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HIV/AIDS in context: The culture of health promotion among Ndau women in rural Zimbabwe

Lynne Duffy

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The Culture of Health Promotion

Among Ndau Women in Rural Zimbabwe

by

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BScN, Université de Moncton, 1985

MEd., University of New Brunswick, 1996

Dissertation Submitted in Partial Fulfillment

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DOCTOR OF PHILOSOPHY DISSERTATION

OF

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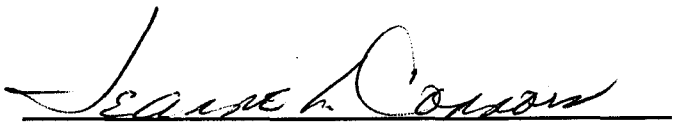

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ABSTRACT

This ethnographic study explored factors that facilitate or hinder women's participation in health promotion and HIV prevention in the Mt. Selinda area of rural Zimbabwe. Rates of HIV and AIDS in Zimbabwe are among the highest in the world and increasing most quickly among young females. A purposeful convenience sample of 11 Ndau women (key participants) was interviewed twice. Seventeen key informants and four focus groups offered further perspectives. The resulting narrative presents a picture of Ndau women's existence that is difficult and oppressive. Females are socialized early to be workers and mothers within a context of limited voice, subservience, violence, and economic powerlessness. Application of a health promotion framework reinforced the reality that these women are generally unable to use measures for HIV prevention. Socio-cultural and economic factors of gender inequality were analyzed through an ecological approach, showing that cultural beliefs and practices, along with national and international forces, support and sustain gender inequality. If there is to be change in the AIDS crisis, the study's findings suggest that HIV prevention strategies should be integrated within a participatory community development model that includes opportunities for both men and women to carry out gender analysis. While health professionals must understand and be sensitive to culture and context, existing unjust and inequitable structures at all levels of society must be examined and challenged.

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DEDICATIONS

This work is first of all dedicated to my husband, Dave, who exemplifies a role model for relationships based on gender justice, and who has supported me through this in so many ways. He is truly "the wind beneath my wings."

Second, this is dedicated to all women who experience oppression and gender injustice. May there be cultural and economic transformation for both women and men so that narratives like these will soon be only stories of the past.

ACKNOWLEDGMENTS

A dissertation process is considered a journey and can be a difficult and lonely one at times. In a distance program this is even more real, and when researching thousands of miles from home and university, the aloneness is amplified. Yet, the faculty and staff of Walden University made it less so through their caring and responsive manner at residencies and through e-mail contact. Dr. Robert Hoye guided me through my first year, and then committee chair Dr. Jeanne Connors, with members Dr. Sigrin Newell and Dr. Ray Thron, continued to challenge and nurture my thinking and writing. Dr. Barbara Knudson joined later as the 4th committee member, and she added further to the support and encouragement.

My mother, Pauline Ervin, deserves recognition for being not only a role model for what women can do, but also for the continued guidance and assistance she has provided over the years.

The Mt. Selinda Hospital staff and all participants were so supportive of this undertaking, as well as Chief Mapungwana, a very wise and caring leader of his people. May this project be a catalyst for social change in Mt. Selinda so that all may enjoy improved health and quality of life.

I am also grateful to Prentice Hall publishers for permission to use Pender's Health Promotion Model.

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INTRODUCTION TO THE STUDY

Introduction

This study emerged from the staff of the Willis F. Pierce Memorial Hospital in Mt. Selinda, Zimbabwe. Despite many years of preventive education, nurses and physicians were convinced that not only were the devastating effects of AIDS seen in hospitals and surrounding communities not declining, but they were getting worse. Why might this be happening when it was accepted that HIV prevention messages should be making a difference?

This researcher sensed that, from a health promotion and, more specifically, a health education perspective, something was missing in the way the learning was approached. Through the preliminary phases of this doctoral program, issues of HIV/AIDS prevention throughout the world were explored through a series of readings and writings. Two important themes emerged from these studies. The first was the apparent unique vulnerability of women to HIV and their critical role in child and family health in Africa. The second was the absence of a single magic solution to this global crisis. Instead, interventions need to be based on a thorough understanding of the contextual issues of people's lives.

Problem Statement

Rates of HIV and AIDS in Zimbabwe are among the highest in the world,

and increasing most quickly among young females. Levels of morbidity and mortality seriously affect all levels of society. Nearly 2 decades of prevention efforts appear to have made little difference in halting or reversing these trends. Many are calling for contextual studies to better understand local realities (Kalipeni, 2000; McGrath et al., 1993; Nzioka, 1996; UNIFEM, 2000). There has been insufficient culturally relevant knowledge of the experiences and beliefs of Zimbabwean women regarding health promotion and HIV prevention.

Background of the Problem

HIV/AIDS prevalence in Zimbabwe, along with other countries in sub-Saharan Africa, has reached alarming levels and is considered an extremely serious public health problem. Although every person has the potential for acquiring HIV, the spread has been unequal since 1998. While incidence rates are generally on the decline in industrialized nations, in the developing world the rates are increasing (UNIFEM, 2000). The transmission of HIV is a complex social and cultural issue in spite of what some see as one of individual responsibility and choice. The developer of the theory of reasoned action (TRA) wrote, "AIDS is first and foremost a consequence of behavior. It is not who one is, but what one does, that determines whether he or she will expose themselves or others to HIV" (Fishbein, 2000, p. 273). In spite of the biological and epidemiological

knowledge of the infection, this simplistic view can only perpetuate the problem. It does appear that who one is and where one lives, along with other biological and environmental determinants, influences not only transmission, but prevention, care, and treatment (Dutta, 1998; Loewenson & Whiteside, 1997). "Any epidemic sustains itself largely because of the social organization that supports its propagation, not simply because of the biological characteristics of the causative agent" (Bassett & Mhloyi, 1991, p. 144).

As with many diseases, AIDS has become known as a disease of poverty, although people in all social strata are infected (Berer, 1993). Women are noted to be more vulnerable and susceptible biologically, economically, and culturally than other segments of the population (Carael, 1996; Esu-Williams, 2000; Howson, Harrison, Hotra, & Law, 1996; Raffaelli & Pranke, 1995; Umeh, 1997; UNAIDS, 1999b).

Estimates from 2001 that 40 million people were infected worldwide placed 28.1 million of these in sub-Saharan Africa (UNAIDS/WHO, 2001). In Zimbabwe alone it was estimated that at the end of 1999 there were 1,500,000 adults and children living with HIV or AIDS out of a total population of 11,500,000; 160,000 deaths were attributed to AIDS in that same year (UNAIDS, 2000a). Ninety percent of HIV transmission in Zimbabwe occurs through heterosexual contact, with at least 25% of the adult population infected (UNIFEM, 2000). Previously

the highest prevalence was in males, but the trends are changing. Two thirds of new infections are occurring among girls and young women. Females between 15 and 19 years of age have five times the level of risk of males the same age (UNIFEM, 2000).

The Ministry of Health in Zimbabwe has now recognized that HIV/AIDS is no longer just a medical problem but a social and economic one that affects the whole country and its future. In the 1999 HIV/AIDS policy document, the minister of health stressed that the crisis required a focus on, and analysis of, gender, cultural norms, and human rights issues, as well as the need to create supportive environments for dealing with all aspects of the epidemic (Health Systems Trust, 1995). HIV/AIDS cases now account for the majority of deaths in the reproductive age group and are responsible for up to two thirds of hospital admissions. Increasing rates in women also translate into increased risk for infants through vertical transmission, as reflected in rising infant mortality rates. The number of orphans is also increasing, with estimates in Zimbabwe of 900,000 since the start of the epidemic (UNAIDS, 2000a). This has serious implications for the lives of these children and that of the country's economic future, with the loss of nurturing and educational opportunities that often follow the death of the mother or both parents.

Women in Zimbabwe are at a disadvantage in many areas of life. The

Gender and Empowerment Measure (GEM) examines three variables: women's political decision making, access to professional opportunities and public participation, and the degree of economic power. With a rating of 0.389, Zimbabwe ranked 43rd in the world. On the Gender Related Development Index (GDI) that measures gender equality, it ranked 83rd. Opportunities for health care, education, and paid work are less for females, while violence and abuse against women in this patriarchal society are at high levels (UNICEF, 1998).

Mulindi (1996) illustrated the complexity, gravity, and far-reaching effects of AIDS with the following:

> AIDS is a global problem of unprecedent consequences in the history of epidemics. It poses serious health, economic, social, ethical, political, religious, legal, cultural and philosophical problems that threaten to undermine the fabric and well being, adherence and understanding upon which societies must function and have functioned for centuries. AIDS is going to shape many aspects of society, its institutions, its norms and values, its interpersonal relationships and its cultural relationships. (p. 19)

The Context

Zimbabwe is a landlocked country in sub-Saharan Africa, bounded by Zambia to the north/northwest, South Africa to the south, Mozambique to the east, and Botswana to the west. Most of the country forms part of a large plateau that results in at least 80% of the land situated more than 900 meters above sea level. The climate is varied and ranges from the cooler, rainy weather in the Eastern Highlands to several hot, dry river valleys. It is a country with rich

agricultural areas including 8.6 million hectares of arable land, along with water sources, forests, minerals, and wildlife. Population figures from 1998 were estimated at 12.5 million with an annual growth rate of 3.1% in 1994, although with gradually declining fertility rates. Because of the strain on resources, the lower fertility rates were viewed as positive. Yet the discouraging reasons behind the fall include the continuing devastation of AIDS. Around 50% of the population is under the age of 18 (Ministry of Health and Child Welfare, 1998).

Approximately 99% of the Zimbabwean people are of African descent, mainly of Bantu origin, with the remaining of European, Asian, or mixed origin. The Bantu are believed to have entered the area during the 15th and 16th centuries with later invasions by other groups in the 19th century. The Shona are the majority at 70% of the population and include many subtribes, the larger of which are the Karanga, Zezuru, Ndau, and Korekore. The Ndebele account for approximately 20% of the remaining inhabitants (Moss & Wilson, 1991). The name Shona was applied by the British when they began colonizing the area (Bourdillon, 1987) and may have been an attempt to provide easy classification of a diverse group of people. Although it is an official name and the Shona language official in the country, many people consider "Shona" to be an artificial designation and instead define themselves through their particular tribal group.

Mt. Selinda

Mt. Selinda is situated on top of a large hill in Chipinge District in the southern most part of the Eastern Highlands of Manicaland province. It is approximately 550 kilometers from the capital Harare and eight kilometers from the border with Mozambique. Other than roadside stands and small shops at the hospital and the secondary school that sell a few food items, the nearest business area is 2 kilometers away in the township of Chako. Many people also travel to Chipinge, the district administration center, for more selection, usually by local buses or smaller commuter vans. Buses do leave the hospital daily for the provincial capital Mutare and the country capital, Harare.

Mt. Selinda is surrounded by the last remaining tropical rain forest in Zimbabwe, the Chirinda reserve, and overlooks fertile valleys that at present are large tea estates with some coffee and tobacco grown. These commercial farms compose about 24% of the catchment area. Approximately 50% of the land is occupied by small-scale farmers growing maize, the staple food, and vegetables and groundnuts. The remaining quarter is mainly government resettlement areas, and a small part consists of communal land (W. F. Pierce Memorial Hospital, 1996). The mission station, of approximately 200 acres, comprises the hospital, a large secondary school, a primary school, the church, and staff housing. Other than the mission housing, there are scattered homesteads in and

around the station. Many homes are still very traditional--round in shape and made of mud with a thatched roof. There can be several in one compound as the extended family is still prevalent in the rural areas. Newer homes are often constructed of locally made mud bricks or cement in a rectangle shape with tin roofing.

The local weather varies with distinct seasons including winter, although rarely below freezing, and the area has one of the highest rainfalls in the country. The one paved road running from Mt. Selinda to Chipinge is in generally poor condition on the Mt. Selinda side. Most roads in and around the mission station are not surfaced and are terribly rutted. Few people have private transport and either walk long distances or travel by donkey cart or public transport. Many roads are impassable without a four-wheel drive vehicle and during the rainy season are often washed out. Wild game, once plentiful, is now found only on reserves in other parts of the country due to clearing of land for farms and overhunting. Wildlife around the station consists of many species of birds and butterflies, two kinds of monkeys, and some baboons. Animals are not usually kept as pets, so many dogs roam about scrounging for a meal among the cattle, chickens, and goats that also spend their day doing the same. The roosters begin crowing very early in the morning to ensure that everyone is up with the sun.

Food is very simple with maize meal used for porridge and cooked thicker

for sadza, which can be eaten for two meals each day. Many say a meal is not complete without sadza. Rice and potatoes are a luxury. Vegetables dishes usually consist of cooked cabbage, rape, kale, or pumpkin leaves fried with a bit of chopped onion and tomato. Meat is another luxury and when available is usually beef or chicken cooked with a seasoned sauce used for dipping the sadza. As in most places, there is plenty of food, but economic conditions determine who has access. This availability fluctuates as the government has recently rolled back prices on basic foods and introduced price freezes on these in attempts to control rampant inflation. Instead of making them more accessible to people, bakers and others are saying they cannot afford to continue producing and will no longer provide these items. Shortages of basic foods such as ground maize for sadza, cooking oil, and sugar became a reality during the study and queuing for supplies when available became a regular occurrence.

Unemployment in the country is high with some figures reaching 70%. The mission station employs a large number of local people, as do the large commercial farms. The hospital at Mt. Selinda has grown to 175 beds with clinics, a waiting-mothers shelter, staff housing, and a nursing school. Under the hospital executive it has responsibility for the 50-bed hospital at Chikore and a nurse-run clinic at Gwenzi. Referrals begin at the community level with village health workers or farm health workers on the commercial estates. Gwenzi and

Chikore also refer more complicated cases for surgery. Monthly ward health meetings are held to discuss problems and solutions.

The official population of the main hospital catchment area is approximately 70,000, but due to the presence of migrant labor on the commercial farms the numbers fluctuate depending on the season. As well, nearly half of the patients travel from Mozambique for health care due to lack of services on that side of the border. Before the border was established between Zimbabwe and Mozambique, the Ndau lived as one people and the mission has felt a moral obligation to provide care for those on both sides. Mt. Selinda Hospital is often the only hope for treatment for these Mozambicans as they are refused care in other Zimbabwean hospitals, and they rarely have Zimbabwean money with them to pay if they were accepted. Patients also come from other parts of Chipinge district, whose total population is 330,000 (W. F. Pierce Memorial Hospital, 2000).

The Women of Mt. Selinda

It is not easy to present a composite picture of the women of this area even after several months of observation and discussions, as well as a case study carried out with an Ndau woman in June 2001. One finding in that case study was the participant's difficulty to describe women without reference to men.

In this patriarchal tribe women are not seen as equals, and many men and their families associate the payment of the marriage lobola to the purchase of the woman. Women tend to be very soft spoken and modest with some speaking so quietly they can hardly be heard. It appears difficult for them to give an opinion in hospital meetings and they often sit quietly, never offering their thoughts about a topic. The use of the other official language, English, may contribute to this as it is not used except in the hospital and only with foreign personnel. Yet there are many degrees of behavior amongst the women, and some could be considered boisterous. But this is not viewed as a positive characteristic.

Deference to men is the norm, and women are generally socialized to the role of reproduction and pleasing the husband. Traditionally it is expected that women are responsible for all aspects of running the house and caring for the children. There is some difference between younger and older women. Younger couples exhibit new ways of relating to each other and even share in the care of house and children. These traditions do not change quickly. The woman interviewed for the case study reported that her husband might help in the house but he closes the curtains first. When he leaves the house and his friends ask him what he was doing, he lies and says he was watching television. The continued high expectation for children means that very few, if any, women in the childbearing years are without a child. Usually there is a baby being carried on

their back and several others in tow.

The standard of living is quite subsistence for the majority. Women's dress is very simple, often a traditional wrap for a skirt, and frequently of drab colors. Men wear Western style clothes while trousers for females are not well accepted in the rural areas. Even when the weather is cold a teenager or young female adult might wear slacks but with a skirt over top. Older women would never consider wearing such an outfit. Women with higher incomes wear Western style dresses and skirts, and some arrive at work very dressed up.

Purpose of the Study

The purpose of this ethnographic study was to explore and describe cultural and contextual issues that may facilitate or hinder female participation in health promotion, especially relating to HIV prevention in the Mt. Selinda area of Zimbabwe. Central to the study was an attempt to understand Ndau women's reality, experiences, beliefs, perceptions, and meanings of health, health promotion, and HIV/AIDS.

These findings are expected to enhance understanding of how culture and health are interrelated. This could provide new directions for HIV prevention that will be relevant and appropriate, and that will begin to effect change in this unrelenting epidemic.

Research Questions

Main Question

What factors facilitate or hinder women's participation in health promotion and prevention of HIV in the Mt. Selinda area of Zimbabwe?

Subquestions

1. What are the local meanings, beliefs, and practices concerning health, illness, and health promotion?
2. How do gender, socio-economic status, religion, and culture interact and influence participation in health promotion and HIV prevention?
3. What other factors are seen as affecting the prevention of HIV? (Personal and environmental).
4. What do the people see as the most pressing needs in relation to improved personal and community level health and wellness?
5. What do they think needs to happen for change in the HIV epidemic?

Conceptual Framework

According to Glanz, Lewis, and Rimer (1997), a conceptual framework refers to "broadly conceived perspectives used to organize ideas" (p. 29). This is an important exercise as the existing perspectives around health and health promotion are varied, complex, sometimes controversial, and continually

evolving. There are many theories and models of health promotion, each with strengths and weaknesses. Therefore, an eclectic approach may be needed in order to fit with the complex reality of research and practice settings. "Health promotion and health behavior are concerns of ever increasing importance to the well-being of humankind worldwide. As scholars, researchers, and practitioners, all of us grapple with the complexities of human beings and societies" (Glanz et al., 1997, p. 31). Michael McGinnis wrote, "Human behavior is the product of the interaction of multiple factors found in the many facets of our biological, environmental, and cultural exposures. Any one of these factors can be powerful but none acts independently" (McGinnis, 1997, p. xvi). Richard et al. (1996) asserted that an understanding of health can only "be achieved if the context in which people live is taken into account" and "the ecological approach compensates for the limitations of traditional individual approaches often associated with victim blaming" (p. 318).

With an appreciation of the complexity of human and environmental interactions, as well as the importance of viewing health and health promotion as greater than individual behavior, an ecological approach underpins this study. Sallis and Owen (1997) stated that an ecological perspective "focuses on the nature of people's transactions with their physical and sociocultural surroundings" (p. 403). The behavior environment in these models refers to "any

space outside the individual" (p. 403). The authors concur that the field is under development and changing quickly, but offer a tentative definition.

> Ecological models of health behavior posit that behaviors are influenced by intrapersonal, social and cultural, and physical environmental variables; posit that these variables are likely to interact; and describe multiple levels of social and cultural and physical environmental variables as relevant for understanding and changing behaviors. (p. 404)

To assist in gaining a broader perspective and increased understanding of the complexity of these issues, several critical influences on the development of an ecological approach to health promotion and examples of several models for research and interventions are discussed in chapter 3.

The Health Promotion Model

A model used to guide this study is the health promotion model (HPM), developed by an American nurse, Dr. Nola Pender. Revised in 1996 following considerable research, it is based on social learning theory, expectancy-value theory, and self-efficacy. It has not been specifically mentioned in the literature as an ecological model, yet Pender's framework reflects a multidimensional, multidisciplinary perspective of health and health promotion--one that is oriented towards wellness and care, not illness and cure.

Pender (1996) stressed the need for theories to "have relevance across genders and cultures" and that cultural sensitivity and cultural competence must

characterize health-promotion and health protection research if it is to make a difference in the health experiences of individuals, families and communities" (p. 47). "Increasing healthy behaviors and decreasing risky or health-damaging behaviors is the major challenge facing health professionals and populations globally during the next several decades" (p. 45).

The HPM (Figure 1) contains 10 determinants of health promoting behavior, described in more detail below. Although not all have been rigorously tested, nor their relationships, they appear to provide a comprehensive guide for assessing and analyzing individual and environmental factors in this research. The 10 determinents include:

1. Prior related behavior—based on studies that have shown that the frequency of people's past behavior is the best predictor of future, similar efforts. It has been shown to have both direct and indirect influence on the probability of engaging in health promoting behaviors. This is related to self-efficacy in that previous successful actions improve one's perception of ability and is influenced by the type of feedback received. The memories one has of the event, including the emotional aspects, are encoded and later retrieved when faced with similar situations (p. 67).

2. Personal factors—biological (age, sex), psychological (self-esteem, self-motivation, definition of health), and sociocultural (race, ethnicity, education,

socioeconomic status). These factors are considered to have a direct effect on cognitions, emotions, and health-promoting behavior (p. 68).

3. Perceived benefits of action—considered a "necessary although not sufficient condition" for undertaking healthy behaviors. There is a need to see some value or reward for change and these can be internal (e.g., feeling better or stronger) or external (better relationships, some tangible reward).

4. Perceived barriers to action—may be perceived or real but often result in low levels of commitment and avoidance of the behavior, especially if these barriers are assessed to be extremely high.

5. Perceived self-efficacy—pertains to one's belief in the ability to carry out a certain act. It is the process, not the outcome, and can involve knowledge and skills. In this model it is seen as directly affecting health-promoting behavior and indirectly through influencing level of commitment and perception of barriers.

6. Activity-related affect—positive feelings encourage the replication of behaviors while negative ones discourage actions. This can be related to the activity itself, personal feelings, or those related to the context in which it takes place. Affect is said to directly influence health behavior and indirectly through self-efficacy and commitment (p. 70).

7. Interpersonal influences—involves the thoughts about how family, friends, community, and others perceive the behavior. Norms, social support,

and modeling are important aspects. These influences are thought to influence behavior directly as well as indirectly through either the pressure or encouragement received from others (p. 71).

8. Situational influences—aspects of the environment that can facilitate or hinder health actions. These can have a direct influence through the provision of behavioral triggers or cues that are either positive or negative. "They may hold an important key to developing new and more effective strategies for facilitating the acquisition and maintenance of health behaviors" (p. 71).

9. Commitment to a plan of action—based on the understanding that people generally behave in organized ways. Commitment to an action involves specifying time, place, people involved, but also specific strategies for carrying out and reinforcing the acts (p. 72).

10. Immediate competing demands and preferences—areas of influence that can interfere with commitment at the time the behavior is to take place. Demands are usually external responsibilities, such as family or work, while preferences are other behaviors the person prefers over the planned one. These both directly affect the probability of carrying out the planned behavior (p. 72).

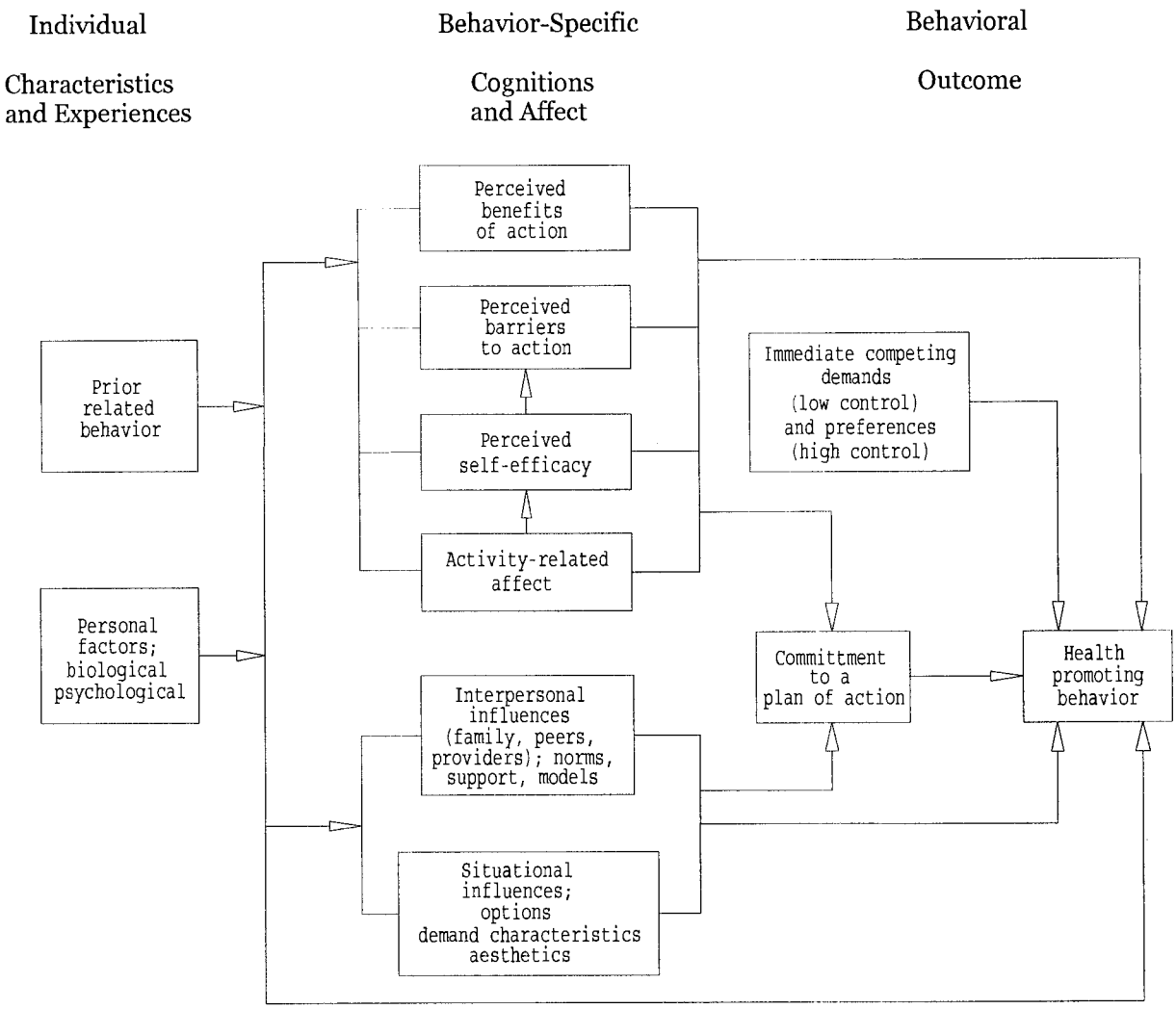

Figure 1. Health promotion model (revised) from *Health Promotion in Nursing Practice* (3rd ed.), 1996, p. 67. Reprinted with permission.

Definition of Terms

AIDS—Abbreviation for acquired immunodeficiency syndrome, the advanced stage of HIV disease, marked by opportunistic infections and malignancies, and a reduction of CD4 lymphocytes to less than 200 per mm^3 of blood (Ward, 1999, p. 392).

Context—"The circumstances relevant to something under consideration" (Allen, 1990, p. 248). "The environment(s) which an individual inhabits before, during and after situations of interactions with others" (Rapport & Overing, 2000).

Ecology—"The study of the relationships between organisms and their environments"(Stokols, 1996).

Gender—"Whereas sex is biological, gender is socially defined. Gender is what it means to be male or female, and how that defines a person's opportunities, roles, responsibilities, and relationships" (UNAIDS, 1999b, p. 11).

Health—"a concept that exists along a continuum; it is a resource for daily life that enables one to meet personal needs as well as realize aspirations" (Murdaugh & Vanderboom, 1997, p. 1). "Health is a positive concept

emphasizing social and personal resources, as well as physical capacities" (WHO, 1986, p. 1). "Health is the actualization of inherent and acquired human potential through goal-directed behavior, competent self-care, and satisfying relationships with others while adjustments are made as needed to maintain structural integrity and harmony with relevant environments" (Pender, 1996, p. 22).

Health promotion – "The process of enabling people to increase control over, and to improve health" (WHO, 1986, p. 1). "A process engaging the physical, emotional, social, physical, psychological and spiritual dimensions of well-being.... applied with a sensitivity to the variety of physical, cultural, social and ecological dimensions involved in promoting healthy lifestyles" (Gillis, 1995, p. 11). "...is concerned with the twin goals of changing both lifestyle and socio-economic-political structures" (Nettleton & Bunton, 1995, p. 44).

HIV – Abbreviation for the human immunodeficiency virus, which is responsible for HIV disease and AIDS. There are two types having the same route of transmission, with HIV-1 being the most common worldwide. HIV-2 is mainly found in West Africa. HIV disease (formerly called ARC or AIDS Related Complex) includes swollen lymph nodes, night sweats, unexplained weight loss,

oral candidiasis, and oral hairy leukoplakia (Ward, 1999, p. 407).

Social ecology of health promotion – an approach that "integrates person-focused efforts to modify person's health behavior with environment-focused interventions to enhance their physical and social surroundings.... a theoretical framework for understanding the dynamic interplay among persons, groups, and their sociophysical milieus" (Stokols, 1996, p. 283).

Assumptions

1. HIV prevention needs to be carried out with an understanding of the forces acting at various levels of people's lives.

2. There are both strengths and limitations existing in most cultures that require critical analysis, especially when faced with major challenges and destabilizing forces such as HIV/AIDS.

3. The local community in general has seldom been involved in assessing contextual factors relating to health and quality of life, or in deciding on appropriate interventions.

4. Local women have much experience and wisdom that remains untapped and should be seen as an essential resource for family and community level change.

Limitations

1. The researcher, who was new to the region, had a different background and was from a culture with differing beliefs, which could bias the representation.

2. The local dialect limited who could participate and increased the possibility of misunderstandings when English, as the participant's second or third language, was used for the interviews. Without an understanding of the language, the researcher may have missed some cultural messages and meanings.

3. The historical inequality of whites and blacks may have had an impact on relationships between the white researcher and local participants and the degree of trust that could be established. As well, gender and power issues may have been barriers to honest responses.

4. The sensitive nature of sexual issues, and the secrecy and stigma around HIV/AIDS in the country, may have limited willingness to openly discuss these issues.

Concerns regarding language and other differences between the researcher and participants were addressed though the involvement of local women in areas of translation, with review of findings and feedback on emergent themes or patterns with a local research assistant.

Significance of the Study

The importance of this study is in achieving greater understanding of the links between culture, other determinants of health, and HIV prevention. People who are living amidst the devastation of AIDS have had an opportunity to be listened to and heard, some whom may rarely have a voice in their health or the health of their communities. Health services are often imposed by external agents and, in the case of Mt. Selinda, have mainly been through American and European missions. This, along with organized religion, has perpetuated the Western biomedical model through continued use of expatriate health providers, and both appear to have played a role in how traditional medicine is practiced and used. Local church ownership since 1974 has been under the leadership of personnel with no health background and living far from the station.

HIV prevention programs to date have shown little positive change and are often based on Western models with little evaluation, especially in the long term. A greater understanding of HIV transmission in different socio-cultural contexts should have important consequences for designing and monitoring educational efforts to encourage self-protective behavior. There is an urgent need to develop a body of country and region specific information concerning patterns of behavior and their determinants. Most AIDS research in Africa continues to be primarily epidemiological, and much more research on patterns of sexual

behavior in any society must be embedded in a thorough knowledge of social values and social organization (Carael, Cleland, Deheneffe, & Adeokun, 1992, p. 63). According to Myntti (1998), research in reproductive health by the World Health Organization (WHO) needs to address the broad context of reproductive and sexual health, start with the needs of women and men at various life stages, include gender analysis, and work towards increased equity (p. 102).

> Campaigns that aim to achieve individual behaviour change simply through persuasion are therefore flawed and may even be counterproductive. This is because such campaigns construct behaviour...as a lifestyle choice, rather than understanding it within a material and cultural framework incorporating an analysis of class, gender, and other inequalities. (Daykin & Naidoo, 1995, p. 61)

There appears to be little recent research on the Ndau people of Zimbabwe, and none specifically on their health practices. This study is a beginning exploration and analysis of some of the contextual issues around health and illness, with the purpose of increasing awareness and understanding in order to effect change at individual and community levels.

Summary

Chapter 1 reviewed the purpose and significance of this qualitative research in the Ndau population of Mt. Selinda, Zimbabwe, with a special focus on women, who appear to be most vulnerable to the ravages of HIV and AIDS. Research questions guided this ethnographic exploration using an ecological

perspective of health promotion that implied not only examining people's beliefs and contexts, but also the interactions that take place between and among them. The ultimate purpose was to provide a new way of looking at health and culture in order to provide direction for programs intent on improving health and, therefore, quality of life. Chapter 2 provides a review the literature on various aspects of the study. These include HIV/AIDS, women, health promotion, and culture, especially within Africa, and more specifically Zimbabwe.

CHAPTER 2
REVIEW OF THE LITERATURE

Introduction

Chapter 2 provides a review of the literature pertaining to the key areas of the study. These include the history of HIV/AIDS with its global and local impact especially in relation to women; the historical context of the study, notably Zimbabwe, Mt. Selinda, and the Ndau people; health promotion; and issues around health and culture. The chapter concludes with a discussion of the research method for this project.

HIV/AIDS

Development

Although several ideas have been proposed, there is no agreement on how HIV began. Several hypotheses, not especially helpful in its eradication, have blamed another part of the world or within certain culture-sharing groups. One theory from Western countries placed the origin of HIV in two species of African monkeys, from which it was then transferred to humans. Other regions implicated the West as producing and releasing the virus from a laboratory experiment (Feldman, 1990). These theories have generally been discounted in the scientific realm, though the myths generated by them still reside in the belief systems of many people. This has led to extreme and coercive measures to

combat this threat both at individual and group levels, and has fostered cross-cultural misunderstandings and racism (Feldman, 1990; Harrison-Chirimuuta & Chirimuuta, 1997; McCombie, 1990). As well, considerable denial has occurred, especially regarding the existence of heterosexual transmission, even though this was documented as early as 1982 (McCombie, 1990). Such denial included the idea that female-to-male transmission was not possible and seen as an extension of a sexual double standard that implies promiscuity is "safe" for men but not for women (McCombie, 1990, p. 17). Denial of HIV/AIDS in general also occurred at national levels, partly due to the racist implications and threats to economies that led to poor or attenuated responses early on in the epidemic (Bassett, 1991; Caldwell, 1992; McGeary, 2001). In Zimbabwe, although AIDS education campaigns began in 1985, no statistics were made public on the extent of the epidemic until 1990. AIDS as a diagnosis was also not allowed on death certificates before that time (Meursing & Sibindi, 1995).

AIDS was first reported in the Center for Disease Control's (CDC) *Morbidity and Mortality Weekly Report* of June 1981. Cases of pneumocystis carinii pneumonia (PCP) from an immune deficiency had been found in five previously healthy males from Los Angeles. In addition to gender and location, the other common factor was that the men were from the gay community. Over the next year and a half other cases appeared in intravenous drug users, recipients of

blood transfusions, people from Haiti, and some children. By the end of 1982, the term AIDS was being used to describe this mysterious syndrome. It also appears to have been recognized in Africa around the same time as in the United States. Case definitions evolved as more was learned about the virus and its clinical manifestations. These changes have affected the reporting and recording of illness and death, which, in turn, have an impact on how the level of seriousness is measured. Since AIDS is often diagnosed in relation to the opportunistic infection that is present, then tuberculosis or PCP may be indicated as the cause of death and not AIDS, which further skews statistics (McCombie, 1990).

Epidemiology

By 1984 the human immunodeficiency virus (HIV) was determined to be the causative agent of AIDS. HIV is a retrovirus and at present has two types, HIV-1 and HIV-2, each with various subtypes. HIV-1 is considered to be more virulent than HIV-2 in that it is more common and symptoms occur earlier following infection. The functioning of the human immune system and the invasive process of HIV are extremely complex. The following is a simplified explanation.

The HIV replicates by attaching to the CD4 molecules on cells of the immune system, where it then gains entry to the cell's cytoplasm. These immune

system cells are a type of white blood cell critical to the body's immune response and are called T lymphocytes, CD4 lymphocytes, or Helper Ts. The normal number of CD4 cells is between 500 and 1,500 cells per cubic millimeter (mm^3). Using host cells, and through the process called reverse transcriptase, the HIV's two RNA strands are converted into a DNA molecule that can then enter the nucleus of the host cell and becomes a permanent part of its chromosome structure. This provirus may remain quiet in the cell, but, if activated such as during cell division, the HIV provirus is also activated and reproduces. It gradually takes over the cell's production of the immune proteins and the host cell is eventually weakened and unable to ensure its own survival. A provirus can produce thousands of offspring, and new virions (virus particles) can be developed within 8-12 hours. Errors can occur during the process of reverse transcriptase, resulting in mutations or genetic changes, which help explain individual drug response and resistance levels (Ward, 1999).

The body's reaction to an invasion of HIV is the activation of the CD4 lymphocytes that are necessary to initiate the two types of immune responses: either cell-mediated (in response to antigen-like molecules on the cell surface), or antibody-mediated (in response to antigens in blood and other fluids). The presence of antibodies (immunoglobulins or Ig) is a result of this latter response. These are large protein molecules stimulated by antigens. The presence of anti-

HIV antibodies in the blood shows up as an HIV positive test. Therefore, it is not the presence of HIV that is tested, but the body's response to it (Ward, 1999).

Transmission of HIV is through three main routes:

1. Sexual contact (heterosexual or homosexual) accounts for about 90% of transmission worldwide. It is thought that male to female spread is around 1 in 100 unprotected sexual contacts, while female to male is considered to be one in every 1,000 sexual contacts. Anal intercourse has the highest risk at 1 in 20. These rates are variable and depend on HIV prevalence rates and individual susceptibility, such as the presence of other infections, especially sexually transmitted diseases (STDs), level of sexual activity, and genetic traits.

2. Contact with infected blood, blood products, body fluids or tissues. This includes blood transfusions, sharing infected needles, using contaminated instruments, and splashing fluids on skin cuts or mucous membranes.

3. Vertical transmission occurs when the virus is spread from mother to baby before or during delivery, or through breastfeeding.

HIV has been found in other body fluids such as saliva, tears, and cerebral spinal fluid, but there are no confirmed cases involving these (CDC, 2001; Ward, 1999).

Once a person has been infected there are four stages of HIV disease progression:

1. Acute infection stage—HIV begins to multiply in infected cells with the immune system triggered after a few weeks. CD4 counts are normal. Blood levels quickly rise and the person is highly contagious. About half of those infected may have no symptoms while others experience a flu-like syndrome lasting 2 weeks to 2 months with fatigue, fever, headache, sore throat, swollen lymph glands, rash, diarrhea, and muscle aches (Ward, 1999, p. 54).

2. Asymptomatic stage—The longest stage, lasting on average up to 10 years, although with much variation. There are few if any symptoms but the virus is quickly multiplying and destroying immune cells. CD4 counts begin to lower but may remain above 500 mm^3. Sometimes certain opportunistic infections take hold or people experience skin conditions.

3. Early HIV disease—The development of one or more opportunistic infections and CD4 counts between 200 and 500 mm^3. Common illnesses include oral candidiasis, herpes simplex, shingles, and oral hairy leukoplakia along with bacterial infections. The presence of these infections stimulates the already affected immune system and results in more targets being available for HIV attack. Symptoms during this stage are a continuation of those from the asymptomatic stage along with recurring diarrhea and unexplained weight loss.

4. Advanced HIV disease (AIDS)—More serious opportunistic infections and cancers are present (e.g. lymphoma, Kaposi's sarcoma, and rectal and

cervical cancer), along with a further drop in CD4 levels to below 200 mm^3. There is a heightened risk of acquiring AIDS-defining infections, especially when CD4 counts are below 50 cells per mm^3. Approximately 30% to 50% of people in this stage develop neurological conditions such as AIDS-related dementia (HIV encephalopathy) (Ward, 1999).

A small percentage of infected individuals (5%-7%) are considered long-term progressors and can be asymptomatic for up to 15 years. A few people may even have a genetic resistance that offers long-term protection. The eventual cause of death is usually from cancer, an opportunistic infection, wasting, or heart disease (Ward, 1999).

New treatments are continually being tested and have changed the direction of the spread and lowered mortality rates in the industrialized world. Unfortunately, because of the extremely high costs, most of these drugs are not available to developing countries. The need for consistent testing and follow up is difficult when even basic or essential health care may not be accessible to all. In spite of efforts to develop a vaccine, none is available yet and there are concerns that one vaccine may not be suitable for all populations because of the wide variations in types of HIV and its frequent mutations (Buckingham, 2001).

Africa

Although HIV/AIDS has been called a pandemic, and therefore present throughout the world, it is in Africa that the greatest number of people have been infected to date. Even here the distribution is not even. Some countries have low prevalence rates while others, such as Uganda and Senegal, are seeing rates decrease (UNAIDS, 2000b). The area known as sub-Saharan Africa appears to be the most severely affected, with some of the highest AIDS related morbidity and mortality rates along with the greatest number of orphans. With 10% of the world's population, the sub-Saharan region has 70% of all AIDS cases in the world, 80% of deaths from AIDS, and 90% of the orphans (UNICEF, 2001, p. 39). Zimbabwe is reported to have an adult prevalence rate of 25% and in 1999 the Minister of Health reported that 250 people were dying each day, mostly from AIDS (UNIFEM, 2000). In 1998, the WHO projected that Zimbabwe would have 2,400 people dying each week from AIDS, resulting in a 45% rate of orphans (Buckingham, 2001, p. 62). AIDS is affecting all levels of society in the region and is considered to be not only an economic developmental crisis, but also a critical security issue. This recognition occurred when the United Nations Security Council meeting in January 2000 had AIDS as its theme, the first time a health concern attained such status (UNAIDS, 2000b).

Heterosexual and mother-to-baby transmission accounts for the majority

of cases in Africa, including in Zimbabwe (National AIDS Coordination Programme, 1998). Although homosexuality exists in the country, there is much secrecy along with increasing political homophobia since 1995 that work to keep the extent of these practices well hidden (Epprecht, 1998). Blood has been screened for HIV in Zimbabwe since 1985 (Ministry of Health, 1999). Young adults and children under the age of 5 are incurring the highest death rates. This has the effect of altering the profile of the population pyramid with potentially serious implications for the future.

Women's Vulnerability

Although prevalence of HIV is nearly equal between men and women, incidence rates for females are increasing faster than for males in many parts of the world (Esu-Williams, 2000). In Zimbabwe the rate in females aged 15-19 years in 2000 was five times that of male peers (National AIDS Coordination Programme, 2000). It is believed that women are more biologically vulnerable to infection (Doyal, 1994; Raffaelli & Pranke, 1995). Women are two to four times more likely to become infected during sexual intercourse for various reasons. First, there is more mucosal area exposed (National AIDS Coordination Programme, 1998). In young girls this is compounded by the presence of immature tissues and reduced or thinner vaginal secretions. Second, there is

usually a higher concentration of the virus in semen than in vaginal secretions. Possibly more important than the sexual bias is a gender bias, with socially defined roles appearing to heavily impact the risk of acquiring HIV.

Women with HIV/AIDS are often blamed for the infection, as they have been throughout history in relation to other STDs (Morrison, 1997; Schoepf, 1995). With an AIDS diagnosis females may be sent away or ostracized by both in-laws and family of origin, even though they most likely contracted the infection from their husbands (Meursing & Sibindi, 1995). This often leads to greater poverty for women. With few if any choices for work in the formal market they rely on sale of sex to survive (Doyal, 1994). Rural women have fewer marketable skills and often less education than their urban counterparts. With increased migration and the resulting competition in towns and cities, the chances of women making a living in the formal sector are further reduced.

Role and Status

One of the most common reasons given for women's differential health status is their inferior standing within the prevailing patriarchal structures found in most of Africa. A study in Zimbabwe found a positive association between level of household decision making and women's health (Hindin, 2000). It is accepted that the male role is to strengthen and perpetuate the family lineage;

therefore, procreation takes a central position in the lives of both men and women. It is critical then that women are faithful to their husbands to avoid "contamination" of the line, while men's infidelity is of less concern (Ankrah, Mhloyi, Manguyu, & Nduati, 1994).

According to Lawson (1999), some cultures believe that it is actually the man's blood that creates the fetus and therefore produces the strong kinship ties between father and children. The woman's role and her value revolve around her ability to produce children, who then belong to the husband and his family. The lobola or dowry is a payment to the woman's family, and carries the implication she is being purchased for the husband's use in both production and reproduction (Ankrah et al., 1994; Stewart, 1995; Watts, Keogh, Ndlovu, & Kwaramba, 1998). Within these practices, a woman's ties with her own family are often weakened or severed. In the event of the husband's death or a divorce, a woman may lose all rights to the children and other resources, yet she is often unable to return to family of origin (Ankrah et al., 1994). This, along with the stigma of living without a partner, increases the chances for multiple, informal relationships for both community acceptance and basic survival (Lawson, 1999).

Sexual Issues

Within the patriarchal structure, needs and desires of women are not

considered important, and women are not expected to express these or take any part in sexual decision making (Watts et al., 1998). This results in women's reluctance to seek information or to find ways to protect themselves (UNAIDS, 1999b). In Zimbabwe, ignorance of sexual matters in females is associated with innocence, which has implications for both prevention and treatment (Ministry of Health, 1999). In some cultures women may not be able to refuse sex with the husband's relatives, let alone their own spouse. Bringing up the subject of condom use indicates they are either guilty of unfaithfulness or do not trust their spouse, even when there is clear evidence of him having other partners (McGeary, 2001; Meursing & Sibindi, 1995; Ray et al., 1995).

Women refusing sexual advances, taking the initiative in sex, or suggesting condom use can lead to violent confrontations. The threat of HIV might seem remote when the concern is with immediate safety or economic security (Bassett & Mhloyi, 1991; Doyal, 1994). It is generally the woman's responsibility to maintain the sanctity of the family, and this seems to depend on her being viewed as an asexual being. These double standards—the forced acceptance or denial of male promiscuousness and lack of women's autonomy—result in high-risk situations. As Esu-Williams (2000) noted, there exists a "gender paradox," for males are most likely to have multiple partners, yet women carry the most blame and suffer the greater stigma (p. 3).

In many African countries women are considered minors all their lives and must submit to the wishes of fathers, brothers, husbands, and later their own sons if left without a husband. Even when laws are passed to prevent this, as occurred in Zimbabwe after independence in 1980, many women remain unaware of their rights (Hindin, 2000). Submission to others is learned early, and it is difficult, if not impossible, for young girls to refuse sexual advances of older males (Meursing et al., 1995). The concept of "sugar daddies" is common in many countries, with men offering money or gifts in exchange for sex. Attaining a place in school or achieving good grades have been linked to sexual exploitation by teachers and headmasters (UNAIDS, 1999b).

The belief that sex with a young person provides protection from HIV or that sex with a virgin can cure one of AIDS increases exploitative practices and the rates of HIV in the young female population. (UNAIDS, 1999a). Sexual coercion and rape are common, with very few girls or women reporting such attacks. If it is made public the victims are often blamed for encouraging it. It is very difficult to find police support for domestic violence. Marital rape generally is not considered a crime. Child sexual abuse is considered to be the most unreported and underreported crime in most countries (Meursing et al., 1995).

In Zimbabwe, violence within marriage is often tolerated as a way of men exercising their rightful power, with women socialized to accept it (Getecha &

Chipilca, 1995). Forced sexual intercourse increases the chances that HIV can be transmitted due to damage to the vaginal wall, and in some countries female genital mutilation continues with resultant trauma during sexual intercourse (UNAIDS, 1999a). Many women in Zimbabwe and other countries practice "dry sex." This involves the instillation of herbs or other drying agents prior to sex that tighten the vagina in order to increase the man's pleasure. Some insist that these practices increase damage to the mucosal lining, and women agree that it can make the sexual act painful. They report a reluctance to stop this practice, as they believe this would cause their partners to seek other women (Civic & Wilson, 1996; McCharen & Sandasi, 1996; Schoofs, 1999). Many in Zimbabwe also associate vaginal lubrication with disease and promiscuity (Coggins, Blanchard, & Friedland, 2000).

Premarital sexual activity is often tolerated in much of sub-Saharan Africa and beginning at age 15 or earlier. This, along with the general developmental challenges of adolescence (e.g., rebellion, curiosity, peer pressure), results in high risk of pregnancy, STDs, and AIDS (Ankrah et al., 1994). Any discussion of sex among family members is usually discouraged. This education has traditionally been left to either leaders of initiation rites or to specific family members such as the father's sister. The extended family structure is changing due to many factors, including migration and wars, and yet family or schools have not taken

over the responsibility (Meursing et al., 1995). Young boys in Zimbabwe have been found to frequent commercial sex workers, often from peer pressure and norms that imply this is expected (Campbell & Mbvizvo, 1994)

Traditional Practices

The levirate system is common in many African cultures and has been implicated in HIV transmission (Lawson, 1999). This practice involves a widow being "cleansed" after her husband's death by having sex with his brother. She is then taken in as one of his wives. In the past this was a way of protecting widows, preventing the family having to repay the dowry, and tended to keep any property within the family. Now with so many men dying of AIDS, and the high risk of the wife being infected, there is a fear that the infection will be passed on to brothers. Some countries have begun a symbolic form of this cleansing and it has become an acceptable replacement (Getecha & Chipilca, 1995; Webb, 1997).

Polygamy, still practiced in various forms in much of Africa, has been implicated in the transmission of HIV, although Frank (1992) argued that this tradition is a protective factor in prevention. This could be true when having multiple partners is acceptable for men, and if those within polygamous structures are free of HIV and remain faithful. Frank contrasts polygamy with

men's informal sexual contacts, which increases the risk of bringing HIV into a monogamous marriage. As has occurred with STDs historically, the male often brings an infection to the marriage from premarital relationships. Therefore, faithfulness within the marriage will not protect the female, as it is already too late (Nilses, Lindmark, Munjanja, & Nystrom, 2000). Women may also become infected before marriage or through extramarital relationships, although it tends to be less of a problem due to greater social control over their actions. This also may be changing as traditions are challenged in the push for modernization. Lawson (1999) stressed that these changes, especially in urban areas, have resulted in confusion about the actual description of tradition, and she prefers to use the term sociocultural practices.

Birth practices in Africa, especially with poorly trained attendants using unclean equipment and scarring rituals using infected instruments can also transmit HIV (Lawson, 1999). The majority of HIV infected mothers have no choice whether to breast feed or not, as using prepared formula carries a higher risk of neonatal mortality from malnutrition and diarrheal diseases. A dilemma for women relates to their reproductive role. Use of condoms to prevent HIV is incompatible with family and societal expectations of fertility, and therefore protection for women is more difficult (Lawson, 1999; Raffaelli & Pranke, 1995).

In many countries a boy's education is considered more important than a

girl's, and by secondary level many females have dropped out of school. Girls are expected to marry and move to the husband's family. A daughter's education is not viewed as valuable, as traditionally sons are expected to take care of parents as they age (Getecha & Chipilca, 1995). Other reasons for dropping out may be lack of money for school fees, house work, pregnancy, or having to care for parents with AIDS or other illnesses (UNICEF, 1998).

Thus can be seen some of the complexity of women's lives in Africa. The AIDS pandemic appears to have increased their vulnerability and impacts on both women's quality and length of life. With these multiple factors it is difficult to determine a single or universal cause. Webb (1997) wrote,

> Behavioural patterns have multiplayer determinants, with culture, individual action and sociopolitical factors having different degrees of importance on the spread of disease at different places and at different times. The study of the social epidemiology of HIV/AIDS is the study of this complex relationship. (p. 32)

All of this, Webb noted, is dependent on the setting where it takes place.

Behavior Change Theories

Much HIV/AIDS prevention research has focused on evaluations of theories of behavior change. The most commonly applied theories appear to be the Health Belief Model, Theory of Reasoned Action/Theory of Planned Behavior, Transtheoretical Stages of Change, and Social Cognitive Theory. All of

these have been utilized in the CDC's AIDS demonstration projects (ACDPs) begun in 1989 and targeting high risk, marginalized groups in five large American cities. Four of the recommendations from this large-scale project included (a) the need to first develop deep knowledge and understanding of the community, (b) that concepts from behavioral theories and models should guide prevention activities including evaluation, (c) the need to be able to adapt an intervention to diverse populations, and (d) ongoing qualitative research to tailor interventions to changing environments over time (CDC, 1996). A major critique of using these models is that they are based on conceptions of rationality, and as Bolton (1995) argued, "AIDS and sex both involve irrationality" (p. 293).

From the Eleventh International Conference on AIDS held in Vancouver in 1996, four principles emerged:

1. The importance of working with clearly identified groups and communities.

2. The value of using local understandings and beliefs about AIDS, sex, drug use, and risk as starting points for health promotion and health education.

3. The advantages of peer-led education.

4. The requirement of supportive environments including accessible resources for prevention. Overall, and perhaps for the first time at such a conference, there was consensus on the need for both information

(communication and education) and enablement (through structural and environmental interventions) (Aggleton, 1997b, p. 35).

According to Satcher (1999), the former surgeon general of the United States, social and political issues have created conditions that allow the unchecked spread of HIV. Education is not enough and interventions and resources are needed at different levels. In Western countries HIV/AIDS cases are increasing rapidly in minority and other marginalized groups such as Blacks, Hispanics, and First Nations People (Gomez, Hernandez, & Faigeles, 1999) as well as among women. Aggleton (1997a) noted that interventions are needed at various levels to change the greater vulnerability of women and other special groups (p 117). Even as Beeker, Guenther-Grey, and Raj (1998) stressed the need for empowerment models in HIV prevention, they recognized that this does not replace traditional models of behavior, but are important to "widen the lens to include the person-in-environment" (p. 838). The final outcome from the CDC demonstration projects published in 1999 concluded that community level interventions that work on social norms and practices show promise as an effective approach. Attention to structural factors such as laws, policies, and social issues are necessary if more than limited success is expected (Fishbein, 2000).

Webb (1997) wrote about HIV in Africa and the limited success of

prevention efforts.

> The importance of understanding the complex dynamics of the epidemic is often overlooked, to the detriment of the formulation of appropriate prevention programs [and] evidence points to the need to reconceptualize the whole idea of prevention into a long term intervention approach with awkward political questions raised regarding resources, human rights, and empowerment. (p. xi, xii).

Webb (1997) recognized the need for prevention programs to be broad and holistic, since too much emphasis on individuals has resulted in limited success in Africa. "Instead of focusing on cultural and social conditions which provide the context for the behaviour, we have reduced the problem to one of the individual actor" (Bolton, 1995, p. 293). Often the African has been blamed for the failure possibly due to something inherent. Instead, the appropriateness of the programs should be examined (Schoepf, 1995). On the other hand, if only social and structural aspects are the focus, then feelings of hopelessness or fatalism can develop and individual behavior change becomes nearly impossible. Webb noted specifically the complexity of the HIV/AIDS epidemic in Africa while stressing the importance of comprehensive, localized programs that have broad-based support and are grounded in development.

Historical Context

Two of the most significant influences on the area now known as Zimbabwe came about in the late 1800s. First, White settlers began claiming land

in the1890s in what was then called Southern Rhodesia, and second, foreign missions were started shortly after. This began a long history of increasingly restrictive economic and political control over the lives of Black Africans while more and more of the arable land was taken over by White farmers. Blacks were pushed onto poor soil of the Tribal Trust Lands or forced to work on White-owned farms in often appalling conditions. It was not long before race defined strict lines of socio-economic status and power.

After a long war of independence, the state of Zimbabwe emerged with African leadership in 1980, although many Whites still controlled much of the industry and the majority of the most fertile land. As mentioned, there existed wide social and economic gaps between the White European settlers and the African Blacks before the liberation struggle. Life and health for Blacks was similar to other developing nations, where much of the burden of illness is related to poverty and where the greatest burden falls on children and women. The Whites, on the other hand, lived much the same lifestyle as their European counterparts. Table 1 shows a comparison between the two groups taken from statistics calculated during the pre-independence years.

Table 1

Comparison between Whites and Blacks in Southern Rhodesia

	Whites	Blacks
Hospital beds (1976)	1 for every 255 persons	1 for every 1,261 persons
Infant Mortality Rate	17 per 1000 (1977)	120-220 per 1,000 births (1970s)
Access to electricity	Not noted	2% of rural households
Average monthly wages (1977)	$513.00	$49.00
Disease patterns	Heart & cardiovascular disease, various cancers	Pneumonia, measles, malnutrition, meningitis, gastro-enteritis, nutritional deficiencies, & tuberculosis

Note. Produced from text information in Gilmurray, Riddell, & Sanders, 1979.

For the first 2 years of independence great improvements were made toward more equitable development. Primary health care, including antenatal and essential drug programs were adopted; access to clean water and proper sanitation was increased, and immunization against childhood illness was enhanced (Iliff, 1995). Free health care for those earning under $150.00 per month (the majority of Blacks) increased accessibility for many. Infant mortality rates

dropped from 100-150 per 1,000 live births in 1980 to 73-79 per 1,000 in 1987. Communicable disease rates began to fall, resulting in improved morbidity and mortality rates until the AIDS impact began to appear in 1985 (Dashwood, 2000, p. 43).

Although Zimbabwe was seen as a shining model of development in the early years, gradually that image began to tarnish. Dashwood (2000) examined the patterns and strategies of the government for the first 20 post-independence years. He described the attenuation of the original government promise for a more socially equitable society and commitment to the poor. Dashwood proposed several reasons for this including the impact of Economic Structural Adjustment Programme (ESAP), the "embourgeoisement of the ruling elite," and the move from a socialist standpoint to one supporting a capitalist market place (p. 96). MacGarry (1993) questioned the government's acceptance of ESAPs when it was clear that the only ones who would profit would be the international banking system, transnational corporations, and the large commercial farms (p. 30).

Renfrew (1992) examined the relationship between ESAP and health. She asserted that the resulting drop in real wages, especially for the lower paid workers and the unemployed, was directly related to lower status of health due to the worsening of social conditions. Mupedziswa (1997) agreed that ESAPs,

and the resulting reduction in health budgets, have had a highly negative impact on the health of vulnerable groups in Zimbabwe, especially children. The introduction of user fees for health care services also was a result of ESAP conditions. With parents having to choose between prevention and care, attendance at immunization clinics fell and rates of childhood communicable diseases began to rise. Although there were several reasons for the increasing levels of poverty, it appears that ESAPs played a major role (Mupedziswa, 1997). Other so-called development programs, notably in the rural areas, also suffered. Munroe (1998) contended that the government's move to increase rural self-reliance in the name of development was a shifting of financial responsibility to the rural areas, while increasing the degree of cooperation and political support.

The promised redistribution of the land to the many landless Blacks has not come close to meeting original targets, and the government has more recently supported illegal and violent takeovers of White-owned farms. In 2002 Zimbabwe appears on the verge of economic and political collapse, with violence and lawlessness increasing nearly as fast as unemployment and inflation rates. Calls by regional and international leaders to return to the rule of law have been ignored, even after agreements are made and documents signed. Critical food shortages are looming as many of the agriculture areas are under siege. Many farmers are unable to harvest or have had crops and other resources destroyed

by illegal occupiers. A regional drought has exacerbated food shortages.

History of Mt. Selinda

In 1891, Cecil Rhodes assigned 1,500 hectares to several representatives of the American Board of Commissioners for Foreign Missions (ABCFM) and their Zulu counterparts to set up a station (Abbot, Lowe & Mudeta, 1993). This was started in 1893 as a dispensary with Dr. W. Thompson as the first physician, and is considered the first mission hospital in Southern Rhodesia. The missionaries cut trees and made bricks, and the hospital was completed in 1912 (Zvobgo, 1996). New hospital buildings and programs have been added over the years, and the mission now includes schools, churches, farms, and clinics. The ABCFM later became the joint mission of the Disciples and the United Church of Christ, USA, and in 1974 properties were handed over to the indigenous church, the United Church of Christ in Zimbabwe (UCCZ) (Abbot et al.).

The hospital is struggling financially to survive, especially with rampant inflation. Government grants are not meeting running costs. There is a critical shortage of drugs, bandages, and other materials. When drugs do arrive from government stores they have expired dates, but more recently there have been no supplies at all. The Ministry of Health and Child Welfare establishes the fees to be collected and for which services, thereby reducing possibilities for income

generation. Funding for mission hospitals is different from government hospitals and the local district hospital, which has only about 50 more beds than Mt. Selinda, receives nearly 10 times the funding (A. Wensink, personal communication, October 12, 2001).

The Ndau

The Ndau are considered a subtribe of the majority Shona people of Zimbabwe. In 1994 they numbered more than 400,000 in the country (Olsen, 1996). There are several variations of how their name came about. One story holds that it was given by another tribe, based on the Ndau greeting, Ndauwe, which means "Hail" (Akers, 1973; Posselt, 1935). The word Ndau is also considered to imply "Those who greet" because of the meticulous way they practice their greetings (Earthy, 1930). Rennie (1976) reported the name Ndau was assigned by the Gaza Nguni as a reminder of their subordinate position, apparently derived from their submissive appearing salutations (p. 155).

Besides occupying the southeastern portion of the country near the Sabi River, the Ndau also extend through Mozambique to the port of Beira on the Indian Ocean. Of the Ndau history that is available, much has been written in Portuguese. English articles by Junod and Earthy dominated in the 1930s and reflect early anthropological interpretations of some aspects of the culture.

Limited documents and oral tradition provide some history from the 15th century onwards; before that only there were only archeological and language studies (Beach, 1984, p. 9). A considerable contribution to Ndau history exists in an extensive thesis by John Keith Rennie (1976), in which he examined the rise of nationalism and its relationship to Christianity and colonialism from 1890 to 1935. Yet Rennie admitted little is really known about the historical movements without a thorough study of the Portuguese texts, and these are scarce before 1880.

Information in existing documents about the Ndau origin and relationship to other tribes in the country is confusing, especially when the languages are compared. Part of this difficulty occurs because the language becomes less orderly and appears to blend into other dialects at the edge of geographical boundaries (Rennie, 1976). Rennie stressed that the distinctness of the Ndau language results in part from the focus and recognition provided by the missionaries through their production of an Ndau dictionary. Bourdillion (1987) surmised that its distinctiness is due to the influence of the Shangaan invaders. In spite of this distinctness, as well as some social, religious, and political differences, he concluded that the Ndau and Shona share common origins (p. 17, 18).

Bourdillion's (1987) comprehensive text of the Shona includes bits of

Ndau history. He wrote that the Shona tribes came from an agricultural and grazing Bantu settlement that was well established by the 15th century on a fertile plateau between the Limpopo and the Zambezi rivers (p. 6). There seemed to be considerable political upheaval by the middle of the 17th century. Possibly for this reason, a group of Rozvi from the northeast side of the plateau migrated southwards. The group that settled in the southeastern territory appears to be the founders of most of the known Ndau dynasties (p. 12).

Rennie (1976) described a possible earlier settlement in the Eastern Highlands as the MBIRE Empire, which was subsequently threatened by the power of the Rozvi. This power increased, mainly through trade with the Portuguese, until the end of the 17th century, (p. 64). As for the Ndau chieftaincies, the stories are gleaned from oral and inferred data, so are also tentative. Through attempts at finding relationships to other tribes, it is still not clear that the Mbizi (zebra) chieftaincy of Chimwoto or Mapungwana originated from the Rozvi. (Mapungwana is the present chief of the Mt. Selinda area.) The chieftaincies are kinship groups with the leader in a hereditary position, and therefore, the chief's name is carried thorough each generation. Rennie suggested that "it is quite possible that the Mount Selinda forest was in fact settled by a group of such hunters from Rimuka (in association with political control from MBIRE) and that they specialized in hunting, trapping and collecting honey"

until into the 19th century, when they were invaded by the Gaza Nguni (p. 70). In addition to hunting and trapping, it appears the Highland Ndau had considerable political power through the ivory trade (p. 74). There was little contact with the Portuguese in this area so not much has been written to help confirm the Ndau origin. "Although the Ndau chieftaincies had different origins at different times, and although there were differences between one another, they were united by a broad common organization, by functional interdependence, by intermarriage, and by a common Rozvi identity" (Rennie, 1976, p. 77). Still, Rennie argued, "the identities of the Ndau were complex and flexible" (p. 85). It appears missionaries, colonizers, traders, and anthropologists have attempted to classify the various tribes on diverse and often limited sources.

The Gaza Nguni Influence

Whatever their origins, a major influence on this highland settlement was the northern movement of the Gaza Nguni from the Zulu tribe of Shaka, who settled around the lower Sabi River. Their leader was Soshangane, and it appears the Nguni had considerable influence on Ndau culture and language (Bourdillon, 1987, p. 14). Beach (1984) contended that the Nguni, with their small population core overseeing a relatively large area, tended to assimilate some of the culture of their subjects (p. 54) and if so, there was a two-way acculturation

process. Rennie (1976) related that the Nguni interrupted the traditional way of living in the area by regulating hunting and trapping and introducing large-scale cattle herding. As the Gaza state was formed, taxes were introduced and collected through an expanding army, but there was no attempt to take over most of the land or the products of the Ndau (p. 136). Changes did occur to the chieftaincies with some disruption and reordering, while movement by outsiders was strictly controlled.

Under the Nguni, social stratification appeared in three levels. First were the "pure" Nguni who had most of the high positions; second, the people who adopted the culture of the invaders; and third, the ones who attempted to maintain their traditional ways (Rennie, 1976, p. 144). Some identifying features of the Nguni culture included a wax head ring, pierced ears, a skin apron rather than one made of cloth, and the use of the Nguni language. The present chief of Mt. Selinda, Mapungwana, has both ears pierced with rather large slits. The chiefs were generally allowed to conduct their everyday affairs as long as they "provided regular tribute and provided men for the regiments" (Rennie, p. 149). Many of the common clan names in the Mt. Selinda area are Nguni words, apparently changed from the original. For example, the name *Sithole* is Nguni for "heart," while traditionally the name was *Mwoyo* (Rennie, p. 157). So, although the Nguni language did not survive, many words became incorporated into the

language of the Shona/Ndau, and Nguni military dress and weapons of the Gaza state became the norm (Beach, 1984, p. 57). Because the Ndau and Nguni had similar religious beliefs and worldviews, the acceptance of Nguni spirits and other cultural practices by the Ndau took place rather quickly. Social and economic conflict, although greater than under the traditional system, was still minimal compared to the next great influence, colonialism (Rennie, p. 158) or capitalism, the term used by Beach.

Settler and Missionary Influence

Rennie (1976) provided a perspective on colonialist influence, and it is his work that is mainly summarized in the rest of this section on the Ndau. Around 1891, the Ndau/Nguni territory was divided by Cecil Rhodes between his British South Africa Company (BSAC) and a Portuguese company. By allowing settlers (White farmers) into the area, Rhodes secured the British government's approval for its claim to ownership and administrative rights. The influx of settlers resulted from overuse of farmland and population increases in the Orange Free State of South Africa. Profits fell and a poor white farmer class emerged. Offers of rich agricultural land in a new territory were attractive.

Gradually the settlers, with little administration supervision, began taking control of the best land and the lives of the indigenous people in Southern

Rhodesia. Over time, the divisions and conflict between White and native farmers grew and were maintained by the BSAC. The Whites not only expected and received the most fertile land, but also needed cheap labor from the indigenous population. They often settled on land already occupied by the Africans in order to use them for their workforce. The settlers thought the local people should pay (in labor) for the privilege of living on these farms. Loyalty was enforced through physical punishment or threats of eviction, while laws emerged that supported these tactics. Some of the poorest land was set aside for African reserves that later came to be known as the Tribal Trust Lands, and here people eked out a subsistence living.

The power of the chieftaincies was considerably weakened in spite of attempts to subvert the colonialist power through physical or written protests. In 1910, the major chiefs, including Mapungwana, were receiving a small payment for services, although they appeared to have little power. They could be fined or their wives imprisoned if they did not carry out the official requests of the administration (Rennie, 1976, p. 225).

In 1893 the American mission Mt. Selinda had considerable influence that was in many ways different from that of the White settlers. Contrary to the settlers who saw no need for their workers and families to have academic education, the missionaries encouraged this in the hope that leaders would

emerge to carry on the work. They also attempted to intervene at times between settlers and the natives when they saw evidence of the latter being treated unfairly (Rennie, 1976, p. 185).

Over time settlers gained more power and support through legal means, such as when desertion was made a criminal offence, movement of Africans was restricted through pass laws, hunting was prevented, and the ability to grow crops was limited (Rennie, 1976, p. 187). As taxes and other charges were imposed, people were forced to seek work on the white-owned farms or migrate to countries such as South Africa in order to pay for these and to support family left behind. For people living on the reserves, taxes could be equal to a year of income. If some administrators attempted to put in a fairer system, the settlers or superiors intervened. Thus, a cheap labor system was maintained and strengthened through physical and economic coercion (Rennie, 1976).

Rennie (1976) noted some interesting differences while comparing the White settlers with previous African invaders. First, white settlers were more powerful and permanent than the earlier, more transient migration of other Africans. Second, the Africans were considered inferior in most of their practices and beliefs, contrary to what happened during the Nguni takeover where culture was shared. The settlers and others had no intention of integrating any "uncivilized" beliefs into their culture. "The African way of life was seen by

them as embodying values antiethical to European ones—social conformity, improvidence, leisure preference, indulgence in drink and sex in place of individual initiative, providence, hard work and self control" (p. 263). The European's aim was to teach the "dignity of labor" and simple crafts to improve their quality of life, while noting that an academic education was a waste of time and did not produce a better worker (p. 264). Only two dissenting voices were heard: American mission personnel and White administrator Peter Nielsen.

The mission influence was by no means minor and not always positive. There was conflict between traditional practices and religious beliefs, and many of the missionaries, like the colonizers, held similar, negative views of the Africans. The role and treatment of women and girls, the system of polygamy, bridewealth payments, and belief in witchcraft are a few examples of the way of life that they saw as needing change. Many missionaries were convinced that Christianity would not take hold unless Western values and skills were adopted (Rennie, 1976).

Early mission concerns about the colonists related to their own freedom and ability to evangelize, but later they became more overtly critical of administration policies towards the Africans. Some missionaries actually saw the benefits of certain local beliefs and practices, although they were generally in the minority. Where the colonizers were seen to exploit the natives, the mission's

aim was to be there for them, to improve their way of life, and even to help them survive and succeed under colonial rule. They did not envision training a group of Christianized slaves, nor to teach them to be content with their situation. Instead, their goal was to assist in educating a new elite that could think critically and provide economic, religious, and business leadership. This development was not without its frustrations in attempts to fashion a "new" Ndau. They soon realized that in order to influence the population they would have to work with the younger people, and so the schools and the discipline they provided became as important as the other mission activities.

In other ways the mission school assisted in the acceptance of the colonist reality through their texts. These books tended to paint the British as kindly patrons who were only thinking of the development of the people and the country, concepts that did not likely match the experience of the students and their parents (p. 341). This implicit approval of colonization may have been tied to the need for government grants to run the schools. Another conflict arose because the mission owned several acres of land, and therefore missionaries became landlords themselves. By 1948 they were supervising 3,000 tenants. Religious control and expected periods of labor were linked to tenancy rights and they had to implement unpopular government regulations. Attempts to sell the farm property to the Africans from 1913 onwards met with much resistance

and bureaucracy (Rennie, 1976). To this day the matter is still bound up in legalities partly due to the small size of the plots after years of dividing among children, and the UCCZ remains a landlord (J. Sibiya, personal communication, September 2, 2001). Rennie concluded that, in spite of some earlier progressive thinking on the side of the missionaries, little action actually took place against colonial policies for various reasons, including the need for government support to continue the work.

The influences of colonization and Western religion on world populations are still being analyzed. This brief overview can hardly do justice to the study of such complex processes and is only meant to point out some of the main historical events to help in understanding the Ndau as they exist today.

When looking at the health of communities and the impact of their culture on health status and quality of life, a health promotion perspective is believed to offer a broad and holistic context for assessment, planning, intervention, and evaluation. The following describes the development and present-day approaches to international health promotion.

Health Promotion

The terms *health promotion* and *health* education have been used interchangeably, and this has led to some confusion in the field of community

health. Health promotion has a wider meaning, with health education one its more important components or intervention strategies (McKenzie & Smeltzer, 1997, p. 3). A look at the development of health promotion will show how it has emerged as a viable strategy for improved health of populations.

Historical Development

The recent use of the concept of health promotion appeared in a document produced by Marc Lalonde, the Canadian Minister of Health in 1974. Lalonde pointed out that health, and how it is created, had moved from the centrality of medicine to such aspects as personal responsibility for health. Other influences on health included human biology, the environment, and available health services, but the main focus was on individual lifestyle (Lalonde, 1974). Programs followed that stressed healthy lifestyles, with prevention implying decreased risk behaviors (Hamilton & Bhatti, 1996).

Three years later, in 1977, the World Health Organization (WHO) published a paper, *Health for All by the Year 2000,* in which health promotion was mentioned 71 times, compared to Lalonde's 1974 report, in which it is found in four places. Both these documents played a critical role in global health, leading to the WHO's Alma Ata Conference in 1978, which launched the primary health care movement. The Alma Alta declaration laid out five basic principles for global

health; one was health promotion/illness prevention (MacDonald, 1998).

In 1979 the U.S government published its first set of national health targets in the report, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. The paper listed five goals to reduce mortality among infants, children, adolescents, and adults. This report was followed in 1980 by the document *Health Promotion – Disease Prevention,* listing 226 specific health goals under the three headings of health promotion, health protection, and preventative health services. In 1990, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* continued the momentum by identifying 22 priority areas, with the goals of increasing healthy years of life, reducing health disparities in different population groups, and improving access to preventive services while adding surveillance and data systems to promotion, protection, and prevention objectives (Office of Disease Prevention and Health Promotion, 2000; Pender, 1996).

Following Alma Alta, discussion among public health professionals expanded the concept to include other factors that impact on health, especially environmental influences such as social, physical, and economic. In 1986 the First International Conference on Health Promotion was held in Ottawa, co-sponsored by WHO, the Canadian Public Health Association, and Health and Welfare Canada. Two resulting documents, *The Ottawa Charter on Health Promotion* and

Achieving Health for All: A Framework for Health Promotion, led to major changes in how public health was practiced. The WHO definition of health promotion and health, which is still in use today, stated:

> Health promotion is the process of enabling people to increase control over and to improve their health. To reach a state of complete mental and social well-being, an individual or groups must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources.... (WHO, 1986, p. 1)

The Ottawa Charter outlined basic conditions for health improvement that included peace, shelter, education, food, income, stable eco-system, social justice, and equity. The five principles of health promotion meant as strategies for action involved building health public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services to become more holistic partnerships (WHO, 1986).

The second document, *Achieving Health for All* by the new Canadian Minister of Health, highlighted three health promotion objectives: reducing inequities in health, increasing disease prevention, and enhancing capacity to cope with chronic disease and disability. The immense challenges in addressing these were recognized and "that our system of health care as it presently exists does not deal adequately with the major health concerns of our time.... Trends suggest we

move toward the approach we call health promotion" (Epp, 1986, National Health Challenges, para. 1, 2). The action strategies of this report included:

- Fostering public participation—helping people take control over the factors that affect health.
- Strengthening community health services—expanding their role while moving to more prevention and promotion, and dealing with the larger issues earlier identified such as the needs of less advantaged groups.
- Coordinating healthy public policy—supproting health promotion by making healthy choices easier, and includes areas such as housing, education, the work place, and transportation.

Epp (1986) recognized that health promotion practice nearly always relied on the dissemination of health information that was expected to lead to individual lifestyle changes. In reality, changes in health status had been slow and minimal. Health messages were then combined with other activities such as research, laws, and community development, while targeting such subjects as drinking and driving, breastfeeding, substance abuse, and smoking. Epp's report concluded that a health promotion approach is a way of dealing with new challenges, of slowing health care costs, and of achieving health for all. It also stressed that three mechanisms are essential to this: self-care, mutual support, and healthy

environments. Epp's conclusion was that the foundation of health promotion had been laid, but it was time to give meaning to the term.

Attempts to more clearly define health promotion and build on the Ottawa Charter were carried out through several international health promotion conferences held in various parts of the world in 1988, 1991, 1997, and 2000. The 4th conference in 1997, "New Players for a New Era—Leading Health Promotion into the 21st Century," was the first held in a developing country. It took place nearly 20 years after Alma Alta so was seen as a time for reflection.

The resulting report noted that prerequisites for health include peace, shelter, education, security, social relations, food, income, the empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights, and equity. Poverty is still, the report said, the greatest threat to health. New trends include increasing urbanization, increase in number of elderly, rising prevalence of chronic diseases, resistance to antibiotics, increased substance abuse, civil and domestic violence, new and re-emerging infectious diseases, greater recognition of mental health problems, the global economy, and environmental destruction. Conference participants stressed convincing evidence from global research showing the effectiveness of health promotion as an approach for realizing greater equity in health. Davies and MacDonald (1998) argued that more work is needed to make health promotion more realistic so as

to "improve practice and make it more effective" (p. 7).

Strategies from the Ottawa Charter were still considered essential at the 4th conference, but that new responses were needed. One important area was in breaking traditional boundaries in government, between government and non-governmental agencies, and between private and public sectors. These priorities were set:

- Promoting social responsibility for health.
- Increasing investments for health development.
- Consolidating and expanding partnerships for health.
- Increasing community capacity and empowering the individual.
- Securing an infrastructure for health promotion (WHO, 1997).

Throughout these developmental years the basic foundations of "modern" health promotion have remained. However, they have moved from an individual responsibility, as noted in LaLonde's report, through to governments and other agencies implementing health promotion strategies, to the recognition that health has many influences, and that locally and internationally, every level of society needs to work in partnership to make a difference. At the 51st World Health Assembly these concepts and the statement from Jakarta were all re-mandated, along with a call for further quantitative and qualitative research to provide a more evidence-based approach (WHO, 1998).

Population Health

More recently, the term population health has become fashionable, and Health Canada has facilitated considerable discussion on this. In a 1994 document, major determinants of health were identified and organized into five categories: social and economic environment, physical environments, personal health practices, individual capacity and coping skills, and health services (Federal/Provincial/ Territorial Advisory Committee on Population Health, 1994). This report confirmed the need for multilevel views of health, especially ones that seriously consider factors beyond the control of the individual.

A conference titled "A Roundtable on Population Health and Health Promotion" was held in Ottawa in 1996 to review the relationship between population health and health promotion. Where population health focused on determinants of health, health promotion was still seen as changing individual behaviors, thus mainly viewed as health education. On the other hand, health promoters tend to see those in population health as only concerned with policymaking and not supporting community action. In spite of perceived and actual differences in methodologies and strategies, the participants agreed they had much in common, and several areas were identified where they could collaborate. These included political and social visions for an equitable and healthy society and how to impact determinants of health (Bhatti, 1996).

In 1998 the Regional office for Europe of the WHO published a report, *Population Health – Putting Concepts into Action,* which also discussed the similarities and differences between the two concepts. Differences revolved around resource allocation and issues concerning epidemiology, genetics, and measurement of cause and effect. Areas of agreement included the belief that health care delivery has limited influence, determinants of health were important, broad participation of many social sectors was necessary, and interventions needed to be carried out in an environment of cooperation and collaboration (Zollner & Lessof, 1998).

Ian Potter, a Canadian Assistant Deputy Minister, wrote the following to describe the importance of a population health approach. "Population health addresses health issues along the entire health continuim, from prevention and promotion to health protection, diagnosis, treatment and care, and integrates and balances actions between them" (Health Promotions and Programs Branch, 1999, p. 6). Here it seems that population health was now firmly entrenched in Canada as the umbrella for all health activities with promotion as one aspect of the plan. Guiding principles include the following.

1. Health is a capacity—a resource for everyday living.

2. The determinants of health are addressed—and are complex and interrelated.

3. The focus is upstream—the earlier the interventions the better the health benefits.

4. Health is everyone's business.

5. Decisions are based on evidence—both quantitative and qualitative.

6. Accountability is increased for health outcomes—with more transparency in government.

7. Management of health issues is horizontal—changing from a top-down approach.

8. Multiple strategies, in multiple settings, in multiple systems and sectors are used (Health Promotions and Programs Branch, 1999, pp. 7-14).

The continuing challenge for health promotion is to be recognized as more than health education. For many people these are still interchangeable terms (Breckon, Harvey, & Lancaster, 1998) and it has not been easy to agree on a definition (Pender, 1996). MacDonald (1998) wrote that one reason for the difficulty in defining health promotion is it "is one of the first and few truly interdisciplinary enterprises ... in health that seems genuinely emancipated from the domination of medicine" (p. 27). Seedhouse (1997) warned that we do not even have a clear definition of health, well being, or quality of life; that evaluation results of health promotion are conflicting; and that health promotion desperately needs a theory to guide practice. Davis and MacDonald (1998) wrote,

"if health promotion is to remain at the forefront of local, national, and international health policy development and investment, it needs to establish as a matter of some urgency, a framework for evidence based practice" and that "traditional positivist approaches" to research no longer provide adequate data for evaluating interventions (p. 1).

The concept of health promotion continues to develop. Emerging understandings of individuals, communities, and their contexts in relation to health support a broad based approach. With decreasing resources, innovative ways are needed to reorganize how health is achieved and maintained, and in finding creative ways to increase involvement and collaboration at all levels of society. Other challenges include demographic shifts such as increase in the elderly population in industrialized nations, and continued high fertility rates and large numbers of youth in developing countries. Re-emerging infectious diseases, increase of chronic illnesses, continuing spread of HIV/AIDS and other STDs, increasing levels of smoking in developing countries, substance abuse, mental illnesses, and newly discovered organisms require enormous effort.

During the historical development of health promotion there has been a change (at least in ideology) from individual efforts to achieve health to broader, more community-based and national level initiatives. The major difference has been in moving from the former biological model of illness that tended to blame

the patient, to contextualizing health by including both biological and social determinants and involving people in health planning and decision making. Through all the documents examined, social factors have been shown to be most important regarding level of health, with socio-economic ones at the top of the list.

Individual versus Population Approaches

In spite of the progress made in establishing and developing a global health promotion or population health approach, Whent (2000) was concerned that the tendency has been "to involve individualistic approaches to encouraging behaviour change" versus community based approaches within a philosophy of sustainable development (p. 48). Watson and Platt (2000) stated, "The endpoint of health promotion action is, or rather should be, the improvement of health and well-being rather than the reduction of morbidity and mortality or the limitation of health damaging lifestyle behaviours" (p. 13).

Abel, Cockerham, and Niemann (2000) critiqued health promotion research and found that

- a focus on a single health behaviour does not adequately represent the complexity of behavioural effects on health,
- a focus on risk or health damaging behaviours is restrictive since it neglects the complexity typical of processes of health maintenance or health risk,
- a perspective that concentrates on individuals tends to overlook social structure and group specific effects on health behaviour, and

> • the study of the relationship between lifestyle and health requires more comprehensive lifestyle models that incorporate cultural, social and psychological effects. (p. 55)

They argued the necessity of linking social, structural, and behavioral aspects. This is echoed by many such as Kelleher (1998), who found limited change at the individual level and recommended "wider social change strategies" (p. 56). Ziglio (2000) agreed in that "the commitment to reduce health risk factors (e.g. behavior) rather than attention to risk conditions (e.g. environment, poverty) has severely limited the effectiveness of efforts to promote population health" (p. 29). Kerr et al. (2000) wrote,

> A common underlying assumption in planning health education efforts is that people adopt risky or unhealthy behaviours because they do not fully understand the consequences of such acts and just do not know any better. Therefore ignorance is the problem and information is the solution. However, although information is necessary, it appears it is not sufficient in itself in creating meaningful change and, despite the efforts of health educators, many individuals continue to engage in behaviours that are known to lead to premature disability and death. (p. 231)

Watson and Platt (2000) stressed that traditional epidemiological and health education objectives are not to be dismissed, but need to be seen as "intermediate outcomes within a socio-ecological model of health" that includes all aspects of a person's environment as well as their genetic makeup (p. 14). Two of the challenges to this multilevel, integrative approach are in the determination of health outcomes and the evaluation of results. It is much easier to plan and measure smoking cessation rates than an enhanced sense of community or level

of empowerment. Individual focused programs have also been noted to be lacking in assessment of long-term outcomes. Health promotion, on the other hand, has been criticized as being too broad or overly ambitious. Davies and MacDonald (1998) wrote that new ways are needed to evaluate health promotion as reliance on outcome measures and quantitative data are outdated and unreliable.

There is also a need to better understand relationships between people and their environment. Clark and McLeroy (1995) stated that the strong social behavioral focus has resulted in the inability of health promotion to adequately understand the relationship of context and program design, including the role of culture and socio-economic determinants. There are also challenges in working with disadvantaged minority populations and lack of effective evaluation (p. 36). In fact, Baum (1998) wrote that the focus on health behavior could result in increased health inequity as those who are most likely to change are already enjoying adequate lifestyles. Ziglio (2000) described health as an investment in the future and quoted three questions (from Kickbusch, 1997) that are necessary for the development of effective health promotion interventions:

- "Where is health promoted and maintained in a given population?
- Which investment and strategies produce the largest population health gains?

- Which investment and strategies help reduce health inequities and are in line with human rights?" (p. 27)

Ziglio added a fourth one; "Which investment provides added value to social and economic development in an equitable and sustainable manner resulting also in high health returns for the overall population?" (p. 27).

Green (1999) provided an historical overview of how health education has contributed to public health. In the early part of the 20th century health was considered a matter of personal hygiene, and improvements in health resulted from health education to increase awareness and knowledge of behavioral impacts, along with more structural improvements such as housing and sanitation. After World War II the medical and clinical model of health services gained prominence, which eventually led to escalating costs that most governments, even in the so-called developed world, have had to scale back. These increased costs resulted in a need to find alternatives to an increasing dependency on health care services and to shift more responsibility for health to the personal level. Resource-based versus population-based planning and development emerged, which was more concerned with how health services are used rather than the health of populations. Some of the well-known health promotion models, such as the Health Belief Model, were designed to evaluate why people did or did not utilize prevention services and later were applied to

health services in general. The goal of health education then became the reduction of unnecessary use of medical care mainly by prevention of illness and accidents. Another major influence of this resource-based model of health education has been the intensive search to match the increasing precision of medical interventions by finding one magic health promotion intervention.

Green (1999) described a meta-analysis completed in the mid-1980s, which concluded that evidence-based practice for health promotion needed to include the broader social, cultural, and political environments and could not be easily borrowed from biomedical research. This, along with more active consumers of health care and other social changes, requires a move away from psychological and behavioral models and a return to population-based planning.

Brownson, Baker, and Novick (1999) agreed with Green that there is a need for a community-based, multi-level approach to prevention and promotion: "Community-based health promotion may have advantages over other methods of creating changes in health and that it is therefore something to strive towards" (p. 15). As health promotion is considered an international health concern, McDonald (1998) acknowledged that health promotion must be viewed within a global context. If that happens, then it needs to be realized that health promotion, as we know it, is a product of culture and may not be transferable to others in the same form.

One critical component of a health promotion approach is the concept of empowerment. This has special implications when it comes to women's health and quality of life, with females very often in positions of limited power throughout their lives.

Empowerment

One of the key components of health promotion that began with the Ottawa Charter and has become further defined and integrated over time is the concept of empowerment. Poland, Green, and Rootman (2000) stressed, "The absence of empowering activities should be a signal that an intervention does not fall within the rubric of health promotion" (p. 8). The earlier review of women and HIV/AIDS in Africa pointed out many areas of unequal power, with reduced empowerment in general for women.

The word *empowerment* comes from the word *power,* which is derived from the Latin *potere* or *potent,* meaning to be able to choose or to be powerful (Brunt, Lindsey, & Hopkinson, 1997). The concept of power, as anthropologist Angela Cheater (1999) wrote, has changed over the past 20 years partly due to the work of French philosopher Michael Foucault. Foucault, she stressed, was not consistent in his definitions, but his idea that "power is vested, even created, in discourses of truth or knowledge rather than in a Weberian command of

(potential) force" seems to have shifted the thinking of many (p. 4). "Foucault sees discourse as a political commodity, and the articulation of discourse and power as a phenomenon of exclusion, limitation, and prohibition, so the link between discourse and (dis)empowerment is easily made" (Cheater, 1999, p. 4). From this, empowerment is viewed as 'having a voice.' Gilligan's (1982) writing on women and psychology included much on the power of voice and of being heard. Cheater asserted that "the mystifying rhetoric of empowerment as expansible, vocal power" is the result of postmodernism and "democratic and negotiated structures" related to individual choices (p. 7). This implies a transfer of power from those who have to those who have not, yet denies the reality that this rarely happens. Travers (1997) described an evaluation by Hart that found when people begin to talk about their experiences with oppression they break "the culture of silence" (p. 349). The concept of power remains complex and paradoxical and this possibly reflects the struggle to describe empowerment within health promotion.

Defining and Understanding Empowerment

Brunt et al. (1997) stressed that empowerment is "better understood by its absence: powerlessness, helplessness, hopelessness, subordination, oppression, dependency" (p. 19). With its relation to power and oppression, the concept has

been developed through application in the fields of community psychology, feminist theory, community development, health education, and social activism (Brunt et al 1997; Gibson 1991). Gibson, in her concept analysis of empowerment, said it is an abstract idea and "independent of a specific time or place"(p. 355). This makes it contextual, and therefore its structure, strategies, and outcomes will vary depending on each situation. Gibson stressed the relationship aspect that goes beyond individual levels of self-esteem or health-promoting behaviors. Her definition of empowerment, following an extensive literature review, encompasses the idea that it is both process and outcome: "a social process of recognizing, promoting, and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives" (p. 359).

Butterfoss et al. (1998) borrowed from Paulo Freire's work on empowerment, which argued that participatory education encourages people to put their values into actions resulting in changed lives. This concept of community empowerment is enacted when participation leads to transformed people who ultimately transform their communities. People, they argued, need to be involved through all parts of any program. This has been the premise of the Primary Health Care movement begun at Alma Ata in 1978 that recognized the need to move away from the previous focus on tertiary care and a medical model

of intervention, to empowering communities to participate in health (Manderson & Mark, 1997).

Travers (1997) described Labonte's empowerment continuum as "a complex of intersections and progressions through personal empowerment, small group development, community organization, coalition advocacy, and political action," and which correspond to the levels of intervention in comprehensive health promotion (p. 352). Feminists claimed that community development with empowerment is the preferred approach in meeting their needs.

> Feminist health promotion empowerment then would begin with women's participation in the design of the research, policy and programming. It would encourage collective action for reflection and action. It would guard against exploitation of women's time and labour and it would work toward structural change. (O'Connor, Denton, Hajdukowski-Ahmed, Zeytinoglu, & Williams, 1999, p. 17)

Raeburn and Rootman (1998) believed the word empowerment is overused; a buzzword of the 1990s, and with this comes the danger of misusing it. Yet, they agreed that it best describes the core of their model of people-centered health promotion (PCHP) (p. 64). They condemned the lack of research on people's experience with empowerment even though much has been written about the concept itself. From their review, the following key components help characterize empowerment: control, competence, and participation that take place within a realistic history. These authors view empowerment as an inner

experience closely related to health or a sense of well-being, that can be seen by others through expressions of confidence and groundedness. Raeburn and Rootman also believed empowerment is a developmental concept that follows a predictable course over time, and that there is always room for further growth.

VanderPlaat (1999) agreed with Gibson (1991) that empowerment is a product of social discourse wherein it is constructed. This may be part of the difficulty in locating a common understanding and definition. Empowerment can be as simple as learning new skills to as complex as taking part in political actions. Many researchers include the goal of empowering those less powerful. Yet others say that one cannot empower others; they must empower themselves (Gibson, 1991; Hagquist & Starrin, 1997). VanderPlaat's (1999) own model of relational empowerment does not rest on the premise that power is given or taken but that "it emerges through interaction with others" (p. 777).

Empowerment and HIV/AIDS Prevention

Programs that work from a holistic view of health, and that include concepts of power and empowerment viewed within the social context, have shown positive results. Wood (1996) contended that after 15 years of experience with the HIV/AIDS epidemic "empowerment is the task and (pre)requisite of HIV prevention" (p. 33).

Zibalese-Crawford (1997) described an empowerment-oriented approach to preventing HIV and STDs in teens under residential care. She stressed the importance of context by noting, "It has been postulated that sexual activity occurs within a social context, replete with assumptions, values, ideals, attitudes and beliefs. Knowledge of this social context is important in understanding sexual behaviors and the mechanisms that may change them" (p. 74). Her stress on empowerment requires "a through analysis of power and powerlessness, and the role of knowledge-creation; and to help those with less power to gain some control over their lives, so as not to perpetuate conditions of oppression" (p. 86).

Beeker et al. (1998) discussed the increasing use of empowerment in AIDS programming but that differing agendas can change intent. Therefore, the authors stressed the need to "examine empowerment, its core assumptions, and its implications for how we respond to the challenges of HIV/AIDS" (p. 831). Any success so far has been mainly at an individual level, and there is a need for innovative applications in the move toward population interventions. The definition by Beeker et al. of a community health empowerment intervention is one that "seeks to effect community-wide change in health-related behaviors by organizing communities to define their health problems, to identify the determinants of those problems, and to engage in individual and collective action to change those determinants" (p. 833).

Gomez et al. (1999) described a program of collaboration between researcher and provider to evaluate an already existing program of HIV/AIDS using an empowerment model. Success, according to participants and staff, resulted from "the process of allowing women to come together, share their plights, and then seek solutions together" (p. 204). The research evaluators were surprised to find that participation in social and political events was associated with increased comfort in sexual communication. As well, the program showed changes in cultural beliefs in sexual and gender roles that are often thought by many to be too ingrained to ever change.

Ecology and Health Promotion

An ecological approach lends another dimension to the already holistic concepts of health promotion described above. The focus on sustainable development and stable environments, beginning with the Ottawa Charter for Health Promotion, implied an ecological approach (Kickbusch, 1999). The health promotion movement has strongly supported action on the determinants of health within a community context. An ecological view recognizes these interdependent and reciprocal interactions. Therefore, it clearly spells out that it is not only health systems and community workers acting on the determinants, but that "health promotion seeks to empower people by giving them control over

their determinants of health, whether these be behavioral or environmental" (Poland et al., 2000, p. 17). This level of control does not come easily, and Kickbusch stressed the advocacy, mediating, and enabling role of health professionals in order to assist people and communities to have that control.

Ecological Influences: Bronfenbrenner and Bandura

Two theorists who have had considerable influence on the development of ecological health concepts are Urie Bronfenbrenner and Albert Bandura (Sallis & Owen, 1997). Bronfenbrenner's theory (1979) is grounded in the fields of psychology, psychiatry, and anthropology. His cross cultural experiences brought him to a new understanding of human diversity, resiliency, and versatility, while also realizing the importance of public policy on people's lives.

In *The Ecology of Human Development,* Bronfenbrenner introduced what he called a new perspective for research in the area of human development.

> The ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts in which the settings are embedded. (1979, p. 21)

He defined development as "a lasting change in the way in which a person perceives and deals with his environment" (p. 3). His theory includes four levels of ecological environments that he equates to a set of nesting Russian dolls. The

first innermost level is the *microsystem,* which "is a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (p. 22). It includes all the interrelations with people and objects on a face-to-face basis within one's immediate setting, such as the home or classroom. Next is the *mesosystem,* which "comprises the interrelations among two or more settings in which the developing person actively participates" (p. 25). It is a system of Microsystems—for example, the relationship between home and school that is enlarged whenever the person moves into a new setting. The third level is the *exosystem,* "one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person" (p. 25). An example he used is the affect of parent's employment on their child's development. The fourth level is the *macrosystem,* "consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such consistencies" (p. 26). Examples could include cultural beliefs and norms.

Bandura is a Canadian-born psychologist associated with Stanford University. In his 1971 *Social Learning Theory,* he attempted to bridge the gap he

believed existed between psychoanalytic theory and strict behaviorism. The former explains behavior as being controlled by internal urges, needs, and drives that are not always at a conscious level. Behaviorism, on the other hand, views humans as controlled by external forces that preclude self-determination. Bandura stressed that this neglects the important role of cognitions. Social learning theory proposed that "psychological functioning is best understood in terms of a continuous reciprocal interaction between behavior and its controlling conditions" (p. 2). This shows a basic similarity with the findings of Bronfenbrenner.

Bandura (1971) named three distinguishing features of humans: the capacity to learn by observation, having superior cognitive capacity, and the ability to create self-regulating influences (p. 2). Under this theory, new ways of behaving are learned either through direct experience, or by observing others. Reinforcement is important, but not all encompassing, and serves more as information and incentive with some response-strengthening potential. Bandura stressed that behavior needs to be learned before it can be performed, and watching others provides a guide to replication. In summary, this theory states that "behavior partly creates the environment and the resultant environment, in turn influences the behavior" (p. 40).

In later writings Bandura (1986) built on social learning theory and

renamed his constructs social cognitive theory. He explained human functioning in terms of a model of triadic reciprocality in which "behavior, cognitive, and other personal factors, and environmental events all operate as interacting determinants of each other" (p. 18). This process he named *reciprocal determinsm.* Bandura noted that the strength of the three influences would vary, depending on the players and the situation. The reactions that occur are also dependent on such aspects as gender, physical size, level of competency, and a person's assigned social position and roles. Therefore there can never be "one environmental cause of behavior" (p. 26).

According to Bandura (1986), beliefs also play an important role in human development, as they help a person to visualize themselves and their environment. "Belief systems thus help to provide structure, direction, and purpose to life. Because personal identity and security become heavily invested in belief systems, they are not readily discardable once acquired" (p. 36). People also create and interpret their own meanings; therefore, beliefs can also be a source of distortions in how experiences are viewed and how interpersonal relationships are carried out (p. 36).

Bandura (1986) described many characteristics that influence human behavior, but stressed "none is more central or pervasive than people's judgment of their capabilities to deal effectively with different realities" (p. 21). This ability

he called self-efficacy and is linked to a level, or perceived level, of control. In a later text he asserted, "None is more central or pervasive than people's beliefs in one's capabilities to organize and execute the courses of action required to manage prospective situations. Efficacy beliefs influence how people think, feel, motivate themselves, and act" (Bandura, 1995, p. 2). All these personal factors are critical to participation in health promotion activities.

Beliefs about efficacy are mainly developed in four ways: through experiences, where mastery is key; vicarious experiences through social modeling; social persuasion or encouragement; and through judgments based on one's physiological and emotional states. These all act through cognitive processing, which helps determine their importance and acceptance into self-efficacy belief systems (Bandura, 1995, pp. 3-5). Bandura stressed that self-efficacy is involved in actions that promote health, and therefore acts at all levels of personal change. "Once equipped with skills and belief in their capabilities, people are better able to adopt behaviors that promote health and to eliminate those that impair it" (p. 28).

As to the idea of collective efficacy, Bandura (1995) stressed the critical importance of societies bringing about changes to their social systems that impact negatively on health and not merely focusing on individual behaviors. "A comprehensive approach to health protection and enhancement must provide

people with knowledge, skills, and sense of collective efficacy to mount social and policy initiatives that affect human health" (p. 33). Only by people organizing and working together will health promotion become a priority for governments. "The stronger they believe in their capabilities to affect social change the more actively they engage their collective efforts to alter national policies and practices" (p. 35).

Ecological Principles

Sallis and Owen (1997) reviewed several ecological models and from their analysis provided the following list of principles.

1. Multiple dimensions of influence on behaviors—the integration of personal, factors and socio-cultural-physical environments, mark the difference between ecological and other theories.

2. Interactions of influences across dimensions—the model should predict the interactions and explain how they occur.

3. Multiple levels of environmental influences—these are usually omitted from interpersonal theories and include influences from the family up to national level laws and public policy setting.

4. Environments directly influence behaviors—the various environments do not merely work through cognitive processes but can act directly to impact on

health and to explain health behaviors (p. 411).

One concern of Sallis and Owen (1997) was that a general ecological model may not be adequate in explaining specific behaviors along with their most important environmental conditions, and that further research will need to delineate these. This same condition of generality also makes research and change efforts more difficult. As well, the various levels are often more difficult to influence as compared to the variables in interpersonal models. It is much easier to plan a program for individuals than to tackle national health policies. Yet, those who ascribe to ecological models are convinced that the most effective change in level of health will only happen when all domains and their levels are targeted, not only acting on personal behaviors, skills, and attitudes. Improving environments can be effective. However, in the attempt to influence these factors, ecological theory reminds us that what is more critical is the interaction between individuals and their environments reflecting an embedded systems approach.

Ecological Models of Health Promotion

Examination of various models of health promotion, especially those within an ecological framework, can be useful for designing community-based studies and interventions. Two models are presented here as examples.

McLeroy, Bibeau, Steckler, and Glanz (1988) developed an ecological model

based on Bronfenbrenner's perspective, among others, that views behavior being influenced by the following:

1. *Intrapersonal factors,* such as knowledge, self-concept, developmental history.

2. *Interpersonal processes,* which include formal and informal social networks and supports.

3. *Institutional factors,* such as their rules and regulations.

4. *Community factors,* which are the relationships between agencies within established boundaries.

5. *Public policy,* including local and national laws (p. 355).

The PRECEDE-PROCEED planning model revised by Green and Kreuter (1991) reinforces the multidimensionality and complexity of health behaviors and is based on Bandura's social cognitive theory. PRECEDE is the diagnostic or needs assessment component and stands for *P*redisposing, *R*einforcing, and *E*nabling *C*onstructs in *E*ducational/Environmental *D*iagnosis and *E*valuation. The aim is to assist the health worker to see the multiple factors impacting on health and to be able to focus on a subset of these for targeting. PROCEED is a developmental stage of health promotion planning and stands for *P*olicy, *R*egulatory, and *O*rganizational *C*onstructs in *E*ducational and *E*nvironmental *D*evelopment. This part adds work on policy formation and further detail on

evaluation. The two components work together to provide a series of steps in planning, implementation, and evaluation of health programs.

The PRECEDE phases can provide guidance in assessment of ecological factors, especially in understanding the predisposing, enabling, and reinforcing factors.

Phase 1—Social diagnosis is "the process of determining people's perceptions of their own needs or quality of life, and their aspirations for the common good through broad participation and the application of multiple information-gathering activities designed to expand understanding of the community" (p. 45).

Phase 2—Epidemiological diagnosis involves identifying the problems underlying the concerns found in phase 1. Data from various sources, including epidemiological and medical findings, help in prioritizing health problems and finding appropriate resources.

Phase 3—Behavioral and Environmental diagnosis involves identifying those factors (both internal and external) that are the most likely to be influencing the health problems (risk factors) and can be altered. This helps in being realistic as well as focusing on what is important.

Phase 4—Educational and organizational diagnosis identifies the most effective strategies that will bring about expected change. Predisposing factors

include people's knowledge, beliefs, and values that might affect motivation, while enabling factors are skills, resources, or barriers that either move the change or prevent it from happening. Reinforcing factors refer to rewards or feedback that encourages or discourages continuation of a new behavior.

Phase 5—Administrative and policy diagnosis is used to assess the capabilities and resources necessary for a successful program with ways of overcoming any limitations. Different programs and settings have unique needs.

The concept of ecology is implied in a comprehensive and holistic application of health promotion. Yet, it is not always clear and therefore may easily be overlooked by those implementing such programs. Kickbusch (1999) said that the important question to ask is, "Where is health created? The ecological answer is that health is created where people live, love, work, and play. People create health by interacting with each other and with their physical environments" (p. 50). Therefore, the everyday lives of people and communities provide the setting for health promotion. An extremely important part of this setting is the cultural context.

Culture and Health

Defining such a broad term as culture, and then finding agreement, has become a challenge, especially in the field of anthropology, where culture is considered an integral theory and critical foundation. Diverse meanings of

culture have been described, such as whether it is information or behavior. These meanings have evolved as new understandings of society emerge through research and experience. For many researchers the meaning of culture will depend on the purpose of the study and their personal worldview. Spradley and McCurdy (1972) limited the definition to "the knowledge people use to generate and interpret social behaviour" where knowledge is both learned and shared (p. 8). This cultural knowledge, they stressed, is "coded in complex systems of symbols" and one's cultural theory helps in making sense out of personal experiences, relationships, and the world in general (p. 8).

For Lee and Poynton (2000), culture is a way of life. They offered Frow and Morris's classical interpretation as "the whole way of life of a social group as it is structured by representation and by power...a network of representations—texts, images, talk, codes of behaviour, and the narrative structures organizing these—which shapes every aspect of life" (p. 7). "Culture lends significance to human experience by selecting from and organizing it.... It refers broadly to the forms through which people make sense of their lives (Rosaldo, 1993, p. 26). Culture, according to Rapport and Overing (2000) is "an acquired system of habitual behaviour which generates (determines) individuals' schemes of action. In short, social structures produce culture which, in turn, generates practices which, finally, reproduce social structures" (p. 2).

Freilich (1989) questioned whether the concept of culture was still relevant to anthropology, and discussed how it has changed from a passive interpretation to one that is complex and at times unmanageable. He updated the term to include culture being an "adaptive mechanism" and quoted Keesing (1974): "cultures are systems (of socially transmitted behavior patterns) that serve to relate human communities to their ecological settings" (p. 10). Hunn (1989) proposed that "the strength of the adaptational approach is its recognition that human behavior both affects and is affected by a complex environment, the social and ecosystems of which humans are but one part" (p. 143). Hunn's theory of ethnoecology is a framework for understanding culture "as a system of information that serves as a blueprint for a way of life and that is ultimately judged by how well it sustains and promotes that way of life" (p. 145).

From these conceptualizations it can be summarized that culture involves learned action or behaviors, along with cognitive processes such as knowing, perceiving, interpreting, and meaning making, woven among patterns of interactions with and within a particular social context. Culture appears to have an important part to play in understanding human thought and behavior. Attitudes are also highly implicated in human agency. An international study of employees at IBM in 40 countries showed the significance of culture in explaining attitudes, and found culture was a stronger predictor of differences

than professional role, age, gender, or race (Gannon, 1994, p. 4). "Culture" Gannon wrote, "operates subtly, often on the unconscious or semiconscious level" (p. 5). It is therefore only made visible through observing and listening to people. Wildavsky (1989) viewed countries as harboring more than one culture, with each of these having unique values and practices (p. 59). Culture is a dynamic concept that is constantly being created by the people socialized within it. Culture has been influenced through interactions with different societies, or when other beliefs and practices are imposed, such as occurred during periods of colonization (Shorter, 1998). Socio-cultural studies of AIDS in Africa have pointed out that the transmission of HIV has two main foundations: "deeply-rooted socio-cultural patterns, and the disruptive course of colonial and post-colonial history" (Scott & Mercer, 1994, p. 82).

"Throughout human history, societies have had particular perceptions of health and disease rooted in their own culture, and which have led to a plurality of practices for disease prevention and cure" (Claxton, 1996, p. 17). Understanding culture, therefore, is important, if not essential, to recognizing and analyzing these unique perceptions of health, illness, and prevention. Cultural values help determine choices and behaviors, and are related to perceptions of risk (Worth, 1990). Claxton (1996) suggested that Western medicine's focus on the cure of an individual through the use of medicine,

without taking into account the social context and one's relationships, may result in inadequate responses to community health concerns. Experience in global health, Claxton noted, has shown the need for a socio-cultural redefinition of health (p. 20). Yet, Western countries continue to influence developing nations in new ways and for various selfish or altruistic reasons. Landry (1977) emphasized that many public health and other development failures were due to attempting change "without awareness of the sociocultural concomitants and consequences" (p. 466). He noted that even as people are convinced of the possible improvements to health by changing behaviors, they do not always realize the impact this might have on their culture and therefore their very way of life.

Generally, traditional health care has taken a holistic view of the person, linking of body and mind, versus the Western attention to particular symptoms or body parts (Claxton, 1996, p. 19). Dubos (1977) insisted that modern medical practice had been enlarging its view of disease and that "dealing with the problems of the 'dis-eased' person, subjective and social factors may be as important as the objective organic lesions or behavioural disturbances" (p. 32). Modern medical care has slowly evolved from magical and religious beliefs and practices that are still in existence today. Hippocrates, born in 460 BCE, has been recognized as the first person to note that disease might have natural and human, not supernatural, causes. However, there is even much earlier evidence

from Egypt, India, and China of disease-specific medical treatments (Claxton, 1996).

Many studies of traditional health care have shown that local knowledge of cures, known as folk or lay medicine, has been similar between different continents even when there was no apparent communication between them. The folklore of cures and treatment is passed on to each generation through tales, songs, and proverbs. Many of these treatments, when analyzed, have proven to have a rational foundation, in spite of initial impressions of them being very simple and unscientific (Claxton, 1996; Junod, 1938). Ancient and traditional medicines are in vogue today and have provided the basis for much pharmaceutical research and improvements in treatment and healing. For various reasons, and partly due to spiraling health care costs, many people are returning to traditional methods, both in the industrialized and the developing world.

With concepts of health and health practices embedded within sociocultural systems, appropriate research methods are needed to assist in understanding these often intricate relationships. Nations (1986) noted the inadequacy of epidemiological models of illness to explain the complexity of people's lives, and that the field "often forsakes the richness of people's way of living for quantitative rigor" (p. 97). Nations also pointed out that research has

"demonstrated how specific cultural beliefs and practices expose people to (or protect them from) the foci of disease transmission, and directly contribute to (or inhibit) infection" (p. 101). These relate to diet, activity, relationships, religious practices, and child care among others.

The field of ethnomedicine examines popular health culture with the assumption that each human grouping has unique health belief systems. Nations (1986) stressed that ethnomedical studies can enhance work in epidemiology by identifying behavioral risk or health promotive features related to health beliefs and perceptions. "Without in-depth knowledge of the social, cultural, and ecological context of the research setting" it is impossible to understand the process of disease transmission that occurs within the complexity of human behavior (p. 116). Scott and Mercer (1994) argued that an understanding of behaviors and cognitions through qualitative research is necessary as "concepts of critical importance to the spread and prevention of AIDS, such as health and sexuality, can differ tremendously between cultures" (p. 83).

Why Ethnography?

Many of the studies examined so far have stressed the need for research on culture and context in order to improve community health interventions, especially regarding prevention of HIV/AIDS. In order to begin to understand

the deeply held meanings of people regarding such personal issues as health and illness, a qualitative approach seems to be best suited for this purpose. Surveys and questionnaires have their place in research, but are known for their more superficial coverage of events. The purpose of this study was to explore and describe cultural and contextual issues that may facilitate or hinder female participation in health promotion, especially relating to HIV prevention in the Mt. Selinda area of Zimbabwe. Central to the study is an attempt to understand Ndau women's reality, experiences, beliefs, perceptions, and meanings of health, health promotion, and HIV/AIDS. These issues are best studied through a qualitative approach.

Creswell (1998) defined qualitative research as

> ...an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 15).

Within qualitative research there are differing traditions of inquiry that need to be examined to determine the best approach. *Tradition of inquiry* is the term used by Creswell, and his text is helpful, among others, in delineating conceptual differences and similarities among five major possibilities. His five approaches include biography, phenomenology, grounded theory, case study, and ethnography.

Briefly, a biography explores the life of an individual, phenomenology

attempts to understand "the essence of experience about a phenomenon," grounded theory aims at theory development, ethnography is for describing and interpreting a cultural or social group, and case study is used for in-depth analysis of one or more cases (Creswell, 1998, p. 65). Ethnography at first glance appears the most appropriate especially as it has emerged from cultural anthropology. A case study or biography are likely too limiting for the type of broad social understanding of health and health practices within a cultural context. Developing a theory in this study is not an explicit goal. Phenomenology, with its basis in sociology, philosophy, and psychology, examines the lived experiences of several individuals about a concept of interest. This could be applicable in the case of understanding the experience of people living with a diagnosis of HIV/AIDS or the way the illness is understood by those living in high prevalence areas such as Zimbabwe.

Phenomenology has several classifications. One is ethnomethodolgy, "a way in which to examine how individuals in society make meanings of their everyday lives" that is accomplished by analyzing conversation (Creswell, 1998, p. 53). This appears to have some overlap with ethnography. Creswell personally supports a more psychological approach to phenomenology focusing on individual, not group experiences. For too long prevention of HIV and other infectious agents has focused on the individual, while neglecting the ecology of

disease transmission (Abel et al., 2000).

Phenomenology appears to center around a specific experience that is shared by several people. In this study, although HIV/AIDS is important, it is not the central focus. It is not easy to choose one particular phenomenon or experience. Instead, a more general understanding of the cultural and social context of Ndau women is important, as well as social and environmental interactions at various levels, especially as they relate to health promotion. Prevention of HIV is only one aspect of health promotion. Morse and Field (1995) said the essential question in phenomenology is "What is it like to have a certain experience?" (p. 22), and they say its purpose is only to describe, not to develop theory or general explanations (p. 23).

Ethnography, on the other hand, is closely tied to cultural and contextual patterns that are seen to be critical in understanding health and health practices. Morse and Field (1995) wrote that

> ...ethnography is a means of gaining access to the health beliefs and practices of a culture and allows the observer to view phenomena in the context of which they occur, thus facilitating our understanding of health and illness behavior.... Another facet of inquiry is the environmental factors that influence coping and adaptation.... Rather than studying people, ethnographers *learn from* people.... Thus the health care researcher is concerned with revealing culturally embedded norms that implicitly guide individual's actions in a specific culture so that the provision of health care may be culturally acceptable. (pp. 26-27)

According to Creswell (1998), "ethnography is a description and

interpretation of a cultural or social group or system. The researcher studies the meanings of behavior, language, and interactions of the culture-sharing group" (p. 58). He stressed that in order to locate patterns of social and cultural life there is wide ranging "fieldwork, gathering information through observations, interviews, and materials" with procedures resulting in description, analysis, and interpretation. "The final product... is a holistic cultural portrait of the social group" that arises from the participants views (emic) and the researchers interpretation (etic) (p. 60).

Polit and Hungler (1999) concurred that ethnography "provides a framework for studying the meanings, patterns, and experiences of a defined cultural group in a holistic fashion" (p. 243). "The aim of the ethnographer is to learn from (rather than to study) members of a cultural group—to understand their world view as they define it" (p. 245). Referring to health care research Polit and Hungler said that "ethnography provides access to the health beliefs and health practices of a culture or subculture [and] can thus help to facilitate understanding of behaviors affecting health and illness" (p. 246). Hammersley and Atkinson (1995) stated,

> ...the value of ethnography as a social research method is founded upon the existence of such variations in cultural patterns across and within societies, and their significance for understanding social processes. Ethnography exploits the capacity that any social actor possesses for learning new cultures, and the objectivity to which this process gives rise. (p. 9)

"To be of value," they added, "ethnographic research should be concerned not simply with understanding the world but with applying its findings to bring about change" (p. 15).

It is not always easy to distinguish, or to choose between, the various qualitative approaches, especially as many aspects are shared. Phenomenology is a possibility in this type of study but does not seem to be a perfect fit. The above discussion and examples from various researchers seem to point to ethnography as most appropriate. It is aimed at a broader examination of culture and context, as well having the flexibility to focus on particular groups and not necessarily a whole culture.

"The meanings with which AIDS is invested, the social contexts of transmission, and cultural constructions of contagion and disease create constraints to understanding and acting upon information about prevention" (Schoepf, 1995, p. 29). Obbo (1995) went further when she wrote that in spite of the scientific assumptions underlying prevention, such as the need to change behavior and use condoms, "the key to the transmission and control of HIV, however is embedded in the traditional practices that need to be exposed" (p. 79). By this she did not necessarily mean sexual practices, but that an examination of demographics such as gender, social status, and age is required, along with the links between traditional and Western health care. It is the social

context of sexuality that is important to understand, and this has been generally ignored in research. Parker (1995) noted the overreliance on Knowledge, Attitudes, and Practices (KAP) surveys that has perpetuated the focus on individual factors of behavior change while ignoring socio-cultural issues, those issues that could be better served with an ethnographic approach to meanings. "Ethnographic research reveals numerous strong cultural constraints to prevention. It also provides examples of dynamic responses to crises.... Once culture is viewed as offering possibilities for change, new vistas open" (Schoepf, 1995, p. 44)

Related Studies

A search for previous dissertation research related to this study was carried out through UMI using combinations of headings including women and HIV/AIDS, qualitative research, developing countries, health promotion, and Africa.

Morrison (1999) carried out doctoral thesis work entitled *Changing Sexual Behaviour and Women's Risk for HIV/AIDS in Chiang Mai, Thailand: The Fourth Wave*. She strongly promoted an anthropological approach as being able to examine variations and provide deeper description than could epidemiological studies, especially related to HIV/AIDS among cultural groups. She also noted

the limited understanding of the cultural context of sexuality.

Morrison's (1999) methodology included ethnographic, semistructured interviews of women, key informant interviews, focus groups, participant observation, and a review of educational and archival materials. The purpose was "to explore historical, socio-cultural, and economic context of sexual behaviour and sexual networking...and how these put women at risk for HIV" (p. ii). Both men and women's perspectives were sought, and some conclusions reached included the influence of Western culture on changing sexual behaviour and gender roles. Her focus was on commercial sex workers and so does not necessarily provide a realistic view of the lives of ordinary women, although some of the socio-cultural forces are possibly generalizable. She noted that the HIV epidemic in Thailand has resulted in some changes in sexual behavior, yet retention of old traditions and practices are seen as increasing rates of infection.

Dutta (1998) examined determinants of HIV/AIDS awareness among women in India, especially cultural norms, using a cross-sectional, community-based survey in the city of Calcutta. Quantitative data were obtained from the survey and supplemented with qualitative material, notably focus groups and key informant interviews, to garner women's perspectives and to increase understanding of the cultural context. Knowledge level was found to be high, but also many misunderstandings prevailed. Several barriers were identified

including domestic violence, unequal gender power relationships, and women's general vulnerability at many levels. The hope was that the extensive information and analysis would assist in developing culturally acceptable preventive programs.

Dutta (1998) stressed that attempts to stop the epidemic will be unsuccessful unless both social and biological factors are considered (p. 3). As well, there has been little research on how women can influence or modify their sexual relations with husbands. She recommended that more qualitative studies are needed to examine the factors of women's ability to implement preventive actions.

Baronowski (1999) researched health perceptions, barriers to health, and health priorities as experienced by marginalized women in poverty. She explored general health issues using qualitative methodology with data gathered mainly through focus groups. She cited Helman as believing "that health is personally defined, and health practices are influenced by the ability of the ecosystem to offer sociopolitical, cultural, biological and environmental conditions conducive to a healthy lifestyle" (p. 23). The majority of research, she stressed, does so with the individual separated from their environment, and there are no studies that explore meanings, barriers, and health in the everyday lives of marginalized women. After an extensive review of health promotion models and their

application (including Pender's), Baronowski concluded, "It is clear from a number of studies that health beliefs and perceptions are one of the strongest predictors of health behavior, and deserve more extensive exploration" (p. 57).

An earlier, master's-level paper, but one focused on HIV and African women, entailed an extensive review carried out by Hardy (1991) on mainly urban areas. She concluded that individualistic approaches to prevention were hampered by the socio-economic systems in developing countries. As well, the socioeconomic aftermath of colonialism is borne in the "productive subsistence of labor of African women" (p. 101). Hardy also stressed that prevention programs need to respect the diversity of African societies, and must address wider, contextual level changes if anything is to improve.

Summary

Examination of aspects of the HIV/AIDS pandemic, especially in Africa, has shown a complex relationship between the virus, individuals, and their environments. Much research has focused on epidemiology and treatments, as well as knowledge, attitudes, and practices. Much less has been done on understanding the socio-economic-political culture of transmission and health promotion. The result of this has been possibly inappropriate or, at the least, less effective prevention.

Females appear to be especially vulnerable to HIV/AIDS for biological and contextual reasons. When a woman becomes HIV positive the effects are far reaching for the family and for future pregnancies. Women in Africa also carry the major responsibility for their children's socialization, including messages about health promotion, and so the health of future generations is jeopardized when mothers become ill or die prematurely.

All this strongly suggests a need for more contextual studies of women's lives to understand what hinders or facilitates health promotion, including the sensitive issues around HIV prevention. This information cannot be found through rapid or superficial research. Therefore, an in-depth ethnographic approach was undertaken to capture some of the local context and culture that might impact on prevention and care. It was hoped that the women of Mt. Selinda could be seen as more than providers of information but essential in finding solutions to the ominous problem that surrounds them.

CHAPTER 3
METHODOLOGY

Introduction

Chapter 3 describes all aspects of the research design, including the tradition of inquiry, target population, sampling strategies, data collection, and analysis. The purpose of this ethnographic study was to explore and describe cultural and contextual issues that may facilitate or hinder female participation in health promotion, especially relating to HIV prevention in the Mt. Selinda area of Zimbabwe. Central to the study is an attempt to understand Ndau women's reality, experiences, beliefs, perceptions, and meanings of health, health promotion, and HIV/AIDS. The findings may increase understanding of culture and context in relation to health and provide relevant and appropriate directions for HIV prevention. As well, the research provides for transferability by providing a clear written record of the process.

The main research question is: What factors facilitate or hinder women's participation in health promotion and prevention of HIV in the Mt. Selinda area of Zimbabwe?

Subquestions include:

1. What are the local meanings, beliefs, and practices concerning health, illness, and health promotion?

2. How do gender, socio-economic status, religion, and culture interact and

influence participation in health promotion and HIV prevention?

3. What other factors are seen as affecting the prevention of HIV? (Personal and environmental).

4. What do the people see as the most pressing needs in relation to improved personal and community level health and wellness?

5. What do they think needs to happen for change in the HIV epidemic?

It was not expected that all of these questions would be answered in depth through this one study. Because of the exploratory nature, these questions served to guide and shape the inquiry. The use of a qualitative design means that the researcher focuses on certain patterns as they emerge, while those not seeming to be as important are set aside.

Research Design

It is important that any research methodology be based on the purpose and questions to be answered. The overarching approach for this study is qualitative or naturalistic. This method is useful when the complexity of human experience is to be explored.

Qualitative Inquiry and Research Paradigms

Qualitative or naturalistic inquiry occurs where people are living and

working (the field). Data collected are considered rich, have considerable detail and depth, and are capable of revealing multiple dimensions (Creswell, 1998; Polit & Hungler, 1999, p. 14). The researcher is considered the study instrument. The aim is to elicit the participant's perspective, and the process is holistic and inductive (Creswell, 1998; Miles & Huberman, 1994; Morse & Field, 1995). According to Morse and Field, "Qualitative research enables us to make sense of reality, to describe and explain the social world, and to develop explanatory models and theories" (p. 5).

Creswell (1998) provided a list of quality criteria expected of naturalistic inquiry: rigorous data collection and analysis, adequate time in the field, framed within qualitative concepts like an evolving design and multiple realities, beginning with a single focus, attention to detail, multiple levels of abstraction, and persuasive, clear, and engaging writing (p. 21).

Ethnography

Various descriptions or definitions of ethnography were discussed in the previous chapter. This section will examine ethnography in more depth with several of the aspects that are either unique to this tradition, or shared with other qualitative approaches.

Wolcott (1999) stated that the practice of ethnography is going in many

directions and has been adopted by many disciplines. He compared the use of ethnographic methods with the study and writing of a "full-blown ethnography" (p. 13). Ethnography can be seen as both a process and a product, and Wolcott stressed the difference between "doing ethnography and borrowing ethnographic techniques" (p. 41). The boundaries are not always clear. Wolcott stressed that ethnography is a way of "conceptualizing, as well as a way of looking" (p. 17). Later he said ethnography is also a way of seeing, and this seemed to imply that "looking" referred to methods, while "seeing" related to thinking and writing (p. 66). He stressed that, no matter what ethnography has been or is becoming, it "is still about groups of people engaging in customary forms of social interactions" (p. 39). This study attempted a total approach (both looking and seeing) that implied using ethnographic methods throughout data collection, analysis, and reporting.

Ethnography is closely associated with cultural anthropology and continues to evolve in its types and application. All forms, though, are seen to be

> ...holistic, contextual, and reflexive.... An ethnographer asks, "In what ways do members of a community actively construct their world?" and "what are the environmental factors that influence coping and adaptation?... Ideally, the ethnographic process eventually moves beyond description to reveal or explain aspects of social patterns or observed conduct. (Morse & Field, pp. 26, 27)

This study examined some of the ways that Ndau women construct their world, especially regarding health issues and how they make sense of these.

Atkinson and Hammersley (1998) delineated several features of ethnography. These include exploring social phenomena, collecting rather unstructured (not precoded) data, studying a small number of cases, and analysis and interpretation of human behavior (pp. 110-111). Two perspectives are important in ethnography. The *emic* perspective reflects the participant's worldview expressed through language and concepts that "name and characterize their experiences." *Etic* refers to the researcher's perspective from outside the setting, the ideas and language that informs the interpretation. One goal of ethnography is to view the setting through the emic view and to uncover the more covert aspects of the experiences (Polit & Hungler, 1999, p. 245). Attempts have been made to capture this emic perspective of the women in the study, and to find a balance with the etic view of the researcher, which is a necessary component in ethnographic analysis and interpretation.

Creswell's (1998) comparison of five traditions of qualitative inquiry is helpful in delineating the unique characteristics and language of ethnography. He stressed that there are many approaches to ethnography that is "a description and interpretation of a cultural or social group or system" (p. 58). Ethnography is concerned with "looking for what people do (behaviors), what they say (language), and some tension between what they do and what they ought to do, as well as what they make and use (artifacts)" (p. 59). One aim, Creswell said, is

to uncover themes that represent the culture and this is done through immersion in the setting or field in some form of participant observation. Access is gained through gatekeepers, and important information is found through in-depth interviews with key informants and participants. The description, analysis, and interpretation of the culture-sharing group attempts to be holistic (as complete as possible), leading to a cultural portrait (an overview exhibiting its complexity). The result is expected to reflect both the emic and etic viewpoint. Regarding the concept of holism, Wolcott (1999) pointed out that ethnographers cannot possibly discover everything about a culture-sharing group, and he prefers the term context to holism. Context, he stressed, is the focus of ethnography (p. 79).

Creswell (1998) also discussed several field issues, including reflexivity, reactivity, reciprocality, going native, and deception (p. 113). Going native is important in how the culture is observed and interpreted. Hammersley and Atkinson (1995) wrote that being a "stranger" provides a certain objectivity that is necessary to view what the insider takes for granted or is not even aware of. Once a researcher becomes too familiar with the setting, known as "going native," this objectivity can be threatened. There is a need for balance between familiarity and strangeness. Reactivity refers to how people respond to the researcher, especially concerning honesty (Creswell, 1998). Hammersley and Atkinson stressed that this can be minimized, monitored, and even used to

advantage. Deception is the degree of openness and honesty of the researcher regarding the purpose and use of the research, and could also refer to how honest the participants are in responding to questions.

One important characteristic of ethnography is the fact that the design evolves while in the context and, therefore, it cannot be completely preprogrammed ahead of time. Judgments are made continually, depending on what has already been observed and recorded (Hammersley & Atkinson, 1995). In spite of this, much can be done to prepare for the field and considerable organization and planning is necessary. Wolcott (1999) stressed that for a study to be considered ethnographic, the researcher needs to know what is appropriate for data collection, analysis, and interpretation. There is no strict agenda and much depends upon the purpose of the study (p. 51). It appears there is no single way to present the results of an ethnographic study.

Target Population and Sample

The population of study is Ndau women between the ages of 18 and 45 years living in the Mt. Selinda area of Zimbabwe. The sample included a core group of 11 women called key participants. The population was limited to women in the main childbearing years as they are the ones most sexually active and therefore vulnerable to HIV infection. It is a societal expectation that women

will have children.

One inclusion requirement was that they needed to speak and understand English. Because this limited who could participate and is not representative of many of the local women, the majority of the key participant interviews were carried out by a native research assistant in the local language (ChiNdau). The two modes of interviewing were compared for quality and depth of the information. Although English is one of the official languages, it is not regularly used in this rural area and implies that a certain level of education has been reached. This education was most likely gained through attendance at the local mission schools. It is recognized that this type of religious based schooling, and the women's ability to communicate in English, could have influenced their beliefs, practices, and socialization in ways different from those who did not attend these schools. Carrying out interviews with women having less formal education, and using the local language, provided some comparison.

Other than the key participants (core group), 17 people in the community were included as key informants in order to locate different viewpoints of health, illness, and health promotion practices. Key informants are members of the culture-sharing group "who possess special knowledge, status, or communication skills, who are willing to share their knowledge and skills, and who have access to perspectives or observations denied the researcher"

(Gilchrist, 1992, p. 75). As well, four focus groups, with a total of 20 people, were held to add to the richness and variety of the information. These were homogenous groupings of female nurses, schoolteachers, male nurses, and women living positively with HIV/AIDS.

Sampling Procedures

Key participants for this study were chosen through a purposeful, non-random sampling process: Women were recruited based on the purpose of the study and who best could help answer the research questions. Endeavors were made to find a representative, possibly typical (average) sample that could provide rich data. As well, other participants were included through attempts at maximum variation sampling, meaning that a diverse sample of people were recruited to provide broad perspectives that could enhance, confirm, or challenge understanding (Kuzel, 1992; Polit & Hungler, 1999).

Partially this involved a convenience sample because of the difficulty in traveling around the catchment area. There are few roads; those that exist are in poor condition and are often impassable during the rainy season. Therefore, several of the key participants were recruited through the Family Child Health Clinic at the hospital. Women come from various parts of the catchment area, especially those staying in the self-care waiting area, for the last month of

pregnancy so they can deliver safely in the hospital. Involving women through the clinic was an effective use of time, and in consideration of transport issues. For any who did travel—and this helped maintain their privacy—transportation costs were reimbursed or the researcher provided transport.

Key informants and focus group members were chosen purposefully depending on the perspective it was expected they could offer. Snowball sampling was not especially useful as very few people referred others, but initially, several were referred through a gatekeeper from the high school. Focus group members were recruited through purposeful, homogenous sampling to allow a more "focused inquiry" (Polit & Hungler, 1999, p. 298).

Sample Size

Sample size was not predetermined before the study began, as this type of inquiry requires a flexible approach. Six key participants was the minimum number to be considered, with adjustments made depending on what had been learned in and through subsequent interviews. Sampling and interviewing continued until saturation of information was achieved, depending on the adequacy and quality of the data obtained throughout the process (Polit & Hungler, 1999). "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases

selected and the observational/analytical capabilities of the researcher than with sample size" (Patton, 1990, p. 185).

Recruitment

The researcher generally approached key informants and focus group members, while the nurse at the Family Child Health Clinic (FCHC) facilitated recruitment of key participants. A local teacher also assisted in initial recruitment outside the hospital. The nurse on duty provided initial information to women who arrived for antenatal, postnatal, family planning, or child health visits, and who met the criteria for inclusion (Appendix A). If women expressed interest in participating, they were referred to the researcher for further information and informed consent (Appendix B). At this time, if they agreed to participate, some initial demographic information was collected, and date and time arranged for the first interview.

Clinic nurses could be considered gatekeepers in an ethnographic sense—the persons who facilitate the researcher's entry into the setting. In this case they did not necessarily control entry, but certainly facilitated making contacts. By introducing the study and the researcher, a certain level of credibility was gained and rapport was facilitated. An unexpected gatekeeper, in the form of a local teacher, also helped in early recruitment. The local chief, church leaders, and the

medical superintendent of the hospital who gave approval for the study added to the credibility and acceptance.

Key informants and focus group members had the study explained by the researcher, or assistant if in the local language, and informed consent was obtained from those who agreed to participate (Appendixes C and D). All consent forms were translated into ChiNdau, and if any participants could not read, the research assistant read it to them.

Ethical Considerations

There are several ethical issues in qualitative research, with the following particularly critical.

Confidentiality/anonymity. The only record of a participant's full name is on the informed consent. An ID number and a pseudonym (if desired) were assigned and used instead of actual names on any notes, tapes, or transcripts. Consent forms are kept locked and separate from any other notes and tapes, and only accessible to the primary researcher. The research assistant signed a confidentiality form (Appendix E) with these issues again reviewed when her work was completed. All materials are stored in a locked file. The resulting report attempts to provide a composite picture of women, not one of particular individuals. Because certain statements made by people could cause them to be

recognized by others, attempts were made to prevent this by carefully considering possible consequences of any of the statements becoming public. However, the majority of participants preferred to use their real name and wanted to be recognized.

It was difficult to provide complete privacy, as the community is not large or densely populated. It was impossible for the researcher to travel throughout the catchment area without being noticed, as there are few expatriates in the area. As well, most people live in extended family units and would rarely be alone in their homes. Carrying out most interviews at the researcher's home provided the best degree of privacy. The participants were able to choose the preferred venue, date, and time. Only a very few were concerned about privacy, and others questioned the need for such formalized concern as expressed in the consent form.

Deception/disclosure. Every attempt was made to be open with participants regarding the nature of the study, the risks and benefits, and researcher responsibilities as related through the consent form. Translated forms were developed for those not able to read English. Any questions were promptly and honestly answered, but the majority found the consent form provided enough information. It was difficult to anticipate all possible situations, as questions were not fixed and often emerged from previous comments. The consent form

clearly stated that participants could refuse to answer any questions and withdraw at any time. These and other issues were discussed in the Application to the Institutional Review Board at Walden University that gave approval for the study. A letter of support from the Hospital Executive was included in the application (Appendix F).

Data Collection

One of the strengths of an ethnographic approach is the variety of qualitative data collection methods that are routinely used. The use of several methods is considered data triangulation and can help in not only broadening the base of data collection but also assist in verification. The following methods were utilized in this study.

Participant Observation

A participant observer is defined as a researcher who gathers information through observation of the culture-sharing group through some form of participation. According to Jorgensen, quoted in Bogdewic (1992), the purpose is to "generate practical and theoretical truths about human life grounded in the realities of everyday existence" (p. 46). Scientific observation is not a passive exercise, but is systematic and purposeful (Adler & Adler, 1998).

The level of researcher participation can be considered on a continuum from partial to complete and has been classified in different ways. One typology includes four categories: complete observer, observer as participant, participant as observer, and complete participant. It depends on how much is known and revealed about the research, the researcher, and the activities undertaken (Atkinson & Hammersley, 1998, p. 111). Participant observation is useful to view how the context and interactions of members of a culture-sharing group influence beliefs and behaviors (Bogdewic, 1992).

In this study the researcher had been working in the Mt. Selinda community since December 2000, invited to open a nursing school and to teach. This position appears to fall under participant as observer since the job is the reason for living here and the research is secondary. By participating in various activities and rituals it had been possible to begin to know the people and observe their practices while beginning to be accepted as part of the community. Although not everyone knew this secondary role as student/researcher, it initially was conveyed to the president of the denomination, the hospital executive, the community station council, local church deacon, several nurses, and the local chief. This was done to initially test for potential problems with the project, but there was only acceptance and approval. As the research got underway, many people in the community heard about it or read the recruitment

notice in the hospital administration building where staff and patients gather. Bogdewic (1992) offered some ideas for developing and maintaining rapport once in the setting and these include: be unobtrusive, be honest, be unassuming, be a reflective listener, and be self-revealing (p. 52).

Field Notes

Field notes are personal records kept by the researcher and are sequential accounts of what is happening in the field—both the context and the processes. They can contain descriptions of the setting, the people involved, the activities, artifacts, actions, events, time and sequence, goals, and emotions. These, wrote Bogdewic (1992), encourage the collection of thick description. Personal responses, ideas, and reflections of the researcher are also important to record. Each page needs to be labeled with date, time, location, and page number. A wide margin provides space for later thoughts, comments, or emerging themes or categories. Bogdewic called these personal reflections "the intellectual and emotional journey of the researcher" (p. 64). The researcher kept a notebook of personal observations that tracked activities, and included questions and concerns of what was being observed or heard before, during, and after data collection.

Semistructured, In-depth Interviews

Interviewing is a foundational method of qualitative data collection. In ethnography it complements observation, for not everything can be observed. To begin to understand the other's perspectives, thoughts, feelings, beliefs, and meanings, questions need to be asked (Gilchrist, 1992, p. 196). Interview styles range from totally structured to completely unstructured. Too much structure can limit the responses and amount and type of information acquired. Overly informal methods increase the chance of extraneous material being gathered and therefore data are much more difficult to analyze

This study used a semistructured or focused format. A list of questions or topics to be covered was prepared in the form of interview guides. One was prepared for the core group or key participants (Appendix G), and one for key informants (Appendix H). Questions were open-ended to allow participants to talk freely, respond in their own way, and not be overly influenced by the ideas of the researcher (Polit & Hungler, 1999). Probes and other questions were used to encourage more detail and depth. The use of a guide made more efficient use of the interview time and encouraged some consistency between different respondents. This was important for making comparisons. Questions were adapted from the guide to match different categories of participants and the order was flexible. These adaptations were made ahead of the interview,

especially in the case of interviewing health workers, a historian, and people living with HIV/AIDS, although some of the basic questions were retained to assist in comparing. "The fundamental principle of qualitative interviewing is to provide a framework within which respondents can express their own understandings in their own terms" (Patton, 1990, p. 205).

In total, 41 interviews were completed and all were tape-recorded and transcribed as soon as possible after each interview. Tapes were kept locked when not in use and they, along with all other notes and documents, will be stored for a required 5 years.

Focus Groups

Focus group discussions are a form of group interviewing, usually composed of a homogenous group with a moderator. One benefit is they can offer a different perspective from individual interviews. They may not provide the depth of the latter, but can provide a broader range of viewpoints (Jackson, 1998). "One premise related to the use of focus groups is that attitudes and perceptions are not developed in isolation but through interaction with other people" (Morse & Field, 1995, p. 31). This supports an ecological approach of interdependence and the importance of relationships within the social setting. Morgan (1997) stressed that focus groups can support the data from personal

interviews by filling in gaps in understanding. On the other hand, information gathered in a group could conflict with other interview or observation data, as people respond differently in diverse situations. Morgan argued that this can be related to contextual issues and should not be seen as disconfirming. Instead it can be a beneficial way of seeing "different aspects of the overall behavior pattern" (p. 12).

This study used the focus group format to complement the individual interviews and participant observation. As with the other interviews, group discussions were tape-recorded and transcribed. The Ndau appear to be very sociable people, and people often meet in groups or share in the daily work, so this type of activity was natural to them. The oral traditions, along with limited forms of formal communication in the area, most likely encourage verbal interactions. The researcher had considerable experience in facilitating group work, especially through nursing management roles, working with adolescent groups in psychiatry, and participatory education workshops for youth and adults.

The use of focus groups needs to be well planned with guiding questions or topic outlines prepared (Appendix I), although the process is possibly less structured than individual interviews. People were invited for the different perspective they had to offer, such as from their professional role as nurses and

teachers. As the study progressed members of a local HIV/AIDS support group were included. Most were not fluent in English, so the researcher prepared a special interview guide (Appendix J) that was translated by the research assistant. The assistant was then provided with training in focus groups, and she facilitated this last group in the local language.

Confidentiality is possibly a greater concern in focus groups with the number of people involved. Participants were asked to sign a confidentiality form (Appendix K) after its importance was explained at the beginning of each session. These documents, with their signature, are kept with the consent forms and therefore separate from the collected data. Participants were offered the chance to use a pseudonym during the discussion.

Documents

Historical and more current documents, such as Ministry of Health publications, were introduced in chapter 2 as a way of understanding some of the history and present-day status of the Ndau and their context. Texts on the Shona people were used to compare and help understand common traditional belief systems, especially about health and illness. The Ndau are considered a subtribe of the Shona, but they do have a distinct dialect, which might mean other differences exist. There is little written by the Ndau people themselves, as

they follow an oral-based tradition.

Data Management

The amount of information that can be amassed during qualitative research is considerable and can become overwhelming. It is important to keep it organized and under control and to begin this early on in the process.

Field notes were kept in a separate notebook. Personal thoughts and perceptions were bracketed or placed in a margin. This notebook also included the date of each group or individual interview and observations of occurrences that might not be apparent on the tape (for example, body language especially expressions). These actions assist in the compilation of an audit trail.

Tape-recorded sessions were transcribed into MS Word on a notebook computer as soon after the interviews as possible (or after the research assistant completed written translations), usually within 24 hours. The interview was then transferred into The Ethnograph v.5.0 program with formatting and spell checking done. Although advertised as an analysis program, The Ethnograph is basically a code and retrieval program especially for text-based data. Each project that is set up can contain unlimited data files. Codes are applied to lines or segments and a codebook is automatically generated. In the codebook, definitions were assigned to each code. Memos up to 32 pages long can be added

to specific lines in a file or to the file itself. Memos are personal notes of the researcher and could come from the field notebook or include any thoughts while entering or reviewing data. It is possible to search for single code words, or multiple code strings using the operators "and" and "not," or by other identifiers. Segments of text can be cross-referenced. At a minimum, weekly backups were made onto floppy discs for word processing and Ethnograph entries. These were also backed up on the researcher's main computer. As well, each interview in Word was printed in order to have a hard copy for safety and for ease of reviewing.

Data Analysis

Although the features of The Ethnograph can assist in analysis, this is really the cognitive work of the researcher. Analysis ideally begins as soon as data collection is started. It is an "emergent product of a process of gradual induction" (Lofland & Lofland, 1995, p. 181). Lofland and Lofland stressed that analysis is creative work that does not happen automatically. It involves interpretation that many writers insist is one foundation of ethnography.

Core activities of analysis, according to Lofland and Lofland (1995), are coding and memoing (p. 186). Questions are continually asked about the data as to what is going on, what does it mean, and what category might it represent.

The answers to these questions result in codes that provide a concise meaning, and assist in categorizing, retrieving, and organizing. Webb (1999) stressed that coding is more than a mechanical task; it is a component of analysis and relates to theories and interpretations. She stressed that it is necessary to continually move between codes and text so as to not lose sight of the context. Coffey and Atkinson (1996) preferred to think of coding in a less mechanical way as a means of "generating concepts" (p. 26). Miles and Huberman (1994) strongly recommended that coding start with initial data entry, and that each interview or field note be coded before the next visit or interview. Coding leads to pattern recognition and therefore can be a powerful tool to prepare for ensuing data collection (p. 65).

Memos are "explanations and elaborations of the coding categories" that the researcher adds to the collected data to enhance and make sense of it (Lofland & Lofland, 1995, p. 193). The Loflands also offered other ways of organizing data such as diagramming, building a matrix, concept charting, and flow-charting. Memoing represents a conceptual exercise that helps in linking important parts of the data and is a way of "making sense" of the material and ideas that emerge while working with it (Miles & Huberman, 1994, p. 72).

Strauss and Corbin (1990) stressed two important elements of analysis. The first is asking questions, and the second is making comparisons that they call

"the constant comparative method of analysis" (p. 62). This means comparing segments of data or situations in the search for similarities and differences.

In this study a narrative style of analysis was carried out in contrast to content analysis. The latter is more of a quantitative text analysis that, according to Manning and Cullum-Swan (1998), "has been unable to capture the context within which a written text has meaning (p. 248). Riessman (1993) noted that the purpose of narrative analysis is examination of how participants, through the telling of their stories, "impose order on the flow of experience to make sense of events and actions in their lives" (p. 2), and "studying narratives is additionally useful for what they reveal about social life—culture *speaks itself*" (p. 5).

Several conditions made alternating between analysis and data collection difficult in this study. First, many of the key participants were nearing time of delivery, and the two interviews needed to be done close together. Shortly after delivery the women returned to their rural homesteads and would be difficult to reach. For others, approximately a week lapsed between the first and second interview. Second, these women from the more remote areas were interviewed in the Ndau language and the assistant was brought into the area for a limited time. This meant that she was doing a second interview before translating the previous one, and the researcher did not have access to the data. Third, the nurse at the clinic (gatekeeper) was reassigned to other wards and shifts during most of the

data collection time due to a critical nursing shortage. There was only a 3-week period when the assistant was present at the same time that this nurse was working at the Family Child Health Center. Fourth, frequent and unplanned power outages, some lasting for whole days, made it impossible to use the computer for transcription, the tape recorder for translating, and to recharge batteries for the microcassette used for interviews. Fifth, in the larger context, the political situation in Zimbabwe continued to deteriorate in the lead up to the presidential elections set for March 9 and 10, 2002. There was escalating violence against members of the opposition party and racist attacks on Whites. The researcher was advised to leave the country until after the election and until the post-election effects could be determined—including the possibility of civil war. Therefore, there was some urgency to complete data collection in a timely a manner as possible.

Recruitment began on November 9, 2001, with the first interview on November 17 continuing up to February 17, 2002. Translations and computer entries, with partial coding, were completed by February 18, 2002. The researcher temporarily relocated to neighboring Mozambique on February 24 to wait out the elections. Initial coding was completed on March 8, 2002.

Issues of Quality and Ethics

"An ethnography is written representation of a culture (or selected aspects of a culture). It carries quite serious intellectual and moral responsibilities, for the images of others inscribed in writing are most assuredly not neutral" (Van Maanen, 1988, p. 1). This statement refers to what is known as representation. In the mid-1980s, questions arose as to whether anyone was able to "directly capture lived experience," with the argument that the experience is created within the written texts (Denzin & Lincoln, 1998a, p. 21).

While writing about the intangibility of culture, Van Maanen (1988) said, "Culture is not itself visible, but is only made visible through its representation" (p. 3). The ethnographer must take the experience of the field and transpose it into something called culture (p. 4). This end result, or representation, is very much influenced by the researcher, not only through personal characteristics, but as well through the style of interpretation and writing. Culture is also a dynamic concept and one that holds personal constructions and meanings for each person at a specific point in time. Another influence on the end result is that of the audience, and it is accepted that this increases the levels of interpretations (Van Maanen, 1988, p. 35).

While the aspect of how to adequately and appropriately represent the other remains an issue, it is more widely accepted now that the researcher is

closely connected with the process and cannot be seen as a separate, impartial entity. This had been the expectation in research endeavors with a more positivist leaning that stressed clear objectivity. Related concerns are how much the researcher should be included in the narrative (as there is a danger that the other may be submerged in a certain level of ethnocentrism), and how to know where each is situated. One solution to the latter is through the use of the participant's own voices or "multivoiced as opposed to single-voiced texts" (Denzin, 1998, p. 320).

Objectivity refers to the ability to remain somewhat apart from the research process, thereby reducing bias and presenting an accurate picture of the context and people under study. Spradley and McCurdy (1972) argued that complete objectivity is not possible and that a researcher will selectively observe and interpret because of the fact of being human. One way they suggested to compensate for this lack of objectivity is to recognize any beliefs, values, and perspectives that might be influencing the data collection and analysis. A second safeguard is basing data selection and interpretation on an explicit theory and not on indiscriminate practices. Spradley and McCurdy also recommended that using the classifications and descriptions of the participants, and not those of the researcher, could reduce some of the challenges to objectivity.

A concept related to objectivity is *reflexivity*. This term, according to

Hammersley and Atkinson (1995), recognizes the interconnection and interaction between researcher and participants, and the social impact this type of research can have on all involved. Davies (1999) defined reflexivity in social research as the "ways in which the products of research are affected by the personnel and process of doing research," and is especially important in ethnography where the researcher is in close proximity to the culture-sharing group (p. 4). By their presence and interactions, researchers construct their observations while their personal socio-cultural background is implicated in this construction (p. 5). As can be seen, reflexivity, objectivity, and representation are overlapping concepts.

Also of concern regarding quality is *legitimation*, or claims to authority (Denzin, 1998). Denzin and Lincoln (1998b) wrote that traditional, scientific ways of evaluating research, such as validity, reliability, and generalizability, are not useful and that new criteria are needed that is more reflective of the process (p. 21). With description being so important in this type of study, then validity is less important than credibility, or "whether or not a given explanation fits for a given description" (Janesick, 1998, p. 50). Janesick suggested that having a clear audit trail and carrying out member checking (participants, colleagues, or both) can help, but still questioned the stress on validity. She referred to a 1990 book by Wolcott, who stated that with the acceptance of multiple realities in ethnography, the idea of validity and reliability is illogical. There is some

controversy regarding member checking, or as Hammersley and Atkinson (1995) called it, "respondent validation" (p. 228). They warned that member checking needs to be used with caution because of the many human variables and different perspectives that could actually complicate or bias the process, and lead to a less credible report.

"Qualitative research...is carried out in ways that are sensitive to the nature of human and cultural social contexts, and is commonly guided by the ethic to remain loyal or true to the phenomena under study, rather than to any particular set of methodological techniques of principles" (Altheide & Johnson, 1998, p. 290). Altheide and Johnson offered four alternative criteria for assessing quality of ethnography: "plausibility, credibility, relevance, and importance of the topic" (p. 293). Some ways of applying these criteria include the faithful reporting of the participant's perspective; being clear on the researcher's own perspective; clear temporal recording and reporting of process, problems, and how addressed; and having transparent purposes with clear interpretations to enhance reader understanding (pp. 293-294).

Regarding generalizability, Morse and Field (1995) preferred Leininger's term of transferability that means, "general similarities can be applied under similar conditions, contexts, or circumstances" (p. 146). A good record of field notes and other transparent practices for a clear audit trail support this concept

of transferability. The localized nature of this study means the findings will not be generalizable, but detailed, sequential record keeping has been carried out to maintain conditions of transferability. Goodall (2000) stressed the "scholarly value" of ethnography as a measure of quality. This refers to whether the questions are interesting, the purpose is important, the study is informed by current literature, and the writing helps readers learn while fulfilling the purpose (p. 192).

The Ethnographic Text

The writing of ethnographic texts takes many forms, and it appears the possibilities are constantly expanding. Van Maanen (1988), in his *Tales of the Field,* described three ways of reporting the ethnographic experience. The first, and most traditional, he called the *realist* tale. In this the researcher describes the setting and people in a "dispassionate, third-person voice" and attempts to present an authentic story (p. 45). This style is likened to a documentary with considerable and methodical detail, and openly attempting to present the story of the other; yet clearly the researcher has the final word on interpretation and therefore holds considerable power.

Van Maanan (1988) named the second form *confessional* tales. As opposed to the realist format, the researcher is a central figure as evidenced by the use of

the first person and descriptions of experiences in the field. Instead of a focus on the native's voice, the fieldworker's viewpoint is presented. This may be seen as an attempt to make fieldwork more transparent instead of assuming legitimacy, as well as to challenge traditional ways of writing ethnography (p. 92).

The third major type Van Maanen (1988) called *impressionist* tales, and here an attempt is made to balance the role of self and other. The narrative is focused more on exceptional or extraordinary events as they unfold. This narrative is written in a colorful way, possibly using metaphors and other imagery that attempt to actively involve the reader in the story. Interpretation by the researcher is limited and therefore is left more open for the audience. This is the less well known of the types, while at times components of this style can be found within realist and confessional tales (p. 106).

Goodall (2000) wrote about the "new ethnography...a story based on the represented, or evoked, experiences of a self, with others, within a context" (p. 83). He talked about the new ethnography "evolving to a higher level of scholarly consciousness" ... to provide a "dialogic ethic, and a transformational vision," in order to bring about change in the world (p. 198).

These few examples demonstrate the dynamic state of ethnography and the many possibilities for reporting. The choice is strongly influenced by patterns emerging from the data and their analysis. It is important to avoid repeating

some of the earlier practices of classical ethnography where often cultures were made to appear exotic or static, and where it happened that people did not recognize themselves in the ethnographic interpretations (Davies, 1999). Rosaldo (1993) said, "there is no single recipe for representing other cultures" (p. 61). Finding the most appropriate way to represent the women of Mt. Selinda, their context, and their culture has been a priority consideration and concern throughout the process, and a multi-voiced narrative is the result.

The Research Participants

Eleven women who met the criteria for inclusion were interviewed either in English (3) or ChiNdau (8). When asking people in the community to describe a "typical Ndau woman," comments almost always included that this group had not completed formal education. Therefore, the majority of key participants was chosen to reflect this, and required interviews to be held in the local language. Even on completion of high school, in-depth conversation in English can be difficult.

Two interviews, each lasting about 1½ hours, were carried out with 9 of the women. The research assistant decided a second meeting with one participant in ChiNdau was not worthwhile because the first interview was of such poor quality. When the researcher reviewed the transcript it appeared there

might have been a personality clash between the two, as not all of the assistant's probes or questions were typical. This may have been induced by the degree or type of responses she received from the participant, or the type of questions and probes themselves resulted in a negative response from the woman. This participant herself did not seem upset, as she asked a few days later when they would meet again, and it may have something to do with her intelligence level or her ability to articulate even in her native tongue. Nothing like this occurred with the other 15 interviews in ChiNdau.

One English interview combined both sections in one. This woman, unable to find transport, had walked 5 kilometers and some of that in a torrential rain. Because of the effort she made, her busy schedule, the pregnancy, and slight difficulty in English, it was jointly agreed to have one longer session instead of two shorter ones, and she received the same remuneration as if she had completed two interviews. Two other English-speaking participants who signed the consent form did not turn up for appointments, while a third one was not present at the agreed time when the researcher arrived at her home. Women generally required permission from their husbands or in-laws to participate, and even though they initially consented, they may have been refused by their families or had second thoughts. There was no way to follow up on their reasons without causing them embarrassment. Those who did take part were very

willing, and all returned for a second interview if arranged.

Table 2 outlines key participants' demographic information. In Zimbabwe, primary school includes Grades 1 to 7 and secondary includes Forms 1 to 4 to obtain "O" levels. This allows entrance into trade schools or colleges. Another 2 years for "A" levels is required for university, for a total of 13 years. Occupation was frequently given as housewife, but this almost always involves work in the family fields and often piecework (magau). Magau is temporary employment, usually on one of the surrounding farms, or the large commercial tea and coffee estates.

Table 2
Key Participant's Sociodemographic Information

ID #	Name/ Pseudonym	Age	Years of School	# Live Children	Occupation	Residence
KP-01	Shooria	33	11	3	Housewife	Mt. Selinda
KP-02	Vision	35	11 + College	2	Teacher	Mt. Selinda
KP-03	Prisca	33	7	4	Housewife/ N'anga Assistant	Chinyaduma
KP-04	Rudu	29	11	3	Housekeeper	Marozva
KP-05	Edinah	36	9	3	Housewife	Mt. Selinda
KP-06	Winnimore	19	8	1	Housewife	Musirizwi
KP-07	Makanyi	20	0	1	Housewife	Mt. Selinda
KP-08	Sinikwe	23	10	3	Housewife	Jersey
KP-09	Thandiwe	30	7	4 (1 died)	Housewife	Chibuwe
KP-10	Rose	36	0	3 (4 died)	Housewife	Mt. Selinda
KP-11	Sylia	20	0	2	Housewife	Mt. Selinda

Table 3 introduces the key informants. Sixteen of these interviews were done in English. One informant was having difficulty in communicating, and since the assistant was available she was called in to take over. On average, interviews took place over a 1½-hour period.

Table 3
Key Informants Demographics

ID #	Name/ Pseudonym	Age	Sex	Notes
KI-01	Gegi	50	F	Girl's Boarding Mistress; son HIV positive
KI-02	Mapungwana	73	M	Local Chief
KI-03	Maposa	61	F	Retired teacher, married to Ndau minister
KI-04	Guidance	20	M	High school student
KI-05	Tommy	49	M	Owner of local drinking establishment
KI-06	Katherine	70	F	Retired teacher/business woman
KI-07	Simon	37	M	N'anga (Traditional Healer)
KI-08	Setu	30	F	HIV/Systemic Counselor
KI-09	Pat	35	F	Self-employed/Married to Ndau man
KI-10	Sitembile	47	F	N'anga
KI-11	Sarah	46	F	Farm Health Worker
KI-12	Angeline	18	F	High School Student
KI-13	Savemore	34	F	Farm Health Worker
KI-14	Mlanga	70	M	Farmer/Historian
KI-15	Thokozani	53	F	Village Health Worker (in ChiNdau)
KI-16	Tendai	55	F	Living Positively with HIV
KI-17	Arjan	35	M	Medical Doctor/Superintendent

The four focus groups included a total of 20 people (Table 4). Three groups were facilitated in English and one, the women living with HIV/AIDS, was carried out in the Ndau language. Each session lasted 1 ½ to 2 hours, was held at the home of the researcher, and always included a meal.

Table 4
Focus Group Demographics

ID #	Name/ Pseudonym	Occupation	Age	Sex	Marital Status	Tribal Group
FG-01	Florence	Teacher	33	F	Divorced	Shona
FG-02	Chipo	Teacher	28	F	Married	Ndau
FG-03	Emma	Teacher	36	F	Married	Ndau
FG-04	Thandi	Teacher	34	F	Single	Ndau
FG-05	Nyasha	Teacher	30	F	Single	Shona
FG-06	Greater	Nurse	38	F	Married	Ndau
FG-07	Rebecca	Nurse	38	F	Separated	Shona
FG-08	Noline	Nurse	28	F	Married	Ndau
FG-09	Blessing	Nurse	34	F	Married	Ndau
FG-10	Sithu	Nurse	32	F	Married	Ndau
FG-11	Trymore	Nurse	35	M	Married	Ndau
FG-12	Benjamin	Nurse	37	M	Married	Ndau
FG-13	Nxumalo	Nurse	30	M	Married	Ndau
FG-14	Muniya	Nurse	33	M	Married	Ndau
FG-15	Cleopatra	Housewife	35	F	Married	Ndau
FG-16	Mirriam	Farmer	26	F	Widowed	Ndau
FG-17	Tendai	Housewife	28	F	Widowed	Ndau
FG-18	Mary	Housewife	38	F	Widowed	Ndau
FG-19	Susan	Farmer	24	F	Divorced	Maniyka
FG-20	Margie	Farmer	30	F	Widowed	Ndau

Summary

In order to fulfill the purpose of this study, an ethnographic approach was taken. The target population consisted of a core group of women. Information, especially regarding culture, health issues, and women's lives, was supplemented by interviewing key informants from the general community. Focus groups added another dimension to the data. A variety of sampling procedures was used and depended on the type of participant. Data triangulation was planned to provide a broad-based, yet in-depth perspective, on health promotion and HIV prevention in the Mt. Selinda area of rural Zimbabwe.

Data were managed in various ways, with analysis enhanced through The Ethnograph code and retrieval program. The use of coding, memoing, and comparison assisted in the search for themes and patterns. Instead of positivist measures of quality, others more suited to qualitative, ethnographic research were employed such as credibility and relevance. Measures were taken throughout the process in reaching and maintaining an ethical and quality project, while being attuned to issues of reflexivity and legitimation.

CHAPTER 4
RESEARCH FINDINGS

Introduction

> "It really is worse than I thought; or does it make that much difference if you just read about women's lives or actually have them tell you face to face?" (Field notes, February 3, 2002)

Reading means you can stop "listening" at any time. However, as people recount their personal lives while you listen with intent to understand their context and reality, you cannot simply stop the discussion when it becomes difficult.

This ethnographic study of Ndau women in the Mt. Selinda area of rural Zimbabwe addresses issues of health, health promotion, and HIV/AIDS. The main research question was, "What factors facilitate or hinder women's participation in health promotion and HIV prevention in the Mt. Selinda area of rural Zimbabwe?" The first section contains material from key participant interviews specific to their particular development and life experiences. Following sections integrate all interview data to further describe the lives of Ndau women and the cultural context of health, health promotion, and HIV/AIDS in response to the study's subquestions. The concluding section returns to the key participants stories viewed through the lens of Pender's Health Promotion Model.

The Key Participants

Table 5
Key Participant Data (Adapted from Table 2)

ID #	Name/Pseudonym	Age	Years ofSchool
KP-01	Shooria	33	11
KP-02	Vision	35	11 +college
KP-03	Prisca	33	7
KP-04	Rudu	29	11
KP-05	Edinah	36	9
KP-06	Winnimore	19	8
KP-07	Makanyi	20	0
KP-08	Sinikwe	23	10
KP-09	Thandiwe	30	7
KP-10	Rose	36	0
KP-11	Sylia	20	0

Early Childhood

The worldview of the Ndau, as with many traditional cultures, appears centered in the present. This may be reflected in the limited discussion when asked about childhood memories. The women were all raised in surrounding rural areas with many parents carrying out subsistence farming. Being poor was a common thread with only one or two noting that meeting basic needs was not a problem. For most, the main effect of poverty was inadequate food and clothing, and not being able to attend school because of the fees. Fathers often had more than one wife and many children (see Table 6). The extended family

has historically been strong, with sons marrying and then living in the same compound with parents and other family members. Looking at the nuclear family does not provide a clear picture of either family income or scope of parental responsibility.

Table 6
Family Composite of Key Participants

Name/ Pseudonym	Raised by	Number of wives	Children	Father's occupation
Shooria	Parents	1 (mother was third wife- 2 others were divorced)	15	Cook for white family/farmer
Vision	Parents	1	8	Farming
Prisca	Father. (Mother died when Prisca was 5)	1 (remarried 5 years later)	3	Farming
Rudu	Parents	1	2	Farming
Edinah	Parents	2	19	Tractor driver
Winnimore	Grandparents (both parents died when she was below 5 years)	--	5	--
Makanyi	Mother, but often sick (father died when she was less than five years)	--	7	Farming
Sinikwe	Aunt (Mother often sick, father home monthly)	1	9	"Worked away"
Thandiwe	Parents	2	12	Miner; visited once or twice a month
Rose	Parents	3	29	Butcher
Sylia	Parents	5	24	N'anga (Traditional healer)

Shooria received little encouragement to go to school. "I think it was just within me. You had to find it (how to go to school) for yourself." Makanyi never

got to school at all though she badly wanted to, and by age 8 was working with her mother on a coffee estate where they were living. Even though Sylia's family was able to provide adequate food and clothing, her father refused to allow his daughters to attend school, yet all her brothers completed "O" levels. "He said we would become prostitutes if we were learned." Prisca managed to complete Grades 4 to 7 by working on a tea estate but choose not to continue. Two of the participants became pregnant while in secondary school and were unable to complete. Only three (see Table 5) were able to finish basic secondary education resulting in "O" levels. Rudu was successful only by alternating school and animal herding to earn her fees. Vision, who loved school and received much encouragement, was forced to drop out in Grade 6 due to financial problems. At age 12 she left home to join a combined work/school program at the surrounding commercial farms and was able to graduate.

Adolescence

Apart from school and work, adolescent memories were mainly focused on boy-girl relationships. With females historically socialized for marriage, it was expected that a love relationship would develop. Edinah was the only one to mention participation in sports (netball), with her conversation soon leading to the social benefits this provided.

I became popular and so many boys would be proposing love. I was very

> proud of being popular. It was also an added advantage because I had more time to talk to them (boys) than in the village. If a girl was found talking to a boy she was beaten thoroughly. It's an Ndau belief that if a girl talks to a boy she is very mischievous and is likely to be called a prostitute.

Different families had different age expectations depending on how they viewed girl's schooling. For some, involvement with the opposite sex was to be postponed until "O" levels were finished. Makanyi said, " Parents would never say make love, fall in love, marry, but would just expect it to happen." Girls were expected to be virgins, and in some families this was checked at frequent intervals by the aunt. Several girls lied to their parents so they could be with their boyfriend.

For the majority, if a relationship had not developed by age 15 to 17, the son or daughter would be taken to a traditional healer. Thandiwe explained, "A female or girl's career is to get married. If one did not want to marry or wants to remain single like nuns it would mean they were possessed."

The father's sister has traditionally been responsible for girl's sex education, and even menstruation is not talked about between mothers and daughters. Eight of the 11 women, several key informants, and some focus groups participants described an important adolescent ritual. Between ages 8 and 12 an aunt would wake the girls in the early morning, take them into the bush, and teach them to pull their labia. They were rarely told why this was necessary, but eventually learned that it was so the husband would be aroused in bed and enjoy

sex. A few mentioned that it would also increase the woman's desire for sex. The majority felt that most girls today are not taught this practice, or they are refusing to do it. Only Thandiwe admitted to resisting, "I did not pull the labia. Moreover, I did not see the usefulness of it. My aunt said that would help in bed and if you did not, you were sent home. Ah, that was a lie because I am married. My husband still enjoys sex."

Shooria mentioned receiving some sex education in school but the main topic was sexually transmitted diseases. She said it is difficult for mothers to discuss these issues with their daughters, and girls actually receive little preparation. Her learning "just happened, it's natural." Most women said they were taught about sex by a boyfriend or husband, who are taught by uncles. The role of aunts and uncles appears to be less important, with concern by several that parents are not taking over and that youth are learning on their own and at a much earlier stage.

Adulthood

Thandiwe said that a woman's "career" is marriage. This is not an isolated comment; any other lifestyle choice is viewed as aberrant. There are both traditional and church marriages, often combining aspects of both. Although the majority was accepting of childhood experiences in spite of few choices, hard

work, and some parental beatings, life changed considerably once married. Several women were pregnant when married and would generally elope if others were aware of their condition. Elopement means less lobola (bride payment), and, according to Rose, "Elopement does not give self-pride to the girl because as no cultural wedding ceremony (*mutimba*) would be held."

Each woman described different marriage experiences, but only a few stated they were happily married. Vision and Shooria are happy although living with the many social restrictions of Ndau women. Vision's opinion is that men are "kings" and women are "slaves," as echoed by Prisca, who asserted, "I can say there is no love in most marriages because women are slaves." Shooria is unable to have the type of family life and home she expected as she and her husband have responsibility for many siblings since the death of their parents. This impacts on the use of the family income, as instead of a family of four, there are 11 altogether. She said, "Ah, there's no marriage where you are 100% happy. You must make yourself happy." When asked how she does that she replied, "You ignore a lot of things."

Sylia and Rudu were fortunate in the welcome they received in their new home. For others, such as Edinah, entry into the household was difficult, especially if in-laws did not approve of the son's choice. Makanyi said:

> My mother-in-law is very rude. She did not help me with any work. I did everything, cooking, washing, cleaning the houses, fetching water and firewood, and working in the fields. I used to work all day without eating

> or have one meal only.

In spite of some intervention by her husband, Makanyi is still not happy. "If the in-laws do bad things, you are not supposed to complain. You would be beaten up. Ah, the Ndau men are very rude.... I wish I was not married." She compared the teen years with her present life.

> I liked my teenage years. Most because I could work, earn money and choose how to spend the money.... I was always happy. I had freedom of choice, unlike now when married. Ah, it's sad. Sometimes you are given or not, not allowed to work, and poor quality of food and working hard all day. Money for own use like grinding mealie-meal you have to do piece jobs. Failure to do that you would starve. That's when I sometimes regret.... Men are murderers, they are destroyers. At times I wish I was not married. I am in prison.

Hopes and Dreams

Living in the present and faced with the challenges of providing for families, few gave thoughts of the future. Shooria, who completed Form 4, would just like to have a home with husband and children, not, as she put it with "full time dependents." Prisca wants a better life for her children and feels that will come with their education. Rudu wanted to be a nurse and stated, "If I get the chance I would do that. When I give birth to this [third] child I don't want to have any more. I will try and find a course to do and work for my own." Edinah is planning on returning to school. "We discussed the issue, and my husband agreed that when the child is grown up, about 2 years, I will start schooling."

Makanyi feels she missed out by not going to school. "Even now if I find someone who sends me to school I would love that. I will forget about marriage and concentrate with my studies so that I would have a happy life." Realizing that this is unlikely to happen, she wants to buy and sell second hand clothes to the farms for some income. Sinikwe had to leave school when her pregnancy was discovered a week before the final exams in Form 3.

> At first I wanted to abort because I wanted to complete my O level but he (boyfriend) persuaded me not to. My aim was to complete Form 4 and become a typist. I admired those typists, well-dressed and answering phones always.

When asked about completing studies, she replied, "I wanted to, but my husband says no. I have no hope anymore. He told me to forget about schooling." Thandiwe also married quickly because of pregnancy. "My parents and others had high hopes for their children, to complete school, and become teachers or nurses." Rose is ensuring her children do attend and related the following.

> Those who went to school were more clever than us. They knew a lot of things we didn't know. The thinking rate of an educated was higher than one who was not. Education is very important in people's lives. If someone said, here is the money go to school, I would love that. I don't mind about my age. I will forget about problems in these marriages and concentrate on my studies so that I would be someone in the future.

Sylia hopes to return so she could become a nurse or a teacher. "If I get money. My husband once talked about it and suggested that I would go only if it's an

adult school."

These life discussions began and ended with education. The women believe education can provide a better life, more status, and self-pride. It is accepted that the education level of a woman has a direct and positive relationship on the health of the family. Education can increase opportunities for improved socioeconomic status and exposure to and understanding of specific health issues. These women do not seem to be asking for much, yet their hopes and dreams are most likely very elusive.

Coding

The previous introduction to the 11 key participants and the following sections were developed from first level coding in The Ethnograph (Appendix K). These codes were based on the research questions, with subsequent ones added as themes emerged. Single or multiple code searches were carried out for all 41 files (each interview is one file) that provided a focused process for answering the subquestions.

Subquestion 1

What are the local meanings, beliefs, and practices concerning health, illness, and health promotion?

Spirits

To begin to understand the health of the Ndau it is critical to explore traditional beliefs, whichare based on an earthly connection with the spirit world.

> With the Ndau, the main factor in maintaining one's health has to do with the spirit; it has a lot to do with the spirits of the dead, of the ancestors. There is a belief that if the ancestors are not happy it is enough to make one unhealthy. That's the key point, the appeasing of ancestors, and there is continuity of contact between the living and the dead. If there is a disruption or disobedience somewhere along the way, the sprits of the dead can be angry and can cause ill luck on the family. (Trymore)

These spirits can be the ancestors of each family (*mudzimu*) or they can be evil spirits (*mhamba* or *mbvuri*). The ancestral spirits are for guidance and protection but also can bring harm, often through illness, to family members. The illness or misfortune is seen as a warning that good ways are not being followed. There is also a belief in one creator (Musikavanhu) who is contacted through ancestral spirits. The chief of the area, who is a former teacher, explained the importance of the ancestors for his position.

> The 70-year-old chief slowly, but proudly, led me into his modest house and his very tiny and cluttered office. Across the back of his desk sat several small wooden bottles each with a fur-topped lid. These he said are

> snuff containers and he began to fill one of the bottles. He explained that each one represented an ancestor. He had one from the very first leader of his tribe and he, as the present Chief Mapungwana, is the 12th. The bottle on the end to his right side was his father's and he talks to it telling him everything, even putting it into his jacket pocket whenever he goes out, "so my father is always with me." (Field Notes, November 23, 2001)

The concept of soul allows the person who dies to enter the spirit world. The mother and father's blood creates a baby, while God provides the soul that completes the human being. After death, admission to the spirit world is facilitated through several ceremonies. Failing these, the soul will wander about and "is considered unpredictable and dangerous" (Chavunduka, 1994, pp. 57-58). Besides ancestral spirits, there is belief in *muroyi* (witches) who bring harm to people. Other spirits such as *mashavi* (animals or strangers), foreigners (e.g., dzviti/Zulu spirit, White person's spirit), or *njuzi* (mermaids/water spirits) are present in healing practices.

Traditional Healers

The most common type of traditional healer is a *N'anga*, who deals with both physical and social problems. Others include *mushoperi* (diviner), *godobori* (herbalist), and *nyamakuta* (midwife). N'angas and other *varapi* (healers) in Zimbabwe can belong to an organization called ZINATHA (Zimbabwean National Traditional Healers Association). ZINATHA's aims are to "unite all traditional healers of Zimbabwe into one body," "to promote traditional

medicine and practice," "to promote training in the art of herbal medicine," and "to preserve and promote beneficial aspects of African culture" (Chavunduka, 1994, p. 23).

Participants had differing views on the use and effectiveness of N'angas. Only a few who professed to follow Christianity said they never went to a N'anga and believed that those who consult N'angas are not Christians. For many though, a N'anga was the first line treatment, possibly after any home remedies failed to make a difference.

> What do the people do here when they are ill? They go to traditional healers that some people call witch doctors. These witch doctors have a way of arriving at a diagnosis...they have their own art. Sometimes they can really tell everything before you say anything. They can arrive at a diagnosis and some prescriptions just like the doctors do. The prescription can be in the form of herbs that you have to take. They can also be in the form of rituals. (Trymore)

Benjamin was quick to clarify that the term witch doctor is not correct. N'angas, he said, "help people get healthy" while "the word *witch* means the one who hunts and hounds someone." Trymore concurred that the missionaries introduced the term witch doctor to portray N'angas in negative way and to discourage their use.

The Dutch medical doctor at Mt. Selinda Hospital (Arjan) noted a difference between practices in the rural areas and towns or cities. The latter tend to use clinics and hospitals as first line treatment, where rural people

> never start with a clinic or a regular health institution. They will start to

> solve the problem at home; they seek advice from people around them or who have knowledge of health. Minor problems, they often take the drugs you can buy in the markets or shops, or take herbs. But serious problems they go to N'angas and start to solve the problem there. But if it persists, then they finally in the end they are coming to the hospital, often too late.

Trymore agreed. "Whenever we are talking about the health of the Ndau people we should not forget where they go when they are ill. When they go to hospital it is secondary. They would have exhausted the other (traditional healer) first." Vision explained one reason why people go to N'angas first.

> They say if someone falls ill and you just rush to the hospital then maybe those at the hospital cannot cure that person because he is having shadows, what can I say, he will be having evil sprits. So it's better to take off the evil spirits first and then take him to the hospital.

Without that preliminary traditional care, Prisca stated, nothing the hospital does would help. Rose said that this is especially important in her area, as there are many witches that can possess people, and N'angas are able to treat the cause and resulting illness. Several participants had a concern with the herbs and other medicines used by N'angas. There were stories of fatal overdoses and less serious, although worrisome, issues of improper storage and measurement.

The training and experience of every N'anga is unique, although similar in basic form. Some become healers through apprenticeship, the majority through spirit possession (Chavunduka, 1998, p. 47). In order to better understand the traditional health care system the researcher interviewed two N'angas, one male and one female, in two different communities in the catchment area.

Simon is a gentle, soft-spoken man who became a N'anga through dreams that started when he was 7 years old. His parents took him to a traditional healer, who said, "Something wants to come up in you." He was told to buy some red material and the spirits would come. He ended school at Grade 7 as his vision was clouded from the dreams and he couldn't see well enough to write the exams. He began working on a tea estate and slowly began to build his practice so that by 1980 he was able to work at it full time. All he learned, such as collection, preparation, and administration of medicines, came to him through these dreams. The dreams continue and often foretell the future.

Simon stressed that he refers patients to the hospital for such things as burns, tuberculosis, and malaria, or if someone is not improving. Similar to Dr. Arjan, he also has trouble with people coming late for treatment. "A person should come as soon as he feels his body is not alright. If he delays I cannot help." On the other side he told of people who did not get better in hospitals, yet recovered when he intervened. "N'angas are not so bad because we try to make somebody's life better. Our war here is to fight against diseases in the people, only that and nothing else. We are trying to make people's life good." He appears to take a balanced approach to illness and has some, although limited knowledge of modern care.

For the second *matare* (N'anga's surgery) visit, it was arranged to meet

Sitembile at her shop in the middle of a bustling community near one of the large tea states. Ambuya Nesi (grandmother nurse), as she is known in the area, became a N'anga in 1993 after the community tested her healing abilities and approved her practice. Prior to this she became ill and was taken to a N'anga. He discovered she was possessed by her father's sprit and was told she should become a healer. Later other spirits possessed her, and altogether she has seven. Each spirit has a different function depending on the presenting problem of the patient. Besides spirit healing she counsels many women who come with symptoms of sexually transmitted diseases (STDs) or marriage problems.

The key informant village and farm health workers do not openly support traditional ways, having received training through the ministry of health. They expressed concern about the money people spend on N'angas when they could be buying food or other necessities. Some participants said that good N'angas are members of ZINATHA, but not all agreed that this guarantees quality. Others felt that it depends on their age with younger ones not always as creditable as those over 50 years. Several believed if they don't charge for their services they are "real," compared to "fake" N'angas who are only in the business for "fundraising" (to make money). Edinah explained the search for a good N'anga.

> The best reason for going to a N'anga is that it casts out demons and bad spirits and it would foretell about somebody's life. The N'anga could foretell all your problems, illnesses and your life. It would also say the causes of that illness. You would only stop looking for N'angas when you were satisfied.

Finding a cause often involves blaming another person.

> When my husband was sick (with AIDS) my in-laws consulted N'angas. I didn't go because they did not allow me.... When they returned they said I was possessed by bad spirits that makes the husband sick. They said that I witched my husband so I would remain enjoying pension benefits. (Tendai)

Later she told how at her husband's funeral the in-laws accused her of killing their son. Margie shared a similar story. "Women are accused of witching men so that they would remain enjoying their wealth. Eh, normally at N'angas, women are said to be possessing bad spirits that makes the husband sick." The group was unanimous in that men are never possessed in this way. Mirriam told of her experience of being ostracized. "I was sent home when I became sick. I was pregnant then. They said I am possessed by an avenging spirit, and they did not like me anymore." Families are often split apart when a relative is accused. In some parts of the country witch hunters are hired to search out and exorcise bad spirits seen as hurting the community. People accused of being witches are not welcome in the area, can be evicted from their villages, and possibly maimed or killed in exorcising rituals.

Tendai (KI), who is also HIV positive, was accused of bewitching her ill husband and eventually had her children temporarily taken away. Still, she finds N'angas helpful, but only goes for treatment and refuses to allow them to name any cause. Sarah, a health worker, is suspicious when N'angas consult her. "If the wife of a traditional healer is sick he comes for tablets for her. Why does he

do that? He should know what he is doing."

Health

The majority of participants were asked about personal and community meanings of health, and more specifically among Ndau women. Out of 33 responses, 13 mentioned physical fitness or being fit, which for a few also included mental and social fitness. Four others stated health meant being strong. Not unexpectedly, both the female and male nurses provided a broader definition, with the term *well being* used frequently. Blessing said health is "the well being of a human being, including the physical fitness, sexual aspect, economic factors, everything that will go along with being healthy." Nurses also used terms such as continuity, holistic, and stress/distress. As for the average Ndau woman, Greater had the opinion, "I don't think they get to the point of thinking about it, but probably it is the absence of disease."

The main descriptor of health for one teacher, the male N'anga, and five key participants was cleanliness. This included hygiene of one's body and home, and proper food handling. Gegi was thinking beyond the present movement and talked about health promotion.

> Health is something I, or somebody in my community, should do to have a hope for tomorrow. And to keep themselves going, that is if they take care of their bodies, take care of their uh, homes and take care of their children, I think that will promote good health.

Next they were asked about healthy and unhealthy behaviors. Healthy behaviors included hygiene measures both personally and within and around the home, eating enough good food—which includes variety, and working hard. Sweeping the yard each day and frequently smearing the houses with mud keeps insects under control. Working in the fields is seen as critical. "What they collect from the fields makes them healthy," Vision explained. "Lazy people are not healthy." Without hard work one cannot get enough food, and as Prisca said, "If you don't work your mind is not clear." Sylia, on the other hand, felt that too much work in the fields makes one too thin and having a housemaid would help one stay healthy. It is most likely that becoming thin is more related to the amount of work compared to the amount of food one is able to access. Savemore estimated that half of the children of the farmworkers on her compound are malnourished. Programmed exercise is not common except for school-based sports programs. With all the manual work to be done, staying healthy is not intentional. Tommy said that "people keep healthy without knowing it." Limiting family size and faithfulness in marriage were also mentioned.

The many unhealthy behaviors included use of snuff, dry sex, excessive beer drinking, and smoking. Dry sex involves the instillation of herbs or even ice in the vagina to tighten it to increase the man's pleasure during intercourse. The focus group of nurses said this was common and they had seen some harmful

results such as vaginal bleeding and lacerations. Similar remedies, formed into pessaries, are also used in treating children and adults for rectal prolapse, worms, and backache.

Cigarette smoking is not widespread, possibly due to the cost, but smoking *mbange* (marijuana) is common as it can be grown locally. Mbange is thought to decrease inhibitions, resulting in more fights, promiscuity with prostitutes, and unsafe sexual practices. Brewing and drinking beer are important traditional ceremonies, but ordinary beer drinking is a frequent pastime for men. Many can be seen early in the day and very late at night at drinking establishments, part of every community. Lack of adequate diet leads women into *magau* or piecework and can mean leaving young children unsupervised and uncared for the whole day. The increased workload also means they have less time and energy to carry out necessary home duties, and houses and yards can be dirty. Use of "bush toilets" (meaning no toilet and using the fields or bush) is also unhealthy. This results in uncovered feces attracting flies, which in turn can carry harmful microorganisms to food. Many people are still obtaining water from unprotected sources, which increases the risk of water borne illnesses such as cholera. Others lack knowledge of how to prepare and administer ORS (Oral Rehydration Solution) that is so important with the high level of diarrhea often leading to fatal dehydration. Rubbish is carelessly thrown around. Many have a rubbish pit that

is regularly burned, but there are few if any roadside bins to encourage cleanliness outside the home, and does not appear to be an important teaching for young people or adults.

Other unhealthy behaviors include wife beating, men expecting sex after they have been away for several days, the increasing prevalence of "Sugar Daddies," and unsafe abortions. Abortions are illegal in Zimbabwe except for very limited situations; yet different practitioners perform them, at times with serious complications.

Specific Beliefs and Practices.

The following sampling of the many health beliefs and practices offered by participants include both prevention and treatment rituals and many refer to reproduction issues. Comments or explanations of the researcher are in brackets.

- It is said that water is water and is never bad. We fetch water from the river and drink. It would be dirty because many people wash and bath in the river.

- If the water is dirty and someone is getting dysentery, they will say someone is bewitching me. And we will spend some days with that dysentery without coming to the hospital.

- Women were always taught not to sleep with their husbands during menstruation. That would cause disease both for the man and the woman. They believe the blood goes into the man and it causes disease and it is not healthy.

- When we are pregnant we stop sleeping with a man. Because we are given herbs to drink that will open everything up and delivery will be like throwing a ball. They say they if you have sex while taking the herbs they will not work.

- Women have an advantage of menstruating, which cleans up their stomach. Unlike men, they would look for herbs to clean up their stomach.

- They say that when you get pregnant all the pores open up, all areas open up, and any diseases can come when you are pregnant

- When you've just had a baby, just delivered a baby; Ndau women believe that they don't have to sleep with their husbands for 6 months.

- And if a woman has a stillbirth the husband is not supposed to go out and sleep with another woman. If he does, even if he is a polygamist he has to sleep with this woman first, the one who had the miscarriage, before he can go to the other wife. If he went ahead and did it with another woman then he will cough blood and have the signs and symptoms of this TB, losing of weight.

- The Ndau believe that as long as the husband coughs blood it shows the woman has had a private affair. By the end of the day the husband will die so you can't stay there, as they will see you as the killer. In our mother's day they would confess and I don't know what kind of medicine they would take to heal that coughing. Today this disease is called TB.

- We think that a person gets ill because they are bewitched. Or people get ill, or get mad, because they have a history of having killed somebody long back and that person comes back now and avenges. So it is not just an illness that comes from nowhere. There is a cause behind it.

- [After delivery] there are times when the child doesn't suckle. They think one, it is because the mother is a witch, or the mother had another husband/boyfriend. [The mother must confess or is taken to a N'anga who will tell the reason for the baby not breast-feeding. After either of these takes place, the baby begins to nurse].

- [If a woman has labor pains but they stop before delivery]. It means maybe that woman is having a bad spirit that wants to be removed. Or else there is someone who wants to deliver that woman. He can tie knots to that woman so she can't deliver. [This means that a N'anga must remove the spirit so the uterus becomes 'un-tied' and the woman can then deliver, otherwise a caesarian section at the hospital is needed].

- [Malaria increase during mango season] The mosquitoes may bite the mangoes [leaving bacteria] and if a person eats those mangoes the person can be

easily infected.

- If a girl would marry before menstruating she could become unhealthy. Her hair would be falling or it could grow very thin. That was the only disease that could take long to heal.

Tuberculosis (TB) is endemic with more cases appearing as an opportunistic infection of AIDS. Some believe there is no cure and say this because they have observed it lasting a long time and later returning, not understanding that re-infection is occurring. Several said it exists in two forms, TB1 and TB2, with the latter sometimes used interchangeably with AIDS. It appears this may originate with the two types of treatment. Category 1 is for new cases and involves pills. Category 2 is for repeated, more resistant cases and includes an injection. There is a high risk that people receiving TB treatment 2 are also infected with HIV, hence the connection.

Prevention and Promotion

An Institutional Review Board (IRB) approved case study of an Ndau woman was carried out in June 2001 for an earlier module for this program. During the two interviews it seemed difficult for her to discuss illness prevention and health promotion. With probing she was able to think of some prevention activities, but the talk would soon return to treatment and cure. In her experience, hospitals and medicine seemed to be most important when it came to

staying healthy.

Given the busy lives of women it is not surprising that the concept of health does not receive much intentional focus. Yet, this present, larger research revealed many traditional practices employed by the Ndau regarding prevention. Prevention involves three levels: primary, secondary, and tertiary. In this study the main interest is primary—an intervention applied before someone has an illness or disease. One is the collection of naturally growing herbs and plant roots that are prepared in many forms, often as powders added to food or drinks. People have taken herbs to stay young and healthy, with men using them to remain sexually active when they take younger wives. One person noted that the "English" influence has resulted in people not using herbs, while no preventive medicine was offered as a replacement. Rituals such as brewing beer are still important, especially in appeasing angry ancestors, or intervening before they become dissatisfied, in order to prevent illness or to hasten healing. Other examples follow:

- Twins are taken to the rubbish pit and rolled in the ashes to prevent fever. If one twin does get sick this also prevents the second one from falling ill.

- A rope made from a certain tree is tied around the child's waist when there is a measles outbreak.

- Once the umbilical cord dries and falls off, it is sewn into a cloth and tied around the infant's waist to prevent disease.

- A string around the waist with a button is believed to prevent disease and monitors baby's growth.

- If someone is witched with meat and becomes ill, meat is taken to a N'anga who mixes it with herbs. It is cooked and eaten by the patient who becomes well.

- Bad luck or failure to achieve something after many tries requires traditional intervention even if one believes in the theory of disease and contamination.

- Prayer/praying on water that is used as a medicine/praying on colored yarn that is then tied on wrists or around waist.

- To ease delivery, traditional midwives spread the white of an egg around the vagina, as they are unable to do episiotomies.

- Herbs mixed in water are taken from the 6th month of pregnancy to allow muscles to expand and therefore ease delivery.

- Parents are spoiling their daughters by tying a herb around their waists. They think these prevent the girls from falling pregnant.

- One when pregnant must not eat eggs most of the time [to prevent chepamusoro, which relates to a condition of the baby's fontanel].

Gradually more mothers are bringing children for immunizations, but for well-baby check-ups, health workers said some only come when an injection is due or there is already an outbreak of malaria or measles. Dr. Arjan reported that children often arrive in a serious malnourished state, often too late for intervention. Many women do not come for regular antenatal care, others only when there are problems.

Rebecca felt that "mostly they (women) reserve their illness, and worry about clothing and feeding the family." Greater added, "Women tend to ignore their own physical discomfort, their own minor illnesses (more) than men do."

Blessing stressed that women are responsible for family health with much time and energy expended procuring and preparing food. Clinic or hospital fees, lack of childcare, lack of decision making, and illiteracy were noted as impediments to accessing health services. The importance placed on traditional systems as first line of treatment also means valuable time could be lost waiting for improvement or cure.

When asked how people valued health, the most common response was similar to Edinah's explanation. "I think if one has a good health...you can live longer, eh, many years. You won't suffer from disease and your physical appearance would be good." In spite of the value of health Chipo reminded us that many women

> don't even have time to bathe some days. There is little time to think about anything else. Feeding the kids, looking for firewood, fetching the water, bathing the kids, and by 10:00 [at night] she is tired and says, ah, I didn't have a bath today but I am too tired, just let me go to bed and I sleep.

If health of families implies meeting basic needs in order to survive, then it is inherent in many of the women's daily activities.

In summary, traditional beliefs and practices around health and illness are still prevalent among the Ndau. Their present reality is closely integrated with the spirits of their ancestors who are believed to be able to both protect and bring harm. Even with some understanding and acceptance of the concept of microorganisms, many still feel there must be an underlying supernatural cause

to illness. Both traditional and modern systems of health care are often utilized, and there is considerable flexibility when searching for a cure. Having health care choices is seen as positive, while on the negative side it can lead to serious delays in finding the right treatment, interpersonal and intrafamilial conflict, and difficulty understanding and coping with such a frightening disease as AIDS. Health promotion does not appear to be something that is intentionally planned, yet many activities are carried out to protect against illness. With the amount of labor expected of women, being healthy is seen as extremely important and basically means being physically fit.

Subquestion 2

How do gender, socio-economic status, religion, and culture interact and influence participation in health promotion and HIV prevention?

Gender and Socialization

When asked to describe what life is like for Ndau women, a collective picture emerged with two common words: "hard" or "difficult." Ndau society is a patriarchal system, and roles of both men and women are established early with messages both subtle and overt. Several participants stressed that Ndau people are different from people in other tribes, even within Zimbabwe. Vision

gave her impression of an Ndau woman and some of the cultural expectations.

> An Ndau woman is someone who is hardworking, industrious somebody who should be physically fit to work in the fields most of her life. An Ndau woman is reserved because of this culture, maybe which says women should be quiet whenever men are talking. So the dressing is different from any other tribes. They way you talk, the way you walk, the way you work, shows all that this one is Ndau.

As for being a girl child, Vision sadly noted,

> When you are married and you give birth to your first child, a baby girl, they will not be as happy as if you gave birth to a baby boy. You'll see that some women will keep on giving birth if they keep on having girl children... up until they have a boy and then the father will be happy.

Later she added,

> Te key factor... is that the baby boy enhances the family name more than the girl. The baby girl will enhance the name of the other family there; she is going to bear children for another family. So it is the baby boy who makes the name of the family continue, he putting more emphasis on the boy.

Greater talked about the effect on one's self-esteem: "Seeing our mother continuing to bear children as she was looking for a male...it's enough to give an inferiority complex." Setu said, "If you have only girl children he will have to find another wife to have a boy so the name goes on." Benjamin further explained the importance.

> The first-born holds the spirits of the family. No matter whether you are educated or not there is a bias to say I should have a baby boy in this family. If not, then I don't have children. So if you have a baby boy there is the tendency to give more energy and you can do it unnoticed.

When asked what happens when the first child is a female, the answer was clear

that this recognition only applies to the first-born male.

> According to culture it has to be a boy, why? Well it's culture. A boy is brought up to be a leader, to be a boss. If you look at what people used to do, they said girls should go to school only to be able to write a letter. Then after being able to write a letter, the next thing is to get married, full stop. So a girl child is only brought up to be a good wife. Where a male is brought up to be a leader.... (Trymore)

The expectation to be a "good" wife, mother, and member of society was echoed by others. Gender role separation begins early with a clear division of labor.

> You see the girl child grows into the kitchen and she goes out for firewood, for vegetables, and back to the kitchen. The men go fishing, go herding cattle; they are away from the family for a long time. And they come back in the evening, maybe with some food after hunting. But the woman is at home always. (Benjamin)

Boys and girls at the high school do not eat in the same dining hall. In marriage, men and women spend little time together and adult roles are even more clearly defined. At church and other public events they do not normally sit together. Benjamin concluded,

> When we don't move around with our women it's not that we don't want to. It just happens unconsciously because my direction and my wife's directions are just not the same. She is at home taking care of the children and I have to move around and refresh myself. So when I go with my wife to the beer hall, who would look after the children? Who will cook for me when I come back? It's simply a matter of roles. Our women don't feel they want to move with us. There is a very fixed role.

Grater described how women are socialized to be submissive and subservient.

> It's not like mothers really say you should submit to your man, it's the socialization process... you always find the boys being respected more than

> the girls, getting better parts of situations or even being asked to be in charge or decide over the girls in the family and even to the women. Like an 18-year-old boy would be considered to be a representative of his father, should his father be away.

She explained how even norms around food reinforce one's place in society.

> There are things like parts of the chicken that are considered very important and are to be eaten only by males. So even if he is a very small boy, as long as he can eat, then women are not to touch. He is considered the leader.

Ndau women historically had less education than men and considered as having "shallow minds" as Sitembile's husband told her. Vision said, "Normally women in the Ndau culture are taken to be tabula rasa, those without anything in their heads." Gender messages, subtle or direct, are clear. Female children taught to kneel when speaking to elders and later husbands, quickly find themselves in a lifelong inferior social position. Seen as less valuable than a male, with marriage the only acceptable role, the female child is also disadvantaged when attending school. Disparity between males and females appears to increase if the family is poor.

Socioeconomic Status

Another common theme related to financial issues and their impact on daily life. Economic status has been recognized as the most important determinant of health. Discussions on finances were clearly revealed here in

relation to power and control. A basic health and survival issue is acquiring and preparing adequate meals for the family, as Blessing explained: "The woman is responsible for family health." Providing a varied diet is most difficult when there is little variety of crops, no money to supplement the diet, and high inflation (estimated over 100%). Chief Mapungwana noted that for most people "meat was a visitor." Many stressed that if women did not work in the fields families would be deprived and suffer from malnutrition.

> Nowadays there is hunger, there is this money fluctuation [inflation], there is not much money. The families in the old days they would take a female child and sell to another family, that's no longer happening. But you will see we cannot give enough food to our children, we can't get them to school, the school fees are high. (Gegi)

Women's participation in paid employment is influenced by limited education while family responsibilities impact on how far they can travel to find work. Women can be labeled as prostitutes if they sell at a market or attempt to enter the formal setting. Females are not given full time positions at nearby tea estates and are hired for piece jobs (called *magau*), which seems socially acceptable.

Men employed full time may not earn enough to adequately care for the family, especially with continuing deflation of the dollar. On the other hand, there are many stories of how husband's misuse income they do earn. Thokozani finds men less responsible than in her father's time.

Men work but do not look after the family. Men spend their money in beer

> halls entertaining themselves. Moreover men are promiscuous; therefore [they] spend a lot of money trying to please their prostitutes at the same time neglecting the family. Women are responsible for every need in the family. If we ask men for some money or complain then we would be harassed or beaten up. Men have so many excuses for not being responsible.

Trymore explained the strong feelings against women working outside the home.

> Some people have such a strong feeling that if a woman goes to work she will become a prostitute. It's just out of jealousy, she will be exposed to a lot of men, they will admire her, so she has to stay at home. It is a protective measure....

Vision noted some positive changes regarding formal employment.

> A while back women were not even allowed to work, and if a woman worked she was going to get a less salary than the husband, so there was that oppression. But now I can say it has changed because we are allowed to go and work and get equal salary. The change is there but comes slowly in rural areas.

Husbands decide if, when, and where a woman will work and also how her earnings are spent. Thus, having a job does not guarantee autonomy. Shooria says life is still very different depending if one is a male or female. "The women are all working yet they don't decide what to do, only the man." Vision told of a woman who earned her own money and one day left it at home. When she returned nothing was left. She asked her husband where her money was and he replied,

> Your money? Where are you? Are you at your home or are you at my house? That is not your money, that is my money. You and that money are all mine. I don't want to hear any stories pertaining money here. I have

> used it. My second wife is coming. [He had used her money to pay lobola for a second wife.]

Prisca related how husbands prevent wives from investing in livestock or told they must keep any animals at the maternal home. The reason, she said, is that the husband must not be seen having to ask his wife's permission to slaughter an animal, or that it appears she owns something better than him. Rose's experience also reflects this issue of ownership. "My husband said `women are bought and so should not own anything; like slaves.'" Sylia stated that if she owned animals it would be seen as control over her husband and only chickens are allowed.

Rudu lamented how very little money her husband gives her. He is working in the capital, 550 kilometers away, and only leaves one fourth of his salary for her and the three children. Makanyi said how surprised she was the first time she saw her husband's pay slip when he buys so little for the famil,y and she concluded, "Men are very selfish." Vision emphasized that not all Ndau women know their husband's salary. "On the second of every month you are given your salary, you come home. Then the woman will kneel down, starting to show respect by clapping the hands, may I have soap, we don't have enough food to eat."

Employment patterns are slowly changing and the social messages are mixed. Trymore stated emphatically that women should stay home, as "In our

culture the man is the breadwinner of the family." However, Prisca reported a different understanding. "[Men] say it is our culture for a woman to go and work and come with food while they stay at home." In spite of the general belief that women's minds are inferior, Trymore said, "men are slowly beginning to realize that women have got the capability to be a breadwinner."

In spite of some changing attitudes and practices there are fears that women's economic independence will upset the balance of power in the home. Benjamin added, "And if the woman becomes economically stable she becomes difficult to control."

> So there are two sides to a coin, because if they are now able to work and earn the same amount as you, who are you to challenge me? It also has a lot to do with the economic muscle. So if she also has an equally big muscle, then there are two bulls and she can say no to that. If you notice most of the women here who are highly educated and have high paying jobs are unmarried. Why? Because they do not want to be controlled by the man (Trymore).

Rose is clear that an unfair system is in place.

> Ndau women are oppressed because they are not allowed to own anything. Men say the homes and fields and anything in them belongs to them. We women have a big problem and no one is better off than the other when it comes to oppression.

Religion

Examining the role of religion is important in understanding Ndau health beliefs and practices. Western-based health care systems arrived shortly after the

missionaries when it was realized that a healthy body was important to converting souls. Both traditional and Christian beliefs have exerted much influence over health practices. A third system of prophets and faith healing exists within certain churches and they often discourage or prohibit members from using hospitals or family planning services.

Both the Christian church and the colonialist government have attempted to change traditional beliefs and practices. In 1889, the Rhodesian government passed the Witchcraft Suppression Act; witchcraft was broadly defined to include throwing of bones (divination) and use of charms. This attempt at eliminating negative practices also affected positive ones as well (Chavunduka, 1994, p. 102). In spite of all the admonitions and laws to reduce or eliminate traditional beliefs they have prevailed and are especially strong in rural areas. The traditional system appears more open to alternatives in health care than regular or religious-based systems, although Rudu disagreed and said they are told by N'angas not to pray. "If you pray and you go back you will die. And so we were afraid to go to the church and the hospital. There are some people who just died because they were frightened." Trymore disagreed.

> It is not hard and fast, there is a lot of flexibility. It is not like someone says, we don't have to go to hospital, we don't have to go to church. People are free to do whatever. Rigidity mostly comes with religions like Christianity; it actually spells out what you are not to do. But with tradition, whatever helps is acceptable.

The church's inflexibility has either been ignored with both systems used openly, has led to many rejecting traditional ways, or resulted in internal or relationship conflict and secrecy. Benjamin described the dilemma the Ndau face in denying tradition.

> No matter what you say, you are physically a Christian, but the spiritual world still follows you. So that is why you see some churchgoers, who think they are a real church person, they will do both. During broad daylight they are at church and claim straightforward they are Christians. But at night they are going to traditional things.

Trymore said there are many similarities between Christian and traditional beliefs based on the concept of one Creator. He explained where he sees conflict.

> The difference, the striking difference is how we approach God.... The culture, its way of approaching God is through the elders, through their dead. Whereas for Christians, they say they talk to God through Jesus. There now, the culture says, who is this Jesus, we don't know him. I know my father and he is the one who can link me with God.

These conflicts are seen to contribute to illness if the ancestor's messages are ignored.

> Now in real sense of Ndau, the father never dies, the spirit never dies, it is the flesh that dies. You go to church, you don't want to hear anything about spirits anymore because the church doesn't allow that. But these spirits are angry and you must brew beer, you must do this and that, but you say, No, no, I no longer touch that, it is dirty. So the question is has the church been helpful, and in that sense it has not been. Because if the ancestors are angry, you find a child can go insane. The spirit can make a person go insane, as a protest of saying, Hey why aren't you listening to what I am saying? (Trymore)

> Churches in general are becoming more involved in the AIDS crisis as they

lose members and as whole communities are affected. Their messages, though, tend to focus on moralistic themes that do not always relate to people's reality. Chipo is expected by her family to attend church but talked of her confusion and feeling out of place.

> The church tells us to stick to one partner, to be faithful, to respect yourself, to make yourself the table of the Lord. All that helps. But the problem with the church is that it only talks, talks, talks, and it doesn't get to know what the person is experiencing. What I can say, I am a kind of a young woman (28) and I can't fit into the church because mostly the church is filled up with old women. And all they talk about is "in the old days we used to do this".... I've got this young boy for a husband and what he believes is not what these old women tell me.

The teachers continued to explain church teachings and their reality.

> *Florence*: But as far as HIV is concerned the women are sticking to one man, but the men always have their share of other women.
>
> *Chipo*: And in our culture it is not bad for a man to indulge in extramarital affairs.
>
> *Researcher*: Even if the church says no?
>
> *Chipo*: Even when the church says no. You can't even go to an aunt and say to her my husband is in love with.... She will say all men do that, why are you complaining? They always get out of it, just wait for a number of years it will be ok.
>
> *Florence:* That's why you said that Christians behave in a particular way at a particular time. The men of God themselves, they have a pastor's face in the church and out there they are somebody else.

In the female nurse's focus group it was mentioned that churches are now more directly involved in health issues and not just managing health systems.

"They are also carrying out their own campaigns," Greater said. "They are praying for strength and a solution, they are also having support groups in the churches." Sinikwe said, "Now at church, women are taught to behave well in bed (be active) so that men won't have many affairs outside marriage. This would lessen chances of getting infected with STDs."

Trymore said that churches have been a positive influence on health, as families do not have time for reinforcing behavioral messages. "And yet on the negative side people have abandoned their ancestors. The Bible says the spirits of the dead are evil spirits." Benjamin agreed that schools and hospitals have been valuable, but also that the church's influence has been negative with its unrealistic expectations.

> Before [missionaries] came people were surviving with their own rituals and their own beliefs. The first thing the church did was to demonize our culture, to make us run away from what belongs to us and from our being. And they continue to hammer that what you are doing is demonic. They go on now to say, don't respect what is yours, just run away from what is yours. And people will never run away from what is theirs, it is not possible.

Tommy finds it unfortunate that the church and colonizers arrived together.

> When it comes to the missionaries they did a good thing, but what some people don't realize is that when they came the colonizers also came. So they said, David Livingston, go in there and teach people the morals, when you go inside we are behind to grab the land.

It also appears that when facing difficult economic, political, and misunderstood health problems such as AIDS, people tend to return to former

beliefs, especially when the present ones do not seem to be working. Guidance, a high school student, does not see the church providing direct health messages and if they did they would face challenges in a context of poverty.

> What I have noticed is that they have the habit of taking the spiritual message and put it in everyday life. It's more about kindness, charity, hospitality, judgment, adultery, fornication, money. But the health messages are none. I doubt that there is any need for a health message 'cause the people would not take it to mind. How would you pass a health message to people whose diet cannot change?

As well, he finds the teachings regarding behavior are not always well accepted by the youth. "They'll say don't, don't with their mouths but there are a lot of things that are happening in this community that the adults do and which is adultery. So when adults are saying don't, we've got our eyes open." Angeline, another student, said,

> The church teaches us that behavior change is the key for us to remain healthy, as most of the preachers are aware of this latest killer, I mean AIDS. So they are preaching day and night that those who have misbehaved must change behavior.

When health teaching is provided, fear is often part of the package including both negative earthly or heavenly consequences for disobeying.

> At church the youth are taught... that if they indulge into sex it's a sin and God will punish them. Those who will be promiscuous, God will not answer their prayers, therefore they will not succeed in life. They will remain poor. (Edinah)

Discussion on HIV prevention is limited and the use of condoms, even if supported, is rarely talked about. Vision reported on church teachings, "This

topic of AIDS? There will be a lesson. We are told there is no cure, and for us to be free from AIDS we need to be faithful to our partners, one wife, one man, you cannot go beyond that."

Culture

Several cultural practices and beliefs have already been discussed. One other important practice is the bride price, or lobola. This appears to influence women's status in a negative way today, although the purpose of it may have been corrupted through time and social change. Originally it was a sign of a man's love and commitment as well as appreciation to the woman's family for raising their daughter in a good way. It signified compensation for their loss of a daughter to another family.

> If I paid lobola it was to join two families. Culturally men have to pay lobola. It was not because I was buying. Who will leave their parents to the other? It is the lady who joins my family. Now that family has been robbed of their daughter who is going to give all the services to the other. So there must be some compensation. (Trymore)

Benjamin said it has become commercialized.

> In the olden days only a hoe was enough for lobola, it was only a token, a bonding. But today, this young girl of mine is highly educated, she completed Form 6, I sent her to university, I paid a lot of money so I have to recover....

From the simple hoe, the lobola became several head or even herds of cattle. As people moved to cities and did not have cattle or other animals, hard currency

replaced it. Today thousands of Zimbabwean dollars are charged. No one was sure when the lobola became implicated as representing a purchase.

> When men pay lobola, they say they are buying, and women are bought. So it's an object to me, I am buying an object and my wardrobe cannot voice a thing. I will say, shut up wardrobe, I bought you. They (women) are not happy because their rights are all stripped away from them, just because they were bought and have to be submissive in everything. (Trymore)

Thoko Ruzvidzo, a cabinet minister in the Zimbabwean government, was asked her opinion of lobola and said she

> would like to understand it a bit more. Personally, I would like to relieve my daughter from lobola, but before I do that, I would like to understand the repercussions for her.... I don't see any advantages with lobola at the moment. It only assists to sell the woman. It helps reinforce women's inferiority. Some women see it as a form of security in marriage.... For some women it may be, because they have not found another alternative. (Getecha, 1995, p. 21)

In summary, gender, socioeconomic status, religion, and culture are interdependent concepts affecting health and health promotion. Both boys and girls are early socialized to their respective and separate gender roles. Gender-based roles determine educational and employment opportunities, degree of freedom, and life long health status. Roles and other gender influences greatly impact on socioeconomic status that is a powerful determinant of health. Cultural norms and traditional practices, along with religious beliefs, generally sustain a deeply rooted inequality between males and females.

Subquestion 3

What other factors are seen as affecting the prevention of HIV?

(Personal and environmental)

HIV/AIDS

Within this context of gender inequality, increasing levels of poverty, and limited access to minimal health services, the Human Immunodeficiency Virus continues its insidious assault unabated. Participants were asked various questions about their understanding of the situation and the disease process itself.

The Scope

Participants were asked if HIV/AIDS was a serious health problem in the area. All agreed that it was just as much an epidemic here as in other parts of the country and was becoming more prevalent. Several admitted to losing a relative to AIDS, while others strongly suspected it was the cause of death. Funerals are increasing. "You can't spend a month without burying somebody in the community," reported Thandi, and some said five funerals a week are common.

The two N'angas are seeing an increase in AIDS-related problems. Simon estimated he might see five every month and feels "most people are affected."

Sitembile stated that AIDS-related illnesses are the most common reason people come to consult her. Muniya noted the changes since he became a nurse in 1992. "We had a few cases and we were very much interested in what it looked like, to see someone suffering from AIDS. And now, we are not so eager because the figures are rising; everyday you see someone coming in with signs and symptoms." Dr. Arjan found it serious when he arrived at Mt. Selinda Hospital two years ago.

> I knew it was pretty bad before I came here. I was prepared for it, we got all the statistics and you heard the stories that many of your patients will have AIDS-related problems, but I didn't realize it was so bad. And in the short period I've been here, I see an increase; already it's getting worse.

Gegi revealed that her oldest son was HIV positive (he died 3 months after our interview). She said people are losing their young adult children, the men are starting to die, and in 3 years the wife passes away. Thandiwe believes "AIDS is there to kill everyone" and Pat's opinion was that "almost everyone is having it."

General Knowledge and Understandings

Participants were asked the reasons for such high statistics, the cause of HIV, and its transmission. Reasons and causes at times overlapped. For example, promiscuity was seen as a cause and also felt to fuel the epidemic. Responses were mixed and many participants felt the disease is not well understood in their communities, especially among illiterate people. HIV/AIDS is often explained as

a "strong force that is killing people" and this is "coupled with a weakness in the ancestors leading their children to get infected and die of AIDS" (Greater). This belief appears to help people explain why some families are more affected than others. Traditional explanations are also a way of protecting the AIDS patient, so others view them in a more positive way. "Way back when it started people did not believe it. As it continued people tried to describe it in a normal (traditional) way." These explanations included sleeping with a woman who had a miscarriage, looking for a witch, but eventually "they are beginning to see that poverty is the cause" (Katherine).

Benjamin suggested the present high levels do not imply the rate of new infections is increasing as these people were most likely infected before 1992. Trymore argued that the high levels of STDs he sees in the hospital laboratory attest to the reality that people are not changing their behavior. Many agreed that sexual promiscuity and prostitution are getting worse. "You hear someone talking about it now, but tonight you find him with someone, yet he has two wives at home" (Sarah). Cleopatra said people's lack of concern is the problem and Merriam added, "People don't care." They also say that if rich, famous, and professional people are dying of AIDS, what can one expect from an "ordinary person?" Other beliefs about HIV/AIDS were often similar to general health beliefs.

- Sex with a woman having her periods. "If you get that blood into your

stomach it is bad." Another cause is when a woman has an abortion and "the very time she wants men she will be killing those men.... It gives them HIV."

- "The blood that comes out after delivery is very dangerous to a man. That very blood is the one that causes AIDS."

- It's more dangerous for a man because it takes time for a girl to become infected. "The HIV might be there but it keeps getting out because of her monthly periods." This is verified when a baby is born and soon dies while the mother remains looking healthy. It is after menopause that "her (HIV) status starts."

- Some causes are a mother who has an injection used by someone who is HIV positive, and the razors used by N'angas with the same people.

- Rich men entice young girls with promises of gifts and money.

- Men don't give respect to their women.

- Men come home from traveling and don't use a condom.

- Girls in the townships don't have a job and they "hang around" looking for men. "These are the same men who like to marry people.... The love of money is the main cause of AIDS."

- "People are ignorant about using condoms. They don't believe in it."

- Men used to have many wives but now they have other "private wives" and these women can also have other relationships when the man is not there.

- Multiple reasons with "the inequity between men and women that is definitely for me the major contributing factor of why the virus is spreading so fast." There is a lack of understanding and even though people say they accept and understand "they don't work on it.... And there is so much migration."

- "Maybe from the hospital, you are going to have an operation you might get it. Or going to the dentist, maybe have an accident, so many ways."

- Besides prostitution you get it, "From stepping in toilets barefooted and eating people's leftovers."

- A television show interviewed prostitutes and asked them if they understood that AIDS kills. Their response was, "It is better for HIV to kill me after I have educated my children."

- When a man dies his brother is supposed to "inherit" the wife (kugara nkaka), but Tendai stressed, "It doesn't enter into their brain that something is wrong"

- AIDS is a body lotion, or caused by poisoning, or an accident at work.

- "If someone bumped into a rock and left blood stains on it and someone passing through the same road (barefooted) would get AIDS. If an AIDS person coughs in front of you then you would have AIDS too."

- If you mix AIDS with other diseases like malaria, you will die.

Other modes of transmission besides sexual included mosquito bites, washing in the same river as someone with AIDS, using the same towels, sharing cups and plates, shaking hands, sharing clothes, and kissing. Participants with the lowest education had the least information. Thandiwe said, "People do not know about HIV. How can one be concerned with something he or she does not know?"

Whether or not people hold natural (spirit-based) explanations for the spread of HIV, or understand it as a sexually transmitted disease, only a few said they or others know the difference between HIV and AIDS. Some say if you have HIV, in the end you will also have AIDS.Therefore "you are still on the same train" (Chipo). For most, seeing the symptoms means it is AIDS, and since HIV disease is not clearly visible, then it is difficult to comprehend. People are

considered "safe" if they are "fat." Guidance said even if people look healthy you could tell by their face. Benjamin noted that in the Ndau culture there is difficulty understanding the concept of microorganism, due to the belief that disease and illness are caused by spirits, not germs. Even if people understand that HIV is transmitted sexually, it may be that they believe certain people are more vulnerable through supernatural causes.

AIDS has many designations. A modern one is *mukondombera*, but is more commonly known by traditional names of illnesses, the most common being *runyoka*. This refers to violation of sexual taboos resulting in stomach problems, and people seek health services for symptoms of stomach pain and diarrhea. Another term is *zvikanyi*, meaning someone is suffering no matter how far from home, and *muchirahombe*, an illness of young girls (below 12 years of age) who have sex with older men.

Knowing when someone has AIDS was clear to them, and participants all described similar symptoms. The problem comes when someone loses weight from other causes and is labeled an AIDS patient. Mary offered additional reasons why people might be thin, such as other diseases, depression, bereavement, lack of money, and being ill-treated by husband or in-laws. However, she said, "People think only AIDS makes one thin."

Some learned about AIDS at school, from other people, through

newspapers, radio and television, and posters at the hospital. Makanyi said, "Nobody taught us about AIDS in our area. We hear the word AIDS in gossip." A few mentioned seeing dramas. Sarah, who trained as a health worker in 1986 under a government program, did not hear about AIDS until some time between 1994 and 1996. Overall, it appears education has been late coming to the area, was sporadic, and misconceptions abound. The difficulty in understanding HIV infection carries important implications for prevention. In earlier times N'angas could always come up with a reason for an illness, but the overwhelming presence of HIV/AIDS that is affecting every family in some way or another has people confused as to what is happening. Rose reflected the perplexity of HIV/AIDS when she lamented, " What type of disease has no medicine (cure)?

Risk

Participants were asked their perception of who was at most risk for acquiring HIV. Seventeen said "women," seven said "men," four said "everyone," and 10 said children or teenagers. A few said both men and women. Men were named because of their general promiscuous behavior. Women because they are married to these men and are unable to refuse sex "even if they know their husband is infected"(Chipo), "can see he is ill" (Vision), or because "women are forced in bed even if the man knows he has sores on his penis"

(Susan). Women who are single or unemployed are especially vulnerable "as women have always looked to men for protection, for provisions" (Chipo). "Women may be able to prevent HIV from piercing but not through intercourse, which is their greater risk. Husbands do not tell their wives if they have an STD. Even if they found his medical card, some of the women cannot read so would not know for sure" (Tendai, FG). Other women at risk include commercial sex workers (prostitutes) and the uneducated since "they don't fear anything" (meaning they do not know enough to be afraid) (Katherine).

Children and youth were mentioned frequently as being especially vulnerable. Young girls are having relationships with "Sugar Daddies" (men who can provide money or gifts), or teachers offering passing grades or other rewards. The practice of *kuputsa,* or marrying young daughters to older, often polygamous men, still continues, and participants felt that these men are most likely HIV positive. A more modern day version of this practice could be when parents enable their daughter to offer sex for money or goods that benefit the family.

Being in an unhealthy state was noted as increasing the risk for acquiring HIV. One belief is that a woman's immune system is weaker because of blood loss after delivery (Shooria). Another reason given for poor health is inadequate food intake. Three participants noted poverty as an important part of the context.

The difficulty people face finding enough food, paying school fees, and students competing with their friends (clothes, shoes, spending money), are all fueling high levels of promiscuity.

Protection

Participants were asked how women or people in general could protect themselves from HIV. The most common response was similar to Chipo's: "It is very difficult for a woman to protect herself." Even stronger was Maposa's reply: "Women have no means to protect themselves." There was nearly unanimous agreement that it is a man's choice whether condoms are used in any relationship. If a woman suggests such things she would be suspected of infidelity and liable to be beaten. Refusing to have sex could result in similar violence or being sent away and the marriage would end. Gegi said, "You could never ask him to wear a condom, never." When asked what could happen she replied, "Ah, talking about it to him, an African man? It's risky." Said Edinah: "Women are forced in bed and they are not allowed to talk about sex." Chipo stressed, "In the African tradition you can't even discuss it with a man because he will say, `I paid lobola, why do you want to use a plastic with me?' You can't, it's a non-discusser.... People hear about condoms but they are dying because it is in their pockets, not where it's supposed to be." A common slogan is that using

a condom is comparable to "eating a sweet in a wrapper."

The reluctance to use condoms is present in both men and women. Condoms are strongly associated with prostitution. Regular or "permanent girlfriends" are considered safe, although most of the participants were not convinced they are necessarily faithful to one man. If men suggest using a condom in marriage, women can take it as an insult. Sitembile told of four women who came to her complaining of this and she told them they were foolish. "If a man introduces a condom it means he is a good man, he's trying to protect himself and yourself. Why do you refuse?" They replied that they did not know it was good; that only prostitutes use condoms.

A few participants felt that condoms increase rates of promiscuity when abstinence before marriage, and faithfulness afterwards, are and should continue to be the main messages. The topic of condoms is especially controversial when it comes to sex education in schools and one key informant asked, "Do condoms have anything to do with young ones? Ah, I think such topics should be removed from the syllabus." While some believed that condoms increase the level of promiscuity among youth, others stressed the need to quickly reach young people with awareness and prevention messages, and as early as possible. When one focus group member was stressing abstinence and faithfulness, Benjamin quickly argued for a more "holistic" approach, as people are different and there

needs to be choices depending on one's situation. "To say that condoms encourage promiscuity, no. Condoms encourage prevention."

Condoms are not always easily accessible. Except for the counselor at the hospital, the nearest outlet is a small shopping area two kilometers from the high school where over 1,000 students attend. Shops close at 5:00 PM each night and noon on Saturday. Tommy said he sells them in his drinking establishment but some people say they can't afford them. Health workers say they do not have enough for all the people that could use them.

Several myths appear to influence both men's and women's acceptance of condoms. Some feel that using a condom is "underrating their manhood" and strongly discouraged by friends (Guidance). People generally do not have confidence that the condom will remain intact, thereby, according to Simon, "letting in disease." If you use a condom twice without removing you can "suck disease" into the penis. "The sperm mixes with the starch inside...you will suck that starch inside you. You won't feel all right." Simon described other problems. If it is broken getting into a period (menstruating) woman he sucks that blood. "If it is not broken, that rubber I think is too tight for a man. It reduces the power...the power of the veins. If he puts it on, tomorrow, after a week, it reduces the power of the penis to come up."

Many others were convinced that condoms are not 100% safe, and this is

enough to prevent their use. Shooria was worried about the lubrication and where that goes. "Won't that affect us? So it is not good as it is the women who are most affected." Vision suggested that condoms were invented as a method of birth control, not for HIV prevention, and someone told her recently that because of this "the AIDS virus can penetrate." Makanyi reported, "Some people say that if you use condoms they will remain in the vagina and swim up the intestines. It would then burst so you would die. I don't want to die because of a condom." Sinikwe said if they remain in the vagina women would need to an operation to have it removed.

Only a few participants knew about female condoms and others thought it would be a good idea if they were available. The closest shop is 32 km from the hospital, and they are more expensive than the male condom. Still, in this context, Florence stressed that it is not a simple matter. "Like we are saying, women have always been of inferior status. So just putting it on without having consent from the man...we haven't been able to get our voices through to decide on contraceptives." The hope of some easy, affordable method to prevent HIV, one that does not require permission to use, remains obscure.

Testing

HIV testing is viewed as an important component of any prevention

program. In the Mt. Selinda area testing is controversial. Once people receive a diagnosis of HIV they expect to die very quickly and so not knowing is preferred. "Once you say you are positive it already means you are ill" (Gegi). "They say if you are HIV you are AIDS. You are in the process of dying" (Vision). Fear of suicide discourages families from naming the illness.

Several of the female participants said they wanted to be tested and a few stated they had been tested at least once. It is difficult, if not impossible, to convince partners. Emma related, "But the man will have nothing of that saying, If you don't want me then get going" Most believed it was important to be tested before marriage and conception. Several thought it should be mandatory, with others questioning the benefit. "Suppose we go today and they tell us we are both negative" said Florence, "Tomorrow he sleeps with X; are we supposed to go for an AIDS test every month?" Chipo has been tested three times and does not really believe she is negative.

> The problem is that I'm a cup with another saucer. If you lift the cup you don't know where the saucer is. It may be broken, but you still have the cup, they have to work together. But they can't always be together. Sometimes you take the cup and go to the kitchen...and leave the saucer. Sometimes the saucer breaks up. The saucer can also be used for something else. If you were one thing I would believe the results, but I keep going (for testing) because I think the saucer might be doing something else.

Chipo also talked about friends who had their husbands tested. When they found out they were negative, completely changed their previous promiscuous

behavior to be faithful to their marriage. Florence had a different experience saying her husband once tested negative but soon returned to having many girlfriends.

Setu, the hospital counselor, said the service has only been in existence for just over a year but she is seeing an increase in people coming for pre and post testing. Many are women whose husbands have died "after a long illness" and they want to know if they are also affected. The service is free while the test costs Zim $50.00 (about US$1). When the test fee was introduced, numbers started declining and after pretest counseling people would not have the money, or used it as an excuse not to continue in the process. Later donation money was found to purchase the kits, but since September 2001, no reliable supply has been available in the country.

Dr. Arjan used to suggest testing to many of his patients but most would refuse. "People do not like it when you say that to them." Instead, he tries to help them with their immediate, most acute problems and does not talk about the future. "It costs too much energy to keep trying with each patient, again and again. And they don't bring up the issue themselves, with a few exceptions. Then I'm extremely happy."

Setu finds an overall positive response from the systemic counseling process she has learned and finds it is empowering for people. "Once they bring

up the problem, the solutions are easier." She also is sensitive to women's difficulty when attempting to involve their husbands, and together they find creative ways to overcome this. A critical influence on people's changed attitude to counseling and testing comes with the promised confidentiality the service offers. She finds that "the problem is that people don't have someone to share with. Maybe it is the way we grow, or maybe it is our culture." Women are often isolated from someone they might safely confide in.

For those who do know their status, such as the six women living positively, the information has resulted in a changed outlook on life and death. When asked what it has been like since they knew, all found it to be a liberating experience as they described in the following excerpt from their interview. Also apparent are the benefits gained from belonging to the support group.

> *Margie:* Knowing the type of illness I have is very important because now I would not worry about things like bad spirits. I am no longer suspicious of what it could be. I am now able to treat myself in an acceptable way.
>
> *Susan:* Same applies to me. I am no longer thinking too much, I can say I am no longer stressed because I now know what to do.
>
> *Mary:* I am happy because I later discovered that I was not the only one with HIV. Ah, we are so many. Now I have many HIV positive friends who help me to do away with depression. All these days I don't mind anything.
>
> *Tendai*: I was the happiest because it was a long wait for me to know my health status. I am happy because even if I have diarrhea I would know how to help myself. I have now peace of mind. I can help others who may have the same health problems.

> *Mirriam*: I once said I used to cry, but now I am happy. I am no longer stressed. I am not worried because I was advised and counseled about how to live positively. I now have people to talk to when I would have a problem. These people comfort me always, especially Susan. I don't know how to thank her. Also I know that HIV has no cure so I rejoice because I am alive.
>
> *Cleopatra:* Knowing my health status gave me peace of mind. Moreover with the help of the support group I know how to live positively and (more) accepting myself as before. I now have less problems.

In spite of the positive outcome of knowing their status, these women disclosed to very few people. Society and individual communities establish norms of what are considered acceptable and appropriate behaviors. Anything else is considered deviant and certain things are enacted to return the person to the "normal" state, or failing that, the person is often no longer welcome to participate as usual. Lack of acceptance and being treated differently are real fears for these women.

Stigma

Several respondents mentioned the word stigma when talking about public perceptions of a person with HIV/AIDS. Stigma is a concept recognized as a major influence in treatment and care of ill persons and groups, and relates to how persons are viewed within their respective communities. More recently it is being linked to prevention issues of HIV/AIDS by many social science researchers building on the work of Irving Goffman. As one of the pioneers in

attempting to understand how stigma relates to disease processes, Goffman (1963) wrote that it was originally a Greek term and referred to "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (p. 1). Those who are HIV positive have common physical symptoms, often from the opportunistic infections that occur, and are quickly labeled as an AIDS patient. These manifestations are considered clear indications of immoral behavior and therefore mark someone to be avoided or ill-treated. Goffman noted that people being marked as different means they are "thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma" (p. 3). Because the stigmatized person is thus seen as "not quite human," as substandard, it is easier to discriminate, resulting in reduced opportunities for that person (p. 5).

The issue of stigma as an important public health issue, especially concerning HIV/AIDS, is reflected in the 2002-2003 theme for the UNAIDS campaign: Stigma and Discrimination. As well, a 2001 National Institute of Health conference held in the United States titled "Stigma and Global Health: Developing a Research Agenda" attempted to consolidate understandings of stigma and disease. The public response to HIV/AIDS will impact on how people view themselves within their context. This Goffman (1963) called their "social identity" (p. 2).

When participants were asked how people with AIDS are treated, there seemed to be an understanding that they should be accepted as normal. Therefore, it appears that an official antidiscrimination message has been widely disseminated. However, it seems that fear, suspicion, and victim blaming are common. Thokozani noticed that treatment of people living with AIDS very much depends on individual families. "But mostly they are ill-treated. Nobody likes to associate or share anything with an AIDS patient. In most cases they are considered repugnant or repulsive." Gegi, whose son was HIV positive, said "people will run away" and the person remains alone with their problem. They are given separate eating utensils and towels, any leftover food is thrown away (instead of being eaten by others), and people tend to clap hands when greeting instead of the very important hand shaking that is the norm (along with clapping) in the Ndau culture.

Nurses see many AIDS patients and their visitors, and have observed negative interactions. "They are treated differently, they isolate them, they don't take care of them, they don't even socialize with them or listen to their problems...serves you right, why did you acquire it?" (Noline). HIV, they said, is strongly associated with promiscuity, with the terms nearly interchangeable. Even though there are other means of transmission they are apparently unknown or ignored, and Noline added, "People in the society that are promiscuous are

generally rejected." Therefore, once labeled as an AIDS patient, you take personal responsibility for the illness.

Susan stressed that "telling everybody is not easy. People would start to dislike you and would classify you under prostitutes. Nobody would respect you for you would be an AIDS person. " From earlier discussions this seems to apply more to women than men. The six women who are living positively with HIV only told one or two people who they trusted to accept them unconditionally and maintain confidentiality. Cleopatra only told her husband as she said she would be laughed at. "People would have found jokes (about me) for months. They would talk bad about me." Others explained why they have been secretive about their status.

> *Mary*: Let's say people would know that I am HIV positive. If we go to a funeral they would not like to sit next to me or share anything with me. Even eating from the same bowl, they would refuse.
>
> *Margie*: Let's say you go to the river to bath, everybody would stop washing and bathing until you finish.
>
> *Cleopatra*: You would be an outcast in the society. Nobody would love you.

Women can also be blamed for infecting their husbands—If not through promiscuity, then through bewitching or evil spirits, adding to reluctance to disclose. Not only would they be in danger of losing property, belongings, and children, their own health and lives could be in danger. Being HIV positive

carries a strong sense of shame, isolation, and loneliness. The public disgrace is also felt by the family and even if they do provide good care the particular illness is not mentioned.

Denial

It is not surprising that with the degree of stigma there is a corresponding level of denial and secrecy. The expression "the silence is deafening" seems to apply, as everyone at some point is affectedly the epidemic yet are still not able or willing to openly discuss it. Other aspects of the society are wrapped in secrecy and denial that also feed into the spread of HIV, and few people are willing to bring these into the public domain. Incest and the sugar daddy phenomena appear to be all too common. The hospital counselor, physicians, and nurses are seeing increasing cases of incest. People are afraid to confront the perpetrators for various reasons, including personal safety and shame.

At all levels of society the subject of HIV/AIDS is avoided. Florence talked about the death of her brother whom she knows died of AIDS, yet 5 years later she is still searching for another reason. She recalled a time when he began to make a partial recovery. "So I said to myself, these doctors are used by the devil. Look, he is up now and about." Even though she could see he was not back to normal, "in my mind I dismissed what that doctor had said about him

being HIV positive." Her denial today is based on the fact that his wife is still alive and their daughter is healthy. As well, she still believes that her father's death was not appeased and there could be a relationship. Cleopatra pointed out that many believe AIDS is not a real disease; they that "God wants us to die, that's why he sends AIDS to people."

When people first started hearing about AIDS they were convinced that everyone was going to get sick and "the whole community would be wiped out," related Chipo. When that did not happen she said people stopped worrying about it. When they see a promiscuous woman who is still alive after many of her partners have died, "It means it is not AIDS, there is something else that is killing these men.... So we start looking for the unknown but we don't want to deal with what is before us." Some people believe that by treating the TB or the diarrhea the illness (AIDS) is also cured.

The female nurses talked about how even government denies while supposedly supporting interventions. When high-level cabinet ministers showed clear signs of AIDS, they reported the death as due to a long illness or malaria. "When it started people said there is nothing like AIDS. It was an American way of discouraging sex. No one was taking that seriously" (Benjamin). Trymore added that even if people admit that AIDS exists they think that personally they are immune. "It won't affect me, it's over there, and we are always pointing

fingers." He explained that the denial is abetted because of the tradition of going to N'angas to find out the cause of an illness. The diagnosis of unhappy ancestors or bewitching feeds into the denial while providing psychological comfort. The spirit mediums will say, "ah, it is not a virus, it's because the spirits are not happy." Trymore also blames earlier belief and acceptance that "death is death" whether "you are eaten by a crocodile or bitten by a snake...it's all death, no one comes back" so why be concerned about a specific illness when you are still healthy.

The male nurses discussed the falling rates in Uganda where the government encouraged openness about diagnoses even at funerals. All agreed this would not happen here. "You can't say somebody has HIV at a grave, you can't do that. If you do you destroy the whole family one way or another. If you say that they will shun the children, they will shun the wife and everybody. It's a no go area" (Benjamin).

Nurses themselves are contributing to the level of denial. Tendai was suspicious of her status and staff told her she was looking healthy so did not have HIV. Doctors are asked by the nurses not to write the diagnosis on the chart or the death certificate, as this causes problems for families and impacts on insurance. Instead, the term RVI, for "retroviral illness," is used. Dr. Arjan stressed, "It's like there is a huge denial and passive attitude to the whole

problem where I expected that some people would stand up and try to fight. But it's not really like that." He described what happens when he attempts to give a correct diagnosis to someone. "People suddenly change the subject completely.... They ask, doctor, did you already give malaria tablets, did you do this, and they just avoid it." He added, "So the denial is not just with the patients themselves, it's throughout the whole society. Even in official reports they don't expect you, or they don't want you, to write down the correct diagnosis."

People are said to be talking about the problem, but not openly. The use of various names like TB2, whole body illness, home based care, and various indigenous names, increases the level of denial. The two N'angas also said they never tell a patient directly as it would not be accepted. Even with advanced symptoms Sitembile said, "You don't tell her that she has it." Simon uses an indirect approach with clients and drew an imaginary line on his carpet, moving his hands around the hakata pieces to demonstrate the twisted route he takes. Setu had a sister who died of AIDS at 22 and her parents insisted on seeing a N'anga. She said it is easy to talk about malaria or TB "but with AIDS we feel we should not mention it. When it comes to HIV, it's a long illness." Denial not only impacts on care and treatment, it has serious implications for prevention that is critical in a disease with such a long subclinical phase.

Marriage

Many aspects of women's lives have an impact on health status and ability to participate in HIV prevention. Marriage is expected to be, and endorsed as, the main role for women, an attitude with many health implications. Once marriage ceremonies are over a woman takes on a new role as wife and becomes the *murowa* (daughter-in-law) with accompanying norms and high expectations. Traditionally the girl would move to the in-law's compound, although more young, educated people are setting up their own homes if working away from rural areas.

Two main themes predominate for an Ndau woman within marriage; production and reproduction. These encompass all she does and is expected to do. With high expectation for women and men to be married, it is difficult to discuss one gender without reference to the other and often lives of women and men were compared. Vision described daily life and most participants recited similar routines.

> You are an African woman, you are an Ndau woman, you must work. You have the child at the back, you are pregnant, you are having a big basket, and a bag and the husband will just be moving empty handed. Those full time house women, they spend all day in the fields, from the fields you have to have firewood, you rush home and you go to the river to fetch water and you come and prepare food on the open fire, from there you sit people to eat, from there you rush to the river and fetch water, you wash plates, after that you go to the fields for the second part of the day, from there.... It is very difficult.

She stressed that all this is done with acceptance and with one's place in the new family firmly entrenched and maintained by cultural norms.

> And you need not to complain. That's the pattern of life, no complaining. And in other homes because of the extended family there will be a lot of women and a lot of children, and the small boys and girls, I must not be allowed to send them to do anything, according to our culture. You work for them, you are still new (as the young murowa). You reached that place after they were born and you have to respect them.

Even as a teacher she is expected to work in the fields and carry out certain community responsibilities. Vision is fortunate she can afford a housemaid, and her husband does help at times with housework and child care, but they do not live with in-laws.

Women's workload appears to be increasing while men seem to have more leisure time. Males are more affected by the high unemployment rate since they have had easier access to formal employment. Greater compares their roles.

> The woman is the farmer, she is the cleaner, she is the cooker, she is doing virtually almost everything. And the husband is not working. What he knows is just to sit down under the tree with a pot of beer, or go around looking for beer while the woman goes to the fields, carrying pregnancy after pregnancy, she is breastfeeding, she has to find food for the whole family.

Benjamin recognized that women are overworking and not receiving recognition. Prisca recited a proverb that says "a husband is your first child." Even when husbands help, the labor is not divided evenly, according to Vision.

> But after working in the fields it is you the woman who will bring the firewood and the husband will just be walking. It will be a bundle of firewood and the hoes. You come and rush to the river and the husband will just be relaxing. You come and prepare food and he will say, "You are

> delaying, be quick, I am tired, I have been working." It seems as if he was working and I was not. You can see the Ndau woman is not a happy woman I can say. I used to say they seemed to be slaves.

Only a few women said they were happy in marriage, and there is a strong sense of powerlessness. Moving to the husband's home implies the wife no longer has rights to ownership other than what the husband allows. Prisca stated sadly:

> I can say most Ndau women are suffering. People have fields that are not fertile. Therefore, they produce little because the husbands do not buy fertilizer. Women starve with the children and have no good clothes to put on. They would walk long distances bare-footed and the children in rags. They work hard in magau and earn very little which would be for food only and may be not enough because they have many children.... The home belongs to men and they say they have the right to do anything.

Dr. Arjan noted the limited effect of education and the strength of tradition, at least what he observes in this rural area.

> The men are in charge and they have power over their women. It's also because of how they marry in the traditional way. The wife goes to the family of the man and belongs to that family so she is just there to serve and to bear children. Even when they are educated it was surprising that most girls are going to school, are quite well educated, as soon as they are a bit older they get married and they are back in their traditional, social role. And the funny thing is that, like the nurses in the hospital and the teachers at the school with prominent jobs, in their work they are an important figure, they talk about equality. But as soon as they close the door of the work place they are home in their old role of the submissive wife, kneeling for her husband.

As well as strong norms around marriage and women's roles, several important sub themes emerged. These were coded as decision making, violence,

and voice.

Decision Making

It was acknowledged that men have the decision-making power in the family. Only two key participants said they shared in family decisions.

> So because of culture and the way we were brought up we have to respect the husband as much as possible. We don't know where it started but we grew up seeing that most of the words have been said by the father, and most of the decisions have been done by the father. (Setu)

Prisca noted early in the relationship the rules are clear.

> We could meet in the township and discuss our marriage but normally it was the boy who would decide what is going to happen. The girls would listen and no suggestions or contributions were they allowed to make. This is still happening among the Ndau people. Women are not allowed to decide or suggest anything.

Savemore has six children and would like to stop conceiving.

> Just now, we Ndau people, mmmn, the education is very low. You should not do anything on your own, you should not. Our husbands, you should first get permission from him. If he says you can have sterilization, you can do it.

Spacing of children is certainly a health issue, and Florence agreed that

> the decision of how many children to have is on the man and his relatives. So some women may go on and on giving birth, at the same time working with children on their backs. At the end of the day you are ruined. You can't say I've had enough children.

Besides family planning decisions, access to other health services is influenced as well. From experience in the family/child health clinic, Noline has noticed,

> Some husbands...tend to give some rules to the wife that you should not leave the home and go to the hospital without my knowledge yet they will be living very far away. The majority of the Ndau women, especially those not working, those who are illiterate, they don't have a final decision in anything and have to wait for the husband and you wonder why they delay and have more problems and illness.

Edinah, married to a teacher, does not appear to benefit from his higher level of education and must ask permission to visit her own parents.

> You can't do anything without notifying your husband because he is the head of the family. My husband decides everything to be done by the family and I have no right to say no or do against him. If I want to travel or buy something I have to ask him. I have to bow down and kneel before him asking for permission.

Rose stated that even when a husband makes a bad decision he is never challenged. "They don't apologize. To say sorry, it's for women. If a woman does something against the man's decisions then she is forced to kneel down and clap hands asking for forgiveness or is beaten up."

Violence

"Being beaten up" is a common threat and reality in many women's lives. Benjamin stated, "If a woman does something wrong and has angered the husband, he has the right to kick her, to beat her. " Dr. Arjan is dismayed at what he sees in the hospital. "Every day I see the results of this difference in power, the unequal distribution of power. So many women are beaten up and domestic violence is incredibly high." He is reluctant to refer these women to untrained

people, such as hospital nurses.

> Most of them will respond in the same way as most of the women do, that it's your own fault as you should obey your husband. So they go back to what a woman should do and they justify the violence in an indirect way. I think violence can never be justified, no matter what is behind it. And it's not only violence; it's also sexual violence and harassment. I think it's worldwide that most of the women are raped within their own marriage and it is definitely happening here.

The doctor does have confidence in the trained counselors. One is Setu, who intervenes with cases of domestic violence when referred. Although her statistics are not specific for violence, in 2001 she counseled 19 cases of suicide attempts, 10 cases of child abuse, and 42 cases of domestic violence and social problems. Shooria said violence is real for many. "There was a certain teacher here, he would beat his wife from (below the neck) to the knees. There would be swollen parts but you couldn't see. He would use even chairs to hit her." This happens behind closed doors, and only later would she show the injuries to a close friend.

Participants told of spousal beatings for anything considered disrespectful of the husband's opinion. Threatening behaviors include complaining, arguing, going against his decisions, advising, refusing or initiating sex, suggesting condom use, reports of ill treatment by the in-laws, and showing up at his workplace without permission. Also included are eating the parts of the chicken reserved for men, practicing birth control without permission, expressing one's

feelings, purchasing goods without approval, and for reporting violence.

The accepted trajectory for dealing with family problems is for the wife to go to her sister-in-law. If no resolution, then other family members might be involved and in some cases women will report to their own families. It is in the best interest of both families for the couple to stay together. If a wife leaves, the in-laws lose a worker and mother for the children, while the woman's parents would likely be expected to repay the lobola, which could cause much hardship. Divorce is connected to sense of shame.

Rarely are cases of spousal abuse reported to local authorities. Prisca said, "Reporting means lack of respect for your husband." Sinikwe agreed there is little support. "Even if they report to the chief, the man would win the case. He would say I was beating her because she disobeyed my home rules. I can only say men are rulers."

> Ah, a woman is not allowed to say something against the husband because it's lack of respect. They don't report anything, either at the chief or the police. The husband's relatives say it's a rule for the men to beat their wives. It's acceptable. Some women are disabled because of the beatings. Ah, no, it's bad. (Edinah)

Sylia also mentioned disability and described one incident where a woman's family reported such an attack. The man is now in prison. This appears to be the exception and normally there is little recourse to justice even from one's family.

Men don't want us to visit our parents because they fear women would

> report their cruelty to their parents. They would state how they are oppressed. Men don't like to have a bad reputation although they are the oppressors.

These examples reveal that deeply entrenched roles, expectations, and norms are perpetuated through many different layers of society. In Prisca's opinion, "The world belongs to men. They beat up children and women and are not arrested. It's their right to ill treat women. "

Voice

The concept of voice, or lack of it, became apparent early on in interviews. In Ndau culture this goes beyond decision making to include women's ability to speak freely. Not only are women not listened to, they are not expected to speak much at all.

Dr. Arjan noted both the value of women and their silence. "They are very important women here. They raise the children, they work at home, often doing work in the fields, taking care of the relatives, so they are kind of the center of the family, yet on the other hand they hardly have anything to say." Gegi described the need to be quiet in order to be seen as a good woman.

> When you are married you should praise your husband, even if he does anything wrong. If he doesn't want you to talk about it to your friends and relatives, you've got to keep quiet. If he doesn't give you money you should be quiet. Look as if you are satisfied. Even if he has a girlfriend you can't say, who is that girlfriend, or even if you pick a letter from his pocket, traditionally you have to keep quiet, honor him, even if he does wrong. That is the type of culture our men like.

She concluded that level of education does not make a difference. "And if you get married to someone you think is educated, that element is still in him."

> Women are not allowed to do anything like talking in front of men. Like in churches women are not allowed to preach. Some women are intelligent and are talented to do something but cannot show their talents or intelligence because they are oppressed. (Edinah)

In Vision's denomination women preach and can become ordained ministers. Still she described the challenges of chairing a women's gathering.

> You pose a question and they will not answer quickly. The women will take time to think. Then you will ask, have you heard me correctly? It will take time. Then later on you will see a hand up. Then you say, Oh Mrs....can you please contribute? She will first show that respect, (clapping hands) saying excuse me, and then she will start to talk.

It is even more difficult for women attending public sessions with men present. Vision explained some of the history behind women's lack of public voice.

> Sometime back, women were taken, I can say, as workers, and they were not allowed to talk at a meeting. Even if you had a good point or good idea to put across, you remain silent. And you'll be considered to be a well-behaved woman. If you talk, talk, talk then when you are at home the husband will ask, what were you trying to do? And you'll be in problems; you'll be beaten for that.

Women are raised to be obedient and quiet, which is reinforced within the marriage. Vision stated, "Maybe the husband you marry keeps on pushing you down, be quiet, don't talk. So at times we tend to be quiet, even if we know the answer to a problem that is being asked. But because I am a woman I must be silent." She added she is free to discuss with her husband but with her in-laws

she would not offer an opinion or idea unless asked. She also had an experience of trying to help her brother-in-law. But in the end, the man "didn't listen to me and he didn't get my advice, simply because I am a woman. So at times you can contribute, you can give a valued point, but it can be watered down because you are a woman."

Pat's advice for a happy life is "you must not argue with him, you must keep quiet, whether he is doing good or bad you just have to keep your mouth closed to live a happy life." When asked if women are happy, she replied, "No, women are not happy, but if you keep on fighting it is worse. If you keep quiet it goes well and he will change when he wants to change." Women's silence is pervasive and appears to be a safety mechanism against various types of abuse.

Exploration of subquestion three exposed many personal and environmental factors affecting HIV prevention, and further revealed the complexity of the epidemic. Many myths and misunderstandings exist around the causes and prevention of HIV including use of condoms and testing. Openly denounced, yet culturally sanctioned, male promiscuity appears to be prevalent. Female partners have little or no power to protect themselves, even when they are aware of the risks. Marriage is basically the only socially approved role for women, and is focused on their ability to be efficient producers and fertile reproducers. Other emerging and interrelated themes stressed the limitations

and barriers women face in prevention. These include fear related to high levels of actual or threatened violence, lack of voice, limited decision-making power, and little or no environmental support for change. Stigma and shame seem to encourage considerable denial, secrecy, and avoidance of the overwhelming reality of HIV/AIDS, and they negatively impact prevention efforts.

Subquestion 4

What do people see as the most pressing needs in relation to improved personal and community level health and wellness?

Participants were asked what they would do to improve the health of their communities. Many answers reflected basic public health issues such as education on the importance of using clean water or boiling, building proper toilets, having clean houses and yards, covering food, growing a variety of vegetables, digging a rubbish pit, cutting grass, and smearing their houses. Several included the need for supervision to ensure these things were happening. Savemore, a farm health worker, would encourage men as well as women to bring their children to mobile immunization clinics.

Thokozani, a village health worker, thought it important for women to have home-based income generating projects. This would free up time to keep a

cleaner home, and children would not be left to care for themselves. Shooria believed it important for women to have other females for support and advice so they could share experiences. She has experience with support groups that can assist women in such things as legal matters. Other suggestions are included in the following section specifically about HIV.

Subquestion 5

What do they think needs to happen for a change in the HIV epidemic?

Challenges and Change

Participants were asked what they think is needed for an improvement in the HIV/AIDS epidemic. Similar to looking into the past, thinking about future possibilities for change also seemed difficult. Responses tended to either represent a yearning for past times or a repetition of what has already been done, and included reminders of the challenges or barriers they face. The following is a summary of comments from the three categories of participants.

Table 7
Key Participants and Change

Name	*Challenges*	*Suggestions for Change*
Shooria	-Most people don't have TV, and some don't have radios, or get newspapers. -People don't talk about it. -People do not think they will be infected, don't care about dying, and they don't think about the future.	-Continue those AIDS campaigns. -Dramas in public places, both in English and Shona. In churches, in the townships, in beer halls, and shopping places. -Those who are infected if they could...go in public... people would learn from them.
Vision	-The Ndau men are controlling -people who are talking about faithfulness, are also going to Chako to find a single mother. -our culture is a difficult culture, if you try to introduce something at times it will not succeed.	-This subject of AIDS must be talked to the men first. They are the ones who can make a change. Men want this respect, they want to be talked to first. Then we ask their permission to talk to the women. -we need to pray to God to intervene.
Prisca	-Men know a lot about AIDS but we women don't know much about it. -women are deprived by men.	-People, especially women need to be educated -women need to be allowed to say their complaints about health.
Rudu	-they don't understand being told by myself. -in our area there is little knowledge, the uneducated do not understand.	-people need to be told about the seriousness by people such as nurses walking around. -if we had health workers people would easily understand.
Edinah	-men work in towns very far from their wives and can spend 7 months or one year without visiting his family. That means they are having other sexual partners there.	-the government should make a law that a man must stay with his wife. -I think people should say the cause of death. The hospital should write HIV/AIDS. By doing so it would be accepted as any other illness.
Makanyi	-men are the key problems and only a few women are promiscuous.	-Men should be educated about behavior change then it will be easier for women -using condoms is the only solution to AIDS.
Sinikwe	-men do not like to use condoms. -if men are given condoms they would have many love affairs.	-Men should be educated on HIV/AIDS -women have to tell their husbands not to misbehave.
Thandiwe	-even if men know they have an STD they don't like to use condoms. -women can spend a year without sex and men they can't. The Ndau culture says that a woman remains at home while the husband goes to the cities.	-women should be given condoms and pills for prevention of STDs. That would help a lot -we need prevention medicines so that we are all safe.
Rose	-even if they (men) know they are infected they continue asking for sex. -men have no money to look after their families but can afford to spend money on prostitutes.	-the only solution we need and can do is use condoms always. -men must be educated about AIDS until they know what it is and how bad it is. -men must have teachings that make them stop.
Sylia		-women must force men to wear condoms every time they have sex.

Table 8
Key Informants and Change

Name	*Challenges*	*Suggestions for Change*
Gegi		-I would like to take the men to understand that this is no longer the world in which our fathers lived and with all those beliefs.
Mapung-wana	-youth having sex because of condoms -(having sex outside of marriage) --that spirit circulates within people.	-to discuss about HIV/AIDS in small groups -for each person to protect him or herself -to continue teaching my people
Maposa	-there are few health workers and they concentrate on one area. They don't really meet people in the community, they stay in the hospital. -it is very difficult to change things these days.	-if there was a program of going from village to village. -if there could be a change of attitude toward sex, to get a partner and be faithful. -would make everyone rich enough to make a living. You don't have to sell your body.
Guidance	-The message we are given is the truth but it is sweetened. It's like giving a person cyanide put in candy floss. -there are posters but maybe I can't read, I am given condoms but I blow them up and hang them in my room, you get rid of prostitutes but who will feed their children? -Ministers will tell you one thing and being human he is going to sin.	-I believe we need to be told the truth in a manner that will open our eyes and the subconscious. -I doubt if there is one strong program that this is what we can say we can do. We need to look at the real causes. We need people who will take the time to think of ways to prevent this. -we need good role models.
Tommy	-people are still not conscious, the message is not really home with people. -the (older) guys don't want to know much about it.	-reinforce services in the rural areas. -people need reminding openly and often -we especially need to go to the kids. - there should be seminars, workshops, and incentives to lure the people, -mix entertainment with the message, some drama, condom distribution, even for women, for when the shops are closed.
Katherine		-the government to get people tested and the affected ones would stay at their own place. -I would go to places where they have meetings or parties and talk about AIDS. -school children should be preached from an early age, mothers to be a little strict with their girl children.
Simon	-I'll be trying to heal but you can't finish the HIV in the blood.	-I think God will cure that, not people living here. I would teach people to be capable (to work hard, do good things and not to sin.)

(*table continues*)

Name	*Challenges*	*Suggestions for Change*
Setu	-men are getting (it) but the steps are slow, so very slow. We will reach 2010 and the statistics will go up instead of declining. -everyone (at the hospital) is aware but the problem is there is no behavior change But look at the community, there are a lot of people and they are not aware. -We don't mention it. How long can we say confidentiality when people are dying? Here I know of only one person who said what he had. We usually hear it is TB or he is bewitched.	-we need some strong awareness campaigns. -once men change their behavior then this problem will disappear. -we need to stimulate the community. -I would spend the biggest percentage (NAC funds) on prevention. -a lot of men should do the AIDS activities. Women and men will listen to men. Men given full responsibility will feel honored. -if we could use the (few) men who come for counseling and testing to motivate others. -I would hire people to go door-to-door.
Pat	-men are having a lot of prostitutes, they only change (their behavior) when they are sick.	-I would start with the teens not to have sex before marriage, then suppose they started an affair then to stick to one partner. -I would close all the bars then build churches everywhere.
Sitembile	I hear some people say that we need to get rid of the beer halls but I tell them sex doesn't have a real place.	-keep on educating, treating STDs.
Sarah		-to meet the people regularly like we were taught, to explain what will happen if they don't.
Angeline	-behavior change to young kids takes a long time. Peer pressure is the main thing.	-for someone to change behavior they must change their circle of friends.
Thokozani	-men who are not learned are problem.	-we have to keep teaching people about HIV/AIDS and urging them to stop promiscuity.
Tendai	-no one takes the time to be serious about it. No one discusses. -many people are illiterate. -not much is going on in the communities. -people don't want to take advice unless it is from their own relatives.	-at times I would like to talk (about her HIV status) but how would they react? I would like to give them the example, but then I shy away. -unless God provides a medicine we are all going to die.
Arjan	-the role of the health sector is very minor. It is not capable of changing social structures, social relationships, traditional behaviors and so on, -changes go slowly. -when a whole society feels they can fight for something they will achieve it; and that is what is missing here at the moment. -they will listen to me and even all those workshops and trainings, they say yes, we have to work on it but in reality there is not much happening.	-cooperation between the public health sector and the N'angas. -this problem needs a lot of communication and working on relationships. -the really respected authorities and leaders need to work on it, to cooperate. -more commitment from the Ministry; -to focus more on how people live. -people are always inventive. Even though they seem passive, probably at a certain point they will find strategies.

Focus Groups and Change

Several participants of the teacher's group thought higher education would help: the further one goes in school the level of health literacy increases. This includes what medications to take and how to prevent disease. However, it is not only level of education that is important, but also the social aspect. "Mixing with different religions and different societies and to see how other people live," is important, according to Florence from the teacher's group. This "mix with other cultures" was also mentioned in the first nurse's group. Setu said with more and more children attending school, adopting practices from other cultures would increase women's status and degree of equality and opportunity so that "eventually the problem will phase out."

The secondary school in Mt. Selinda has students from all over Zimbabwe representing many different tribes and both rural and urban populations. The farm schools also have youth from various parts of the country. Some view this cross-cultural experience as positive due to the learning of different ways of living. For others, the influences on behavior can be negative as teens from urban areas are often of a higher socio-economic status, consider themselves more superior, and are more promiscuous (Vision). Girls from poorer families aspire to attain the things they see these wealthier girls owning, and this is believed to increase the chances they will use sex to acquire them.

The teachers held little hope that change would come quickly, but more sadly, a sense of resignation and acceptance that their own life spans are affected.

Florence: It will take time

Researcher: What is going to happen in that time?

Florence: Well, some generations will have passed and new minds will be coming up and new understandings will be given to them.

Researcher: Where will this come from?

Florence: From the educators, from the health institutions. They are doing quite a lot.

Chipo: But it is not working.

Florence: It is not working fast; it is just working slowly.

Researcher: Why is it so slow?

Florence: Because of this background, the beliefs that I told you about before that live in most of us.

Nyasha: And some people resist.

Florence: That resistance comes out of the beliefs that we have, out of the folk stories we are told.... Perhaps in the third or fourth generation people might be changed....

Researcher: So you don't see much hope for this generation?

Chipo: Oh, we are going to die. I think most of us won't reach 50. Since AIDS, the average age for women in Zimbabwe is 33. Before it was 60.

Florence said with more education, rates of HIV will subside, and "stability will reign just like in Europe."

Chipo: But economic conditions will also impact on AIDS because when I am hungry I will look for someone to provide for me and that someone....

Emma: Also they (Western countries) can afford the drugs and the rate at which AIDS is multiplying is much lower than here. So poverty is contributing a lot in African countries.

Thandi: We still have a long way to go.

The female nurses see a change in men's behavior: more people are returning to the area for terminal, home-based care. There is less activity around the growth points (new towns) late at night, "because people are fearing" (Blessing). They also stressed that AIDS needs to be brought out into the open so that eventually the stigma would be removed.

These nurses stressed the danger young girls are facing as older men are "searching for the AIDS free generation." Therefore, Noline pointed out the need for early sexual education, before the age of 10. "So maybe if we could have some discussions with our children, even though we have these boundaries in our culture that we cannot talk of sexual things with our child, but we need to bring

a change and to make our children aware of these issues."

The male nurses see change only in people who are educated. Muniya reported, "If you go to the areas were people are not educated then nothing changes," or at best "only a slight change." The men do see a difference in males resisting more the advances of prostitutes in beer halls and think statistics will go down as those who understand will live (be HIV negative). Benjamin stressed, "Change is very difficult," and what is important is openness. Trymore said the topic has to be overemphasized, that people should disclose their status, and go on to educate others. He also stressed that condoms are seen as encouraging promiscuity and there is need to encourage abstinence and faithfulness. Muniya argued it was too late for such messages.

Trymore thought more fear would help yet the group said people are already afraid and not much is changing. When challenged he said people are afraid of HIV, but because of the indirect way it is talked about, the message is getting lost and the fear is circumvented. He suggested that government has an important role to play with enacting laws and in being clear in their AIDS messages. People that are "burnt" have to be the one to carry the message so others will listen and avoid the same fate, and this is more effective if the person is a public figure (Trymore).

Benjamin, a member of the AIDS committee, has carried out numerous

workshops at community level. He does not admit the education has been ineffective but "we are not addressing the real issues." Training, he stressed, has been too general in trying to meet everyone's needs and instead "we are not addressing individual community issues." The community needs to understand its own area problems. What good does it do, he said, to tell a "prostitute to leave the profession" if there are no alternatives.

Trymore: You give them projects. That's the problem with us here; we don't have alternatives. We talked about income-generating projects but if it's only one in a big community what can it do? Nothing.

Nxumalo: And only a few people benefit

Benjamin: The way we channel our resources is not the way to prevent it from spreading. You have the Ministry of Health and their budget. Where are they spending their budget? Talking, talking. Talking is not enough. Moving around with microphones is preventing HIV? It's not enough! The money is in the Wards (district divisions). No projects.... They hold meetings. What does a meeting leave in a community? That money should leave foundations, structures that continually maintain the teaching and life of that community.... When other money comes it builds on that foundation. There needs to be a satellite of people who understand prevention and who will continually address those (community) problems.

The group of women living positively with HIV had more superficial and rigid ideas for change. Margie and Tendai thought government should introduce a law that would imprison people practicing prostitution or adultery. At very least, they said, prostitutes should be sent to work on large farms where they would have no time for beer halls. Mirriam though that checking girls for virginity should be reinstated and if found not to be, the girl and her sexual partner should be sent to prison. They all agreed with Merriam that without laws controlling promiscuity "people would never change their sexual behavior."

For such a diverse group of participants there was much agreement and understanding of the challenges people face in addressing HIV/AIDS prevention. It appears that momentum for change is strongly influenced by culture, economics, education level, and traditional practices, especially concerning roles, rights, and expected behaviors of both men and women.

A second narrative review again focused on the eleven key participants through a search of their edited interviews with codes representing the variables in Pender's Health Promotion Model introduced in chapter 1 (see Figure 1). The purpose was to assess the usefulness of this model in further understanding women's participation in HIV prevention.

The Health Promotion Model

The Health Promotion Model (HPM) contains 10 determinants that provide a holistic and comprehensive guide for analyzing individual and environmental factors that influence health promoting behavior and outcomes. Explanations in this section have been taken from the fourth edition of "Health Promotion in Nursing Practice" (Pender, Murdaugh, & Parsons, 2002) but the model itself has not changed.

Although the study was not aimed at testing the HPM variables, this analysis provides a different approach to the previous discussion that centered on the research questions. Each variable was assigned a code word in the Ethnograph (Appendix L). The interviews of the key participants were first edited and compiled into one file for each. Single and multiple searches were done for each variable across all eleven files.

Individual Characteristics and Experiences

"Each person has unique personal characteristics and experiences that affect subsequent actions" (Pender et al., 2002, p. 68). The particular factors assessed will depend on the actual target behavior. Although health promotion and quality of life is the overriding concern for the population, this study focused on the context of HIV prevention. Since HIV transmission is mainly

linked to heterosexual intercourse, prevention involves practicing safe sex. Safe sex involves refusing unsafe sexual encounters or practices, or insisting on the use of a male or female condom. However, HIV prevention is much more complex and many factors are involved.

1. *Prior related behavior.* "The best predictor of behavior is the frequency of the same or similar behavior in the past" (p. 68).

Since none of the women admitted to previous use of condoms or insistence on other protective measures in their sexual relationships, this area was expanded to include any previous attempts to exhibit autonomous behaviors or forms of social or interpersonal resistance. Overall there was little indication of this. Sinikwe explained how she successfully refused to allow her husband to wake her and the children up to entertain him when he came home drunk. Others who talked about resistance were punished, or did it in the future tense as something they or others should or would do, sometimes in relation to insisting on condom use.

2. *Personal factors.* Biological (e.g., age, physical strength, and developmental status, i.e. puberty, menopause); psychological (e.g., self-esteem, motivation, perceived health status); and sociocultural (e.g., race, ethnicity, education, socioeconomic status). Each aspect was coded separately.

(a) *Biological* factors included women's physical health, with major barriers

to prevention related to factors of gender, age, violence, and nutrition. Stress and hard physical labor were also mentioned. If one is not in a healthy state it is more difficult to be concerned about health promotion or to achieve one's potential. "I think for human beings to be as we are, we must be healthy, to be free" (Shooria). Age is implicated with young girls involved in sexual relationships, often with older boys or men who are accepted as the authority. Females are under societal pressure to continue reproducing often without much birth spacing, and violence and poverty including lack of food, have far reaching health consequences for both women and their children.

(b) *Psychological* factors included aspects of personality that influence health. There is considerable intentional and early socialization around what is acceptable behavior for females. Appropriate female characteristics mentioned were being generous, obedient, quiet, uncomplaining, not expressing or showing one's feelings or disappointments, and innocence in sexual matters.

There are many influences on woman's self-esteem. Treatment by husbands, in-laws, and other relatives can be abusive with a constant fear of doing something wrong. Even when they do something right there is little or no appreciation. "You could do something good but the boy's aunt would say it was wrong. Daughters-in-law are not allowed to make a mistake. They used to say it was better to send me home and get their lobola back than to keep me" (Rose).

Others described this lack of approval no matter how hard they worked. "Men force women to work very hard and never give them anything as a way of appreciation" (Makanyi). Self-esteem is also related to ability to acquire assets. "Men do not want women to own anything. Mostly this is common in my area; men refuse to do anything that would give women recognition." Having to kneel down when addressing men and continually begging for food or money can only have a negative impact on psychological health. With little money for soap to properly wash clothes and bodies, walking barefoot, and wearing ragged clothes does nothing to improve one's self-esteem. Always waiting for others to make decisions, having good ideas but not being taken seriously, and having to live with unpopular decisions is demeaning.

Self-esteem is related to social identity and for women is mainly achieved through child bearing. "Having children is important because you would be recognized in the society as a real man or woman. If you don't have a child you would not have an identity" (Sylia). One's state of happiness is tied to ability to conceive and deliver a healthy baby, but more specifically a boy. Women continue to wonder why they are unable to satisfy their husbands no matter what they do. Shooria tries to keep up to the many demands of extended family, "But I am failing." Makanyi told of how her husband sets impossible expectations for fieldwork and then calls her lazy if she objects to the amount of

work.

The local high school does not encourage girls who become pregnant to continue their education or to return later, as they are seen as negative role models. Failure to graduate leads to lowered self-esteem and fewer employment opportunities. With the low self-esteem and depressed mood resulting from the control, expectations, and burdens placed on women, it is not surprising that motivation to participate in HIV/AIDS prevention is low or nonexistent.

(c) *Sociocultural* aspects dominated and were subdivided into four areas.

(i) *Health belief and practices.* A few asserted they never use traditional systems, often because their parent's did not. These feel that people who use N'angas are wasting their money and those who do not are healthier. Some are afraid of them, and yet as health care resources become scarcer it may be that people will resort to more traditional methods. As Vision noted, "It is not only AIDS which kills people, even malaria, because we don't have enough drugs. Our country is poor. We go to the hospital and they say we have only Panadol (acetaminophen). Can Panadol cure malaria?" The majority use N'angas to some extent, some for first line treatment, all using the hospital for certain illnesses, and most have chosen to come to the hospital for delivery. Sylia's father and Prisca's husband are N'angas, but they use both systems. A few described at least one personal possession or bewitching experience and do not see these as

unusual. Traditional beliefs appear to encourage denial of the dangers of HIV and this is supported by cultural understandings of disease and illness. The concept of germs and viruses is very difficult to comprehend and does not fit with previous beliefs and experiences of causation, for example, unhappy ancestors or bewitching that have been "cured" in the past by traditional methods.

(ii) *Religion.* Religious practices include institutionalized church and traditional beliefs, with both influencing health-seeking behavior. There are various sects of Christianity in the area and some discourage or forbid members from using the "unholy" medicines of the hospital or clinics. These are often the same ones that permit polygamy, prohibit family planning, and arrange marriages of older men to very young girls, especially if the girls are no longer found to be virgins.

With their generally unhappy lives, some see religion as eventually providing some peace. Makanyi said religion is good because, "When you die you will live a good life in heaven." Others do not attend church for various reasons. Some brought up in strict traditional ways were never exposed to formal religion, while others say the church expects too much financial commitment.

The churches have been preaching against adultery, prostitution, and

promiscuity while promoting abstinence before marriage. Fear of retribution, lifelong poverty, and promise of eternal life if one behaves are messages used by these churches to control behavior and encourage change. Some churches are taking a proactive role by teaching women "how to behave well in bed," and a few have reduced the period of abstinence following childbirth. (Sinikwe). While this reduction may be positive, without access to other family planning methods, women are at risk for early pregnancy if they rely solely on lactation to prevent ovulation.

Chipo found the church's absolute message does not take into consideration individual needs or realities. It seems that mostly women are responding to the message of faithfulness in marriage. Some ministers and church leaders are not "practicing what they are preaching" and therefore lose further credibility.

(iii) *Education.* Education for girls in the Mt. Selinda area has historically been a lower priority than for boys, and many young women in the area have never gone to school. All key participants thought that education is the key to a better life. Education for today is now seen more of a family asset than a liability, especially as fathers are charging higher lobola prices that reflect their daughter's education level. There appears to be a demand for educated women, where previously one with little or no education was preferred since she only needed to

be obedient, industrious, and strong enough to work hard in the home and the fields.

Many Ndau families are moving from subsistence existence to one based on a market economy and there is need for more income to survive, and keep up to rampant inflation. Still, several noted men's lack of support to have children in school, so women are left with the responsibility of finding school fees and other associated costs such as books and uniforms. Enrollment at the secondary school in Mt. Selinda includes nearly equal proportion of boys and girls, but likely more girls than boys will drop out for various reasons. For those who do finish, there is much competition for university and college seats. If one does not know someone with connections or is not willing to "barter" for a position (usually sexual), these are nearly impossible to acquire. Unemployment rates of 70% make it even more difficult as competition for scarce jobs increases.

(iv) *Gender.* The various narrations clearly portray the presence of extensive systemic inequality between males and females that is a major part of a lifespan socialization process. Both men and woman expressed the difference in value between boy and girl children. Shooria has one daughter and wants another. When asked how girls are important she replied that the younger one would have someone to go to when she is hurt.

Researcher. Don't they have any other importance?

Shooria. Ah, no.

During childhood boys were seen as having much more freedom to play and go to school. As adults, even if a few men choose to help out in the house, they are considered bewitched and under the control of their wives.

Behavior-Specific Cognitions and Affect

Pender stressed that these variables have "major motivational significance" and "constitute a critical core for intervention because they are subject to modification through nursing actions" (p. 69).

3. Perceived benefits of action. "One's plan to engage in a particular behavior is proposed as hinging on the anticipated benefits or outcomes" (p. 69).

Although most were aware of the sexual transmission of HIV/AIDS, they also were generally resigned to whatever would happen. The one thing that might be considered a benefit to action would be attachment to their children and the desire to remain in a healthy state in order to care for them. On the other hand, offspring also appear to act as a barrier to action, as women generally want to remain in the marriage at whatever cost. If divorced they may not have access to the children and do not trust that the husband will care for them properly if left behind. There are also financial or other barriers that block access to legal services.

4. *Perceived barriers to action.* Barriers can be "imagined or real" and are "viewed as blocks, hurdles, or personal costs of undertaking a particular behavior" (p. 70).

Barriers to safe sex, including condom use, are high. First, there are many misconceptions about the safety and effectiveness of condoms and their strong links to prostitution. Second, is the constant threat of beatings, of being sent "home" (to parents), or both. Third, is the lack of communication between husband and wife enhanced by the latter's subservient position and other societal norms. Since a woman's role is marriage, divorce brings shame and loss of community status, not only for the woman, but also her family of origin. There are many other repercussions to divorce involving lobola repayment, custody and care of children, and even greater poverty.

Girls have traditionally been expected to have only one boyfriend whom they would eventually marry. If later discovered he was not suitable, "you were not allowed to leave him" (Rose). The repercussions are that the female has little bargaining power when it comes to insisting on abstinence, safe sex practices, or a violence-free relationship. The boy only has to threaten to leave and she would face the wrath of family and community. For youth attending school today the restrictions may be less, while the increasing pressure of economic factors may be canceling out any possible benefits.

5. *Perceived self-efficacy.* This is not necessarily one's actual skill level, but the belief that one has the ability or proficiency to execute the behavior. Self-efficacy is based on four types of information: (a) previous success, either self-rated or provided externally; (b) observing others and their outcomes (vicarious experience); (c) encouragement or persuasion by others that one is capable; and (d) one's physiological state—for example, apprehension, fear, and composure.

From the narratives it is clear that most of this information pertaining to safe sex is absent or is negative in the women's lives. Only a few saw any way of resisting, and this would probably mean the end of the marriage. Rudu reported that her friends are afraid of HIV but that they are more afraid to tell their husbands to get checked and to use condoms, as they would be called a prostitute and be beaten. In her own situation she said, "But myself, I am not afraid to tell him. He is very harsh but if you don't become very harsh you will die." Rose talked about testing and said, "Men refuse, but women must say it and ask them to use condoms. I would tell him if he loves me he should do that for I would be afraid of the disease." It is difficult to know if she really would carry this out. If she was sure he was HIV positive and she was negative Rose added, "I would refuse to have sex without condoms. I would tell him that he is not supposed to kill me." Makanyi, who only wants to have two children in order to be able to provide for them, says she will take steps to prevent further

pregnancies, even though her husband is against family planning and would beat her if he knew she was using anything. "I will hide the pills and continue to take them secretly. Even if he asks me I would deny anything about prevention." The only other one in the key participants group to say they would attempt a change was Sylia, who says her husband so far has only threatened to beat her, but "For him to beat me he would have to be very strong. Ah, you would die if you don't fight back." She also said if she knew her husband was HIV positive she would be firm. "I won't accept to have sex with him. I would prefer divorcing. Ah, no, I would divorce. Even my parents would support me." Support from their family of origin appears to be critical in decisions to leave, and it is not clear how many women have that backing. In spite of the generally negative and fearful environment surrounding these women, and the barriers to health promotion and illness prevention, several see themselves as able to resist, and that is an important step towards greater self-efficacy.

6. *Activity-related effect.* Positive and negative feelings stimulated prior to, during, or following a behavior that impact on both initial action and long-term maintenance of the behavior. These emotions are retained in memory and linked to ensuing thoughts of repeating that behavior. Pender included three components as "emotional arousal to the action itself (act related), the self acting (self-related), or the environment in which the action takes place (context

related)" (p. 71).

None of the women admitted to trying the behaviors, only what they might do if deemed necessary. The very thought of attempting a change brought out expressions of hopelessness based on past experiences with less controversial topics. In their position of unequal power and previous negative consequences of attempting new behaviors, it is not surprising they rarely, if ever, attempt to protect themselves from HIV. Vision stated, "That's why I say an Ndau woman is sort of a slave. After that hard working you have no word, no say." Slaves are not in a position to negotiate with their masters.

7. *Interpersonal influence.* The individual's rating of the opinions, whether real or imagined, of other people including health care providers. "Interpersonal influences include norms (expectations of significant others), social support (instrumental and emotional encouragement), and modeling (vicarious learning through observing others)." Pender et al. (2002) added, "Some cultures may place more emphasis on interpersonal influences than others" (p. 72).

Interpersonal influences appear to play a major role in these women's lives and their ability to make changes. There are few positive role models of women who have made a break from tradition. Those that do are partially or totally outcast and made to feel they are to blame for the failed relationship. The societal message is clear that choosing to be single or divorced is abnormal.

Influences begin at birth with women's conformity guarded by many. Parents and brothers watch out for daughters and sisters, extended family and surrounding community are involved, and then husbands and in-laws take over. N'angas or church leaders provide further regulation. It is as if women are seen as needing constant protection from their sexual desires and any resulting wanton behaviors.

8. *Situational influence.* This refers to an individual's perception of the setting where the behavior will take place, and includes available choices, safety issues, reassurances, etc. Situational expectations set "demand characteristics" that provide cues to action or inaction.

For the most part, expressed perceptions were that few if any choices exist, they must accept the way things are, and make the best of it. "Women are harassed, insulted, and forced to do things against their will, but they have no choice because we don't know how to get out of it."(Thandiwe). It is understood that for many women the environment is viewed as extremely threatening and unsafe, thus reinforcing the considerable pressure to conform to the heavy demands and expectations of being female. The situational "cues" are strong but they support inaction and compliance, not change and resistance.

9. *Commitment to a plan of action.* Commitment is the beginning for action, unless demands or preferences have a stronger influence than the variables that

might lead to that commitment. Commitment includes having a clear established plan, and specific strategies for carrying out the plan. Rewards are considered important.

Two women stated they would challenge their husbands but have only a very tentative plan. Rose did mention how she would talk to her husband so he would not get angry. However, these women have little support in strategizing, or few chances of receiving reinforcement or tangible benefits. If they were able to be successful, it would likely bring about internal rewards such as increased sense of autonomy, empowerment, and self-efficacy that could possibly translate into other areas of life.

10. *Immediate competing demands and preferences.* These are "alternative behaviors that intrude into consciousness as possible courses of action immediately prior to the intended occurrence of a planned health-promoting behavior" (p. 73). *Competing demands* are seen as mainly outside the control of a person and may have negative consequences if ignored. *Competing preferences* are "last minute urges"; other options that are strongly reinforced. Both of these may sabotage one's commitment if unable to refuse or resist.

Although not possible to assess this factor in the model, it is likely that competing demands could easily interfere with commitment to a plan for these women. Females are allowed little freedom to care for themselves, are fatigued,

and constantly bombarded with demands from children, husbands, and in-laws. Socialization of obedience and subservience makes it difficult for them to refuse a competing demand. Competing preferences may be the desire to be safe in the present, with any risk of HIV infection a vague and distant threat.

Behavioral Outcome

A behavior outcome is the "endpoint" of behavior "ultimately directed toward attaining positive health outcomes..." with actions leading to "improved health, enhanced functional ability, and better quality of life" (Pender et al., 2002, p. 74).

The barriers for these women to attain a more positive health status and higher quality of life are many, while there appear to be few facilitating factors to compensate. The Health Promotion Model is likely more appropriate for individual assessments. Although it takes into consideration the person's environment, it is missing a deep assessment of other environmental and interactive influences. These include broader contextual issues that may impact directly or indirectly on health promotion and may be the reason the HPM has not been classified as an ecological model. The stories in this research have pointed out a complexity that goes beyond the immediate area of Mt. Selinda, and there are national and international influences that need to be considered in

an ecological analysis.

Summary

This chapter offered a partial snapshot of Ndau culture in the Mt. Selinda area at a particular time, in response to the research questions. The voices of the participants were heard through their narratives and these were compiled from multiple searches of coded interviews in The Ethnograph. The lives of 11 women were first briefly portrayed, with further cultural, traditional, and societal data obtained from the key participant, key informant, and focus group interviews. A diversity of backgrounds, education, and experiences was incorporated, resulting in many viewpoints and considerable verification of the lives of women and men, and the reality of the HIV/AIDS epidemic in the area. As well, the application of the Health Promotion Model further focused the discussion.

With few exceptions there are pervasive feelings of helplessness and hopelessness in the present lives of the women and for any improvement in the rate of HIV infection. The Ndau people are extremely patient, as reflected in their response to a terrifying challenge that few are able or willing to entirely face at this time. Other societal forces beyond the community reinforce this response and limit their ability to change what is occurring. Chapter 5 presents an analysis of these findings of Ndau women, health, and HIV prevention.

CHAPTER 5
REFLECTIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to explore and describe cultural and contextual factors that may facilitate or hinder female participation in health promotion, especially relating to HIV prevention in the Mt. Selinda area of rural Zimbabwe. An ethnographic, qualitative process was undertaken using individual and focus group interviews and participant observation. A total of 38 females and 10 males contributed. After working in the area as a nurse educator for the preceding year, the researcher was known in the community, and most people approached were eager to take part. Two local women acted as gatekeepers to facilitate contact with certain groups and individuals, and a research assistant was hired to carry out several interviews in the local language ChiNdau, and translate them into English. Carrinah lived with the researcher for 5 of the 13 weeks of data collection and assisted in cultural interpretations.

While much has been written about women, health, and HIV in Africa, there has been little research in rural Zimbabwe and no known health studies on the Ndau people of this area. The majority of HIV studies carried out in the country have been Knowledge, Attitude, and Behavior surveys with limited qualitative investigation. There have been numerous calls in the field of international health for localized, contextual research to help in understanding

the unique factors inherent in different cultures. This has been particularly important in light of the failure of generic HIV prevention programs to stem the rising rates of HIV and AIDS in most parts of the developing world. The researcher thought that it was critical to hear from the people of the community to help understand their reality, strengths, and challenges in everyday life, and the impact of these and other factors on health promotion. Although the main focus of this study was women, it became clear during data collection that it was also necessary to hear from men. They play a critical role in maintenance of culture and tradition, which significantly impacts the lives and health of women. As noted in chapter 3, the study was guided by an ecological approach that "focuses on the nature of people's transactions with their physical and sociocultural surroundings" (Sallis & Owen, 1997, p. 403).

Women and men participated with surprising openness and enthusiasm, a few walking for 2 to 3 hours to take part in an interview, sometimes with a baby on their back. The women's resilience, strength, and sense of humor in the face of seemingly insurmountable barriers to health and quality of life continued to amaze the researcher.

Narratives

Through the use of focused, open-ended questions, participants were

encouraged to discuss their experiences and perceptions of health promotion and HIV prevention, in order to answer the main research question. Together, their responses formed a story or personal narrative through which, according to Riessman (1993), "individuals construct past events and actions ... to claim identities and construct lives" (p. 2). By forming narratives people can begin to make sense of their situation, "especially true of difficult life transitions and trauma" (p. 4). "Studying narratives is additionally useful for what they reveal about social life—culture speaks itself through an individual's story" (p. 5). Throughout this study the researcher listened to and recorded the voices of the participants through their stories. The following study narrative is the researcher's interpretation of what those voices might mean in their particular context, while examining historic and present day realities. It begins with the predominant theme that emerged from all the stories.

Discussion of Findings

The recurring dominant reality has been clearly voiced as women's oppression and is the major factor that influences participation in health promotion and specifically HIV prevention. *The Concise Oxford Dictionary* (1990) defines oppression as (1) the act of an instance of oppressing (oppress: to keep in subservience by coercion, govern or treat harshly or with cruel injustice); (2)

Prolonged harsh or cruel treatment or control; and (3) Mental distress. Isasi-Diaz (1996), who called oppression "the everyday experience of injustice," quoted Iris Young's explanation of oppression as "systemic constraints that are embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules, and the collective consequences of following those rules" (p. 19). The opposite of oppression is justice, which "has to do with right relationships, relationships that respect, empower, promote, uphold, and care ... not only of personal relationships but also the web of multiple relationships that constitute and define society" (p. 18).

All participants who described women's lives used either a direct reference to oppression, or related words and expressions such as *suffering, subordinate, always under the husband, men's domination, submissive, women don't have much power, men have power over women, exploitation of women, women's rights stripped away, control,* and *cruelty.* In other words, Ndau women are clearly in unequal relationships with men. Women can also be involved in oppressing other women and girls, often based on inequality in socioeconomic status. The employer-employee relationship was not explored in this study, but mothers and female members of the husband's family, especially the mother-in-law, are in many instances implicated in oppression of the new wife. Women also criticize other females who do not meet the expected standards for household management, are

considered lazy, or attempt to bring about changes in gender relationships or norms for female behavior. These are important considerations that help sustain female subordination. However, the focus here is on aspects of gender equality, or rather inequality, identified through acts of male oppression that are strongly implicated in HIV prevention. This will be discussed under the two major headings of Socio-Cultural and Economic Inequality.

Factors of Socio-Cultural Inequality

Participants described various factors in Ndau culture that support unequal relationships between men and women and increase the risk of HIV transmission. Some are traditional practices; others are social situations or beliefs that have developed and been integrated through social change. Overall, in the patriarchal system the male is head of the household and women are subservient even to young boys. This family or kinship system has not been lost to modernization, and new forms of subordination may have arisen over time.

Specific Practices

The deep-rooted practice of lobola is intended to be a symbol of family unity that has evolved to signify the ownership of a woman by her husband, and has become highly commercialized. The threat of their families having to repay

lobola if the marriage breaks up discourages women from leaving the relationship no matter how abusive. Wife inheritance, where a dead husband's brother "inherits" the widow and all the family's belongings, possibly no longer serves its original purpose of protecting the woman who would have no other means of support in previous times. Many families selfishly take all their sons or brother's property, leaving the widow with no assets. There are practices of marrying very young girls to older men. Some fathers sell their daughters when very young, and at adolescence the young women become new wives in a polygamous marriage. Even if that is not as common today, and this is difficult to determine, there are newer forms where parents are enabling their daughter's sexual involvement with older men if they can provide gifts or money for the household.

Polygamy itself is still evident in this rural area as well as among the educated and urban wealthy. While it can have a protective effect if the man is faithful within the marriage compound, as practiced today it is often much more casual and secretive, providing less monitoring of the partner's behavior. Men are also known to treat each wife differently, thus setting up unequal relationships between the women and increasing competition for the husband's attention.

The Institution of Marriage

The very purpose of marriage in Ndau culture appears more an economic and social contract between two families and not necessarily a relationship involving love and commitment. It is seen as financial and social protection for dependent women who are then expected to provide labor and children for the husband's family. Men are also viewed as having strong sex drives that must be satisfied with little waiting between liaisons, and it is generally believed that one woman can rarely provide this satisfaction. Therefore, in spite of the legal and religious exhortations against polygamy and adultery, there is tacit approval of men's freedom to seek frequent social and sexual fulfillment. The social aspect is met mainly with male friends and often involves alcohol, while girlfriends or prostitutes fulfill sexual desires outside of marriage. Males are under pressure from peers to prove they are head of the family and are expected to spend spare time with these friends, often in beer halls. This pressure is reflected in the way they treat or mistreat their wives and how they control family decision making. The clear separation of men and women's social life (the latter being very limited) results in poor patterns of communication that are usually one-way. For many couples it is the man giving orders and the woman remaining silent. Women are not expected to complain, argue, or offer ideas. Females enter marriage as the outsider of the family and, depending on the family, some never

feel they really belong (Getecha & Chipilca, 1995, p. 148).

Reproductive and sexual practices are strongly regulated within the socio-cultural environment, which places both responsibility for proper behavior and condemnation for deviant behavior on women. Because little was written about Ndau history prior to the colonist period it is difficult to establish the exact status of women in these traditional societies. For Zimbabwe in general, Cawthorne (1999) argued that women were more valued for their input, had some power, especially as grandmothers, were able to own some land that was granted at the time of marriage, and received part of any lobola payments when daughters married (p. 57).

Legal Institutions

Both men and women in the study used the expression "the culture says..." to support the present inequitable practices between men and women. In Zimbabwe much of this refers to the social and cultural norms that have been incorporated into the legal system. Laws began to be formalized by the former colonialist governments to maintain order, while controlling the lives of the Blacks and offering economic and protection for the Whites. The colonists wrote laws that reflected their social set-up and worldview, which did not necessarily match that of the local people. May (1987) described how the idea of equality has

been part of Western culture for 3 centuries and how this is now written into international conventions. Women's rights are seen as human rights. These beliefs have resulted in conflict when nationalities strive to maintain traditional systems that may run counter to ideas of gender equality. Cries of imperialism and Western imposition are heard when outsiders attempt to change customs. Even when laws are in place to uphold human rights, the social aspect can interfere. As May wrote, "It is an essay in legal futility to secure constitutional rights and freedoms to women generally and yet to leave a male tyrant in the home with total control over the wife economically, socially, and physically as well" (p. 26).

The development of customary laws based on tradition needs to be questioned. Before the colonists arrived, the indigenous people had their own system of social protection and control. Gradually, the colonists wrote these traditional laws into customary law, versus the externally imposed government statute laws. For Blacks, then, two forms of justice existed depending on the crime, and at times the two were in conflict. Today, men rely on customary law to uphold their social position as the leaders in family and social life—which is to say their desire to maintain power and control over women's lives.

May (1987) offered an interpretation of how these interests came to be enshrined in the legal system and helped explain how they have resisted social

change. She asserted that the very event of writing down oral tradition resulted in inevitable changes to original meaning. Indigenous law was flexible, negotiated, and based on consensus. Once removed from the social context those processes lost much of their original meaning and intent, and in fact were hardly recognizable. May also charged that local chiefs had been losing influence, and were not averse to having some judicial power restored through customary law. With churches pushing for more gender equality, and male oppression increasing at the hands of the colonialists, male power bases were threatened and men increased their control of women. Since it was male opinions and views that were solicited by the colonists, it was their interests that were preserved into customary law. Ranger (in May, 1987) went further to more fully implicate colonial governments in the development of customary law.

> The most far-reaching inventions of tradition in colonial Africa took place when the Europeans believed themselves to be respecting age-old African custom. What were called customary law, customary land-rights, customary political structure and so on were in fact all invented by colonial codification. (p. 28)

These laws are used to support and maintain a system of inequality 100 years later. Any resistance, then, is seen as an affront to culture and tradition, and may even imply lack of respect for the ancestors.

When laws are enacted that offer some protection for women they are still interpreted within a male-controlled judiciary and open to some degree of

personal interpretation (May, 1987). With the many influences on customary law it is difficult to determine what actually has changed for women. Another consideration is that many women, especially those who live in rural areas or are illiterate, do not recognize their rights regarding laws implemented since independence. These rulings themselves are questionable and Cawthorne (1999) asserted the government of independence has "not fulfilled its commitment to women's advancement and empowerment" (p. 55). The 1982 Legal Age of Majority Act allowed women at age 18 to sign contracts, be married without a guardian's consent, own property, and be caretakers for their children. This law caused considerable backlash as a threat to tradition, and the president reassured dissenters that it was in place mainly to provide Black women with a vote.

Although there have been other improvements regarding women's legal rights since 1980, studies have shown that most women do not benefit from them for various reasons (Cawthorne, 1999, p. 56). These could include ignorance of the newer laws, and therefore they remain minors under customary law, or they do not realize they are eligible for custody of children and maintenance payments in the case of divorce. Illiteracy, prohibitive distance from and lack of money to access legal services, and women's inability to move out of their community without permission from their husbands are other possible reasons. The 1981 Wages Legislation ensures equal pay for equal work, which has

benefited women who are able to find work in the formal sector. It does not include the many informal jobs seen as women's work, such as housemaids and piecework on commercial farms, often the only options for poorly educated women. As well, the law does not address the considerable amount of unremunerated work that women do to support the family.

The Colonial Period

Colonial invasion influenced most areas of social life of indigenous Zimbabweans. Land use was disrupted and people were relocated onto less fertile areas, while others lived and worked on large commercial farms. The introduction of taxes required men to do more than subsistence farming and changed the way goods and services were handled. The need to have money provided a much-needed work force for the colonial capitalist system concerned with supplying external markets. With not enough work in local areas, a migrant labor system was introduced. This resulted in disruption of usual family and kinship patterns of living and working, while encouraging promiscuity as husbands and wives spent long periods of time apart. This practice continues today as men seek employment in larger towns and surrounding countries. A major effect of men working away for long periods was the increase in women's workload to manage the household, fields, and animals. Another major

disruption was when tribes were divided such as happened to the Ndau when the boundaries between Mozambique and Southern Rhodesia were established. This separated families and kinship units, and people in the two areas began to develop different histories

Cawthorne (1999) wrote that even with divergent views in the literature regarding women's social status before colonization, there is agreement that "Colonization drastically changed African economy, social relations, gender relations, and labour. For women especially, whatever power and prestige they had before this point was taken away" (p. 58). She discussed an analysis by Schmidt of Black women and colonialism and concluded that "African and European structures of patriarchy reinforced and transformed each other resulting in the development of new forms of oppression" (p. 59). Colonial governments changed women's roles and status through the criminalizing of beer brewing. This resulted in a loss of income and status, as beer is an important element in traditional rituals. The introduction of Western clothes and other products arrived with the message that local dress and handicrafts were inferior (p. 59). More money was needed to buy these products perceived as better than their own, and this increased the available labor force for colonial businesses.

Religious Institutions

Churches are another important social organization, established in the area over the last 120 years. Several people in the study viewed the church as having brought the area into the modern age, especially regarding health care and education. On the other hand, this has resulted in some conflict and competition with traditional beliefs and practices that still exists today. Cawthorne (1999) noted that missionaries removed traditional healers from mission property, thus reducing the importance of these positions held by both men and women. They encouraged hospital deliveries and Western treatments, thereby lowering the status of traditional midwives and other healers. By requiring children to attend school, the importance of grandmothers as cultural teachers was reduced. School fees were also needed, and since men were the only ones earning currency, women became more dependent on them.

Although the churches may have attempted to protect women from some abuse and control in the past, it seems there has been little if any questioning of gender inequality. Women are taking a more active role in the church, but men and women still sit apart during services and women kneel or curtsey when addressing male members. If mentioned at all, sermons continue to moralize the situation of HIV/AIDS or to instill fear, and female obedience is encouraged. The influence of culture and tradition and the violence and other abuse that women

experience appear to be unaddressed by the church, although church advocacy for women possibly was masked by the researcher's limited contact and language differences. However, the researcher's observations have noted a relatively conservative church concerned with growth and saving souls, while attempting to maintain schools and hospitals inherited in the 1970s when foreign mission boards left. This suggests little remaining energy for challenging the status quo of power and gender relations, or providing the creative, transforming leadership and action needed to make a difference in the AIDS epidemic. Brickner (1996) stressed that "the role of religion is not to keep people on their knees, it is to get them on their feet, self-empowered, secure, and independent" (p. 108). This does not appear to be happening.

Health Institutions

Health care introduced by the colonists had been centered in major cities with a strong focus on the tertiary level. Attempts to change this with rural development programs after independence brought many improvements to public health. These gains have unfortunately deteriorated since the mid-1980s due to severe mismanagement and corruption (F. Sithole, personal communication, 2002). The implementation of Structural Adjustment Programs has also negatively influenced spending on health, notably cutting into

preventive programs such as mobile childhood immunization clinics (Renfrew, 1992). In spite of the postindependence focus on outreach, health care budgets were still biased toward large centers. A few participants in this study spoke of the lack of community-based services, some with no contact with a village health worker, and living far from a clinic or hospital.

More recently the Ministry of Health and Child Welfare has been decentralizing much of its work. It is not clear that the necessary authority has accompanied the increased responsibility given to provincial and district levels. The ministry is still highly bureaucratic. Dr. Arjan, the medical superintendent at Mt. Selinda, described the complexity and slow pace of decision making, if it happens at all. The government attempts to maintain high international standards for training personnel, and the appropriateness of this in meeting priority health needs of a developing nation needs to be questioned. Policy makers in the well-developed capital city may forget that the majority of Zimbabweans reside in the rural areas, many without clean water or electricity, and will never have access to these central hospitals.

Nurse training is still focused on tertiary level care (major hospital-centered cure and rehabilitation) instead of a broader based primary health care model (PHC). While training curriculums claim to be based on concepts of PHC, there is little beyond a token recognition. Instead, PHC appears to be interpreted as

provision of care at the clinic level under a medical or biological model, with little focus on prevention.

There appears to have been little or no collaboration between Western-based and traditional health care. They exist side by side and provide different options for people seeking health, but their separation tends to encourage competition and even intra and interpersonal conflict. The status accorded N'angas and other healers by the formation of ZINATA has no doubt helped strengthen and improve the public image of this system that so many people still rely upon. Special trainings are sometimes provided for traditional healers, and possibly what is missing is supervision, more consistent guidelines for appropriate and quality interventions, and tighter regulation.

The first reported case of AIDS in Zimbabwe occurred in 1985, and 2 years later the government initiated the AIDS Prevention and Control Program. The early intentions and understanding of what was needed appears to be appropriate, but the increasing rates show that the plan was either flawed or was implemented in a haphazard way. The name has changed to the National AIDS Council (NAC) and it has been riddled with controversy concerning management of funds and ability to handle the crisis. Governments and NGOs are working on separate HIV/AIDS agendas, resulting in lack of integrated planning and implementation. Evaluation appears to be limited. Government

employees in Zimbabwe pay a certain percentage of their earnings as an AIDS levy. This is generally resented, as many in the Mt. Selinda area have not seen any positive results at the community or individual level. For example, home-based care volunteers trained by the hospital AIDS committee visit families who cannot afford a basic diet, let alone the recommended foods that would improve the nutritional status of the HIV affected family member. The volunteers have worked without any remuneration, gloves, soap, or even basic first aid supplies.

Modern health care in general has been instituted with little if any community level input. Services are provided to people within a medical model brought from the West and still requiring Western expertise to maintain it. Women as the primary care givers in family and community have not been involved, and part of the reason is their limited voice and lack of power or status.

Socio-cultural Change

Life for many of the people of Zimbabwe has changed dramatically over the past 100 years. The country has a well-developed and modern capital city, while many areas of the country are still lacking access to clean water and toilets. Life in rural Mt. Selinda has evolved more slowly. The difference between urban life and the subsistence farming existence within the catchment area is vast. There appears to be considerable resistance to new ideas here, making change a

more gradual process. Vision explained, "The change is there. But it comes slowly in the rural areas." Later she added, "So our culture is a difficult culture. If you try to introduce something, at times it will not succeed. They'll say, No that's not it, our forefathers used to do 1,2, 3, why are you telling us something else?"

Munro (1998) compared rural development efforts in Zimbabwe under the colonizers and the postindependent state. Increasing coercive and manipulative measures were introduced by earlier regimes to gain control of rural lands and people. Both governments, however, "found it difficult to penetrate and stabilize rural society" (p. 348) and the introduction of various programs tended to increase local conflict rather than build community. One strategy of governments to enter local society was to target women and youth for income generating programs. This only served to threaten the power and social control of men over these subordinate groups, and domination became more gendered than ever.

Summary of Socio-cultural Factors

Many traditional and cultural practices remain today and have a negative impact on socio-cultural equality between men and women. From a historical perspective, women's lives have become more devalued and marginalized through colonial and missionary influence. The power, importance, and strength

of local tradition shows that cultural change is difficult in spite of years of colonial and religious attempts to change people's basic beliefs. Still, it seems that it is more acceptable for men to change and adapt to new influences such as in behaviors and dress. Meanwhile, Getecha and Chipilca (1995) said, "women are seen as the custodians of this our culture and the culture is not seen as a dynamic thing which can be changed to suit the times" (p. 148). But life is changing and at increasing speed. Culture in the Mt. Selinda area has been changing, albeit slowly, but it appears to be in the direction of even less, not more, equality for women in general. Until this is challenged, then women, especially, will continue to be at high risk for HIV.

One hope for change lies with the youth currently attending school. Angeline presented a different picture of life for girls who are educated. As well, boys seem to be more open to the changing roles of men and women in the country, and she says they debate traditional practices. The boys say they will not be repeating what they see their fathers and other adults doing, and appear to recognize that girls are intelligent. Their relationships, according to Angeline, are more equal. It must be remembered that many students at the local high school come from different sections of the country, and this influence is important to modeling new ways of being male and female. The difficulty with this sign of progress is that more girls are dropping out of school due to family

pressures often related to AIDS, and this could set back any gains made by this socialization process. It is yet to be determined if these male assertions for more equal and respectful relationships will be maintained within strong cultural and traditional systems. More young people are leaving extended family groups and living in urban areas as a nuclear family. This may lessen the negative influences, while the supportive nature of the extended family is also reduced and has its own implications for health.

Factors of Economic Inequality

If social-cultural factors in context initiate and organize conditions for gender inequality, economic factors assist in strengthening and maintaining it. A few historical implications for the relationship between gender inequality and economics have already been discussed. For the majority of women in the Mt. Selinda region, poverty is a way of life, and there are few opportunities for escape. Males control most household assets and income while also controlling decisions on how it is to be spent, even if earned by women. Health promotion research has clearly identified a positive correlation between health and socio-economic status and the links with other determinants of health. Townson (1999) wrote, "Poverty may determine the type of housing a family has; lack of education may limit earning power; poverty and early childhood development

may limit the educational opportunities people have" (p. iv).

Postindependence

Zimbabwe at the time of Independence was relatively rich compared to other countries in the sub-Saharan region. Wealth, though, was mainly in the hands of Whites, who had been in control for nearly 100 years, and there was clear, economic discrimination based on race. With independence there appeared to be initial efforts by government to protect the inherited modern infrastructure, while moving to the formation of a more equitable, socialist state. These plans were laid out in the 1981 document *Growth with Equity* and were aimed at a "restructuring of the economic and social framework" (Renfrew, 1992, p. 11). This included reducing racial economic differences mainly through land distribution, but also ensuring increased prosperity through rural development programs. Major improvements in education and health status of indigenous people were achieved.

At the time of independence Whites were given many concessions in order to support the existing infrastructure and prevent mass exodus. Unfortunately, many colonist policies remained that diluted socialist intentions, and soon more nationalist directions took form (Dashwood, 2000). The land reform promises faded; members of the growing Black elite obtained large agricultural

concessions, and within a few years the focus on equity was weakened. Large expenditures on health and education were beginning to be cut in the early 1990s. Once again wealth was concentrated within a minority of Blacks and Whites. This new elite often represented members of the ruling party and their extended families. Meanwhile, the majority of people continued in their pre-independent state of poverty and underdevelopment. If some health and education services had reached them, these services gradually began to deteriorate. The exceptions were remote areas where missions continued to manage schools and hospitals with the support of overseas donors.

Structural Adjustment Programs

In 1991 the Zimbabwean government began to implement Economic Structural Adjustment Programs (ESAPs) according to the requirements of the World Bank and the International Monetary Fund (IMF) for further loans. Earlier attempts to introduce ESAPs failed when the dollar was devalued in 1982. Seeing the devastating effects on the poor, the government refused to continue. However, during the 1980s there had been high levels of borrowing for extensive social programs, and the debt was building. Borrowing continued in order to support further moves to a market economy. The only way to maintain credit was to introduce ESAPS. By the 1990s growth was still on the government's

agenda, while equity seemed to have disappeared (MacGarry, 1993).

ESAP conditions aim for expansion mainly through increasing exports and reducing government spending. The former is done through removing internal subsidies from food and agricultural products and thus making them less competitive, focusing on crops or other products for export rather than for local consumption, and devaluing currency to make exports cheaper. Policies are put in place to encourage investment, including prohibiting unions, lowering corporate taxes, and relaxing environmental controls. Reducing government spending usually involves major cuts to civil service employment and massive declines in social services, especially health and education. Studies from various countries under ESAPs have shown that poverty has not been alleviated and, in fact, is often worsened under these programs (Inter-Church Coalition on Africa, 1996). Government autonomy and sovereignty are also severely diminished, and economic control is more influenced by external agents and market forces.

The development theory of the "trickle-down effect" through increasing national wealth has proven to be ineffective all over the world (de la Barra, 1998). Economic globalization continues to concentrate wealth in fewer hands, often in transnational corporations, while more and more people move into poverty. This phenomenon has been called neo-colonialism and has major implications for health. Scambler and Higgs (1999) stated it is "core members of the capitalist

executive that supply the conditions necessary for the production and the reproduction of health inequalities" (p. 28).

Dashwood (1999) asserted that although ESAPs have led to deteriorating conditions in Zimbabwe, the ruling elite played a major role in determining the magnitude of the outcomes, while doing little or nothing to alleviate them. Instead, families and other community organizations have been expected to mitigate the effects of ESAPs. Now with AIDS overwhelming social and economic structures at all levels, this is becoming a much more difficult task. Munro (1998) wrote, "The tendency for structural adjustment to increase the precariousness of many rural livelihoods, and to exacerbate inequalities, makes it more likely to entrench, rather than reform the organizing principles of power in rural Zimbabwe" (p. 352).

The Feminization of Poverty

Globalization appears to be especially harmful to women's quality of life, and poverty is often seen as having a feminine face (Inter-Church Coalition on Africa, 1996). While poverty for the majority continues in Zimbabwe, the effects are not shared equally. This is because conditions of inequality are not the same for all people. Women throughout the world are at a greater disadvantage when it comes to economics. Being female, having little power, and being Black

increase gender disparities in health (Townson, 1999). Not only women but their children as well are deprived of even a minimum quality of life. The participant's stories clearly implicated lack of economic power or "muscle" as increasing the risk of HIV transmission. This is from the low status that comes with poverty, having few choices or opportunities for economic advancement, and continued dependence on men for survival of self and children. Poverty is seen as driving girls and women into unsafe sexual relationships. The concern for immediate survival overwhelms thoughts of risk and the future. One participant related that even married women forced to earn money to support the whole household may resort to selling sexual services in order to avoid a violent confrontation at home.

Work opportunities are limited, especially in the formal sector and more so in rural areas. It seems that surrounding farms rarely provide full time employment for women. Females are disadvantaged with the pressure to bear many children. The many and closely spaced pregnancies not only create conflict between paid work and childcare, but also affect their state of health. Large families were once encouraged for expanding the economic base of the family by assisting in production and providing social services in the parent's old age. With access to land an increasing challenge, and the expectations for children to be educated, they may now be more of an economic burden with increasing costs of school and health care. ESAPs, through subsidy removal and currency

devaluation, also reduce the buying power of already meager incomes. In the study area, it seems that women are shouldering the main responsibility for earning enough to provide basic needs for the family. Currency devaluation and high inflation are making it more impossible to do even that.

Recent Events

Other forces are at work in Zimbabwe with serious financial implications for the people. The past 2 years have been ones of escalating economic and political chaos as the government of independence does what ever it can to retain power. Political violence became endemic before the last two elections, especially the presidential election in March 2002. Many international observers reported the elections were not free and fair, with the ruling party reelected under suspicious circumstances. Retaining power was not enough, and in the period following, a campaign of revenge against perceived opposition has continued that is further disrupting the lives of many people and whole communities already affected by poverty and AIDS.

Men and women are both targeted, with women especially vulnerable, as rape is often part of these attacks. The usual mental and physical consequences of rape are enough to bear especially when there is little in the way of counseling and support. In a country with such a high prevalence of HIV the outcome can

be more serious. Land reforms that did not take place as planned after independence are now being "fast tracked," and over 5,000 of the 8,000 White-owned farms have or will soon be forcibly taken over, at times with farmers and their workers losing their lives. Hundreds of thousands of farm workers are being evicted and living as refugees in their own country. Other than the trauma of losing homes and work, their children's future is in jeopardy as the family sinks into poverty, and they are unable to return to school.

These large farms were the backbone of the agricultural sector. With major disruptions to planting and harvesting, along with a drought throughout the southern African region, the country is experiencing severe famine. No one disagrees that land reform is a critical issue for a more equitable country. It is the way it has been carried out with little benefit yet to the many landless and homeless people while creating a serious economic and social crisis. This is supported with token interventions and soft diplomacy from surrounding countries, and silence and generally weak and ineffective actions from the international community.

Summary of Economic Factors

Study participants stressed the importance of economic factors contributing to health promotion and HIV prevention. Economic status is

directly related to quality of life and health, and, although not the only measure, it often makes a more positive difference when it is higher than lower. Mt. Selinda is located in the far southeastern reaches of the country and considered isolated and remote by many. Much of the social change that has taken place, especially since independence, has not had a positive impact on the lives of many people. In fact, the whole Chipinge district has been somewhat ignored in social development plans. Without input from the missions, modern education and health care systems might still be lacking. When there was government input, issues of gender caused serious divisions between state and local interests. "While these faultlines may be traced to long-established patterns of social hierarchy, their current forms are a product of modern political interactions and shaped in response to socioeconomic change" (Munro, 1998, p. 355).

In spite of the apparent geographical and political isolation, the area is not immune to the various levels of economic forces at work, not only in the country but internationally as well. Policies and practices of politicians in the capital Harare and in other countries, sometimes carried out through such agencies as the World Bank, the IMF, or the World Trade Organization, have serious repercussions on quality of life throughout Zimbabwe. Very often it is the people who have the least to lose who suffer the most, and generally this means poor women and children. Decisions made by bureaucrats in New York, London,

Ottawa, or Geneva for example, do affect life for millions around the world. Meanwhile the rich of Zimbabwe get richer, often directly benefiting from those international decisions and resulting "development" programs. It seems the original intention of the Chimurenga (war of independence) that so many ordinary Zimbabweans fought so hard for, has long been forgotten in the national and international race for prosperity for a few.

Lessons From Primary Health Care.

The primary health care (PHC) movement was launched in 1978 in the former USSR at Alma Ata (later renamed Almaty, in the newly formed republic of Kazakhstan). Many people were beginning to realize the links between poverty and illness, and that "substantial improvements in health cannot be achieved without improvement of social and economic conditions" (Dhillon & Phillips, 1994, p. 1). The resulting document was radical for its time. Health came to be seen as a fundamental human right and serious global inequalities in health status became unacceptable. People's participation and intersectoral collaboration became cornerstones for more effective and appropriate health care (WHO, 1978).

There were numerous challenges to implementation. First-world countries thought that PHC was only for the developing world. Some developing countries

did succeed in reducing levels of morbidity and mortality. Unfortunately, in the ensuing years of the Alma Ata declaration, principles expected to lead to "Health for All" became weakened, as their implementation was haphazard and donor dependent. Public participation was threatening to health provider's control, and there was lack of integration that was needed for a comprehensive approach. The debt crisis and structural adjustment programs limited government's ability to improve health care. The move to a market economy has meant that health has also become a commodity and those who can afford to pay have access. More importantly, the wealthier countries found the economic implications too risky and backed off from changes that a more equitable global system would require them to make.

The health promotion movement has attempted to revitalize a Health for All strategy and focused on personal and environmental determinants of health. However, strong forces of globalization impact on many areas of health promotion and health service provision. The foundation has been laid for a more equitable and just world, but the political will is not yet there to see that it is given a chance to succeed. There are too many personal interests from individuals, governments, local, and transnational corporations to allow such a revolutionary agenda to take place. Until that happens it will be very difficult to effect long lasting change at community and individual levels.

The lessons learned from the experience of primary health care should act as a warning that such visionary changes are extremely risky and difficult to implement. Yet the work that has been done is a reminder of what is necessary. Committed individuals and organizations need to continue to work toward a vision of a world that integrates human rights, justice, and equity. HIV/AIDS is a global problem and as such requires global cooperation in the search for appropriate local solutions. Gender inequality and oppression are present in varying degrees throughout the world. International and regional women's conferences can be a starting point for far reaching changes and sources of support and empowerment for women worldwide. The Fourth World Conference on Women in 1995 produced the following statement. "Equality between women and men is a matter of human rights and a condition for social justice and is also a necessary and fundamental prerequisite for...development and peace" (CEDPA, 1996). There is a great need to unite in finding solutions to female inequality and its resulting oppression, solutions that will improve the lives of all women no matter where they reside.

National Level Challenges

Zimbabwe has one of the highest HIV/AIDS prevalence rates in the world. This is occurring in a time of great civil and political unrest. Poverty is

increasing, famine is spreading, and the most educated and skilled people are dying or emigrating for a better life. The government continues to cut funding for health care. Hospitals and equipment are in disrepair and health professionals are demoralized with few resources to work with. After agreeing to international covenants on gender equity the Zimbabwean constitution states that these do not have to be reflected in domestic statutes. It appears that instead of making progress, women are losing ground (Silvera House, 1999, p. 31). In this climate it is difficult to imagine how needed improvements regarding HIV/AIDS could take place. As more HIV positive people enter the AIDS phase of the syndrome it is tempting to use the limited resources for alleviation of suffering and not prevention.

Applicability of the Findings to Practice

This study explored the various factors and forces impacting health promotion and HIV prevention for women in the Mt. Selinda area of Zimbabwe only. Comparing results with studies of women in other African and developing countries shows many similarities in levels of oppression related to gender inequality. Many national and international forces affecting health and quality of life are also the same. The findings may therefore be beneficial to health workers in various parts of the world, especially those working cross-culturally. The

findings also reveal the way one traditional society approaches prevention and care, and how important it is to understand these for appropriate program planning.

The findings of this study, along with the analysis of historical and present-day realities that have influenced gender inequality, can assist health professionals understand the complexity of these relationships and how they have developed over time. This complexity means that simple interventions will probably not work. On one hand it might be easy to be discouraged by the findings, leading to hopelessness and apathy in finding solutions. Instead, the findings and analysis should be a starting point for seeing that what appear to be strongly entrenched gender roles and expectations, have evolved over time, and are able to be changed if only the right process can be found for each culture. Therefore, an important and potentially controversial proposition made here is that culture may not be as sacred as is generally accepted. Although a common expression is that "culture is dynamic," it appears a more accepted belief is that culture is not really open to change as people use it to defend or excuse inequality and oppression. This means, especially for those working in cross-cultural settings, that in the quest to be culturally sensitive they may in fact be perpetuating systems of inequality and therefore injustice.

Because of the pervasive nature of gender inequality, local implications

from this study may also be useful in other areas. Although there are many areas of intervention only a few will be highlighted, under the headings of education, health services, and development.

Education

Broad-based generic programs of HIV prevention do not appear to have made much difference to the Ndau people's attitudes and practices concerning HIV prevention, even if some knowledge is present. The messages of the government, NGOs, and some churches continue to be the same for everyone. There is a serious misconception among many, including health professionals, that providing "education" is all that is needed for people to change behavior or to comply. When this does not occur, the problem is often seen to be with the client. During the wait for more macrolevel improvements, the work at the grass roots needs to continue, as this is where the real change in the epidemic needs to be seen.

Recommendations for Change

Programming needs to move beyond individual approaches of prevention, to take into consideration the socio-cultural-and economic factors of people's lives. The reality for many Ndau women is that they have few choices, little voice,

almost no decision-making power, limited autonomy, are often in poverty, usually overworked and unappreciated, and subject to emotional, physical, and sexual cruelty. It most certainly appears to be a great need to move beyond packaged messages of faithfulness in marriage and condom use when women have little or no negotiating strength and are, in fact, enslaved in a subordinate position.

- Programs need to be culturally sensitive, while assisting people to question and explore entrenched patterns of injustice such as violence and abuse. Integrating gender analysis in any program of HIV prevention is a priority. Meanwhile, Vision, a key participant, stressed the need to first meet with men as nothing will change without their approval. With most programs targeting all people, the usual courtesies that men expect as a sign of respect are missing. As mentioned earlier, when this happened in the past with development focusing on women, inequalities increased and women's lives did not improve.
- There is need for increased cooperation and coordination between the many NGOs, including churches that are now working on separate programs. Absence of collaboration leads to gaps or duplication of services, and inconsistent and contradictory messages. The latter fuels the many misconceptions that abound.
- Prevention messages need to be developed in consideration of people's

traditional beliefs that so strongly influence their worldview and how they make sense of their lives and the problems they face.

- There is need to examine successful programs and continue their implementation. Targeted work with such groups as commercial sex workers, farm workers, and long-distance truckers has shown some degree of success. Such programs need to be strengthened and supported throughout the country without increasing stigmatization of certain groups.
- The need to strengthen and introduce early, appropriate reproductive health education in schools that includes gender role analysis, communication, and male-female relationships is critical. Peer education programs should be increased and enhanced. Teachers first need to be properly trained in more than didactic teaching. Ways must be found to reach out-of-school youth with similar programs. Education needs to include recognition of early sexual encounters, different sexual norms for males and females, and peer pressure, while providing strategies and options for diverse situations.
- Nurses and other health educators require training in principles of adult education and participatory methods of teaching and learning.

Health Services

The development of three separate systems of health care in the country

has provided choice but also induced conflict. Traditional, religious, and Western health care are well-established systems, but not always monitored for quality. With the lack of attention to primary prevention, especially regarding basic needs, people spend considerable time and money seeking treatment and cure. Women are often unable to access treatment for social or economic reasons and usually require their husband's permission for any intervention relating to reproduction.

Recommendations for Change

- Provide improved coverage where it is lacking. This includes having adequate numbers of village health workers (VHWs) trained and empowered to monitor the health of their communities and to provide first level prevention and care. VHWs require consistent supervision and support including supplies of basic resources. The provision of family planning services, including HIV counseling, should be integral.
- Increased training in HIV prevention is critical for all cadres of health providers to reduce the misinformation that is circulating.
- Women and men both need to have equal, appropriate, and confidential access to comprehensive and integrated health services, especially regarding STD treatment and voluntary HIV testing and counseling.

- There is a need to begin a dialogue among the three types of health care systems to increase mutual understanding. This would hopefully lead to collaboration and appropriate referral systems between them. This will not be easy with the low level of trust that exists, and the strength of people's beliefs about each system.

Community Development

HIV/AIDS has now been recognized by such international bodies as UNDP and UNAIDS as a development issue, and this helps move it from a narrow biomedical model focus to a more socio-cultural-economic one. This study has shown that these latter aspects of women's lives are severely affecting health promotion. It has also been noted that attempting to introduce rural development programs can lead to further oppression of women. Development is most often considered as increasing the economic base of individuals and communities. Poverty increases women's risk of participating in more casual and potentially unsafe sexual relationships for purposes of survival. Although economics are important to survival and health, and as AIDS continues to seriously impact economic development, the social and cultural aspects are also important. Some of these are freedom, safety, mutual respect, voice, employment, and recreation. Development requires a multisectoral approach so

that government departments, schools, churches, businesses, and health systems work together in promoting health and improving quality of life. Very often development is something that is done to a community with or without assessing or considering their interests and needs.

Recommendations for Change

- Community participation and ownership is critical for success: People must be involved from assessment and planning through to evaluation. Development programs should focus on gender and community empowerment. Sensitivity to existing power structures is needed while slowly moving toward more equitable ones. Capacity building is critical so people are able to participate at various levels when they feel capable.
- Development requires support through good governance at all levels, including enforceable laws to promote equity and protect vulnerable groups. Police, local chiefs, community leaders, and judges need training in gender equality and sensitive handling of domestic and sexual violence.
- Identification and training of leaders who will not abuse power is critical for successful programming. This management role requires ongoing support in many areas, and implies accountability and transparency. Effective leadership is necessary to help people move from apathy and fear to action and change.

- Development strategies necessitate an ecological approach in understanding and advocating for change and social justice at all levels of society.
- HIV/AIDS prevention and community development efforts and programs should be integrated for most effective results.

Education, health services, and development are mutually supporting areas for change. Obbo's (1990) words remind us of the importance of a gender justice focus in any attempt at change. "Development will occur when poverty is reduced, and the only way to reduce poverty is to reduce gender inequality" (p. 221). This may be a somewhat simplistic view, as it has been shown that poverty is influenced at many levels. However, with gender inequality removed at local and national levels women will have a fairer chance of participating in health promotion including HIV prevention, and in improving their quality of life.

Strengths and Limitations of the Study

Several aspects of this study may be considered limitations. The sampling was purposive and partly convenient due to the inadequate local infrastructure, such as roads and communication systems. Random sampling was not thought to be necessary in this type of study, yet an attempt was made to find a representative sample of women in the area. One limitation to the convenience

sampling may be to consider who was excluded. The key participants were either living close to the hospital or had traveled to the waiting mothers shelter to await delivery. Women who do not use hospital or clinic services may represent slightly different stories. As well, single unemployed mothers were also not included and, although thought to be a small percentage, may have offered different perspectives.

Language certainly imposes its own limitations. Women interviewed in English by the researcher were using a second language, which may have limited the depth of their narratives. Using a research assistant to carry out interviews in the local language has its drawbacks, as it is more difficult for the researcher to maintain similar standards throughout. Training and supervision of the assistant were included to ensure she understood the important aspects and aims of the study, and was able to facilitate individual and group interviews. The differences in the age and race of researcher and assistant may also have elicited different responses. It appears that local people are more trusting of foreigners to maintain confidentiality, and yet the women in both groups appeared to be open and honest. The researcher was present during explanations and signing of the consent forms when translations were needed. Any limitations to having a research assistant in this study were offset by her ability to interview the majority of the key participants in their native tongue, and to provide cultural

explanations to the expatriate researcher.

One strength was the use of several data collection processes. Although experiences of individual women were sought, the purpose was to better understand these experiences within the cultural context. As such, individual interviews provided privacy and confidentiality, while focus groups offered a forum for interpersonal interactions. The latter could induce responses that are perceived to be socially desirable to others in the group, while this can also happen with individual interviews. People construct their stories according to their individual memories, perceptions, and experiences, and there is usually a need to make an impression on the listener. The latter was not apparent, and participants appeared open and relaxed throughout the process.

Toward the end of the data collection period there appeared to be considerable saturation of information; thus, an adequate sample size was achieved, as was extra confirmation through focus group and key informant interviews. The study process remained flexible, and men were later included that helped in verification of women's experiences. Although few in number, they supported the gender role separation and division of labor and provided important understandings on beliefs and health practices.

The choice of qualitative method worked well in eliciting a certain depth of information that would not have been possible with more quantitative measures.

Using prearranged questionnaires would have limited both the amount and depth of information shared by the participants. The flexibility of a qualitative approach meant that different questions could be asked of different key informants, while attempting to retain some continuity. The informal, conversational setting encouraged a certain comfort level. Only one person appeared threatened by the questioning. All others seemed to be at ease with both the interviewers and the questions, with no indications of distress.

Because of the presidential elections in early March and the rising levels of violence, a temporary evacuation of the researcher to a neighboring country took place for 6 weeks. This disrupted the research plan and placed time restrictions to ensure data collection and translation were complete before leaving. This was important in the event a return to Zimbabwe was not possible. It may have compromised further recruitment, although saturation seemed to have taken place. One result was that most analysis had to wait until the data were collected, instead of a more integrated process of collection and analysis. This may have hindered exploration of new ideas during subsequent interviews.

Reflections on the Health Promotion Model

The Health Promotion Model appears to be a fairly comprehensive and flexible model (see Figure 1). There is a clear recognition that each person is

unique with different life experiences, and that these aspects strongly influence future actions. Pender (2002) suggested that the importance of the variables depends on the type of health promoting behavior being targeted allowing for different applications (p. 68). Several studies have shown that many of the variables have moderate to high strength in predicting health-promoting outcomes. Not all variables have been measured in every study, and Pender recommends further research, especially with the three added in 1996.

The model is useful in that it portrays the intricacy of behavior change. Too often health promotion is reduced to passing on information with little consideration of the complexity of humans and their relationships. The detail of the model can guide nurses and other health professionals in helping clients evaluate their readiness and commitment for change, and in exploring the many intrinsic and extrinsic factors that might enable or hinder actions. The use of the HPM encourages a partnership between health worker and client and identifies specific areas of intervention. It also recognizes the possible impact of the professional through the variable of interpersonal influences.

Another positive aspect is the acknowledgment of the interdependency of many of the variables with both direct and indirect influences on each other and on outcomes. For example, prior related behavior has been shown to be a strong predictor of future actions. However, no behavior is separate from thoughts,

feelings, and physiological responses that are addressed under the variable of activity-related effect. One question may be whether these can really be separated as different variables, or even if they should be, if people are viewed in a holistic way.

Pender (2000) is cognizant of cultural issues, but few studies have been carried out in other countries. Most cross-cultural studies have been with immigrants living within the United States and using the related Health-Promoting Lifestyle Profile (HPLF) (Walker, Sechrist & Pender, 1987). The HPLF is based on the HPM and, using such constructs as self-actualization, stress management, and exercise, may not be appropriate for women in the Mt. Selinda area. Life there is completely different and far removed from life in North America, and it may be that a focused analysis of this research and further qualitative, localized studies could provide more relevant concepts for cross-cultural applications.

Situational influences as a predictor of future behavior have shown only moderate support in empirical studies of the HPM. With ecological frameworks gaining prominence in the field of health promotion, Pender (2002) stressed the need for more meticulous measures of this variable. This present study has noted the importance of context regarding women's ability to participate in HIV prevention and other health promoting activities. It has also stressed the

influence of the wider environment such as historical, regional, national, and international forces that influence people's lives at the local level. This model does not take these into consideration and therefore they could be easily overlooked. These are also forces that are not easily influenced, but somehow need to be addressed for meaningful change to take place especially concerning oppressed and marginalized populations.

Therefore, the Health Promotion Model appears more useful for individual consultations and would be difficult to apply in community level assessments. Although behavior change is ultimately about individual action, situations such as the high prevalence of HIV/AIDS demand population or community-based approaches for efficient use of human and physical resources. It is also important to address the many contextual issues that will assist in implementing change and that will support it over the long term. This requires a broad, ecological, and community-focused approach.

Directions for Future Research

The amount of literature available on HIV/AIDS and women indicates that considerable research has been done. What is less clear is how these studies have positively impacted women's lives or slowed the spread of HIV. To be complete, research needs to make a difference, to bring about social change, or at

least to leave something positive as a result. The sense is that often this does not happen. This study and others may have offered women an opportunity to express their views in a safe place, possibly for the first time, and it may have been a cathartic experience for them. However, it is not clear how their lives will be improved considering the major social and cultural implications for change. With these thoughts, and the clear indication that gender inequality is one of the greatest challenges to effective HIV prevention (UNAIDS, 1999a), future studies should include participatory action research or similar methodologies. This may be a step to greater empowerment, as women and men become actively involved in the research process.

There are many unanswered questions for future research regarding gender, race, culture, sexuality, and violence, to name only a few. What is needed to bring about a change in gender relations, and under what conditions? What are the differences between men and women in rural and urban areas? How do social norms and culture impact on men's roles, including their sexual behaviors? Is there really a difference in behavior and attitudes of adolescents as compared to adults? Will adolescents be able to overcome the powerful cultural gender expectations as they mature? What research methods are most effective for bringing about social change? What are the most effective processes for engaging communities in social and cultural change? Are there successful local

programs that might be transferred to other communities? Will integration of traditional and western health care provide improved level of community health? What is the most effective role for churches and NGOs in HIV prevention?

Research can also serve as an evaluation tool for existing and future programs, especially in measuring both short-term and long-term effectiveness. Energy and interest for programming is often high at the beginning for planning and implementation, while outcome evaluation is neglected. Culturally appropriate indicators are needed to help assess changes in economic and social inequality, and qualitative studies could help determining these. Medical research needs to prioritize development and testing of preventive methods that are controlled by women and do not require permission to be used. Clinical trials on vaccines need to continue. All types of indigenous research need to be supported that could enhance community level change for the longer term.

No matter what methods are used, it is critical to study sexuality and HIV transmission with an ecological approach that includes males and females and their social relationships. One example is Goodman and Leatherman's (1998) *Biocultural Synthesis*, a political economic model of health that could strengthen anthropological studies. "What is key" these authors wrote, "is understanding local realities in global contexts" (p. 4). Goodman and Leatherman called for a

search of fundamental causes in order to find solutions to the serious and complex problems faced by so many. "Most research, however, still fails to assess the roots of socioeconomic variation or historical forces of change" (p. 16). They stressed the need to place social sciences within an ethical context:

> A new ethics of practice mandates that we examine the human condition with an eye to the complex social relations that shape lives and biologies, and with a commitment that our analyses should be relevant to relieving persistent suffering.... There is no natural division between science and human rights... Too often, we view undernutrition and illness as regrettable but inevitable consequences of an impoverished environment, as if poverty were a component of a natural environment and not a product of social relations and inequality.... People don't just end up rich or poor, sick or healthy, landed or landless. These all happen for reasons and these reasons frequently lie upstream. (pp. 24-25, 33)

Conclusion

Ndau women's quality of life, health status, HIV risk, and vulnerability are all affected by a mutually supporting relationship of socio-cultural and economic factors. If a woman is able to achieve some economic improvement through her labor, the socio-cultural environment prevents her from using this to her advantage. In turn, the strict socio-cultural roles for a woman severely limit chances of improving her economic status. Each factor on its own exerts considerable power. Together they form a nearly impossible set of barriers to overcome. These factors reach beyond local communities, and to date there is little reason to think there exists an international will to tackle such a broad and

risky agenda for change.

This research explored a group of women and a few men who have never been studied. Their experiences and insights, so generously shared with the researcher, will hopefully inform local programming for HIV prevention and health in general. The participants were knowledgeable about the factors impacting on their health and women's general inability to participate in HIV prevention. Many of the stories are replete with sadness, hopelessness, and oppression, but as Riessman (1993) stressed, "All sorrows can be born if we can put them into a story" (p. 4). It is not apparent how change will be affected. However, the beginning of change is the recognition of the problem. The participants have named the problem, and with this there is some hope for a better future.

Issues of economic and sociocultural inequality that support and enhance gender inequality need to be addressed at various levels. An important task for nurses and other health professionals is challenging oppressive structures while advocating for and enabling people to eventually confront these themselves. This type of empowerment is as important as behavioral empowerment where people have the skills and ability to protect themselves. Effective, localized strategies are critical for social change, but the issues around HIV/AIDS, one of the most sinister diseases faced by humankind, also need to be addressed at national and

international levels.

It may be that HIV/AIDS is the one global force that will eventually bring about much needed social and cultural change, resulting in justice for all people. It seems that only disasters motivate the global community to act. Yet many remain untouched by the plight of people living in high prevalence areas within a culture of poverty and inequality. Meanwhile for millions, including several participants in the study, prevention efforts are already too late. Shooria lamented, "It starts with making love and in the end you die. We are killed by love." This concept of love requires a redefinition. Both short-term and long-term solutions are quickly needed that include a package of prevention, care, and mitigation while not forgetting that

> the greater task is to move our societies to a new and different place where the rights of all citizens are guaranteed and accessible through a development process, which is inclusive of the multiple identities of person and the recognition of human diversity and creativity. A key component of this transformative process is the definition of women as persons with equal rights and access to justice, property, political, and economic power and the production of new cultural and artistic values and practices, which will enhance the livelihoods of all in their respective societies. (McFadden, 1999, preface)

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APPENDIXES

Appendix A

Research Invitation Guide for FCH Clinic Nurses

The nursing tutor at Mt. Selinda hospital (Lynne Duffy) is doing a research project about women, health, and HIV prevention. In order to better understand what these mean in this culture, she is looking for women who would agree to two or more informal interviews. The purpose is that by listening to women and hearing their stories, new and better ways may be found for providing prevention and health promotion programs for the members of the community, especially women.

You need to be between the ages of 18 and 45 years, be a member of the Ndau culture, and live in the Mt. Selinda Hospital Catchment area. You must also be able to understand and express yourself well in English. If you are interested in participating I will arrange a meeting with her. She will then explain the project in more detail. At that point you can decide if you wish to continue or not. This is completely voluntary and you may withdraw at any time.

Appendix B

CONSENT FORM: Core Group (Key Participants)

A Study of Women and Health Promotion in the Mt. Selinda Area.

You are invited to participate in a research of health. The researcher wants to hear about your experiences and views in order to better understand your beliefs and meanings of health, illness and health promotion, with a special focus on HIV prevention. You were chosen because you are a female member of the Ndau culture, between the age of 18 and 45 years of age, and able to communicate in English.

This study is being conducted by Lynne Duffy, Nursing Tutor at the Mt. Selinda School of Nursing, who is a doctoral student at Walden University. The final report will be part of the requirements for her program of study.

Background Information: The purpose of this study is to describe and examine local meanings of health, illness, and HIV prevention in Ndau women in the Mt. Selinda area. The results are expected to provide information for more effective HIV prevention and other health promotion programs in the area.

Procedures: If you agree to be in this study, you will be asked to take part in two or more interviews over the next few weeks, at a time and place that will be private and convenient for you. The exact number of interviews will depend on the information provided and your available time. You will be asked about your experiences and beliefs regarding various aspects of health and the factors that influence your health practices. The researcher may also request follow-up visits to clarify information or to have you check the information to see if she has understood your views. You are free to withdraw from the study at any time or to refuse to answer specific questions.

Risks and Benefits of Being in the Study: There are no known risks to your participation in this study. Possibly some of the discussion/questions will be of a sensitive nature and may cause embarrassment or anxiety. Counseling will be arranged for any emotional distress.

The benefits to participation are the opportunity to discuss personal health issues, concerns, and perceptions with the hope that the information might help in developing health promotion programmes for all women in this area, including yourself and family members. The researcher will provide any health education that you might request or to arrange to have this done by an appropriate health worker, including written material as needed.

Compensation: In order to compensate you for your time and expertise, you will receive a payment of Z$200.00 to be paid at the end of each interview. If transportation costs are involved, they will be covered or transport will be provided.

Confidentiality: Your name will not appear on any of the records including transcripts and computer files and only an ID number will be used. Any documents with your name will be kept locked in a separate file. All records will be kept confidential. Any report that might be published will attempt to keep your identity private including the use of a fictitious name. Research records will be kept in a locked file and only the researcher, or those assigned to work

with her, will have access to them. Tape recordings, and other documents related to the interview, will be kept in a locked file for a required five years.

Voluntary Nature of the Study: Your decision of whether or not to participate is completely voluntary and will not affect your current or future relations with the Willis F. Pierce Memorial Hospital at Mt. Selinda or the Nursing School. If you decide to participate, you are also free to withdraw at any time without affecting those relationships. In fact, hospital staff will not know whether you have participated or not.

Contacts and Questions: The researcher conducting this study is Lynne Duffy. The student's advisor is Dr. Jeanne Connors. You may ask any questions you have now. If you have questions later, you may also contact either of them.

Lynne Duffy, P.O. Box 509, Mt. Selinda. Phone 4468
Dr. Jeanne Connors, N6967 Balsam Road Row, Shawano, WI, USA. 54166
Phone 1-715-5243697

You will be given a copy of this form to keep for your records.

A. Statement of Consent:
I have read the above information and have received answers for any questions I had.
I consent to participate in the study.

Signature:_____Date:_____

Signature of Researcher:_____Date:_____

B. I agree to have photographs taken if the researcher so decides. I understand they may be used for future publication and presentations....
(Check only one)

1) Only if in a larger picture where I cannot be identified ___
2) It does not matter if can be identified or not___
3) I do not want my picture taken _____
4) Only pictures of my home or property _____

Signature:_____Date:_____

I would like to have a copy _____.

The researcher agrees to respect the decision regarding the taking and use of photographs.

Signature of Researcher:_____Date:_____

Appendix C

CONSENT FORM: Key Informants

A Study of Women and Health Promotion in the Mt. Selinda Area.

You are invited to take part in a research about health. The researcher wants to hear about your experiences and views in order to better understand local beliefs and meanings of health, illness, health promotion, and HIV prevention.

Lynne Duffy, Nursing Tutor at the Mt. Selinda School of Nursing, is doing the research. She is a doctoral student at Walden University.

Background Information:

The purpose of this study is to understand local meanings of health, illness, and HIV prevention of women in this area.

Procedures:

If you agree to be in this study, you will be asked to take part in an interview at a place that will be private and convenient for you. You will be asked about Ndau or local beliefs on different aspects of health, illness, and prevention practices. The researcher may also request a follow-up visit to check if your views have been understood. You are free to withdraw from the study at any time or to refuse to answer certain questions.

Risks and Benefits of Being in the Study:

There are no known risks to your joining in this study although some of the topics or questions may be sensitive. Counseling will be arranged for any emotional distress if needed.

The benefits include the opportunity to discuss personal and community health issues, concerns, and ideas about health promotion and disease prevention. It is hoped that the information will help in developing health promotion and prevention programs in this area. The researcher will provide any health education, including written health material that you might request. Any transport costs will be covered.

Confidentiality:

Your name will not appear on any of the research reports. Only an identification number will be used. Any papers with your name will be kept locked in a separate file. All records will be kept private. Any report that might be published will attempt to keep your identity a secret, and your real name will not be used. Tape recordings and papers relating to the interviews will be kept in a locked file for a required period of five years. Only the researcher will have access to them.

Voluntary Nature of the Study:

Your decision whether to be involved or not is completely voluntary and will not affect your relationship with the Willis F. Pierce Memorial Hospital or the Mt. Selinda School of Nursing. If you decide to take part, you are also free to stop at any time without affecting those relationships.

Contacts and Questions:

The researcher for this study is Lynne Duffy. Her advisor is Dr. Jeanne Connors. You may ask any questions now. If you have questions later, you may contact either of them.

Lynne Duffy, P.O. Box 509, Mt. Selinda. Phone 4468
Dr. Jeanne Connors, N6967 Balsam Road Row, Shawano, WI, USA. 54166
Phone 1-715-5243697

You will be given a copy of this form to keep for your records.

A. Statement of Consent:

I have read and understood this information and received answers for any questions.
I agree to take part in the study.

Signature:_____Date:_____

Signature of
Researcher:_____Date:_____

B. I agree to have photographs taken if the researcher so decides. I understand they may be used for future publication and presentations....

(Check only one)

1) Only if in a larger picture where I cannot be identified ___
2) It does not matter if can be identified or not ___
3) I do not want my picture taken _____
4) Only pictures of my home or property _____

Signature:_____Date:_____

I would like to have a copy _____.

The researcher agrees to respect the decision regarding the taking and use of photographs.

Signature of Researcher:_____Date:_____

Appendix D

CONSENT FORM: Focus Groups

A Study of Women and Health Promotion in the Mt. Selinda Area.

You are invited to take part in a research about health. The researcher wants to hear about your experiences and views in order to better understand local beliefs and meanings of health, illness, health promotion, and HIV prevention.

Lynne Duffy, Nursing Tutor at the Mt. Selinda School of Nursing, is doing the research. She is a doctoral student at Walden University.

Background Information:

The purpose of this study is to understand local meanings of health, illness, and HIV prevention of women in this area.

Procedures:

If you agree to be in this study, you will be asked to take part in a group interview with other women, at a place that will be private and convenient for everyone. You will be asked about local beliefs on different aspects of health, illness, and prevention practices especially as they relate to Ndau women's experiences. The researcher may also request a follow-up visit to check if your views have been understood. You are free to withdraw from the study at any time or to refuse to answer certain questions.

Risks and Benefits of Being in the Study:

There are no known risks to your joining in this study although some of the topics or questions may be sensitive. Counseling will be arranged for any emotional distress if needed.

The benefits include the opportunity to discuss personal and community health issues, concerns, and ideas about health promotion and disease prevention. It is hoped that the information will help in developing health promotion and prevention programs in this area. The researcher will provide any health education, including written health material that you might request. A meal will be provided and any transport costs will be covered.

Confidentiality:

Your name will not appear on any of the research reports. Only an identification number will be used. Any papers with your name will be kept locked in a separate file. All records will be kept private. Any report that might be published will attempt to keep your identity a secret, and your real name will not be used. Tape recordings and papers relating to the interviews will be kept in a locked file for a required period of five years. Only the researcher will have access to them. Each group participant will sign a confidentiality form.

Voluntary Nature of the Study:

Your decision whether to be involved or not is completely voluntary and will not affect your

relationship with the Willis F. Pierce Memorial Hospital or the Mt. Selinda School of Nursing. If you decide to take part, you are also free to stop at any time without affecting those relationships.

Contacts and Questions:

The researcher for this study is Lynne Duffy. Her advisor is Dr. Jeanne Connors. You may ask any questions now. If you have questions later, you may contact either of them.

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Dr. Jeanne Connors, N6967 Balsam Road Row, Shawano, WI, USA. 54166
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You will be given a copy of this form to keep for your records.

A. Statement of Consent:

I have read and understood this information and received answers to any questions. I agree to take part in the study.

Signature:_____Date:_____

Signature of
Researcher:_____Date:_____

B. I agree to have photographs taken of the group process if the researcher so decides. I understand they may be used for future publication and presentations....

(Check only one)

1) Only if I cannot be identified ___
2) It does not matter if can be identified or not ___
3) I do not want any pictures taken _____

Signature:_____Date:_____

I would like to have a copy _____.

The researcher agrees to respect the wishes of the group, as well as individual members, regarding the taking and use of photographs.

Signature of
Researcher:_____Date:_____

Appendix E

Confidentiality Form: Research Assistant

Study Title: HIV/AIDS in Context: The Culture of Health Promotion Among Ndau Women in rural Zimbabwe

The researcher has explained to me the significance of respecting the confidentiality and privacy of the participants of this research project that has been promised in the informed consents, and I understand how important this is. I will not discuss any of what is discussed between myself and the participants or the researcher; now or in the future. I will not disclose any participant's names or other identifying information to anyone else. I will ensure all materials (e.g. field notes, tapes and transcripts) are locked in the appropriate files when not in use.

Signature:

Research Assistant _____

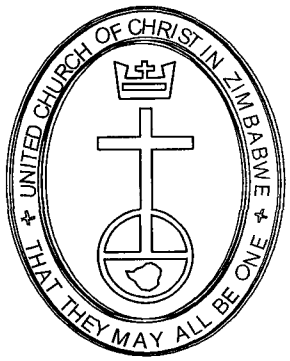
Witness:

Researcher: _____

Date: _____

Appendix F

Hospital Executive Approval



EST - 1893

WILLIS F. PIERCE MEMORIAL HOSPITAL
(MT. SELINDA HOSPITAL)

Phone 2424
2235
3329
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P.O. Box 509
Mt. Selinda
Chipinge

August 22, 2001

Institutional Review Board
Walden University
155 Fifth Ave South
Minneapolis, MN
55401

This letter is regarding the proposed PhD dissertation research of Mrs. Lynne Duffy.

As explained to us, Mrs. Duffy wishes to investigate the contextual issues around health promotion-and HIV prevention among Ndau women in our catchment area. She will use a purposeful sample and as long as ethical standards are respected, she may interview staff, patients, and family members who agree to participate. Generally, though, it is expected that the major group of participants will be women recruited by the nurses at our Family Child Health clinic.

The Hospital Executive supports this research, and it is hoped that the results of this study may help to inform and improve our efforts at HIV/AIDS prevention.

Yours faithfully,

Dr. A. J. F. Wensink, MD
Medical Superintendent
W.F. Pierce Memorial Hospital

Appendix G

Interview Guide: Core Group (Key Participants)

Purpose: To gain an understanding of Ndau women's realities, life experiences, and beliefs, meanings and perceptions of health, illness and health promotion especially regarding HIV prevention

The following categories were covered in two interviews of approximately 1½ hour each.

1. Discussion of early memories of childhood and adolescence with special attention to family, school, church, and other community health beliefs, practices, and norms.

2. Female role socialization and adolescent male-female relationships.

3. Perception of own role as an Ndau woman. Discussion around own marriage and childbearing, personal and present-day family health and health practices. Perceived support and social/structural/environmental health influences. Influence of culture and tradition on health of women and families.

4. HIV/AIDS. Beliefs, perceptions, meanings, experiences, education/knowledge, personal risk, and protection/prevention.

5. Synthesis through reflection on previous discussions. Filling in any gaps, clarification, and possibly verification. Thoughts and ideas for improved health for self, family, and community. Thoughts and ideas regarding prevention of HIV.

An attempt will be made to follow the order so that more sensitive topics are introduced later. Where appropriate, similar questions to those from the key informant and focus group interviews will be integrated, along with other open-ended queries to elicit narrative description on the topics.

Appendix H

Interview Guide: Key Informants

Purpose: To explore local beliefs and meanings around health, health promotion, and HIV.

1. What is understood by the word health in this area?
2. What things do people do to stay healthy?
3. What do you consider as unhealthy behaviors?
4. How important is health in relation to other areas of life?
5. What things prevent people from being healthy?
6. a) What are some common beliefs about health and illness?

b) How do traditional health beliefs and practices differ from those introduced by outsiders (settlers, missionaries, etc.)?

7. If you were given the responsibility to improve the health of the community, what do you see as the most important things that are needed?
8. Although there are many health concerns in the area, it is said that there is an epidemic of HIV/AIDS throughout the country.
    a. What do you see happening around here? Are people concerned?
    b. What do you think are the reasons for such high levels of HIV?
    c. What do people say about the causes of HIV/AIDS?
    d. Who is at risk for HIV?
    e. How can people protect themselves?
    f. What prevents people from protecting themselves?
    g. What do you think needs to happen for an improvement in the epidemic?
9. Other comments.

Appendix I

Interview Guide: Focus Groups

Purpose: To explore issues around Ndau women and health, health promotion and HIV.

1. What is the meaning of "health" for Ndau women?

2. What things do women do to stay healthy?

3. What are some unhealthy behaviors of women you see?

4. How important is being healthy in relation to other aspects of life?

5. What things prevent women from being healthy?

6. How do cultural and religious beliefs influence health?

7. If you were given the responsibility for improving the health of women, what would you see as the most important things needed?

8. Although there are many health concerns in the area, it is said that there is an epidemic of HIV/AIDS throughout the country.

   a. What do you see happening around here? Are people concerned?
   b. What do you think are the reasons for such high levels of HIV?
   c. What do people say about the causes of HIV/AIDS?
   d. Who is at risk for HIV?
   e. How can women protect themselves?
   f. What prevents women from protecting themselves?
   g. What do you think needs to happen for an improvement in the epidemic?

9. Other comments.

Appendix J

Confidentiality Form: Focus Groups

I agree that everything discussed at these focus groups will be kept confidential. This means that I will not repeat any part of the discussions to others who were not involved. I will also not disclose the names of other participants.

Signed: _____

Witness: _____

Date: _____

Appendix K

Preliminary and Emerging* Codes

Code	*Definition*
+ Behav	Positive or healthy behaviors
- Behav	Negative or unhealthy behaviors
Adolescence	Life as a teenager in Ndau society
Barriers	Perceived barriers to healthy behaviors
Change	What needs to change for improvement in the epidemic
Childhood*	Women's experiences in childhood
Com Preven	Community health practices while growing up
Communic*	Communication between males and females
Condoms*	Use of, and attitudes toward, condoms (male and female)
Culture	Specific Ndau cultural beliefs
Dec-making	Family decision making
Denial*	Denial of diagnosis or avoidance of topic of HIV/AIDS
Dreams*	Women's hopes and dreams for the future
Economics*	Economic factors influencing health or health practices
Fam Belief	Health beliefs learned from family of origin
Fam Health	Health of family of origin
Fam Influ	Family influences on health behaviors
Fam Preven	What family did to stay healthy
Fam Treat	Family interventions to maintain health/treat illness
Health	Personal definition or meaning of health
HIV Care*	How people with HIV/AIDS are treated
HIV Cause	Impressions of the cause of HIV
HIV Knowl*	General knowledge of HIV/AIDS
HIV Preven*	How people can protect themselves
HIV Reason	Impression of the reasons for the high rates of HIV/AIDS
HIV Risk	Who they consider most at risk/personal risk for HIV
HIV Scope	Impression of the scope of the epidemic (seriousness)
HIV Trans	Understanding and knowledge of HIV transmission
HLT Belief	Beliefs about health, illness, prevention, and treatment
HLT Emot*	Emotional/mental health and stress
HLT Needs	Things needed for an improvement in health of the community
HLT Prac*	Present health seeking or self help behaviors

(table continues)

Code	*Definition*
HLT Promot	Present health practices to keep self and family healthy
HLT Risk*	Behaviors, other influences that compromise health
HLT Value	Value or importance of health
Life-F	Life for Ndau woman
Life-M	Life for Ndau man
Marriage	Process/expectations for marriage in Ndau culture
Power*	Differences in level of power indicated by oppression/dominance.
Production	Work expectations/obligations/roles
Protection*	Ways people can or cannot protect their health
Religion	Religious influences on health belief and practices
Reproduction	Reproduction issues in Ndau culture
Resistance*	Behaviors that avoid, minimize, or circumvent negative experiences
Secrecy*	Behaviors that attempt to keep information from others
Sex Ed	Sexual education/preparation for marriage
Sex Prac*	Sexual practices/behaviors/activities
Sex-F*	Female issues of sex and sexuality
Sex-M*	Male issues of sex and sexuality
Sex-Teens*	Teenage sexual practices and behaviors
Socializ	Socialization of males and females
Spirits*	Supernatural beliefs in ancestors or other spirits
Stigma*	Negative treatment of people who have AIDS
Support	Emotional and other support networks
Testing*	Issues around and attitudes towards, HIV testing
Violence*	Domestic violence/abuse
Voice*	The freedom to speak, give opinions, ask for help/be listened to

Appendix L

Codes from Pender's Health Promotion Model

Code	*Definition*
PRB	Prior Related Behavior—frequency of same or similar behavior in the past, improved with repetition
PF-BI	Personal Factors-Biological
PF-PS	Personal Factors-Psychological
PF-SO	Personal Factors-Sociocultural
PBEA	Perceived Benefits to Action—action related to anticipated positive benefits or outcomes, direct motivator
PBAA	Perceived Barriers to Action—anticipated barriers, imagined or real, blocks, hurdles, personal costs
PSE	Perceived Self-Efficacy—a judgment of one's perceived skills or abilities
ARE	Activity-Related Effect—Subjective feeling before, during, or after an activity
INI	Interpersonal Influences—perceived opinions of others re the behavior. Includes norms, social support, and modeling
SI	Situational Influences—perceptions of the setting or context where the behavior will take place.
ICDP	Immediate Competing Demands and Preferences—interruptions/sabotage by others or other choices that carry high rewards and may not be able to be resisted.
CTPA	Commitment to a Plan of Action—agreement, specific plan, and strategies to act

Appendix M

Permission to use Pender's Model
Via Electronic Mail

Date: Wed, 27 Feb 2002 10:20:32 -0500
From: Adam.Hirschberg@PearsonEd.com
Subject: Pender permission
To: lduffy@waldenu.edu
Message-id:
<4B725D4CC820D211945A00104B09B86E01C9AD9E@oldtms013.schuster.com>
X-Mailer: Internet Mail Service (5.5.2654.89)
Content-transfer-encoding: 7BIT
X-UIDL: ca13ba68697a52fba5e2f97ec25905c0
Status: RO
X-Status:
X-Keywords:
X-UID: 32

Hi Mrs. Duffy,

You have Prentice Hall's permission to use Pender's Health Promotional model from the book, HEALTH PROMOTION IN NURSING PRACTICE, in your dissertation.

Adam Hirschberg

Permissions Adm.

201-236-3275

CURRICULUM VITA

Work Experience

Mt. Selinda School of Nursing, Mt. Selinda, Zimbabwe. **Principal Tutor.** Facilitated opening of the school. Responsible for school management, classroom and clinical teaching. Mentoring of clinical instructor. October 2000-present.

The University of New Brunswick, Faculty of Nursing, Moncton, N.B. **Instructor.** Classroom teaching and community supervision. September 1999-April 2000.

The Aga Khan University, Faculty of Health Sciences, Karachi, Pakistan. **Senior Instructor.** Classroom and clinical teaching of Post-RN, BSCN students and mentoring of national faculty. October 1997-August 1999.

South-East Health Care Corporation, The Moncton Hospital. Moncton, N.B.
Clinical Coordinator/Nurse Manager. Provincial Child/Adolescent Psychiatry Unit. Responsible for multidisciplinary team management and clinical organization. Carried a small caseload of outpatients. May 1992-October 1997.
Staff Nurse. Neonatal Unit, Oncology/Chemotherapy. August 1991-May 1992.
Patient Education Coordinator. Research project entitled "Evaluation of Nurse-Provided Patient Education at The Moncton Hospital." February-June 1991.
Nurse Manager. Child/Adolescent Psychiatry Unit. Coordinated the setup of the first unit in New Brunswick, facilitated staff orientation, and provided team management. September 1990-February 1991.

Scott Hospital, Morija, Lesotho. **Health Service Area Nursing Consultant.**
Community Health Care Department: Assisted in supervision of the 14 outpost health centers, planned and implemented a mobile immunization campaign, facilitated health and adult education programs for staff, and coordinated the introduction of a Community-Based Family Planning Program.
Main Hospital: assisted in design of new Labour Ward and Premature Nursery, equipment purchases, and staff in-service training. October 1987-June 1990.

The Moncton Hospital, Moncton, N.B
Head Nurse. Family Centered Maternity Care. Implementation of Combined Care Maternity Program and unit management. October 1984-June 1987.
Staff Nurse. Nursery/Neonatal Unit. May 1977 - October 1984.

Registered Nurses Private Duty Registry, Halifax, N.S. January 1971-December 1976.

Grace Maternity Hospital, Halifax, and N.S. October 1969-November 1970

Education

Walden University, **PhD in Health Services: Community Health**. November 2002.
Aga Khan University, Karachi, Pakistan, Community Health Sciences Department. **Epidemiology 1.** September to December 1998. **Seminar in Public Health.** January to March 1999.
Canadian Nurses Association, **Certification in Psychiatric/Mental Health Nursing.** 1996.
University of New Brunswick, Fredericton, N.B. **Masters of Education.** (Adult Education). 1996.
Zimbabwe Christian Council Training Center, Harare, Zimbabwe. **Training for Transformation.** 1989.
Nursing Distance Education Program, Ottawa, Ontario. **Introduction to Nursing Management** Certificate. 1985-1986.
Université de Moncton, Moncton, N.B. **B.Sc. in Nursing.** 1985.
The Moncton Hospital, Moncton, N.B. **Diploma in Nursing.** 1969.
Harrison Trimble High School, Moncton, N.B. **High School Diploma,** 1966.

Other Education

Computer Skills: Word 2000, Power Point, SPSS, Epi Info, The Ethnograph.

Moncton Hospital/NBCC, **Conversational French.** "Intermediate Plus" rating, June 1995. Maintenance program - September 1996 to May 1997.
Personal Empowerment Through Type), **Personality Type Assessments.** 1995, 1996.
Living Works Education, Inc., **Suicide Intervention Training.** 1995.
William Glasser Institute, **Reality Therapy Certified.** 1994
The Moncton Hospital, **Standards of Chemotherapy Certification.** 1991.
International Diabetes Center, Minneapolis, MN. **"Team Management of Diabetes."** 1991.
Université de Moncton, Moncton, N.B. **"Conversational French,"** Level II. 1991
Université de Moncton, **Introduction to Spanish.** 1985.

Committees/Affiliations

Mt. Selinda Hospital AIDS Committee, Hospital Executive committee.
Zimbabwe Nurses Council, Zimbabwe Nurses Association.

Nurses Association of New Brunswick, Canada.

Publications

Duffy, L. (2000). From rote to reflection: An incredible learning journey. *The Canadian Nurse, 96*(7), 30-33.