figure 2: Herbs used for dry sex

Figure 2 above illustrates herbs that are inserted in the vagina for dry sex, although they are different in terms of textures and colour. The difference is a result of the different plant species utilised and production methods. The quantity of the herbs inserted into the vagina and the timing it's inserted before sexual intercourse would determine the extent of vaginal dryness.

Inswe *Mushekeshela*

Figure 3: Herbs that are consumed in tea or porridge to heat the body

Figure 3 shows herbs that are used in porridge or tea. These herbs warm up the body. NGOs female staff spoke more favourable about using these herbs to enhance their sexual experience, than inserting the herbs into the vagina. They raised the concern of vaginal lesions resulting from inserting herbs into the vagina that has a drying effect.

The majority of female research participants utilised either the herbs that dried the vagina or those consumed in tea or thin porridge. Those females who did not have the herbs, knew to direct the researcher when she enquired where to acquire the herbs. There was no secret or shame around acquiring these herbs. On the contrary, women spoke as if these were useful herbs for every woman to utilise, as the herbs could save sexual relations and marriages. Research participants indicated that this practice was very common among women of reproductive age, even with people who were educated and lived in urban areas. The representative from the Red Cross reiterated that the possibility of this practice declining seemed unlikely because women accepted that it was their responsibility to satisfy their men sexually by using the herbs. The researcher noted that the research participants in Kabbe who were 15 to 17 years old did not know about the herbs; however, their peers in Katima Mulilo knew about the herbs and were also buying them.

5.3.3 Dry sex experience for men and women

The non-governmental organisations and RACOC are responsible for HIV and AIDS behaviour change programmes. Representatives from these organizations raised the fact that the practice of dry sex was commonly mentioned by community members during community outreach programmes as a driver of HIV and AIDS.

Vaginal and penile glans tearing was identified as common during dry sex. The tearing was also considered a major vehicle for spreading viruses, including STIs, and caused painful sexual encounters for both sexual partners. Induna Sinvula alerted that dry sex could potentially injure the penis. The majority of the participants were sceptical about the use of a condom when women were using herbs to dry the vagina. Induna Sinvula confirmed that communities, where dry sex was preferred, were unlikely to use condoms because of the lubricant

on the condoms that makes sexual intercourse smooth. He, furthermore, explained that the practice of dry sex and condom use did not go together as the condom was likely to be damaged as a result of forced penetration. Induna Sinvula said,

> The more the person forces himself into the woman as a result of vaginal tightness, the more the condom is damaged and by the time when he ultimately penetrates, the condom will be damaged; thus, defeating the purpose of using the condom in the first place.

Nakwezi was also sceptical about condom use, saying that "when a person is used to dry sex, condom use dampens sexual pleasure, particularly for men; they will not feel anything because of the use of a condom". The possibility of the condom bursting if the vagina was not lubricated was high, he warned. Leo, despite his preference for dry sex, also mentioned the possibility of the penis glans getting cuts and, as a result, becoming exposed to different diseases, such as HIV and AIDS.

Sibolile also cautioned against the cuts on the glans of the penis among men who were not circumcised because of the tenderness of the glans. In instances where the vagina was dry, its smallness and tightness led to penetration that resulted in the development of sores on the glans of the penis. Mwinga, the male Life Skills teacher, also said that men who penetrated women causing themselves and the women pain were impatient. He advised that they needed to engage in foreplay to ensure that their woman was lubricated. In the same vein, he made a distinction between normal and abnormal vaginal fluids and that women suffering from abnormal vaginal fluids should help themselves by using herbs to dry the vagina.

The female traditional healer and the CAA volunteer were both sikenge trainers. They warned that the new generation of women was often using herbs for drying the vagina wrongly. They claimed that the use of these herbs was never intended to dry the vagina to

the point where intercourse was painful for both women and men. They were only meant to suck the vaginal fluids, but not to dry the vagina.

> *The elderly female traditional healer sold herbs that dry the vagina to the researcher. When the researcher inquired about pain and lesions during sexual intercourse when using the herbs, she illustrated to the researcher how to use the herbs by taking some herbs between her fingers and mixing them with her saliva. The herbs created a glue-like texture. She also brought some water in a cup with a tablespoon for the researcher and the fieldwork research assistant to mix it with the herbs. She explained that a small amount is sufficient to be inserted into the vagina and can thus reduce the vaginal fluids (***Focused observation on how to use the herbs that dry the vagina, Kabbe***)*

The question around female sexual pleasure was not as directly implied by the participants, as is the case with male sexual pleasure. During Sikenge initiation rituals the emphasis is put on the role of women to maintain the marital union and to sexually satisfy their husbands. There were however participants who mentioned men who are impatient during sexual intercourse, which results in a painful sexual encounter for the women. An elderly female traditional healer also mentioned the quantity of the herbs that women insert, if they are too much, they might dry the vagina more than it is necessary. Hence, all these factors when combined can diminish women's sexual pleasure.

Male participants spoke about dry sex and sexual pleasure, whilst women spoke about dry sex and sexual pain. Similarly, male participants in polygynous marriages spoke about their prerogative to have more than one woman, if he finds the current wife or wife not sexually pleasing. While female participants recalled the risks of being exposed to HIV and AIDS as a result of being in polygynous marriages. Conversely, for the majority of women who practise dry sex and who are in polygynous marriages sex and sexual pleasure

are silenced. Firstly, speaking about sex or sexual pleasure remains culturally taboo for many black African women. When women speak about their sexual pleasure it is about providing sexual pleasure to their sexual partner and not necessarily for them to prioritise sexual pleasure. The sexual silence surrounding female sexual pleasure supports ideologies of shame and stigma and it has broader implications for women's limited knowledge when it comes to sexual health and sexual negotiation (Ussher et al., 2017). Not only does this sexual silence suggest that female sexual pleasure is still an unspeakable topic, but it also promotes negative perceptions about women's bodies and sexualities. The cultural silence of sexual pleasure is thus strongly linked to gendered ideas about the body and power and emphasises patriarchal notions about the pleasure that favour man. Furthermore, Muzenda (2014) suggest that women need to gain knowledge on female sexualities and also recognise the stigmas and shame associated with female sexual pleasure. For women to gain an understanding of their sexuality, it implies that they reflect on practices that regulate and control female sexuality. This reflection should take place at a personal level with one's own sexual beliefs and experiences, but also openly talking about sex and sexual pleasure with other women as a way to deepen female understandings of sexualities. The reflection on sexual practices should include the way couples communicate about their sexual interest and needs to each other, by allowing women to express their sexual agency to participate actively in sexual encounters. While some women can negotiate their roles in sexual relations, not all women can overtly express their pleasures or displeasures.

5.4 The purpose of polygyny

Participants stated that, in their context, polygyny was the practice of one man marrying more than one wife. There were different opinions among the participants regarding whether these practices were still very common or on the decline. Some participants considered polygyny a common practice. The 69year-old induna illustrated how common this cultural practice was. He said,

> When we were born, we found our parents marrying more than two wives. We just followed that example, if you were man enough. Even if you will marry one wife, you will still be having affairs outside marriage.

Patrice mentioned that, although there were still men who married more than one wife, the practice, in general, was on the decline. She recalled that, when she was younger, more men were married to more than one woman, but nowadays the practice was slowly changing. She emphasised that currently only a few men were married to more than one woman.

Several of the participants in this study were part of polygynous unions. The 16-year-old female learner participant, Sheeba, said that her father was a polygamist. They lived in Kabbe. Sibeso, the female traditional healer, was also in a polygynous marriage. Masangu, the male traditional healer, was still married to two wives; they lived in Katima Mulilo. Mushe, a staff member working for DAPP/TCE, was in a polygynous marriage but had since divorced one of his wives because he found it expensive to maintain several households. A brother of Boitumelo, a 26-year-old female participant, was also a polygamist and lived in Kabbe.

Nanvula and Sepiso stated that the practice of polygyny had been the prerogative of the chiefs, the indunas and traditional healers. Rarely did commoners marry more than one

wife. The chiefs were also tasked with the responsibility of providing an heir to the throne; hence, the more wives the chief had, the greater likelihood to beget an offspring with the necessary capability to rule the tribe. Induna Sinvula, furthermore, elaborated the justification for a chief or induna to marry polygynous, namely that when a man was married to only one woman, it was a sign that he would not be able to administer the affairs of the community since the skills to administer a tribe was groomed at home. Hence, if a man was unable to rule a small group of people at the household level, the question would be posed whether he could be in charge of a very large group of people.

Sibolile alluded to men in polygynous marriages as strong and rich. A man who was able to marry multiple wives would be able to establish large homesteads. Even if the man was not physically at the homestead, it would still be referred to as his, irrespective of whether the wife built the homestead. The participants also indicated that women in polygynous marriages could not be all in the same homestead. Custom requires that each of them should have their homestead. Mwiya stated that women in polygynous marriages could not share a homestead, because they did not get along.

Women's inability to satisfy a man sexually was also mentioned as a justification to establish a polygynous union. A lack of elongated labia in a married wife had been seen as a justification to take a subsequent wife. Kahundu, the sikenge instructor in Kabbe, said that, if a woman did not have elongated labia, she forced her husband to take another wife, as sex with a woman without malebe was considered not satisfying to most men. Furthermore, Selelo, the 28-year-old female, VTC apprentice, also alluded to men "getting tired of one vagina"; thus, the practice of polygyny allowed him to take another wife. According to Werona,

some men were unable to control their sexuality, and the male sexual power could not be controlled by one woman, hence, the need for men to have more than one wife.

The notion that women tended to age faster than men, particularly after childbirth, had also been mentioned as a justification for husbands to marry another woman. Mwiya mentioned that, when a man married another woman, he was doing his wife a favour by providing her with a helper, as, by then, the first wife would be considered sexually incapable of satisfying her husband. Mwiya was quick to demystify the fact that older men were also reaching a level where they were incapable of sexually satisfying their younger wives and whether there was an alternative for women who found themselves in such a situation.

Sepiso also emphasised that it was still considered a form of social status for a man to have many children. As a result, men who thought that they could not have the number of children they wanted from one woman were likely to marry more than one woman. This position was further elaborated by Werona who highlighted that bareness among couples could also lead to men having extramarital relationships as an attempt to test whether he was the cause of the barrenness. In most cases, when such an adulterous relationship led to pregnancy, the husband might suggest to the wife that he marries his mistress to keep the baby.

5.4.1 Justification for polygyny among women

Women agreed to marry in a polygynous union because they had been socially programmed to believe that marriage was an important milestone in women's lives; consequently, women who might have waited too long to marry might agree to be a second or third wife. On the other hand, women benefitted from polygynous unions because of the value that society placed on the institution of marriage. Sibolile alluded that, for many women, it was not easy to find a suitor to marry her to acquire the status and respect accorded to married

women. The scarcity of illegible men was further confirmed by SFH, Kachana. Hence, being married, even to a shared husband accorded her the respect of being so-and-so's wife. Giving birth to children born out of wedlock was still frowned upon; hence, polygynous marriages allowed women to bear children in wedlock in a dignified manner. All marriages were preceded by the payment of bride price; for poorer women and her family, the payment of bride price could come in very handy in terms of alleviating household poverty. Hence, Sibolile argued that irrespective of how one wanted to view the practice of polygyny, it was beneficial to both women and men.

Nalishebo, a Life Skills teacher at a local school, confirmed that poverty was not a justification for women to marry polygynous. She informed the researcher that she attended a polygynous wedding. One wife was a teacher in Katima Mulilo and the other a director in Windhoek, whilst their husband was also a director in Katima Mulilo. Sepiso ruled out poverty as a reason why women agreed to be in polygynous marriages. She justified her statement by saying:

> I know some women who are very much educated with good jobs and being a second wife is not because they are poor or uneducated, but because culture makes it compulsory for a woman to marry, even if it is as a second, third or fourth wife. Marriage alleviates women social status. Patrice argued that the practice of polygyny was not only confined to a rural and uneducated segment of society, but rooted in culture for both men and women, and not so much as a result of poverty.

5.4.2 Differences in experience about polygyny for men and women

Reflections from men, women and the youth on the experience of polygyny varied. Sheeba, a 16-year-old female learner whose father was married to more than one wife, raised the concern of family neglect as a result of polygyny. Her mother was the first wife but had

been neglected since the father remarried. Sheeba mentioned that her father did not provide for her mother's homestead. This scenario of emotional and financial neglect was also raised by Sibeso, the elderly female traditional healer, who was also in a polygynous marriage. Her husband had four wives. She mentioned that she could not divorce her husband, because he had paid a bride price to her parents for her marriage. However, later on during her marriage, her husband and one of the younger wife's succumbed to AIDS. In the participant's own words, "The two of us who survived our husband were usually neglected because we were too old, but luckily that saved us from contracting HIV." Sibeso, the female traditional healer, considered the practice of polygyny as abusive to women since a polygamist could only focus on just one household, both financially and emotionally and, consequently, ignored the others. Tradition did not allow the neglected wife to follow her husband to the other wife's homestead.

Despite the practice of polygyny being considered on the decline, Kahundu believed that more young people were in polygynous marriages. Selelo, the 28-year-old female VTC apprentice, also confirmed that polygynous marriages were not only common among elderly couples but that many young couples around 20 and 30 years were also in polygynous marriages. This was considered normal, she said since their culture condoned it. Boitumelo's brother who was a polygamist was in his early 30s.

Sibeso, the female traditional healer, stated that her husband had not sought her permission to marry other wives. She stated, furthermore, that refusing your husband to marry another wife would be tantamount to disrespecting him. Women participants alluded to the fact that a woman could be beaten for refusing her husband to marry another wife. Alternatively, she would just be told by her husband that, "I am marrying another woman, and you have

no business refusing me because it is not you who pays the bride price for her hand in marriage". Similarly, Masangu, the male traditional leader, also indicated that he had not sought his first wife's permission to marry the second wife. He used his discretion that there was a need for the first wife to have a helper at home. Mwiya, furthermore, elaborated that, should the first wife not agree that her husband marries another wife, she could be divorced. A woman who was divorced forfeited her right to her marital property and would be returned to her parental home and divorce was also shunned.

5.4.3 Polygyny and the risk of HIV

The participants provided conflicting views on whether polygyny perpetuated the spread of HIV or whether it inhibited its spread. Nanvula raised the point that polygyny could both perpetuate the spread and also protect against the spread of HIV. She said, "if those in the polygynous union practise 'zero gracing' and they engage in sexual relations only among themselves, provided they are all HIV negative, in such instance polygyny can inhibit the spread of HIV". She, however, also warned that,

> If either the husband or one of the wives has sexual intercourse outside the polygynous unit and this person happens to be HIV positive, then it will have a cascading or rippling effect within the polygynous unit, where the others within the unit will be infected with the virus.

Nanvula, therefore, saw polygyny as having advantages and disadvantages as far as perpetuating HIV.

Masangu, a male traditional healer, indicated that he is married to two wives. His justification was that it was protecting against HIV and other STIs, as neither he nor his

wives had sexual intercourse with people outside the trio. He, furthermore, indicated that the reason he married two wives was that the one wife had longer elongated labia.

> I have two wives because I don't want to get this HIV, I am trusting my wives. If I find this one is tasteless (sexually not satisfying) then I go to the other one. One wife has a short malebe while the other has a long malebe.

He found that the sexual experiences between the two women differed as a result of the different sizes of their labia; the woman with the long labia was sexually more satisfying.

Induna Sinvula indicated that polygyny had been linked to multiple concurrent sexual partners in the HIV and AIDS discourse, which was one of the major drivers of HIV and AIDS. According to him, polygyny could contribute to HIV because a man had no control over the behaviour of the woman brought into the polygynous union. It was also difficult for one man to satisfy all the wives sexually; as a result, there could be one wife who might have an extramarital relationship. Because she was cheating, she might not know the type of man with whom she was cheating, and he might be infected with HIV. Consequently, she would bring the HIV infection into the polygynous union, thus spreading it to everybody. If the husband was married to five wives, they would all be infected. Therefore, HIV and AIDS behaviour change programmes discouraged the practice, he said.

Sibolile also warned that, once a relationship consisted of more than two people, there was no guarantee that everyone would be faithful because people differ according to the way they felt, their characters and their ways of life. Hence, if one of the people in the polygynous union failed to adhere to the relationship values, the risk of exposing everyone else to HIV and AIDS did exist.

5.4.4. Bunyazi is a form of multiple concurrent sexual partnerships

All the participants mentioned the practice of bunyazi in the same vein as polygyny. Bunyazi is a form of multiple concurrent sexual partnerships. Participants concurred that bunyazi was not a cultural practice, because society did not condone either a married man or married woman to have an adulterous relationship. Where such a relationship existed, it was punished and the guilty party had to pay compensation to the grieved party. However, all the participants alluded to bunyazi as a very common practice. Sibolile mentioned that, for a married man to avoid penalties as a result of an adulterous relationship, in particular, if he had impregnated the woman with whom he had an adulterous relationship, the easiest way out would be to ask his mistress's hand in marriage. Because culture did not require the wife's permission if the husband wanted to marry another woman, it was only required that the wife be informed. Hence, the practice of bunyazi continued to be rampant, further perpetuating the spread of HIV. The practice of Bunyazi, although not socially sanctioned and polygyny is the prerogative of men. To address these practices men are to be targeted through HIV and AIDS prevention programmes. The implications of concurrent multiples sexual partners need to be addressed.

5.5 Social construction of gender norms

This sub-section highlight how the cultural practices of polygyny and dry sex expose women and men differently to HIV and AIDS. Gender relations and the expression of one's sexuality have much bearing on the extent to which a person is vulnerable to HIV and AIDS. HIV and AIDS is generalised medical condition that is sexually transmitted. Hence, this subsection will interrogate gender dynamics, as well as sexual decision-making and learnt behaviours about sex and sexuality among men and women in the Zambezi region.

5.5.1 HIV and AIDS: A woman's problem

Sepiso noted that, during the onset of HIV and AIDS in the Zambezi region, the high prevalence of HIV among women had led to behaviour changes and women's empowerment programmes targeted at women. He said:

> The first people who were reached with HIV prevention programmes were women and men were left out. This resulted in the notion among men that HIV and AIDS is a woman's issue. Till now, not much effort is put into educating men about HIV and AIDS. Excluding men from HIV and AIDS prevention programmes left women with the responsibility to convince their sexual partners to invest in safe sexual behaviour.

The research participants were asked, what is the notion of proper womanhood in the Zambezi region? Some participants among both the young and the old considered a woman, who had attended the sikenge initiation ritual a proper woman. During the sikenge initiation rituals, girls are taught about submission, how to be disciplined, be honest and trustworthy, how to take care of their homes, such as collecting water and firewood, ploughing, doing laundry, as well as making sure that the homestead is clean, she should wear Shitenge and a headscarf.

> *The lifestyle in Kabbe is similar to the village where the researcher was raised. Women's roles entailed cooking on the open fire, water for household consumption is collected from a community well. When food is served women eat together, boys eat together and girls eat together. Elder women and men had each their plates and did not eat out of the same plates with other family members. (**Female Chores, Kabbe**)*

A woman who is also able to satisfy her husband sexually is considered a proper woman in marriage. Young girls who attend the sikenge initiation rituals are taught how to do "the

dance", which is moving their waist during sexual intercourse. These teachings are imparted to young girls as young as 12 years, who just started menstruating. Menstruation is considered a sign of womanhood says Nalishebo, an advocate against harmful cultural practices and a Life Skills teacher at a local junior secondary school.

*The researcher attended the Mafwe cultural festival, during the festival, one of the keynote speakers, who is a PhD holder in education, urged the Mafwe Royal King and the elders to reinstitute Sikenge-girl child initiation rituals, as such practices are important for cultural identity. The need to revive Sikenge rituals were also mentioned by a CAA volunteer and a female traditional healer. Both these participants informally told the researcher that they had applied for land to set up initiation schools both in Katima Mulilo and Kabbe respectively. The female traditional header is based in Kabbe and will therefore seek land from the MaSubia traditional authority and the CAA volunteer is based in Katima Mulilo and will request land from the town council. These informal conversations dawned upon the researcher that Sikenge is a common practice and more parents are requesting for their daughters to be taken through initiation. The female life skill teacher, who is an advocate against the practice of Sikenge, mentioned that Sikenge is so popular that family members who do not find an elder to initiate their daughters, send them to relatives in Zambia to attend initiation rituals. (***Reinstitute Sikenge girl child initiation rituals, Katima Mulilo, Kabbe***).*

The researcher learnt that her fieldwork research assistant was a Sikenge initiate at 14 years. When the researcher enquired from her what she learnt at Sikenge, she refuses to divulge what she learnt.

From the informal conversation with the fieldwork research assistant, the researcher could deduce that Sikenge initiation rituals place a key role in the construction of

*womanhood. The researcher inquired about what is taught to girls during Sikenge initiation rituals. The female field research assistant mentioned that she is a Sikenge initiate. She however refused to disclose to the researcher what she was taught. Sharing with outsiders about what is taught during Sikenge is taboo, can lead to bad luck to the initiate. (**Informal conversation about Sikenge with a female fieldwork research assistant, Kabbe**)*

5.5.2 Intergeneration and transactional sexual relations

Intergenerational and transactional sexual intercourse were acknowledged as some of the factors that perpetuated women's vulnerability to contracting HIV. A major reason, according to Chaze, a CAA volunteer, was that elderly men enticed young girls with money and gifts in exchange for sex. The transitional nature of sexual intercourse was mentioned by several participants, including those from RACOC and NGOs. Participants, furthermore, mentioned that elderly men who engaged sexually with these young girls could be married to women their peers. On the other hand, the young girls who engaged sexually with the elderly men in exchange for money and gifts were also likely to be having relationships with their peers. These webs of relationships perpetuated the spread of the virus.

The geographical location of the Zambezi region, bordering Botswana, Zimbabwe and Zambia, was regarded as also contributing to the increased prevalence of HIV in the region, according to Mwinga, a male Life Skills teacher. Furthermore, truck drivers who were enroute to some of these neighbouring countries had been observed at local drinking spots or truck ports with local young girls and women. Mwinga, furthermore, alluded to the fact that sexual relationships between the truck drivers and the local girls and women were transactional. He raised the concern that the nature of these sexual relationships left the local girls and women with minimal negotiation power to practise safe sex. Induna Chunga

raised the concern that the locals in the Zambezi region mix with nationalities from different countries. He related to the difficulty for people to be aware of who was HIV infected because one could not assess whether a person was HIV positive by merely looking at him or her. The induna lamented that the migrants were particularly targeting young girls by enticing them with money, gifts and alcohol.

Not only were migrants, such as truck drivers, considered to contribute to the spread of HIV, married women mentioned Zambian girls who were working as domestic workers in Katima Mulilo as also engaging sexually with "their husbands". Migrants had been implicated in the discourse on HIV and AIDS in the SADC region.

5.5.3 Cultural notion of masculinity

It was noted that among the participants who were younger than 20 years, none could identify the characteristics of being a man in their community. Among the community members in the Zambezi region, there are no initiation rituals for boys, unlike for girls, where there are formalised structures such as sikenge. Consequently, boys are groomed into manhood by their fathers, uncles and grandfathers. As stated by a 66-year-old man in Kabbe village, a boy is taught how to be a proper man by sitting him down and advising him about good and bad behaviour in society, as well as educating him about the cultural way of life. Similarly, Mwala, the 69-year-old induna, stressed the importance of preparing young men for marriage. He said, that before his son married, he took him to the bush to find herbs that he put in porridge and gave to his son. Once the son had taken this herb he would become sexually strong.

Induna Chunga also emphasised the role of the man as head of the household and stated that to be the head of household a man should be hardworking, be in a position to protect his family and be honourable. Men were considered heads of households and a woman

who disobeyed the instructions of her husband could be divorced and reported to her aunties where she would be disciplined accordingly. Mwinga, the male Life Skills teacher stated that, in the Zambezi region, tradition and religion dictated that men be heads of households, irrespective of the educational level of the women or their marital status. Under being born a woman, the title of the head of the household could not be bestowed on a woman. He had the following to say, "the position of women as subordinates to men will never change irrespective of their economic level or educational level, whether they are registered, nurses or teachers". He, furthermore, elaborated on the extent to which men were considered heads of household. All the royal establishments and all indunas in the Zambezi region were men. This was also observed by the researcher during the visit to the Masubia Royal Establishment, where all the indunas in the palace were men except for the secretary. The only justification for male headship and the insubordinate position of women was religious and cultural doctrines.

HIV and AIDS behaviour change programmes continue to be over-focused on women, with very few men benefiting from these programmes. Nanvula raised the challenge of convincing men to attend community outreach programmes. Similarly, they also discovered that outreach programmes where men, women and the youth were in attendance, inhibited the depth of the discussions. Nanvula indicated that women and the youth who would be normally the most articulate would be very quiet when men, particularly, indunas were in attendance. Indunas were considered the representatives of their communities and would, therefore, speak on behalf of their communities. Allowing men and indunas to speak on behalf of the community was deemed respectful. In a certain social context, concerns raised are only addressed based on the narrator's social position.

For example, youth and female research participants alluded to the difficulties they find to speak up during community meetings in the presence of men and indunas

5.6 Inclusion of cultural practices in HIV and AIDS behaviour change programmes

This subsection will discuss the extent to which HIV and AIDS behaviour change programmes are incorporating the cultural practices of dry sex and polygyny. The section will particularly focus on the role of the Regional AIDS Coordinating Committee in the Zambezi region and NGOs working in HIV and AIDS prevention. Furthermore, the factors that inhibit the inclusion of these cultural practices will also be highlighted.

The Women Leadership Centre was the only NGO that developed training and advocacy materials linking cultural practices and HIV and AIDS from a human rights perspective. The following books on cultural practices in the Zambezi region had been developed by WLC. *Violence is not our culture: Women claiming their rights in Caprivi region; Cultural Practices, Women's Rights and HIV and Aids – A Case Study of the Caprivi Region in Namibia;* written by /Khaxas and Frank from the Women Leadership Centre. These books are in both English and Silozi. The training manuals address the practices of dry sex and polygyny from a human rights perspective.

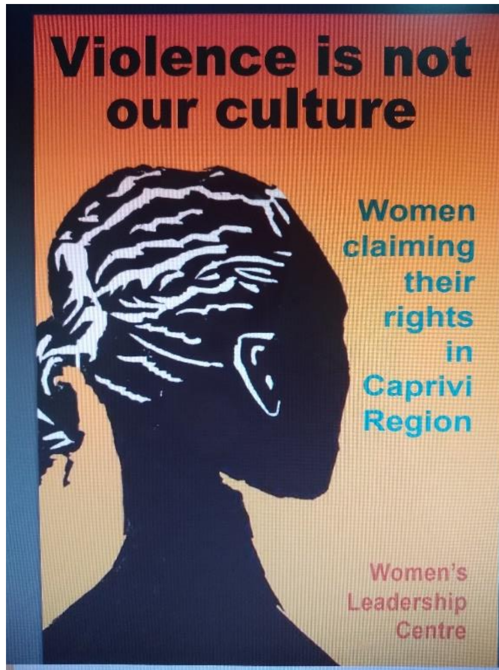


Figure 4: Advocacy booklet on harmful cultural practices from WLC

> *Women's Leadership Centre has been an advocate and at the forefront of addressing the impact of harmful cultural practices on the wellbeing of women. The organization published several books and monographs, such as; Cultural Practices, Women's Rights and HIV and Aids a Case Study of the Caprivi Region in Namibia and advocacy material titled Women and girls of Namibia claim our right to survive HIV and Aids by challenging poverty, oppressive cultural practices and violence. (**WLC, Training materials, Windhoek**).*

According to Gladys from the WLC, their training targeted traditional leaders, women, men and political office bearers, such as the Zambezi regional councillor and constituency councillors. She said that this training aimed to allow community members, including their leaders, to interrogate their own culture and identify cultural practices that perpetuate HIV. The intention of these interventions was never prescriptive in terms of whether community members should discard or retain a cultural practice or not. It was rather to understand how

some of the cultural practices perpetuated HIV and violated women's rights. Their intervention also focused on teaching about the constitutional rights of women and the gender-responsive laws of Namibia.

Gladys, furthermore, elaborated that the volunteers who worked on the WLC projects were individuals from the Zambezi region. They were thus familiar with the cultural practices under discussion. Nalishebo, a Life Skills teacher at a local school in Katima Mulilo, has been trained by WLC. Furthermore, induna Kamwi confirmed that he had undergone training by the WLC. The WLC had also conducted advocacy training for parliamentarians to raise awareness of how to address cultural practices that perpetuated and violated human rights. Gladys also referred to the work of NANGOF, a Shadow Report to the Namibia Fourth and Fifth Periodic Report of the CEDAW Committee on Harmful Cultural Practices in Namibia, and the Legal Assistance Centre Namibia Gender Analysis that advocated for the government to address cultural practises perpetuating HIV and violating human rights (Frank, 2015; Legal Assistance Centre, 2017).

Copies of the advocacy materials from WLC were also found at SFH and the RACOC office. RACOC and SFH indicated that, although their organisations had not developed a training manual on cultural practices and HIV and AIDS, they had been referring to the books developed by WLC when they were conducting their community training. NGOs such as SFH were focusing on Commercial Sex Workers and HIV and AIDS prevention.

CONTENTS

CONTENTS 3
INTRODUCTION 4
FOREWORD 7
UNDERSTANDING THE MANUAL 9
FACILITATION SKILLS FOR THE PEER FACILITATOR 12
HOLDING THE SPACE 16
SUGGESTED ENERGISERS 19
SESSION SUMMARY 21
MATERIALS REQUIRED 24

SESSION 1 Taking Care of Business: Tools of The Trade 25
SESSION 2 Taking Care of Business: Using Our Business Cards Well 31
SESSION 3 Taking Care of Business: Reducing Risk 42
SESSION 4 Taking Care of Business: Safety Drill 50
SESSION 5 Taking Care of Business: Safety and Sexual Health 55
SESSION 6 Taking Care of Business: Emotional Wellness 62
SESSION 7 Taking Care of Business: Planning 69
SESSION 8 Taking Care of Business: Living with HIV 79
SESSION 9 Taking Care of Business: HIV-Free Babies and TB 88
SESSION 10 Taking Care of Business Into the Future 97

REFERENCES 10
FLIP FILE POSTERS AND PAGES 1

Figure 5: Training manual from SFH, covering materials on Commercial Sex Work and HIV and AIDS prevention

*Figure 5 is a table of content from a Training Manual from SFH on Commercial Sex Work and HIV and AIDS prevention. (**SHF training material with a focus on CSW, Katima Mulilo**)*

5.6.1 Inclusion of dry sex in HIV and AIDS behaviour change programmes

CAA, DAPP/TCE, NANASO and the Red Cross highlighted that no intervention strategy that addressed the cultural practice of dry sex was in place. The majority of the organisations mentioned that, during the community outreach, dry sex had been mentioned as a risk to HIV.

Figure 6: NANASO poster marketing a public dialogue on Challenging Gender dynamics in a cultural context to address HIV

> *Figure 6 NANASO dialogue poster, the researcher could however not access the materials used to facilitate the dialogue. It is however commendable that such dialogues are held in the context of culture and HIV and AIDS and their impacts on women's vulnerability (**NANASO public dialogue material, Windhoek**)*

Sepiso from CAA narrated how information about dry sex was addressed by community members. She highlighted that,

> Many women say that they lose their marriages because of vaginal fluids because their husbands prefer dry sex. They would then bring in a "nyazi" which is another woman who is willing to use herbs to dry the vagina.

Sepiso, furthermore, urged the researcher to go into villagers and question community members about the practice of dry sex and where to obtain the herbs that women were inserting into their vaginas. Despite this knowledge of dry sex, the CAA did not have a targeted intervention to address the practice and its associated risks to HIV and AIDS.

Sibolile from the Red Cross also highlighted that dry sex had been raised by community members during community consultation workshops, but the Red Cross had as yet not designed intervention programmes to address dry sex among community members.

Despite community members addressing dry sex as an HIV risk, RACOC did not design training programmes or allocate funding for addressing the HIV risks associated with dry sex. Mrs Nanvula also pointed out that the MoHSS was aware of the practice of dry sex and the risk it posed to the spread of HIV. The Ministry, however, had not designed a training manual incorporating dry sex. Only a standard HIV and AIDS behaviour change programme prioritising the aspects of Sexual Abstinence, being faithful to one sexual partner and Consistent Condom Use, PMTCT, VMMC, PreP and other biomedical interventions was in place. The aspect of dry sex and its link to increasing the spread of HIV would be discussed as issues among the community members only when raised by the audience. Ms Nanvula thus said, “There is no training manual that addresses dry sex, thus it is not written, but it will be discussed because the community members know about these practices”.

Boyde indicated that his division was also aware of the practice of dry sex, and acknowledged that the practice posed a risk to the spread of HIV. He, furthermore, stated that dry sex was addressed under the condom logistics programme and safe sex. He argued that the lubricants in the use of condoms should counter dry sex.

There were different HIV and AIDS training manuals at the NGOs where this study was conducted. They varied from *My Future is My Choice* which is a Life Skills intervention targeted 15 to 18-year-olds with information on sexual and reproductive health, HIV and AIDS, as well as the decision-making and communication skills which they require to make a positive decision. A 2010 revised version of the *My Future is My Choice* manual included

components on ART treatment and testing, gender-based violence and alcohol abuse. There was also a poster stating 'No Means No'. This highlights the following key learning lessons: to say no to unwanted and teenage pregnancy, love and relationships and their bodies, as well as how to protect themselves against STDs and HIV. This training manual was a collaboration between the Ministry of Education and UNICEF.

The Take Control Namibia HIV and AIDS Campaign has a component of Life Skills training activities, with the provision of IEC materials and interpersonal communication aiming at creating awareness among the general population. TCE/DAPP had to Take Control posters, games and pamphlets which highlighted the importance of openness about one's HIV status, respect in relationships, HIV testing, sexual abstinence and consistent condom use.

The Take Control Namibia HIV and AIDS Campaign has a booklet titled *Let's Talk*. The booklet provides the capacity to parents and caregivers on the way to communicate with their teenagers about issues related to sexuality. The key issues addressed are peer pressure, sugar daddies, alcohol and drug abuse, as well as HIV and AIDS. Some of the other materials under the Take Control Campaign are the *Play it Safe* leaflets/posters for adolescents. The Take Control Namibia HIV and AIDS Campaign has been developed by the Ministry of Health and Social Services. This training manual can improve sexual negotiations among couples. It can also create awareness of intergenerational and transactional sexual relations among young women. These booklets were at the Red Cross and SFH.

CAA had comic magazines, such as *Popya* and *Stepping Stones*, like training manuals in peer education programmes directed at young adults. Other related training materials were *HIV and AIDS and Nutrition; Community Home Based Care training manual*; *Engaging men at the Community Level*; *Psychosocial Support for Orphans and Vulnerable Children;*

Focusing on the Drivers of HIV and AIDS 10-14 years; Training Care of Business: A guide for peer facilitators of sex workers in Namibia.

None of the training manuals indicated above covered any of the cultural practices discussed in this study. That omission was not surprising, as these training manuals were meant to be generic and employed in all 14 regions of the country and not to respond to the HIV and AIDS vulnerabilities unique to the Zambezi region or any region for that matter. The practice of dry sex had not been integrated into behaviour change programmes. When multiple concurrent sexual, partnerships were discussed, it implied reference to polygyny, although none of the training manuals reviewed indicated polygyny.

5.6.2 Inclusion of polygyny in HIV and AIDS behaviour change programmes

HIV and AIDS behaviour change practitioners in both NGOs and at the RACOC were aware of the practice of polygyny in the Zambezi region. Organisations such as CAA, DAPP/TCE, NANASO and the Red Cross who did not have training manuals that specifically addressed polygyny, highlighted that practices such as polygyny had been incorporated under multiple concurrent sexual partners. Sepiso from the CAA indicated that during the community outreach dialogues, polygyny would be discussed as an example of multiple concurrent sexual activities.

The participants indicated that multiple concurrent sexual partners referred to individuals who had two or more sexual partnerships that overlap in time and engaged sexually without condoms. Hence, they argued that addressing multiple concurrent sexual activities should also address polygyny. Namasiku, furthermore, emphasised consistent condom use, VCT as important components in curbing HIV and AIDS among couples in multiple concurrent

sexual relations. Hence, introducing a new sexual partner into a polygynous marriage would require that the HIV risk of the person was ruled out; if not, the entire polygynous unit would be at risk of contracting HIV.

There was a sense of despair among some participants regarding whether cultural practices, such as polygyny, could be changed through HIV and AIDS behaviour change programmes. Mwala, the 69year-old induna, argued that changing a practice that had been inherited from ancestors, was not an easy task because such practices tend to be passed from generation to generation.

Patrice from RACOC stated the difficulty of changing the attitudes of the community regarding such practices were budget constraints for, despite community members raising the concern of HIV risks associated with the practice. Furthermore, when the DSP/MoHSS did not include these practices in the National HIV and AIDS training manual, it became difficult for the organisations conducting community outreach to address these cultural practices. The reason for their exclusion was that they were not classified as issues of national concern as far as their risk to HIV and AIDS was concerned.

A female, traditional healer stated that polygyny was so ingrained in the society that even men who did not find themselves in polygynous marriages were committing adultery under the disguise of bunyazi. She argued that it was one thing to abolish the practice of polygyny, but she was not convinced that the practice of multiple concurrent sexual partnerships could be abolished since “most people say that HIV came to people. So, we just have to continue with our lives, irrespective of whether one marries 2 or 3 women”.

In summary, the majority of the participants agreed that polygyny had the potential to perpetuate HIV. Although there were still couples in polygynous marriages, there were, however, indications that the practice was on the decline. Not all the NGOs in HIV and AIDS prevention incorporated polygyny in their prevention programmes. Furthermore, the majority of the participants were not aware of the provisions in the National Strategic Framework for HIV and AIDS Response in Namibia, 2017/18 to 2021/22, which state that cultural practices can potentially perpetuate the spread of HIV. This policy provision stipulates that culture and religion shape human behaviour and, thus, dictate people's choices and lifestyles; this, in turn, can influence their sexual risk-taking. The policies, therefore, stress that the state must protect its citizens against violence, which includes sexual violence, forms of coerced sex, as well as traditional and religious practices that affect people's health negatively.

The majority of the participants from the NGO sector and RACOC, including traditional leaders, traditional healers and community members at large, except participants from MoHSS, and WLC knew about the provisions highlighted in the two policy documents. Sibolile from the Red Cross indicated that one of the shortfalls in the formulation of the HIV and AIDS policy was that "policies are drafted without the inputs from NGOs operating in the regions and policies are drafted by consultants who might not know the local contexts". Because of this process of policy formulation, they tended not to address the reality on the ground. On the other hand, it became difficult for organisations to respond to policy directives. During the process of formulating the HIV and AIDS policy, the Red Cross in the Zambezi region had no opportunity to contribute to the formation of the policy. This was the case with the majority of the NGO's, except WLC.

5.7 Challengers designing culturally responsive HIV and AIDS behaviour change programmes

Nelson, from NANASO, expressed the challenges of relying on external donors funding for HIV and AIDS prevention. He mentioned that between 95% and 98% of HIV and AIDS funding came from the Global Fund. Under the Global Fund component HIV and AIDS, malaria and TB treatment were classified together. Because HIV and AIDS did longer have their funding, they had to share the resources with the eradication of malaria and TB treatment programmes. This posed problems in terms of the number of resources that could be allocated to all the components of HIV and AIDS. Nelson provided a breakdown of funding for HIV and AIDS, varying from ART, Pre-exposure prophylaxis or PrEP, Prevention of mother-to-child transmission (PMTCT, also known as prevention of vertical transmission), to voluntary, medical, male circumcision (VMMC) and the combined treatment of TB and AIDS. Then there was another component of behaviour change programmes that entailed community education and mobilisation, as well as feeding programmes for people living with HIV and AIDS and those who were on ART.

Sibolile from the Red Cross, Nelson from NANASO, and Patrice from RACOC explained that donor funding is designated for the NGO sector is already allocated for specific activities. Because of the reporting mechanisms, it becomes difficult to divert funding into non-budgeted activities such as addressing polygyny and dry sex and the risk they pose to HIV and AIDS. Boyde and Nanvula from MoHSS are responsible for designing HIV and AIDS behaviour change programmes that are of national interest. They have not designated or approved HIV and AIDS programmes that respond to concerns that are specific to a region, such as addressing polygyny and dry sex in the Zambezi region.

RACOC in the Zambezi region consisted of thirty-six members representing community-based and faith-based organisations, as well as the traditional healers' associations and all government line ministries operating at the regional level. The office of the Zambezi regional governor hosted and coordinated the RACOC activities. They were responsible for the regional coordination and response to HIV and AIDS, TB and Malaria.

Patrice from RACOC indicated that it was a challenge to design an HIV and AIDS behaviour change programme that addressed the unique concerns of the Zambezi region. RACOC compiles reports on the outcome of their HIV and AIDS prevention programmes and some of these reports highlighted community dialogues on dry sex and polygyny and the risks they pose to HIV and AIDS. The researcher collected some of these reports. However, findings from these reports were not channelled anywhere. According to Patrice, no platform to report to national DSP/MoHSS existed on HIV and AIDS challenges that are unique to the Zambezi region, this is despite a representative from MoHSS serving on RACOC. As a result, they were not used to inform HIV and AIDS behaviour change programmes at the regional level. Patrice from RACOC, Nanvula and Simasiku from MoHSS stated that the HIV and AIDS behaviour change programmes are centralised. What and whom to train was informed by the DSP through the Ministry of Health and Social Services.

Narrative research stresses that such representations vary drastically over time, and across the circumstances within which one lives, so that a single phenomenon may produce very different stories, even from the same person (Andrews, Squire, & Tamboukou, 2013). Narrative research also provides opportunities for research participants to share their experiences and views from their perspectives. The expression thus becomes an important platform through which research participants can exercise their agency. Research

participants, who attended community HIV and AIDS prevention sessions, alluded to having informed NGO's and RACOC about their perceived HIV risks of polygyny and dry sex. Similarly, RACOC annual reports also highlighted these findings from their community engagements. Despite, what has been mentioned by the communities, and has also been captured in the RACOC documentation, this has not been transferred to intervention programmes to address the concerns raised by the communities. Narratives of personal stories are also interested in the social effect or agency. They are therefore pursued because they offer a humanist assertion of individuals and collective potential to improve or better the circumstances of the narratives (Homolar, & Rodríguez-Merino, 2019; Moezzi, Janda, & Rotmann, 2017).

In narrative research, the responsibilities of the researcher during the research process is also queried. What are the responsibilities of the individuals who listened to the narrations, who recorded the narrations? This research, therefore, advocates for the inclusion of polygyny and dry sex into HIV and AIDS prevention programmes.

It is stated that community members during the RACOC consultations raised that polygyny and dry sex heightens HIV. However, despite these issues being raised HIV and AIDS behaviour change programmes have not incorporated these cultural practices into HIV prevention programmes. There is, therefore, a need to continue interrogating the process through which HIV and AIDS behaviour change programmes are designed, such as who decide the thematic areas to be covered in these programmes; what opportunities exist for community members, in particular women to determine the thematic focus of HIV and AIDS behaviour change programmes. Caution needs to be taken that the process of

narration should not become a futile exercise, particularly if no action has been taken to address the issues raised.

These approaches provided the opportunity for research participants to express their subject positions through their reflection on dry sex and polygyny. On the other hand, as a researcher who is engaging with the data, it was possible to reflect on women's subjective place within power relations and to contextual the socio-cultural factors that heighten women's vulnerabilities to HIV in the Zambezi region.

RACOC and its member organizations were best placed to identify cultural practices that could potentially perpetuate HIV and ensure that they were included in HIV and AIDS behaviour change programmes because of their proximity to the community. Traditional leaders had been identified as key custodians of culture. Namasiku emphasised the importance of involving traditional leaders in HIV and AIDS community education because once they understood the essence of HIV and AIDS treatment, they would provide the necessary support to service providers, who would thus be able to convince community members to alter their behaviours.

Despite this well-thought-out mechanism of coordinating RACOC, challenges remained. Not all the member institutions had a designated individual as a permanent HIV and AIDS focal person, serving on RACOC. This resulted in many members not attending the RACOC meetings. Furthermore, the CACOC was also not active, because there were no people permanently employed at the constituency office to coordinate CACOC activities. The coordination mechanism at the National Strategic Framework made it compulsory to appoint coordination committees at the constituency level. According to Patrice, there were eight constituencies in the Zambezi region. The fact that none of the constituencies had

appointed a CACOC coordinator, implied that RACOC at the regional level was attending to HIV programmes at the constituency level as well. To further elaborate this challenge, Patrice stated that,

> We have eight constituencies and because we do not have CACOC coordinators, the RACOC coordinator has to take care of all the programme activities at the constituency level.

To reduce the burden on the RACOC office, and also due to the physical distance between the regional office and the constituency office, some of the HIV and AIDS-related responsibilities were assigned to the Control Administrator Officer at the constituency office. Given that HIV and AIDS activities were responsibilities added to the duties of the Control Administrator's office, in most cases, these duties were neglected. Given this shortfall, the whole region was reliant on the RACOC staff to implement HIV and AIDS behaviour change programmes.

Staff shortage and retrenchment was also the norm in the majority of the NGOs operating in the Zambezi region. The researcher observed that the Red Cross and CAA were understaffed. The staff shortage had implications for programme implementation and expansion.

> *At the Red Cross, there was only 1 staff with 2 foreign volunteers and the representative also spoke about a few community members who are volunteering, but they are few as they no longer can provide them with food parcels. The CAA introduced a new programme targeting Adolescent girls. The programme coordinator for this programme has not been recruited as a result of funding decline (**Decline in funding affect staff component in Red Cross and CAA, Katima Mulilo**)*

Furthermore, Nelson, in his attempt to explain what seemed to be a fragmented mechanism between the RACOC, Ministry of Regional and Local Government, Housing and Rural Development and Ministry of Health and Social Services said,

> The RACOCs are created under the Ministry of Regional and Local Government, Housing and Rural Development because during their inception Ministry of Health and Social Services did not see how the RACOCs are linked to their mandates. As a result, the RACOC structure remained weak and under-resourced.

Patrice was quick to commend the work done by NGOs and the active roles they played in rolling out HIV and AIDS behaviour change programmes. She elaborated that NGOs worked directly with the communities. Furthermore, during the RACOC meetings, NGOs reported every quarter about the programmes they were implementing in the communities. The various NGOs that participated in this study indicated that, as members of RACOC, they had to complete a reporting form on their activities every quarter.

Boyde highlighted that a major challenge was the lack of accurate data on HIV and AIDS behaviour change programmes. He said that the decline in funding resulted in attitude and practice (KAP) studies not being conducted anymore. The fact that these studies were no longer conducted challenged the identification of the kinds of behaviour that should be addressed in HIV and AIDS programme interventions. He, furthermore, argued that KAP studies were best suited to identify cultural practices that perpetuated HIV. He continued that, "unfortunately, over the years, the HIV and AIDS funding towards behaviour change programmes has been going down. As a result, we have not been able to conduct KAP studies for quite some time now". Neither donor funding nor government funding could be set aside for KAP studies; the current Namibian financial constraints had further exacerbated the situation. This was confirmed by Nelson from NANASO who stated that,

> Knowledge, attitude and practice (KAP) study that the Ministry of Health and Social Service employed to conduct on an annual basis, to help them to identify the kind of behaviour in the community that heighten HIV risk have not been conducted due to lack of donor funding.

Gladys, furthermore, noted the struggle her NGO experienced with donor organisations to include cultural practices in the priority areas for funding. She stated that,

> We tried to push for a space to incorporate harmful cultural practices that heighten the risk of HIV and AIDS. We have been told over and over again that there is no space for dry sex, girls initiation rituals, sexual readiness testing. This shows that donors are not interested in dealing with issues of cultural practices and HIV and AIDS as they are considered too politically sensitive. Such interventions might be perceived as an attack on the cultural identity of the communities where programmes are rolled out. Hence, donors are very reluctant to allocate funding to address cultural practices.

Funding challenges were not just raised at the national, but also at the regional level by NGOs operating in the Zambezi region. Nalishebo, a Life Skills teacher and an advocate against harmful cultural practices, raised a concern regarding the lack of funding to expand their activities. She said,

> You will find that the Zambezi region has four traditional authorities and it might also look like the region is small, but it is not easy to reach every corner of this region and share the information with everyone as a result of lack of funding.

She, furthermore, stated that expanding on their activities remained a challenge. She said, "We don't have the resources to conduct work in the whole of the Zambezi region; we tend to focus on areas that are near the roads and that are easily accessible". She continued by emphasising the impact their work had in terms of raising awareness among traditional leaders and community members regarding the HIV risks of certain cultural practices. She, however, reiterated that the little work that they had done with limited funding had yielded results because, during their community follow-up, they noticed that the community members whom they had reached through their programmes had a changed mindset regarding some cultural practices, while those who had not been targeted continued with the practices unabatedly. Unfortunately, their work could not continue, she lamented.

The decline in donor funding had also led to the scaling down of HIV and AIDS community outreach programmes and the distribution of seeds, food rations and blankets for OVCs and people living with HIV and AIDS. Patrice narrated that through RACOC, the Zambezi region used to have many HIV and AIDS behaviour change programmes; however, most of those projects had closed down and there were only four active programmes as a result.

> *The student was struck by the few NGOs that she found operating in the Zambezi region compared to the list of NGO's that were in operation during the 2010 NANASO Directory. There has been a decline in the number of NGOs that work in HIV and AIDS behaviour change programmes. (**Decline in NGOs operating in HIV and AIDS behaviour change programmes, Katima Mulilo**).*

Nelson confirmed the funding challenges faced by the RACOCs nationally. RACOCs are, however, not that effective anymore as the members did not attend the meetings. He said that some of the members would say "I don't have funding any longer so what am I going to sit and

report on to RACOC". He raised the apprehension that RACOC was one of those structures that were created on paper but continued to be underfunded. He felt that it needed to be reviewed. All the NGOs in these studies indicated that they were members of RACOC.

*Most of the buildings where NGO's operated were debilitated as a result of lack of maintenance. Some of the gardens were overgrown. Informal conversation with NGO representatives alluded to the lack of budget allocated for construction and maintaining the infrastructure. NGO's were all renting their offices, as they could not afford to purchase their infrastructures (**Debilitated rented offices, Katima Mulilo**).*

5.8 Perspectives on preserving cultural practices of dry sex and polygyny

All the study participants, irrespective of whether they were representatives from NGOs, RACOC, indunas from the traditional authorities or men, women and the youth from the community, raised the importance of keeping one's cultural practices. The different language/ethnic groups in the Zambezi region (Silozi, Nyanja, Balangwe, Mafwe, Subia, Yeyi and Shikwe) all indicated the importance of preserving their culture, as well as how their culture shaped their identity. The culture was considered sacred and the substance that glued the community together. Boyde describes culture as the sets of beliefs and norms that harmonised a specific community or group of people. Culture, furthermore, was described as those practices beneficial to community members that were shared in the community. Ms Sepiso from CAA also stressed that culture played an important role in instilling respect for one another and adults. Mwinga, a male Life Skills teacher, referred to a statement on the culture that was made by the Namibian president, "A nation without culture is lost or a group without culture is lost".

Culture is transferred from one generation to the next. Some participants thought that culture could not be altered and should be kept the way it originally developed, while others perceived culture as a dynamic system. Patrice perceived culture as a system comprising both positive and negative values. Community members should, therefore, be given the prerogative to uphold or not uphold all their cultural values. She said,

> … All the rules that exist within our culture I tend to agree with. There are other things that I feel like NO, here I don't fit and there are things that this is what I can live with and I don't have a problem with it. Although I might not follow a particular cultural value, I will still respect those in my community who uphold them.

Boyde also argued that, even if a person believed in his or her culture, he or she could choose a different pattern of life, and that life did not need to be dictated by cultural doctrines. One of the factors that gave community members the prerogative to choose what cultural values to adopt and which ones to discard was determined by their educational level. Patrice explained the impact that education had on the choices that members of a community could make by stating that:

> Someone who has not gone through formal education might not have the liberty to make the choice. For example, given the phenomenon of dry sex, I don't believe in dry sex, but if another woman in my community happens to believe or feels like it's the right thing to do, I will respect that. I do not have the right to tell her that those are the wrong issues, but the best way is to try to educate the person the same way that I went through education. I was taught about the harmful cultural practices that perpetuate HIV in my formal education when I was doing my studies with the International University of Management, during my Bachelor Degree in HIV and AIDS Management.

Gladys from the WLC thought that individuals who were exposed to formal education and had the chance to interact with people outside their communities showed more indications of social adaptation in their cultures. Gladys said, in general, that the proposed adaptation was usually around reducing the bride price. She continued that bride price as a practice should not be abolished completely; however, with regards to sikenge, the violence perpetrated against the initiates should be done away with. Furthermore, there was generally a sense of retaining the practice of polygyny but changing those aspects of polygyny that were risky.

There were, therefore, different perspectives of what should be retained and what should be adopted in their culture. Overall, Gladys stated that, in her work in the Zambezi region, community members had never expressed the desire to discard their cultural practices completely. On the contrary, there was a suggestion regarding how cultural practices could be adapted to ensure that they were safe. Another factor that is key to cultural adaption was highlighted by Gladys. She said that it depended on the extent to which community members were urbanised, the extent to which they lived in the confines of their community and their exposure to other cultures.

The youth argued that culture was dynamic, and the contemporary era in which they were living allowed them to choose what was good from both the African culture and modern lifestyles. They also had the prerogative to discard what was unacceptable in those African and modern cultures. Nanvula presented the position that "we cannot throw away our culture because there are also good things in our culture. There is, therefore, a need to take precaution while practising culture". Nanvula highlighted positive cultural values that were upheld in the past. One such value she mentioned was:

Girls were told they shouldn't indulge themselves in sex at an early stage and it was happening like that. Culture also stipulated that women be married while they are virgins. If those values are to be revived they could be helpful in HIV and AIDS prevention.

5.8.1 Reluctance to change cultural practices of dry sex and polygyny

NGOs working in HIV and AIDS behaviour change programmes also indicated that community members were not easily receptive to the idea of changing their traditions. Some were totally against the idea, while others were more receptive. Nakwezi from DAPP/TCE narrated that for the majority of community members, the knowledge they had received from their grandparents had been deeply rooted and they found it difficult to deviate from it. Furthermore, she said that, when everyone in a community or village held a common belief and cultural practice, it became more difficult to change. She said,

> If there is a common understanding among community members that a woman must have malebe – elongated labia – and she must use herbs to dry the vagina during sexual intercourse. Any woman who deviates from this cultural notion will be seen as *abnormal.* There was also pressure from various social structures, such as parents, elders, sexual partners and peers, who ensured that women toe the line and did not deviate from this social expectation.

The CAA representative did not condone the cultural practice of dry sex or labia elongation. Neither did she take her children through Sikenge. She described herself as a religious person. Informally she shared with the researcher that her mother is from Zambia and upholds all these traditional practices as important lessons for girls. She is however concerned that the influence of her mom on her children and the pressure her children might get from friends might get them to use the herbs that dry the vagina.

*One of the female NGO representatives alluded that she started to elongate her labia because her peers that she shared a hostel room with did the practice. (**Importance of grandparents and peer in influencing behaviour, Katima Mulilo**)*

5.8.2 Backlash on advocates of cultural change

Gladys from WLC aired her frustration about being an advocate against harmful cultural practices in the Zambezi region dealing with both the problem of backlash. Kachana from SFH also raised the issue of public criticism. She described an instance when her organisation raised the cultural practices that could potentially perpetuate HIV; the critique she faced from the community was that she was trying to do away with our culture'.

WLC experienced backlash which was published on the One Africa website on 23 August 2018, where a booklet about the 'women claiming their rights in the Zambezi region was discussed. The booklet consisted of recorded testimonies of women who had experienced harmful cultural practices. There was a backlash on social media after the report. Most viewers argued that the report was false and misinterpreted the cultures discussed. Gladys reacted by saying that they were used to such negative sentiments when addressing the issues of harmful traditional practices and human rights violations. Countless booklets on harmful cultural practices had been written before by reputable organisations, such as the Legal Assistance Centre (LAC) and Namibian NGO Forum Trust (NANGOF). Despite this evidence, there were cultural practices that could potentially perpetuate the spread of HIV. No programme had consistently incorporated cultural practices into HIV and AIDS behaviour change programmes.

In summary, various participants in this study could draw a link on how dry sex and polygyny perpetuated HIV. They also highlighted co-factors that perpetuated the spread of

HIV. Gender norms also shed their unique vulnerabilities to HIV and AIDS, which are different for men and women. The social justification of dry sex and polygyny were further elaborated on and in particular the significance of these practices for men and women. Despite the HIV and AIDS risks posed by these practices, they have not been incorporated in HIV and AIDS behaviour change programmes. Several justifications are indicated for their exclusion varying from HIV and AIDS programmes that are designed at the national level and are thus not reflecting region-specific HIV and AIDS vulnerabilities, community reluctance to change the culture, to backlash. RACOC, NGOs and traditional leaders are identified as grassroots organizations best placed to identify cultural practices that perpetuate HIV in the Zambezi region.

CHAPTER 6: DISCUSSION

6.1 Introduction

This chapter interrogates literature, theories that inform HIV and AIDS behaviour change programmes and the inclusion of dry sex and polygyny in HIV and AIDS behaviour change programmes in the Zambezi region. The theories that inform HIV and AIDS behaviour change programmes are critiqued for their limitations in informing culturally appropriate HIV and AIDS behaviour change intervention particularly in light of dry sex and polygyny. The chapter also elaborates on the ways that cultural practices of dry sex and polygyny shape sexual relations, and argue for the need to take into consideration the social context in which the individuals are socialised when designing HIV and AIDS prevention programmes. Gender inequality, which is perpetuated through the social construction of manhood and womanhood is also highlighted as a risk to HIV; therefore, the chapter advocates that HIV and AIDS behaviour change programmes need to transform gender relations and address social-cultural risk factors.

6.2 Policy frameworks guiding cultural practices that perpetuate HIV

HIV and AIDS policy directives in several countries are alluding to the linkages between cultural practices and the vulnerability to contract HIV (Republic of Namibia, 2017; Government of the Kingdom of Eswatini, 2018; Papua New Guinea, 2018). The National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22 (Republic of Namibia, 2017) state that cultural practices have the potential to perpetuate the spread of HIV. It furthermore, stipulates that culture and religion shape human behaviour and, thus, dictate people's choices and lifestyles which can influence their sexual risk-taking.

The Namibian constitution, including the international instruments of which Namibia is a signatory, protects both the rights to practise culture, religion and also advocate for gender equality. Namibia is a signatory to the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), African Charter on Human and People's Rights and the Universal Declaration of Human Rights (UDHR) CEDAW, 1992; Organization of African Unit, *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1982; UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948). These instruments highlight the role of the state to abolish practices associated with customary and religious marriages, like polygyny. For example, the Universal Declaration of Human Rights states that equality of treatment about the right to marry implies that polygyny is incompatible with these principles. Polygyny violates the dignity of women and, as such, it is inadmissible discrimination against women. Consequently, it should be abolished wherever it continues to exist (CEDAW, 1992).

Namibia ratified the CEDAW without any reservations in November 1992. The CEDAW requires state parties to address various forms of discrimination against women in matters related to marriage, including polygyny. Article 16 of CEDAW requires that the impact of customary laws on women be addressed. It, particularly, suggests the removal of all barriers to women's land ownership, as well as the implementation of programmes that discourage polygyny (CEDAW, 1992). Despite this commitment, the media reported heated debates in the Namibian Parliament with opposing views as to whether polygyny should be outlawed or not. Male parliamentarians were opposing the provision of the Customary Marriage Bill that outlawed polygyny while female parliamentarians were in full support (*New Era* Reporter, 2016).

The current National Strategic Framework (NSF) is an HIV and AIDS document (2017/18 to 2021/22) aimed at guiding HIV and AIDS planning, programming and implementation at the national level over five years. The NSF has the following focus areas: i. Social and behaviour change communication; ii. Comprehensive condom programming; iii. Voluntary medical male circumcision; iv. Sexually transmitted infections; v. HIV testing services; vi. Elimination of mother to child transmission; vii. Treatment (ART); viii. Critical enablers; ix. Synergies with other development sectors (Republic of Namibia, 2017).

The National Strategic Framework expanded identified critical HIV programme enablers as gender inequality, gender-based violence, harmful cultural practices and repressive gender laws. The majority of the NGOs were not addressing these enablers (Republic of Namibia, 2017). The only NGO attending to these aspects was the WLC. However, all the biomedical HIV and AIDS interventions were addressed by the majority of the NGOs. For example, DAPP/TCE, SFH and CAA all had a nurse in their staff establishment responsible for biomedical HIV and AIDS intervention, such as voluntary medical male circumcision, STI, HIV testing and PMTCT.

The notion of a single universal approach to HIV and AIDS prevention has long been refuted (Ehiri et al., 2016). Theories that guide HIV and AIDS prevention strategies have been critiqued for their focus, particularly in Africa, the Caribbean, Latin America and Asia (Kaufman et al., 2014). As psychological theories, they do not consider structural, economic and environmental factors that may influence individual health behaviour. Neither do they incorporate the influence of peer pressure and social norms on people's decision-making regarding health-seeking behaviour.

Holman, Lynch and Reeves (2017) suggest transdisciplinary theories that inform behaviour aimed at the prevention of HIV and AIDS. Jayasinghe, (2015) and Blue et al., (2016) also argue that health is determined by the social structure, as well as individual choices. Despite the recognition of the influence of social structure on the health choices of the individual, Holman, Lynch and Reeves (2017) posit that no study has attempted to assess the different ways, as well as their extent to which health behaviour interventions have so far incorporated the wider social context of health in their design and evaluation empirically. The factors that can impact behavioural health intervention are identified by Holman, Lynch & Reeves, (2017) as a cultural, social, political, economic and geographical context in which behaviour change intervention occurs.

According to the Social Constructivist Theory, most, if not all, aspects of human behaviour and experience are constructed by the culture in which they exist. This idea is meant to oppose the biological essentialist view that portrays various human phenomena as being biologically essential or natural to the human condition, rather than merely a product of culture (Andreychik, & Gill, 2015). Essentialism implies a belief that certain phenomena are natural, inevitable, universal and biologically determined (Yalcinkaya, Estrada-Villalta, & Adams, 2017). Essentialist theories, furthermore, assume that sexual phenomena, such as sexual orientation, reside within the individual, in the form of hormones and personality traits, among others (Bailey et al., 2016). This view is in sharp contrast with social constructivism, whose proponents view these phenomena as external to the individual, defined by social understandings and discourse (Ponizovskiy et al., 2019).

Knowledge is believed by social constructivists to be developed by humans socially and culturally (Thomas et al., 2014). Meaning is generated through people's interactions with

each other and with the world around them. Social constructivists consider learning to be a social process, a process that is determined by external forces and that there is thus no place for passive development of behaviours. Engagement in social interactions allows for meaningful learning to take place. Vygotsky social constructivist theory affirms that policy position because of the way community members come to learn about cultural practices such as polygyny and dry sex. The policy, consequently, states that the state must protect its citizens against violence, including sexual violence, forms of coerced sex, as well as against traditional and religious practices that affect people's health negatively (Republic of Namibia, 2007).

6.3 Cultural practices of dry sex and polygyny counteract HIV and AIDS prevention programmes

Vygotsky's theory of Social Constructivist states that culture is one of the key processes that facilitate how individuals get to know about their surroundings and that process is affected by other people and the community in which the individual lives (Vygotsky, 1978; Qiang & Yanru, 2020). Idang (2015) posits that culture is not something that a person is taught formally in society. Thus, every human being who grows up in a particular society is likely to become infused with the culture of that society, whether knowingly or unknowingly, during the process of social interaction. Cultural socialisation refers to the process by which children learn about the history and traditions of a culture, acquire cultural beliefs and values and develop positive attitudes towards that culture (Wang & Benner, 2016).

All the participants in this study knew about the practice of polygyny. Five of the research participants were part of polygynous family unions, of which two were married in a polygynous union, one female learner was raised in a polygynous household, and a female participant's brother was married in a polygynous union. The pro-women stand upheld in

this study argue that polygyny advances the interest of men. Men are perceived to have a stronger biological urge for sexual intercourse than women. Polygyny is therefore seen to satisfy this hyper-sexuality, sexual libido and stamina (Ekerbiçer, et al., 2016). The normalization of the discourse that men need more sex than women has led to men taking on additional wives or men engaging in extra-marital affairs sometimes with or without the knowledge of their wives. Polygyny is also closely connected to male fertility. A man can take on additional wives if his current wife is barren (Dierickx, et al, 2019). Studies have also indicated the abuse, stigma endured by women in polygynous unions who are not able to conceive (Ahinkorah, 2021; Jansen, Agadjanian 2020). The labour of the wives and their children also contribute to wealth creation for the polygynous husband (University of California - Davis. 2015, October 29).

According to the Native Administration Proclamation 15 of 1928, polygyny is permitted in Namibia, provided that couples in polygynous unions declare it (Republic of Namibia, 1928). However, according to this proclamation, only black men are to enter into polygynous relations. The Customary Marriage Bill proposes the recognition of a customary marriage but outlaw polygynous marriages (Legal Assistance Center, 2005a). The reform of customary marriages law is based on the principle that customary law marriages should be accorded the same level of recognition and benefits as the consequent privileges that are currently only available to common-law marriages (Commonwealth Law Bulletin, 2005). According to the Bill, existing polygynous marriages contracted before the bill became law, would enjoy legal protection; however, any polygynous marriages that were entered after the bill had become an act would be illegal. Vision 2030 indicated that many Namibians still prefer to marry under customary law and others prefer to cohabitate. The rights of women in these relations are insecure, despite customary marriages being socially

recognised and the informal unions more accepted; however, none of these relational arrangements is legally recognised (Republic of Namibia, 2004). This has implications for the livelihoods of women and their children in polygynous unions.

In this study, polygyny and dry sex are identified as cultural practices that can potentially perpetuate HIV. The relationship between culture practice and the risk of contracting HIV should, therefore, be considered in conjunction with other structural co-factors (Zhou, Majumdar & Vattikonda, 2016) as transmission pathways are non-linear, varied and highly contextual. Consequently, no single causal factor alone should be attributed to being an HIV risk (Ramjee et al., 2016).

The cultural practices of dry sex and polygyny counteract HIV and AIDS prevention strategies. The HIV and AIDS prevention strategies advocates for the decrease in the number of sexual partners, to which polygyny is in contradiction, as it allows one male to be married to multiple wives. The Demographic Health Survey also confirmed that women in polygynous marriages are likely to be HIV positive when compared to women in monogamous marriages or those who are single (NSA, 2014). Furthermore, HIV and AIDS prevention strategies advocate for the delay of the onset of first sexual intercourse. There is, however, invalidated in the Sikenge rituals by initiating 14 years girls and the initiates are taught “Dance” which emulates sexual moves to perform with their husbands. Sikenge initiates who do not follow the instructions are beaten to obedience to ensure they conform to their female gender roles (Khaxas & Frank, 2010; Frank, 2015; Legal Assistance Centre, 2017). Sikenge initiates that are recruited at such as young age, are likely to put into practice what they learnt. It is the result of teaching initiates to subdue themselves to their future husbands and partners that leads to women and girls being unable to assert themselves and

negotiate for safe sex. Sexual negotiations as stated by Ung et al. (2014), is an important skill to delay the first sexual encounter. Peasant et al. (2017) also report that women who did not feel that they had control over, or the right to insist on, using condoms did not act on their knowledge of the risk of HIV and were thus less likely to practice safer sex. Polygyny, is equally, counteracting the HIV and AIDS prevention strategies, as women in polygynous marriages do not exercise their self-efficacy by engaging in protective behaviour against HIV and AIDS.

The social constructivist theory explains how the various aspects of sexual scripts are socially constructed, as well as the purpose of the cultural practices of polygyny and dry sex. Furthermore, Foucault's interpretation of power and the way that power distinguishes between permitted and forbidden sex also explain how the regulation of sex creates HIV and AIDS vulnerability. This theory explains how sexuality is mediated by social factors. Mayer, and McHugh, (2016) furthermore, emphasise the extent to which human sexuality is influenced by the societal factors in which the individual lives. They acknowledge that sexuality is grounded in biological drives, but biology does not dictate where, how, when and with whom a person engages in sexual behaviour. Although sexual desire may be biologically driven, its expression is socially constructed. The constructivist theory suggests that the constructs and ideas associated with traditional, sexual scripts remain unchanged and are rooted in traditional gender roles that were established. It, therefore, argues that, as much as sexual decision-making is personal, it is equally influenced by cultural factors that are common in a particular community; hence, sexual relations are governed by society. For example, in a certain context, a widow cannot retain what she and her late husband have accumulated, neither can she continue to plough the fields and remain in her late husband's land unless she remarries someone from the late husband's family.

This practice remains the norm, despite inheritance laws that protect the rights of widows, irrespective of the type of marital union (Legal Assistance Centre, 2005b; Lomba, 2014; Perry et al., 2014). It should be noted that this social practice may not hold for another widow elsewhere, because a sexual act does not carry with it a universal social meaning; it is, therefore, not fixed and can thus be changed. The social constructionist theory holds the view that physical sexual acts may have varying social significance and subjective meanings, depending on the way that they are defined and understood in different cultures and historical periods (Vance, 2001; Aranguren, 2017).

By delving into sexual pleasure raises the importance of focusing not only on negative experiences emanating from the cultural practices of dry sex and polygyny such as, the associated pain during dry sex, or having no control over whether a new wife will be introduced into the polygynous marital union. But to also focus on sexual pleasure within the broader discussion of sexuality (Ford et al., 2019). According to Gruskin et al., (2019, p. 31), sexual pleasure has emerged as 'the newest arrival to the sexual health and sexual rights policy landscape, yet it is the least developed and potentially the most open to interpretation'. It is therefore important that studies must explore pleasure even in situations where sexual rights are constrained. This includes women's sexual desire and choice of intimate partnerships in contexts of gender inequity and power imbalances (Logie, Perez-Brumer, & Parker, 2021).

It was obvious from the research participants that sexuality and its expressions are inextricably entangled with the local context and cultural systems that underpin people's lived experiences. For example, in the conversation about dry sex women did not mention the importance of using the herb for their sexual pleasure, they however mentioned that they use the herbs to sexually satisfy their sexual partners. On the other hand, male research participants

mentioned that women use herbs to provide sexual pleasure to males. This fits well with the perspective that women may be more prone to self-sacrificing and investing in nurturing romantic relationships, perhaps even at the cost of their health (Peasant et al., 2015).

HIV and AIDS behaviour change programmes provide opportune spaces to learn about and to open the dialogue about sex, sexualities and sexual pleasure. Talking about sex is believed to not only reduce associated stigma and shame but also improve couples' communication, thus affording women the opportunities to reclaim their sexual agency and experience sexual pleasure. Marais (2019) emphasise that this might disrupt the premise of hetero-patriarchal relationships that portray women as the subservient sexual objects of men's desires. Including female sexual pleasure in academic conversation may help in placing dry sex and polygyny in the centre of the conversation about women's sexuality. This can aid women to scrutinise their sexual experiences.

6.4 Social construction of polygyny

Some participants indicated that polygyny plays an important role in society. The social justification for polygyny varies from economic considerations, social protection for women and children to religious and cultural beliefs. Lawson et al., (2015) indicates that women may experience some benefits, such as sharing the burden of work with other wives. On the other hand, women in polygynous marriages have to share emotional and material benefits provided by their polygynous husbands. It can be deduced that a polygynous marriage, provides a man several services rendered by women, including access to sex and reproduction (Thobejane, & Takayindisa, 2014).

In other parts of the world, such as in Cameroon, polygyny is motivated by economic considerations. It is claimed that it makes for an economically stronger family because there

are more people, including children, working and bringing money into the home (Thobejane, & Takayindisa, 2014). Women and children are viewed largely as labourers and producers. Wives produce children and gardens, while girl children produce dowry, personal service and are valuable for increasing garden income. Women are perceived to benefit from polygyny by attaining material security through their polygynous husbands. Furthermore, it has also been argued that co-wives in polygynous marriages share house chores including child-rearing, thus leaving women with enough time to pursue studies, careers or to run businesses. In Kyrgyzstan, many believe that, due to ongoing financial instability, a collective approach to making ends meet is more pragmatic than an individual effort. Poverty among the general population becomes a major driver in sustaining polygyny (Toursunof, 2007). The practice of polygyny can thus not be eliminated without addressing ingrained factors that perpetuate poverty.

The social pressure on women to bear children in marriage also supports the practice of polygyny. According to Dierickx et al., (2019), the infertility of the first wife does not only permit her husband to take on another wife, but her status as the first wife also lowers. The demand for a boy child and the power embedded in husbands to replace women who cannot bear male children portray men as important. Such patriarchal systems subjugate women (Wood, 2019). A couple's infertility and the husband's right to take another wife were also raised in this study. A wife's barrenness would entice the husband to impregnate a woman and then bring this woman and her baby into the polygynous marriage. It was considered of high social status for men to bear many children. Polygyny also made it possible for every woman in a village to have a husband, for children to have an acknowledged father and to belong to a clan. Dierickx et al., (2019) alluded that some customs permits that a man can take a subsequent wife when his first wife is unable to give him a son.

Among various groups, religious and cultural beliefs also play a role in the formation of polygynous marriages. Islam permits men to have as many as four wives (Safiyanu, 2014). Safiyanu, (2014), states that, in Islam, polygyny is seen to protect the family from possible deviation from illegal sexual intercourse and contracting sexually transmitted diseases. According to a study conducted by Anyolo (2008) about polygyny among the Ovambandja in Namibia, women considered polygyny beneficial in the sense that it dignified them as well as provided marital status. It prevented immorality in the community and controlled diseases… it also reduced extramarital affairs among men. This position was also raised by a research participant. His justification for marrying the two wives was to protect them from HIV and other STIs, as neither he nor his wives had sexual intercourse with people outside the trio.

In some African communities, polygyny was only practised among the royals. Participants in this study noted that in the past, polygyny was the prerogative of indunas and ngambelas. However, in modern times, men who are commoners and could afford several wives, opt to marry polygynous. Men marry polygynous as it offers economic and social benefits, as well as status (Koos, & Neupert-Wentz, 2020). Furthermore, wealthy men with good social standing are in a position to marry polygynous as is the case with the Zulus of South Africa (Zungu, 2019).

6.5 Challengers within Polygyny unions

Despite the perceived benefits of polygyny, proponents problematise polygyny as perpetuating gender inequality and increasing HIV risks for women (Gazimbi et al., 2020). The common denominator in all societies practising polygyny is the cultural construct of patriarchy (Gender Links, 2013). Feminists critique polygyny for gender inequalities and the violation of human rights perpetrated by this form of marriage. For example, Jansen, & Agadjanian, (2020) state that polygyny perpetuates women's subjugation by men.

The social and economic conditions which made polygyny a beneficial option in society no longer exist today, particularly in the context of Namibia. Marriage is no longer the only avenue for women to obtain material resources or economic upward mobility. Namibia is a signatory to several gender equality treaties that guarantee women the same rights and privileges as men (UN General Assembly, 1948; CEDAW, 1992; Republic of Namibia, 2010). There are legal provisions for women to succeed economically in their own right and to exercise sexual autonomy. In South Africa, women stated that the economic justification for polygyny no longer holds. Most women no longer do agricultural chores; as a result, there is no longer any purpose for multiple wives and several children to attend to agricultural chores. Furthermore, most of these tasks are done by hired labourers (Scoones, 2021). Findings from this study also refuted that poverty is the social justification behind polygyny. On the contrary the financially well-off men are likely to marry polygynous. However, poorer families are likely to marry off their daughters to well-off man (Muggaga et al., 2022).

Similarly, polygyny also exposes family members to economic hardship. The standard of living is higher today and consumer items and other necessities of life, such as education, medical care, shelter and clothing, are much more expensive. A negative effect resulting from this economic stress is the inability to provide for all the co-wives and children. The emotional and financial neglect from the husband was mainly towards the first, older wives who had fallen out of his favour. Thobejane, & Takayindisa, (2014) & Mabaso, Malope, & Simbayi, (2018), in a study conducted in South Africa about women's experiences of polygyny, stated that the issue of both emotional and financial neglect was raised by women. A study by Al-Sharfi, Pfeffer and Miller (2016) also highlights the negative effects

on children and adolescents raised in polygynous families; these vary from mental health and social problems to lower academic achievement. Some families in polygynous marriages experienced psychological problems as a result of the man favouring the children of other wives instead of seeing all the children as equal. This, in most instances, resulted in siblings showing signs of low self-esteem and rejection.

South African gender expert, Nomboniso Gasa, states, "It is the height of irresponsibility for men whose positions do not allow them to ensure that all wives and children are treated equitably and adequately supported, to enter into polygynous unions." (Gender Links, 2013, p. 8) She notes that the reality in South Africa is that most men cannot afford to have multiple wives, but many still aspire to. Besides, men in such relationships are more likely to have lower levels of education than men in monogamous relationships. Gazimbi et al., (2020) state that women in polygynous marriages do not exercise their negotiation power; they are also less educated and have more relationship problems. Furthermore, Dierickx et al., (2019) found that women in polygynous marriages had experienced psychological, physical, economic and sexual abuse. Polygyny thus creates inequality among co-wives since the husband is in most instances unable to cater for all their and their children's needs. Polygyny thus gives men power and authority over women (Zungu, 2019).

In this study research participants indicated that when additional wives were introduced into the polygynous union, the 1st wives and their children were economically and emotionally neglected. Gazimbi et al., (2020) allude to the fact that polygyny exposes women to HIV and AIDS because it increases the number of the husband's sexual partners. Zungu, (2019) also alludes to women's inferior status in a polygynous marriage that affords them little or no power to protect themselves by insisting on condom use or refusing

unprotected sexual intercourse. In this study, an elderly female traditional healer, whose husband and two of his co-wives had succumbed to HIV and AIDS, shared her experience on the HIV risks in polygynous marriages. She also expressed a lack of consultation regarding whether the husband would take additional wives or not. Thobejane and Takayindisa, (2014) and Mabaso, Malope, and Simbayi, (2018) also referred to the lack of sexual negotiation among co-wives and their polygynous husband. The desire of co-wives to seek favour and please their husband leads to women having sex without a condom. This then results in women and their husbands contracting HIV. In societies where marriage is highly regarded. Where women cannot find eligible men to marry, polygyny becomes the alternative. Marriage as an institution that men and women should strive for is highly regarded in traditional and religious settings. In societies where singlehood and bearing a child out of wedlock is frowned upon, women would then opt for polygyny even if it is their last resort.

The sexual scripting theory illustrates ways in which sexuality and gender are interconnected (Masters et al., 2013; Rossetto, & Tollison, 2017). Men and women take up different sexual scripts in the performance of masculinity and femininity. For example, what is considered acceptable sexual behaviour for men, might not necessarily be acceptable in a certain social context. Men can be married polygynous, however, polyandry is not an acceptable sexual norm in Namibia, but it is else acceptable, such as in Nepal (Gurung, 2012; NSA, 2014).

Feminists argue that polygyny should be seen as a form of discrimination, which goes against laws of gender equality as enshrined in the Namibian constitution and the international legal frameworks that Namibia domesticated, such as the United Nations

Convention on the Elimination of Discrimination against Women (CEDAW). (Republic of Namibia, 1990; CEDAW, 1992).

6.6 Dry Sex: Its Pros and Cons

The practice of utilising herbs and other agents to dry the vagina for sexual intercourse is not unique to the Zambezi region. The use of vaginal drying agents has been reported in other countries, such as Costa Rica, Haiti, Cameroon, South Africa, Senegal, Malawi, Zambia, Kenya, Saudi Arabia, Zaire and Zimbabwe (Fahs, 2017; Chen, Bruning, Rubino, & Eder, 2017; Doherty et al., 2014). Despite knowledge of this practice, the international health community knows little about its prevalence or how to implement culturally sensitive and effective educational interventions addressing its potential health consequences. A study by Chinsembu and Hedimbi (2010) also indicated that women in the Zambezi region insert herbs in the vagina for medical purposes, they, in particular, highlighted the treatment of candidiasis, vaginal thrush, herpes zoster a skin rash. Vaginal drying agents are employed when there is a preference for a dry rather than a lubricated vagina. Reasons for this preference vary. In South Africa, men have reported that vaginal wetness during sexual intercourse was an indicator of a woman's infidelity. They have also associated vaginal lubrication with sexually transmitted diseases (STDs) and the use of contraceptives (Doherty et al., 2014). In Zaire, as well as in Zimbabwe, it is stated that both men and women have expressed preferences for vaginal dryness and tightness during intercourse as it is reported to increase sexual satisfaction and pleasure for the male partner (Fahs, 2017).

Women indicated that utilising drying agents in the vagina had many benefits, varying from increasing friction (warmth), tightening of the vagina walls and improving general blood circulation to enhance sexual performance. These were among the key motivations for dry sex

(Chen, Bruning, Rubino, & Eder, 2017). Loosli (2004), furthermore, elaborates that in some parts of Senegal, community members believe that it is necessary for hygiene reasons to remove vaginal fluids and create a clean environment for procreation. Dry sex also rules out the negative connotations regarding a wet vagina which is associated with unfaithfulness, abnormality, disease, dirtiness and lack of sexual pleasure (Chen, Bruning, Rubino, & Eder, 2017).

The justification for the dislike of vaginal fluids is unfounded as studies show that vaginal discharge serves an important housekeeping function in the female reproductive system. Fluid made by glands inside the vagina and cervix carries away dead cells and bacteria. This keeps the vagina clean and helps prevent infection. Most of the time, vaginal discharge is perfectly normal (Zemouri et al., 2016). The level of ignorance about the anatomy of the male and female reproductive system is creating the demand for dry sex.

The rough texture of the herbs also contributes to the tearing of the vaginal walls. The tearing of the vaginal walls contributes to painful sexual experiences for women. In addition to friction during intercourse, lesions occur in the vagina's mucous membrane causing micro-lacerations during intercourse. HIV transmission is known to be enhanced in the presence of genital lesions and ulcerations (Kieselova et al., 2017 & Abbai, Wand, & Ramjee, 2016). Since vaginal drying agents have been documented as producing lesions that disrupt membrane integrity, the practice may also increase the risk of HIV. Besides, intravaginal substances may alter the vaginal pH, which normally serves as a protective factor against the contraction of HIV (Lazarus et al., 2019; Eastment, & McClelland, 2018). Intravaginal product use is also identified to change the natural vaginal pH (acidity and alkalinity) and thus undermine its natural defence against microbes, making infection more likely. Loosli (2004), furthermore, alludes to the pain and discomfort associated with dry

sex where both men and women in the Caribbean, as well as in Africa, have reported tearing and bleeding during dry sex.

Vaginal wall tearing was identified as a major vehicle for spreading the virus. The pain associated with dry sex among women was confirmed by Loosli (2004) who reports that a high percentage of women confided that they experienced pain rather than pleasure and resented this. Most women performed dry sex to satisfy their partners or husbands. The men believed that friction enhanced their sexual stimulation and pleasure. Research participants argued that a vagina with less moisture held the penis more firmly during a sexual encounter and this provided more friction and sexual pleasure to the male. The continued expectations from women to have a tight vagina as they mature and have children is not only unrealistic but unnatural. This is also raising the question of whether the notion of sexual pleasure is a result of cultural socialisation. Women rarely stated their sexual pleasure as a justification to use dry agents. This was also confirmed in a study conducted in South Africa among women who insert drying agents (Doherty et al., 2014). Similarly, in this study, the same sentiments about vaginal fluids were raised. The female and male participants spoke about vaginal fluid as if it was something detestable and abnormal in women. The vagina was thus perceived as being unable to excrete its vaginal fluids. Doherty et al. (2014) confirmed in their studies that lubrication was not considered an essential element in pleasurable sexual intercourse; hence, participants indicated that vaginal drying agents made them “like a virgin” and that this enhanced their partner’s sexual pleasure. Women in this study rarely stated their female sexual pleasure as a justification for using herbs.

Loosli (2004), furthermore, states that there are many consequences of dry sex, such as inhibiting condom use. Condoms are ineffective in dry sex as the process excludes any lubricant in the vagina or on the condom. If a condom is used it could easily break. Participants indicated difficulty to use condoms effectively when practising dry sex. The possibility of the condom bursting if the vagina was not lubricated was high. In a study that was conducted in South Africa Reddy et al., (2009) also indicate that condom use was problematic during dry sex. The participant from the Red Cross also cautioned against the cuts on the glans of the penis among men who were not circumcised, because of its tenderness. The perspective of men being injured during dry sex was also mentioned in a study by Fahs, (2017). He reports the opinion of one participant, "It's natural for all guys to go crazy for a woman who is dry, but you have to make love carefully. If you want to be rough, you can get hurt. A man can get cuts and wounds and catch diseases" Fahs, (2017, 34).

6.7 Application of the theory of gender and power on how construction of womanhood and manhood perpetuate HIV

African women continue to bear the brunt of HIV and AIDS (Arrey, 2015; Naicker et al., 2015; Madiba & Ngwenya 2017; Melesse et al., 2020; Mottiar, & Dubula, 2021). HIV prevalence is highest among women in Namibia and the Zambezi region, in particular. Women account for more than half of the HIV infections in the region. The Zambezi region has the highest HIV prevalence among pregnant women receiving anti-natal care (ANC). The Namibia Demographic and Health Survey indicates HIV prevalence is 30.9% among women and 15.9% among men (NSA, 2014). Besides, the highest HIV prevalence among women 15- 24 years was observed in Katima Mulilo (20.5%) (Republic of Namibia, 2016).

The extent to which individual behaviour is dictated by social norms was expressed by research participants in the manner in which they explained the pressure under which women found themselves to use herbs that dry the vagina, despite their knowledge of the risk this is posed to the contraction of HIV. These cultural notions of womanhood dictate the way that society depicts female sexuality and the extent to which female, sexual autonomy rests with the male sexual partner; it indicates that women lack the power to negotiate safe sex. Foucault (1978) and Connell's (1987) interpretation of power and how power determines what is permitted sex, dictates the way sex is performed. In these social contexts, socially accepted, sexual encounters where dry sex and polygyny are the norms, create vulnerability to HIV and AIDS among women. Women's experience of sex as painful raised the concern that dry sex could potentially be a risk factor in HIV and AIDS; it, furthermore, constitutes a form of violence against, and subjugation of the female (Wood, 2019). Traditional, gender norms where women are expected to be submissive and male dominance is the norm encourage high sexual risk-taking among men.

Wingood and DiClemente (2000) elaborate on Connell's (1987) Theory of gender and power by explaining women's vulnerability to HIV and AIDS. Their application of the theory will be employed to provide an insight into this study. Connell's theory applies to this research as it highlights gender imbalances, about the cultural practices of polygyny and dry sex. Polygyny as a practice is based on unequal power structures between men and women. In a society where polygyny is practiced, it is the man who has the prerogative to take as many wives as he wishes. Similarly, given that men pay bride price (lobola) for the hand of women in a marriage that gives them more power over their wives. Polygynous men, will have sexual intercourse with all their wives and sometimes with other women outside the marital union. Despite women knowing about the concurrent sexual relationship within their

polygynous marriage and the risk it might pose to HIV, it provides them with limited sexual negotiation power. Due to the power men have over women, particularly in polygynous marriages, accompanied by culturally-based inequalities, religious proxies, women are not able to decide when it comes to practising safe sex.

Connell (1987; 113) also mentions the double standard regarding male and female sexuality, where men are allowed to engage in multiple sexual relations through socially sanctioned practices of polygyny but forbid women to have sexual relations with many men. This has nothing to do with greater sexuality within men, but with the power and privileges, society bestows on men. Different standards are used to measure male and female sexuality, with a certain degree of tolerance for male sexual promiscuity. Such behaviours increase women's risk of HIV and perpetuate the spread of HIV in the general.

Furthermore, Connell's Theory of gender and power analyses the underlying justification for women to practice dry sex. Studies have indicated that women practice dry sex to provide sexual pleasure to their male partners. Similarly, it has been indicated that the cultural practice of dry sex inhibits the effective use of condoms and also heightens women's risk of HIV. The structure of cathexis as alluded to by Connell helps to clarify how women and men express their sexuality and the extent to which women will go to preserve such sexual relationships. Several social structures such as the family, in particular, elderly women in the family and men exert pressure on women to toe the line. Family, conservative gender and cultural norms can be risk factors to social exposure (Connell (1987). It is argued that practices are closely connected to power since the dominant and strong people within a community are those who are deciding what norms should be seen as acceptable behaviour. Cislaghi & Heise, (2020) states that the power

differences between men and women which are occurring in many societies have created different norms for the two sexes. Connell's theory helps create some structure in which to analyse what is considered appropriate sexual behaviour and the attached expectations within the confines of the society under study, as is the case in the Zambezi region.

Connell (1987) connects the influence of the legal frameworks on the vulnerability of women. The government legal framework on HIV prevention in Namibia recognises the extent to which culture and religion heighten women's risk of HIV. The state, therefore, has the responsibility to put mechanisms that would avert women's HIV risk. Practices such as property grabbing after the death of a spouse renders women vulnerable as they have nothing to survive with their children. Despite the existence of gender-responsive legal frameworks such as equitable marital laws, inheritance laws, there are still instances where customary laws are used as a justification to disown women. Although gendered commitments are in place, HIV and AIDS prevention programmes have not included the interrogation of cultural practices such as polygyny and dry sex into HIV and AIDS prevention programmes. Connell's gender and power theory emphasize the impact male partners, families and cultural practices in women´s environment have on women's vulnerability to HIV and AIDS.

Men are equally at risk of HIV infection as a result of culture, hegemonic masculinities and patriarchal traditions. Men indicated that dry sex was equally painful to them, despite finding the sexual encounter pleasurable. There was more social tolerance for men who involve in multiple concurrent sexual partnerships. It was also socially condoned for a man to introduce a new sexual partner into a polygynous union. In social contexts where the prevalence of HIV and AIDS is high and HIV testing low, such sexual behaviour exposes men

and their sexual partners to HIV and AIDS. Heise et al. (2019) and Klaas, Thupayagale-Tshweneagae, & Makua, (2018) indicate that gendered, social and sexual norms determine both men and women's sexual behaviour and play a role in exposure to HIV.

It is the unequal gender relations that perpetuate women's vulnerability, hence, emancipating women is imperative. However, it is also important to transform perceptions of how men relate to women and the sexual behaviour that exposes men to HIV and AIDS. Excluding men from these conversations, burdens women with the responsibilities to convince their sexual partners to alter their sexual behaviour. In a social context where women cannot dictate or tell men what to do, men thus remain ignorant and excluded from HIV and AIDS prevention intervention. Consequently, it is necessary to target men and challenge their notions of manhood that contribute to their own and women's vulnerability to HIV and AIDS. Sovran (2013) stresses that there is a correlation between HIV and AIDS and gender inequality. It is argued that, where gender equality was increased, the prevalence of HIV decreased. Thus, it is suggested that gender inequality and HIV are strongly linked, but also that improvements in gender relations can have a positive impact on stemming the spread of HIV in a population.

Jewkes et al. (2015) posit that hegemonic masculinity oppresses men also by constraining what they can and cannot think and do. Men's identities and behaviour are also undoubtedly shaped by culture. For example, men consistently have higher rates of changing sexual partners than women, a behavioural pattern that creates vulnerability to HIV. Available evidence shows low rates of HIV testing, male circumcision, condom use and comprehensive knowledge of HIV and enrolment on ART participation in PMTCT to couple counselling among men (Republic of Namibia, 2017). Okal et al. (2020) indicate

that men were much less likely than women to attend VCT and, therefore, less likely to be aware of their HIV and AIDS status. This study, however, shows that the social construction of manhood and womanhood heightens the vulnerability of HIV and AIDS. Hence, efforts must be made to engage also men in HIV and AIDS discourse and to transform notions of manhood that render them vulnerable to HIV and AIDS. Expectations of "masculine" sexual behaviour are often reinforced from childhood through adolescence. Given the enormous pressure put on women and men that perpetuate risks to HIV, it is important that HIV and AIDS behaviour change programmes should not blame men for women's vulnerability to HIV and AIDS or vice versa, but rather should aim to change the cultural and structural norms to transform the construction of manhood and womanhood.

6.7.1 Conservative gender roles embedded in cultural norms and traditional beliefs

Traditional gender norms are at the root of many power imbalances in heterosexual relationships where male dominance is a key feature. It is such norms that encourage men to engage in high-risk sexual behaviour, such as having multiple concurrent sexual partners and women's tolerance of male control. Women who hold traditional gender norms and believe that a woman should 'serve' her man have a reduced ability to negotiate in their sexual relationships (Nankinga, Misinde, & Kwagala, 2016), specifically to negotiating safer sex. Women who adhere to these cultural gender norms may find it difficult to discuss with others, including the sexual partner, taboo issues, such as sexuality and HIV. On the other hand, women with non-conservative beliefs towards gender roles seem to have more control over safer-sex practices. For example, females scoring high on non-traditional attitudes to the gendered double standard are more likely to suggest and provide condoms.

Similarly, those who report male control in relationships as non-normative are more likely to refuse unwanted sex (Lefkowitz, 2014).

Gendered social and sexual norms are influenced by cultural practices. A study conducted by Bordini, and Sperb, (2013) on sexual double standards show that women are expected to accept the sexual behaviour of their male partners even in the light of the associated risks. Cultural norms and patriarchal traditions determine women's behaviour and conduct. Bhana and Anderson (2013) state that, for the majority of girls and women, the opportunity to refuse to participate in cultural rituals is minimal as it defines their notions of womanhood. In the debate on HIV and AIDS, the role of women is central to the way that women's vulnerability to HIV infection is understood. The feminisation of HIV and AIDS raises questions about the extent to which women and girls can exercise autonomous choice over their sexuality and fertility (Edwards, 2007).

Guo,(2019) and Endendijk, van Baar, & Deković, (2020) show that men of various ethnicities, who scored high on traditional male role attitudes, were more likely to report more sexual partners in the past and inconsistent condom use, as well as hold negative attitudes towards the use of condoms. Similarly, men who supported inequitable gender norms were more likely to report having an STI, refraining from using contraception and using sexual and physical force against their partner (Pulerwitz et al., 2006).

Feminist theorists contend that hegemonic masculinities, patriarchal traditions and cultures have inherent tendencies to be abusive towards women and girls (Morrell et al., 2013). Hegemonic masculinities refer to attitudes and practices that maintain gender inequality and are employed to dominate women and men who are considered less powerful, such as men from minority groups (Messerschmidt, 2019). Hegemonic masculinity is also harmful

to men. Jewkes et al. (2015) state that the cultural systems that keep men in a position of power over women and in competition with other men come at a cost for men in terms of their health and quality of life. In particular, men do find it hard to seek healthcare and engage in preventive activities (Novak et al., 2019). This form of masculinity is in certain social contexts upheld as a cultural ideal of manhood, which is rewarded by women's interest, attention and efforts to replicate in young males. On the other hand, women and girls are socialised to accept and be tolerant of this notion of masculinity.

Culture forms the foundation of values, norms and beliefs for many individuals, and may influence women's decision-making choices with regards to sexual practices. Cultural practices have been found as a justification as to why some women do not suggest condom use to their partners (Fladseth et al., 2015). For example, higher rates of polygyny, as well as condoning concurrent partnerships, are common in the Zambezi region (Namibia Statistics Agency, 2014). As suggested in one study, women in polygynous marriages have reduced negotiating power (Zungu, 2019). It has also been reported that, in comparison to women in monogamous marriages, women in polygynous marriages tend to be less educated and have more relationship problems.

The intersectionality of gender, age, ethnicity, class and sexuality with cultural practices of polygyny and dry sex do subjugate women. Women who adhere to cultural practices of polygyny and dry sex do so to either conform to societal notions of womanhood or to pleasure their sexual partners. In this gendered suppression, women are policed by the patriarchal system to toe the line. Both cultural practices of polygyny and dry sex benefit men, by having access to women and their children's labour through polygynous marital arrangements and by enjoying sexual encounters with women using herbs to dry their

vagina at the expense of women's pain. When men introduce subsequent wives into polygynous marriage, the new wives are likely to be much younger. This brings challenges for a young wife to negotiate sexually as a result of the age differences. Gender, age, ethnicity and sexuality thus becomes axes of subordination through which women are dominated (Hvenegård-Lassen, Staunæs, & Lund, 2020). The interaction of the geographical location, of the Zambezi region, with gender and sexuality, perpetuate women's vulnerabilities to HIV and AIDS. The Zambezi region borders Botswana, Zambia and Zimbabwe have high human migration, which further heightens HIV risks.

6.7.2 Lack of interpersonal communication as a barrier to HIV prevention

Interpersonal communication regarding HIV prevention is inhibited by cultural factors that dictate whether husband and wife, parents and children can talk freely about sex and HIV and AIDS. Erulkar, (2013) show that women fear intimate partner violence if they initiate communication about safe sex with their male sexual partners Furthermore, women and men's socialisation patterns also create communication barriers. For example, female participants alluded to experiencing dry sex as painful, while the male participants indicated that they found it enjoyable and considered a lubricated vagina as a woman's illness. The different experiences of dry sex by men and women created a communication barrier. Women, on the other hand, were also raised with the notion that it was their duty to satisfy their husbands sexually; this had a stake in the upkeep of their marriage. The pain resulting from women utilising herbs to dry their vaginas is tantamount to violence against women and this practice perpetuates female subordination. A woman who finds herself in a position of subordination will be challenged to engage constructively with her sexual partner for safe sex. Particularly if safe sex practices, such as condom use, are perceived by men as reducing sexual pleasure.

6.8 Dry sex and polygyny excluded in HIV and AIDS behaviour change programmes

Some of the NGOs, such as WLC, that was doing advocacy work on harmful cultural practices and women's rights, incorporated the inclusion of dry sex and polygyny in their interventions. Other NGO representatives such as CAA, Red Cross, NANASO, DAPP/TCE did not incorporate cultural practices such as dry sex and polygyny in their training sessions. One possible justification for WLC to address the gender repressive patterns of polygyny and dry sex in their programmes could be due to the fact that WLC is a feminist organization with the mandate to address gender inequality. The fact that other NGOs are aware of the risk that polygyny and dry sex pose to HIV and AIDS, but did not incorporate it in their programmes. It creates the impression that issues around gender equality are not mainstreamed across institutions, but rather relegated to feminist institutions.

It could be deduced from the findings of this study that NGO representatives, who knew about cultural practices of dry sex and polygyny were not able to influence the HIV and AIDS programme design. This is in contradiction with the theory proposed by Resnicow et al. (2000), who proposed that programme coordinators must be from the targeted recipients; this they believed will ensure that the cultural practices that perpetuate HIV will be incorporated in the programmes. In this study the awareness about dry sex and polygyny and the risk they pose to HIV and AIDS and the cultural background of the NGO representatives as individuals that are from the Zambezi region did not ensure that polygyny and dry sex are incorporated into HIV and AIDS programmes. Numerous factors lead to this exclusion, varying from respect for one's culture, the notion of addressing cultural practices was perceived by some participants as being against your own culture. Various hindrances were raised why they thought it was not their place to incorporate some

cultural practices into behaviour change programmes. These varied from the argument that HIV and AIDS behaviour change programmes were not designed at the regional level. HIV and AIDS behaviour change programmes were designed at the national level, hence the NGOs did not have the mandate to divert from the national HIV and AIDS behaviour change programmes, irrespective of the reality they found at the regional level. Programmes, such as in the case of CAA, came from head office where the Catholic Bishops Office took a strict position on some of the HIV and AIDS behaviour change programmes regarding condom distribution and condom use. Despite representatives from the NGOs knowing the risks certain cultural practices posed to HIV and AIDS, it seems they were not at liberty to introduce HIV and AIDS behaviour change programmes that would counter these cultural practices. These programmes were therefore implemented in the region without consideration for the regional unique context. This top-down approach ignores the cultural context, specific to the Zambezi region.

6.9 Need for coordination mechanisms that is inclusive of traditional structures in the Zambezi region

Building a stronger strategic coordination mechanism at all levels of the health system in the public, private NGO sectors and community is important to address HIV and AIDS. Traditional healers and traditional leaders are part of RACOC, however, Sikenge initiation instructors are not part of the RACOC structures and ought to be included. The inclusion of traditional structures in RACOC provides a platform where cultural practices such as polygyny and dry sex can be incorporated in Zambezi regional HIV and AIDS prevention programmes. Vygotsky's Social Constructivist Theory (1978) supports the inclusion of traditional structures as they play an important role in the socialization process of individuals. Social constructivists' theorists represent knowledge as a human product that

is socially and culturally constructed (Vygotsky, 1978). They argue that human learning is constructed, that learners build new knowledge upon the foundation of previous learning. This prior knowledge influences what new or modified knowledge an individual will construct from new learning experiences (Thomas et al., 2014; Knapp, 2019). It is therefore important that the traditional structures that are responsible for socialization are part of the HIV and AIDS coordination mechanism. The HIV and AIDS coordination mechanism has over the years faced challenges. There is a scaling down of HIV and AIDS prevention programmes in areas where such programmes are most needed. Downscaling on behaviour change programmes was also raised by several representatives from the NGOs. Banks, Hulme and Edwards (2015) also allude to the reduction of funding earmarked for HIV prevention programmes. This has huge implications for programme rollout.

Another hindrance that was raised by participants were donors dictating the priority areas on which funding had to be spent. For example, the majority of the NGOs identified the key populations as commercial sex workers and truck drivers, as well as adolescents and young women. The key populations are also identified by the Ministry of Health and Social Services through the Directorate of Special Programmes (Republic of Namibia, 2014a). Hence, no funding provision was allocated to addressing cultural practices that could potentially perpetuate the spread of HIV among the general population. Attempts by some NGOs to lobby for funding to address cultural practices that perpetuate HIV were not funded. According to Foucault (1978) discourse power, and knowledge are all linked because those who are in power, control discourse. They decide how sex can be spoken about, and by whom, and so they control also the kind of knowledge regarding sex. On the other hand, this control over discourse is closely linked to their maintenance of power. The control of knowledge regarding sexuality can be seen in taboo regarding sex conversations.

Furthermore, the types of knowledge to be conveyed on matters of sexuality is also controlled. The conversations that are considered socially approved are prevention of HIV and AIDS, teenage pregnancy, sexually transmitted diseases, incest, rape. However, discourses on sexual pleasure are sanctioned.

The fact that the government is making a financial contribution to HIV and AIDS prevention programmes provides opportunity to determine the focus areas. It should, furthermore, be noted that the HIV and AIDS Strategic Framework did prioritise cultural practices as potential risks to HIV and AIDS. This then begs the question of whether the HIV and AIDS funding portion from the government can be employed to construct culturally appropriate and context-specific HIV and AIDS interventions. This study also aimed to understand the extent to which funding from the government could dictate priority areas for HIV and AIDS prevention.

Regardless of the multi-faceted nature of HIV and AIDS, the intervention tends to be predominantly biomedical; thus, ignoring culture as the foundation on which health behaviour in general and HIV and AIDS, in particular, is expressed and through which health must be defined and understood. According to Airhihenbuwa and Webster (2004) and Nkosi, (2012), the realisation of cultural centrality to health has resulted from the need to question and examine critically the assumption inherent in western-based conventional theories, which postulates that health behaviour is a-cultural. Igulot and Magadi (2018) stress that theories and modules which focus solely on HIV risk reduction strategies (which are sexual abstinence, faithfulness to one sexual partner and consistent condom use) are rarely appropriate in addressing the underlying socio-cultural and socio-economic issues which influence vulnerability to HIV and AIDS.

Chapter 6 highlighted the importance of cultural sensitivity and cultural competence in health intervention. The chapter is grounded in Social Constructive theories and Connell's theory of gender and power on how messages regarding HIV and AIDS behaviour change should be constructed and conveyed to the intended audiences in line with their cultural identities. Michielsen et al., (2012), mention the following as non-structural but established oral channels for transmission and confirmation of communication in communities: folklore, storytelling, poetry, community role play, local songs, club formation, peer education (role modelling) and dance, as well as discussions and debates. Hence, HIV and AIDS intervention needs to be target cultural systems such as Sikenge rituals, as a way of transforming its teachings to advocate for female agency. This study proposes that interventions concerned with HIV and AIDS behaviour change should be able to locate culture in theoretical frameworks that allow flexibility when communicating HIV and AIDS prevention. The next chapter draws conclusions from this study.

CHAPTER 7: CONCLUSION

7.1 Introduction

In this conclusion chapter, the various threads to this entire dissertation are brought together. Firstly, key findings and discussions of this research in relations to the themes and the analytical framework used in the study are discussed. Secondly, the contrast between biomedical and social constructivism approach to HIV are deliberated on, with a particular focus on key issues around social cultural factors that makes women particularly vulnerable to HIV. Particular focus is also paid to whether the theories of social constructivism and Connell's theory of gender and power support the argument brought forward in this dissertation. Finally, the study will demonstrate how it contributes to academic knowledge.

This study was to exploree the extent to which dry sex and polygyny might promote the spread of HIV among women, as well as assessing whether HIV and AIDS behaviour change programmes adopted culturally appropriate and sensitive prevention strategies. The findings of this study reveal that there is a practical-knowledge gap in HIV and AIDS prevention policies and extent to which they do not speak to the realities that impact women's HIV vulnerabilities. This is despite the presence of HIV and AIDS policy frameworks that require that cultural practices that potentially perpetuate HIV, must be addressed. There appears to be a knowledge-practice gap on how to identify and integrate cultural practices of polygyny and dry sex in HIV and AIDS behavior change programmes.

Furthermore, intervention approaches that are culturally appropriate and sensitive have not been incorporated into HIV and AIDS behaviour change programmes to lessen women's vulnerability to HIV. Many studies focus on individual cognitive behavior when informing

HIV and AIDS behavior change programmes (Davis et al., 2015; Williams, & Rhodes, 2016; Hinton, 2017; Goodenow, & Gaist, 2019). However, there are very few practical studies that focuses on the inclusion of polygyny and dry sex in HIV and AIDS behavior change programmes. The research participants in this study, who work in HIV and AIDS prevention sector recounted at length the risk that polygyny and dry sex posed to HIV and particularly to women.

Connell's theory of gender and power is used to provide an understanding on the role cultural practices of polygyny and dry sex act in rendering women vulnerable to HIV (Connell, 1987). Female participants elaborated in this study how women are not consultant when subsequent wives are joining the polygynous marriage. Women and men research participants in this study also indicated men's preference for dry sex, despite women stating that the practice of drying the vagina during sexual intercourse is painful. In both incidences of polygyny and dry sex condom use was a problem. Condom are not used in polygynous marriages as stated by a male traditional healer who is married to two wives because there is trust among him and his wives. On the other hand, a mother female participant who was also married in a polygynous union noted that her husband and his young wives all succumbed to HIV. She survived the ordeal because as the eldest wife she had fallen out of husband's favor, and had to endure economic hardship. The use of condom was also indicated to be difficult when women are inserting herbs that dry the vagina. Cosma and Gurevich, (2020). alludes to social cultural practices that makes women vulnerable to HIV because of the notion that women cannot refuse sexual intercourse because of a universal masculine sex right, where men have the right to demand for sex and women assume the duty of sexually satisfying their man.

According to the theory of social constructivism, social worlds develop out of individuals' interactions with their culture and society. Cultural practices such a polygyny and dry sex becomes assimilated practices that both women and men abide to. Sikweyiya et al. (2020) therefore, argues that cultural practices, religious doctrines are not by themselves the problem, but rather in certain context it is the way thy perpetuate misogynistic values that produce and sustains abusive and violent practices against women and children. A participant in this study alluded to her sexual partner requesting that she uses herbs to dry the vagina. Cultural notions of what it entails to be a proper woman robs women from opportunities to negotiate for safe sexual practices (Kharsany & Karim, 2016).

The Namibian HIV and AIDS policy framework advocates to sensitise community members regarding harmful cultural factors that may increase the risk of HIV and AIDS. Furthermore, measures should be developed to deal with harmful cultural practices that increase the vulnerability to HIV infection. Lastly, support services and remedies are to be provided to individuals who are victimised because they have rejected harmful traditional practices (Republic of Namibia, 2017). Despite this policy recognition, there remains a policy-knowledge gap, where cultural practices such as polygyny and dry sex are not incorporated neither discussed in HIV and AIDS policy dialogue. There is also no policy plan of action that translates policy directives into tangible action to be taken to address the potential risk of HIV posed by cultural practices such a dry sex and polygyny.

One of the justifications for overlooking cultural practices that perpetuate HIV among women is because HIV tend to be viewed from a purely biomedical perspective (Thiabaud, 2020). Theories that informs HIV and AIDS prevention put emphasize on building capacity of individual self-efficacy in order for the individual to exercise their agency and take

whatever measures to protect themselves against HIV and AIDS (Davis et al., 2015; Williams, & Rhodes, 2016). The following theories have been prominent in informing HIV and AIDS prevention programmes, the Health Belief Model, the Theory of Self-regulation, Theory of Reasoned Action, Social Cognitive learning Theory, the Planned Behaviour Theory, interpersonal relations and Stages of Change Protection Motivation Theory. These theories focus on influencing behaviour on an interpersonal and personal level. Hinton, (2017) noted that HIV and AIDS behavior change programmes that focusess on cognitive constructs of behaviour, their interventions explicitly or implicitly start from the assumption that cognitions influence the person's thinking and decision making and thus drive sexual behaviour.

This biomedical perspective that informs HIV and AIDS prevention programmes is in contrast with the proposition from the social constructivism theorist that posit that individual sexual behavior is shaped by norms and attitudes within their broader social groups. It means that the individual is influenced by the society in which they reside on matters of sexuality. Hence, uniform HIV and AIDS behaviour change programmes that do not take into consideration, the uniqueness of how culture shapes individual sexuality tend to be superficial and does not delft into the cultural aspects that perpetuate HIV. By using both social constructivist theory and Connell’s theory of gender and power best explains how the structure of cathexis interplays to perpetuate women’s vulnerability to HIV.

Thus, HIV and AIDS Behaviour change theories that focus on individual cognitive processes, agency, self-efficacy and decisions tends to down play the impact of social contexts in which the induvial reside. Societal pressure and contexts do play a role in shaping human behaviour, including human sexuality. Within the biomedical sciences HIV

transmission is viewed through form of unprotected sex with an infected person (Rwafa, Shamu, & Christofides, 2019). Other forms of transmissions are attributed to blood transmission resulting from intravenous drug use, needle-stick injury and blood transfusion. Besides, HIV can also be transmitted from mother to child during pregnancy, childbirth or breastfeeding (Blanche, 2020).

Engaging in sexual relationships with older men, who are like likely to be sexually experienced and hence more, likely to be HIV-positive heightens adolescent girls and women's HIV risk. Often, intergenerational sexual relations tend to be transactional, with money or gifts given in exchange for sexual intercourse (Maher, 2020). This further inhibits the ability for sexual negotiations. As a result of these inhibiting factors, women's increased vulnerability to HIV and AIDS may be ascribed to economic dependency which places them in a particularly difficult position to act in ways that could protect them from becoming infected with HIV.

Many factors made negotiating safe sex complex for women which varies from living in a patriarchal society where women play no part in sexual decision making, the fear of possible consequences of insisting on condom use, women's inferior social position in marital relationships, cultural practices such as bride price, and gender inequality were the main barriers to practising safer sex. In societies where condom use may be associated with prostitution, promiscuity and disease, women often find it difficult to ask men to use condom out for fear of appearing promiscuous. Bond et al. (2018) described how discussions of condom use in the context of relationships that are perceived to be monogamous threaten the relationship; condoms have symbolic meanings and are indicators of infidelity and lack of trust

for some individuals. Connell's theory of gender and power best describes women's vulnerability to HIV and AIDS due to gender unequal relations.

7.2 The key issues from the various chapters in this dissertation.

Chapter one starts by highlighting the policy directives that requires that cultural and religious practices that can potentially perpetuate the spread of HIV are identified. The chapter further posit that culture and religion shape human behavior and thus dictate people's choices and lifestyles which can influence their sexual risk taking. Edwards, (2007) stated that regardless of the policy position, social cultural construction of sexuality is unexplored in Namibia. Very few studies have been conducted on the influence of cultural practices on sexuality and in particular the risk these cultural practices pose to HIV. It is hoped that this dissertation will in a humble way contribute to cultural construction of sexuality and how it perpetuates HIV through cultural practices of polygyny and dry sex.

Chapter two delved into the field of anthropology focusing on cultural practices of polygyny and dry sex and the manner in which they perpetuate women's risk to HIV and AIDS. The chapter highlighted the multiple concurrent sexual partnership of polygyny and the vaginal lesions that are caused by using herbs during sexual intercourse. Emphasize is also placed on the difficulty of condom use for women in polygynous marriages and how dry sex cause condom tearing. Ndebele, Ruzario, and Gutsire-Zinyama, (2013) explained how the practice of dry sex increases the risk of condom tearing and the increased probability that the vaginal wall will tear. Consequently, women are exposed to an even greater risk of contracting HIV, or STD infections. Gazimbi et al. (2020) also pointed out how polygynous marriages create a sexual network when new wives are introduced into the polygynous marital unions. Polygyny, therefore, amplifies risky sexual behaviours

such as sexual networking and concurrent sexual partnerships, all of which were found to be significantly associated with the risk of HIV transmission.

The chapter also discussed other social factors that makes women particularly vulnerable to HIV, such as women's economic dependence on their sexual partners, lack of knowledge about HIV and AIDS transmission particularly among the elderly. The role of HIV and AIDS behavior change programmes in prevention of HIV were also discussed. This chapter ended with the origin and history of HIV and AIDS.

Chapter three, shows the transdisciplinary nature of this study. The chapter particularly show how Connell's theory of gender and power and Vygotsky's social constructivism theory influences arguments on the inclusion of cultural practices on HIV and AIDS behavior change programmes. HIV and AIDS prevention approaches tends to be predominantly biomedical, with a focus anti-HIV vaccine; antiretrovirals, topical protection treatments; and additional biomedical and barrier approaches, such as controlling sexually transmitted diseases, number of sexual partners and male circumcision (Mayer, Skeer, & Mimiaga, 2010). Muhinda, and Pazvakawambwa, (2017) also indicated other non-medical factors that influenced HIV and AIDS such as culture, socio-economic status, and marital status. By using Connell's theory on gender and power and Vygotsky social constructivist theory, this dissertation takes a shift from a biomedical position when assessing the risk of HIV and AIDS. Airhihenbuwa and Webster (2004) and Nkosi, (2012), argues that there is a need to question and examine critically the assumption inherent in western-based conventional theories, which postulates that health behaviour is a-cultural. Igulot and Magadi (2018) stress that theories and modules which focus solely on HIV risk reduction strategies (which are sexual abstinence, faithfulness to one sexual partner and consistent

condom use) are rarely appropriate in addressing the underlying socio-cultural and socio-economic issues which influence vulnerability to HIV and AIDS, and which makes women vulnerable to HIV and AIDS. This study is guided by a feminist perspective and therefore examines how patriarchy and male dominance in sexual relations perpetuate women's HIV risk.

In this chapter a conceptual framework has been useful in providing research concepts, assumptions and beliefs that are necessary for guiding the research plan. The conceptual framework demonstrated how HIV as a biological process is perpetuated through social cultural processes such as polygyny and dry sex, thus revealing the social construction of HIV and how power and gender relations makes women vulnerable

Chapter four, lays out the methodological design used in the study. The study is qualitative, and thus explores the cultural practices of dry sex and polygyny and whether they have been incorporated into HIV and AIDS prevention programmes. The study employed focused ethnography approaches, the interviews methods where unstructured and semi-structured. Other methods used were participants observation. Focus observation also meant that the field work was short, but sufficient data was collected within that fieldwork period.

There are few epistemological assumptions in this study, firstly, cultural practices of dry sex and polygyny are indicated by research participants to be occurring in their communities. Secondly these practices are considered of social significance and some research participants advocated to retain the practices. Research participants could however also highlight the HIV vulnerabilities as a result of dry sex and polygyny. The axiological consideration in this study required we adhered to the ethical principle in executing this study. The research on cultural practices and HIV is of particular interest to the researcher,

in particular because of the cultural similarities between communities in the Zambezi region and the community of the researcher.

Chapter five, presents key findings of the study which start off by providing a description of the demographic characteristics of the participants. In-depth, face-to-face semi-structured interviewed where conducted with 33 research participants. The findings were also derived from focused observations, photographs and field notes.

It could be deduced from the findings that research participants know about the cultural practices of polygyny and dry sex. Participants could also draw linkages of the risk these practices pose for HIV. Despite their risk to HIV, there were social significant in upholding cultural practices of polygyny and dry sex. This study also revealed that men and women have different opinions regarding the cultural practices of dry sex and polygyny. Gender relations and expressions of one's sexuality plays an important role to one's exposure to HIV. This study showed that women are particularly at risk of contracting HIV as a result of polygyny and dry sex. The factors that perpetuate women's vulnerabilities are intergeneration and transactional sex, where women and girls have limited negotiations over safe sexual practices.

This chapter also indicated the hindrances experienced in incorporating polygyny and dry sex into HIV and AIDS prevention programmes. It has drawn attention to the fact that, currently, HIV and AIDS behavior change programmes were not incorporating these cultural practices.

Numerous factors contributed to this omission, and range from: Representatives from NGOs working in HIV and AIDS behavior change programmes were not aware of the policy directive that required the identification of cultural practices that perpetuated HIV;

as a result, they had not made this a priority in their work; HIV and AIDS behavior change programmes were designed at a national level, and thus did not reflect polygyny and dry sex that potentially perpetuated HIV at the regional and constituency level in the Zambezi region; HIV and AIDS behavior change programmes have been reliant on donor funding, and donors are not prioritizing dry sex and polygyny as key focus areas.

It is, however, highly commendable that National HIV and AIDS policy directives recognize that culture and religion shape human behavior and dictate people's choices and lifestyles which influence sexual risk-taking (Republic of Namibia, 2017). Hence, HIV and AIDS behavior change programmes need to incorporate those cultural practices that perpetuate HIV.

This study, furthermore, alludes to the challenges faced by NGOs that address cultural practices that perpetuate HIV, as certain individuals or segments of the community might find this offensive and intrusive to their cultural identity. Hence, it requires HIV and AIDS interventionists to be aware of such triggers and the need to be sensitive in their approach.

NGOs, such as WLC and SFH, indicated that they had experienced backlash as a result of their work on human rights violations resulting from cultural practices (/Khaxas, 2008; /Khaxas and Frank, 2010). Certain individuals in the community perceived their work as an attack on their cultural identities. More community awareness of issues around culture is needed, with the understanding that such community interventions would not be aimed at abolishing cultural practices, but rather to eliminate those aspects of the culture that perpetuate HIV. Such programmes are to be designed and implemented in close consultation with the targeted community members.

This study noted that the representatives from the various NGOs and, who were from the Zambezi region, knew about polygyny and dry sex although not all agreed that they condoned or upheld them. Thus, NGOs should be cognisant of backlash from individuals or groups of individuals in the community who might find discussions on cultural practices as an attack on their cultural identity and personhood. The potential for backlash on work done in this field of study requires caution. There is, however, a need for academic engagement in such sensitive, albeit important, discourse. To address the complexity of HIV and AIDS effectively, culture must be located at the centre of all HIV and AIDS prevention efforts through an transdisciplinary approach.

Some of the hindrances where the concern that by incorporating cultural practices in to HIV prevention programmes, it could be perceived as ,if individuals are against their own cultures, others indicated that community members where not keen to the idea of changing their own cultural practices. NGOs working in addressing cultural practices that violate women's rights and perpetuate HIV, experienced backlash from some sectors of the community.

Chapter six interrogates literature, theories and data collected for this study. The theories that inform HIV and AIDS behaviour change programmes are critiqued for their limitations in informing culturally appropriate HIV and AIDS behaviour change intervention particularly in light of dry sex and polygyny. The chapter also elaborates on the ways that cultural practices of dry sex and polygyny shape sexual relations, and argue for the need to take into consideration the social context in which the individuals are socialised when designing HIV and AIDS prevention programmes. Gender inequality, which is perpetuated through the social construction of manhood and womanhood is also highlighted as a risk to

HIV; therefore, the chapter advocates that HIV and AIDS behaviour change programmes need to transform gender relations and address social-cultural risk factors.

Chapter seven draws on the conclusion of this study. The conclusion chapter highlight some of the academic contributions this study made. In this chapter, emphasized is put on the importance of addressing gender inequality and issues of sexual power that are embedded in cultural practices that perpetuate women's HIV risk. It is therefore argued that HIV prevention programmes should relay messages that address both biomedical and socio-cultural issues that perpetuate HIV for effective programme implementation.

Chapter eight, highlights the steps needed for the inclusion of cultural practices of dry sex and polygyny in HIV and AIDS behaviour change programmes. The recommendations are reflective of the multifaceted nature of HIV prevention and the recognition that a single intervention to address HIV in not sufficient.

7.3 The Three Main Arguments

First and main argument is that socio-cultural factors that perpetuate women's vulnerability to HIV needs to be addressed. It is important to have a policy position that emphasizes on the risk that certain cultural and religious practices play in heightening women HIV risk. However, without actual strategies on how to address these cultural and religious practices these policy intentions will remain abstract.

Secondly, this chapter also argue that aspects of culture and religion that violate women's rights causes harm and denies access to resources and positions of decision-making increases women HIV vulnerability.

Thirdly, incorporating cultural and religious practices that perpetuate HIV would require that HIV implementation programmes addresses the hindrances in including them into the programme.

7.4 Contribution to academic knowledge

This study intends to make contributions to academic knowledge, by advocating for transdisciplinary theories that inform prevention behavior related to HIV and AIDS (Holman, Lynch & Reeves, 2017). Jayasinghe, (2015) and Blue et al. (2016) furthermore, argue that health is determined by the social structure as well as individual choices.

7.4.1 Importance of behaviour change programmes that are culturally sensitive

Literature shows that theories that inform HIV and AIDS behavior change programmes are focused on altering individual behavior, as opposed to group behavior, that may pose risks to contracting HIV (Kaufman et al., 2014). Such theories ignore the social context that influences the behavior of the individual. These theories which are based on cognitive abilities ignore the influence of society on the behavior of the individual and the extent to which it shapes the individual behavior. HIV and AIDS are both medical and social conditions; hence, theories need to take into consideration the broader social context and cultural practices that shape individual behavior, particularly those that perpetuate HIV. A transdisciplinary approach informed by both biomedical and social theorists is better placed to inform HIV and AIDS behavior change programmes. These theories will consider individual-perceived risks to HIV and AIDS and also the social context in which the individual lives and the way that the social context influences individual behavior.

Scientific inquiries on the relationship between HIV and AIDS and cultural practices, such as dry sex and polygyny, have not been fully incorporated into HIV and AIDS behavior change programmes. This is despite the policy frameworks that are in place. For example, women utilized herbs to dry the vagina; however, in the scientific domain, the composition

of these herbs and the risk they pose to HIV and AIDS and other STIs are not known (Doherty et al., 2014; Fahs, 2017).

By addressing aspects that perpetuate HIV, there is need to design culturally sensitive HIV and AIDS behavior change programmes that can ensure that the ethnic/cultural characteristics unique to the Zambezi region, namely their experiences, norms, values, behavioral patterns and beliefs, form part of the design, delivery, and evaluation of targeted health promotion materials and programmes (Stubbe, (2020). By providing guidance on how to design culturally sensitive HIV and AIDS behavior change programmes the knowledge-practice in the inclusion of cultural practices can be addressed.

Focusing on female sexualities and pleasure highlights the extent to which female sexuality is misconstrued and neglected, it also provides opportunities to deconstruct patriarchal power that shields the supremacy of male desire, power and control. Akinyemi, DE Wet & Odimegwu (2016) contends that so long women are not experiencing sexual pleasure it becomes a hindrance to attain their empowerment. Sexual pleasure and power are deeply connected and that for the majority of black African women, this connection is often not recognized McFadden (2003) emphasized. Instead, female sexuality continues to be linked to reproduction, and female sexual pleasure remains suppressed through vigilant cultural surveillance and patriarchal policing of women's rights and freedoms. According to Chertow, (2019) pleasure is power, and when women can reassert their feminist agency and harness their pleasure, their personal experiences become infused with a liberating political force.

7.4.1.1 The evolving nature of culture

Scholars who write about culture portray it as having the capacity to change (Dutta, 2020) Education and the opportunity to intermingle with other cultures have an altering effect on

one's cultural predisposition. HIV and AIDS behavior change programmes interventionists and custodians of culture such as traditional leaders and Sikenge instructors can provide an informed directive on the way to alter cultural practices such as polygyny and dry sex that can potentially perpetuate the spread of HIV. HIV and AIDS behavior change interventionists need to be cautious not to be dismissive about the role of cultural practices in HIV and AIDS, without the buy-in of custodians of culture.

The notion that cultural practices should not be exposed to scientific enquiry needs to be revisited. All parts of life and humanity are to be exposed to scientific enquiry. There is a concern that western theories are not appropriate for investigating African cultural practices or may not produce results that are in line with African ways of being (Idang, 2015). Perhaps the theories of scientific enquiry must be adapted to ensure that they are appropriate for informing African cultural practices.

7.4.2 HIV and AIDS behaviour change Policy and practice

The second academic contribution made in this study is the importance of understanding how policy impacts practice. There is a discrepancy between the policy directives and practice on the ground. This discrepancy is noted in the National HIV and AIDS Strategic frameworks identifying harmful cultural practices that can perpetuate HIV. However, in the Zambezi region, culturally appropriate intervention is not designed to address dry sex and polygyny. It is argued that excluding the impact of social context on individual sexual behavior can be an obstacle to HIV and AIDS prevention. Therefore, the inclusion of the social context, in particular, cultural practices such as dry sex and polygyny should become a cross-cutting theme in the construction of HIV and AIDS prevention policies.

At the level of the UN and some African countries, policy directives have been designed that require the investigation of cultural practices that perpetuate HIV (Republic of Namibia, 2017; Government of the Kingdom of Eswatini, 2018; Papua New Guinea, 2018). Despite this policy framework being in place, the mechanisms to apply these policy directives remained vague, as was noted in this study. For example, despite the policy framework being in place, none of the NGOs' representatives and research participants knew about its existence and that they had to identify cultural practices that perpetuated HIV. This shows that there were limited mechanisms in place that would help roll out the policy framework on cultural practices and their influence on HIV and AIDS. This vacuum in policy implementation has a direct effect on HIV and AIDS behavior change programmes, as there is no policy guidance on ways to incorporate cultural practices that perpetuate HIV in behavior change programmes.

7.4.3 Conducting sensitive research and presentations of findings

The third contribution to academic knowledge relates to conducting sensitive research. This study addressed the following sensitive aspects: gender, sexuality, HIV and AIDS, as well as cultural practices of polygyny and dry sex. Undertaking qualitative research on sensitive topics often raises a variety of ethical challenges. Poudel, Newland, & Simkhada, (2016) highlight the challenges that are to be expected when conducting sensitive research. They vary from appropriate questioning and accurate representation of the research participants' voices to ethical issues around informed consent, institutional ethical approval and the power relationships between the researcher and the research participants.

This study acquired ethical clearance from the University of Namibia. Permission was gained from the regional councilor's office in the Zambezi region, including the

constituency councilors in Kabbe. Furthermore, the Masubia traditional authority, including the village indunas, were also informed of the study. Finally, research participants had to sign a consent form and parents of minors signed the assents forms. Informed consent and assent forms were also translated into Silozi for ease of comprehension. They were all at liberty to withdraw from participating in the research interview process without any consequence. The sensitive nature of this study required that the interviews were conducted anonymously. Confidentiality was guaranteed to all the research participants. Given the sensitive nature of this study, the researcher was aware that each gatekeeper might respond differently when informed of the topic to be researched. Fortunately, throughout the entire research endeavor, the researcher had been received well and the research participants were cooperative and eager to share their perspectives on the matter under discussion.

The researcher was conflicted on how to present the research findings. For example, only a few NGOs were operating in the Zambezi region; furthermore, they had few staff members. Hence, the researcher was conflicted about whether to give the NGOs pseudonyms or to provide only the interviewee from these NGOs with a pseudonym or the position of the interviewee. It remains the responsibility of the researcher to conceal the identities of the research participants and institutions from where data were collected. The researcher assumed, that concealing the names of the research participants, their age and their titles in the organization, would protect their identity and no harm would have been done as a result of this study.

The field research assistants were responsible for the translations. To ensure that the assistants understood the issues under discussion and that their translations were in line with what the researcher had said, they were trained in ways to pose sensitive research questions.

7.5 Cautionary measures when studying cultural practices

With the advent of HIV and AIDS, some of the cultural practices such as dry sex, polygyny, child marriages, traditional healing practices, however, have been implicated in perpetuating the disease (Khaxas, 2008; Khaxas & Frank, 2010; Sovran, 2013; Page, 2019). In the same vein, the debates about cultural practices perpetuating HIV have been contested as stigmatising and blaming the HIV and AIDS victims (Sovran, 2013). Furthermore, the debates on African culture and HIV and AIDS were also employed to explain patterns of the disease in western society compared to that of African society, thus, oversimplifying a very complex phenomenon. According to Sovran (2013), caution must be applied when exploring the causality between culture and HIV and AIDS in Africa because there is a tendency to strip cultural practices of their meaning, societal context and historical positioning, and transform them into co-factors of the disease. In order to adhere to this position, this dissertation highlighted the social justification of dry sex and polygyny.

Chigozi and Ekechukwu, (2015) argue that the debate on HIV and AIDS and culture is complex and sensitive. Despite the complexity and sensitivity, in this study, it is argued that the debates on cultural practices, HIV and AIDS and the inclusion in behaviour change programmes warrant to be revisited. In light of the above, discussions that draw a link between cultural practices and HIV and AIDS require a great deal of cultural sensitivity. This study intends to appreciate the role and importance of each cultural practice to the community and, hopefully, advocate a position that identifies and suggests changes that maintain, and even strengthen, cultural practices, provided that the risks they pose to HIV and AIDS are eliminated.

This study discussed in detail cultural practices of dry sex and polygyny, both their pros and cons. It furthermore advocates to preserve aspects of dry sex and polygyny that is not harmful, does not perpetuate gender inequality and violate human rights. It is also hoped that this study can improve intellectual and perceptions on sensitive topics such as dry sex and polygyny to expand views regarding the importance of engaging in non-judgemental dialogues.

This study, therefore, proposes that HIV and AIDS behaviour change programmes should not advocate abolishing cultural practices without paying due diligence to their significance. There is therefore a need to distinguish between cultural practice and aspects of cultural practice that heighten HIV among women Idang (2015) argues that we try to show the relevance of African culture and values to the contemporary society but maintain that these values be critically assessed, and those found to be inimical to the well-being and holistic development of the society, be discarded. In this way, African culture and values can be revaluated, their relevance established and sustained to give credence to authentic African identity.

The intention of this study is therefore to contribute to social learning mechanisms and to hopefully also provide an understanding of the dynamics of HIV and AIDS behaviour change at both individual and group levels. Shi-xu, (2012) therefore remind non-western scholars to start an earnest investigation into unfamiliar, indigenous (especially non-Western) discourses to find a locally practical, acceptable and constructive solution. This research is therefore advocating for a culturally conscious, reflexive approach to the study of polygyny and dry sex and their risk to HIV.

CHAPTER 8: RECOMMENDATIONS

8.1 Introduction

This chapter advocates for HIV and AIDS prevention programmes that respond to socio-cultural factors that perpetuate HIV. It therefore recommends for the inclusion of polygyny and dry sex in HIV and AIDS prevention programmes. Recommendations emanating from this study are: create awareness among RACOC members and others stakeholders about the provisions in the HIV and AIDS policy frameworks and other international legal frameworks that Namibia rectified on the inclusion of cultural practices of polygyny and dry sex in HIV and AIDS prevention programmes; strengthen regional and constituency coordination mechanisms to address dry sex and polygyny in HIV and AIDS prevention programmes; Design cultural appropriate HIV and AIDS prevention programmes and finally abolish socio-cultural practices that heighten women's vulnerability to HIV and AIDS.

8.2 Awareness creation on policy directives regarding the inclusion of cultural practices in HIV and AIDS prevention programmes

The Namibian National HIV and AIDS and the National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22 (Republic of Namibia, 2007; Republic of Namibia, 2017) recognise the impact of culture on people's health. These policy frameworks acknowledge that culture shapes human behaviour and, thus, dictates people's choices and lifestyles which, subsequently, can influence their sexual risk-taking. It is therefore important to address the HIV risk of polygyny and dry sex. Integrating dry sex and polygyny in HIV and AIDS behaviour change programmes is important in the prevention strategy. Broader awareness-raising among HIV and AIDS advocates on the

provisions made in the two policy frameworks is needed, to translate these into practice. There is a need to sensitize NGO representatives, traditional healers, traditional leaders, Sikenge instructors, members of RACOC and CACOC and MoHSS on dry sex and polygyny and the risk they pose to HIV and AIDS. The National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22 are in line with UNAIDS, CEDAW and WHO guidelines regarding the inclusion of cultural practices in HIV and AIDS prevention programmes.

8.3 Strengthen regional and constituency coordination mechanisms to address dry sex and polygyny in HIV and AIDS Prevention Programmes

HIV and AIDS behaviour change programmes tends to be homogenous and thus overlook the cultural context in which individuals and communities live. Hence, there is need to strengthen the RACOC and CACOC's structures at the regional and constituency level to respond to cultural practices such as dry sex and polygyny that might perpetuate HIV. RACOC and CACOC are multi-stakeholder structures that are composed of government line ministries, NGO's, traditional healers, traditional leaders and FBOs. It is recommended that this multi-stakeholder structure also include Sikenge girl child initiation instructors. This study further recommends that cultural structures such as Sikenge girls initiation rituals and HIV and AIDS prevention programmes must strategize to find synergies of collaboration. A community engagement report by RACOC and response from sikenge girl-child instructors referred to community members requesting for the revival of cultural practices, such as Sikenge girl-child initiation rituals. One sikenge instructor was in the process of engaging the regional council to open a sikenge initiation school. It was alleged that sikenge rituals could educate girls on the value of sexual chastity and, by implication,

reduce the risk of HIV infection among them. It is thus recommended that the teaching accorded girls should be extended to boys. Such teaching should include aspects of gender transformation, where girls are taught to exercise their agency and boys are taught to perceive girls as equal partners and not subordinates.

This study recommends that Sikenge initiation rituals and HIV and AIDS behaviour change programmes should work in complementarity with each other, to harness the potential embedded in each system. For example, Sikenge initiation rites is a cultural system that is established where community members take their daughters for initiation. On the other hand, HIV and AIDS prevention programmes are government initiatives that are rolled out in the communities where Sikenge is conducted. Hence it will be in the interest of the Sikenge initiators to incorporate HIV prevention lessons into Sikenge initiation rituals. These two systems, therefore, provides opportunities for cross-fertilization of ideas in scaling up HIV prevention initiatives. Collaboration between the two structures will reduce structural resistance. Just as traditional healers have been incorporated into RACOC structures because of the recognition that people living with HIV and AIDS seek medical intervention from traditional healers, likewise Sikenge instructors should be included in RACOC as a mitigation strategy for dry sex and cultural teachings that subjugate women. These collaborations will hopefully incorporate polygyny and dry sex into HIV and AIDS behaviour change programmes.

Cultural practices that perpetuate HIV occur in communities that are under the jurisdiction of traditional leaders, constituency councillors and regional councillors. NGOs have been effective in doing grassroots work in HIV and AIDS prevention. To ensure an effective, indigenization of HIV and AIDS intervention, RACOC and CACOC multi-stakeholder structures need to be strengthened to be able to execute their duties more effectively.

The roles of CACOC and RACOC need to be emphasised to ensure that the HIV and AIDS response is culturally appropriate and context-specific. RACOC and CACOC are also better placed to identify cultural practices that can potentially perpetuate HIV, given that they are based in the regions and constituencies. NGOs that work at grassroots levels are members of both CACOC and RACOC and report to these bodies. It has been stated that CACOC positions in all the constituencies in the Zambezi region remain vacant. Given the role CACOC plays, it is in the interest of community members to revive their structures.

RACOC members should be alerted to their roles in identifying cultural practices that perpetuate HIV and designing appropriate interventions. Hence, the effective operations of RACOC are instrumental in the indigenization process of HIV and AIDS behaviour change programmes through culturally appropriate and context-specific interventions.

More importantly, the reporting mechanisms of RACOC and CACOC need to be streamlined to inform policy at the national level, within MoHSS, DSP. This would require that awareness of the importance of cultural sensitivity and context-specific HIV and AIDS prevention programmes are created at all levels of HIV and AIDS programme design. It should, furthermore, include donors, HIV and AIDS behavioural change programme designers, government entities responsible for HIV and AIDS prevention, such as the Ministry of Health and Social Services in particular the Division of Special Programmes.

To ensure an enhanced and sustained HIV and AIDS response in recognition of the epidemic as a cross-cutting and development issue, all sectors of society should mainstream and address HIV and AIDS from a cultural approach in their plans and programmes. Collaboration and sharing of experiences among stakeholders, such as donors, government entities, NGOs, traditional authorities and communities, are key principles in the design,

implementation and monitoring of an indigenised culturally appropriate HIV and AIDS prevention programme. Therefore, HIV and AIDS behaviour change intervention should be planned, implemented and evaluated in co-operation with communities, traditional leaders, traditional healers, local NGOs, Sikenge girl child instructors and other relevant organizations to take account of the circumstances that shape the individuals' sexuality within the cultural contexts.

Participants in this study alluded to the decline in funding, staff shortage and high levels of staff retrenchment that hampered the operation of HIV and AIDS behaviour change programmes. They also confirmed that community outreach programmes, such as drama, songs, poetry and dance had been scaled down as a result of the decline in donor funding. Participants indicated that donors had been reluctant to allocate funding to address cultural practices that perpetuate HIV. By strengthening the indigenization approach to HIV and AIDS behaviour change programming, cultural practices that perpetuate HIV can be identified and culturally sensitive interventions designed. Adequate financial resources should be availed to design such prevention activities at national, regional, constituency and community levels.

Disregarding how culture impacts the health-seeking behaviour and well-being of community members has a direct consequence for HIV and AIDS behaviour change programmes. For instance, health communication and promotion programmes implemented in Africa tend to undervalue the importance of oral communication as a genre of disseminating HIV and AIDS messages (Bekalu, & Eggermont, 2014). Participants alluded to theatre groups that performed drama, songs and dance in the community as part of the HIV and AIDS awareness-raising. These interventions targeted a wider audience and had greater community involvement. There has however been a downscaling of this activities as donor funding in HIV and AIDS declined.

8.4 Design cultural appropriate HIV and AIDS prevention programmes

Stubbe, (2020), indicated the following variables as important for a health intervention programme to meet cultural sensitivity criteria. The first criterion is a peripheral linguistic strategy that ensures that the message is packaged in a manner receptive and accessible to the target audience. This would entail the use of native languages and culturally sensitive scripts and contexts relatable to the programme recipients. It is thus important to use existing traditional systems to disseminate HIV and AIDS prevention messages, e.g. through the traditional authorities (khuta), Sikenge initiation structures, traditional healers. By building alliances between traditional systems and NGO's working on HIV and AIDS prevention programmes. This would require that there is a collective effort among all parties to identify cultural practices that perpetuate HIV.

HIV and AIDS prevention messages need to be packaged in a manner that is receptive and accessible to the communities of the Zambezi region. One example would be to translate prevention programmes into local dialects, such as Silozi, SiSubia, Sifwe, Siyeyi and others. By utilising native languages and culturally sensitive scripts, the HIV and AIDS prevention programmes would be relatable to the targeted audience. Furthermore, the HIV and AIDS training programmes should be reflective of the context, beliefs, norms and experiences of the people in the Zambezi region. Such prevention programmes should include aspects, such as dry sex and polygyny, which may perpetuate the risk of contracting HIV. Eliminating the risks these practices pose to contracting HIV should be prioritised.

The next criterion in a training programme is the socio-cultural strategy which requires that the HIV and AIDS prevention messages are reflective of the context, beliefs, norms, experiences and priorities of the programme recipients. Thus, by disseminating HIV and

AIDS prevention information through existing traditional structures counterproductive beliefs and norms can be identified and addressed. Caution needs to be taken that by excluding these traditional structures and their norms and belief systems in the HIV and AIDS prevention programmes, achieving the goals of eliminating HIV and AIDS will remain slow.

Dry sex heightens HIV risk due to three factors, the texture of the herbs are coarse, because of the granules, the quantity of the herbs that are inserted and the reduction of vaginal fluids during sexual intercourse. These factors lead to vaginal wall tearing, penile glans cuts and they also inhibit condom use due to condom tearing. It is recommended that HIV and AIDS prevention programmes highlight these risks factors when doing community outreach programmes.

Furthermore, polygyny also heightens HIV risk because of two factors. The factors are the introduction of new sexual partners into the polygynous marital union and unprotected sexual intercourse outside the marital union. It is therefore argued in the study that polygyny as a practice is perhaps less of a concern; but rather, the implications that men who choose to marry polygynous are also more likely to engage in extra-marital sex, raising secondary questions about such men's patterns of sexual networking and concurrent multiple-sexual relations. Furthermore, women in polygynous union who seek sexual pleasure outside the union also pose a risk to the entire system. It is therefore recommended that heightened HIV risk in polygynous marriages can be identified by controlling the variables of extra-marital affairs and duration of partnering. Therefore, it is argued that the role of polygyny in spreading the HIV epidemic should be viewed and be examined alongside multiple concurrent sexual relationships. This study, therefore, recommends that couples in polygynous marriages should strictly adhere to "zero gracing" including refraining from practising "bunyazi". This study further recommends that traditional

authorities that solemnise customary marriages including polygynous unions should issue a decree that those in the union and the new member introduced in the polygynous union should issue a negative HIV result. Thus, knowing ones HIV status including the status of all those within the polygynous marital union should be a prerequisite to enter into polygyny. By intentionally addressing those measures in dry sex and polygyny, the risks these cultural practices pose to HIV and AIDS can be addressed.

NGOs working in the field of HIV and AIDS prevention need to acquire the skills to deal with the inclusion of cultural practices that perpetuate HIV in a socially and culturally appropriate manner when engaging the communities, traditional leaders, Sikenge instructors, the Zambezi regional leadership and political leaders. This could facilitate the inclusion of cultural practices in the overall HIV and AIDS prevention policies and programmes. HIV and AIDS have to be addressed in a socially and culturally appropriate manner, with consideration of local beliefs, values and traditions to prevent the spread of the epidemic effectively. This implies that the individual(s) that informs the HIV and AIDS programme design must be from the targeted recipients. For these criteria to yield results these individuals must undergo thorough training on HIV and AIDS prevention. Furthermore, they must become advocates of change by identifying and addressing cultural practices that can potentially perpetuate HIV in the community. In the study, the majority of the representatives from the NGOs are from the Zambezi region and some have personal experiences about the cultural practices discussed in this study. Representatives from the various NGOs in the Zambezi region also articulated the risk such practices posed to HIV and AIDS. They could link the cultural practices that heightened the spread of HIV. Despite their knowledge only one NGO incorporated cultural practices that perpetuated HIV and AIDS into their programmes. The WLC is a feminist organization, hence, deliberate efforts

to address cultural practices that perpetuate gender inequality and heightens women's risk to HIV.

Given the established linkages between cultural practices of dry sex and polygyny and HIV, cultural practice that perpetuate HIV must be prioritised in behaviour change programmes and should be a central organising concept in HIV and AIDS prevention education programmes. The cultural practices that perpetuate HIV in a constituency or region should be incorporated into HIV and AIDS training programmes. Such programmes should address the risk associated with polygyny, and dry sex. HIV and AIDS prevention interventions aimed at addressing cultural practices that perpetuate HIV should aim to abolish that aspect of culture that heightens HIV.

8.5 Abolish socio-cultural factors that heighten women's vulnerability to HIV and AIDS

Several socio-cultural factors that perpetuate women's vulnerability to HIV have been identified such as submissiveness of women that is perpetuated through Sikenge girl child rituals, gender-based violence and human rights violations, women's inability to negotiate safe sex and polygyny. Cultural teaching, which incorporates corporal punishment during Sikenge training, condones gender-based violence. Furthermore, it teachers' initiates not to exercise their agencies with their husbands because initiatives are taught to avoid eye contact with the opposite sex as it is considered a sign of sexual inviting and being disrespectful or showing interest in the opposite sex. Such training perpetuates female subordination and inhibits sexual negotiations. To address these risk factors, traditional authorities and elders in the community can play a pivotal role in advocating for the elimination of cultural practices that perpetuate female submission. Furthermore, HIV and AIDS intervention

programmes aimed at addressing women's vulnerability to HIV and AIDS need to eradicate those social factors that lead to women's economic dependence on men through women's economic empowerment programmes or cash transfer programmes.

8.6 Positioning female sexual pleasure in HIV and AIDS prevention programme

Sexual pleasure is a central driver of sexual behaviour and encompasses elements of overall wellbeing. Is it therefore important that sexual pleasure be integrated into HIV and AIDS prevention programmes? Experts in human sexuality studies noted that sexual pleasure is insufficiently addressed in public health programmes including HIV and AIDS prevention programmes (Arrington-Sanders et al., 2015). They further argue that improving sexual health and wellbeing has a direct consequence of boosting sexual pleasure. HIV and AIDS behaviour change programmes tend to focus on securing sexual rights, however, sexual pleasure within the broader HIV and AIDS rights frameworks tend to be omitted.

Sexual pleasure is a very important motivation for engaging in sexual activity, a motivation that is often more important than the preservation of health. This study advocates that this reality needs to be better understood and included in sexual health promotion messages and practice. To ignore sexual pleasure in global health efforts is to present a conceptualization of sexual health that is unrealistic and disconnected from people's experiences, aspirations, and concerns, because at the bottom of it all consensual sexual intercourse is pleasurable.

In the same light, further studies need to be conducted that interrogate social notions of sexual pleasure for men and women where dry sex and polygyny is the norm. In this study women and men spoke about dry sex heightening male sexual pleasure. There was however

no reference made to female sexual pleasure, on the contrary female participants spoke about dry sex as a painful experience.

8.7 Transdisciplinary studies to assess the toxicity and medicinal properties of herbs used for dry sex

The use of herbs to dry the vagina has been indicated in the literature to be a common phenomenon globally, however, in the scientific domain, the composition of these herbs and the risks they pose to HIV and AIDS and other STIs are not known (Doherty et al, 2014; Fahs, 2017). Participants indicated that some of the herbs that women insert into their vaginas have medicinal value in treating sexually transmitted diseases (Nazer et al., 2019). Chinsembu and Hedimbi (2010) also studied traditional herbs that are used for vaginal hygiene and to treat STIs in the Zambezi region. Participants however raised the concern that some herbs have a coarse texture, which tears vaginal walls during sexual intercourse. It is therefore recommended for transdisciplinary collaboration between social sciences and biomedical sciences to assess the toxicity and medicinal properties of these herbs, in particularly the impacts on female and male sexual and reproductive health.

8.8 Conduct Knowledge Attitude and Practice studies to assess prevalence of cultural practices that perpetuate HIV.

Behaviour change programmes on HIV prevention are based on assumptions regarding how people make decisions about risks and how they respond to attempts to persuade them to change their behaviour. Sometimes these assumptions are broadly correct, but sometimes researchers have discovered significant problems with such assumptions when they are tested, particularly in contexts where culture shapes individual and group behaviour (Nkwi & Bernard, 2012; Nkosi, 2012; Sovran, 2013). Despite the knowledge that cultural practices have the potential to promote HIV and AIDS, this knowledge has not been

translated into programmes that either interrogate cultural practices or design HIV and AIDS behaviour changing culturally appropriate programmes. Most HIV and AIDS prevention programmes continue to overlook cultural practices that facilitate HIV and AIDS (Loosli, 2004; Sovran, 2013; Uwah, 2013; Page, 2019).

Mogotsi (2019), indicates that culturally appropriate education and awareness interventions are key components in altering cultural practices that potentially perpetuate the spread of HIV. With regards to women's vulnerability to HIV and AIDS, a culturally sensitive intervention must include the identification of cultural practices that condone violence against females and the violation of women's rights. The pain experienced by women during sexual intercourse when using herbs to dry the vagina is a form of violence against females and a violation of women's rights. Williams-Breault (2018) presents a similar argument regarding the eradication of female genital cutting, claiming that this practice is both a form of gender oppression and human rights violation. Furthermore, a culturally sensitive intervention must also address conservative gender and cultural norms and traditional beliefs as they are likely to encourage high sexual risk behaviour among men and women's tolerance for such behaviour. The NSA (2014) indicates that more than 10% of couples in the Zambezi region are married in polygynous unions and the Vision 2030 report has raised the concern of concurrent marital sexual partnership as an accepted sexual norm for men but not for women (Republic of Namibia, 2004). A review by Gazimbi et al. (2020) shows that polygyny heightened HIV and AIDS risks among women as it amplifies risky sexual behaviors such as sexual networking and concurrent sexual partnerships. It also diminishes women's sexual negotiation power. Miedema, (2019) argues that it is, critical to design culturally sensitive HIV and AIDS programmes that address the social

construction of gender and sexuality as these are likely to discourage polygyny and advance transformative gender equality.

Given the influence of cultural practices on HIV vulnerability, there is need for data that will inform the design of HIV and AIDS behavior change programmes that is indigenized. Data on polygyny is available through NDHS, however, there is no data on the prevalence and geographical distribution of dry sex. It is therefore recommended that KAP studies be conducted or by incorporating KAP questions in HIV sentinel surveillances and populations based and community surveys in order to identify and characterize key sites and track the extent of dry sex.

In summary, among all the participants, there was not a single participant who suggested that cultural practices of polygyny and dry sex should be discarded totally. The conversations were more directed towards ways in which to reform the cultural practices to eliminate the risks that perpetuate HIV. It is argued in this chapter that positive dimensions of African cultural practices should be encouraged and retained, given the fact that culture ought to be knowledgeably innovative and instrumentally beneficial to people in such a way that the society can move from one level of development to another. Idang (2015) and Page (2019) advocate for abolishing negative and harmful traditional practices that dehumanise people and portray them as unimproved and backward. Only the component of culture that upholds an adaptive system with those values that play a central role in giving the society its uniqueness must be retained (Loosli, 2004). It is argued in this dissertation that, given the complexity of cultural practices that perpetuate HIV, it is the prerogative of the community to distinguish between cultural practices that should be retained in their original form, reformed or discarded totally.

The role of RACOC and NGOs working in HIV and AIDS behaviour change is critical in facilitating this process to ensure that aspects of dry sex and polygyny that perpetuate HIV, as well as condoning gender inequality, social suppression and human rights violations, are highlighted and addressed. Cultural reformation is; therefore, a guided process and it should not happen in a vacuum. In this study, cultural reformation should contribute to the HIV among women in particular.

The decision, however, to abolish a harmful cultural practice must be the prerogative of the community practising it. The duties of HIV and AIDS interventionists is to create awareness on the pros and cons of cultural practices. The intention should be to make the cultural practices safe and not necessary to abolish them. This is to ensure a win-win situation where the community continues with their cultural practice and the risks associated with HIV and AIDS are abolished. Finally, the right to the cultural expression of each community has to be respected and safeguarded. This, however, should not remove the responsibility to address those cultural practices that heighten women's risk of HIV and AIDS.

REFERENCES

Abbai, N.S., Wand, H. & Ramjee, G. (2016). Biological factors that place women at risk for HIV: evidence from a large-scale clinical trial in Durban. *BMC Women's Health* 16(19). https://doi.org/10.1186/s12905-016-0295-5

Adebajo, S., Eluwa, G., Njab, J., Oginni, A., Ukwuije, F., Ahonsi, B. & Lorenc, T. 2015, 'Evaluating the effect of HIV prevention strategies on uptake of HIV counselling and testing among male most-at-risk-populations in Nigeria; A cross-sectional analysis', *Sex Transmitted Infections* 91(8), 555–560. 10.1136/sextrans-2014-051659

Adom, D., Hussein, E. K., & Agyem, J. A. (2018). Theoretical and conceptual framework: mandatory ingredients of a quality research. *International journal of scientific research* (7(1). Pp93-98

African Union (1981). African (Banjul) Charter on human and peoples' rights (adopted 27 June 1981, OAUdoc. Cab/leg/67/3 rev. 5, 21 i.l.m. 58 (1982), entered into force 21 October 1986). Banjul, Gambia.

African Union, (2005). Protocol to the African Charter on human and people's rights on the rights of women in Africa adopted by the 2nd ordinary session of the assembly of the Union Maputo, Mozambique 11th July 2003 entry into force 25th November 2005. Maputo, Mozambique.

Ahinkorah, B. O. (2021). Polygyny and intimate partner violence in sub-Saharan Africa: Evidence from 16 cross-sectional demographic and health surveys, *Population Health*, (13) https://doi.org/10.1016/j.ssmph.2021.100729.

Ajrouch, K. J. (2015). Toward a Vigorous Incorporation of Culture in the Study of Human Development, *Research in Human Development*, 12:3-4, 202-208, DOI:10.1080/15427609.2015.1068046

Akkuş, B., Postmes, T., & Stroebe, K. (2017). Community Collectivism: A social dynamic approach to conceptualizing culture. *PLoS ONE* 12(9): e0185725. https://doi.org/10.1371/journal.pone.0185725

Akinyemi, J. O., De Wet, N., & Odimegwu, C. O. (2016). Review of Sexuality Studies in Africa: Setting a New Post-2015 Research Agenda. *African Journal of Reproductive Health*. 20(1). pp. 21-28 Women's Health and Action Research Centre (WHARC).

Al-Ababneh, M., M. (2020). Linking Ontology, Epistemology and Research Methodology. *Science & Philosophy*. 8(1), pp. 75-91. DOI: 10.23756/sp.v8i1.500

Alexander, K. A., Coleman, C. L., Deatrick, J. A., & Jemott, L. S. (2012). Moving beyond safe sex to women-controlled safe sex: A concept analysis. *Journal of Advanced Nursing,* 68(8), 1858-1869. doi: 10.1111/j.1365-2648.2011.05881.

Al-Sharfi, M., Pfeffer, K., & Miller, K. A. (2016). The effects of polygyny on children and adolescents: a systematic review, *Journal of Family Studies*, 22(3), 272-286, doi: 10.1080/13229400.2015.1086405.

Andrews, M., Squire, C., & Tamboukou, M. (2013). *Doing Narrative Research*. Second Edition. DOI: https://dx.doi.org/10.4135/9781526402271

Andreychik, M. R., & Gill, M. J. (2015). Do natural kind beliefs about social groups contribute to prejudice? Distinguishing bio-somatic essentialism from bio-behavioural essentialism, and both of these from entitativity. *Group Processes & Intergroup Relations*, 18(4), 454–474. https://doi.org/10.1177/1368430214550341

Anyolo, P. (2008). *Polygyny among the Ovambandja: A female perspective*. In *Women and custom in Namibia: Cultural Practice versus Gender Equality?* In O. C. Ruppel, (Ed.). Human Rights and Documentation Centre. Windhoek.

Anokye, R., Acheampong, E., Budu-Ainooson, A., Obeng, E. I., Tetteh, E., Acheampong, Y. S., & Nettey-Marbell, C. E. (2019). Knowledge of HIV and AIDS among older adults (50 years and above) in a peri-urban setting: a descriptive cross-sectional study. *BMC Geriatr* 19, 304. https://doi.org/10.1186/s12877-019-1335-4

Austin, K. F., Choi, M. M., & Berndt, V. (2017). Trading sex for security: Unemployment and the unequal HIV burden among young women in developing nations. *International Sociology*, 32(3), 343–368. https://doi.org/10.1177/0268580917693172

Ba', S. (2021). The critique of Sociology of Childhood: Human capital as the concrete 'social construction of childhood.' *Power and Education*, 13(2), 73–87. https://doi.org/10.1177/17577438211011637

Baffour, A. (2019, March, 13). *"We deliberately spread AIDS in South Africa"*. NewAfrican. Retrieved: https://newafricanmagazine.com/18285/

Bame, R., Wiysonge, C. S., & Kongnyuy, E. J. (2018). Female condoms for preventing HIV and sexually transmitted infections. *Cochrane Database Syst Rev*., (2). doi: 10.1002/14651858.CD003652.pub3.

Bandura, A. (2000). Health promotion from the perspective of social cognitive theory. In P. Norman, C. Abraham & M. Conner (Eds.). *Understanding and changing health behaviour: From health beliefs to self-regulation*. (299-339). Amsterdam, The Netherlands: Harwood Academic Publishers.

Bandura, A. (2012). On the Functional Properties of Perceived Self-Efficacy Revisited. *Journal of Management*, 38(1), 9–44. https://doi.org/10.1177/0149206311410606

Banks, N., Hulme, D., & Edwards, M. (2015). NGOs, States, And Donors Revisited: Still Too Close for Comfort? *World Development,* (66), 707-718.

Bashir, N. (2018). Doing research in people's homes: Fieldwork, ethics and safety – on the practical challenges of researching and representing life on the margins. *Qualitative Research. Sage,* 18(6). 638–653. doi:org/10.1177/1468794117731808

Bazeley, P. (2013). *Qualitative Data Analysis: Practical Strategies*. London: SAGE.

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of Biomedical Ethics*. (7th Ed.) Oxford: Oxford University Press.

Becerra, J. C., Bildstein, L. S., & Gach, J. S. (2016). Recent Insights into the HIV AND AIDS Pandemic. *Microbial cell (Graz, Austria)*, *3*(9), 451–475. https://doi.org/10.15698/mic2016.09.529

Bekalu, M. A., & Eggermont, S. (2014). Aligning HIV AND AIDS Communication with the Oral Tradition of Africans: A Theory-Based Content Analysis of Songs' Potential in Prevention Efforts. *Health Communication* 30(5). DOI:10.1080/10410236.2013.867004

Benedict, L. A. (2017). Polyandry around the World. *Social and Cultural Anthropology Commons.* Available at: https://digitalscholarship.unlv.edu/award/28

Bergen, N. (2018). Narrative Depictions of Working with Language Interpreters in Cross-Language Qualitative Research. *International Journal of Qualitative Methods*. https://doi.org/10.1177/1609406918812301

Bhana, D., & Anderson, B. (2013). Desire and constraint in the construction of South African teenage women's sexualities. *Sexualities,* 16(5/6), 548-64.

Biruk, C. (2020). The invention of 'Harmful Cultural Practices' in the Era of AIDS in Malawi. *Journal of Southern African Studies*, 46(2). 339–356, https://doi.org/10.1080/03057070.2020.1723341

Blanche, S. (2020). Mini-review: Prevention of mother-child transmission of HIV: 25 years of continuous progress toward the eradication of pediatric AIDS, *Virulence*, (11:1), 14-22, DOI: 10.1080/21505594.2019.1697136

Blue, S., Shove, E., Carmona, C., & Kelly, M. P. (2016). Theories of practice and public health: understanding (un)healthy practices, *Critical Public Health,* 26(1), 36-50, DOI: 10.1080/09581596.2014.980396

Bond, K. T., Frye, V., Cupid, M., Lucy, D., & Koblin, B. A. (2018). HIV-Related Communication and Safe Sex Practices among Heterosexual Black Men: *A Qualitative Report. Journal of black sexuality and relationships,* 4(3), 10.1353/bsr.2018.0001. https://doi.org/10.1353/bsr.2018.0001

Bordini, G., S, & Sperb, T., M. (2013). Sexual double standard: A review of the literature between 2001 and 2010. *Sexuality and Culture*.17:686–704.

Boyle, P. (2002). Population Geography: Transnational Women on the Move, *Progress in Human Geography,* 26(4), 531-543.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), 77-101.

Bruce, A., Beuthin, R., Sheilds, L., Molzahn, A., & Schick-Makaroff, K. (2016). Narrative Research Evolving: Evolving Through Narrative Research. *International Journal of Qualitative Methods*. https://doi.org/10.1177/1609406916659292

Busetto, L., Wick, W. & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurol. Res. Pract*. 2(14) https://doi.org/10.1186/s42466-020-00059-z

Carlson, Å. (2016) Sex, Biological Functions and Social Norms: A Simple Constructivist Theory of Sex, *NORA - Nordic Journal of Feminist and Gender Research*, 24:1, 18-29, DOI: 10.1080/08038740.2015.1136681

Carmody, M., & Ovenden, G. (2013). "Putting Ethical Sex into Practice: Sexual Negotiation, Gender and Citizenship in the Lives of Young Women and Men." *Journal of Youth Studies* 16: 792–807.

Cense. M. (2019). Rethinking sexual agency: proposing a multicomponent model based on young people's life stories, *Sex Education*, 19:3, 247-262, DOI: 10.1080/14681811.2018.1535968.

Charurat, M. E., Emmanuel, B., Akolo, C., Keshinro, B., Nowak, R. G., Kennedy, S., Orazulike, I., Ake, J., Njoku, O., Baral, S., Blattner, W., TRUST Study Group. (2015). *J Acquir Immune Defic* 1(68) Suppl 2:S114-23.

Chen, Y., Bruning, E., Rubino, J., & Eder, S. E. (2017). Role of female intimate hygiene in vulvovaginal health: Global hygiene practices and product usage. *Women's Health,* 58–67. https://doi.org/10.1177/1745505717731011

Chertow, S. (2019). "*Understanding Sexual Pleasure and Health: A Study of Urban Middle-Class Women's Narratives in New Delhi, India*" Independent Study Project (ISP) Collection. 3073. https://digitalcollections.sit.edu/isp_collection/3073

Chinsembu, K., C & Hedimbi, M. (2010). An ethnobotanical survey of plants employed to manage HIV AND AIDS opportunistic infections in Katima Mulilo, Caprivi region, Namibia. *Journal of Ethnobiology and Ethnomedicine,* 6(25), doi: http://www.ethnobiomed.com/content/6/1/25

Chigozi, O. C., & Ekechukwu, R. (2015). Relationship between cultural practices and HIV and AIDS transmission in River State, Nigeria. *European Journal of Research in Social Sciences.* 3 (3). Pp.2056-5429

Cislaghi, B., & Heise, L. (2020). Gender norms and social norms: differences, similarities and why they matter in prevention science. *Sociology of Health and Illness*. 42(2). 407-422. https://doi.org/10.1111/1467-9566.13008

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26(2), 120-123.

Cohen, M. S., Council, O. D., & Chen, J. S. (2019). Sexually transmitted infections and HIV in the era of antiretroviral treatment and prevention: the biologic basis for epidemiologic synergy. *Journal of the International AIDS Society, 22 Suppl 6*(Suppl 6), e25355. https://doi.org/10.1002/jia2.25355

Collins, C. S., & Stockton, C. M. (2018). The Central Role of Theory in Qualitative Research. *International Journal of Qualitative Methods*. https://doi.org/10.1177/1609406918797475

Colvin C. J. (2017). Gender, Health and Change in South Africa: Three Ways of Working with Men and Boys for Gender Justice. *Recherches sociologiques et anthropologiques : RS & A*, *48*(1), 109–124.

Commonwealth Law Bulletin. (2005). Law reform and development commission of Namibia report on customary law marriages, Commonwealth Law Bulletin, 31(1), 105-116. doi:10.1080/03050718.2005.9986671

Connell, R. W. (1987). *Gender and power.* Stanford: Stanford University Press.

Connell, R. W. (1995). *Masculinities*. Berkeley: University of California Press.

Connor, S. (1987). AIDS: Mystery of the Missing Data; AIDS: Science Stands on Trial. *New Scientist*, 116(19), 49-58.

Conrad, P., & Barker, K. K. (2010). The Social Construction of Illness: Key Insights and Policy Implications. *Journal of Health and Social Behaviour.* 51(S) S67–S79 DOI: 10.1177/0022146510383495.

Conroy, A., McGrath, T., van Rooyen, H., Hosegood, V., Johnson, M. O., Fritz, K., Marr, A., Ngubane, T., & Darbes, L. A. (2016). Power and the association with relationship quality in South African couples: Implications for HIV AND AIDS interventions. *Social Science and Medicine,* 153, 1-11.

Convention on the Elimination of All Forms of Discrimination against Women (2007). 37th Session: Concluding Comments of the Committee on the Elimination of Discrimination against Women, Namibia, CEDAW/C/NAM/CO/3 (2 February 2007). Available from undocs.org/cedaw/c/nam/co/3.

Cosma, S., & Gurevich, M. (2020). Securing sex: Embattled masculinity and the pressured pursuit of women's bodies in men's online sex advice. *Feminism & Psychology*, 30(1), 42–62. https://doi.org/10.1177/0959353519857754

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches.* (3rd ed.). Thousand Oaks, CA: Sage.

Cross, R. (2012). *Psychology: The Science of Mind and Behaviour*. Hodder Education.

Da Silva Nascimento, L & Steinbruch, F., K. (2019). "The interviews were transcribed", but how? Reflections on management research. *RAUSP Management Journal* pp. 413-429 54 (4) DOI 10.1108/RAUSP-05-2019-0092

Davis, R., Campbell, R., Hildon, Z., Hobbs, L., & Michie, S. (2015). Theories of behaviour and behaviour change across the social and behavioural sciences: a scoping review. *Health psychology review*, 9(3), 323–344. https://doi.org/10.1080/17437199.2014.941722

de Vasconcelos, S., Toskin, I., Cooper, B., Chollier, M., Stephenson, R., Blondeel, K., (2018). Behaviour change techniques in brief interventions to prevent HIV, STI and unintended pregnancies: A systematic review. *PLoS ONE* 13(9): e0204088. https://doi.org/10.1371/journal.pone.0204088.

de Vries, J., Landouré, G., & Wonkama, A. (2020). Stigma in African genomics research: Gendered blame, polygamy, ancestry and disease causal beliefs impact on the risk of harm. *Social Science & Medicine*. (258) https://doi.org/10.1016/j.socscimed.2020.113091

Dierickx, S., Coene, G., Jarju, B., & Longman, C. (2019). Women with infertility complying with and resisting polygyny: an explorative qualitative study in the urban Gambia. *Reproductive Health*. 16 (103). Pp. 1-11 https://doi.org/10.1186/s12978-019-0762-

Dlamini, B. T., & Shongwe, M. C. (2020). Barriers to Female Condom Use among Undergraduate Health Science Students: Barriers to female condom use in Eswatini. *Africa Journal of Nursing and Midwifery*, *22*(1), 16 pages. https://doi.org/10.25159/2520-5293/6530

Doherty, K. E., Anahtar, M., Ghebremichael, M., Thogabekale, C., Padavattan, N., Dong, K., Walker, B. D., Ndung'u, T. and Kwon S. D. (2014). Effects of Intra-vaginal Drying Agents on Mucosal Immune Activation and Risk for HIV Acquisition in South African Women. *AIDS Research and Human Retroviruses.* (30) S1. doi.org/10.1089/aid.2014.5506.abstract

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, 13(3). 7-21. doi: 10.7748/nr2006.04.13.3.7.c5975 reflections on progress in the HIV AND AIDS epidemic. *American Journal of Public Health*, 97, 13-8.

Dreher, J. (2016). The Social Construction of Power: Reflections Beyond Berger/Luckmann and Bourdieu. *Cultural Sociology*, 10(1), 53–68. https://doi.org/10.1177/1749975515615623

Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntryre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*, 363, 1415-1421.

Dutta, M. (2020). *Communication, Culture and Social Change Meaning, Co-option, Resistance.* Palgrave Studies in Communication for Social Change. Doi 10.1007/978-3-030-26470-3_1

Eastment, M. C., & McClelland, R. S. (2018). Vaginal microbiota and susceptibility to HIV. AIDS (London, England), 32(6), 687–698. https://doi.org/10.1097/QAD.0000000000001768

Edwards, L. (2007). HIV and AIDS, Gender and Sexuality: Socio-cultural impediments to Women's Sexual and Reproductive Autonomy. In S. LaFont & D. Hubbard (Eds.). *Unravelling taboos, Gender and sexuality in Namibia*. Windhoek, Namibia: Legal Assistance Centre.

Edwards-Jauch, L. (2010). Gender-based violence and masculinity in Namibia: A structuralist framing of the debate. *Journal for Studies in Humanities and Social Sciences,* 5(1), 49-62.

Edwards, R. & Holland J. (2013). *What is qualitative interviewing?* Bloomsbury. Online

Ehiri, J. E., Iwelunmor, J., Iheanacho, T., Blackstone, S., Obiefune, M. C., Ogidi, A. G., Ahunanya, F. U., Nnadi, D., Patel, D., Hunt, A. T., & Ezeanolue, E. E. (2016). Using a Cultural Framework to Understand Factors Influencing HIV Testing in Nigeria. *International Quarterly of Community Health Education*, 37(1), 33–42. https://doi.org/10.1177/0272684X16685258

Endendijk, J. J., van Baar, A. L., & Deković, M. (2020). He is a Stud, She is a Slut! A Meta-Analysis on the Continued Existence of Sexual Double Standards. Personality and Social Psychology Review, 24(2), 163–190. https://doi.org/10.1177/1088868319891310

Ekerbiçer, H. Ç., Resim, S., Efe, E., Bahar, M. R., Altunören, Ö., Küçükdurmaz, F., & Benlioğlu, C. (2016). A Comparison of Sexual Function, Psychological Status, and Sociodemographic Characteristics of Turkish Men within Polygamous and Monogamous Marriages. *Balkan Medical Journal*, 33(4), 383–389. https://doi.org/10.5152/balkanmedj.2016.16459

Elliott, C. M. A., & Martin, J. M. A. (2013). Developing and Establishing a good Rapport. *Information Outlook* (Online), 17(2), 32-33.

Erastus, F., K. & Harosh, E., H. (2020). Global and local hybridity in African youth language practice. African Development, Vol. XLV. 3. Pp13-32. *Counsel for the Development of Social Science Research in Africa.*

Erulkar, A. (2013). Early marriage, marital relations and intimate partner violence in Ethiopia. *Int Perspect Sex Reprod Health*. 39 (1): 6-13.

Fahs, B. (2017). Slippery desire: Women's qualitative accounts of their vaginal lubrication and wetnesss. *Feminism & Psychology,* 27(3), 280–297. https://doi.org/10.1177/0959353516674239

Faini, D., Hanson, C., Baisley, K., Kapiga, S., & Hayes. R. (2020) Sexual behaviour, changes in sexual behaviour and associated factors among women at high risk of HIV participating in feasibility studies for prevention trials in Tanzania. *PLoS ONE* 15(4): e0231766. https://doi.org/10.1371/journal.pone.0231766

Fard, H. D. (2012). Research paradigms in public administration. *International Journal of Humanities,* 19, (4), pp.55-108.

Fay, H., Baral, S.D., Trapence, G., Motimedi, F., Umar, E., Iipinge, S., Dausab, F., Wirtz, A., & Beyrer, C. (2011). 'Stigma, health care access, and HIV knowledge among men who have sex

with men in Malawi, Namibia, and Botswana', *AIDS and Behaviour* 15(6), 1088–1097. 10.1007/s10461-010-9861-2

Ferguson, J. (2015). *Give a man a fish: Reflections on the new politics of distribution.* Durham, NC: Duke University Press.

Fladseth, K., Gafos, M., Newell, M. L., & McGrath, N. (2015). The Impact of Gender Norms on Condom Use among HIV-Positive Adults in KwaZulu-Natal, South Africa. *PLOS ONE* 10(6): e0129637. https://doi.org/10.1371/journal.pone.0129637

Fleming, P. J., Andes, K. L., DiClemente, R. J. (2013) 'But I'm not like that': young men's navigation of normative masculinities in a marginalised urban community in Paraguay. *Culture, Health & Sexuality*. 15(6):652–666

Fleming, P., DiClemente, R., & Barringtons, C. (2016). Masculinity and HIV: Dimensions of masculine norms that contribute to men's HIV-related sexual behaviours. *AIDS and Behaviour*, 20(4), 788–798.

Flicker, S., & Gut, A. (2008). Ethical approaches to adolescent participation in sexual health research. *J Adolescent Health*. 42(1):3-10. doi: 10.1016/j.jadohealth.2007.07.017

Ford, J. V., Vargas, E. C., Finotelli Jr, I., Fortenberry, J. D., Kismödi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2019). Why Pleasure Matters: Its Global Relevance for Sexual Health, Sexual Rights and Wellbeing. *International Journal of Sexual Health*. 31(3). Pp. 217-230 DOI: https://doi.org/10.1080/19317611.2019.1654587

Foucault, M. (1978). *The history of sexuality, Vol. 1. An introduction*. New York: Pantheon.

Frank, L. (2015). Namibia Non-Governmental Organisations' Forum Trust NGO Shadow Report to the Namibia Fourth and Fifth Periodic Report to the CEDAW Committee Focus: Harmful Cultural Practices in Namibia for Submission to the United Nations CEDAW Committee. Namibia Non-Governmental Organisations' Forum Trust NGO, Windhoek, Namibia.

Frew, P. M., Parker, K., Vo, Haley, D., O'Leary, A., Diallo, D. D., Golin, C. E., Kuo, I., Soto-Torres, L., Wang, J., Adimora, A. A., Randall, L. A., del Rio, C., Hodder, S & the HIV Prevention Trials Network 064 (HTPN) Study Team. (2016). Socioecological factors influencing women's HIV risk in the United States: qualitative findings from the women's

HIV Sero Incidence study (HPTN 064). BMC Public Health 16, 803. https://doi.org/10.1186/s12889-016-3364-7

Friese, S. (2014). *Qualitative data analysis with ATLAS.ti* (2nd Ed.). London, UK: SAGE.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report,* 20(9). 1408-1416.

Gagnon, J. H., & Simon. W. (1973). *Sexual Conduct: The Social Origins of Human Sexuality*. Chicago: Aldine.

Galbin, A. (2014). An Introduction to Social Constructionism. *Social Research Reports*. 26. 82-92.

Ganle, J. K. (2015). *Hegemonic Masculinity, HIV AND AIDS Risk Perception, and Sexual Behaviour Change Among Young People in Ghana*. Qualitative health research.

Gaolathe, T., Wirth, K. E., Holme, M. P., (2016). Botswana's progress toward achieving the 2020 UNAIDS 90-90-90 antiretroviral therapy and virological suppression goals: a population-based survey. *Lancet HIV* (3): e221–30.

Garcia, M, & Moore, C. (2012). *The cash dividend: the rise of cash transfer programs in Sub-Saharan Africa.* DOI: 10.1596/978-0-8213-8897-6. The World Bank, Washington DC.

Gazimbi, M. M., Magadi, M. A., Onyango-Ouma, W., Walker, E., Cresswell, R. B., Kaseje, M., & Wafula, C. O. (2020). Is polygyny a risk factor in the transmission of HIV in sub- Saharan Africa? A systematic review. *African Journal of Reproductive*. 24 (4): 198-212. DOI: 10.29063/ajrh2020/v24i4.20

Geldsetzer, P., Francis, J. M., Ulenga, N, Sando, D., Lema, I, A., Vaikath, M., Koda, H., Lwezaula, S., Hu, J., Noor, R. A., Olofin, I., Larson, E., Fawzi, W., & Bärnighausen, T. (2017). The impact of community health worker-led home delivery of antiretroviral therapy on virological suppression: A non-inferiority cluster-randomized health systems trial in Dar-es-Salaam, Tanzania. *BMC Health Service Research,* 17(1). https://doi.org/10.1186/s12913-017-2032-7

Gender Links Policy Brief. (2013). *Women's rights and polygyny*. Johannesburg, South Africa

Gentles, S. J., Charles, C., Ploeg, J., & McKibbon, K. (2015). Sampling in Qualitative Research: Insights from an Overview of the Methods Literature. *The Qualitative Report*, 20(11), 1772-1789.

George, G., Maughan-Brown, B., Beckett, S., Evans, M., Cawood, C., Khanyile, D., Govender, Ayesha, K., & Kharsany, B. M. (2019). Coital frequency and condom use in age-disparate partnerships involving women aged 15 to 24: evidence from a cross-sectional study in KwaZulu-Natal, South Africa. *BMJ Open* ;9:e024362. doi: 10.1136/BMJ open-2018-024362

Gleadle, K. (2013). The Imagined Communities of Women's History: Current debates and emerging themes, a rhizomatic approach. *Women's History Review*, 22(4), 524-540, doi: 10.1080/09612025.2012.751766.

Global Advisory Board for Sexual Health and Wellbeing. (2016). A working definition of sexual pleasure. Retrieved from http://www.gab-shw.org/our-work/working-definition-of-sexual-pleasure/

González-Alcaide, G., Menchi-Elanzi, M., Nacarapa, E. & Ramos-Rincón, J. M. (2020). HIV AND AIDS research in Africa and the Middle East: participation and equity in North-South collaborations and relationships. *Global Health* 16, 83. https://doi.org/10.1186/s12992-020-00609-9

Goodenow, M, & Gaist, P. (2019). Importance of HIV AND AIDS-Related Behavioural and Social Sciences Research at the NIH and Beyond, *JAIDS Journal of Acquired Immune Deficiency Syndromes*: 82 - p S84-S87 doi: 10.1097/QAI.0000000000002163

Government of the Kingdom of Eswatini. (2018). *The National Multi-sectoral HIV and AIDS Strategic Framework 2018-2023*.National Emergency Response Council on HIV and AIDS.

Graham, S. M., Micheni, M., Secor, A., van der Elst, E. M., Kombo, B., Operario, D., Amico, K. R., Sanders, E. J., & Simoni, J. M. (2018). HIV care engagement and ART adherence among Kenyan gay, bisexual, and other men who have sex with men: a multi-level model informed by qualitative research. *AIDS care*, *30*(sup5), S97–S105. https://doi.org/10.1080/09540121.2018.1515471

Greco, J. (2013). "Gender: A Social Construction," *Sociological Imagination: Western's Undergraduate Sociology Student Journal*: 2(2), Article 8.

Greene-Moton, E., & Minkler, M. (2020). Cultural Competence or Cultural Humility? Moving Beyond the Debate. *Health Promotion Practice,* 21(1), 142–145. https://doi.org/10.1177/1524839919884912

Guillemin, M., Barnard, E., Allen, A., Stewart, P., Walker, H., Rosenthal, D., & Gillam, L. (2018). Do Research Participants Trust Researchers or Their Institution? Journal of Empirical Research on Human Research Ethics, 13(3), 285–294. https://doi.org/10.1177/1556264618763253

Guo, Y. (2019). Sexual Double Standards in White and Asian Americans: Ethnicity, Gender, and Acculturation. *Sexuality & Culture* 23, 57–95. https://doi.org/10.1007/s12119-018-9543-1

Gurung, J. B. (2012). Rapid Cultural Change: A Case Study of Polyandry Marriage System among the Gurung Community from Upper Mustang, Nepal. *Dhaulagiri Journal of Sociology and Anthropology* Vol. 6, pp. 75-105.

Haffejee, F., & Maharajh, R. (2019). Addressing Female Condom Use among Women in South Africa: A Review of the Literature, 31(3), 297-307, DOI: 10.1080/19317611.2019.1643813

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. (3rd Ed.) London and New York: Routledge.

Hargons, C. N., Mosley, D. V., Meiller, C., Stuck, J., Kirkpatrick, B., Adams, C., & Angyal, B. (2018). "It Feels So Good": Pleasure in Last Sexual Encounter Narratives of Black University Students. *Journal of Black Psychology*, 44(2), 103–127. https://doi.org/10.1177/0095798417749400

Harring, S. L., & Odendaal, W. (2012). *"God stopped making land", Land rights, conflict and law in Caprivi region.* Legal Assistance Centre, Windhoek.

Harrison, R., Walton, M., Chauhan, A. Manias, E., Chitkara, U., Latanik, M., & Leone, D. (2019). What is the role of cultural competence in ethnic minority consumer engagement? An analysis in community healthcare. *Int J Equity Health* 18, 191. https://doi.org/10.1186/s12939-019-1104-1

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., on behalf of the Gender Equality, Norms, and Health Steering Committee. (2019). Gender

Equality, Norms, and Health 1 Gender inequality and restrictive gender norms: framing the challenges to health *Lancet*; 393: 2440–54. DOI:org/10.1016/ S0140-6736(19)30652-X

Higgins, J. A., & Hirsch, J. S. (2008). Pleasure, power, and inequality: incorporating sexuality into research on contraceptive use. *American journal of public health*, 98(10), 1803–1813. https://doi.org/10.2105/AJPH.2007.115790

Higginbottom, G. M., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report*, 18(9). 1 - 6. Retrieved from http://nsuworks.nova/tqr/vol18/iss9/1 on 27 November 2019

Hinton, P. (2017). Implicit stereotypes and the predictive brain: cognition and culture in "biased" person perception. *Palgrave Commun* 3, 17086. https://doi.org/10.1057/palcomms.2017.86

Hogg, R., Nkala, B., Dietrich, J., Collins, A., Closson, K., Cui, Z., Kanters, S., Chia, J., Barhafuma, B., Palmer, A., Kaida, A., Gray, G., & Miller, C. (2017). Conspiracy beliefs and knowledge about HIV origins among adolescents in Soweto, South Africa. *PLoS One.* 12(2). doi: 10.1371/journal.pone.0165087

Holman, D., Lynch, R., & Reeves, A. (2017). How do health behaviour interventions take account of social context? A literature trend and co-citation analysis. Health. London. 22(4). 389-410. https://doi.org/10.1177/1363459317695630

Holmes, A. & Darwin, G. (2020). "Researcher Positionality - A Consideration of Its Influence and Place in Qualitative Research - A New Researcher Guide." *Shanlax International Journal of Education*, 8(4). pp. 1-10 https://doi.org/10.34293/ education.v8i4.3232

Homolar, A., & Rodríguez-Merino, P. A. (2019). Making sense of terrorism: a narrative approach to the study of violent events. *Critical Studies on Terrorism* 12(4), pp. 561-581.

Höppner, G. (2017). Rethinking Socialization Research through the Lens of New Materialism. *Frontiers in Sociology*. doi.org/10.3389/fsoc.2017.00013

Hubbard, D. (2000). *Why the Law on Sodomy should be Repealed*? Legal Assistance Centre, Windhoek.

Hunter, M. (2015). The political economy of concurrent partners: Toward a history of sex-love-gift connections in the time of AIDS. Review of African Political Economy 42(145): 362–375.

Hvenegård-Lassen, K., Staunæs, D., & Lund, R. (2020). Intersectionality, Yes, but How? Approaches and Conceptualizations in Nordic Feminist Research and Activism, *NORA - Nordic Journal of Feminist and Gender Research*, 28:3, 173-182, DOI: 10.1080/08038740.2020.1790826

Idang, G., E. (2015). African culture and values. Phronimon, 16(2), 97-111 *Phronimon*

Jacobson. D., Glazer, E., Mason, R., Duplessis, D., Blom, K., Du Mont, J., Jassal, N., & Einstein, G. (2018). The lived experience of female genital cutting (FGC) in Somali-Canadian women's daily lives. PLoS ONE 13(11): e0206886. https://doi.org/10.1371/journal.pone.0206886

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of basic and clinical pharmacy*, 5(4), 87–88. https://doi.org/10.4103/0976-0105.141942

Jansen, N. A., & Agadjanian, V. (2020). Polygyny and Intimate Partner Violence in Mozambique. *Journal of family issues*, 41(3), 338–358. https://doi.org/10.1177/0192513x19876075

Jayasinghe, S. (2015). Social determinants of health inequalities: towards a theoretical perspective using systems science. *Int J Equity Health* 14(71). https://doi.org/10.1186/s12939-015-0205-8

Jewkes R, & Morrell R. (2010). Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. J *Int AIDS Soc.*;13:6.

Jewkes, R., Morrell, R., Hearn, J., Lundqvist, E., Blackbeard, D., Lindegger, G., Quayle, M., Sikweyiya, Y., & Gottzén, L. (2015). Hegemonic masculinity: combining theory and practice in gender interventions. *Culture, Health & Sexuality,* 17(sup2), 96–111. doi: 10.1080/13691058.2015.1085094.

Joe-Ikechebelu, N. N., Azuike, E. C., Nwankwo, B. E., Ezebialu, I. U. , Ngene, W. O., & Eleje, G. U. (2019). HIV prevention cascade theory and its relation to social dimensions of health: a case for Nigeria. *HIV AND AIDS-Research and Palliative Care*. (11). pp 193—200. https://doi.org/10.2147/HIV.S210190

Joint United Nations Programme on HIV AND AIDS. (2019a). *UNAIDS data,* UNAIDS, Geneva.

Joint United Nations Programme on HIV AND AIDS. (2019b). *Communities at the centre defending rights breaking barriers reaching people with HIV services*, UNAIDS, Geneva.

Jong, Y., O. & Jung, C. K. (2015). The Development of Interview Techniques in Language Studies: Facilitating the Researchers' Views on Interactive Encounters. *English Language Teaching*; 8(7). Pp. 30-39. doi:10.5539/elt.v8n7p30

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic scoping review. *BMC health services research*, 18(1), 232. https://doi.org/10.1186/s12913-018-3001-5

Johnson, A. T. (2014). Performing and defying gender: An exploration of the lived experiences of women higher education administrators in sub-Saharan Africa. *Educational Management Administration & Leadership,* 42(6), 835–850. https://doi.org/10.1177/1741143214523014

Kalra, G., & Bhugra, D. (2013). Sexual violence against women: Understanding cross-cultural intersections. Indian journal of psychiatry, 55(3), 244–249. https://doi.org/10.4103/0019-5545.117139

Kanda, L., & Mash, R. (2018). Reasons for inconsistent condom use by young adults in Mahalapye, Botswana. African journal of primary health care & family medicine, 10(1), e1–e7. https://doi.org/10.4102/phcfm.v10i1.1492

Kalvelage, L., Revilla Diez, J. & Bollig, M. (2021). Do Tar Roads Bring Tourism? Growth Corridor Policy and Tourism Development in the Zambezi region, Namibia. European Journal of Development Research. https://doi.org/10.1057/s41287-021-00402-3

Karpov, A. O. (2016). *Socialization for the Knowledge Society*. *International Journal 0f Environmental & Science Education.* 11(10). 3487-3496.

Kashima, Y. (2014). How can you capture cultural dynamics? *Frontiers in psychology*, 5, 995. https://doi.org/10.3389/fpsyg.2014.00995

Kaufman, M. R., Cornish, F., Zimmerman, R. S. & Johnson, B. T. (2014). Health behaviour change models for HIV prevention and AIDS care: Practical recommendations for a multi-level approach. *Journal of Acquired Immune Deficiency Syndromes,* 66(3), 250-258. https://doi.org/10.1097/ QAI.0000000000000236

/Khaxas, E. & Frank, E. (2010). *Violence is not our culture: Women claiming their rights in the Caprivi region*. Windhoek, Namibia: Women Leadership Centre.

/Khaxas, E. (2008). *We must choose life: Writings by Namibian women on culture, violence, HIV and AIDS*. Windhoek, Namibia: Women's Leadership Centre.

Kharsany, A. B. M., & Karim, Q. (2016). HIV Infection and AIDS in Sub-Saharan Africa: Current Status, Challenges and Opportunities. *Open AIDS Journal,* 10, 34-48. doi:10. 2174/1874613601616001003‌4

Khosla, R., Banerjee, J., Chou, D., Say, L., & Fried, S. T. (2017). Gender equality and human rights approach to female genital mutilation: a review of international human rights norms and standards. *Reproductive health,* 14(1), 59. https://doi.org/10.1186/s12978-017-0322-5

Khumalo, S., Taylor, M., Makusha, T., Mabaso, M. (2020). Intersectionality of cultural norms and sexual behaviors: a qualitative study of young Black male students at a university in KwaZulu-Natal, South Africa. *Reprod Health* 17, 188 (https://doi.org/10.1186/s12978-020-01041-3

Klaas, N. E., Thupayagale-Tshweneagae, G., & Makua, T. P. (2018). The role of gender in the spread of HIV and AIDS among farmworkers in South Africa. African journal of primary health care & family medicine, 10(1), e1–e8. https://doi.org/10.4102/phcfm.v10i1.1668

Kieselova, K., Santiago, F., Falhas, C.,& Henrique, M. (2017). Chronic penile ulcer as the first manifestation of HIV infection. *BMJ Case Reports.* doi:10.1136/bcr-2017-221604

Kim, Y. S. (2015). Obstacles to the response to HIV AND AIDS in South Africa: Historical legacies in perception and policy environment in 1994–2006. *International Area Studies Review,* 18(2), 199–215. https://doi.org/10.1177/2233865914565931

Kivunja, C., & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education,* 6(5). doi:10.5430/ijhe.v6n5p26

Knapp, N. F. (2019). *The Shape Activity: Social Constructivism in the Psychology Classroom. Teaching of Psychology*, 46(1), 87–91. https://doi.org/10.1177/0098628318816181

Knight, R., Small, W., Thomson, K., Gilbert, M., & Shoveller, J. (2016). Implementation challenges and opportunities for HIV Treatment as Prevention (TasP) among young men in Vancouver, Canada: a qualitative study. BMC Public Health 16(262). https://doi.org/10.1186/s12889-016-2943-y

Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Social Research*. 6(3). Art 44. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs0503440.

Kohler, H., P. & Thornton, R., L. (2012). 'Conditional cash transfers and HIV AND AIDS prevention: unconditionally promising?' *World Bank Economic Review* 26(2): 165–190.

Koos, C., & Neupert-Wentz, C. (2020). Polygynous Neighbors, Excess Men, and Intergroup Conflict in Rural Africa. *Journal of Conflict Resolution*, 64(2–3), 402–431. https://doi.org/10.1177/0022002719859636

Krishnaratne, S., Hensen, B., Cordes, J., Enstone, J., & Hargreaves, J. R. (2016). Interventions to strengthen the HIV prevention cascade: a systematic review of reviews. *The Lancet HIV*. 3(7), E307-E317, DOI:https://doi.org/10.1016/S2352-3018(16)30038-8

Lagarde, M., Haines, A., & Palmer, N. (2009). *The impact of conditional cash transfers on health outcomes and use of health services in low and middle-income countries. Cochrane Database of Systematic Reviews,* Issue 4. Art. No.: CD008137. DOI: 10.1002/14651858.CD008137.

Laurencin, C. T., Murdock, C. J., Laurencin, L., & Christensen, D. M. (2018). HIV AND AIDS and the -American Community 2018: A Decade Call to Action. *Journal of Racial and Ethnic Health Disparities* https://doi.org/10.1007/s40615-018-0491-0

Lawson, D. W., James, S., Ngadaya, E., Ngowi, B., Mfinanga, S. G., & Borgerhoff Mulder, M. (2015). No evidence that polygynous marriage is a harmful cultural practice in northern Tanzania. Proceedings of the National Academy of Sciences of the United States of America, 112(45), 13827–13832. https://doi.org/10.1073/pnas.1507151112

Lawrence-Hart, G. (2019). The Socio-Cultural Significance of Polygamy Africa. *International Journal of Social Sciences and Humanities*. 5(1). Pp. 01- 06.

Lazarus, E., Otwombe, K., Dietrich, J., Andrasik, M. P., Morgan, C. A., Kublin, J. G., Gray, G. E., Isaacs, A. J., & Laher, F. (2019). Vaginal practices among women at risk for HIV acquisition in Soweto, South Africa. Southern African Journal of HIV medicine, 20(1), 866. https://doi.org/10.4102/sajhivmed.v20i1.866

Leeds-Hurwitz, W. (2009). The social construction of reality. In S. Littlejohn, & K. Foss, (Eds.), *Encyclopaedia of communication theory*. 892-895. Thousand Oaks, CA: SAGE Publications, Inc. doi.10.4135/9781412959384.n344

Lefkowitz, E. S., Shearer, C. L., Gillen, M. M., & Espinosa-Hernandez, G. (2014). How Gendered Attitudes Relate to Women's and Men's Sexual Behaviors and Beliefs. Sexuality & Culture, 18(4), 833–846. https://doi.org/10.1007/s12119-014-9225-6

Legal Assistance Centre. (n.d.). Struggle to Survive A Report on HIV AND AIDS and Prisoners' Rights in Namibia, Windhoek.

Legal Assistance Center. (2005a). *Recognition of customary marriages a summary of the Law Reform and Development Commission proposal*. Windhoek. Namibia

Legal Assistance Centre. (2005b). *Inheritance Issues*. Windhoek. Retrieved on January 2020. https://www.lac.org.na/projects/grap/Pdf/inherit.pdf

Legal Assistance Centre. (2017). *Namibia Gender Analysis Report prepared for the Delegation of the European Union to Namibia*, Windhoek. Namibia.

Legarea, C. H. (2017). Cumulative cultural learning: Development and diversity. *Proceedings of the National Academy of Sciences Jul 2017*, 114 (30) 7877-7883; DOI: 10.1073/pnas.1620743114

le Roux, E., Bartelink, B. E., & Palm, S. (2017). What is the harm in 'harmful traditional practices? *POLICY BRIEF. UK AID*, London.

Lewis, D. (1973). *Anthropology and Colonialism,* 14(5), 581-602. The University of Chicago Press on behalf of Wenner-Gren Foundation for Anthropological Research.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Thousand Oaks: SAGE Publications.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences revisited. In. N. K. Denzin & Y. S. Lindon, *The Sage Handbook of qualitative research* (4th Ed., 97-128). Thousand Oaks, CA: Sage.

Linneberg, M. S., & Korsgaard, S. (2019). Coding qualitative data: a synthesis guiding the novice. *Qualitative Research Journal*. 19(3), pp. 259-270. DOI 10.1108/QRJ-12-2018-0012

Litman, L., Robinson, J., Rosen, Z., Rosenzweig, C., Waxman, J., & Bates, L. M. (2020). The persistence of pay inequality: The gender pay gap in an anonymous online labour market. *PLoS ONE* 15(2): e0229383. https://doi.org/10.1371/journal.pone.0229383

Logie, C. H., Perez-Brumer, A., & Parker, R. (2021). The contested global politics of pleasure and danger: Sexuality, gender, health and human rights, *Global Public Health*. 16(5). 651-663. DOI: 10.1080/17441692.2021.1893373

Lomba, P. (2014). Widow Cleansing in Malawi. *American International Journal of Contemporary Research* 4(1). pp. 34-40

Longman, C., & Bradley, T. (2015). Interrogating the Concept of "Harmful Cultural Practices". In C. Longman & T. Bradley (Eds.), I*nterrogating Harmful Cultural Practices: Gender, Culture and Coercion* (pp. 11-30). Routledge.

Loosli, B. C. (2004). *Traditional practices and HIV prevention in Sub Saharan Africa*. Genève, Switzerland: International Committee of the Red Cross.

Mabaso, M. L. H., Malope, N .F. & Simbayi, L. C. (2018). Socio-demographic and behavioural profile of women in polygamous relationships in South Africa: a retrospective analysis of the 2002 population-based household survey data. *BMC Women's Health 18,* 133 (2018). https://doi.org/10.1186/s12905-018-0626-9

Madiba, S., & Ngwenya, N. (2017). Cultural practices, gender inequality and inconsistent condom use increase vulnerability to HIV infection: narratives from married and cohabiting women in rural communities in Mpumalanga province, South Africa, *Global Health Action*, 10:sup2, DOI: 10.1080/16549716.2017.1341597

Mafigiri, R., Matovu, J.K.B., Makumbi, F.E., Ndyanabo, A., Nabukalu, D., Sakor, M., Kigozi, G., Nalugoda, F., & Wanyenze, R. K. (2017). HIV prevalence and uptake of HIV AND AIDS services among youths (15–24 Years) in fishing and neighbouring communities of Kasensero, Rakai District, South Western Uganda. *BMC Public Health* 17, 251 https://doi.org/10.1186/s12889-017-4166-2

Majid, M. A. A., Othman, M., Mohamad, S. T., Lim, S., & Yusof, A., (2017). Piloting for Interviews in Qualitative Research: Operationalization and Lessons Learnt. *International Journal of Academic Research in Business and Social Sciences.* 7(4). DOI:10.6007/IJARBSS/v7-i4/2916

Makoye, K. (2013). *The Widow Cleansing ritual continues in Tanzania*, [online article] Reuters Foundation

Maniraj, S. (2019). The importance of recognizing African customs and values consistent with biblical principles in African missionary endeavours. *The South African Baptist Journal of Theology.* Diaspora, Hybridity and the Missio Dei (28)

Marais, K. (2019) Calls for Pleasure: how African feminists are challenging and unsilencing women's sexualities, Agenda, 33:3, 87-95, DOI: 10.1080/10130950.2019.1644960

Marenga, R., & Amupanda, J. S. (2021). The Coronavirus and Social Justice in Namibia, *South African Journal of Political Studies*, 48(2), 206-225, DOI: 10.1080/02589346.2021.1913803

Martin, W. J. (2015). Chimpanzees Inoculated with Cytomegalovirus Contaminated Polio Vaccines may Explain Origin of HIV-1: Implication of Treatment in the Developing World. *J Hum Virol Retrovirol* 2(2): 00035. DOI: 10.15406/jhvrv.2015.02.00035

Martins, C. (2015). Polyphonic Disconcert around Polygyny. *Cahiers d'études africaines*, 220 |787-810. DOI : https://doi.org/10.4000/etudesafricaines.18305

Masters, N. T., Casey, E., Wells, E. A., & Morrison, D. M. (2013) Sexual Scripts among Young Heterosexually Active Men and Women: Continuity and Change, *The Journal of Sex Research*, 50:5, 409-420, DOI: 10.1080/00224499.2012.661102

Matthews, J., Avery, L., & Nashandi, J. (2018). Southern African Social Work Students' Acceptance of Rape Myths. *Social Sciences*, 7(9), 152. doi:10.3390/socsci7090152

Mayer, K. H., & de Vries, H. (2018). HIV and sexually transmitted infections: responding to the "newest normal". *Journal of the International AIDS Society*, 21(7), e25164. https://doi.org/10.1002/jia2.25164

Mayer, K. H., Skeer, M., & Mimiaga, M. J. (2010). Biomedical approaches to HIV prevention. Alcohol research & health: *the journal of the National Institute on Alcohol Abuse and Alcoholism*, 33(3), 195–202.

Mayer, L. S., & McHugh, P. R. (2016). Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *Special Report: Sexuality and Gender The New Atlantis* pp. 10-143.

Maynard, G., & Ong, C. (2016) Economic dependency and HIV AND AIDS prevalence in the developing world: A comparative, longitudinal analysis. *Sociological Inquiry* 26(2): 189–215.

McCoy, S., Ralph, L., Njau, P., Msolla, M. & Padian, N. (2014). Food insecurity, socioeconomic status, and HIV-related risk behaviour among women in farming households in Tanzania. *AIDS and Behaviour,* 18(7), 1224–36.

McFadden, P. (2003). 'Sexual pleasure as feminist choice', in Feminist Africa, 2, available at: http://www.agi.ac.za/sites/default/files/image_tool/images/429/feminist_africa_journals/archive/02/fa_2_ standpoint_1.pdf.

Menges, W. (2018). *Global Fund Cuts deepen Namibia's woes*. *Namibian* Newspaper. Available at: https://www.namibian.com.na/174350/archive-read/Global-Fund-cuts-deepen-Namibias-woes

Mensah, R. O., Agyemang, F., Acquah, A., Babah, P.A & Dontoh, J. (2020). Discourses on Conceptual and theoretical Frameworks in Research: Meaning and Implications for Researchers. *Journal of African Interdisciplinary Studies*. 4(5), 53 – 64.

Messerschmidt, J. W. (2019). The Salience of "Hegemonic Masculinity." *Men and Masculinities*, 22(1), 85–91. https://doi.org/10.1177/1097184X18805555

Meylakhs, P., Rykov, Y., Koltsova, O. & Koltsov, S. (2014). An AIDS-Denialist Online Community on a Russian Social Networking Service: Patterns of Interactions With Newcomers and Rhetorical Strategies of Persuasion. *J Med Internet Res*. 16(11):e261. doi: 10.2196/jmir.3338

Michielsen, K., Chersich, M., Temmerman, M., Dooms, T., and Ronan, T, Van Rossem, R. (2012). "Nothing as Practical as a Good Theory? The Theoretical Basis of HIV Prevention Interventions for Young People in Sub-Saharan Africa: A Systematic Review", AIDS Research and Treatment, vol. 2012, Article ID 345327, 18 pages, 2012. https://doi.org/10.1155/2012/345327

Miedema, E. (2019). 'Culture speak' is everywhere: an analysis of culturalist narratives in approaches to sexuality education in Mozambique, *Comparative Education*, 55(2), 220-242, DOI: 10.1080/03050068.2018.1541658

Ministry of Health and Social Services (MoHSS) (2019), *Namibia Population-based HIV Impact Assessment (NAMPHIA) 2017*: Final Report. Windhoek: MoHSS, Namibia.

Moezzi, M., Janda, K. B., & Rotmann, S. (2017). Using stories, narratives, and storytelling in energy and climate change research, *Energy Research & Social Science*, (31). pp. 1-10, https://doi.org/10.1016/j.erss.2017.06.034.

Mogotsi, I. (2019, July, 23 - 24). *Inclusion of the cultural practice of dry sex in HIV and AIDS behavioural change programmes: Case study of Zambezi region, Namibia*. Conference Proceedings; 3rd Multi/Interdisciplinary Research Conference. "The Africa we want Wealth creation for Sustainable Growth and Social Transformation", University of Namibia, Windhoek.

Mohajan, H. (2018): Qualitative Research Methodology in Social Sciences and Related Subjects. *Journal of Economic Development, Environment and People*, 7(1), 23-48.

Mohammed, S., H, & Kinyo, L. (2020). The Role of Constructivism in the Enhancement of Social Studies Education. *Journal of Critical Reviews*. 2394-5125. 7(7).

Mojola, S., A. (2014*) Love, Money, and HIV: Becoming a Modern African Woman in the Age of AIDS*. Berkeley: University of California Press

Molyneux, M., Jones, N., & Samuels, F. (2016). Can Cash Transfer Programmes Have 'Transformative' Effects? *The Journal of Development Studies*, 52:8, 1087-1098, DOI: 10.1080/00220388.2015.1134781

Morrell, R., Jewkes, R., Lindegger, G., & Hamlall, V. (2013). Hegemonic masculinity: Reviewing the gendered analysis of men's power in South Africa. *South African Review of Sociology,* 44(1), 3-21. doi: 10.1080/21528586.2013.784445

Mouinga-Ondémé, A., & Kazanji, M. (2013). Simian Foamy Virus in Non-Human Primates and Cross-Species Transmission to Humans in Gabon: An Emerging Zoonotic Disease in Central

Africa? *Viruses,* 5(6), 1536–1552. MDPI AG. Retrieved from http://dx.doi.org/10.3390/v5061536

Moyo, I., Macherera, M., & Mavhandu-Mudzusi, A. H. (2021). The lived experiences of men who have sex with men when accessing HIV care services in Zimbabwe. *Health SA = SA Gesondheid,* 26, 1462. https://doi.org/10.4102 /hsag.v26i0.1462

Moore, E., & Llompart, J. (2017). Collecting, transcribing, analyzing and presenting plurilingual interactional data. In E. Moore & M. Dooly (Eds), *Qualitative approaches to research on plurilingual education* (pp. 403-417). Research-publishing.net. https://doi.org/10.14705/rpnet.2017.emmd2016.638

Mshweshwe, L. (2020). Understanding domestic violence: masculinity, culture, traditions. *Heliyon*, 6(10). https://doi.org/10.1016/j.heliyon.2020.e05334.

Msuya, N. H. (2020). Advocating positive traditional culture to eradicate harmful aspects of traditional culture for gender equality in Africa. *Obiter*, *41*(1), 45-62.

Muhanguzi, F. K. (2015). "Sex is Sweet": women from low-income contexts in Uganda talk about sexual desire and pleasure', in *Reproductive Health Matters*, 23, 46, 62-70.

Muhinda, J. C., & Pazvakawambwa, L. (2017). HIV Testing among Women in Namibia: Patterns and Determinants .1(3). *Biomedical Journal of Scientific and Technical Research.* DOI: 10.26717/BJSTR.2017.01.000248

Muggaga,C., Basil, M., Okello-Uma, I., Kaaya, A, N., Taylor, D., & Ongeng, D. (2022) Recommended daily allowance-based contribution of household's own agricultural production to food and nutrition security in Karamoja sub-region of Uganda. *Agriculture & Food Security* 11:1

Musisi, N. (2014). Gender and sexuality in African history: a personal reflection. *The Journal of African History,* 55(3), 303-315. doi:10.1017/S0021853714000589.

Muzenda, G. (2014) 'Menstruating and masturbating: The stains and strains of experiencing bodily pleasure for women', in *BUWA! A Journal on African Women's Expe*riences, 5, 34-39

Mwambene, L., M. (2017). "What is the Future of Polygyny (Polygamy) in Africa?" *Potchefstroom Electronic Law Journal.* (20) - DOI http://dx.doi.org/10.17159/1727-3781/2017/v20i0a1357

Myers, J. R., Ball, K., Jeffers, S., L. & Lawson, W. B. (2018). Medical Mistrust, HIV-Related Conspiracy Beliefs, and the Need for Cognitive Closure among Urban-Residing African American Women: An Exploratory Study. *Journal of Health Disparities Research and Practice*. 11 (4). pp. 138-148.

Naibei, P. (2014). Culture and sustainable development. Conference Paper, 27 to 29 August 2014. Utility of Easements as a Development Control Tool for Regulating Land Use Developments Outside Protected Parks in Kenya.

Namibia Statistics Agency. (2011). *Population and Housing Census. Zambezi regional profile*. Windhoek.

Namibia Statistics Agency. (2014). *Namibia Demographic and Health Survey*. Ministry of Health and Social Services, Windhoek.

Namibia Statistics Agency. (2017). *Namibia Labour Force Survey 2016 Report.* Windhoek.

Namibia Network of AIDS Service Organisations (NANASO). (2007). *NANASO Directory of Civil Society AIDS Service Organizations.* Ondjambi, Windhoek.

Namibia Network of AIDS Service Organisations (NANASO). (2010). *Support groups for People Living with HIV and AIDS Directory*. World Health Organization. Windhoek

Nankinga, O., Misinde, C. & Kwagala, B. (2016). Gender relations, sexual behaviour, and risk of contracting sexually transmitted infections among women in the marital union in Uganda. *BMC Public Health* (16) 440 https://doi.org/10.1186/s12889-016-3103-0

Nattrass, N. (2012). *The AIDS Controversy*, *Science Fights Back*. Columbia University Press.

Nazer, M., Abbaszadeh, S., Darvishi, M., Kheirollahi, A., Shahsavari, S., & Moghadasi, M. (2019). The Most Important Herbs Used in the Treatment of Sexually Transmitted Infections in Traditional Medicine, *Sudan Journal of Medical Sciences*, 14(2) pp.41–64. DOI 10.18502/sjms.v14i2.4691

Ndebele, P., Ruzario, S., & Gutsire-Zinyama, R. (2013). Interpreting and dismissing the relevance of the "wait and wipe" finding from the circumcision studies conducted in Africa. *Malawi Medical Journal: the journal of Medical Association of Malawi*, *25*(4), 113–115.

Nelson, J. (2017). Using conceptual depth criteria: addressing the challenge of reaching saturation in qualitative research. *Qualitative Research*, 17(5). 554 - 570.

Nelson, O., & Bigala, P. (2016). Creating HIV AND AIDS Awareness through Localized Communication for Health Development in South Africa. *Journal of Health Management*, 18(3), 439–446. https://doi.org/10.1177/0972063416651567

New Era Reporter. (2016, May, 17). Mensah-Williams, Shangala differ on polygyny. *New Era.* Retrieved from https://neweralive.na/posts/mensah-williams-shanghala-differ-polygyny on 2 January 2019

Nguyen, T. T. L. (2019). *Selection of research paradigms in English Language teaching: Personal reflections and future directions: in the second annual international conference on language and literature, KnE Social Sciences*, pp.1–19. DOI 10.18502/kss.v3i19.4826

Nkosi, B. M. (2012). Understanding and Exploring Illness and Disease in South Africa: A Medical Anthropology Context. *International Journal of Humanities and Social Science.* 2(24). Pp. 84-93

Nkwi, P. N., & Bernard, H. R. (2012). Culture, Behavior and AIDS in Africa. In S. Ige, & T. Quinlan (Eds.). *African Responses to HIV AND AIDS: Between Speech and Action*. University of KwaZulu-Natal Press. KwaZulu-Natal, South Africa.

Novak, J. R., Peak, T., Gast, J., & Arnell, M. (2019). Associations Between Masculine Norms and Health-Care Utilization in Highly Religious, Heterosexual Men. *American journal of men's health,* 13(3), 1557988319856739. https://doi.org/10.1177/1557988319856739

Office of the President. (2012). *Annual Economic Development Report*. Windhoek, Namibia. National Planning Commission.

Okal, J., Lango, D., Matheka, J., Obare, F., Ngunu-Gituathi, C., Mugambi, M., & Sarna, A. (2020) “It is always better for a man to know his HIV status” – A qualitative study exploring the context, barriers and facilitators of HIV testing among men in Nairobi, Kenya. *PLoS ONE* 15(4): e0231645. https://doi.org/10.1371/journal.pone.0231645

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces*, 84(2), 1273-1289.

Olutayo, A. M. (2015). Trado-cultural Practices, Situation, Analysis and Epidemiological Factors in the Spread of HIV AND AIDS in Nigeria. *Journal of Education and Practice,* 6(21), 65-70.

Organization of African Unity (OAU), *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), available at: https://www.refworld.org/docid/3ae6b3630.html.

Otto, A., & Goldbeck, M. (2014). *The people of Namibia's Eastern Zambezi Region (Eastern Caprivi) A historical perspective* . Gondwana Publishers. Windhoek, Namibia

Page, S. (2019). *Development, Sexual Cultural Practices and HIV AND AIDS in Africa*. Switzerland: Palgrave Macmillan.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration and policy in mental health*, 42(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Papua New Guinea, (2018). *National STI and HIV Strategy 2018-2022*. National AIDS Council.

Patterson, O. (2014). Making Sense of Culture. *Annu. Rev. Sociol*. 40:1–30 doi: 10.1146/annurev-soc-071913-043123

Patnaik, E. (2013). Reflexivity: Situating the Researcher in Qualitative Research. *Humanities and Social Science Studies*, 2(2), 98-106.

Pauli, J. (2019). The Decline of Marriage in Namibia. Kinship and Social Class in a Rural Community. *Cultural and Social Practice. Verlag*, https://doi.org/10.14361/9783839443033

Peasant, C., Parra, G. R., Okwumabua, T. M., Greene, G. J., Andrews, R., Kuper, L., Hoff, C. C. (2015). Condom negotiation: Findings and future directions. *Journal of Sex Research,* 43, 1–15. doi:10.1177/0886260514532527

Peasant, C., Sullivan, T. P., Weiss, N. H., Martinez, I., & Meyer, J. P. (2017). Beyond the syndemic: condom negotiation and use among women experiencing partner violence. *AIDS care*, 29(4), 516–523. https://doi.org/10.1080/ 09540121.2016.1224296

Perrin, N., Marsh, M., Clough, A., Desgroppes,A., Phanuel, C. Y., Abdi, A., Kaburu, F., Heitmann, S., Yamashina, M., Ross, B., S Read-Hamilton, S., Turner, R., Heise, L. & Glass,

N. (2019). Social norms and beliefs about gender-based violence scale: a measure for use with gender-based violence prevention programs in low-resource and humanitarian settings. *Conflict and Health volume* 13, (6). https://doi.org/10.1186/s13031-019-0189-x

Perry, B., Oluoch, L., Agot, K., Taylor, J., Onyango, J., Ouma, L., & Corneli, A. (2014). Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centred HIV prevention options. *Journal of the International AIDS Society*, 17.

Poudel, A. N., Newland, D., & Simkhada, P. (2016). Issues and Problems in Conducting Sensitive Re-search: A Case of HIV AND AIDS in Nepal. *Health Prospect*.;15(2):5-10. Doi: ttp://www.nepjol.info/index.php/HPROSPECT/issue

Pouw, N., & McGregor, A. (2014). *An economics of wellbeing. What would economics look like if it were focused on human wellbeing?* Institute of Development Studies Working Paper no. 436. Brighton: Institute of Development Studies

Presidential AIDS Advisory Panel. (2001). Presidential AIDS Advisory Panel Report: A synthesis report of the deliberations by the panel of experts invited by the President of the Republic of South Africa, the Honourable Mr Thabo Mbeki. Available from: http://www.virusmyth.com/aids/hiv/panel/aidsreport.pdf.

Pulerwitz, J., Barker, G., Segundo, M., & Nascimento, M. (2006). *Promoting more gender-equitable norms and behaviours among young men as an HIV AND AIDS prevention strategy.* Washington: The Population Council.

Qiang, C., & Yanru, C. (2020) Influencing factors of knowledge collaboration effects in knowledge alliances, *Knowledge Management Research & Practice*, 18:4, 380-393, DOI: 10.1080/14778238.2019.1678412

Qing, S. (2020). Gender role attitudes and male-female income differences in China. *J. Chin. Social.* 7, 12 https://doi.org/10.1186/s40711-020-00123-w

Ramjee, G. & Daniels, B. (2013). Women and HIV in Sub-Saharan Africa: *AIDS Research and Therapy.* 10(30). doi:10.1186/1742-6405-10-30

Ramjee, G., Moonsamy, S., Abbai, N. S., & Wand, H. (2016). Individual and Population-Level Impact of Key HIV Risk Factors on HIV Incidence Rates in Durban, South Africa. *PLoS ONE* 11(4): e0153969. https://doi.org/10.1371/journal.pone.0153969

Reddy, P., Saleh-Onoya, D., Sifunda, S., Lang, D., Wingood, G., van den Borne, B., & Ruiter, R. A. C. (2009). Preference for dry sex, condom use and risk of STI among HIV-negative black women in the Western Cape Province, South Africa. *South African Journal of Science,* 105(1-2), 73-76.

Republic of Namibia. (1928). *Native Administration Proclamation 15 of 1928, sections 17-18 and 23-27.* Windhoek. Namibia.

Republic of Namibia. (1990).*The Constitution of the Republic of Namibian*. Chapter 3: Fundamental Human Rights and Freedoms, Article 10: Equality and Freedom from Discrimination. Windhoek.

Republic of Namibia. (2004*). Namibia Vision 2030. Policy Framework for Long Term National Development*. National Planning Commission, Windhoek.

Republic of Namibia. (2007). *National Policy on HIV and AIDS*. Ministry of Health and Social Services. Directorate of Special Programmes. Windhoek.

Republic of Namibia. (2010) *National Gender Policy (2010 – 2020)*. Ministry of Gender Equality and Child Welfare (MGECW). Windhoek.

Republic of Namibia. (2014a). *Namibia National AIDS Spending Assessment (NASA) 2012/13 and 2013/14.* Ministry of Health and Social Services. Directorate of Special Programs. Windhoek.

Republic of Namibia. (2014b). Results of the Namibia Men's Health Study: Integrated Biological and Behavioral Surveillance Studies among Men who have Sex with Men in Namibia. Ministry of Health and Social Services, Windhoek.

Republic of Namibia (2015). *The Namibia AIDS Response Progress Report. Reporting Period: 2013-2014*. Ministry of Health and Social Services. Directorate of Special Programs. Windhoek.

Republic of Namibia. (2016). *Surveillance Report of the 2016 National HIV Sentinel Survey.* Ministry of Health and Social Services. Directorate of Special Programs. Windhoek.

Republic of Namibia (2017). *National Strategic Framework for HIV and AIDS Response in Namibia 2017/18 to 2021/22*. Ministry of Health and Social Services. Directorate of Special Programs. Windhoek.

Republic of Namibia. (2021). *Report on the abolishment of the Common Law offences of Sodomy and Unnatural Sexual Offences*; Law Reform and Development Commission, Windhoek.

Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S. & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology*, (28(3), 271-290.

Richards, L., & Morse, J. M. (2007). *Read me first for a user's guide to qualitative methods.* London: SAGE Publications.

Richardson, E. T., Collins, S. E., Kung, T., Jones, J. H., Hoan Tram, K., Boggiano, V. L., Bekker, L. G., & Zolopa, A. R. (2014). Gender inequality and HIV transmission: a global analysis. *Journal of the International AIDS Society*, 17(1), 19035. https://doi.org/10.7448/IAS.17.1.19035

Riese, J. (2019). What is 'access' in the context of qualitative research? Qualitative Research, 19(6), 669–684. https://doi.org/10.1177/1468794118787713

Robinson, J. L., Narasimhan, M., Amin, A., Morse, S., Beres, K. L., Yeh, P. T., & Kennedy, C E. (2018). Interventions to address unequal gender and power relations and improve self-efficacy and empowerment for sexual and reproductive health decision-making for women living with HIV: A systematic review. *PLoS One,* 12(8). doi: 10.1371/journal.pone.0180699.

Rossetto, K. R., & Tollison, A. C. (2017). Feminist Agency, Sexual Scripts, and Sexual Violence: Developing a Model for Postgendered Family Communication. *Family Relations.* 66(1). Pp 61-74. https://doi.org/10.1111/fare.12232

Rossi, P. (2018). *Strategic Choices in Polygamous Households: Theory and Evidence from Senegal.* ffhalshs-01340567v2f

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative Interviewing: The art of hearing data.* (3rd Ed.). London, UK: Sage.

Ruppel, C. O., & Ambunda, L. O. (n.d.) *The Justice Sector & the Rule of Law in Namibia Framework, Selected Legal Aspects and Cases*. Namibia Institute for Democracy, Human Rights and Documentation Centre. Windhoek, Namibia

Rwafa, T., Shamu, S. & Christofides, N. (2019). Relationship power and HIV sero-status: an analysis of their relationship among low-income urban Zimbabwean postpartum women. *BMC Public Health* 19(792). https://doi.org/10.1186/s12889-019-7137-y

Sabri, B., Wirtz, A, L., Ssekasanvu, J., Nonyane, B. A. S., Nalugoda, F., Kagaayi, J., Ssekubugu, R., & Wagman, J. A. (2019). Intimate partner violence, HIV and sexually transmitted infections in fishing, trading and agrarian communities in Rakai, Uganda. *BMC Public Health* (19) 594 . https://doi.org/10.1186/s12889-019-6909-8

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M., & Cheraghi, M. A. (2014). Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of medical ethics and history of medicine*, 7, 14.

Sandberg, J. (2012). Conditional cash transfers and social mobility: The role of asymmetric structures and segmentation processes. *Development and Change,* 43(6), 1337–1359. doi:10.1111/dech.2012.43.issue-6

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. & Jinks, C. (2017). Saturation in qualitative research: Exploring its conceptualisation and operationalisation. *Quality and Quantity,* 1-15. Retrieved from https://doi.org/10.1007/s11135-017-0574-8 on 2 January 2019.

Scelza, B., Prall, S., & Starkweather, K. (2021). The Role of Spousal Separation on Norms Related to Gender and Sexuality among Himba Pastoralists. *Social Sciences*, 10(5), 174. MDPI AG. Retrieved from http://dx.doi.org/10.3390/socsci10050174

Scheffelaar, A; Janssen, M; & Luijkx, K. (2021). The Story as a Quality Instrument: Developing an Instrument for Quality Improvement Based on Narratives of Older Adults Receiving Long-Term Care. *Int. J. Environ. Res. Public Health.* 18(2773). https://doi.org/10.3390/ijerph18052773

Scoones, I. (2021). Pastoralists and peasants: perspectives on agrarian change, *The Journal of Peasant Studies*, 48:1, 1-47, DOI: 10.1080/03066150.2020.1802249

Shabani, K., & Ewing, B. F. (2016). Applications of Vygotsky's sociocultural approach for teachers' professional development, *Cogent Education,* 3(1), DOI: 10.1080/2331186X.2016.1252177

Sharp, P. M. & Hahn, B. H. (2011). Origins of HIV and the AIDS Pandemic. *Cold Spring Harbor Perspectives in Medicine.* doi: 10.1101/cshperspect.a006841.

Shepler, D. K., Johnson, K. P., & Width, A. A. (2017). Risky Sexual Behavior and Knowledge of HIV AND AIDS Transmission in a Community Sample: Sexual Orientation, Race, and Gender. *Journal of Social, Behavioral, and Health Sciences*. 11 (1). 147–162 DOI:10.5590/JSBHS.2017.11.1.10

Shi-xu, D. (2012) Why do cultural discourse studies? Towards a culturally conscious and critical approach to human discourses, *Critical Arts,* 26:4, 484-503, DOI: 10.1080/02560046.2012.723814

Sia, D., Onadja, Y., Hajizadeh,M., Heymann, S. J., Brewer, T. F., & Nandi, A. (2016). What explains gender inequalities in HIV AND AIDS prevalence in sub-Saharan Africa? Evidence from the demographic and health surveys. *BMC Public Health* 16(1136), https://doi.org/10.1186/s12889-016-3783-5

Siaplay, M. (2012). '*The impact of social cash transfers on young adults' labour force participation, schooling, and sexual behaviours in South Africa'*. Oklahoma State University.

Sikweyiya, Y., Addo-Lartey, A.A., Alangea, D.O. Dako-Gyeke, P., Chirwa, E. D., Coker-Appiah, D., Adanu, R. M. K., & Jewkes, R. (2020). Patriarchy and gender-inequitable attitudes as drivers of intimate partner violence against women in the central region of Ghana. *BMC Public Health* 20, 682 (2020).https://doi.org/10.1186/s12889-020-08825-z

Simon, J. A., Nappi, R. E., Kingsberg, S. A., Maamari, R., & Brown, V. (2014). Clarifying Vaginal Atrophy's Impact on Sex and Relationships (CLOSER) survey: emotional and physical impact of vaginal discomfort on North American postmenopausal women and their partners. *Menopause*, 21(2), 137-142.

Simon, W. & Gagnon, J. H. (1986). Sexual scripts: Permanence and change. *Archives of Sexual Behavior*, 15, 97-120.

Sinha, S. (2015). Reasons for Women's Entry into Sex Work: A Case Study of Kolkata, India. *Sexuality & Culture* 19, 216–235. https://doi.org/10.1007/s12119-014-9256-z

Skovdal, M., Wringe, A., Seeley, J., Renju, J., Paparini, S., Wamoyi, J., Moshabela, M., Ddaaki, W., Nyamukapa, C., Ondenge, K., Bernays, S. & Bonnington, O. (2017). Using theories of practice to understand HIV-positive persons varied engagement with HIV services: a qualitative study in six Sub-Saharan African countries. *Sexually Transmitted Infections*. 93 (3).:e052977.

Smart, C. A. (2019). African oral tradition, cultural retentions and the transmission of knowledge in the West Indies. *IFLA Journal,* 45(1), 16–25. https://doi.org/10.1177/0340035218823219

Sousa, J. D., Muller, V, & Vandamme, A. M. (2017). The epidemic emergence of HIV: what novel enabling factors were involved? *Future Virol*. 12(11), 685–707

Sovran, S. (2013). Understanding culture and HIV AND AIDS in sub-Saharan Africa. *SAHARA-J: Journal of Social Aspects of HIV AND AIDS,* 10(1), 32-41. doi:10.1080/17290376.2013.807071

Ssewanyana, D., Mwangala, P. N., van Baar, A., Newton, C. R., & Abubakar, A. (2018). Health Risk Behaviour among Adolescents Living with HIV in Sub-Saharan Africa: A Systematic Review and Meta-Analysis. *Hindawi BioMed Research International*. https://doi.org/10.1155/2018/7375831.

Stevens, P. (2015). *Culture and sexuality*, In Whelehan, P. & Bolin, A. (Eds.). The International Encyclopedia of Human Sexuality, First Edition. DOI: 10.1002/9781118896877.wbiehs110

Stoebenau, K., Heise, L., Wamoyi, J., & Bobrova, N. (2016). Revisiting the understanding of "transactional sex" in sub-Saharan Africa: A review and synthesis of the literature. *Social Science & Medicine*, 168, 186-197.

Stubbe, D. E. (2020). Practicing Cultural Competency and Cultural Humility in the Care of Diverse Patients. *The journal of lifelong learning in psychiatry*. doi.org/10.1176/appi.focus.20190041

Sundararajan, R., Langa, P. V., Morshed, T., & Manuel, S. (2021). Traditional healers as client advocates in the HIV-endemic region of Maputo, Mozambique: results from a qualitative study, *SAHARA-J: Journal of Social Aspects of HIV AND AIDS,* 18:1, 77-85, DOI: 10.1080/17290376.2021.1909492

Swank, E., & Fahs, B. (2017). Understanding Feminist Activism among Women: Resources, Consciousness, and Social Networks. *Socius*. https://doi.org/10.1177/2378023117734081

Tam, K-P. (2015). Understanding Intergenerational Cultural Transmission Through the Role of Perceived Norms. *Journal of Cross-Cultural Psychology*. 46(10). DOI:10.1177/0022022115600074

Thiabaud, A., Triulzi, I., Orel, E., Tal, K., & Keiser, O. (2020). Social, Behavioral, and Cultural factors of HIV in Malawi: Semi-Automated Systematic Review. *J Med Internet Res* URL:DOI: 10.2196/18747

Thobejane, T. D & Takayindisa, F. (2014). An Exploration of Polygynous Marriages: A Worldview. *Mediterranean Journal of Social Sciences,* 5(27). doi:10.5901/mjss.2014.v5n27p1058.

Thomas, A., Menon, A., Boruff, J., & Ahmed, S. (2014). Applications of social constructivist learning theories in knowledge translation for healthcare professionals: a scoping review. Implementation Sci 9, 54 (2014). https://doi.org/10.1186/1748-5908-9-54

Toursunof, H. (2007). *Kyrgyzstan: Polygyny issue sparks debate*. EurasiaNet. Available at: https://www.refworld.org/docid/46cc321023.html.

Tugume, L. H. (2015). Attitudes of Christian missionaries towards African traditional religious beliefs in East Africa during the British colonial rule. *African Journal of History and Culture*, 7(10), 193-199, https://doi.org/10.5897/AJHC2015.0276

United Nations. (2016). *Report of the Working Group on the Universal Periodic Review: Namibia*. A/HRC/32/4, paras. 137.69, 137.70, 137.71, 137.72, 137.73 and 137.81. https://documents-dsny.un.org/doc/UNDOC/GEN/G16/078/53/ DF/G1607853.pdf?OpenElement

UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III). Available at https://www.refworld.org/docid/3ae6b3712c.html

UN Committee on the Elimination of Discrimination against Women (CEDAW). UN Committee on the Elimination of Discrimination against Women: State Party Report, Namibia, November 1992. Available at https://www.refworld.org/ docid/3ae6ae088.html

UNAIDS. (2014). *Social and behavioural change programming, guidance note*. Geneva. Switzerland. UNAIDS. (2017). *UNAIDS Data 2017.* Geneva, Switzerland.

Ung, M., Boateng, G., Armah, F., Amoyaw, J., Luginaah, I., & Kuuire, V. (2014). Negotiation for safer sex among married women in Cambodia: the role of women's autonomy. *Journal of biosocial science*, 46(1), 90-106. Doi:10.1017/s0021932013000151

University of California - Davis. (2015, October 29). Often decried, polygyny may sometimes have advantages. *ScienceDaily*. www.sciencedaily.com/releases/ 2015/10/151029102240.htm

USAID, (2019). *Performance Evaluation of Namibia's Dreams Program.* Global Health Program Cycle Improvement Project, Washington DC.

Ussher J. M. (2017). Unravelling the Mystery of "The Specificity of Women's Sexual Response and Its Relationship with Sexual Orientations": The Social Construction of Sex and Sexual Identities. *Archives of sexual behaviour*, 46(5), 1207–1211. https://doi.org/10.1007/s10508-017-0957-x

Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R. & Estoesta. J. (2017) 'Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment', in *Archives of Sexual Behavior*, 46, 7, 1901-1921.

Uwah, C. (2013). The role of culture in effective HIV AND AIDS communication by the theatre in South Africa. *SAHARA Journal,* 10(3-4), 140-149. doi: 10.1080/17290376.2014.903809

Van der Helm, J. J., Schim van der Loeff, M. F., de Vries, E., van der Veer, C., Grünberg, A. W., Mans, D., & de Vries, H. (2019). Vaginal herb use and Chlamydia trachomatis infection: cross-sectional study among women of various ethnic groups in Suriname. *BMJ open*, 9(5), e025417. https://doi.org/10.1136/bmjopen-2018-025417

Van der Poll, L. (2009). The impact of traditional sex practices on the construction of female sexuality: an African human rights perspective. *Law, Democracy and Development.* 13(2). Doi.4314/ldd.v13i2.66851

Vance, C. S. (2001). Social construction theory: Problems in the history of sexuality. In Kenneth Plummer (Ed.) *Sexualities Vol. 1: Making a Sociology of sexualities*, 356-371. London, UK: Routledge.

Vance M. A. (2019). Conflicting Views in Narratives on HIV Transmission via Medical Care. *Journal of the International Association of Providers of AIDS Care*, 18, 2325958218821961. https://doi.org/10.1177/2325958218821961

Vanclay, F., Baines, J., T, & Taylor, C. N. (2013) Principles for ethical research involving humans: ethical professional practice in impact assessment Part I, Impact Assessment and Project Appraisal, 31(4), 243-253, DOI: 10.1080/14615517.2013.850307

Verd, J. M., Barranco, O., & Lozares, C. (2021). Blending the Focused Ethnographic Method and Case Study Research: Implications Regarding Case Selection and Generalization of Results. *Field Methods*, 33(1), 25–41. https://doi.org/10.1177/1525822X20932495

Vermund, S. H., Sheldon, B. A., & Sidat, M. (2015). Southern Africa: The highest priority region for HIV prevention and care interventions. *Curr HIV AND AIDS Rep*. 12(2): 191–195. doi: 10.1007/s11904-015-0270-z

Vermund, S. H., Fidler, S. J., Ayles, H., Beyers, N., & Hayes, R. J. (2013). Can combination prevention strategies reduce HIV transmission in generalized epidemic settings in Africa? The HPTN 071 (PopART) study plan in South Africa and Zambia. *Journal of acquired immune deficiency syndromes* (1999), 63 Suppl 2(0 2), S221–S227. https://doi.org/10.1097/QAI.0b013e318299c3f4

Vygotsky, L. S. (1978). *Mind in society*. Cambridge, UK: Harvard University Press.

Waetjen, L. E., Crawford, S. L., Chang, P. Y., Reed, B. D., Hess, R., Avis, N. E., Harlow, S. D., Greendale, G. A., Dugan, S. A., Gold, E. B., & Study of Women's Health Across the Nation (SWAN) (2018). Factors associated with developing vaginal dryness symptoms in women transitioning through menopause: a longitudinal study. Menopause (New York, N.Y.), 25(10), 1094–1104. https://doi.org/10.1097/GME.0000000000001130

Wall, S. S. (2015). Focused ethnography: A methodological adaptation for social research in emerging contexts. Forum: *Qualitative Social Research*, 16(1), Art1.

Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs150111.

Wang, C. C., & Geale, S. K. (2015). The power of story: Narrative inquiry as a methodology in nursing research. *International Journal of Nursing Sciences*. 2(2). Pp. 195-198

Wang, Y., & Benner, A. D. (2016). Cultural Socialization Across Contexts: Family-Peer Congruence and Adolescent Well-Being. *Journal of youth and adolescence*, 45(3), 594–611. https://doi.org/10.1007/s10964-016-0426-1

Wegerif, R. (2008). Dialogic or dialectic? The significance of ontological assumptions in research on educational dialogue, *British Educational Research Journal*, 34(3), 347-361, DOI: 10.1080/01411920701532228

Weitzman, A. (2014). Women's and men's relative status and intimate partner violence in India. *Population and Development Review*, 40(1), 55-75.

Williams-Breault, B. D. (2018). Eradicating Female Genital Mutilation/Cutting. Human Rights-Based Approaches of Legislation, Education, and Community Empowerment. *Health and Human Rights Journal,* 20(2), 223-233.

Williams, D. M., & Rhodes, R. E. (2016). The confounded self-efficacy construct conceptual analysis and recommendations for future research. *Health psychology review*, 10(2), 113–128. https://doi.org/10.1080/17437199.2014.941998

Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Educ Behav*. 27(5):539-65. doi: 10.1177/109019810002700502.

World Health Organization. (2015). *Global health observatory (GHO) data*. Geneva. Switzerland. URL. http://www.who.int/gho/tb/en.

World Health Organization. (2016). *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection – Recommendations for a public health approach.* Second edition. Geneva: Switzerland.

Wood, J., Desmarais, S., Burleigh, T., & Milhausen, R. (2018). Reasons for sex and relational outcomes in consensually nonmonogamous and monogamous relationships: A self-

determination theory approach. *Journal of Social and Personal Relationships*, 35, 632–654. doi:10.1177/0265407517743082

Wood, H. J. (2019). Gender inequality: The problem of harmful, patriarchal, traditional and cultural gender practices in the church. *HTS Theological Studies*, 75(1), 1-8. https://dx.doi.org/10.4102/hts.v75i1.5177

Woolfork, M. N., Fox, A., Swartzendruber, A., S Rathbun, S., Lee, J., Mutanga, J. N., & Ezeamama, A. E. (2020) Empowerment and HIV Risk Behaviours in Couples: Modelling the Theory of gender and power in an African Context. *Women's Health Reports* (1)1, pages 89-101.

Yalcinkaya, S. N., Estrada-Villalta, S., & Adams, G. (2017). The (Biological or Cultural) Essence of Essentialism: Implications for Policy Support among Dominant and Subordinated Groups. *Frontiers in Psychology,* 8(900). https://doi.org/10.3389/fpsyg.2017.00900

Yang, Y., & Thai, S. (2017). Sociocultural Influences on the Transmission of HIV From Husbands to Wives in Cambodia: The Male Point of View. *American Journal of Men's Health*, 845–854. https://doi.org/10.1177/1557988317690079

Yearby, R. (2019). When Equal Pay Is Not Enough: The Influence of Employment Discrimination on Health Disparities. *Public Health Reports*, *134*(4), 447–450. https://doi.org/10.1177/0033354919847743

Zahle, J. (2017). Privacy, Informed Consent, and Participant Observation. *Perspectives on Science* 25 (4): 465–487. doi: https://doi.org/10.1162/POSC_a_ 00250

Zemouri, C., Wi, T. E., Kiarie, J., Seuc, A., Mogasale, V., Latif, A., & Broutet, N. (2016). The Performance of the Vaginal Discharge Syndromic Management in Treating Vaginal and Cervical Infection: A Systematic Review and Meta-Analysis. *PLOS One*, 11(10).

Zhou, Y. R., Majumdar, B. & Vattikond, N. (2016). "Culture, but More than Culture: An Exploratory Study of the HIV Vulnerability of Indian Immigrants in Canada." *Culture, Health & Sexuality,* 18 (9), 1067-1080. doi:10.1080/13691058. 2016.1162328.

Zungu, E. B. (2019). When culture equals femicide: 'affluent polygyny' a South African dilemma. *International Journal of Language, Literature and Gender Studies (LALIGENS),* 8 (2), 80-90. DOI: http://dx.doi.org/10.4314/laligens.v8i2.7

APPENDICES

Appendix 1: List of research participants

No	Pseudonym and characteristics of participants	Role and responsibility of the participant	Local languages spoken
Government participants			
1	Namasiku, a 58-year-old female	Directorate of Special Programmes, Responsible for HIV and AIDS	Yeyi, Mbalangwe, Sifwe, Silozi
2.	Nanvula, a 25-year-old female	Health Programme Officer in the MoHSS, Katima Mulilo, Member of RACOC	Sisubia, Silozi
3	Patrice, a 41year old female	Communication Officer Responsible for Zambezi region Coordination and Response to HIV and AIDS, Member of RACOC	Balangwe, Silozi
4	Boyde, a 35 year old male	Social Behaviour Change and Communication officer based in Windhoek	Oshiwambo
5	Simataa, a 50 year old male	Health Extension Worker, MoHSS	Sisubia and Silozi
Participants from nongovernmental organisations			
6	Nelson, a 50-year-old male	Representative of NANASO	Otjiherero
7	Sepiso, a 50-year-old female	A representative of the Catholic AIDS action	Shikwe, Silozi
8	Kachana, a 34 year old female	A representative of the Society for Family Health	Silozi, Sisubia, Mafwe
9	Nakwezi, a 46 year old female	A representative of DAPP/TCE	Balangwe, Sifwe, Silozi
10	Sibolile, a 45 year old male	A representative from Red Cross	Sifwe and Silozi
11	Gladys, a 35 year old female	A representative of the Women's Leadership Centre	English
Traditional healers			
12	Masangu, a 47-year-old male	Traditional healer, based in Katima Mulilo	Sifwe, Silozi
13	Sibeso, a 76 year old female	Traditional healer, based in Kabbe; also, a Sikenge girl initiation mentor	Subia
Life Skills teachers			
14	Nalishebo, a 38-year-old female	Female Life Skills teacher and an advocate against harmful cultural practices	Silozi, Sisubia

15	Mwinga, a 43 year old male	Male Life Skills teacher at a senior secondary school in Katima; also, a volunteer at Red Cross	Silozi, Sifwe
Traditional leaders from the Masubia Traditional Establishment			
16	Chunga, a 58 year old male	Induna	Silozi, Sisubia
17	Kamwi, a 75-year-old male	Induna	Nyanja, Silozi, Sisubia
18	Sinvula, an 82-year-old male	Induna	Sisubia, Silozi
19	Mwala, a 69-year-old male	Induna	Sisubia, Silozi
Community members			
Youth aged 15 to 17 years			
20	Peter, a 15-year-old male	Learner at a Secondary school at Bukalo	Sisubia and Silozi
21	Sheeba, a 16-year-old female	Learner at a Secondary school at Bukalo	Sisubia and Silozi
22	Beauty, a 17-year-old female	Learner at a Secondary school at Bukalo	Sisubia and Silozi
Participants in their 20s			
23	Charity, a 23-year-old female	A married mother of 2 children	Sisubia and Silozi
24	Leo, a 24-year-old male	Graduated from Kayec in Mechanics	Sisubia and Silozi
25	Boitumelo, a 26-year-old female	A salesperson at the village shop	Sisubia and Silozi
26	Tuelo, a 27-year-old male	Housekeeper	Silozi
27	Selelo, a 28-year-old female	Apprentice at Zambezi VTC	Sisubia and Silozi
Participants in their 30s			
28	Werona, a 38-year-old female	Housewife	Sisubia and Silozi
Participants in their 50s			
29	Mushe, a 56 year old male	Driver at DAPP/TCE, Kabbe	Sifwe, Silozi
Participants who are pensioners			
30	Chaze, a 71-year-old female	HIV and AIDS Home-based care volunteer at the Catholic AIDS Action, based in Katima Mulilo	Silozi
31	Kahundu, a 62 year old female	Selling traditional medicine for drying the vagina and making the body hot	Silozi, Sisubia
32	Theodor, 86-year-old male	Pensioner	Sifwe, Sisubia and Silozi
33	Kuku, 96 years old female	Pensioner	Sisubia and Silozi

Appendix 2: Ethical Clearance Certificate

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS /429/2017 **Date: 1 October, 2018**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Hiv And Aids Behaviour Change Programmes And Cultural Practices: Case Studies From Selected Ngos In Kabbe South Constituency

Researcher: IMMACULATE MOGOTSI

Student number: 9324380

Supervisor(s): Dr Lucy Edwards-Jauch

Faculty: Faculty of Humanities and Social Sciences

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
(d) The UREC retains the right to:
(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research.

UREC wishes you the best in your research.

Dr. J.E. de Villiers: UREC Chairperson

Ms. P. Claassen: UREC Secretary

Appendix 3: Informed Consent Forms for Adults

Title of study: **HIV AND AIDS BEHAVIOUR CHANGE PROGRAMMES AND CULTURAL PRACTICES: CASE STUDIES FROM SELECTED NGOs IN ZAMBEZI REGION, NAMIBIA**

Informed Consent Form for:

Adult men and Men
HIV and AIDs Behavior Change Programme Facilitators:
Directors/Heads of NGOs.
RACOC members
Directorate of Special Programmes HIV and AIDS.

Principal Investigator: Ms Immaculate Mogotsi
Name of organization: University of Namibia
Dear Participant
Purpose of the study:
Good day, my name is Immaculate Mogotsi, I am a registered PhD student at the University of Namibia. This research is part of my PhD studies.
I am researching HIV and AIDS prevention and polygyny and dry sex and I want to find out whether NGOs that are training on HIV and AIDS prevention are including cultural practices in their training.
The Objectives of this study are to:

1. Explore polygyny and dry sex that may promote HIV spread in Kabbe.
2. Assess the value and significance attached to cultural practices that may promote the spread of HIV.
3. Enquire about the extent to which NGOs working in HIV and AIDS behaviour change programmes are aware of the link between cultural practices and the spread of HIV.
4. Investigate whether NGOs working in HIV and AIDS behaviour change programmes have adopted culturally appropriate prevention strategies.

Study participation

I would like to invite you to take part in this interview. I will be asking you about Demographic background, HIV and AIDS health-seeking behaviour and cultural practices.
Your participation in this interview is voluntary and you are not obliged to take part in this research. The choice of whether to participate or not is yours alone. However, I will appreciate, if you share your perspectives with me. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time or withdraw your participation without penalty and you will **NOT** be prejudiced in **ANY** way.
The research will take over 3 months in total. During that time, I might visit you more than once for interviewing you and each interview will last for about 1 hour. Interviews will be conducted at a place that is safe and convenient for you and me.

Confidential

This research will be done in the community and may draw attention and if you participate you may be asked questions by other people in the community. I would like to assure you that I will not share information about you and the information you provided with anyone. The information that I collect from this research will be kept private. Any information that I collect about you will be given a different name and we will keep the information in a safe place, where it will not be easily accessible.
Furthermore, all-digital recordings will be transcribed but your name will not be recorded anywhere during the digital recording of the interview or on the transcript. No one will be able to link you to the responses you give, all individual information will remain confidential. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Ethics Committee at the

University of Namibia. Otherwise, records that identify you will be available only to me. The information you provide may be published. All identifying information will be kept in a locked file cabinet and will not be available to others. We will refer to you by a pseudonym in any publication.

Risks/Discomforts:

This study will involve discussion of sensitive, private and well-regarded materials on sexuality, health-seeking behaviours, sexual risk-taking behaviours, sexual experiences and cultural practices. Sharing this information with me may make you feel uncomfortable talking about some of the topics. All efforts will be made to make the interview as comfortable for you as possible. Remember that you do not have to answer any question or take part in the interview if you don't wish to do so.

Benefits:

There are no immediate benefits to you from participating in this study. However, this study will be extremely helpful to us in understanding the link between HIV and AIDS and cultural practices.

Reimbursement:

You will not be provided with an incentive to take part in the research.

Who to contact if you have been harmed or have any concerns

This research has been approved by the University of Namibia Ethics Committee, which is a committee whose task is to make sure that research participants are protected from harm. If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the PhD Candidate at 081 3475 889 or the PhD Supervisor, Prof Lucy Edwards-Jauch Tel: +264 (0) 206 3139
E-mail: ledwards@unam.na

You can ask me any question about anything I informed you about so far if you wish to do so. Do you have any questions?

Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Name of Participant…………………………………………………….
Signature of Participant……………………………………………..
Date…………………………………………………………………
(Day/Month/Year).

I have witnessed the accurate reading of the consent form to the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has given the consent freely.

Name of witness……………………………………………
Signature of witness………………………………………..
Date……………………………………………………..
(Day/Month/Year).

Thump print of participant

Statement by the researcher

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understood.

I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participants have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Name of researcher………………………………………
Signature of researcher………………………………….
Date……………………………………………………..

Appendix 4: Assent Form

Title of study: **HIV AND AIDS BEHAVIOUR CHANGE PROGRAMMES AND CULTURAL PRACTICES: CASE STUDIES FROM SELECTED NGOs IN ZAMBEZI REGION, NAMIBIA**

This Consent Form is for Parents with children 15 to 18years who are research participants.
Principal Investigator: Ms Immaculate Mogotsi.
Name of organization: University of Namibia
Dear Participant
This informed Consent Form has two parts:

1. Information sheet to share the study with you.
2. Certificate of Consent for signature if you agree that your child may participate.

Part 1: Information Sheet

Introduction

My name is Immaculate Mogotsi, I am a PhD registered student at the University of Namibia. I am researching HIV and AIDS prevention and polygyny and dry sex and I want to find out whether NGOs that are training on HIV and AIDS prevention are including cultural practices in their training.

During this study we will talk to teenagers, both boys and girls and ask them several questions about cultural practices and whether they received any training on HIV and AIDS. Prevention. Whenever researchers study children, we talk to the parents and ask them for their permission. After you have heard more about the study, and if you agree, then the next thing I will do is ask your daughter/son for their agreement as well. Both of you have to agree independently before I can begin.

You do not have to decide today whether or not you agree to have your child participate in this research.

There may be some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask for clarification.

Purpose

We want to find out whether there is a link between polygyny and dry sex in your community and the spread of HIV. We also want to find out what is the importance of these cultural practices in your community. There are NGOs in your community that have been teaching people about HIV and AIDS prevention, I am also interested to know whether these NGOs are talking about the link between polygyny and dry sex and the spread of HIV and what can community members do to prevent the spread of HIV as a result of these cultural practices.

Type of Research Intervention

I will have a face-to-face interview with your child. It might take approximately 30minutes to 1hour to complete the interview.

Selection of Participants

I want to talk to teenagers about the link between HIV prevention and polygyny and dry sex. One part of health that we want to talk to them about is sexuality, health-seeking behaviour, sexual risk-taking, sexual experiences and polygyny and dry sex. We would like to ask your daughter/son to participate because she/he is a teenager and lives in this area.

Voluntary Participation

We know that the decision can be difficult when it involves your children. And it can be especially hard when the research includes sensitive topics like sexuality or something as important as one's culture. You can ask as many questions as you like and I will take the time to answer them. You don't have to decide today. You can think about it and tell me what your decision is later. You do not have to agree that your daughter/son can talk to me. You can choose to say no and I will respect your decision.

Procedure

Your daughter/son will participate in an interview with me.

This study will involve discussion of sensitive, private and well-regarded materials on sexuality, health-seeking behaviours, sexual risk-taking behaviours, sexual experiences and cultural practices.
If your daughter/son does not wish to answer any of the questions during the interview, she may say so and I will move on to the next question. The interview will take place at a private place at either an office at the church, school or NGO and no one else but the interviewer will be present unless your child asks for someone else to be there. I will also seek permission from your child to use a recording device. The information recorded is confidential, and no one else except me will have access to the information documented during the interview. The digital recorders and transcribed interviews will be kept in a safe place, where they will be locked in an office cabinet. After transcribing the interviews, the recorders will be destroyed immediately.

Risks and Discomforts

I will be asking your son/daughter to share with us some very personal and confidential information, and he/she may feel uncomfortable talking about some of the topics on sexuality, HIV risk behaviours, polygyny and dry sex. You must know that he/she does not have to answer any question or take part in the interview if he/she doesn't wish to do so, and that is also fine. He/she does not have to give us any reason for not responding to any question, or for refusing to take part in the interview.

Benefits

There will be no immediate and direct benefit to your child or you, but your child's participation is likely to help us find out more about the health needs of teenage girls and boys and we hope that these will help improve service provisions to teenagers in the future.

Reimbursements

Your daughter/son will not be provided with any payment as a result of participating in the study.

Confidentiality:

If your daughter/son participates, s/he and you may be asked questions by other people in the community.
We will not be sharing information about your son or daughter outside of the research team. The information that we collect from this research project will be kept confidential. Information about your child that will be collected from the research will be put away and no one but the researchers will be able to see it. Any information about your child will have a pseudonym on it instead of his/her name. The researchers will lock that information up with a lock and key. The records from your daughter/son's participation may be reviewed by people responsible for making sure that research is done properly, including members of the Ethics Committee at the University of Namibia and my PhD. supervisor.

Sharing of Research Findings

Nothing that your child will tell us today will be shared with anybody outside the research team, and nothing will be attributed to him/her by name. We will also publish the results so that other interested people may learn from this research.

Who to Contact

If you have any questions you may ask them now or later, even after the study has started. If you wish to ask questions later, you may contact me, Ms Immaculate Mogotsi at 081 3475 889.
This research has been approved by the University of Namibia Ethics Committee, which is a committee whose task is to make sure that research participants are protected from harm. If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the PhD Candidate at 081 3475 889 or the PhD Supervisor, Prof Lucy Edwards-Jauch Tel: +264 (0) 206 3139
E-mail: ledwards@unam.na

Part II: Certificate of Consent

I have been asked to give consent for my daughter/son to participate in this research study which will involve her completing a face-to-face interview I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a participant in this study.

Print Name of Parent or Guardian ....

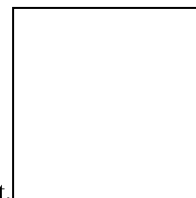
Signature of Parent or Guardian……………………………………
Date…………………………………………………………………….
Day/month/year

If illiterate

A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Illiterate participants should include their thumbprints as well.

I have witnessed the accurate reading of the consent form to the parent of the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness……………………………. AND Thumbprint of participant



Signature of witness ……………………………..
Date…………………………………………………
Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the parent of the minor participant, my ability made sure that the person understands that the following will be done:

1. Their daughter/son will be interviewed face-to-face

I confirm that the parent/guardian was allowed to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the parent or guardian of the participant

Print Name of Researcher/person taking the consent________________________

An Informed Assent Form will ____ OR will not ____ be completed.

Appendix 5: Research Tools: Key Informants

HIV AND AIDS BEHAVIOUR CHANGE PROGRAMMES AND CULTURAL PRACTICES: CASE STUDIES FROM SELECTED NGOs IN ZAMBEZI REGION, NAMIBIA

This tool is to be employed on:

HIV and AIDS Behavior Change Facilitators
Representatives from NGOs
RACOC members
HIV and AIDs National Coordination Committees
Directorate of Special Programmes HIV and AIDS

Introduction:

Good day, my name is Immaculate Mogotsi, I am a registered PhD student at the University of Namibia. This research is part of my PhD studies.

I am researching HIV and AIDS prevention and polygyny and dry sex and I want to find out whether NGOs that are training on HIV and AIDS prevention are including cultural practices in their training.

(Sign the Consent Form)

(Start Recorder)

Number of Interviewees……………………	**Age…………………………………….**
Sex of Interviewee………………………	**Name of research site………………………….**
Date………………………………….	

Demographic Background

I would like to ask you questions about your ***background****.*

1. Are you able to speak local languages? Which languages do you speak?
2. What is the highest educational grade you completed?
3. What do you currently do (probe studying, working, self-employed, unemployed)

Cultural practices

I would like to ask some questions on the link between polygyny and dry sex and the Spread of HIV, understanding/awareness of cultural identity and the link between culture and the spread of HIV. What is your understanding/definition of culture?

1. What role do you think culture plays in the lives of people?
2. Please explain what happens during these practices? (Probe for each practice individually)

- polygyny(***Libali***),
- Drying out the vagina for 'dry sex' **– (*Kuomisa busali)***

What are the purposes of these cultural practices in your community (Probe the importance of each one separately: wife inheritance, widow cleansing, child marriages polygyny

1. Given your role in the prevention of HIV and AIDs, do you think cultural practices contribute to the spread of HIV? (Probe: In what ways does each of the practices contribute)
2. Do you think cultural practices should be modified (Probe, How, by whom, what is the alternative to the polygyny and dry sex)

3. What do you think is fuelling the HIV pandemic in Kabbe and Katima Mulilo in general?
4. From your expert opinion, what is your perception about people in Kabbe and Katima Mulilo in particular about their general knowledge on how HIV spread?

Programmes

1. Is polygyny and dry sex occurring in the area where you are conducting HIV prevention programmes?
2. What programs are you working in related to IEC and HIV and AIDS?
3. Who develops IEC materials at the national level (Probe further at the regional level, constituency level, national level)
4. Do the CBOs develop any HIV and AIDS behaviour change training materials (Probe what region-specific issues have been incorporated into training materials?)

(*Request to collect hard and or soft copies of the training materials*)

Policy

1. Have you conducted any of your research or needs assessment about polygyny and dry sex in this community? (Probe: if yes ask for copies of both assessment tools and reports)
2. The National Strategic Framework for HIV and AIDS Response in Namibia between 2017/18 and 2021/22 speaks specifically about harmful cultural practices that fuel HIV and AIDS, what initiatives are in place nationally, regionally and at constituency level to address harmful cultural practices that fuel HIV and AIDS? Specifically, polygyny and dry sex

(*Request to collect reports or any documentation were gender relations transformation was documented, cultural practices of polygyny and dry sex discussed, training materials were recommended*)

End of Interview

We have reached the end of our interview. I want to thank you for the interview and for agreeing to be recorded. *(Stop Recorder)*

Appendix 6: Research Tools: General Population

Title of Study: **HIV AND AIDS BEHAVIOUR CHANGE PROGRAMMES AND CULTURAL PRACTICES: CASE STUDIES FROM SELECTED NGOs IN ZAMBEZI REGION, NAMIBIA**

This tool is to be employed on:

Men, women, Youth

Introduction:

Good day, my name is Immaculate Mogotsi, I am a registered PhD student at the University of Namibia. This research is part of my PhD studies.

I am researching HIV and AIDS prevention and polygyny and dry sex and I want to find out whether NGOs that are training on HIV and AIDS prevention are including cultural practices in their training.

(Sign the Consent Form)

(Start Recorder)

Number of Interviewees…………………………	**Age………………………**
Sex of Interviewee………………………	**Name of research site…………………**
Date………………………………….	

Demographic Background

I would like to ask you questions about your ***background****.*

1. Are you able to speak local languages? Which languages do you speak?
2. What is the highest educational grade you completed?
3. What do you currently do (probe studying, working, self-employed, unemployed)

Knowledge about Health seeking behaviour

1. How do people come to learn about HIV and AIDs prevention?
2. What kind of behaviour facilitates the transmission of HIV? Why (probe: what are men doing that could expose them to HIV, what are women doing that could expose them to HIV, what are young boys doing, what are young girls that could expose them to HIV)
3. Did information about HIV prevention also address the following cultural practices

(Probe for each one of the practices separately)

- polygyny(***Libali***),
- Drying out the vagina for 'dry sex' **– (*Kuomisa busali)***

4. How were the practices (mention each one separately) discussed with the contraction of HIV? (Probe for information that links the practices to the spread of HIV)

Impression about service delivery

1. Do people talk about the service they received on HIV prevention (Probe what do they say about services on prevention)
2. How easy or difficult do people find it to discuss HIV prevention with other family members, peers or spouses?
3. How can community members become more involved in preventing HIV and AIDS in their communities? (Probe what can women do, what can men do, what can the youth do)

Information and Decision to engage in sexual relation

In this conversation, we will talk about how people talk and learn about sex and sexual relationships within your community

1. How do people first come to learn about sex and sexuality (Probe parents, selected elders in the community, siblings, peers, do boys and girls learn the same way)
2. Are there any rite of passage that a young person must go through before they can start with sex (Probe, can you share with me what is done during the rite of passage, what are boys taught, what are girls taught, who is facilitating the teaching)
3. When people encounter sexual related problems, to whom do they talk? (Probe: Parents, selected elders in the community, siblings, peers, does the same applies to males and females)
    1. Are men and women guided on how to behave in a sexual relationship? (Probe, In what way? How different are men guided compared to females)?
    2. What are the factors/attributes that men consider when deciding with whom to have sexual relations?
    3. What are the factors/attributes that women consider when deciding with whom to have sexual relations?
    4. What are the factors that people consider when deciding whether to have or not to have a sexual relationship with someone? (Probe: are men considering the same things as women, how different are the factors, are the young people considering the same things as the elders)
    5. In sexual relationships who makes decisions about condom use?
    6. Under what conditions can a husband refuse to have sex with his wife (Probe what are the consequence for the husband who refuses)
    7. Under what conditions can a wife refuse to have sex with her husband (Probe: what are the consequence for the wife who refuses)

Cultural practices

1. What is the purpose of these cultural practices in your community (Probe the importance of each one separately:

- polygyny(***Libali***),
- Drying out the vagina for 'dry sex' **– (*Kuomisa busali*)**

2. What will happen in the community if the cultural practice of polygyny and dry sex is not followed (Probe rituals about bad omen)
3. Is there a perception in the community that these practices are promoting risky sexual behaviour? (Probe, How? Among women, men, youth)

Gender Dynamics

1. Among intimate partners, in your community who makes the decisions when it comes to sex?
2. How are women perceived in your community? (Probe What is their role? How much value is attached to their role, probe for submissiveness)
3. How are men perceived in your community? Probe What is their role? How much value is attached to their role, probe for dominance)
4. Does your community condone multiple sexual partners (bunyazi) (Probe: is it condoned if men are the ones involved in multiple sexual relations, is it condoned if women are involved in multiple sexual relations)?

End of Interview

We have reached the end of our interview. I want to thank you for the interview and for agreeing to be recorded. *(Stop Recorder)*