DECISION-MAKING ON SEXUAL AND REPRODUCTIVE HEALTH ISSUES AMONG WOMEN IN HETEROSEXUAL MARITAL RELATIONSHIPS IN MAHIKENG, SOUTH AFRICA

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DECLARATION

I declare that "Decision-making on Sexual and Reproductive Health Issues among Women in Heterosexual Marital Relationships in Mahikeng, South Africa" is my own work, that it has not been submitted for any degree or examination in any other University and that all the sources I have quoted have been indicated and acknowledged by complete references.

Full name: **Osuafor, Godswill Nwabuisi** Date: 08/09/2024

Signed_____

DEDICATION

This work is dedicated to my father Ephraim Chukwurah Osuafor (KSP) of blessed memory who sojourned to the luminous garden before the completion of my doctoral program. Peace be with him.

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AIDS	Acquired Immunodeficiency syndrome
CDC	Center for Disease Control
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
DHS	Demographic and Health Survey
DoH	Department of Health
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IDIs	Individual in-depth interviews
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IPV	Intimate partner violence
MDGs	Millennium Development Goals
SAP	Structural Adjustment Programme
SPSS	Statistical Package for Service Solutions
SRPS	Sexual Relation Power Scale
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS

ABSTRACT

Problem statement: Sexual and reproductive decision-making has emerged as an important health indicator as husbands dominate in family reproductive health issues and continue to be the greatest source of sexually transmitted infections including HIV to their wives. While there is evidence of male dominance in sexual and reproductive health decision, the role of socio-demographic factors on women's control over their sexuality is not well understood. Using the theory of gender and power, it was conceptualized that socio-cultural and socio-economic factors influence women's control over their sexuality.

Objectives: The aim of this study was to investigate the extent to which women in marital and cohabiting unions have control over their sexuality and implications on reproductive health.

Method: To achieve this purpose sexual and reproductive health decision-making survey of 568 respondents and 33 in-depth interviews was conducted among married and cohabiting women in Mahikeng, South Africa in 2012. Data were collected on respondents' socio-demographic characteristics and reproductive health matters under which the relationship exits. Quantitative data were analyzed using descriptive and logistic regression analyses. Qualitative information was analyzed manually using thematic content analysis approach.

Result: The data reveals that unemployed women and those in traditional union were less likely to agree that women can demand or reject sex from their husbands. Rural women and those in arranged marriages showed lack of autonomy in decisions on when to have sex and family size. Gap in knowledge of condom efficiency and the usage seems to stem from lack of spousal communication. Qualitative data revealed that sexual control are intertwined with cultural, religious belief and perception that husbands have sexual right over their wives. Fear of accusation and violence impaired the ability of women to suggest condom use to their partners.

Conclusion: It may be concluded that limited control women had over their sexuality (sexual and reproductive health decision-making) stemmed from poor economic status, cultural gender norm and patriarchal dominance. These may have negative implications on women's sexual and reproductive health.

Recommendation: Sexual and reproductive health decision-making in marital or cohabiting relationships cut across secular, cultural and religious domain. Government strategy to improve married women's control over sexuality need partnerships of their husbands, traditional and religious leaders which should focus on empowering women with income earning skills and bridging sexual communication gap between couples.

CHAPTER ONE: GENERAL INTRODUCTION

1.0 INTRODUCTION

Reproductive health issues have continued to arouse global concern following the International Conference on Population and Development in Cairo (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006). The hallmark of the Cairo plan of action was the move from the interdependent mutualism in spousal decision-making to individual choices characterised by women's sole reproductive decision-making (Morgan & Niraula, 1995; Woldemicael, 2009). Studies have suggested that women should have the right to make independent decisions on when, where, how to have sex, number of children they want and spacing of births, without coercion or violence (Obermeyer, 2005; Shaw, 2010).

A number of studies have shown that women who had considerable control over their sexual lives and reproductive decision-making power were more likely to innovate and avoid risky sexual health outcomes (Blanc, 2001; Blanc & Wolff, 2001; Gage, 1994). Studies in many developing countries have associated lower fertility with women's greater power in reproductive decision-making on contraceptive use (Balk, 1994; Crissman, Adanu, & Harlow, 2012; Jejeebhoy, 1991; Kritz & Makinwa-Adebusoye, 1999). Some other studies did not observe any associations between women's reproductive decision-making ability and contraceptive use (Fikree, Khan, Kadir, Sajan, & Rahbar, 2001; Mumtaz & Salway, 2009). These findings suggest that there are other factors such as structural factors that may have influenced women's sexual and reproductive decision-making.

Empirical findings have shown that education and employment are strong predictors of women's sexual and reproductive decision-making ability, independent of gender power relations (Jejeebhoy, 1991; Singh, 2010; Woldemicael, 2009). But on the other hand, other studies have shown that educated and economically privileged women may not exert their sexual control or reproductive decision-making choices due to male dominance in reproductive matters and the pronatalist worldview (Caldwell, Orubuloye, & Caldwell, 1992; Crissman et al., 2012; Isiugo-Abanihe, 1994; Woldemicael, 2009). These findings suggest that in the midst of

structural factors, their socio-cultural background may have an influence on women's sexual and reproductive decision-making power.

Since reproductive health awareness emerged as a means to ensure physical, social and psychological health of women, it has become a prominent area of research around the world (Ghuman, Lee, & Smith, 2006; Mullany, Hindin, & Becker, 2005; Woldemicael, 2009). However, studies in African sexuality have focused on men's extramarital affairs, promiscuity and gender-based violence while neglecting women's sexual decision-making and reproductive health matters in marital relationships (Ackermann & Klerk, 2002; Delius & Glaser, 2004; Smith, 2007). Sexual double standards, which demand women to be sexually faithful to their husbands and accept the promiscuous behaviour of their husbands as inherent in the nature of men, exist in many African societies (Awusabo-Asare, Anarfi, & Agyeman, 1993). This expectation of sexual subservience limits women's sexual decision-making power and access to reproductive health services (Kohan, Simbar, & Taleghani, 2012). Thus societal sexual double standards put women's sexuality in the hands of the husband and his family (Jejeebhoy & Sathar, 2001; Rivers et al., 1998; Wolff, Blanc, & Gage, 2000). Sexuality of women being under the power of the husband may be a constraint on their ability to take charge of their sexual decision-making and reproductive health issues.

Studies have found married women were powerless to declare their stand on sexual issues (Jewkes, Levin, & Penn-Kekana, 2003; Langen, 2007; Schoepf, 1993). The powerlessness of women in safer sex decision-making seems to be entrenched in cultural norms such as submissiveness to the husband (Jewkes et al., 2003; Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 1999), socio-economic dependency on men and limited education for women (Krishnan et al., 2008; Wodi, 2005). The powerlessness of married women to negotiate sex puts them at a disadvantage and hence most vulnerable to sexually transmitted infections. For instance, the unequal prevalence of HIV/AIDS among males and females has been attributed to women's poor sexual control in their marital unions (Krishnan et al., 2008; Wodi, 2005).

Women's sexuality has emerged as a central theme in the international development policy agenda, owing to the fact that husbands and sexual partners pose the greatest risk of infecting women who are in marital and consensual unions, with sexually transmitted diseases (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008; Langen, 2007; Ogunjuyigbe & Adeyemi, 2005; Wodi, 2005). For instance, studies have shown that married women in Africa are becoming infected with HIV at a higher rate than single, sexually active young women of the same age (Glynn et al., 2001). Studies have reported a higher prevalence of HIV/AIDS among widows than widowers in Africa (Lopman et al., 2009). Recent studies in South Africa have shown a high prevalence of STIs among young women attending antenatal clinics (Peltzer, 2013; Villar-Loubet et al., 2013). Women do not have the power to demand safer sex even when there is evidence of infidelity from their husbands (Panchanadeswaran et al., 2007; Schoepf, 1993; Tsai, Hung, & Weiser, 2012) thus, compromising their sexual health. This is a concern that appeals for an investigation of the socio-cultural and structural factors that influence women's sexual and reproductive decision-making.

1.1 MARRIAGE AND COHABITATION IN SOUTH AFRICA

In South Africa a couple can choose to have a civil (or Christian) or customary (or traditional) marriage. Whilst the civil marriage is a straight-forward exercise involving getting a marriage certificate from the government (i.e. Department of Home Affairs), the customary marriage is a process which can take a short duration of a few weeks or as long as ten years or more. Common to Black South Africans, a customary marriage culminates by payment of *lobola* (bride price) which symbolizes the joining of the two (bride's and groom's) families (Bakker & Heaton, 2012; Peart, 1983). Many couples use the Department of Home Affairs after the payment of *lobola* to get a marriage certificate, but some decide to get a marriage document from their traditional Chief. Cohabitation happens when a man and a woman decide to live together like a husband and wife but do not have a legal document. Cohabiting relations are generally accepted in South Africa but there is no payment of *lobola* (Mindry et al., 2011; Swart-Kruger & Richter, 1997).

The African traditional marriage system, where there is sexual ownership of the wife by the husband, has paved way to non-traditional marriage (Budlender,

Chobokoane, & Simelane, 2004; Jewkes et al., 1999). With the advent of non-traditional marriage, has emerged different patterns of marriages and unions such as marriage in community of property or marriage out of community of property (Budlender et al., 2004). In addition, South Africa is experiencing an unprecedented level of cohabitation (Albertyn, 2003; Hosegood, McGrath, & Moultrie, 2009) which is acceptable in common law. The proportion of women aged 18-49 in cohabiting unions in South Africa was 13.8% in 1996, 22.3% in 2001, and 28.9% in 2011 (StatsSA, 2013). This showed a consistent increasing proportion of cohabitation between 1996 and 2011. Earlier studies in Sub-Saharan African countries attributed the increasing rate of cohabitation to social dynamics as a result of westernization that sweep across many traditional societies (Bledsoe & Cohen, 1993). Furthermore, women may delay marriage to acquire higher education which accords the opportunity for better jobs and self-sufficiency (McLaughlin & Lichter, 1997).

Irrespective of the patterns of marriages, women are no more compelled or obliged to relinquish their maiden names, property and assume subservience to their husbands (Budlender et al., 2004; Mbatha, 2002). Furthermore, informal initiation schools where women undergo training prior to marriage have become extinct in many African cultural settings (Nyanzi, Nyanzi, Wolff, & Whitworth, 2005). In addition women are aware of the acceptability to accuse of rape against her (Walker, 2005). The changes may suggest that the sexuality of women in marital relationships has undergone considerable transformations.

1.2 PROBLEM STATEMENT

Although reproductive health research has become prominent globally, the field of sexuality has remained understudied in sub-Saharan Africa especially in marital relationships (Wusu & Isiugo-Abanihe, 2010). Socio-cultural realities and complexities of sexual decision-making are rarely addressed (Krishnan et al., 2008; Panchanadeswaran et al., 2007). Evidently, there is a paucity of studies on sexual and reproductive health decision-making among women in steady relationships in South Africa (Miles, 1992; Varga, 1997; Varga & Makubalo, 1996). In addition, these studies that have been carried out were conducted among unmarried people in KwaZulu-Natal province in the 1990s. Among recent studies in South Africa,

there has been a concentration on unmarried women, with an emphasis on the HIV/AIDS epidemic and sexual risks (Jewkes & Morrell, 2010; van Loggerenberg et al., 2012).

The subordination to husbands was strengthened by the cultural norms and economic advantages which were in favour of the men (Wodi, 2005). Women were destined to endure difficulties that arose in the marriages with fortitude (Davhana-Maselesele, Myburgh, & Poggenpoel, 2009; Fox et al., 2007; Nyanzi et al., 2005). The cultural assumption of sexual "ownership" remains a barrier to reproductive health rights, better law enforcement, provision of support and care to victims of marital rape (Boonzaier & de La Rey, 2003; Jewkes et al., 1999). Thus, there is neglect of studies of sexual and reproductive decision-making among married or cohabiting women in recent times.

The concern is that women in marital or cohabiting relationships have been neglected in the campaign to encourage the practice of safer sex through consistent condom use despite the high prevalence and incidence of HIV/AIDS (Montesi, Fauber, Gordon, & Heimberg, 2011; Shisana et al., 2004) and HIV/AIDS related deaths (Lopman et al., 2009) among them. A few studies on gender power imbalance in negotiating safer sex among sexually active women and condom use within marital and cohabiting partnerships were conducted in KwaZulu-Natal in the early 2000 (Langen, 2007; Maharaj, 2006; Maharaj & Cleland, 2004). Furthermore KwaZulu-Natal is dominantly IsiZulu-speaking with a different culture from the Tswana people who are the major inhabitants of Mahikeng municipality, in the North-West province. Versteeg and Murray (2008) conducted a study on condom use in a few remote communities in North-West. It seems that there are no studies on condom use among women in marital or steady relationship in Mahikeng. Hence, a study among people of a different culture is pertinent for unravelling and documenting the dynamics in sexual and reproductive health decision-making across cultural settings in South Africa. The diversity in sexual control across socio-cultural and demographic settings appeals for profound demographic research.

1.3 RESEARCH OBJECTIVES

1.3.1 General

The main aim of this study is to investigate the extent to which women have control over their sexuality, and the implications to reproductive health as cultural and economic dependency barriers subside.

1.3.2 Specific

The specific objectives of this study are:

- To examine women's control over sexuality (ability to demand or reject sex with their husbands/partners);
- To assess women's participation in reproductive health decision-making (when to have sex, when to use contraception, and family size);
- To investigate factors that influence women's sexual risk-taking;
- To examine the extent of condom use among married and cohabiting women.

1.3.3 Hypotheses

In accordance with the objectives of the study, it is hypothesised that:

- Women in a traditional union are less likely to state that women can demand sex from their husbands compared to women in a civil union.
- Unemployed women are less likely to agree that women can reject sex from their husbands compared to employed women.
- Women in an arranged union are less likely to indicate that they participate in decision-making on when to have sex compared to women who made the choice of their husbands/partners.
- Rural women are less likely to state that they participate in decision-making on family size compared to urban women.
- Women who stated spousal discussion about sex to be very difficult are less likely to report condom use compared to women who found spousal discussion about sex not to be difficult.

1.4 RATIONALE, RELEVANCE AND SIGNIFICANCE OF THE STUDY

Concerns about married women's control over their sexuality were heightened because married women in Africa are becoming infected with HIV at higher rates

than single, sexually active young women of the same age (Glynn et al., 2001; Montesi et al., 2011). The higher susceptibility of married women to sexually transmitted infections (STIs) including HIV has been attributed to the African patriarchal norms of men dominating family related decision-making and the biological vulnerability of women (Ackermann & Klerk, 2002; Coombs, Reichelderfer, & Landay, 2003; Dako-Gyeke, 2013; Magadi, 2011; Wingood & DiClemente, 2000). Women's autonomy in reproductive health issues remain an important factor in the control they have over their sexuality. Despite the expediency of women's autonomy in sexual and reproductive health decisions in policy and programme development for women empowerment, there exists a dearth of information among married and cohabiting women in Mahikeng. The present study would examine women's autonomy in sexual and reproductive health in the midst of rapid socio-cultural transformation and changes in historical gender power differentials in South Africa.

In order to address the imbalances in sexual and reproductive health matters which women experience in sexual relationships, the extent to which women make decisions about sex matters must be made clear. A sexual decision is the ability of one partner to declare a stand on sexual matters. The level of control women have over the host of reproductive health issues depends on the outcome of negotiating the terms and conditions of sex with their partners. Given the tempo of the HIV/AIDS epidemic in South Africa (Shisana et al., 2004) and social values in marital sexuality (Boonzaier & de La Rey, 2003), understanding the extent to which social values influence the sexual control and vulnerability of women to HIV infections in marital relationships is desirable.

Furthermore, it is posited that geographical location may be an impediment to demographic research in Mahikeng the capital of the North West province, despite the heterogeneous nature of the inhabitants. Since Versteeg and Murray (2008) reported cultural barriers and gender related reasons as hinderances to condom use in the North-West province, no study has assessed whether there is change of attitude to condom use. The range of factors that influence women's attitude to sexual and reproductive decision-making such as depending on men for food and material resources are prominent issues in South Africa (Tsai et al., 2012;

Katharine Wood & Jewkes, 1997; Katharine Wood, Maforah, & Jewkes, 1998). These characteristics of the inhabitants can contribute to social dynamics that influence women sexual and reproductive decision-making. The present study will contribute to the framework that promotes women's health measures in marital relationships. It will further advance the knowledge of educators, researchers and service providers on experiences of women's sexual and reproductive decision-making as an integral skill in sustainable sexual equity in marital relationships. Studying sexual and reproductive decision-making contributes to a larger body of knowledge about the dynamics in demographic gender expectations shift which culture accommodates.

1.5 ORGANISATION OF THE THESIS

The thesis is composed of nine chapters organised in three broad clusters. The first four chapters constitute the introduction, literature review, theoretical and methodological procedures and characteristics of the sample. Chapter one provides an overview of the study, the problem statement, rationale, together with the objectives and hypotheses. Chapter two provides the literature review and conceptual frame work. Chapter three addresses the data sources and the methodology of the study including: design, sampling, target population, study instruments, analyses, ethical considerations and limitations. Chapter four presents the background characteristics of the study Population.

The second cluster (chapters 5-8) is the analytical chapters of the survey data. The analytical chapters are organised around the specific objectives. Interpretation and discussions are concurrently done in the analytical chapters. Chapter five is the first analytical chapter in which attitudes of women to their sexual control in relation to their demographic characteristics are examined. Chapter six, the second analytical chapter addresses women's autonomy in sexual and reproductive health decision-making and association with demographic characteristics. Chapter seven is the third analytical chapter and it presents the attitudes of women to risky sexual decision-making. Chapter eight, the fourth analytical chapter presents condom use in marital or cohabiting relationships. Finally, the third cluster is chapter nine which provides the summary, conclusion and recommendation of the study.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 INTRODUCTION

The chapter provides a review of the relevant literature and theoretical framework guiding the study. It also addresses the conceptual framework on sexual and reproductive decision-making processes.

2.1 LITERATURE REVIEW

2.1.1 Overview of power influence in reproductive decision-making

Gender-based power imbalance has been reported as the main cause of women's inability to make reproductive health decisions or negotiate safer sex (Langen, 2007; Neblett, Davey-Rothwell, Chander, & Latkin, 2011; Nunn et al., 2011; Wodi, 2005). Studies have shown that men's greater influence over when, where and how sex will occur (Dixon-Mueller, 1993), and control over sexual initiation and refusal (Blumstein & Schwartz, 1983) restricts women's reproductive health decisions, access to reproductive health services and safer sex discussion (Acharya, Bell, Simkhada, van Teijlingen, & Regmi, 2010; Blanc, 2001). Differentials in power access between men and women further manifest as men maintaining more sexual partners than women (Awusabo-Asare et al., 1993; Carol, Burns, & Rothspan, 1995; Oyediran, Isiugo-Abanihe, Feyisetan, & Ishola, 2010; Shannon et al., 2012).

Unequal gender relationships and patriarchal dominance which exacerbate the inability of women to make decisions about reproductive health and sexual matters have been reported in sub-Saharan African countries (Schoepf, 1994; Wodi, 2005), in the United States of America (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009; Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002; J. K. Williams, Wyatt, & Wingood, 2010; Wyatt et al., 2000) and south Asian countries (Mukti & Lutfunnahar, 2014). For instance, African-American and Latin-American women's cultural values support relationships in which personal needs are sacrificed and this heightens the risk of unwanted sexual outcomes (Tillerson, 2008; Wyatt, 1992). Studies have shown that women settled for less desirable partners, accept infidelity and were

content to engage in unprotected sex because of the imbalance in the gender relations (Bowleg, 2004; Elengi-Molaye et al., 2001). These studies revealed that women may not apply disease preventive measures because they have no right to refuse sex in marriage (Awusabo-Asare et al., 1993; Chandran et al., 2012; El-Bassel et al., 2009; Meursing & Sibindi, 1995; Wasserheit & Holmes, 1992; Wodi, 2005).

Sexual faithfulness is an obligation wives owe their husbands although it is usually not a reciprocal obligation (Awusabo-Asare et al., 1993). Hence, women are expected to guard the moral order and have greater control over their sexual impulses (Carol et al., 1995; Wodi, 2005). In effect, women cannot openly communicate about sex because they would be tagged as being promiscuous (Balmer, Gikundi, Kanyotu, & Waithaka, 1995). Societal sexual double standards put women's sexuality under the control of their husbands and their families (Wolff, Blanc, & Gage, 2000). Awusabo-Asare et al. (1993) reported that married women have limited control over their sexuality in Ghana despite the fact that tradition accorded them sexual rights. Awusabo-Asare and his colleagues concluded that the inability of women to refuse sex was on the premise that male fidelity is not a cultural expectation. Evidence from developing countries shows that formally educated and working class women may be facing the same barriers to sexual and reproductive decision-making with their partners as uneducated and non-working class women (Nyanzi et al., 2005; Ulin, 1992).

On the other hand, the findings in Nigeria revealed that women have considerable control over their sexuality especially when there is evidence of infidelity and disease infection (Ogunjuyigbe & Adeyemi, 2005; Orubuloye, Caldwell, & Caldwell, 1992; Wusu & Isiugo-Abanihe, 2010). Factors that have a positive impact on women's sexual decision-making and safer sex negotiation in a particular group may not exhibit the same effect among people in another group. Thus, sexual and reproductive decision-making among women in marital and steady relationships are complex.

2.1.2 Contemporary views on women's autonomy

The International Conference on Population and Development (ICPD) (UNFPA, 1994), Millennium Development Goals (MDGs) (UN, 2000) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (UN, 2003) raise issues on reproductive health decision-making and the reproductive rights of women. Autonomy of women in reproductive health decision-making is considered a realization of their reproductive rights, gender equity and women empowerment. Autonomy has been defined only operationally by scholars due to a lack of a definitive consensus on the concept. Jejeebhoy and Sathar (2001) define autonomy as the "control women have over their own lives—the extent to which they have an equal voice with their husbands in matters affecting themselves and their families, control over material and other resources, access to knowledge and information, the authority to make independent decisions, freedom from constraints on physical mobility, and the ability to forge equitable power relationships within families" (page 688). Mumtaz and Salway (2009), fervent critics of the autonomy paradigm questioned the undue emphasis on women autonomy because in families, husbands and wives are united in an emotional and structural bond. They argued that "gendered inequality in access to resources beyond the home simply depicts that the interests of women are strongly vested in their families". Based on their argument, women's autonomy on reproductive health issues may continue to dominate in the development and reproductive policy agenda.

Following the Cairo declaration in 1994, studies have emerged on direct and proxy indicators of women's autonomy in reproductive health decision-making. The role of power in sexual relationships and gender differences in sexual and reproductive health decision-making has been examined (DeRose & Ezeh, 2010; Krishnan et al., 2008; Speizer, Whittle, & Carter, 2005). Other studies have examined the association between autonomy in reproductive health issues and family structure (Jejeebhoy & Sathar, 2001; Sathar & Kazi, 2000; Wusu & Isiugo-Abanihe, 2004) and contraceptive use (Blanc, 2001; Bogale et al., 2011; DeRose & Ezeh, 2010). Other researchers have investigated sexual control among women (Awusabo-Asare et al., 1993; Ogunjuyigbe & Adeyemi, 2005; Wusu & Isiugo-Abanihe, 2010).

2.1.3 Implication of power imbalance in heterosexual relationship

Power imbalance may affect fertility preferences and contraceptive use decision-making because women may not be able to broach the subject of contraception. Studies in Sub-Saharan African countries on couples fertility and contraceptive use decision-making showed that men and women rarely have similar fertility desires (Bankole & Singh, 1998). Women, therefore, practice contraception secretly (Belohlav & Karra, 2013) and avoid discussions on the desired fertility preference with the men. For instance, women in Brazil and India prefer using sterilization to avoid discussing reproductive issues related to who has more say on contraceptive use decisions (Gupta & Weiss, 1993). Where there is no communication on sex, reproductive decision-making may be non-existent. Thus, women may give birth to many children, which has adverse effects on the health of both the women and the children.

Vulnerability of women to a wide range of negative sexual and reproductive outcomes is attributed to their limited power in sexual relations (Campbell & MacPhail, 2002; Wingood & DiClemente, 2000; Wingood, Hunter-Gamble, & DiClemente, 1993). There is empirical evidence that the majority of HIV positive women in the developing world have been infected by their spouse (Eaton, Flisher, & Aarø, 2003; Ogunjuyigbe & Adeyemi, 2005; Varga, 1997; Wodi, 2005). On the other hand, studies have reported that both married men and women engage in extra-marital sex (Biraro et al., 2009; de Walque & Kline, 2011; Nnko, Boerma, Urassa, Mwaluko, & Zaba, 2004). However, these studies showed that the prevalence of extra-marital sex is higher among men than women.

Infidelity among men in sexual relationships may continue to fuel vulnerability of women to infections especially in marital and consensual unions. Between 2002 and 2013, the South African population living with HIV increased from 4 million to 5.3 million (StatsSA, 2013). About 17% of South African women of reproductive ages 15-49 years are HIV positive (StatsSA, 2013). This has been attributed to the vulnerability of women in heterosexual relationships where cultural and economic factors play significant roles (Leclerc-Madlala, Simbayi, & Cloete, 2009; Pettifor et al., 2004). HIV has fostered cases of divorce, separation and dissolution of families

in sub-Saharan Africa, due to the fact that sexual unfaithfulness is the main route of contracting and spreading HIV and STIs in marital relationships (Porter et al., 2004; Reniers, 2008).

2.1.4 Factors affecting the sexual decision-making capability of women

Sexual and reproductive decision-making between men and women is indeed complex and confounding. The power imbalance that influences the sexual and reproductive decision-making capability of women operates through socio-cultural and structural factors such as economic dependency and feminization of poverty (Dunkle et al., 2004; Falola & Heaton, 2007; Jewkes et al., 1999; Wodi, 2005; Zulu, Dodoo, & Ezeh, 2003), religious beliefs (Falola & Heaton, 2007; Wyatt et al., 2000), and being in a consensual union (Grady, Klepinger, Billy, & Cubbins, 2010; Speizer et al., 2005). Others include limited formal educational opportunities for women (Mathews & Abrahams, 2001; Wodi, 2005), place of residence (Maharaj & Cleland, 2004; Wodi, 2005), age difference within a couple, duration of the union (Langen, 2007; Speizer et al., 2005; Wusu & Isiugo-Abanihe, 2010) and spousal communication (Ogunjuyigbe & Adeyemi, 2005).

2.1.4.1 Place of residence and ethnicity

Place of residence has been shown to play a crucial role in the sexual and reproductive decision-making of women (Bloom, Wypij, & Gupta, 2001; Bogale, Wondafrash, Tilahun, & Girma, 2011; Petchesky, 1998). Studies conducted in developing countries revealed that in most cases the ability of a woman to control her sexual life is higher among women living in urban areas than their rural counterparts (Orubuloye, Oguntimehin, & Sadiq, 1997; Wusu & Isiugo-Abanihe, 2010). Wusu and Isiugo-Abanihe (2010) demonstrated that among the Ogu clan, urban women have a greater right to reject sex compared to rural women. In another study in Ethiopia, Bogale et al. (2011) showed that the urban setting is associated with a greater decision making power of women to use modern contraceptive methods compared to their rural counterparts. Their study revealed that better knowledge about modern contraceptive methods, gender equitable attitude, and socio-cultural flexibility on fertility enhanced the decision making power of women in urban areas. However, the right of urban women to refuse sex is not universal. For instance, Wolff, Blanc, and Gage (2000) documented that low bride

wealth amongst rural Baganda women exerts greater control in sexual issues compared to high bride wealth in urban Lango women in Uganda. Furthermore, ethnicity signified by language is associated with the tendency of women to exercise control over their sexual lives (Soet, Dudley, & Dilorio, 1999).

2.1.4.2 Education and employment

Factors such as Higher education and employment combine with urban residence, access to information and social networks to promote an egalitarian relationship between sexual partners (Adamczyk & Greif, 2011; Kroska & Elman, 2009; Shu, 2004). In a study, Mahraj and Cleland (2005) analyzed condom use among married or cohabiting couples in urban and rural South Africa in 1999-2000 using household survey data. They found that consistent and occasional use of condoms was 8% and 11% for men and women respectively with limited education in rural areas, whereas, the use of condoms among educated couples in urban areas was 29% and 34% for men and women respectively. In a study on condom use within marriage and consensual unions, Muhwava (2004) used quantitative and qualitative data from residents residing in both urban and rural areas. He observed that 27.8% of uneducated women use condoms consistently compared to 59.7% with tertiary education. Similar evidence of association between education and the prevalence of condom use was reported among women with secondary or higher education at 52.3%; primary and no education at 20.1% and 14.4% respectively in Tanzania (Exavery et al., 2012). However, a recent study in South Africa did not observe a significant association between education and condom use (Browne, Wechsberg, Bowling, & Luseno, 2012).

The social status of women, defined by education and occupation (Ogunjuyigbe & Adeyemi, 2005; Panchanadeswaran et al., 2007), has been found to play a critical role in sexual and reproductive decision-making. Higher education and economic advantage equip women with sexual and reproductive health autonomy (Finer & Zolna, 2011; Upadhyay, Dworkin, Weitz, & Foster, 2014). Vlassoff and Fonn (2001) noted that South African women who had more than secondary education were less restricted than those without formal education in reproductive health decision-making. Furthermore, decision-making on family planning was higher among women with higher levels of formal education than those with limited formal

education (Vlassoff & Fonn, 2001). A study in Ghana revealed that poor control over sexual lives was exacerbated among women with no formal education. (Awusabo-Asare et al., 1993). On the other hand, the level of formal education can empower women by changing the job status (Adamczyk & Greif, 2011) and encourage an attitude that is compatible with gender equality into safer sex-related behaviour (Adamczyk & Greif, 2011; Grady et al., 2010). In addition, men with some level of formal education exhibit a positive conjugal attitude which enhances their wives' right to turn down sexual advances (Ogunjuyigbe & Adeyemi, 2005; Wusu & Isiugo-Abanihe, 2010).

Women's socio-economic dependency on men has conferred on men the decision-making power in reproductive issues and may continue to be a challenge to women's sexual control (Jewkes & Morrell, 2010; Mindry et al., 2011). Studies in Cape Town (Mathews & Abrahams, 2001), Eastern Cape (Katharine Wood et al., 1998) and KwaZulu-Natal (Varga, 2003; Katharine Wood & Jewkes, 1998) revealed that financial dependence and gifts of clothing compelled women to stay in a relationship even if the men are violent, coercive and sexually dominant.

Other studies in South Africa indicated that young women and older women see sex as an opportunity for material gain and as means of barter (Jewkes & Abrahams, 2002; Leclerc-Madlala, 2003, 2008) leading to poor control of their sexuality. A study in Uganda showed that women accepted multiple partners due to economic needs (McGrath et al., 1993) despite high AIDS awareness. These studies reveal characteristics such as low level of formal education and having no job had a negative influence on the women's sexual and reproductive health decision-making. Conversely, the ability of women to exert control over their sexual lives was associated with economic independence (Blumstein & Schwartz, 1983; Ogunjuyigbe & Adeyemi, 2005; Orubuloye et al., 1992; Wusu & Isiugo-Abanihe, 2010). Studies (G. Becker, Murphy, & Tamura, 1994; Zulu et al., 2003) have documented that increasing women's human capital and greater incentive empowers women to practice safer sex and lowers the chances of sex for money. These studies give credence to the economic status of women being one of the determinants that inhibits women's bargaining power in sexual issues (Folbre, 1986; McElroy, 1990).

There are studies that contradict the relevance of economic independence in enhancing sexual control and sexual decision-making of women (Davhana-Maselesele et al., 2009; Nyanzi et al., 2005; Omeje, Oshi, & Oshi, 2011). For instance, ownership of income generating ventures did not improve women's bargaining power in reproductive decision-making in Nigeria (Omeje et al., 2011). In fact, economic independence of women led to their spouse relinquishing financial responsibilities in the household without any effect on sexual empowerment (Nyanzi et al., 2005). Nyanzi et al. (2005) concluded that the economic independence of women only avails them greater opportunity to enter and exit relationships than their counterparts who are not economically independent. Davhana-Maselesele et al. (2009) observed that earning salaries gave women neither economic freedom nor decision-making power in Vhembe district, South Africa. Economic advantage plays some role in empowering women but social norms may wield greater influence in reproductive decision-making power than the economic stability of women (Davhana-Maselesele et al., 2009; Omeje et al., 2011). In other words, economic independency may not entirely explain the inequality in participating in sexual and reproductive decision-making among women in marital or steady relationships.

2.1.4.3 Women's age, duration of union and living children

Demographic and socio-cultural factors such as age, ethnicity and gender norms can further the understanding of sexual and reproductive decision-making (Hearst & Chen, 2004; Shisana, Rehle, Simbayi, Zuma, & Jooste, 2009). A comparative study in South Africa and Botswana revealed that the greater the age difference within a couple, the less likelihood that a woman can negotiate safer sex or have control over her sexual life (Langen, 2007). A study in South Africa revealed that the age of the male partner is more associated with sexual risk taking than the age of the woman (Hargreaves et al., 2009). Studies in Nigeria show that the ability of women to control their sexual life increases with age and the duration of the union (Ogunjuyigbe & Adeyemi, 2005; Wusu & Isiugo-Abanihe, 2010).

There was evidence that the use of condoms decreases with increasing age (Exavery et al., 2012; Muhwava, 2004). A recent study in Tanzania showed that 48% of women less than 20 years old reported condom use in the last sexual

intercourse compared to 11% of women aged 40-49 years (Exavery et al., 2012). However, other studies did not show any link between condom use, age and place of residence (Browne et al., 2012; Maharaj & Cleland, 2004). Several studies have shown that as the duration of the union extends, greater trust is established leading to non- use of condom (Bond et al., 1997; Langen, 2007; Tavory & Swidler, 2009). Thus a decision to use condoms at a later stage in the relationship may suggest a breakdown in the already established trust, or infidelity.

In some settings, having children increased the sexual control of women (Isiugo-Abanihe, 1994), whereas women without children have less or no power in reproductive decision-making (Dyer, Abrahams, Hoffman, & van der Spuy, 2002). Langen (2007) noted that women do not negotiate conditions to engage in sex with their partners because they want to get pregnant as is expected of married women. The ability to discuss safer sex or exercise control over sexuality is overtaken by the desire to have children. Even in consensual relationships, women's powerlessness over their sexual lives was partly caused because they had no children (Speizer et al., 2005).

2.1.4.4 Marriage and cohabitation

In the context of marriage, men believe that by fulfilling the cultural obligation of paying *lobola* women become their property (Jewkes et al., 1999; Scott, 2010) thus dispossessing women of their individuality and compromising their fundamental human rights to some extent. The depth of this cultural belief is often demonstrated by women acknowledging that their husbands have a right to demand sex (Awusabo-Asare et al., 1993; Elengi-Molaye et al., 2001). Hence, the social and cultural context under which relationships exist hinders women from protecting themselves from STIs (Awusabo-Asare et al., 1993; van Loggerenberg et al., 2012).

Marriage in a patriarchal society suggests that husbands are household heads and decision makers, which is influenced by the extent to which they are able to cater for the household welfare (Jewkes et al., 1999; Wusu & Isiugo-Abanihe, 2010). The South African institution of marriage has undergone drastic changes as a result of modernization but the payment of *lobola* (bridewealth) by man to the woman's family remains important for a marriage to be recognised by black people

(Hargreaves et al., 2009; Peart, 1983; Rudwick & Posel, 2014). Studies have shown that a cultural stronghold for men to control their wives revolves around their ability to pay the bridewealth (Jewkes et al., 1999; Ramphele, 1989).

Cohabiting relationships have added a new dimension to the concept of a marital relationship in Africa generally accepted in South Africa (Matshidze, Richter, Ellison, Levin, & McIntyre, 1998; Mindry et al., 2011). Notwithstanding how the relationship is established, men exercise control over women in sexual and reproductive matters (Chimbiri, 2007; Jewkes et al., 1999; Muhwava, 2004). Obbo (1987) observed that vulnerability to male pressure is high among cohabiting women in East Africa who yearn for marriage. Furthermore, a study in Honduras showed that the vulnerability of the cohabiting women was aggravated by dependence on men for economic support (Speizer et al., 2005). The inability of cohabiting women to assert their position on sexual issues was attributed to the expectation that the relationship may translate to marriage (Obbo, 1987; Speizer et al., 2005). Given this imbalance in sexual relationships, married or cohabiting women may be at highest risk of negative sexual and reproductive health outcomes because the tendency to have sex occurs very often with little or no preventive measures. Lack of reproductive health decision making may account for the surge of STIs, including HIV, among married or cohabiting women (Clark, 2004; Glynn et al., 2001; Matovu, 2010).

2.1.4.5 Spousal communication

Women's reproductive decision-making power and access to reproductive health services have been found to be associated with spousal communication (Hamid, Stephenson, & Rubenson, 2011; Klomegah, 2006; Ngom et al., 1997). Couples who engage in spousal communication were more likely to discuss fertility and practice safer sex (Gage, 1994; Hamid et al., 2011; Klomegah, 2006). Studies have shown that women who initiated communication about safer sex were more likely to use condoms or apply protective measure (Chandrasekaran et al., 2006; Islam, Padmadas, & Smith, 2010; Jones et al., 2013). Elengi-Molaye et al. (2001) reported that 51% of the women in KwaZulu-Natal who could not raise a discussion on condom use were afraid of provoking their partners. Furthermore, 30% of the women dreaded abandonment if they suggested condom use to their partners.

Empirical evidence from Zimbabwe revealed that 85.5% of women who discused condom use were using them compared to 7.1% who never discussed it with their partners (Muhwava, 2004). Spousal communication can shape the power dynamics within marital and consensual relationships and in discussions about condom use and safer sex practices. Perrino, Fernández, Bowen, and Arheart (2006) documented that low income African-American women who persuade their male partners to use condoms were 10 times more likely to use than their counterparts. Evidence from Kassena-Nankana District of northern Ghana revealed that spousal communication was a predictor of contraceptive behaviour in the midst of other structural factors such as education and occupation (Bawah, 2002). Lack of or ineffective sexual communications compounds vulnerability to sexual risk-taking among youths in South Africa (Varga, 1997).

HIV/AIDS awareness and programmes on preventive measures to control the spread of HIV/AIDS are displayed on television, broadcast on radio, printed in magazines and newspapers (Muturi, 2007; Ross, Dick, & Ferguson, 2006). However, studies have shown that the interpersonal communications necessary to translate the information into protective behaviours are deficient within sexual relationships (Blanc, 2001; Muturi, 2007). The lack of communication has been attributed to the imbalance in gender relations where women are often younger, more inexperienced and poorer than male partners (Muturi, 2007; Schoepf, 1993, 1994). Thus, self-perceived low esteem of women continues to impair their ability to make use of information necessary to strengthen control of their sexuality.

Spousal communication between men and women is indispensable in sexual decision-making. Studies have shown that women's sexual negotiation and decision-making capacity were weak in relationships where spousal communication did not exist (Varga, 1997; Varga & Makubalo, 1996). Spousal communication was avoided because of the fear of being rejected, physical abuse and withdrawal of material benefits (Varga, 1997). These findings suggest that empowering women with communication skills may emerge as one of the strategies to promote women's sexual and reproductive decision health making in marital or steady relationships.

2.1.4.6 Reasons for sex

Understanding the reasons why women engage in sexual activities may provide the context of sexual decision-making. Wyatt et al. (2000) noted the reasons why women engage in sex are overlooked in research. The issues of concern in reproductive health are unintended pregnancy and sexually transmitted infections including HIV. Women's reasons for sex may be confounded by the dual purpose of procreation and recreation (Wyatt, 1994). Since sex is a natural act, women may want to enjoy sex without becoming pregnant, but use ineffective methods that do not protect them against disease transmission. Studies have shown that the decision to discontinue the use of contraception among women was associated with interference with sexual pleasure (Buck et al., 2005; Costello et al., 2002). Fertility is viewed as the main purpose for being a woman in South Africa. Women who do not have children tend to engage in unprotected sex in order get pregnant (Dyer et al., 2002; Langen, 2007). In some other African societies such as in Zimbabwe and Malawi, men's sexual pleasure was more important to women than their own pleasure (Woodsong & Alleman, 2008). In another study, Martin Hilber et al. (2010) reported that the sexual pleasure of men was the main reason for vaginal practices, including painful dry sex, which they believe will improve hygiene and improve genital health. Understanding the reasons for engaging in sex may be relevant in sexual and reproductive health decision making empowerment.

2.1.4.7 Reproductive decision-making social context of women in South Africa

The South African patriarchal society combined with the apartheid legacy impacted on poor reproductive health decision-making power and on sexual violence against women (Hargreaves et al., 2009; Jewkes & Abrahams, 2002; Maharaj, 2001; O'Sullivan, Harrison, Morrell, Monroe-Wise, & Kubeka, 2006; Katharine Wood et al., 1998). Partners programme promoting sexual and reproductive health in South Africa revealed that the suppression of black women benefited black men during the apartheid era (Peacock & Levack, 2004). sexual violence and reproductive health abuses against women have been reported in Cape Town (Jewkes, Vundule, Maforah, & Jordaan, 2001) and rural Transkei (Buga, Amoko, & Ncayiyana, 1996;

Dunkle et al., 2004). The traditional attitude to sexual relationships that perceives a woman as an object for sex and a baby-making machinery has not changed (Posel, Rudwick, & Casale, 2011; Preston-Whyte, Zondi, Mavundla, & Gumede, 1990; Katharine Wood, Maepa, & Jewkes, 1997). For instance, men encourage young women to become pregnant as evidence of love, womanhood, and fertility (Gage, 1998; Preston-Whyte et al., 1990; Katharine Wood & Jewkes, 1997). In addition, grandmothers encourage young girls to produce babies for their homes while the mothers advocate teenage pregnancies rather than infertility (Katharine Wood et al., 1997).

Preston-Whyte (1988) observed that fertility is an integral part of the cultural construct of the female self among people regardless of age or marital status. The cultural importance of female fertility discouraged the motivation to negotiate contraceptive use among women in South Africa (Varga & Makubalo, 1996; Kate Wood & Jewkes, 2006). The cultural milieu thus controls women's spheres of reproductive behaviour. Given that young women have been socialized to accept dependency raises the question as to whether women in marital and steady unions can participate in reproductive decision-making.

The post-apartheid era in South Africa did not witness only political emancipation but also a rapid socio-cultural transformation and changes in historical power differentials between men and women (Enslin, 2003; Posel, 2004). South African social and political climates offer equal opportunities to men and women. Women actively participate in the labour force: have access to education and access to family planning. The new dispensation has ushered in a flexible marriage system. Hence, women have a right to be in a marital relationship that is in community or out of community of property, a practice that seems peculiar to South Africa (Budlender et al., 2004). Marriage can give women access to control resources independent of husband/partners interference. These social transformations may alter the traditional sexual norms and values. This underscores the need for research into married and cohabiting women's autonomy in participating in sexual and reproductive decision-making in the midst of socio-cultural dynamics.

Notwithstanding the modernization in South African society, reproductive decision-making involves a multifaceted interplay of individuals, family interactions and a range of socio-cultural factors. In South Africa, women's aspirations to make sexual and reproductive health decisions independently spurred fierce criticism of rebellion against national, ethnic and religious identity (Klugman, 2000). Hence the call for research into power relations in sexual dynamics remains a matter of concern to researchers and requires some sense of urgency. Despite the myriad of literature in gender roles and reproductive health in South Africa, autonomy in sexual and reproductive decision-making among women in marital and steady unions is unclear.

2.1.4.8 Measuring women's sexual control

The scale of measuring women's economic and fertility decision-making was based on who has the greatest say in specific household matters (Karen O Mason & Smith, 2001). The perception of the weight of women's view in relation to controlling the household budget was used to examine the use of contraceptives and women's role in reproductive decisions (Blanc, 2001). It seems that reproductive decision-making is subject to economic status and therefore measured from the economic output. In the above research designs, economic power of the women may be confounding sexual negotiation capacity.

Studies have integrated proxy measures of power relations between couples through examining the sexual and reproductive health determinants (Blanc, 2001). The proxy measures include age and educational differences between the couple (Wolff, Blanc, & Gage, 2000), difference in earnings (Riley, 1997), type of bride wealth (Dodoo, 1998a; Isiugo-Abanihe, 1994) and spousal communication (Blanc & Wolff, 2001; Ogunjuyigbe & Adeyemi, 2005; Wolff, Blanc, & Ssekamatte-Ssebuliba, 2000). The finality of the proxy measures centres on the woman's acceptance or rejection of sex with some conditions.

2.1.4.9 Women's sexual control

Blanc and Wolff (2001) constructed a fertility-control scale which measures the respondents' perceived ability to determine their own fertility. The question posed to

the respondents was who has greater influence over whether to have sex. Furthermore, the measure of power dynamics was on the question whether a woman can refuse to have sex with her partner. Studies have used this question as the criterion of women's possession of sexual control (Ogunjuyigbe & Adeyemi, 2005; Wolff, Blanc, & Gage, 2000). This question is found to be reliable and valid because there are no confounding factors as only a woman knows whether she has the right to accept or reject sex.

Blanc et al. (1996) expanded the circumstances in which a woman can refuse sex to include decision-making about safer sex. Women may have a right to reject or accept sex but the circumstances under which the right may be altered in favour of the women suggest that they have sexual control. Studies have shown that women can reject sex during breastfeeding and menstruation (Ogunjuyigbe & Adeyemi, 2005; Wolff, Blanc, & Gage, 2000). Even the ill-health of a woman is a condition that requires caring. Hence these conditions may not adequately measure sexual control of the women. However, they are still relevant since there is nothing that prevents sexual activities under such conditions. Other salient conditions under which women's sexual control can be measured are having an extra-marital affair, suspicion of infection and failure of the partner to provide adequate support to name a few. Blanc et al. (1996) in their study included the refusal of sex where the partner is known to be having other sexual partners. Furthermore, the ability of women to demand sex is measure of sexual control (Ogunjuyigbe & Adeyemi, 2005).

2.1.4.10 Sexual decision-making

Westernization and modernization have impacted on traditional norms, but reproductive decision-making remains a vital issue for the unity of the family. Sexual decision-making is the preferences or resolutions made by a person regarding the timing of intercourse and the use of contraceptives when sexual relations occur (Varga, 1997). The major question in reproductive decision-making is whose fertility preference prevails or who has more say on sexual or reproductive decisions (Acharya et al., 2010; Iyayi, Igbinomwanhia, Bardi, & Iyayi, 2011). Generally, fertility desires of men and women differ in the family (Grady, Tanfer, Billy, & Lincoln-Hanson, 1996). The impact of each partner's fertility desire as

regards to practicing contraception or having a child depicts the relative power (Blanc, 2001; Grady et al., 2010). A number of studies in Sub-Saharan African countries (Isiugo-Abanihe, 1994; Iyayi et al., 2011; Orisaremi & Alubo, 2012) and other countries (Hirsch, 2003; Mumtaz & Salway, 2005, 2009) have observed male-controlled sexual and reproductive health decision-making. Conversely, studies have shown that women take major decisions on family planning (S. Becker, Fonseca-Becker, & Schenck-Yglesias, 2006; Kritz & Makinwa-Adebusoye, 1999; Ogunjuyigbe & Adeyemi, 2005). Autonomy in sexual and reproductive health decision-making may have a positive influence in meeting reproductive health goals.

How this power operates remains unclear, because the demand for and use of contraceptives between partners in sexual relationships changes (S. Becker et al., 2006; Ngom et al., 1997). The relative power of one partner is in conflict across settings and inconsistent within the same locale (Blanc, 2001). A study in 18 developing countries showed that the use of modern contraceptives is highest when both partners agree to stop childbearing and lowest when more children are wanted (Bankole & Singh, 1998). However, the pattern is inconsistent when there is disagreement. Multivariate analysis of 14 countries showed that wives' preferences wield greater influence over their husbands' on contraceptive use in Egypt, Kenya, Mali, Morocco, Pakistan and Uganda (Bankole & Singh, 1998). None of the spouses' preference was significant in Burkina Faso, Cote d'Ivoire, Ghana, Tanzania and Zimbabwe. In the remaining three countries, a husband's preference prevailed in Malawi, while spouses' preferences was similar in Bangladesh and Brazil (Bankole & Singh, 1998).

Studies in Ghana and Kenya found that a wife's attitude to contraception is influenced by the husband's attitude and decision (Dodoo, 1998b; Ezeh et al., 1993). In Uganda, partners' disagreement over future childbearing provoked lower contraceptive use among women (Wolff, Blanc, & Ssekamatte-Ssebuliba, 2000). Studies in five Asian countries showed that women's fertility preference on contraceptive use surpasses the power of men's influence (Karen Oppenheim Mason & Smith, 2000). The study showed that in a community where women have greater autonomy, their preference dominates that of men on contraceptive

decision except in the Philippines. The dynamics of sexual decision-making in sub-Saharan African countries and elsewhere within spousal relationships were influenced by other variables. Some of these variables, especially having no children, make sexual decision-making of the woman subject to the husband's preference. Measuring the power of women in sexual or reproductive decision-making were about who has more say on when to have sex, use of contraceptives, family planning methods to use, when to have children and desired family size.

2.1.4.11 Ability to act

The knowledge and attitudes of women about HIV/AIDS and STIs have been used to measure the nature of sexual control exercised by women in conjugal unions (Pulerwitz, Amaro, Jong, Gortmaker, & Rudd, 2002; Pulerwitz, Gortmaker, & DeJong, 2000; Wingood & DiClemente, 2000). These studies have questions about the awareness of HIV/AIDS and STIs and the mode of transmission. Where the knowledge exists, the extent to which women were able to communicate it to their husband is important. There are also questions on the source of the information and the knowledge of contraceptive methods as well as the dual purpose of condom use (Pulerwitz et al., 2000). Where there are cases of infidelity, are the women able to initiate protective measures in their sexual relationships? The quantitative assessment of women's ability to protect themselves from sexually transmitted infections is determined by increased condom use (Pulerwitz et al., 2000). Sexual Relation Power Scale (SRPS) shows positive correlation with consistent condom use (Pulerwitz et al., 2000). For instance, women with higher scores on the SRPS were more likely to make a decision to consistently use condoms than women with lower scores (Dunkle et al., 2004; Pulerwitz et al., 2000). SRPS considers consistent condom use as evidence for having power and control over sexuality. However, an outright rejection of sex is an indication that the woman has control over her sexual life.

2.2 THEORETICAL FRAMEWORK

Several theories such as the theory of planned behaviour, Social cognitive theory, Social exchange theory, and Gender and Power theory have been used to explain sexual and reproductive decision-making. These have looked at sexuality from

different disciplinary and methodological perspectives. These include general socio-economic studies (identified with sociology, social demography and public health), and the psychosocial and microeconomics of power relations dynamics (identified in ethnographic studies, psychology and economics disciplines). The present study used the structural theory of Gender and Power.

2.2.1 Theory of Gender and Power

Connell (1987) developed the theory of gender-based power imbalances on three distinct but overlapping structures of gendered relationship between men and women. According to Connell (1987) these three structures are present at the societal and institutional levels and are sustained by social mechanisms. In the socio-cultural arena, there exist double standards which serve to intensify women's vulnerability in all spheres of life. The three structures are:

- Sexual division of labour – refers to economic inequity between men and women;
- Sexual division of power – refers to male dominance within relations; and
- The structure of the cathexis – refers to societal norms about gender roles.

A theoretical framework such as gender and power is required to understand sexual and reproductive health decision-making. The theory of gender and power is ideal for analysing intersecting identities such as culture, gender and sexuality. The three structures of gender and power theory put married/cohabiting women at the centre of the subject being investigated through the socio-cultural perspective for understanding the life experiences of these women. It offers a wide-ranging analysis of sexual dynamics, promotes women empowerment and integrates male perspective into its definition. Studies have used this theory to account for sexual risk outcomes (Blanc, 2001; Pulerwitz et al., 2000; Wingood & DiClemente, 2000) but limited in determining if the women's sexual decision-making power were compromised (Amaro, 1995; Upadhyay et al., 2014). Some researchers notably, Wingood and DiClemente (2000) extended the theory of gender and power to exposure, risk factors and biological features that influence women's susceptibility to HIV in public health models. This theory can also be extended to understand sexual and reproductive health decision-making among women. The present study therefore seeks to apply the theory of gender and power on sexual and

reproductive decision-making life experiences stemming from married/cohabiting women.

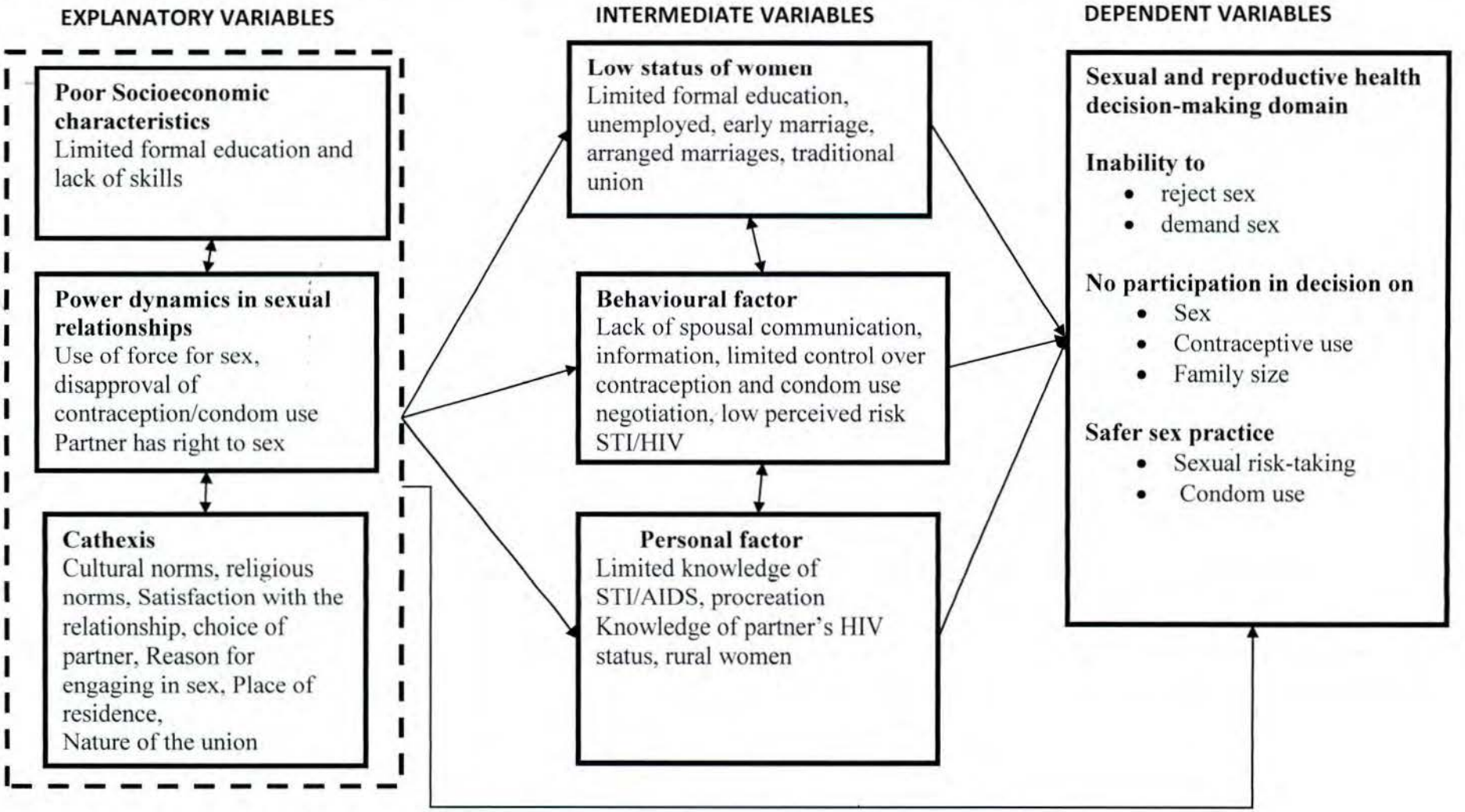
2.3 CONCEPTUAL FRAMEWORK

The conceptualization of sexual and reproductive health decision making described in this study shows a direct or indirect link to the ability to decide or act within the reproductive health sphere as shown in Figure 2.1. In the first place, poor socioeconomic characteristics such as limited formal education and lack of skills act in a vertical relationship to power dynamics in sexual relationships and the social norms (cathexis) related to sexuality to influence low status of women, behavioural and personal factors of an individual. Poor socioeconomic characteristics influence low status of women, expressed through unemployment, limited formal education and early or arranged marriages. Power relation manifests through the use of force for sex, disapproval of contraception and partner's perceived right to sex to influence behaviour such as limited communication and control over contraception. Power relations may have a direct effect on behavioural abilities of partners to procure information vital to their reproductive health, to make decisions related to their health, and to take action to protect or improve their health. The social norms influence women by shaping perceptions by limiting the knowledge of realities such as STI/AIDS, knowledge of partner's HIV status, low perceived risk of STI/HIV and partner's right to sex. Some of the individual items represented more than construct. For instance low perceived risk represents behavioural and personal factors. Perceived right of partner to sex represents power dynamics and social norms. Poor socioeconomic characteristics directly influence the sexual and reproductive health decision-making domain through limited formal education and skills. Power dynamics within sexual relationships link the sexual and reproductive health decision-making domain directly through its sexual coercion between partners. Cathexis also has a direct influence on the sexual and reproductive health decision-making domain through cultural and religious socialization.

Low status of women also acts in a vertical relationship with behavioural and personal factors to influence the sexual and reproductive health decision-making domain. Characteristics such as early or arranged marriages, unemployment, and limited access to formal education influence the ability to make sexual and

reproductive health decisions. The extent to which individuals have information as well as spousal communication and access to reproductive health services would impact on the ability to make sexual and reproductive health decisions. Direct effects of behaviour factors include limited ability to make sexual and reproductive health decisions. Personal factors such as limited knowledge about STIs, no risk perception, and social context such as importance of procreation impact on sexual and reproductive health decisions. Specific measures within the sexual and reproductive health decision-making domain are women's ability to reject or demand sex from their partners, autonomy on when to have sex, use contraception and decide family size. Sexual risk-taking behaviour and consistent condom use which show their ability to practice safer sex are measured in the sexual and reproductive health domain.

Figure 2.1: Conceptual framework for sexual and reproductive health decision-making



Source: Constructed using the theory of gender and power (Connell 1987) by the author.

2.4 CONCLUSION

The role of power dynamics in sexual relationships has been reviewed in the literature. Studies have found that power dynamics influence sexual and reproductive health decision-making (Blanc, 2001; Krishnan et al., 2008; Wingood & DiClemente, 2000). Given also that most societies are patriarchal, men dominate sexual, and reproductive health decision-making and men's extramarital sexual relationships (Akwara, Madise, & Hinde, 2003; Oyediran et al., 2010; Smith, 2007; Wusu & Isiugo-Abanihe, 2010), promoting sexual and reproductive health decision-making among married and cohabiting women demands an understanding of cultural and traditional practices.

Constrained sexual and reproductive health decision-making among women is the cumulative effects of the power imbalance in a sexual relationship within the couples (Jewkes, Dunkle, Nduna, & Shai, 2010; Rivers et al., 1998). Therefore, women's susceptibility to the spectrum of negative sexual and reproductive health outcomes will depend on the understanding of power differentials at socio-cultural levels. In the review of the literature, socio-demographic characteristics of the women were found to influence sexual and reproductive health decision-making. High levels of formal education as well as being employed and engaging in spousal communication are seen to have a positive influence on women's sexual and reproductive health decision-making. Women who had control over their sexuality appeared to have formal education and were employed. Good communication between the partners enhanced sexual and reproductive health decision-making of the women. While enhancing women's status, limiting sexual partners and prioritizing safer sex are emphasized strategies to empower and prevent negative sexual health outcomes among women, it is important to understand the relative effect of these socio-demographic variables on sexual and reproductive health decision-making (Krishnan et al., 2008; Panchanadeswaran et al., 2007).

CHAPTER THREE: METHODOLOGY AND DATA SOURCES

3.0 INTRODUCTION

This chapter presents the study methodology and data sources. The methodology includes study design, target population and sampling techniques. In addition, the variables used in the analyses are presented together with their respective definitions. The chapter further presents the statistical techniques applied in analysing the survey data and the method used to analyse qualitative data. In addition the scope of the study has been described. Finally the chapter discusses the ethical issues pertaining to the study.

3.1 STUDY DESIGN

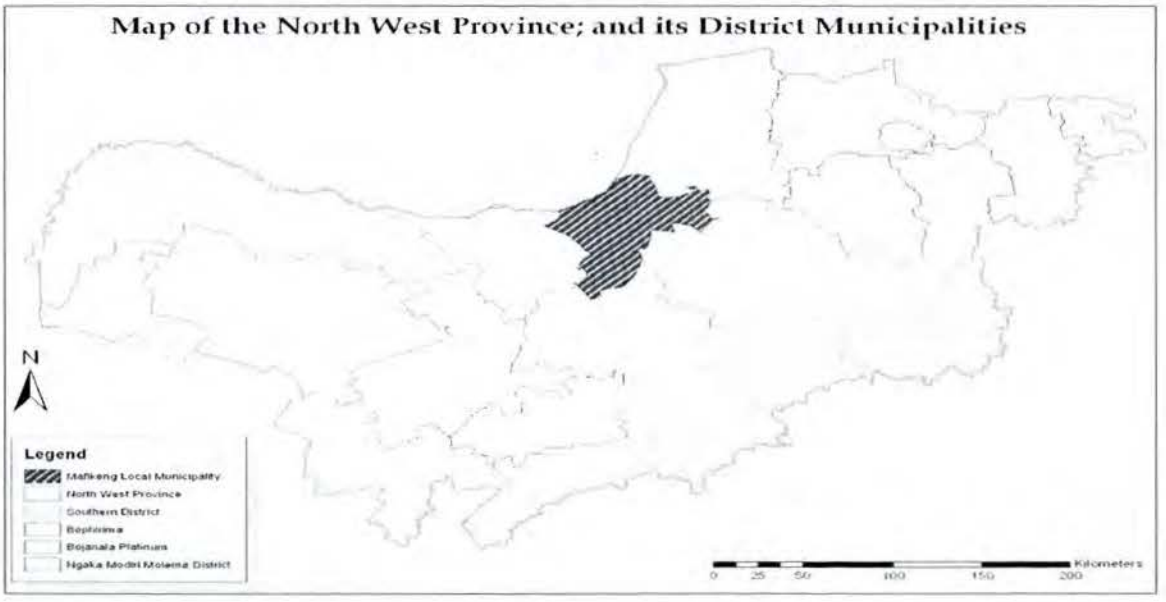
This was a cross sectional descriptive study using mixed methods of quantitative and qualitative approaches. The strength of mixed methodology is the premise that it offsets the weaknesses of either quantitative or qualitative approaches. The complex nature of sexual and reproductive decision-making calls for a combination of quantitative and qualitative data for the investigation. The quantitative data provided a general understanding of sexual and reproductive decision-making in the first phase of the study. In the second phase of the study, the qualitative data were used to support statistical results and to understand the dynamics of decision-making on sexual and reproductive health issues by women. The information generated covered respondents' socio-demographic and reproductive health characteristics.

3.2 PROFILE OF THE STUDY AREA

The map of the study area is presented in Figure 3.1. North West is one of the nine provinces in South Africa. The population was estimated to be about 3.6 million in 2013 (Statistics South Africa, 2013). About 65.0% of the inhabitants of the province are Tswana speaking people. Other groups are Afrikaans, Sotho, IsiZulu, Tsonga and Xhosa speaking people. Administratively, the North-West province is divided into four district municipalities namely Ngaka Modiri Molema, Dr Ruth Segomotsi Mompati, Dr Kenneth Kaunda, and Bojanala. The focus study area was the Mahikeng Local

Municipality in the Modiri Molema District Municipality. Mahikeng, as a local municipality and capital of the North-West province, occupies an area of about 6,465 sq km. It comprises 31 wards within designated residential areas (urban) and 108 villages (rural). About 75% of Mahikeng Local municipality is rural. The southern and western parts of the municipality constitute rural areas which are the tribal territories. Mahikeng and Mmabatho constitute the urban areas which are the suburbs and 16 residential Units. Mahikeng includes Danville, Imperial Reserve, Riviera Park, Golf View, Libertas, Rooigrond and the central business district while Mmabatho consists of Leopard Park, Montshiwa, Extension 39, Extension 38 and the 16 units.

Figure 3. 1: Shows the shaded area which is the Mafikeng Local Municipality where this study was undertaken



3.2.1 Choice of the study area

There are several reasons for choosing Mahikeng Municipality for the study. There is scant information about the Tswana people of Mahikeng Municipality in demographic literature. Mahikeng municipality has continued to experience a declining trend in the number of women in legal marriages whether civil or traditional, and an increasing number of women in cohabitation relationships. The proportion of women aged 18-49 in

legal marriages has declined by 16%, whereas cohabiting women of the same age group increased by 161.2% between 1996 and 2011 (StatsSA, 2012). This may suggest that the Tswana marriage system is undergoing transformation. However, some scholars still argue that culture continues to be an important influence in the daily life of Tswana people, particularly in rural areas (Gulbrandsen, 1986; Nkomozana, 2008). Hence this area is ideal for investigating how married women feel about their culture and traditions on sexual and reproductive health matters compared with religious teachings and westernization. In addition, Mahikeng municipality is one of the few places in the North West province which has a large urban setting. North West province is also the province with the fourth highest prevalence of HIV/AIDS among pregnant women (Shisana et al., 2009) and people living with HIV/AIDS in South Africa (UNAIDS, 2010). A study on sexual and reproductive health decision-making among women in relationships is vital to understand the dynamics of STIs, including HIV.

3.3 TARGET POPULATION AND SAMPLING

The target population was adult heterosexual married women within the reproductive age range (18-49) in Mahikeng Local Municipality. Since cohabitation constitutes a significant proportion of couples in stable unions in the municipality, the study also targeted heterosexual cohabiting women by considering them as married.

3.3.1 Sample Size

In order to make the sample size representative of the whole population in the study area, the Yamane (1973) formula was applied. The virtues of this formula lie in the knowledge of the population size, applying simple and stratified random samples concurrently. A 95% confidence interval and p = 0.05, the level of significance are assumed on the basis of a normal population. The formula states as follows:

$$n = \frac{N}{1 + N\,(e)^2}$$

Where:

n is the sample size

N is the population size

e is the level of precision (sampling error)

Based on the number of currently married women of reproductive age as reported in the 1996 and 2001 censuses, the exponential growth model was used to extrapolate currently married women of the same age group for 2011. The assumption of this model is that population changes by a constant rate over an infinite unit of time. The growth rate (r) was computed using the national population of married women from the censuses of 1996 and 2001.

$r = \ln (POP_{2001}/POP_{1996})/n = \ln (6663071/5922174)/5 = 0.0236$

$r = 0.0236$

The estimated currently married women in 2011 for Mahikeng is computed thus

$$POP_2 = POP_1 e^{tr}$$

Where:

t is number of time intervals between POP_1 and POP_2

POP_1 is initial population of married women

POP_2 is final population of married women

$POP_{2011} = POP_{2001} e^{10*0.0236}$

$POP_{2011} = 32601 e^{10*0.0236} = 41278.5$

By the time the survey was carried out, the South African 2011 census was still at the preparatory stage. Hence the estimation of the married and cohabiting women was based on projection. The sample size was calculated on the premise of the extrapolated sampling frame of 41,278.5 currently married women in Mahikeng municipality

$$n = \frac{41278.5}{1 + 41278.5\ (0.05)^2}$$

$n = 397$

The calculated sample size was 397. However, some researchers add ten percent to the sample size to compensate for non-response and non-reacheable (Israel, 1992). In

general, the sample size was increased by 30% and 10% to compensate for non-reachable and non-responses (Israel, 1992). Thus in the present study 40% of 397 was added to the sample size.

$$x = \frac{40 * 397}{100}$$

Where x is compensating for non-reachable and non-responses

$$x = 158.8$$

Total sample size = 397 + 158.8 ~ 556

For the qualitative study a sample size of 33 women in marital/cohabiting union was used since an adequate sample for qualitative demographic studies ranges between 25 to 50 participants (Coffey, 2006).

3.3.2 Sampling procedure

Cluster sampling technique was employed in the study. The sampling frame for each of the selected areas consisted of the enumeration areas provided by Statistics South Africa (StatsSA 2012). The study area was stratified into urban and rural, designated as formal and traditional residential places respectively. Urban residential areas were further stratified into Mahikeng and Mmabatho. In Mahikeng, three residential places were randomly selected and six were selected from Mmabatho. In the rural area, five traditional residential areas were randomly selected. The selected formal and traditional residential areas were composed of the enumeration areas. These enumeration areas were treated as clusters and each contained about 150 households. Clusters were sampled with probability proportional to the number of households. In the urban areas, 10 households were randomly selected in each cluster and in 15 rural areas. Married or cohabiting women of ages 18-49 were identified in each household. In households where there was more than one eligible respondent, one was randomly selected, and no substitution was used if a household did not meet the criteria. A total of 800 households were selected from the clusters for the study: 192 in urban and 608 in rural areas. The urban locations and rural areas selected for the study are shown in Table 3.1 below.

Table 3. 1: Number of studied areas, enumeration areas (EAs) and households in Mahikeng municipality

Local Municipality	Main Place Name	Sub place Name	EA	Households
Mahikeng				
Urban	Mahikeng	Golf View	4	38
		Libertas	3	21
	Mmabatho	Montshiwa	5	49
		Unit 1	1	11
		Unit 3	1	8
		Unit 6	1	17
		Unit 13	2	22
		Unit 14	2	26
Rural	Magogoe	Magogoe	12	152
	Koikoi	Koikoi	10	147
	Ramosadi	Ramosadi	7	130
	Majemantsho	Majemantsho	6	96
	Lomanyaneng	Lomanyaneng	6	83
Total			60	800

3.4 STUDY INSTRUMENT

Two types of study instruments were developed: a structured questionnaire for the quantitative investigation and a semi-structured interview guide for the qualitative strand.

3.4.1 Quantitative instrument

A structured questionnaire was designed and developed after an intensive and extensive review of previous studies on sexual decision, reproductive decision-making and sexual negotiation (Blanc, 2001; Iyayi et al., 2011; Langen, 2007; Varga, 2003; Wusu & Isiugo-Abanihe, 2010). Reviews of the objectives and questionnaires design were done on demographic research (Awusabo-Asare et al., 1993; Ogunjuyigbe & Adeyemi, 2005; Orubuloye, Caldwell, & Caldwell, 1993). In addition, questions related to HIV and contraception use were adapted from Demographic and Health Surveys (Macro, 2011). The questionnaire was first translated into Setswana by an experienced translator, who has a background in translating health questionnaires. Later, it was reviewed by another independent translator. Finally, it was administered by trained and competent research assistants to the respondents in face to face interviews.

The questionnaire used for the quantitative study is presented in Appendix1. Data were collected under the following themes.

- Socio-demographic characteristics of the women;
- Level of women's sexual control;
- Reproductive decision-making;
- Knowledge and attitude to STIs;
- Knowledge and attitude to contraceptive use and condom use; and
- Reasons for sex

3.4.2 Qualitative investigation

Furthermore, individual in-depth interviews (IDIs) were conducted on sexual and reproductive health issues using a purposeful sample. Given that sex is not publicly discussed in African settings, data were collected on women's experiences on sexual and reproductive decision-making experiences from the perspective of the individual (Moustakas, 1994). Individuals who were willing to describe their experiences in sexual and reproductive decision-making were recruited. Given the relevance of social class in demographic research, background characteristics sampling reflects maximum variations in place of residence, age, duration of union, education and occupation were considered in selecting the participants. The aim was to explore whether perceptions and attitudes vary in issues of sexuality.

Since the questions asked have much to do with women's experience in marriage, only women who were married for at least five years were included in the sample. The reason was that five years is sufficient for a woman to have experience in sexual matters within the context of marriage. To ensure that there is no information lost, the proceedings were recorded using a digital voice recorder. Trained research assistants conducted 30-40 minute interviews in Setswana.

Interviews were conducted using a semi-structured interview guide (Appendix 2). Data were collected under the following themes.

- Socio-demographic characteristics of the women;
- Cultural influence on sexual control;

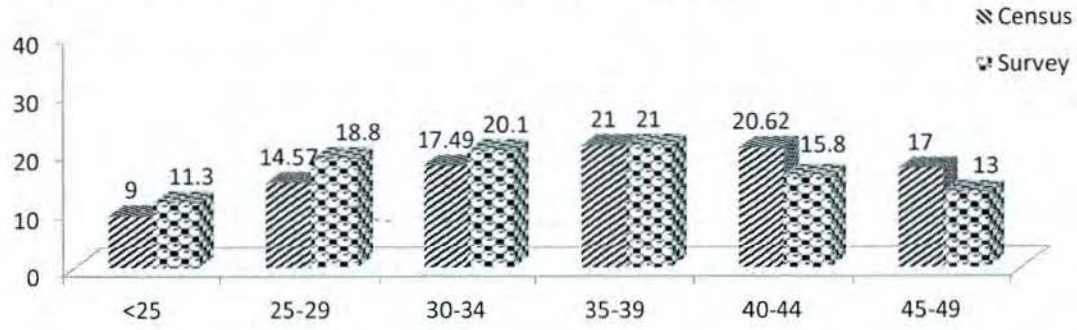
- Perception about condoms.

3.5 DATA QUALITY ASSESSMENT

Several precautionary measures were taken at every stage of the survey preparation. Research assistants were trained in line with the objective of the study. A small-scale trial of the study was carried out to pre-test the accuracy of the questionnaire in answering the objectives. During the data collection process field editing was done by the researcher. In order to check for accuracy of the data entry, 250 questionnaires were randomly selected from the 568 questionnaires and re-entered. Cross-domain analysis was used to compares the data values in two columns to identify inconsistencies.

Quality of data was assessed by comparison with available national census data of Mafikeng municipality 2011 which did not show large variations. Data revealed similarities in age distribution (see figure 3.2). Census data indicated that 9%, 21% and 17% were within the age groups less than 25, 35-39 and 45-49 respectively (StatsSA, 2013). The survey data also revealed that 11%, 21% and 13% were in the same age groups.

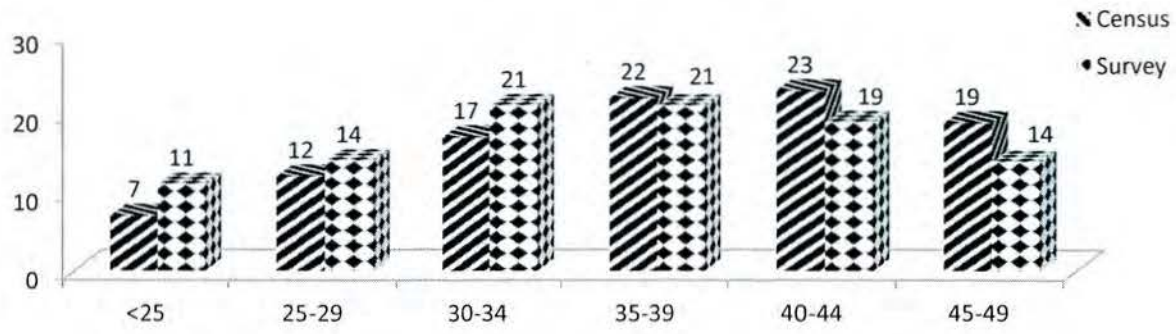
Figure 3.2: Age distribution pattern between census data and survey



Source: (StatsSA, 2013) and Sexual decision-making survey, 2012.

National data on primary education among married women showed a similar pattern to the survey data (see figure 3.3).

Figure 3.3: Age distribution of women by primary education



Source: Source: (StatsSA, 2013) and Sexual decision-making survey, 2012.

3.6 DATA PROCESSING

The number of questionnaires returned was 582. After screening the returned questionnaires, 14 of them were removed because they were incomplete. The IBM Statistical Package for Service Solutions (SPSS) version 20 was used for data processing.

3.7 VARIABLES CATEGORIES AND THEIR OPERATIONALIZATION

3.7.1 Independent variables

There are three groups of independent variables used in predicting sexual and reproductive decision-making among women. These are (1) socio-demographic variables; (2) STI/HIV/AIDS related knowledge and attitude; and (3) Reason for sexual activities.

- **Socio-demographic characteristics:** Respondents reported their age, age at marriage, duration of the union, type of union, home language, level of education, occupation, place of residence, religion, and number of living children, husband's occupation, spousal communication, husband's right to sex, use of force for sex, his approval of family planning, choice of partner and satisfaction with the partner.
- **Knowledge and attitude to STI/HIV/AIDS:** on the basis of empirical findings, decision and attitude to practice safer sex are influenced by an individual's

perceived risk of being infected, knowledge of partner's HIV status, HIV risk factor, condom use efficacy and ability to suggest the use of condom, knowledge and misconception about mode of HIV transmission.

- **Reasons for sex:** Respondents were asked to state the level of importance on eight statements related to the reasons for engaging in sex on a scale of four points.

Some independent variables which are continuous were coded in categories as they could be more meaningful in understanding transition in dependent variables with time. The age of the women was coded into six categories as follows: <25, 25-29, 30-34, 35-39, 40-44, and 45-49. The age of women at commencement of the union was coded into three categories (<25, 25-29, and 30+). The duration of the union was coded into three categories (< 5, 5-9, 10+) The number of living children was coded into four categories (None, 1-2, 3-4, and 5+).

3.7.2 Dependent variables

Decision-making on sexual and reproductive issues which was the dependent variable was classified into broad headings as follows: (1) level of women's sexual control; (2) participation in reproductive decision-making; (3) risky sexual decision-making; and (4) condom use. The measures of the various dependent variables were described in the relevant analytical chapters.

3.7.3 Analytical procedure

At the univariate level, frequency and percentages were used. Bivariate analysis was employed for the relationships between the dependent and independent variables. Analyses were done in the form of cross tabulations of women's profiles with regards to sexual control, sexual decision-making and condom use etc.

Multivariate regression models were applied to establish the nature of associations between the outcome variables and the predictors. Multivariate binary logistic

regression models are ideal when the dependent variable is dichotomous (for example current condom use, rejection of sexual intercourse etc) and the independent variables (Age, place of residence, educational level etc) are of any type. Multivariate analysis establishes that the dependent variable is related to the independent variables and error term. The general mathematical form of the model is as follows:

$Y = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \ldots\ldots\ldots + \beta_pX_p + E$

Y represents the dependent variable

$X_1, X_2, X_3, X4\ldots\ldots\ldots X_p$ represent the independent variables

$\beta_0, \beta_2, \beta_3, \beta_4\ldots\ldots\ldots\beta_p$ represent coefficients

E is the error term.

The distribution of the logistic model is binomial with values 0 or 1. The relationship between the outcome (dependent variable) and the predictor (independent variables) is expected to be non-linear (s-shaped). The logistic regression model gives the probability that the outcome is an exponential function of the independent variables (Knoke *et al.*, 2002).

Data therefore can be fitted in an equation of this form:

$\text{Logit}(p) = \alpha + b_1X_1 + b_2X_2 + \ldots + b_nX_n$

Where logit (p) is the log of the odds that the dependent variables (condom use, demand or reject sexual intercourse and participation in reproductive health decision-making) is 1; α is the intercept; $b_1, b_2\ldots b_n$ are the regression coefficients and $X_1, X_2 \ldots X_n$ are independent covariates (selected characteristics of the respondent). Multivariate analyses were presented as odds ratios and 95% confidence interval.

3.7.4 Multicollinearity:

Prior to the logistic regression modelling, multicollinearity diagnoses were performed for all the independent (regressor) variables. Multicollinearity occurs when there is a high degree of correlation between regressor variables. The adverse effect of multicollinearity is inflating variances of parameter estimates. Collinearity diagnoses

were performed to eliminate such problem by applying SPSS collinearity diagnoses of variance inflation factors (VIFs) test on the regressor variables. VIF relationships among regressor variables generated in SPSS indicated that the regressors were not strongly correlated and none of them was excluded from the investigation (VIFs = ~ 2).

3.8 QUALITATIVE ANALYSIS

The data were transcribed, typed, translated to English and analyzed manually using thematic content analysis. The robustness of content analysis is that codes and categories emerge from the raw data without preconceived ideas or theoretical perspectives (Hsieh & Shannon, 2005). The information gathered from the qualitative interview was read, reread and organized under broad headings that portray different categories that depict women's experiences in sexual and reproductive health decision-making within marriage and cohabitation, using a spreadsheet. The important statements and phrases were noted and the substantive ideas were extracted and labeled as codes. Codes that were overlapping were merged and a primary categorization of data was performed. Data reduction continued in all analysis units until main categories evolved. The categories were subsequently examined for relationships across different categories for consistency. Striking expressions were noted and reproduced verbatim or edited to make them easily readable where necessary. Inter-transcript reliability was carried out by an independent qualitative researcher. In order to respect the anonymity of the participants, only place of residence, duration of the union and the type of union were stated in the analysis. Results were presented in themes by category and sub-category.

3.8.1 Presentation of findings

All the figures and tables were placed below their various interpretations. The presentation and interpretation of the quantitative and qualitative findings were done sequentially. The discussion and conclusion were presented concurrently in the relevant chapters.

3.9 SCOPE AND LIMITATIONS

Irrespective of how developed South Africa may appear, sex in the African context remains a sensitive issue. The first limitation was that data collected were based on self-reporting and there was no method that was used to verify the responses. However, the researcher made use of appropriate mechanisms during data collection to ensure that the above limitation was minimized. One strategy that was used was asking questions for the opinions of respondents rather than their personal experiences. In addition, Demographic and Health Surveys questions are robust source of information on HIV/AIDS, sexuality and reproductive health (Żaba et al., 2009). Survey research on structural and socio-cultural influences on women's sexual decision-making has produced credible and consistent findings such as the ones used in the study (Hamid et al., 2011; Hargreaves et al., 2009; Kaiser et al., 2011; Shannon et al., 2012).

The second limitation was that the in-depth interviews were conducted only with black people whose main home language was Setswana. So opinions of other ethnic groups residing in Mahikeng were not reflected. These limitations were taken into account when interpreting the findings.

3.10 ETHICAL ISSUES

In accordance with the ethical guidelines for protecting human research subjects, research clearance was obtained from the North-West University (Appendix 3). The approval of the local municipality or local chief under which the enumeration areas and households fall was obtained. The awareness of the relevant authority about the study enhanced participation and easy data collection. Consent of the husbands/partners of the women was obtained in each household prior to proceeding with interview. This created a rapport for the successful data collection.

The participants in the study were assured of the confidentiality of their responses and that the information sourced from them would be used only for the purpose of the research. The instrument that was used to collect information may contain questions which are regarded as sensitive by some participants. However, the researcher

acknowledged that participants have the right to privacy, voluntary participation and anonymity. Participants felt secure to share their experiences in interviews where there was assurance of anonymity. To create such an enabling platform for the interview, the objectives of the study were made clear to the respondents in the informed consent form which was completed before data collection process began. The informed consent form is presented in Appendix 4.

CHAPTER FOUR: BACKGROUND CHARACTERISTICS OF THE STUDY POPULATION

4.0 INTRODUCTION

Chapter 4 presents background characteristics of the respondents, knowledge and attitude to STIs and the reason why women engage in sexual activities. Background characteristics and reasons for engaging in sexual activities were presented in relation to the type of union. Knowledge and attitude were shown by place of residence.

4.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

An examination of the type of union showed that civil marriage is the most popular form of marriage followed by traditional marriages (Table 4.1). Cohabiting women formed the lowest percentage of the respondents (17.0%). Apart from contraceptive use approval by the partners, chi-square analyses revealed association between the type of union and all other socio-demographic characteristics. About two-fifth of the women were between 30-39 years old. Over 50% of the women in religious union were between 35-44 years old, while over 60% of the cohabiting women were below 29 years old. Seventy-eight percent of the women resided in rural areas. Over four-fifths of the cohabiting women were residing in rural areas. Fifty-one percent of the respondents had primary or no formal education. Over half of the women in a cohabiting union had primary or no formal education. Occupational distribution revealed that over a quarter (29%) of the women were unemployed. Over two-fifths of women in traditional union (46%) were unemployed. In terms of religious affiliation, 94% of the population were Christians. As expected, Setswana was the major language people speak at home (66.2%). About two-thirds of the respondents had been in a relationship for nine years or less. Eighty-seven percent have living children and 6.0% have 5 children or more. Over a quarter of those in civil, religious or traditional unions had 3-4 children compared to 13% of the cohabiting women.

About one-third of the husbands or partners to the women were employed by government. Ninety three percent of the women reported that they chose their partners

whereas less than one-tenth were in an arranged relationship. Eighty-two percent of the women asserted that they were satisfied in their union or marriages. Women in religious union reported highest percentage of satisfaction in their union (93%). Over three-quarters of the women reported that their spouses do not have the right to use force for sex. However, close to half (49.0%) of the women reported that their spouses sometimes used force for sex. Over 60% of women in traditional or cohabiting union reported that their spouses sometimes used force for sex. Over four-fifths of the women reported that their spouses approved of contraception. Over two-thirds reported the partner's acceptance of condom use. The lowest percentage (58%) reporting partner's acceptance of condom use was found among women in a traditional union. Sixty-four percent of the women also stated that spousal discussion about sex was not difficult. Only 46% of women who had a traditional marriage reported that spousal discussion about sex was not difficult.

The characteristics of the participants in the IDIs are as follows: Their age range was between 26 and 46 years. Sixty-four percent had been married for less than 10 years. Fifty-five percent of them have had primary or no formal education. Slightly over half of respondents (52.0%) were employed and 61.0% resided in the rural areas.

Table 4.1: The percentage distribution of respondents by socio-demographic characteristics and type of union

Characteristics	Total (n=568)	Civil (n=212)	Religious (n=112)	Traditional (n=149)	Cohabitation (n=95)	*p value
Age group						<0.001
< 25	11.1	7.5	2.7	9.4	31.6	
25-29	19.0	16.0	16.1	18.1	30.5	
30-34	20.1	21.7	15.2	21.5	20.0	
35-39	21.1	24.1	25.9	19.5	11.6	
40-44	15.7	17.9	27.7	10.7	4.2	
45-49	13.0	12.7	12.5	20.8	2.1	
Place of Residence						<0.001
Rural	78.3	67.9	78.6	83.9	92.6	
Urban	21.7	32.1	21.4	16.1	7.4	
Education						<0.001
No education	19.7	14.6	19.6	22.1	27.4	
Primary	31.5	28.3	24.1	43.6	28.4	
Secondary	27.5	28.3	19.6	24.2	40.0	
Higher/tertiary	21.3	28.8	36.6	10.1	4.2	
Occupation						<0.001
Unemployed	29.8	20.8	17.9	45.6	38.9	
Business/ trading	13.4	14.2	17.0	11.4	10.5	
Government worker	23.6	28.8	35.7	14.1	12.6	
Teaching/lecturing	10.4	15.1	18.8	4.0	0.0	
Student	8.3	6.1	2.7	6.0	23.2	
Domestic worker	14.6	15.1	8.0	18.8	14.7	
Religion						0.001
Roman Catholic Church	12.7	10.4	16.1	10.7	16.8	
Methodist	25.7	32.1	29.5	19.5	16.8	
Pentecostal	37.5	33.0	35.7	42.3	42.1	
Seventh Day Adventist	16.7	21.2	13.4	16.8	10.5	
Other Religion*	7.4	3.3	5.4	10.7	13.7	
Home language						0.006
Setwana	66.2	72.6	58.9	59.7	70.5	
Afrikaans	3.7	5.2	6.2	0.7	2.1	
IsiXhosa	8.8	5.7	10.7	10.1	11.6	
Sesotho	13.0	10.4	17.9	15.4	9.5	
IsiZulu	8.3	6.1	6.2	14.1	6.3	
Duration of union						<0.001
< 5	40.3	34.4	34.8	32.9	71.6	
5-9	25.5	31.6	25.0	22.1	17.9	
10-14	15.5	15.6	21.4	16.8	6.3	
15-19	5.5	7.5	5.4	4.7	2.1	
20+	13.2	10.8	13.4	23.5	2.1	
Number of living children						<0.001
None	13.6	9.9	3.6	12.1	35.8	
1-2	51.1	52.4	58.9	44.3	49.5	
3-4	29.6	34.0	34.8	30.2	12.6	
5+	5.8	3.8	2.7	13.4	2.1	

Table 4.1 Continued

Characteristics	Total (n=568)	Civil (n=212)	Religion (n=112)	Traditional (n=149)	Cohabitation (n=95)	*p value
Husband/Partner Occupation						<0.001
Unemployed	7.0	6.1	6.2	6.7	10.5	
Farming	4.2	2.8	2.7	8.1	3.2	
Set up private business	24.8	24.5	23.2	22.1	31.6	
Government worker	33.8	38.7	42.9	28.9	20.0	
Teaching	11.1	13.2	18.8	6.7	4.2	
Miners/gardeners	8.1	4.7	3.6	10.1	17.9	
Others*	10.9	9.9	2.7	17.4	12.6	
I chose my partner						<0.001
No	7.0	1.9	10.7	14.1	3.2	
Yes	93.0	98.1	89.3	85.9	96.8	
Satisfied in the union						<0.001
No	7.4	4.7	3.6	10.1	13.7	
Yes	82.0	88.2	92.9	69.8	74.7	
Don't Know	10.6	7.1	3.6	20.1	11.6	
Partner has right to use force for sex						<0.001
No	76.6	83.5	90.2	59.1	72.6	
Yes	8.3	6.1	4.5	14.8	7.4	
Don't Know	15.1	10.4	5.4	26.2	20.0	
Partner uses force for sex sometimes						<0.001
No	51.2	58.5	63.4	39.6	38.9	
Yes	48.8	41.5	36.6	60.4	61.1	
Husband approves contraceptive use						0.082
Disapproves	7.6	6.6	10.0	9.5	3.8	
Approves	88.3	85.1	88.3	88.1	96.2	
Don't Know	4.1	8.3	1.7	2.4	0.0	
Did your partner accept condom use						0.023
No	32.7	27.4	29.5	42.3	33.7	
Yes	67.3	72.6	70.5	57.7	66.3	
Spousal discussion about sex						<0.001
Very difficult	12.9	5.2	3.6	26.2	20.0	
Difficult	23.4	17.9	27.7	27.5	24.2	
Not difficult	63.7	76.9	68.8	46.3	55.8	

*Calculated from Chi–square for measuring differences, significant p<0.05

Source: Mahikeng Sexual and Reproductive Health Survey, 2012.

Note: Other religion* include traditionalist and other religious affiliations whose sample was too small to stand alone in the analysis. 'Others' partner's occupation includes drivers and artisans

4.2 PERCEPTION AND ATTITUDE TOWARDS STIs

Table 4.2 presents the perceptions and attitudes towards STIs by place of residence. There was association between place of residence and respondent at risk of contracting STI and knowledge of partner's HIV status. Association was found between place of residence and misconception questions (A healthy looking person can have the HIV/AID virus and HIV cannot be transmitted by mosquito bite). Fifty percent of women in rural

areas did not consider themselves at risk of contracting STIs. Eighty-seven percent of urban women knew the HIV status of their partners compared to rural women (67%). Over eighty percent of urban and rural women reported that a healthy looking person can have the HIV/AIDs virus. Seventy-eight percent of rural women reported that HIV cannot be transmitted by mosquito bite compared to urban women (62%). Place of residence was not associated with knowledge that condom use prevents STIs or have ever suggested to use condom to partner. Misconception questions about HIV (supernatural transmission and being infected by sharing food with a person who had AIDS) were not associated with place of residence.

Table 4.2: The percentage distribution of women's perception and attitudes toward STIs and preventive controls by place of residence

Knowledge and attitudes toward STIs	Total (N=568)	Rural (n=445)	Urban (n=123)	*p value
Respondent at risk of contracting STI				<0.001
No	270	50.6	44.6	
Yes	122	17.6	38.8	
Don't Know	156	31.9	16.5	
Condom prevents STIs/HIV/AIDS				0.314
No	10	1.9	1.6	
Yes	518	93.5	96.7	
Don't Know	22	4.7	1.6	
Ever suggested the use of condom to partner				0.235
No	239	43.4	37.4	
Yes	329	56.6	62.6	
STIs is a risk factor for HIV/AIDS				0.466
No	16	2.7	3.3	
Yes	510	89.2	91.9	
Don't Know	42	8.1	4.9	
know the HIV status of your partner				<0.00
NO	125	26.2	10.7	
YES	399	68.6	87.6	
Don't know	24	5.2	1.7	
A healthy looking person can have the HIV/AID virus				0.018
No	25	5.4	1.6	
Yes	496	88.1	96.7	
Don't Know	30	6.5	1.6	
HIV cannot be transmitted by mosquito bite				<0.001
No	72	10.1	23.8	
Yes	409	78.2	62.3	
Don't Know	67	11.7	13.9	
HIV cannot be transmitted by supernatural means				0.950
No	95	17.3	18.3	
Yes	273	50.6	49.2	
Don't Know	175	32.2	32.5	
Person cannot be infected by sharing food with a person who has AIDS				0.745
No	42	7.8	7.6	
Yes	482	88.2	89.9	
Don't Know	20	4.0	2.5	

Source: same as Table 4.1

4.3 REASON WHY WOMEN ENGAGE IN SEXUAL ACTIVITIES

Reasons why women engage in sexual activities by type of the union were accessed on a four tier scale of importance presented below in Table 4.3. Fifty-seven percent of cohabiting women reported sex for enjoyment to be 'very important' compared to those in traditional union (35%). Sex to confirm desirability was reported to be 'not important' by women in religious union compared to cohabiting women. Two-fifth of women in

religious union considered sex for health and happiness to be 'not important' compared to cohabiting women. Over two-fifths of women in civil or cohabiting union reported that sex to keep my partner and to satisfy their partner was very important. Type of union was not associated with sexual activity as meaningful experience, procreation, love and closeness to partner or for control partner and show strength.

Table 4.3: Percent distribution of reasons for engaging in sexual activities by type of union

Reason for sexual activities	Total (n=568)	Civil (n=212)	Religious (n=112)	Traditional (n=149)	Cohabitation (n=95)	*p value
Natural and important meaningful experience in my life						0.095
Not Important	30	5.9	7.3	6.2	1.1	
Slightly Important	49	8.9	8.2	9.0	10.0	
Important	226	35.0	37.3	50.3	45.6	
Very Important	243	50.2	47.3	34.5	43.3	
Procreation						
Not Important	66	17	12.8	9.9	5.6	0.226
Slightly Important	97	19.1	16.5	17.6	19.1	
Important	198	32.0	38.5	43.0	37.1	
Very Important	173	32.0	32.1	29.6	38.2	
Enjoyment						0.049
Not Important	25	4.0	3.6	7.6	2.2	
Slightly Important	56	9.9	7.3	11.0	12.2	
Important	209	36.1	40.0	45.5	28.9	
Very Important	257	50.0	49.1	35.2	56.7	
Love and closeness to partner						0.097
Not Important	26	5.0	6.5	4.2	3.4	
Slightly Important	46	6.9	10.2	9.2	9.0	
Important	187	29.7	32.4	45.8	30.3	
Very Important	282	58.4	50.9	40.8	57.3	
Control of partner and show strength						0.859
Not Important	328	60.5	61.8	57.0	64.4	
Slightly Important	68	13.0	12.7	12.0	12.2	
Important	101	17.0	18.2	23.9	14.4	
Very Important	45	9.5	7.3	7.0	8.9	
Confirm desirability						0.010
Not Important	117	17.4	41.3	16.2	15.6	
Slightly Important	80	15.9	14.7	12.7	15.6	
Important	206	33.3	26.6	48.6	45.6	
Very Important	139	33.3	17.4	22.5	23.3	
Health and Happiness						<0.001
Not Important	157	29.5	40	25.9	18.9	
Slightly Important	118	18.0	21.8	20.3	32.2	
Important	191	35.5	26.4	42.7	33.3	
Very Important	77	17.0	11.8	11.2	15.6	
Keep and satisfy partner						0.001
Not Important	49	7.0	16.4	8.4	5.6	
Slightly Important	86	19.0	19.1	9.8	14.4	
Important	199	29.5	40.0	44.1	36.7	
Very Important	209	44.5	24.5	37.8	43.3	

4.4 DISCUSION

The analyses in this chapter were to provide a statistical description of socio-demographic characteristics of the study population in relation to the type of union. It is challenging to compare types of union with the national data because of limited data sources on the patterns adopted in this study. A Lack of demographic documents on trends regarding marriage and partnering in South Africa has been reported, as marriage is far from universal (Budlender et al., 2004; Hosegood et al., 2009). This study showed that cohabiting women were more likely to be in their 20s compared to women in civil, religious or traditional union. In addition, cohabiting women were more likely to have limited formal education as well as residing in a rural area. The characteristics of cohabiting women found in this study have also been reported in the United States (Bumpass, Sweet, & Cherlin, 1991). It contradicts the findings in Kwazulu-Natal that cohabitation is higher among urban women compared to their rural counterparts (Hosegood et al., 2009). This finding may be attributed to the fact that over three quarters of the women in the study population were resident in rural areas.

The data revealed higher percentages of unemployed women among those in traditional and cohabiting unions compared to those in a civil union. This may have some implications for women's reproductive rights. Some researchers have shown that unemployment among women has a negative effect on women's sexual and reproductive health decision-making (Ackermann & Klerk, 2002; Speizer et al., 2005). Most women were Setwana speaking and affiliated to the Pentecostal faith. It is not unexpected because Tswana people were the predominant inhabitants in the area of the study. Affiliation to the Pentecostal faith may be attributed to the revivalist and charismatic nature of Pentecostal church movements (Kalu, 2008; Meyer, 2004). The large number of children observed among women in a traditional union may indicate a desire for the social status which having more children accords to women in society (Dyer et al., 2002; Isiugo-Abanihe, 1994).

Most of the partners of the women in the study were either self-employed or working for the government. In addition, most of the women chose their partners and were happy in their union. Studies have shown that women who chose their partners participate in

sexual and reproductive health decisions in their marriage (Hamid et al., 2011; Jejeebhoy, Santhya, Acharya, & Prakash, 2013). Furthermore, most women stated that their husbands had no right to use force for sex and that their partners approved of condom or contraceptive use. Low acceptance of condom use among the partners of women in a traditional union may indicate negative effects of cultural factors and gender norm on condom use shown in previous studies (Versteeg & Murray, 2008). Finally, a larger percentage stated that spousal communication about sex was not difficult. It is not clear whether this suggests egalitarian relationships which may have positive effects on women's sexual and reproductive health decision-making power. However, about three-fifths of the women in traditional and cohabiting relationships reported that their partner uses force for sex sometimes. This finding is also similar to the previous evidence on sexual coercion among married women (Dunkle et al., 2004; Dunkle et al., 2008).

Knowledge and attitude of women towards contracting STIs is necessary for a sexual and reproductive health policy. Women in the study population demonstrated a good knowledge of how to contract and prevent sexually transmitted infections by place of residence. In terms of reasons for engaging in sexual activities, sexual enjoyment was important or very important to all women. This finding is consistent with previous studies (Higgins & Hirsch, 2008). Engaging in sexual activities for health and to keep and satisfy one's partner was important to women. It seems that the nature of the reasons for engaging in sexual activities may give more sexual powers to their male partners.

4.5 CONCLUSION

Background characteristics presented in this chapter were intended for consideration in studies of sexual and reproductive health decision-making among women in heterosexual relationships. Women had knowledge about contracting STI and preventive measures. Some of the reasons for engaging in sex, which showed a consistently increasing trend from not important to very important may had compromising influences on women's sexual and reproductive health decision-making ability. These include sex for "enjoyment", "to show love and be close to partner" and "to

keep my partner/to satisfy my partner". These differences in background characteristics of the women suggest that the type of union may play some role in sexual and reproductive health decision-making.

CHAPTER FIVE: ATTITUDE TOWARDS SEXUAL CONTROL OVER SEXUALITY

5.0 INTRODUCTION

This chapter discusses the dimensions of sexual control and attitude towards sexual acts. Assessments of sexual control by socio-demographic characteristics of the women are analyzed by descriptive and inferential statistics. It also presents the sexual control construct by cultural values based on the in-depth interviews.

5.1 DEPENDENT VARIABLES

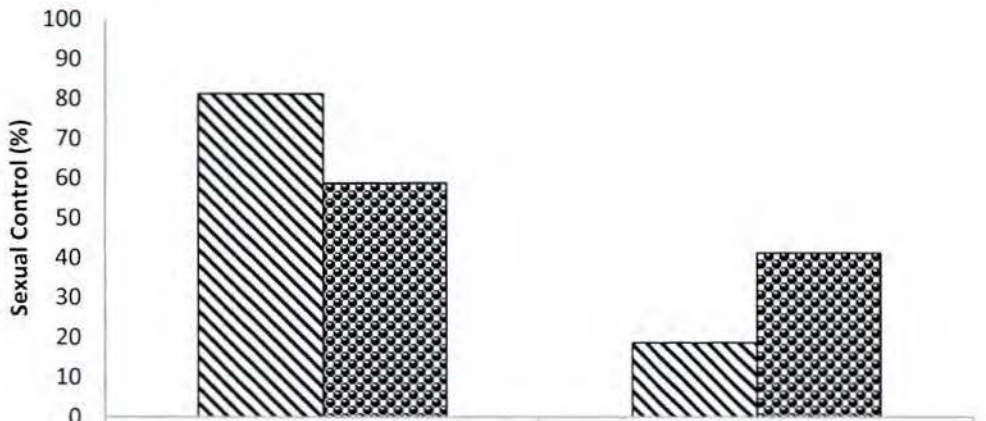
"Can a woman demand sex" and "can a woman reject sex" are the dependent variables used to measure sexual control, defined as the ability of a woman to take a stand on sexual matters. Studies have used this question as the criterion of women's control over sexuality (Ogunjuyigbe & Adeyemi, 2005; Wolff, Blanc, & Gage, 2000). This question has no confounding factors as it is only a woman who knows whether she has the right to accept or reject sex.The response to these questions was "Yes" or "No". Respondents who reported "Yes" to "can a woman demand sex" were coded as 1; while those who responded "No" were coded as 0. Respondent who reported "Yes" to "can a woman reject sex" were coded as 1; while those who responded "No" were coded as 0.

5.2 RESULTS

5.2.1 Dimensions of sexual control: Univariate Analysis

Figure 5.1 presents the distribution of women's control over their sexual lives. Whilst 81% of respondents reported that a married woman can demand sex, 59% asserted that a woman can reject sexual intercourse from her partner. However less than a quarter reported that a married woman cannot demand sex whereas about two-fifths reported that they cannot reject sex from their husbands or partners.

Figure 5.1: Distribution of women's control over their sexual lives by ability to demand or reject sex



	Yes	No
Demand Sex	81.2	18.6
Reject Sex	58.8	41.2

Source: Same as table 4.1

Table 5.1 presents the dimensions of attitudes over sexual acts. For those who approved that a woman can demand sex, 93% reported that it was just natural to do so. In addition, about half of them reported that a woman should demand sex in order to satisfy the husband and a quarter reported that a woman should demand sex when child is desired. For reasons given for a woman to reject sexual intercourse from her husband, over 90% reported that a woman should reject sexual intercourse if the husband beats her, if she is ill or if she suspects that the husband has an STI. Three-quarters or more reported that a woman should reject sex if she was not in the mood, if she knew that the husband had extramarital affairs, if she was menstruating, or if he does not support her.

Table 5.1: Dimensions of women's control and attitude over sexual acts

Evaluation criteria	N=568	Percentage
Conditions when women can demand sex*		
It is natural	427	92.6
To satisfy the husband	249	54.0
When another child is need/desired	116	25.2
Conditions when women can reject sex		
He beats her	306	91.6
She is ill	302	90.4
She suspect he has sexually transmitted infection	301	90.1
He has sex outside marriage (Cheats)	255	76.3
She is not in the mood	252	75.4
During menstruation	249	74.6
He does not support her	241	72.2
He does not support the children	211	63.2
He is drunk	206	60.2
She does not want to get pregnant	181	54.2
During breastfeeding	135	40.4
During pregnancy	71	21.3

Source: Same as table 4.1
Note: * Respondents were allowed to state more than one condition.

5.2.2 The attitude towards sexual control by socio-demographic characteristics of respondents: Bivariate Analysis

Table 5.2 below presents the relationships between attitudes towards control over sexual acts and socio-demographic variables. The tendency of a woman reporting she can demand sex from her partner decreases consistently with increasing age. Women in a traditional marriage showed the lowest percentage (38%) of reporting that a woman can demand sex. Reporting that a woman can demand sex from her husband/partner showed consistent increase with increasing educational level. Unemployed women showed the lowest percentage of reporting that women can demand sex from their husband/partners compared to their employed counterparts. Reporting that a woman can demand sex decreases with the increasing number of living children.

The tendency of reporting that a woman can reject sex showed an inverted u-shape by age. Over three quarters of urban women reported that a woman can reject sex from a

partner. The lowest percentage (38%) of reporting that women can reject sex was observed among cohabiting women. Unemployed and uneducated women showed the lowest percentages 31% and 18% of reporting that women can reject sex from their husband/partners compared to employed and educated women. The lowest percentage (41%) of reporting that women can reject sex was also observed among women in other religions. Women with five or more living children reported the lowest percentage (21%) of those who said a woman can reject sex from the husband.

In terms of place of residence, 87% of urban women reported that they can demand sex, whereas 76.4% said they can reject sex from their husbands compared to their rural counterparts. Eighty-six percent and 76% of Afrikaans speaking women reported they can demand or reject sex from their husbands compared to 75% and 53% of those who speak IsiZulu. Women who adhere to traditional religions reported the lowest percentages that women can demand or reject sex from their husbands or partners.

Table 5.2: Percentage distribution of respondents reporting a spouse has the right to demand or reject sexual intercourse from partner by selected characteristics

Characteristics	N	Can demand sex	Can reject sex
Age group			
< 25	63	96.8	47.6
25-29	108	88.0	68.5
30-34	114	86.0	68.4
35-39	120	80.0	57.5
40-44	89	73.0	56.2
45-49	74	62.2	44.6
Residence			
Rural	445	79.6	53.9
Urban	123	87.0	76.4
Type of union			
Civil	212	87.7	68.4
Religious	112	82.1	71.4
Traditional	149	67.1	49.0
Cohabiting	95	87.4	37.9
Home language			
Setswana	376	83.0	60.4
Afrikaans	21	85.7	76.2
IsiXhosa	50	78.0	52.0
Sesotho	74	77.0	54.1
IsiZulu	47	74.5	53.2
Highest educational level			
No education	112	72.3	17.9
Primary	179	78.2	54.2
Secondary	156	86.5	71.8
Tertiary	121	86.8	86.8
Occupation			
Unemployed	169	73.4	30.8
Business/trading	76	80.3	57.9
Government worker	134	88.8	81.3
Teaching	59	84.7	88.1
Student	47	95.7	68.1
Domestic worker/security	83	74.7	54.2
Religion			
Roman Catholic Church	72	81.9	59.7
Methodist	146	83.6	69.2
Pentecostal	213	85.3	54.5
Seventh Day Adventist	95	79.8	60.0
Other religion*	42	69.0	40.5
Number of living children			
None	77	93.5	51.9
1-2	290	84.5	68.6
3-4	168	76.8	52.4
5+	33	45.5	21.2

Source: Same as Table 4.1 *Other religions include traditionalist and other religious affiliations whose sample was too small to stand alone in the analysis.

5.2.3 Multivariate analysis of the factors related to sexual control

The respondents in the study demonstrated variations in their ability to demand or reject sex by background characteristics. However, it is still not clear how these variables influence the respondents' sexual control in a multivariate perspective. Table 5.3 presents the odds ratios and confidence interval of two logistic regression models. The models examine opinions of married or cohabiting women to sexual control. Of the variables listed in Table 4.1, age, type of union, education and number of living children were found to be significantly related to the respondents' opinion if women can demand sex. Women who had tertiary education were 2.1 times more likely to state that a woman can demand sex than those without formal education. Women who were 40 years old or over were less likely to state married women can demand sex than those aged 25-29. And respondents who were traditionally married and those who had five or more living children were less likely to state that married women can demand sex compared to those without living children. The findings also showed that women who were in traditional/customary marriages were less likely to suggest that a woman can demand sex from her husband compared to those in civil marriages. All the significant variables are related to the approval for demanding sex in the expected direction. Older women, those in traditional marriages, with less formal education and those with large family sizes were more likely to abide by traditional customs and beliefs.

The variables that are significantly related to the respondents reporting that a woman can reject sexual intercourse include age, type of union, education, occupation, and number of living children. Women who were below 25 years old and those aged 35-39 were less likely to report that women can reject sex compared to women aged 25-29. Cohabiting women were less likely to report that a woman can reject sex from her husband/partner compared to women who were in civil marriages. As expected, the higher the educational level the more likely the respondent stated that a woman can reject sex. Women who were doing any type of work or students were more likely to approve rejecting sex than women who were unemployed. Women who had five or more living children were less likely to reject sex than those without a child.

The odds ratios for education and number of living children are in the same direction in the two models. Whilst occupation was only significant in the 'reject sex' model, patterns of age and type of union were not clear. Cohabiting women disapproved of a woman rejecting sex as relationships are not very secure. Women aged 40 and older were less likely to agree that a woman can demand sex whereas those aged less than 25 years and 35-39 years old tended to disapprove that women can reject sex.

Table 5.3: The parsimonious logistic regression model showing the factors related to attitude towards a woman demanding or rejecting sex from her partner

	Can demand sex		Can reject sex	
Variables	**Odds Ratios**	**95% CI**	**Odd Ratios**	**95% CI**
Age group				
< 25	3.716	0.759-18.202	0.414*	0.171-0.999
25-29 (ref)	1.000		1.000	
30-34	0.902	0.398-2.044	0.837	0.419-1.675
35-39	0.528	0.238-1.168	0.371**	0.181-0.757
40-44	0.377*	0.158-0.900	0.551	0.242-1.251
45-49	0.346*	0.144-0.831	0.597	0.258-1.383
Type of Union				
Civil (ref)	1.000		1.000	
Religious	0.694	0.359-1.342	1.166	0.631-2.155
Traditional	0.296**	0.166-0.530	0.686	0.403-1.165
Cohabiting	0.539	0.240-1.211	0.269**	0.139-0.522
Education				
No education (ref)	1.000		1.000	
Primary	1.396	0.766-2.545	5.742**	3.077-10.717
Secondary	1.699	0.868-3.325	8.137**	4.126-16.046
Higher/tertiary	2.073*	1.005-4.276	11.932**	4.386-32.460
Occupation				
Unemployed (ref)			1.000	
Business/ trading			2.605**	1.357-5.002
Government worker			3.375**	1.560-7.304
Teaching/lecturing			4.331**	1.357-13.820
Student			4.178**	1.674-10.430
Domestic worker			2.029*	1.083-3.800
Number of living children				
None (ref)	1.000		1.000	
1-2	0.601	0.202-1.789	1.356	0.637-2.888
3-4	0.562	0.178-1.772	0.729	0.303-1.755
5+	0.262**	0.069-1.002	0.270*	0.073-1.002

Source: Same as Table 4.1 Note: * significant at 0.05 level; ** significant at 0.01 level; – and CI confidence interval

5.2.4 Cultural influence on sexual control: Qualitative study

The general views portray that the social and cultural environment still influences the disposition of most women on the issue of demanding or rejecting sex from their husband/partners. The cultural belief is that husbands have a right to sex, and there could be consequences for rejecting sex. Among the consequences were fear of losing their husband/partner and provocation of violence. Analysis of the participants' description of cultural influence on sexual control is presented below.

Participants had a variety of comments on cultural influences on sexual control. Most women reported that culturally they have the right to demand sex from their husbands. Most declared that there is nothing wrong for a woman to demand sex from the husband except if there is a marital problem. In the words of a participant:

"Yes I demand sex if am not getting it. Usually it is us women who are often tired and would deny the men sex. If am in the mood for sex and it has not been happening, I will tell him and make sure I get it" (urban woman, aged 35, married 9 years)

Pleasing the husband: Participants agreed that demanding sex from the husband gives confidence that there is fidelity. In fact it is culturally acceptable for a woman to demand sex. A participant elucidated further by saying:

*"Culturally a woman is taught how to make her husband happy sexually. You are taught about sex and other important things in marriage during initiation. We do not demand sex but you seduce him. Men would not miss opportunity for sex" (laughter) (*rural woman, aged 46, married 10+)

Another participant indicated that demanding sex from the husband would foster closeness and peaceful relationship especially in a consensual union. She further stated:

*"The reason why I should demand sex is for my man to be secure. Men are very insecure. He may think you are getting it somewhere if you do not ask". (*urban woman, aged 31, cohabiting for 6 years)

However a few reported that culture is a set back to their ability to demand sex and it hinders women's emancipation.

Disrespect: Some of the participants asserted that for a woman to demand sex suggests she is not cultured. One participant noted:

For a married woman to demand sex, your husband and family may regard you as a disrespectful wife. They will call you names along the lines of being a slut. (rural woman, aged 42, married 10+ years).

Some responded that their culture does not support them to reject sex from their husband. A few of the participants claimed that their culture supports them to reject sex from their husband especially when a woman has a new-born baby. In other words, a woman cannot just reject sex from her husband without a valid reason. Two sub-categories emerged on the issue of rejecting sex. These were Husband's right to sex and consequences.

The Husband's right to sex: Most of the women generally accepted that culturally a man has the right to sex when he has paid *lobola*. One of the participants noted:

"According to the society you are not supposed to refuse sex from your husband and my culture does not support me as he is my husband who has fulfilled cultural requirements for marriage" (rural woman, aged 44, married 10+ years).

The younger generations similarly expressed the same view on the tenacity of culture in promoting the conjugal right of the husband to sex. In the words of a participant:

"No, when he wants it (sex) nobody will stop him even if it is red (menstruating) *he does not care. I know it belongs to him; he has right to have it anytime, unless he shares me with somebody, so I think I have no right over sex to him"* (rural woman, age 28, married 9 years).

Consequences: The study revealed that modernization has to some extent given women some power to reject sex. However, the ability to reject sexual advances from

the husband is associated with fear of violence, disruption of the union or development of an unfriendly marital atmosphere. In the words of two participants:

"Woman can reject sex, but it has some consequences like rape, physical abuse, divorce, cheating, patronizing commercial sex workers and polygamy etc" (urban woman, aged 39, married 10+ years)

"Yes, I have the right to reject sex, but our culture disagrees with that. Nowadays the law can protect you. If you take the matter to court that he forces you to have sex, it will be a different story. But I will not take my husband to court I love him" (laugh) (urban woman, aged 29, married 5 years)

Another thing that emerged in the study as an obstacle to the ability to reject sex was religious belief. A few reported that culture has no influence in their sexual lives as they are Christians. In addition, it was indicated that religious teaching stated that a woman should not deny the husband sex. In the words of two participants:

"There is no way culture is involved in my marriage. We follow what the Bible says, we are not cultural people" (urban woman, aged 29, married 5 years).

"From human rights perspectives, I have the right to reject sex from my husband. But the Bible says husbands and wives should not deny one another sex except when they are fasting"(urban woman, aged 37, married 7 years).

5.3 DISCUSSION

This chapter has examined the attitudes of women in marital or cohabiting relationships towards sexual control and its implication for the control of HIV/AIDS. In general, the study indicated that women have considerable control over their sexuality. On operationalizing the dimension of sexual control, the majority of the respondents approved of demanding sex from their partners. The ability of women to demand sex because it is natural, to satisfy their partners and for procreation indicates a shift from the societal norm of women being passive in sexual matters. It is expected that women with no formal education, older women, those in traditional marriages and those with large families do not approve of women demanding sex. This inability to demand sex

may be linked to the socialization of women to be submissive to their husbands or partners in sexual relations. Thus, culture plays out among older women, women with limited formal education, those who are traditionally married and those with large families.

Some respondents stated that a woman can reject sex from her husband/partner during menstruation, illness or when not in the mood. There are circumstances under which sex cannot occur. This study to a large extent concurs with a study in Ghana (Awusabo-Asare et al., 1993) where over four-fifths of women would reject having sex with husbands known to be suffering from sexually transmitted infections. The result contrasts with a recent report among Edo women in Nigeria who cannot reject sex because of the fear of being beaten (Iyayi et al., 2011). On the other hand; it is consistent with the conclusion of Wusu and Isiugo-Abanihe (2010) that fear of being beaten is not a normative practice in marital relationships because of mutual respect. This suggests that women are not treated as sexual objects as earlier findings about women's sexuality indicated. Indeed fear of violence may suppress the courage of women to exercise control over their sexuality.

Salient findings of the chapter are the influence of the nature of the union on the sexual control of a woman. Cohabitation seems to have negative effects on a woman's sexual control which concurs with the findings in Honduras (Speizer et al., 2005). Cohabitation is becoming a norm in South Africa (Budlender et al., 2004; Hosegood et al., 2009), but the consciousness that it is devoid of cultural recognition subjugates the ability of the woman to reject sex. For a man and woman to be together and indulge in sexual activities, there are certain criteria to be met. Since cohabitation is devoid of such criteria, cohabiting women do not feel secure to exercise control over their sexuality.

Consistent with numerous findings (Awusabo-Asare et al., 1993; Iyayi et al., 2011; Langen, 2007; Ogunjuyigbe & Adeyemi, 2005) women with a socio-economic advantage exercise greater control over their sexuality compared to those who are economically disadvantaged. The state of being uneducated and unemployed may

impact negatively on Mahikeng women's control over their sexuality. Such women nurture the fear of losing their husbands to other women. Even in cultural discretion, there are some circumstances where women have some right to refuse sex. However, it is uncertain that such a right could exist among women who have no source of income. The absolute dependence of women on their partners for support presents an impediment to their attitude to sexual control. This has some implications for the control of HIV/AIDS in Mahikeng.

The pattern depicted for age is not very clear. However, women of age 35 and older often display a different pattern of sexual behaviour due to declining fecundity, perceived infertility or reduced frequency of sexual intercourse. It is plausible that women age 40-49 have reached their reproductive goals or have a declining desire for sex. It can also be viewed that older women adhere to traditional socialization where culture does not support sexual freedom in women. That women less than 25 years old were less likely to reject sex is not unexpected. As the primary goal of marriage in African society is childbearing, it is unlikely that women who commenced marriage would have reason to reject sexual intercourse from their husband or partner. It could be speculated those aged 35-39 were not able to reject sex because they have not reached their reproductive goals, because of individual factors not clear from the data.

Religion was not a significant predictor of women's ability either to demand or reject sex from their husband or partner. However, from the qualitative data, a considerable proportion of the women acknowledged that culture does not have effect on their sexual lives because they are Christians. Even then, their religion prohibits them from denying their husbands sex. This finding is consistent with the earlier reports (Ogunjuyigbe & Adeyemi, 2005) that identified religion as an important variable that can influence women's sexual control and reproductive rights

The qualitative findings show that attitude to sexual control is defined within the socio-cultural perceptions and the conduct of women. What stood out clearly in the study is that formal education and economic empowerment are critical determinants of women's

control over their sexuality. The present study suggests that vulnerability of women to STIs including HIV may be linked to their attitude to control over their sexuality.

5.4 CONCLUSION

Most married women approved of demanding sex from their husband/partner and they reported that it is natural to do so. However, some proportion of married women did not approve of married women rejecting sexual intercourse with their husband/partner under any circumstances. This is the group of women that needs serious attention in terms of policy. It boils down to empowering married women to have control over their sexuality. It seems there is still room for the South African government in general and the North West provincial government in particular to continue addressing the issue of improving the status of women.

CHAPTER SIX: AUTONOMY ON WHEN TO HAVE SEX, USE CONTRACEPTION AND FAMILY SIZE

6.0 INTRODUCTION

The chapter presents the socio-demographic factors that influence women's participation in sexual and reproductive health decision-making. It shows descriptive analysis of the dependent variables. Cross tabulation and logistic regression were used to examine socio-demographic characteristics associated with women's participation in sexual and reproductive health decision-making.

6.1 DEPENDENT VARIABLES

In this study autonomy is defined as the degree of women's participation in decision-making on when to have sex, use of contraception and family size. Participation in reproductive decision-making was measured on three dependent variables which are "when to have sex", "when to use contraception" and family size. Questions pertaining to the decisions on "when to have sex" and "when to use contraception" has four actors each: (1) husband; (2) wife; (3) both and (4) others such as doctors and nurses. Responses (2) is full autonomy; (3) is partial autonomy; whereas responses (1) and (4) indicated no autonomy because the woman is not the decision maker in either case. The responses (1) and (4) were merged and assigned the values 0. This implies that the response variable has three categories. The best statistical technique to deal with multiple responses is the multinomial Logit model. The coefficients from a multinomial Logit model are expected to be equal to coefficients obtained when performing two binary Logit models with the same reference category for the response variable (Becg & Gray, 1984). Full autonomy and partial autonomy were combined in the case of "when to have sex" at the multivariate level because the proportion of women reporting full autonomy was too small to stand alone in the analysis. A binary logistic model was used to examine the effect of the socio-demographic characteristics associated with women's autonomy on "when to have sex."

On the decision-making on the use of contraception, the effects of socio-demographic characteristics were examined on full autonomy and partial autonomy. Logistic regression models were conducted first for the full autonomy (woman alone) and second for the partial autonomy (jointly).

Women were further asked "Can a woman decide on the number of children to have"? Question on number of children to have was measured as "Yes" coded as 1 and "No" coded as 0. Binary logistic model was used to identify the effects of socio-demographic characteristics associated with decision-making on family size.

6.2 RESULTS

6.2.1 Reproductive decision-making: Univariate Analysis

Table 6.1 shows that about 60% of the women reported that the decision on when to have sex was jointly made by the husband and wife. On the decision on when to use contraception, the table revealed that 45% reported it was made jointly by the couple. Over two-thirds reported that they have autonomy in decision on the number of children to have.

Table 6.1: Percentage distribution of women's participation in reproductive decision-making

Decision on:	N	Husband/partner	Women	Jointly	Others
When to have sex	568	39.1	1.2	59.5	0.2*
When to use contraception	568	16.5	21.8	45.2	16.4**
		NO	**YES**		
Can woman decide the family size	568	29.9	70.1		

Source: Same as Table 4.1. Others include *mother in-law and **clinics (Doctors and nurse)

6.2.2 Knowledge and use of contraception by method type

Table 6.2 presents knowledge and use of modern contraception by method. Almost all respondents (99.9%) knew about modern contraceptive methods with pills, injections, condoms and female sterilization as the most commonly known methods. About 57.2% were currently using contraception. The most common methods in use were injections (22%), pills (17%) and condoms (16%).

Table 6.2: Percentage distribution of respondents by knowledge and use of contraceptives

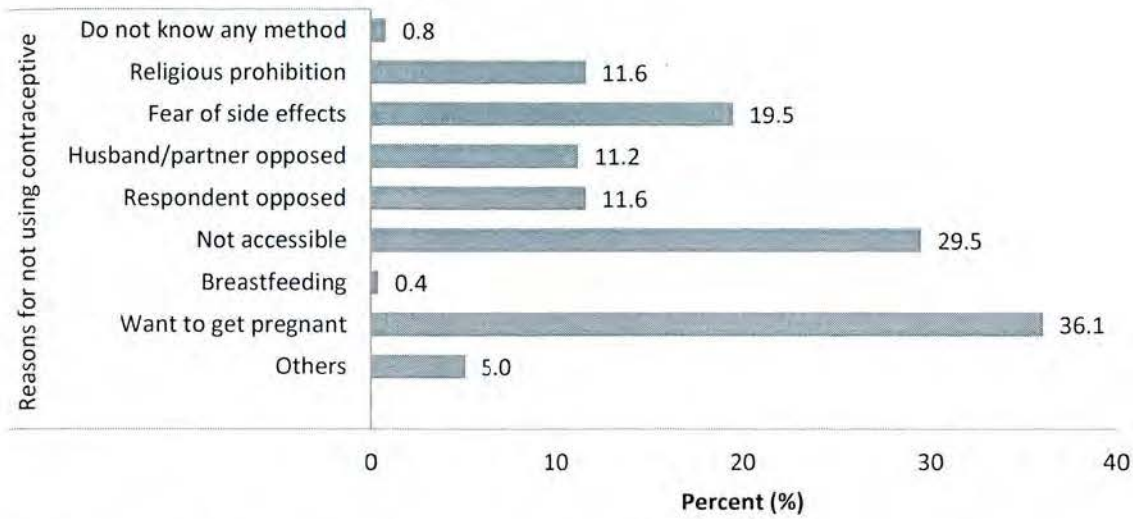
	n =568	Percentage
Knowledge of contraceptive methods		
None	4	0.7
Traditional method	166	29.9
Modern method	552	99.9
Total	*704	100.0
Knowledge of contraceptive by method type		
Pill	530	95.2
IUD	258	46.3
Injection	512	91.9
Diaphragm	35	6.3
Condom	468	84.0
Female sterilization	394	70.7
Periodic abstinence	134	24.1
Withdrawal	16	2.9
Washout	16	2.9
Total	*2364	100.0
Current contraceptive use		
Pill	94	16.6
IUD	16	2.8
Injection	126	22.2
Diaphragm	4	0.7
Condom	92	16.2
Female Sterilization	37	6.5
Periodic Abstinence	7	1.2
Withdrawal	10	1.8
Total	*368	100.0

Source: Same as Table 4.1. Note: * Respondents were allowed to state more than one condition.

6.2.3 Reason for not using a modern contraceptive method

Figure 6.1 presents the reasons for not using contraceptives by the non-users. Among the women who were not currently using any contraceptive method, most wanted to be pregnant, others reported that they have no access to contraceptive methods. Other reasons for not using contraceptives were fear of the side effects, religious opposition, opposition from the respondent and their husbands.

Figure 6.1: Percentage distribution of reasons for not using contraceptives



*Other includes menopausal women and other reasons whose samples were too small to stand alone in the analysis.

6.2.4 Patterns in decision-making on when to have sex by socio- demographic characteristics of respondents: Bivariate analysis

Women in the 30-34 years age group, those who commenced their relationship at age between 25-29 years, and those who relationship is less than 5 years old reported high percentages for joint decision-making on when to have sex as shown in Table 6.3. Women in religious unions showed the highest percentage (65%) reporting a joint decision-making on when to have sex. The proportion of women reporting joint decision-making on when to have sex was also high among rural, Sesotho speaking, women with no formal education and those working for the government. Joint decision-making on when to have sex was low among Pentecostals and women with no children. Joint decision-making on when to have sex was common among those who chose their husband as well as those who were satisfied in their union. Furthermore, joint decision-making was higher among women who stated that husbands have no right to sex compared to those who reported that husbands have right to sex. Women who stated that their partners do not use force for sex showed a higher percentage (70%) compared to those who husband uses force to have sex. Joint decision-making on

when to have sex was high among women who reported that the husband approved contraceptive use as well as those who said discussion about sex was not difficult.

The domination of the husband in decision-making on when to have sex was high among women below the age of 25 years as well as those who were under 25 years old at the commencement of the union. Husband's dominance was also common among urban dwellers, those whose relationship has lasted for over 10 years, cohabiting, teachers and women with no children. Husbands' dominance in decision-making on when to have sex was common among those whose partners had private businesses, in arranged marriages and those unsure of being satisfied in their union. The influence of the husband in decision-making on when to have sex was more dominant among women who reported that a husband has a right to sex, uses force for sex and disapproves of contraception. Husband's dominance in decision-making on when to have sex decreases as difficulty in discussing sex retrogresses.

Table 6.3: Percentage distribution of respondents by pattern of decision-making on when to have sex and demographic characteristics

Characteristics	Husband/partner	Wife	Jointly	Others	N=568
Age group					
< 25	48.4	3.1	46.9	1.6	64
25-29	39.3	1.9	58.9	0.0	107
30-34	34.2	1.8	64.0	0.0	114
35-39	37.8	0.0	62.2	0.0	119
40-44	36.7	1.1	62.2	0.0	90
45-49	43.2	0.0	56.8	0.0	74
Age at marriage					
< 25	44.7	2.1	53.2	0.0	235
25-29	34.5	0.0	65.0	0.5	197
30+	36.0	1.5	62.5	0.0	136
Duration of union					
< 5	26.6	1.4	72.0	0.0	218
5-9	39.2	0.6	59.5	0.6	158
10+	53.1	1.6	45.3	0.0	192
Residence					
Rural	37.5	1.1	61.1	0.2	445
Urban	44.7	1.6	53.7	0.0	123
Type of union					
Civil	40.6	1.9	57.5	0.0	212
Religious	33.9	0.9	65.2	0.0	112
Traditional	37.6	0.0	62.4	0.0	149
Cohabiting	44.2	2.1	52.6	1.1	95
Home language					
Setswana	41.0	0.8	58.0	0.3	376
Afrikaans	38.1	4.8	57.1	0.0	21
IsiXhosa	40.0	2.0	58.0	0.0	50
Sesotho	31.1	2.7	66.2	0.0	74
IsiZulu	36.2	0.0	63.8	0.0	47
Educational level					
No education	32.1	0.0	67.9	0.0	112
Primary	40.8	1.7	57.0	0.6	179
Secondary	43.6	1.3	55.1	0.0	156
Tertiary	37.2	1.7	61.2	0.0	121
Occupation					
Unemployed	39.1	0.6	59.8	0.6	169
Business/trading	42.1	1.3	56.6	0.0	76
Government worker	33.6	2.2	64.2	0.0	134
Teaching	44.1	0.0	55.9	0.0	59
Student	38.3	2.1	59.6	0.0	47
Domestic worker	42.2	1.2	56.6	0.0	83
Religion					
RCC	38.9	1.4	59.7	0.0	72
Methodist	39.0	1.4	59.6	0.0	146
Pentecostal	55.8	1.1	43.2	0.0	213
SDA	35.2	0.9	63.8	0.0	95
Other religion	21.4	2.4	73.8	2.4	42

Table 6.3 Continued

Characteristics	Husband/partner	Wife	Jointly	Others	N=568
Number of living children					
None	48.1	2.6	48.1	1.3	77
1-2	35.9	1.7	62.4	0.0	290
3-4	41.7	0.0	58.3	0.0	168
5+	33.3	0.0	66.7	0.0	33
Husband/Partners occupation					
Unemployed	35.0	0.0	65.0	0.0	40
Farming	33.3	0.0	66.7	0.0	24
Set up private business	48.2	1.4	50.4	0.0	141
Government worker	39.1	1.0	59.4	0.5	192
Teaching	31.7	0.0	68.3	0.0	63
Miners/gardeners	41.3	4.3	54.3	0.0	46
Others*	29.0	1.6	69.4	0.0	62
I choose my partner					
No	77.5	2.5	20.0	0.0	40
Yes	36.2	1.1	62.5	0.2	528
Satisfied in relationship					
No	54.8	2.4	42.9	0.0	42
Yes	33.7	0.9	65.2	0.2	466
Don't know	70.0	3.3	26.7	0.0	60
Partner has right to use force for sex					
No	31.0	1.1	67.8	0.0	435
Yes	66.0	2.1	29.8	2.1	47
Don't Know	65.1	1.2	33.7	0.0	86
Partner use force for sex sometimes					
No	29.2	0.7	69.8	0.3	291
Yes	49.5	1.8	48.7	0.0	277
Husband's approves contraceptive use					
Disapproves	79.2	0.0	20.8	0.0	24
Approves	29.3	1.4	68.9	0.4	280
Don't Know	38.5	0.0	61.5	0.0	13
Spousal discussion about sex					
Very difficult	86.3	0.0	13.7	0.0	73
Difficult	62.3	0.8	36.9	0.0	130
Not difficult	21.4	1.6	76.7	0.3	365

Source: Same as Table 4.1

6.2.5 Patterns in decision-making on when to use contraception by socio-demographic characteristics of respondents: Bivariate analysis

Table 6.4 shows that joint decision-making on when to use contraception was most common among women of age 35-39 years, at the commencement of union at the ages of 25-29 years and the duration of union between 5 to 9 years. The proportion of women reporting joint decision-making for the use of contraception was higher among women in unions solemnised in religious rites (51%) than those in a civil union. Afrikaans speaking

women showed the highest percentage (52%) in reporting joint decision-making on contraceptive use. Joint decision-making on contraceptive use was common among women with primary education, teachers, adherents of 'other' religions and those with 5 living children and above.

The dominance of women in deciding when to use contraception was widespread among older women (45-49 years old), commencing the union at about 30 years or a union duration of 10 years or more. Women's dominance in decision-making on contraceptive use was highest among those in a civil union, students, those with secondary education as well as women with 3-4 living children. Joint decision-making was higher among women whose partners were farmers, those who chose their partners and those who were satisfied in their union. Joint decision-making was also high among those who reported that a husband has no right to use force for sex and those who were forced to have sex. Furthermore, joint decision-making was more common when a woman reported she was unsure of the husband's approval of contraceptive use as well, as no difficulty in discussing sex.

The influence of the husband in decision-making on contraceptive use was higher among women if the husband had a private business, in arranged unions or unsure of satisfaction in the relationship. Husband's dominance in decision-making about contraceptive use was also high among women reporting that husbands have a right to sex, disapprove contraceptive use, and use force to have sex, and when spousal discussion about sex was reported to be difficult.

The influence of the woman in decision-making was higher among those whose partners were miners or gardeners than 'others' occupations. Women who chose their partners as well as those not satisfied in their union showed high percentages reporting sole decision-making on contraceptive use. Over two-fifths of women who reported 'no' to a husband's right to sex as well as the use of force for sex stated sole decision-making on contraceptive use. The influence of a woman on contraceptive use decision-

making was high among those reporting that the husband approved of family planning or had difficulty in discussion about sex.

Table 6.4: Percentage distribution of respondents by pattern of decision -making on when to use contraception and demographic characteristics

Characteristics	Husband/partner	Wife	Both	Others	N=568
Age group					
< 25	14.1	28.1	42.2	15.6	64
25-29	24.3	20.6	46.7	8.4	107
30-34	9.6	22.8	49.1	18.4	114
35-39	18.5	17.6	49.6	14.3	119
40-44	18.9	18.9	36.7	25.6	90
45-49	12.2	27.0	43.2	17.6	74
Age at marriage					
< 25	20.4	23.4	44.7	11.5	235
25-29	13.2	18.3	48.2	20.3	197
30+	14.7	24.3	41.9	19.1	136
Duration of union					
< 5	15.1	18.8	47.2	18.8	218
5-9	13.3	24.1	51.3	11.4	158
10+	20.8	23.4	38.0	17.7	192
Residence					
Rural	15.5	21.8	46.1	16.6	445
Urban	20.3	22.0	42.3	15.4	123
Type of union					
Civil	17.9	25.5	42.0	14.6	212
Religious	13.4	19.6	50.9	16.1	112
Traditional	12.1	19.5	48.3	20.1	149
Cohabiting	24.2	20.0	41.1	14.7	95
Home language					
Setswana	15.7	20.7	44.9	18.6	376
Afrikaans	19.0	19.0	52.4	9.5	21
IsiXhosa	22.0	20.0	46.0	12.0	50
Sesotho	16.2	21.6	51.4	10.8	74
IsiZulu	17.0	34.0	34.0	14.9	47
Educational level					
No education	14.3	26.8	43.8	15.2	112
Primary	12.8	19.0	48.6	19.6	179
Secondary	20.5	25.0	40.4	14.1	156
Tertiary	19.0	17.4	47.9	15.7	121
Occupation					
Unemployed	18.9	19.5	45.0	16.6	169
Business/trading	5.3	25.0	47.4	22.4	76
Government worker	18.7	21.6	45.5	14.2	134
Teaching	18.6	15.3	50.8	15.3	59
Student	14.9	27.7	44.7	12.8	47
Domestic worker	18.1	25.3	39.8	16.9	83
Religion					
RCC	8.3	15.3	54.2	22.2	72
Methodist	18.5	24.0	43.8	13.7	146
Pentecostal	22.1	27.4	29.5	21.1	95
SDA	16.9	21.6	48.4	13.1	213
Other religion	9.5	14.3	54.8	21.4	42

Table 6.4 Continued

Characteristics	Husband/partner	Wife	Both	Others	N=568
Number of living children					
None	19.5	27.3	41.6	11.7	77
1-2	16.9	17.9	47.2	17.9	290
3-4	16.1	28.0	40.5	15.5	168
5+	9.1	12.1	60.6	18.2	33
Husband/Partner occupation					
Unemployed	17.5	15.0	50.0	17.5	40
Farming	16.7	16.7	58.3	8.3	24
Private business	24.1	23.4	36.9	15.6	141
Government worker	12.5	21.9	47.4	18.2	192
Teaching	15.9	23.8	46.0	14.3	63
Miner/gardener	13.0	32.6	41.3	13.0	46
Others*	14.5	14.5	51.6	19.4	62
I chose my partner					
No	35.0	20.0	20.0	25.0	40
Yes	15.2	22	47.2	15.7	528
Satisfied in relationship					
No	21.4	33.3	31.0	14.3	42
Yes	14.6	21.2	48.3	15.9	466
Don't know	28.3	18.3	31.7	21.7	60
Partner has right to use force for sex					
No	11.5	23.7	48.7	16.1	435
Yes	38.3	17.0	25.5	19.1	47
Don't Know	30.2	15.1	38.4	16.3	86
Partner uses force for sex sometimes					
No	14.1	22.7	44.0	19.2	291
Yes	19.1	20.9	46.6	13.4	277
Husband approves contraceptive use					
Disapproves	29.2	16.7	54.2	0.0	24
Approves	7.1	28.2	61.1	3.6	280
Don't Know	0.0	38.5	61.5	0.0	13
Spousal discussion about sex					
Very difficult	35.6	20.5	21.9	21.9	73
Difficult	25.4	23.1	36.9	14.6	130
Not difficult	9.6	21.6	52.9	15.9	365

Source: Same as Table 4.1 *Others in husband/partner occupation includes drivers and other occupations whose sample was too small to stand alone in the analysis.

6.2.6 Women's participation in decision-making on family size by socio-demographic characteristics: Bivariate analysis

Table 6.5 presents the decision-making on family size. Cross tabulation of the data shows that decision-making on family size decreases consistently with increasing age, age at point of marriage and duration of the marriage. The highest percentage in reporting sole decision-making on family size was observed among those living in urban areas, in civil unions and those who speak Afrikaans. Reporting sole decision-making on family size was widespread among women with secondary education, students and

Seventh Day Adventists. Sole decision-making on family size decreases consistently with the increasing number of living children.

The proportion of women reporting sole decision-making on family size was highest among those with unemployed husbands or partners (80%). Reporting sole decision-making on family size was 72% among women who chose their husbands/ partners, higher than those in arranged marriages. The highest percentages in reporting sole decision-making on family size were observed among women who reported 'no' to a husband's right to sex, those forced to have sex as well as those faced with disapproval of family planning. Sole decision-making on family size increases consistently with the decrease in difficulty in spousal discussion about sex.

Table 6.5: Percentage distribution of women's participation in decision-making on family size by socio-demographic characteristics

Characteristics	Decision-making on family size	N=568
Age group		
< 25	93.8	64
25-29	80.4	107
30-34	67.5	114
35-39	64.7	119
40-44	63.3	90
45-49	55.4	74
Age at marriage		
< 25	77.4	235
25-29	70.1	119
30+	57.4	136
Duration of union		
< 5	76.1	218
5-9	69.6	158
10+	63.5	192
Residence		
Rural	64.3	445
Urban	91.1	123
Type of union		
Civil	78.8	212
Religious	68.8	112
Traditional	57.7	149
Cohabiting	71.6	95
Home language		
Setswana	73.7	376
Afrikaans	85.7	21
IsiXhosa	64.0	50
Sesotho	64.9	74
IsiZulu	48.9	47
Educational level		
No education	60.7	112
Primary	61.5	179
Secondary	79.5	156
Tertiary	79.3	121
Occupation		
Unemployed	64.5	169
Business/trading	61.8	76
Government worker	78.4	134
Teaching	78.0	59
Student	85.1	47
Domestic worker	61.4	83
Religion		
RCC	63.9	72
Methodist	73.3	146
Pentecostal	70.4	213
SDA	76.8	95
Other religion	52.4	42

Table 6.5 Continued

Characteristics	Decision-making on family size	N=568
Number of living children		
None	88.3	77
1-2	74.5	290
3-4	61.3	168
5+	33.3	33
Husband/Partners occupation		
Unemployed	80.0	40
Farming	66.7	24
Set up private business	66.7	141
Government worker	70.3	192
Teaching	71.4	63
Miner/gardener	69.6	46
Other	71.0	62
I chose my partner		
No	45.0	40
Yes	72.0	528
Satisfied in relationship		
No	61.9	42
Yes	72.5	466
Don't know	56.7	60
Partner has right to use force for sex		
No	75.4	435
Yes	57.4	47
Don't Know	50.0	86
Partner uses force for sex sometimes		
No	80.4	291
Yes	59.2	277
Husband approves contraceptive use		
Disapproves	83.3	24
Approves	79.3	280
Don't Know	76.9	13
Spousal discussion about sex		
Very difficult	15.1	73
Difficult	67.7	130
Not difficult	81.9	365

Source: Same as Table 4.1 *Other religions include traditionalist and other religious affiliations whose samples was too small to stand alone in the analysis. *Others in husband/partner occupation include drivers and other occupations too small to stand alone in the analysis.

6.2.7 Multivariate analysis of the factors related to women's autonomy in joint decision-making on when to have sex.

Table 6.6 presents the logistic regression model on joint decision-making on when to have sex. Type of union, occupation, living children, choice of husband and husband has a right to use force for sex were significant predictors of women's autonomy in decision-making on when to have sex. Women in religious, traditional as well as those

in cohabiting unions were less likely to participate jointly in decisions about when to have sex compared to those in civil marriages. With the exception of domestic workers, all other categories of occupation showed a higher likelihood of participating in joint decision-making about timing of sex. Lower likelihood in joint decision-making about sex was observed among women with 5 or more living children. Women who chose their husband or partner were four times more likely to participate in joint decision-making on when to have sex than those in arranged relationships. Women who stated 'don't know' about husband's right to sex showed 65% reduced odds of participating in joint decision-making on when to have sex.

Table 6.6: Parsimonious logistic regression showing the factors related to joint decision-making on when to have sex

	Decision on when to have sex	
Variables	**Odds Ratios**	**95% CI**
Type of Union		
Civil (ref)	1.000	
Religious	0.547*	0.321-0.935
Traditional	0.524*	0.315-0.871
Cohabiting	0.512*	0.282-0.931
Occupation		
Unemployed (ref)	1.000	
Business/ trading	1.961*	1.058-3.637
Government worker	2.803**	1.597-4.920
Teaching/lecturing	2.424*	1.174-5.004
Student	4.967**	1.977-12.476
Domestic worker	1.332	0.750-2.364
Number of living children		
None (ref)	1.000	
1-2	1.118	0.600-2.083
3-4	0.651	0.331-1.282
5+	0.169**	0.051-0.561
I chose my partner		
No (ref)	1.000	
Yes	3.811**	1.600-9.076
Partner has right to use force for sex		
No (ref)	1.000	
Yes	0.505	0.241-1.062
Don't Know	0.351*	0.202-0.609

Source: same as table 4.1. *significant at $p < 0.05$; **significant at $p < 0.001$, 1.000– Reference category

Table 6.7 shows the factors related to women's autonomy in decision-making on contraception. The socio-demographic variables associated with full autonomy on

decision-making about contraception were home language, education, religion, duration of union and occupation. Women who speak IsiXhosa were less likely to decide on contraceptive use compared to Setwana speaking women. Women with secondary education and students were 3 times more likely to make the sole decision on contraceptive use compared to those with no formal educaton or unemployed. All religions showed lower odds in contraceptive use autonomy compared to the Roman Catholics. Relationship duration of below 5 years showed 57% reduced odds in contraceptive use autonomy.

Joint decision-making on the use of contraception was significantly associated with the home language, religion, duration of union, occupation, type of union, spousal discussion about sex and being forced to have sex. The odds of joint decision-making were low among IsiXhosa and IsiZulu speaking women compared to Setswana speaking women. Compared to the Roman Catholic, those who professed Methodism, Pentecostalism and other religion were less likely to participate in contraceptive use joint decision-making. Compared to the marital duration of 5 to 9 years, lower likelihoods in joint decision-making about contraception were observed among women in unions less than 5 years as well as those in relationship for 10 year or more. Women employed as government workers and students were more likely to participate in joint decision-making on contraception compared to unemployed women. Cohabiting women were more likely to participate in joint decision-making on contraception compared to those in civil union. The odds of joint decision-making on contraception were 1.9 times and 3.8 times higher if spousal communication about sex was perceived to be difficult or not difficult compared to those who perceived it to be very difficult. A higher likelihood of joint decision-making was observed among women who asserted that husbands force them to have sex compared to those who did not.

Table 6.7: Parsimonious logistic regression showing the factors related to women's and joint decision-making on when to use contraception

	Woman		Jointly	
Variables	**Odds Ratios**	**95% CI**	**Odd Ratios**	**95% CI**
Home language				
Setwana (ref)	1.000		1.000	
Afrikaans	1.067	0.191-5.95	1.733	0.553-5.428
IsiXhosa	0.383*	0.153-0.962	0.507*	0.261-0.984
Sesotho	0.626	0.278-1.407	0.956	0.535-1.709
IsiZulu	0.867	0.357-2.105	0.458*	0.224-0.937
Education				
No education (ref)	1.000			
Primary	1.142	0.550-2.369		
Secondary	2.588*	1.097-6.101		
Higher/tertiary	2.611	0.815-8.369		
Religion				
Roman Catholic Church (ref)	1.000		1.000	
Methodist	0.169**	0.070-0.407	0.329*	0.160-0.676
Pentecostal	0.359*	0.163-0.790	0.434*	0.217-0.865
Seventh Day Adventist	0.370*	0.147-0.930	0.548	0.249-1.206
Other Religion	0.063*	0.015-0.271	0.158*	0.062-0.405
Duration of union				
< 5	0.425*	0.217-0.835	0.424**	0.252-0.714
5-9 (ref)	1.000		1.000	
10+	0.642	0.338-1.218	0.596*	0.359-0.989*
Occupation				
Unemployed (ref)	1.000		1.000	
Business/ trading	0.947	0.383-2.338	1.921	0.989-3.730
Government worker	0.994	0.390-2.533	2.073*	1.142-3.763
Teaching/lecturing	1.127	0.337-3.775	2.085	0.994-4.374
Student	3.279*	1.077-9.980	3.181*	1.235-8.194
Domestic worker	0.754	0.336-1.693	1.151	0.633-2.092
Type of Union				
Civil (ref)			1.000	
Religious			0.860	0.506-1.463
Traditional			0.980	0.587-1.638
Cohabiting			2.277*	1.151-4.506
Spousal discussion about sex				
Very difficult (ref)			1.000	
Difficult			1.934*	1.000-3.738
Not difficult			3.827**	1.954-7.494
Partner uses force for sex sometimes				
No			1.000	
Yes			1.841**	1.197-2.833

Source: same as table 4.1. *significant at $p < 0.05$; **significant at $p < 0.001$, 1.000 – Reference category

Table 6.8 shows that place of residence, age, forced to have sex, type of union, number of living children and partner has right to sex were significant predictors of women's autonomy in decision-making on family size. The urban women were 5 times more likely to decide on family size compared to their rural counterparts. A low likelihood to decide

on family size was observed among women of age 30 and above. Women who stated that their partners use force for sex and those in a traditional union showed 51% and 52% reduced odds in family size decision-making autonomy. Reduced odds in family size decision-making autonomy was observed among women who had 5 living children or more. Women who reported 'don't know' if a partner had a right to use force for sex showed 54% reduced odds in family size decision-making autonomy.

Table 6.8: Parsimonious logistic regression showing the factors related to decision-making on family size.

	Decision on family size	
Variables	**Odds Ratios**	**95% CI**
Residence		
Rural (ref)	1.000	
Urban	4.534**	2.287-8.990
Age group		
< 25	3.019	0.905-10.066
25-29 (ref)	1.000	
30-34	0.394**	0.200-0.775
35-39	0.397**	0.199-0.794
40-44	0.368*	0.168-0.808
45-49	0.376*	0.164-0.861
Partner uses force for sex sometimes		
No (ref)	1.000	
Yes	0.458**	0.300-0.700
Type of Union		
Civil (ref)	1.000	
Religious	0.632	0.358-1.114
Traditional	0.525*	0.305-0.902
Cohabiting	0.524	0.268-1.024
Number of living children		
None (ref)	1.000	
1-2	0.595	0.242-1.465
3-4	0.475	0.181-1.247
5+	0.245*	0.069-0.873
Partner has right to use force for sex		
No (ref)	1.000	
Yes	0.985	0.476-2.037
Don't Know	0.456**	0.259-0.801

Source: same as table 4.1. *significant at $p < 0.05$; **significant at $p < 0.001$, 1.000– Reference category

6.2.8 Social class influence on reproductive decision-making: Qualitative study

There were conflicting views with an expectation of male dominance, yet women actively participate in reproductive health decision-making. Two main categories seem to have emerged: mutual understanding among socially advantaged women and reduced decision-making among socially disadvantaged women, and a number of sub-categories.

Mutual understanding among socially advantaged women:

For most women with higher education as well as those economically advantaged, had a mutual understanding with their partner on sexual and reproductive decision-making. They stated that sex was an event that men initiated which needed to be complimented by women in marriage. One woman said: *"Our sexual life and when to have sex do not have anything to do with my educational level but it is how it appeals to both of us".* (Masters Degree, urban woman, aged 39, married 10+ years).

Participation in reproductive decision-making: Women were of the opinion that the decision on family planning was better if it was taken jointly with partners. Most of the women stated that they made decisions on contraception given that they were the users. Having living children added to the ability of employed women in making decisions on contraceptive use. A woman said: "*Yes am in charge of my body, I decide the exact number of children, when I want, them taking into account the cost".* (urban woman, aged 46, married for 9 years). Some women asserted that education encouraged them to take a stand in reproductive decision-making especially on reproductive health issues. One participant said: **"***My education empowers me because I can read and understand what is happening on radio and TV and can explain it to him, such as child spacing for the safety of both of us; you can even argue with him. They say knowledge is power* (Honours Degree, rural woman, aged 42, married 10+ years).

Reduced decision-making among the socially disadvantaged:

For a number of participants, lack of occupation, nature of the union and gender norms shaped their decision-making power.

Covert contraceptive use: According to some of the women who were economically disadvantaged, there were no mutual grounds to discuss or participate in decision-making on contraceptive use and family size. Two participants said:

"For me depending on him was hell because I did not get what I wanted the time I wanted it. When I was not working, I did not go out or shopping for more than two years, not to talk about my hair, so it was difficult for me then; after I got a job I got some respect from him too". (urban woman, aged 33, married 10+ years).

"I use contraceptives without his knowledge (behind his back) as he still wants children even though he does not take good care of us despite the fact that am (she) unemployed" (rural women, aged 33, married for 7 years).

Therefore, these groups of women who were unemployed resorted to covert contraceptive use.

Cohabiting and decision-making: Cohabiting women's descriptions of their participation in decision-making reflected submissiveness and uncertainty. They noted that economic advantage did not automatically confer decision-making power on women. A number of cohabiting women mentioned making covert decisions to use contraception. In the words of two participants: *"Yes, I decide because I am the person who is using contraception and I already have two kids, I can use it but he will not know if he is not cooperative especially if he wants more kids. I can even say I am using when am not if I want to fall pregnant for a guy I like".* (rural woman, aged 28, cohabiting for 6 years).

"You cannot be making babies for a person you don't know your future with. I have one child. I use injection because I do not want more babies." (rural woman, aged 38, cohabiting for 5 years).

6.3 DISCUSSION

Women's autonomy in participating in sexual and reproductive health decision-making is a critical issue in relationships. The quantitative and qualitative data revealed that women, to some extent, exercise some degree of autonomy in sexual and reproductive health decision-making. The study revealed that factors influencing autonomy vary with reproductive health domain. The findings of the study were discussed under the specific headings of the outcome variables.

6.3.1 Women's decision-making autonomy on when to have sex

The study showed that the type of union influences the extent to which women participate in decisions on when to have sex. South Africa is a secular society with a gender equality agenda that favours women in civil marriages. However, religious and traditional marriages have their own sets of rules which are often in conflict with secular laws of marriages. Religious marriages use the Scriptures as the yardstick with regards to the conduct of men and women in marital affairs. Women are always advised not to deny their husband sex within marriage. In traditional marriages, women are admonished to be available to their husband for sex to avert marital conflicts. This finding is in consonance with previous studies that culture (Isiugo-Abanihe, 1994) and religion (Srikanthan & Reid, 2008) have shaped sexual decision-making ability of married women.

It is observed that cohabiting women were less likely to participate in sexual decision-making compared to the women in civil marriage. Cohabitation is recognized in the South Africa secular law, but it is culturally acceptable making such relationship a quasi-marriage. Thus women in such relationship lack autonomy in participating in sexual decision-making in the family. This finding is in consonance with the evidence in Venezuela (Parrado & Tienda, 1997) and in Honduras (Speizer et al., 2005). Women

in cohabiting relationships are in a more precarious relationship because it is uncertain whether it can translate to real marriage. The expectation of cohabiting women to establish a real marriage may grossly reduce their autonomy in decision-making on sex.

The study revealed a significant association between occupation and participation in decision-making on when to have sex. Employment of women in any job with remuneration bestows on them economic independence which enhances their decision-making power. The impact of economic independence on decision-making was observed in the qualitative findings, where some women reported that depending on husbands for support deterred them from exercising control over some aspects of sexuality. This finding corroborates conclusions from studies in Nepal (Acharya et al., 2010), Gautemala (S. Becker et al., 2006) and Nigeria (Iyayi et al., 2011; Ogunjuyigbe & Adeyemi, 2005) where women's economic dependence on their husbands impaired control over sexual decisions. The economic opportunities in South Africa are highly liberal. Women can enter into any occupation without restrictions, possess assets and productive resources. Hence they may have no difficulty in differentiating free engagement in sex from sex driven by economic pressure. On the other hand, the result contradicts other studies where economic advantage did not lead to women's participation in reproductive decision-making (Omeje et al., 2011).

The study shows that women with five or more children tended to participate less in decision-making on when to have sex compared to those with no children. This finding is in sharp contrast with studies in Lagos (Ogunjuyigbe & Adeyemi, 2005) and Southern Asia (Senarath & Gunawardena, 2009). An increase in the number of children ought to give women some sort of autonomy in reproductive decision-making. However, this was not the case in the study. An increasing number of living children is generally associated with older woman in the absence of fertility regulation. The lack of autonomy among women with at least 5 living children on decision-making when to have sex may be linked to adherence to the cultural socialization of subservience to husbands inculcated in women from childhood about sex in marital relationships (Gage, 1998; Preston-Whyte, 1988).

A woman's ability to choose a husband was found to be associated with autonomy in decision-making about sex. The qualitative evidence of this study supported the findings of the quantitative data that men have a greater say in the decision on when to have sex as well as endorsing joint decision-making rather than women's autonomy. This finding concurs with other studies that documented greater autonomy in decision-making about sex when the marriage was not imposed on a woman (Orisaremi & Alubo, 2012). There is a need to discourage arranged or imposed marriages on women and encourage spousal communication as a strategy to establish egalitarian relationships where joint decision-making on issues of common concern prevails.

The perception that husbands have a right to sex, even with force, was an impediment to egalitarian decision-making about when, where and how a sexual act can occur. Evidence from the in-depth findings also showed that husbands have a right to sex. This finding is similar to other studies (DeKeseredy, Rogness, & Schwartz, 2004; Pornari, Dixon, & Humphreys, 2013; Ryan et al., 2009) which reported that societal patriarchy confers on men a right to sex in marital relationship.

6.3.2 Women's decision-making autonomy on when to use contraception

The study revealed that almost all the women had knowledge of modern contraceptive methods. Most decisions on the use of modern contraception were jointly made which is consistent with studies in Kenya, Nigeria and South Asia (Bogale et al., 2011; Farid, Siddique, Bachmann, Janevic, & Pichika, 2013; Iyayi et al., 2011). The fact that joint decision-making was higher than the respondents' decision-making suggests that approval by the husband is needed for adoption. This emerged in the in-depth interviews where covert use of contraception was reported. In addition, the inclination to use methods that can be used covertly but do not have dual protective effect, considering the severity of the HIV infection among married and cohabiting women may suggest limited autonomy in decision-making on contraception (Pettifor et al., 2004).

Participation of women in decision making on when to use contraception bears on their cultural orientation. The lower likelihood of women who speak IsiXhosa and those who

speak IsiZulu to be involved in making sole and joint decisions respectively on contraceptive use suggests a power imbalance between husband and wife attributed to cultural influences of male dominance in reproductive decision-making. The findings may partly explain the low contraceptive use reported earlier among married black women in Transkei (Chimere-Dan, 1996; Makiwane, 1998). The results were similar to earlier studies that reported decision-making on contraception to be associated with home language (Kritz & Makinwa-Adebusoye, 1999; Wyatt et al., 2000). It further supported several studies in South Africa which have reported that men influence decision-making on contraceptive use (Mantell et al., 2011; Matshidze et al., 1998; Ragnarsson, Townsend, Thorson, Chopra, & Ekström, 2009).

Consistent with previous studies, women with formal education were more likely to exercise autonomy in decision-making on when to use contraception (Al Riyami, Afifi, & Mabry, 2004; Anwar, Shoaib, & Javed, 2013; Saleem & Bobak, 2005; Stephenson, Beke, & Tshibangu, 2008). Formal education for women is associated with egalitarianism which can lead to the ability to participate in decision-making. Furthermore, it empowers women to use innovative ideas such as family planning through the power of knowledge. However tertiary education was not a significant predictor of decision-making on when to use contraception. This may partly be attributed to the small number of women who had tertiary education. Women's economic status also impacts on their decision-making regarding contraceptive usage. The higher likelihood of employed women being able to make decisions on when to use contraception is consistent with other studies (S. Becker et al., 2006; Iyayi et al., 2011). Students' involvement in decision-making on when to use contraceptives can be explained by the desire to postpone childbearing to gain higher education. The reduced tendency to participate in decision-making about contraception among women who were socio-economically disadvantaged was supported by qualitative findings on covert contraceptive use. Thus, covert contraceptive use observed in the qualitative studies can be explained as a partners' influence on women's contraceptive use which is in agreement with previous reports (Belohlav & Karra, 2013; Raine et al., 2011; Valente, Watkins, Jato, Van Der Straten, & Tsitsol, 1997).

In the study, the lower likelihood of reporting contraceptive use among women who professed Methodism, Pentecostalism, SDA and traditional religion implied that most religions do not support equality between husband and wife. Men are supposed to be heads of families and most religious women are expected to communicate their intentions to their husbands. Where there was disagreement, it was a husband's decision which prevailed. Thus, religious belief has continued to be a hindrance in women's ability to use contraception. Different religions have perceived contraceptive use as an act of contravening the injunction of God to procreate and be fruitful. Furthermore, highly religious women do not accept unnatural birth control measures and were less likely to use contraception (Wyatt, 1997). Negative attitude to contraception by committed Methodists, SDA and traditionalist may be the reason for the unwillingness to participate in decision-making. Other factors such as wanting to be pregnant, fear of side effects and opposition by the husband or the respondent could also affect contraceptive decision-making.

A shorter duration of the marriage showed a lower likelihood of joint decision-making on the need to use contraceptives and this was not unexpected. It could be envisaged that the shorter duration concided with the beginning of their reproductive life which makes the need for contraception unnecessary. Studies have early sexual initiation at average ages of 14.9 in Eastern Cape (Buga et al., 1996) and 16 years in KwaZulu-Natal (Manzini, 2001). These studies noted that there was little or no contraceptive use. It is not known whether women had given birth before the inception of the marriage or union in the present study. However, of those women who had already given birth to one or two children, about 33% were less than 25 years old and about 66% were between 25-29 years old. This finding is similar to earlier national reports that among married women, aged less than 20 years old, 35% have been pregnant or had already had a child (DoH, 1999). The DoH (2004) report also indicated that by the age of 19 years, 35% of girls have been pregnant and 30% had given birth at least once. While there is evidence that marriage commences late, with premarital childbearing socially accepted in South Africa (Buga et al., 1996; Makiwane, 1998), it is plausible to speculate that

women who had been in unions for over 10 years may have reached their reproductive goals. Thus decision-making on contraceptive use for fertility control may not be an area of interest to them.

The data revealed that cohabiting favoured contraceptive use autonomy. It is questionable how cohabiting women would exercise autonomy in contraceptive use in a setting where premarital fertility is common and women are coerced to fall pregnant to prove their fertility before the actual marriage. From the in-depth interviews, it was evident that cohabitation was associated with covert contraceptive practice and submissiveness to partners. It is possible that the covert use of contraception was viewed as having autonomy in contraceptive decision-making by the cohabiting women.

The finding that positive spousal discussion was associated with empowering women was in agreement with several other studies that documented that spousal communication enhances women's decision-making on contraceptive use (Bawah, 2002; Link, 2011; Ogunjuyigbe, Ojofeitimi, & Liasu, 2009).

It was unexpected that being forced to have sex was found to be associated with joint decision-making on contraception. Use of force for sex in steady relationships may affect the self-esteem of the women and compromise control over their reproductive lives. However the higher ability to negotiate joint decision-making contraception by women who were coerced to have sex may support a previous study in Eastern Cape, South Africa where women who reported physical violence by partners showed higher contraceptive use than others women (Stephenson et al., 2008). Thus, being forced to have sex may be a bargaining tool for a woman to strike a balance in decision-making on contraception.

6.3.3 Women's decision-making autonomy on family size

As expected, urban women were more likely to participate in decision-making on family size than their counterparts in rural areas. Similar findings have been found in Nigeria (Ogunjuyigbe & Adeyemi, 2005) and South Asia (Acharya et al., 2010; Senarath &

Gunawardena, 2009). Traditionally, it was the duty of the husband, as the sole decision maker, to provide for the family. In recent times the high cost of living and the living arrangements in urban areas have made the income of the husband inadequate to sustain his family. In addition, women are compelled to engage in jobs for pay which gives them courage to participate in decisions on the family size. Furthermore, urban women are exposed to and have access to basic social, economic and health services which give rise to an egalitarian relationship which enhances their decision-making ability. The supremacy of traditional patriarchal society may overrule rural women's participation in reproductive decision-making on family size. Women in rural areas may deem childbearing more important to them than the economic implications of having many children.

The findings that women aged 30-49 years old tended to have no autonomy in decision-making on family size may be due to socialization of such women. Previous studies have shown that at a young age, women were socialized to be wives, mothers and submissive to their husbands (Kambarami, 2006; Kulu, 1990). In addition, payment of *lobola* enabled the husband to control the reproductive rights of women (Garbus & Khumalo-Sakutukwa, 2003; Jewkes et al., 1999). It would appear that inability to decide on family size among women aged 30 and over may be the influence of traditional socialization of women to be submissive to men on reproductive issues. This suggests that modernisation has not completely transformed the traditional patriarchal attitude on sexual and reproductive decision-making as reported in earlier studies in KwaZulu-Natal (Dyer et al., 2002; Varga, 2003).

The study revealed lack of autonomy in decision-making on family size among women who reported being forced to have sex. Over three-quarters of the women conceded that partners do not have the right to use force for sex. However, it was observed that a proportion (49%) of the women reported being forced to have sex. Forced sex suggests devaluation of self-worth and may have serious implications on the sexual and reproductive health of women. In line with a previous study in South Africa, forced sex is associated with inability of women to exercise reproductive health autonomy (Pettifor et al., 2004).

The inability of women in traditional unions to exercise autonomy in family size is consistent with previous studies (Bledsoe, 1990; Isiugo-Abanihe, 1994). A traditional union suggests that the process of instituting the marriage adheres to the concept of ownership of the woman by the husband through the payment of *lobola*. By this the reproductive rights of the women are transferred to the husband. This may suggest that men still hold decision-making power over the fertility of women.

Women with five or more children do not have the ability to exercise autonomy in family size decision-making. It seems that family size is determined by the patriarchal structure in which men derive joy from a large family size. This may suggest male-dominance in family size which is consistent with previous studies (Dyer, Abrahams, Mokoena, & Van der Spuy, 2004; Isiugo-Abanihe, 1994). In addition, cultural values on women's fertility confers more social status on women with children (Dyer et al., 2002; Isiugo-Abanihe, 1994). It appears that decision-making on family size is relinquished intentionally by women for the advantage on having a large family size.

Women who did not know whether a partner has a right to use force for sex also revealed lack of autonomy in family size decision-making. This suggests a gap in the knowledge of the reproductive health rights of these women. This group of women may have difficulty in meeting their reproductive health goals. Sexual rights of women have been promoted to enhance women's ability to exercise autonomy over their sexual and reproductive health. It is not surprising that some women were not well informed on the reproductive rights of their partners given that previous studies suggested that the geographical location of Mafikeng is a challenge to obtaining reproductive health information (Versteeg & Murray, 2008).

6.4 CONCLUSION

South Africa has undergone socio-cultural changes with the demise of apartheid. Among them are changes in the level of women's participation in sexual and reproductive decision-making. However, traditional attitudes to sex and reproductive

decision-making have not been completely eroded. From the study, it was observed that home language, income and place of residence were associated with women's participation in decision-making on sexual and reproductive health. There is a need to embark on community-based programmes for rural and unemployed women for the purpose of giving them income yielding skills. Programmes should also take into consideration the ethnic diversity of the rainbow nation in empowering the women.

Occupation increases women's participation in sexual and reproductive health decision-making, but job insecurity may have negative effects on their participating ability due to the lack of skills. Although women prioritize occupation more than formal education, the latter is capable of equipping them with life skills. Formal education may supersede occupation in terms of women empowerment, as it provides opportunities to enter into high income occupations and self-sufficiency. There is a need to introduce the importance of formal education into any programme for empowering women, and discouraging early marriages. Given that egalitarian decision-making is most ideal in marital or cohabiting relationships, sexual health programmes that focus on improving spousal communication as partners influence the contraceptive decisions of women. Secondly, programmes of empowerment should include partners as a way of bridging the gap of gender-inequality.

CHAPTER SEVEN: SEXUAL RISK-TAKING BEHAVIOUR

7.0 INTRODUCTION

The chapter presents findings on women's sexual risk taking behaviour. Cross tabulation and logistic regression were used to examine socio-demographic characteristics, STI/HIV/AIDS related knowledge and attitudes and the reason for having sex among women in relation to sexual risk taking. In depth explanations for sexual risk-taking behaviour have been provided.

7.1 DEPENDENT VARIABLE

Risky sexual behaviour is defined as the conscious decision of a woman to engage in unprotected sex when there is evidence of sexually transmitted infections. Risky sexual behaviour was measured by two questions.

1) Women were asked "Would you have sexual intercourse with your husband/partner if you have an STI?" This question had three responses in which respondents had to make only one choice: (1) No; (2) Yes (3) Don't Know. Women who responded "No" were considered to practice safer sex and coded 0. Those who responded "Yes" were considered to practice unsafe sex (risky sexual intercourse) and coded as 1. Women who responded with "Don't know" were excluded in the analysis at bivariate and multivariate level because of the small number of responses.

2) Women were asked "would you have sexual intercourse with your husband/partner if he had an STI?" This question had three responses where respondents had to make only one choice: (1) I will refuse sex with partner if he had STIs; (2) I will ask him to use condom if he had STIs; (3) I will not refuse sex to my partner if he had STIs. Women who responded (1) or (2) were considered to practice safer sex while those who responded (3) were considered to practice unsafe sex (risky sexual intercourse) and coded as 1. Responses (1) and (2) which suggest safer sex practice were collapsed and assigned the value 0. This was necessary to create binary variables for analysis.

7.1.1 Analyses

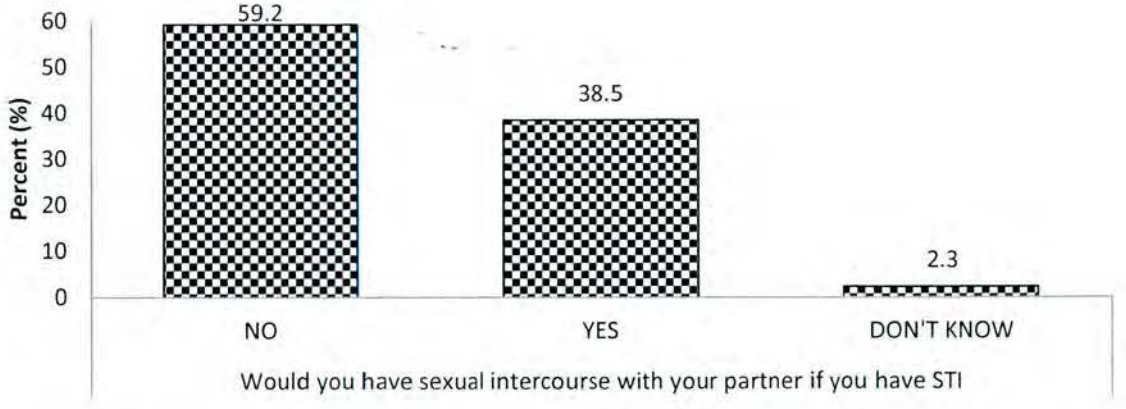
Two separate models were fitted for sexual risk taking behaviour among women. In the first model, the effects of demographic characteristics, knowledge and attitudes to STIs and reasons why women engage in sexual activities were examined on risky sexual behaviour if the woman had an STI. The effects of demographic characteristics, knowledge and attitudes to STIs and reasons why women engage in sexual activities were examined on women's reporting risky sexual behaviour if their partner had an STI in model 2.

7.2 RESULTS

7.2.1 Percentage distribution of women's attitude to risky sexual practices: Univariate Analysis

Figure 7.1 presents the responses of women on whether they would have sex with their partner if they had an STI. Nearly 60% of the women reported they would not engage in sexual intercourse if they had an STI. Nearly two-fifths of the women (38.5%) reported that they would engage in sex if they had an STI.

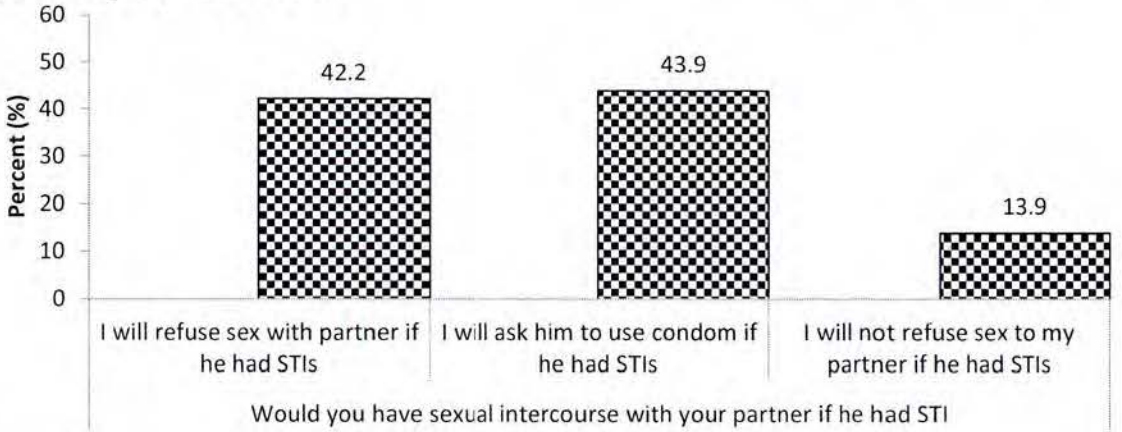
Figure 7.1: Percent distribution of women on attitude to risky sexual practice if they have an STI



Source: Same as Table 4.1

Figure 7.2 presents the responses of women on attitudes to sexual risk taking if their husband or partner had an STI. The data show that over 80% of the women reported that they would take protective action either by refusing sex outright or ask their male partner to use a condom. About 14% of the women said that they would not refuse sexual advances from their male partners even if they had an STI.

Figure 7.2: Percent distribution of women on attitude to risky sexual practice if husband/partner has STI



Source: Same as Table 4.1

7.2.2 Bivariate analysis of women's attitude to sexual risk taking

Table 7.1 presents the cross tabulation of women who would have sex with their partners if they or their partners had an STI by socio-demographic variables. The tendency of reporting that women would have sexual intercourse with the husband/partner if they had an STI showed an inverted u-shape by age, and was higher among those dwelling in rural areas than those in urban areas. The magnitude of reporting that women would have sex if they had an STI decreases with increasing level of education as well as duration of union. Unemployed women showed the highest percentage of those who would engage in sex even if they had an STI. The percentage of women in the Methodist Christian denomination who reported that they would have sex if they had an STI was lower than that of Catholic women.

Women in rural areas showed a greater tendency to engage in sex if they had an STI or their spouse had an STI compared to those in urban areas. The highest percentages reporting that they would have sex if they or the partner had an STI were observed among women who speak IsiZulu as their home language, women with more than five living children, those in traditional marriages and those who commenced their marriage at the age of 30 years and over.

Among all the occupation categories, the percentage of women who reported that they would have sex if they or their partners had an STI was highest among those whose spouses are farmers. In addition, women who were satisfied in their union reported the lowest percentage that they would have sex if they had an STI compared to those who are not, and those who do not know if they are satisfied in their union. The percentage of women who find it very difficult to discuss sex with their spouse was higher in reporting that they would have sex if they had an STI than those who do not. Women who assert that husbands/partners do not have the right to use force for sex are less likely to report the tendency to engage in sex if they have STI than their counterparts. Women who were forced to have sex against their will showed greater tendency to engage in sex even if they had an STI compared to their counterparts. Women who reported that their spouse accepts condom use showed a lower tendency to engage in sex if they have STI compared to women whose male partners reject condom use.

Women in arranged relationships showed higher percentages in reporting that they would have sex if they or their partner had an STI compared to those who chose their partners. The percentage of women who are satisfied in their union was lower in reporting that they would engage in sex if their partner has an STI compared to women who are not or do not know if they are satisfied. Women who easily discuss sex with their spouse a showed lower tendency to engage in sex if their partner has an STI than those who find it very difficult to discuss sex with their spouses.

Women who claimed that their spouse has no right to use force for sex showed a lower tendency to engage in sex if the partner has an STI compared to their counterparts,

while women who claimed that their husbands force them to have sex were more likely to report that they would not reject sex from their partner if he had an STI compared to those who were not forced. In addition, women who reported that their partners accepted condom use showed a lower tendency to engage in sex if their partner had an STI than their counterparts. The lowest percentages to engage in sex if they or their partners had an STI were reported by women whose husband approved of contraception.

Table 7.1: Percentage distribution of women who would have sex if they or their partner had an STI by demographic characteristics

Demographic characteristics	Sex if woman has STI		Sex if partner has STI	
	Yes	Total	Yes	Total
Total (N)	215	546	77	554
Age group				
< 25	38.7	62	8.2	61
25-29	43.1	102	17	106
30-34	41.1	112	14.4	111
35-39	40.7	113	15.5	116
40-44	32.9	85	10.3	87
45-49	37.5	72	15.1	73
Residence				
Rural	43.9	426	15.6	435
Urban	23.3	120	7.6	119
Home language				
Setswana	37.5	360	11.4	368
Afrikaans	30	20	14.3	21
IsiXhosa	46.9	49	18.8	48
Sesotho	40.8	71	16.7	72
IsiZulu	47.8	46	24.4	45
Type of union				
Civil	36.9	203	11.3	203
Religious	34.3	108	7.1	112
Traditional	46.5	144	22.6	146
Cohabiting	39.6	91	14	93
Highest educational level				
No education	65.4	107	23.9	109
Primary	42.1	171	14.8	176
Secondary	30.9	149	11.3	150
Tertiary	22.7	119	6.7	119
Occupation				
Unemployed	58	162	25.8	163

Business/trading	41.4	70	13.3	75
Government worker	27.9	120	6.9	131
Teaching	28.8	59	8.5	59
Student	20	45	2.2	45
Domestic worker	37	81	12.3	81
Religious Affiliation				
Roman Catholic Church	44.9	69	14.1	71
Methodist	29.7	138	10.5	143
Pentecostal	43.7	206	15	207
SDA	34.8	92	14.1	92
Other religion	51.2	41	19.5	41
Number of living children				
None	34.7	75	9.3	75
1-2	38.2	275	11.8	280
3-4	42.1	164	17.4	167
5+	46.9	32	25	32
Age at marriage				
< 25	37.3	225	11.5	227
25-29	37.3	188	13.3	195
30+	43.6	133	18.9	132
Duration of the union				
<5	42.9	210	16.5	212
5-9	37.9	153	12.3	154
10+	36.6	183	12.2	188
Husband/Partner Occupation				
Unemployed	28.9	38	17.5	40
Farming	73.9	23	21.7	23
Private business	37.3	134	15	140
Government worker	36.2	185	10.8	186
Teaching	31.7	60	12.9	62
Miner/gardener	42.2	45	15.6	45
Others	52.5	61	15.5	58
I chose my partner				
No	50	40	27.5	40
Yes	38.5	506	12.8	506
Satisfied in the union				
No	40.9	44	22.7	44
Yes	37.4	447	11.5	452
Don't know	54.5	55	25.9	58
Discuss sex with partner				
Very difficult	60.6	71	41.7	72
Difficult	56.7	127	19.2	130

Not difficult	28.7	348	6.3	352
Husband has right to use force for sex				
No	33.8	417	7.8	424
Yes	52.2	46	30.4	46
Don't Know	60.2	83	35.7	84
Husband sometimes forces you to have sex				
No	29.2	277	7.7	284
Yes	49.8	269	20.4	270
Husband/Partner approves contraception				
Disapprove	56.5	23	20.8	24
Approve	36.4	269	13.4	277
Don't Know	41.7	12	23.1	13
Husband accepts condom use				
No	53.2	139	22.1	145
Yes	33.7	368	10.3	370
Don't Know	43.6	39	17.9	39

Source: Same as Table 4.1

Table 7.2 presents the cross tabulation of women reporting they would have sex with their husband/partner if they or their partner had an STI by STI/HIV/AIDS related knowledge and attitudes. Women who do not know if they were at risk of contracting STIs were more likely to report that they would have sex if they had an STI with their spouse than those who knew they were at risk.

Women who knew that an STI is a risk factor for HIV/AIDS showed a lower tendency to engage in sex if they had an STI compared to those who disagreed and those who did not know whether an STI is a risk factor for HIV/AIDS. Additionally, those who knew their partner's HIV status showed lower percentage to engage in sex compared to those who are ignorant of their partner's HIV status. Women who never suggested condom use to their spouses were more likely to report that they would engage in sex if they had an STI compared to those who have ever suggested condom use to their spouses. Women who did not know whether STI/HIV/AIDS could be prevented through condom use showed greater tendency to engage in sex if they had an STI compared to those who disagreed that condom use prevents transmission of STIs. For the misconception questions in general, women who did not know whether HIV can be transmitted through mosquito bites or through sharing food with an HIV infected person, as well as that a

healthy looking person can have HIV showed a higher tendency to have sex with their partner if they had an STI as compared to those who knew or disagreed. The highest percentages reporting that they would have sex with their partners if they or their partners had an STI were observed among women who were not sure of transmission of HIV by supernatural means.

The tendency to engage in sex if their partner has an STI is higher among women who are unsure of their risk of contracting an STI compared to their counterparts. Women who are unsure that condom use prevents STI/HIV/AIDS were more likely to indulge in sexual activities if their partner had an STI compared with those who knew that condom prevents STIs. Women with knowledge that an STI is a risk factor for HIV and who knew their partner's HIV status were less likely to engage in sex if partner had an STI compared to those who lacked knowledge. In general, women who did not know whether HIV can be transmitted through mosquito bites or through supernatural means that and a healthy looking person could have HIV were more likely to have sex with their partner if he had an STI as compared to those who knew or disagreed.

Table 7.2: Percentage distribution of women who would have sex if they had an STI or if their partner had an STI by knowledge and attitudes related to STI/HIV/AIDS

Knowledge and attitude	Sex if woman has STI		Sex if partner has STI	
	Yes	Total	Yes	Total
Total (N)	**215**	**546**	**77**	**554**
Respondent at risk of contracting STI				
No	32.3	266	11.2	267
Yes	32.5	120	12.6	119
Don't Know	54.4	149	19.9	156
Condom prevents STIs/HIV/AIDS				
No	20.0	10	10.0	10
Yes	37.0	505	12.9	512
Don't Know	76.2	21	40.9	22
Ever suggested the use of condom to partner				
No	45.5	231	16.0	231
Yes	34.9	315	12.4	323
STIs is a risk factor for HIV/AIDS				
No	68.8	16	31.3	16
Yes	36.7	491	11.5	496
Don't Know	61.5	39	35.7	42
Know the HIV status of your partner				
No	55.8	120	23.2	125
Yes	32.0	394	10.4	393
Don't Know	61.9	21	25.0	24
A healthy looking person can have the HIV/AID virus				
No	56.0	25	28.0	25
Yes	36.9	485	11.9	489
Don't Know	59.3	27	34.5	27
HIV cannot be transmitted by mosquito bite				
No	22.5	71	7.0	71
Yes	39.2	403	13.1	404
Don't Know	55.7	61	26.2	65
HIV cannot be transmitted by supernatural means				
No	37.9	95	11.7	94
Yes	37.8	267	10.4	269
Don't Know	42.0	169	20.3	172
Person cannot be infected by sharing food with a person who has AIDS				
No	39.0	41	12.2	41
Yes	37.3	472	13.2	476
Don't Know	78.9	19	30.0	20

Source: Same as Table 4.1

Table 7.3 shows women reporting they would have sex with their husband/partner if they or their partner had an STI by reason for engaging in sex. Those who perceived sex as a natural and a meaningful experience to be 'very important' showed highest percentages of reporting a tendency to engage in sex if they or their partner had an STI. Women who did not considered procreation as the reason for sex showed lowest percentage in reporting engagement in sex if they or their partners had an STI compared to their counterparts. Women who considered sex for enjoyment to be of only

slight importance showed the highest percentage of engaging in sex if they or their husband had an STI. The lowest percentage in reporting that they would engage in sex if they had an STI was observed among women who considered showing love and being closer to their husband/partner as a very important reason for sex. However, those who reported it to be not important showed the lowest percentage of engaging in sex if their partner had an STI. Highest percentages to engage in sex if women or their partner had an STI were observed among women who considered sex to be important to affirm desirability. On the other hand, lowest percentages to engage in sex if respondents or their partners had an STI were observed among women who perceive health and happiness to be very important for sex. Those who engaged in sex to keep or satisfy a partner and see it as very important showed the highest percentage of reporting that they would engage in sex if their partners had an STI.

Table 7. 3: Percentage distribution of women who would have sex if they or their partner had an STI by the reason for sex

Reasons for sex	Sex if woman has STI		Sex if partner has STI	
	Yes	Total	Yes	Total
Total				
Natural and important meaningful experience in my life				
Not important	29.0	31	14.7	34
Slight important	45.1	51	15.4	52
Important	37.4	227	10.9	229
Very important	40.9	235	16.4	238
Procreation				
Not important	29.2	65	3.1	64
Slight important	33.0	94	13.8	94
Important	47.5	200	17.5	200
Very important	37.1	186	13.8	196
For enjoyment				
Not important	16.0	25	4.0	25
Slight important	44.6	56	18.9	53
Important	38.7	212	13.0	215
Very important	41.1	253	14.6	261
To show love and be closer to partner				
Not important	40.0	25	8.0	25
Slight important	37.8	45	15.9	44
Important	43.9	187	13.3	188
Very important	36.7	289	14.5	297
To control my partner and show strength				
Not important	39.8	329	13.6	338
Slight important	34.7	72	17.1	70
Important	39.8	98	10.1	99
Very important	33.8	45	20.0	45
Confirm desirability				
Not important	46.5	114	16.4	116
Slight important	38.0	79	12.7	79
Important	42.1	197	16.8	202
Very important	31.0	155	8.9	157
Health and happiness				
Not important	46.1	154	18.2	154
Slight important	39.8	128	12.7	134
Important	35.5	183	12.3	187
Very important	33.8	77	12.0	75
To keep my partner/ to satisfy my partner				
Not important	46.8	47	10.2	49
Slight important	39.3	84	8.2	85
Important	37.6	194	13.6	198
Very important	39.1	220	17.1	222

Source: Same as Table 4.1

7.2.3 Multivariate analyses of the factors related to women's risky sexual behaviour

Table 7.4 presents multivariate models of women who reported they would engage in unprotected sex with their husbands or partners if they or their partner had a sexually transmitted infection, by demographic characteristics, knowledge and attitude to STI and reasons why women engage in sexual activities. Tendency of women to engage in risky sexual intercourse if they had an STI was associated with education, occupation, occupation of partners, perceived right of husband to sex, husband's use of force for sex, acceptance of condoms and spousal discussion about sex. Compared to those with no formal education, respondents with primary or higher education were less likely to report risky sexual intercourse. Students were less likely to engage in risky sexual intercourse compared to women who were unemployed.

Women whose husbands were farmers showed a higher likelihood to engage in sex with their husbands or partners if they had an STI compared to women whose husbands were unemployed. Women who were unsure whether their husbands have the right to use force for sex were more likely to engage in sexual intercourse with their partner if they had an STI compared to those who disagreed with the statement. Women who reported that their partners force them to have sex sometimes showed a higher tendency to engage in sex if they had an STI compared to women who do not accept that a husband can force them to have sex. Women who reported that their partners accepted condom use were less likely to engage in sex if they had an STI compared to women whose partners rejected condom use. Discussion about sex with ease was associated with lower a likelihood to have sex with husband/partner if a woman had an STI compared to women who found it very difficult to discuss sex.

Perceived risk of contracting an STI and misconception of transmitting HIV by a mosquito bite were significantly associated with risky sexual intercourse. The odds of reporting they were unsure whether they were at risk of contracting an STI were higher than that of women who disagreed that they were at risk of contracting STIs. Compared

to those who disagreed that HIV cannot be transmitted by a mosquito bite, those who were unsure were more likely to engage in risky sexual intercourse. However, other variables such as that an STI is a risk factor for HIV/AIDS, ever suggested condom use to a partner and misconception questions (consisting of a healthy looking person can have HIV/AIDS virus, HIV cannot be transmitted by supernatural means and person cannot be infected by sharing food with a person who has AIDS) were not significant predictors of engaging in risky sexual intercourse.

On the reasons why women engage in sex, it was observed that sex for health and happiness was significantly associated with reporting risky sexual intercourse. Risky sexual intercourse if the woman had an STI was not associated with reasons such as that it is a natural and important meaningful experience in my life, to show love and be close to partner, to control my partner and show my strength, for my health and happiness and to keep my partner/to satisfy my partner.

Variables associated with women reporting tendency to have sex if their partner has an STI showed a significant association with education, perception that husband has the right to use force for sex, spousal discussion about sex and reason for sex such as happiness and procreation. Compared to women with no formal education, those with primary education had 54% reduced odds of engaging in sexual intercourse if the partner had an STI. Compared to those who disagreed that husband had the right to use force for sex, those who agreed and those who were unsure were 3.6 times and 4.4 times more likely to report risky sexual intercourse. The odds of reporting the tendency to engage in risky sexual intercourse was low among women who reported discussion about sex to be difficult or not difficult compared to those who reported such to be very difficult. Those who considered sex for health and happiness to be slightly important or important showed 55% and 53% reduced odds of engaging in sexual intercourse if their partner had an STI. Women who reported procreation to be an important reason for sex were five times more likely to engage in risky sexual intercourse.

Variables that were not associated with engaging in risky sexual intercourse if a partner had an STI include respondent's occupation, age, age at marriage, duration of the union, type of union, education, religion, place of residence and number of living children. The husband's/partner's occupation, choice of partner, satisfied in the union, husband uses force for sex sometimes and his acceptance of condom use were not significant predictors of risky sexual intercourse if the husband had an STI. Knowledge and attitude were not associated with sexual risk taking if partner had an STI. Reasons for sex such as 'natural and important meaningful experience in my life', 'enjoyment', 'to show love and be close to partner', 'to control my partner and show my strength', 'to confirm desirability', and 'to keep my partner/to satisfy my partner' were not significant predictors of risky sexual intercourse if a partner had an STI.

Table 7.4: A parsimonious logistic regression models showing the factors related to sexual risk taking behaviour if a woman or her partner had an STI

	Sex if woman had an STI		Sex if partner had an STI	
Variables	**Odds Ratios**	**95% CI**	**Odds Ratios**	**95% CI**
Demographic characteristics				
Highest educational level				
No education(ref)	1.000		1.000	
Primary	0.357**	0.202-0.631	0.461*	0.225-0.946
Secondary	0.278**	0.145-0.533	0.839	0.382-1.845
Tertiary	0.121**	0.047-0.308	0 649	0.244-1.729
Occupation				
Unemployed(ref)	1.000			
Business/trading	0.654	0.331-0.296		
Government worker	1.314	0.601-2.874		
Teaching	1.701	0.607-4.676		
Student	0.385*	0.155-0.957		
Domestic worker/security	0.587	0.308-1.12		
Husband/Partner Occupation				
Unemployed (ref)	1.000			
Farming	4.774*	1.253-18.191		
Set up private business	1.325	0.531-3.31		
Government worker	2.095	0.856-5.13		
Teaching	1.708	0.606-4.813		
Miner/gardener	1.621	0.543-4.835		
Other	2.494	0.902-6.9		
Husband has right to use force for sex				
No (ref)	1.000		1.000	
Yes	1.148	0.552-2.388	3.659**	1.609-8.319
Don't Know	2.067*	1.153-3.705	4.440**	2.293-8.597

Husband sometimes force you to have sex				
No (ref)	1.000			
Yes	1.937**	1.242-3.023		
Husband accepts condom use				
No (reference)	1.000			
Yes	0.546**	0.350-0.853		
Discuss sex with husband				
Very difficult (ref)			1.000	
Difficult			0.477*	0.230-0.989
Not difficult			0.170**	0.077-0.373
Knowledge and attitude to STI/HIV/AIDS				
Respondent at risk of contracting STI				
No (ref)	1.000			
Yes	1.243	0.696-2.218		
Don't Know	2.156**	1.295-3.59		
HIV cannot be transmitted by mosquito bite				
No (ref)	1.000			
Yes	1.809	0.907-3.608		
Don't Know	2.980*	1.248-7.113		
Reasons for sex				
Health and happiness				
Not Important (ref)	1.000		1.000	
Slight Importance	0.499	0.246-1.013	0.454*	0.216-0.953
Important	0.443**	0.243-0.809	0.476*	0.236-0.957
Very Important	0.367**	0.192-0.704	0.675	0.270-1.687
Procreation				
Not Important (ref)			1.000	
Slight Importance			4.499	0.914-22.141
Important			5.441*	1.194-24.79
Very Important			4.225	0.919-19.431

Source: Same as Table 4.1 Note: * significant at 0.05 level; ** significant at 0.01 level; 1.000 reference category and CI confidence interval

7.2.4 Risky sexual decision-making: Qualitative study

In general a substantial number of women in the quantitative survey did not consider themselves at risk of contracting a sexually transmitted infection. Analysis of the participants' sexual decision-making yielded two main categories: sexual risk taking and avoiding sexual risk taking.

Sexual risk taking

Findings from the in-depth interview revealed that most women would not have sex with their husband if they had an STI. One of the participants said: "*It is very difficult to talk about what I will do at that time. But I will not have sex with him if I discover I have disease. I will rather find a way of manipulating him up until I got cured*". (urban woman, aged 32, married 8 years)

***Trusting of husbands*:** Most of the women were of the opinion that marriage still accords protection against STIs. This view is consistent with findings that marriage is a safe haven from STIs in Botswana and KwaZulu-Natal (Langen 2007). Perceptions of being at risk of sexually transmitted infection were very low. Most did not consider themselves to be at risk of contracting an STI based on the reason that they trusted their husband/partner. One of the participants said: "*My husband does not show me any sign not to trust him*". (urban woman, aged 34, married 10+ years).

Fear of indictment or accusation: According to the participants, the major concern was how they would broach the acceptability of having STIs when their partner is apparently healthy. In the words of a participant: "*Mhmmm the only reason is fear of judgment and rejection from my husband. Again going to the clinic alone they assume you are irresponsible by having many partners and unprotected sex but you are married. It means you are cheating. It is difficult to convince your husband to go and test when you already know you have infection and he does not show any sign*". (rural woman, age 28, married 10 years).

In line with the fear of the outcome of avoiding risky sexual intercourse, one of the participants said: "*The problem is that men do not take no for an answer. We do have fears; it is just that when you say no, they think you are saying yes. It is difficult to give reason sometimes why you don't feel like*". (rural woman, aged 28, cohabiting for 6 years).

Resentments: Few of the participants reported they are at risk of contracting STI because of inconsistent condom use, given that their husband/partner is working outside Mahikeng. In addition, they were not sure of what their husband was doing when they are away from home because men are not very reliable. A participant said: "*Apparently men are the people that bring STI in a relationship, because we women we do not cheat. I don't see the reason why I should have HIV because my husband is the first and only man I have ever slept with. If I have STIs it comes from him and therefore no need to protect anyone".* (urban woman, aged 31, cohabiting for 6 years).

Further evidence of sentiment was observed among those who would have sex because they have no reason to give for avoiding risky sex, knowing that they are faithful to their husband/partner. A participant said: "*I do not want to fight with him, if I lie to be sick or tired today, what will be my reason tomorrow. I am not sure if he is cheating, but men who drink and do not respect their partner are not reliable".* (rural woman, aged 36, married 7 years).

Strategy to avoid risky sexual taking

On the strategy to avert engaging in risky sexual intercourse, some women asserted that communication about safer sex practice between husband and wife was important. They emphasized that sustainable empowerment of women to achieve safer sex practice needed education on their rights and workshops for exchange of experiences.

Education and communication on their sexual rights and workshops: virtually all the women advocated for women to know their rights. Women believe that key to overcoming risky sexual behaviour in marital relationships is knowledge of their rights. One participant said: "*Women must stop being insecure and know their rights. They need to attend workshops where they will be taught about their rights in marriage*" (urban woman, aged 40, married over 10 years). A few believed in organizing workshops and establishing support groups. A participant stated:

"Women's unions are good as they can share experiences and get information on how they can stand for themselves and avoid their husbands manipulating them" (rural woman, aged 30, married 7 years).

7.3 DISCUSSION

The findings from this study revealed that higher levels of formal education significantly reduced sexual risk taking as in Kenya (Adamczyk & Greif, 2011), but contradicts other studies which showed that higher levels of formal education are associated with risky sexual behaviour in Cape town, South Africa (Dinkelman, Lam, & Leibbrandt, 2008; Tenkorang, Maticka-Tyndale, & Rajulton, 2011). The disparities between the present findings and other studies could be due to the differences in study population. For instance, Tenkorang, Maticka-Tyndale, et al. (2011) investigated sexual risk taking among young people whereas the current study focused on woman in a marital relationship. Formal education equips women with knowledge on the repercussions of contracting an STI, which translates to a change of behaviour with the concomitant reduction in likelihood to engage in risky sexual activities. Formal education paves the way to a higher job status which may offer socio-economic security, ultimately minimizing the chances of engaging in risky sexual intercourse.

Finding that students were less likely to engage in risky sexual intercourse concurs with recent reports in Hong Kong (Yip et al., 2013) but are in contrast with a report from Brazil (Sanchez et al., 2013). This ability may stem from their outreach programmes in the colleges and schools where the issue of STI/HIV/AIDS and safer sex practices are emphasized (Shisana et al., 2009). Impacts of HIV/AIDS in South Africa have been felt at household and community levels. Hence, sex education and HIV prevention programmes in South Africa may have equipped students to avoid risky sexual intercourse (Shisana et al., 2009).

The perception that husbands have the right to use force for sex predisposes women to engage in risky sexual intercourse. In many societies, sexual equality between man and woman in a marital relationship is unattainable because women have been socialized to be submissive to their husband/partner and therefore cannot challenge the cultural norm of subservience to their husband. This finding concurs with the earlier studies (Awusabo-Asare et al., 1993, Isiugo-Abanihe, 1994; Rivers et al., 1998) that documented conjugal rights of men. These have implications in a woman's attitude to decision-making on safer sex and sexual outcomes.

The findings are consistent with the previous studies which reported that sexually abused women are more likely to engage in risky sexual intercourse (Bowleg, 2004; Wyatt et al., 2000). About 50% of the women in the study had experienced forced sex in their marriage. The use of force for sex against the will of a woman is certainly evidence of sexual abuse. Women who are sexually abused often have little or no power to negotiate safer sex practices because they lack self- esteem among other reasons. This has a great implication for the spread of STIs.

Both women who acknowledged that and those ignorant as to whether husbands have right to sex showed at least three-fold increased odds to engage in unprotected sex with husbands who had an STI. Ignorance or a claim to be unaware as to whether husbands have the right to sex suggests male sexual dominance shapes a woman's susceptibility to risky sexual intercourse. The findings are in line with a recent study which attributed women's increased sexual risk to gender inequality in Botswana and Swaziland (Shannon et al., 2012). While the perceived right of a husand to use of force may portray evidence of male-dominance, it poses a great risk to men since married women may not have the opportunity to negotiate the terms and conditions to have sex. The need to encourage sexual rights equality in civil, traditional, and religious marital relationships may be a strategy to avert risky sexual behaviour and reduce the spread of HIV.

The study revealed that husband's acceptance of condom use was associated with a low likelihood to engage in risky sexual intercourse. Husband's acceptance of condoms may suggest a change of sexual behavior in response to HIV/AIDS. Although suggesting condom use to partners was not a significant predictor to safer sex practice in the findings, the acceptance of condoms by husbands would mean positive attitudes to safer sex practice. A husband's acceptance of condom use may increase the power of a woman to negotiate safer sex even if the woman had an STI because convincing her partner to use a condom can be done with ease. The acceptance of condom use by spouses may demonstrate a commitment of the couple to safeguard their sexual health in the marital relationship.

The decision to engage in risky sexual intercourse which may culminate in contracting STIs including HIV is not solely determined by the behaviour of the woman. Women who are married to farmers were more likely to engage in risky sexual intercourse than their counterparts who were unemployed. It is possible that the messages about STIs including HIV are not reaching couples who are farm workers. On the other hand, it may be attributed to the negative attitides to safer sex measures which is consistent with previous findings (Awusabo-Asare et al., 1993; Dixon-Mueller, 1993). Evidence from the in-depth interviews showed that men working away from home were predisposed to a higher risk of STI due to their sexual networks. It would be against marital obligations for a woman to turn down sexual advances from her husband after a short or long term separation from one another. Women may have the ability to avoid risky sexual intercourse but may not know the exact time that infection occurs in the marriage because of trusting their husband/partner. The trust women have for their partner may have some implications on their attitudes to negotiate safer sex and thus leave them vulnerable to risky sexual intercourse. The fact that most women who were married to farmers were unemployed, coupled with the claim that marriage accords protection against STIs, suggest that economic dependence and trust may foster risky sexual intercourse in relationships.

Women who are not sure whether they are at risk of contracting STIs were more likely to engage in risky sexual intercourse. It is expected that correct knowledge about the misconceptions on HIV would influence a positive attitude to safer sex practices among the women. The findings were in agreement with several studies (Halperin & Epstein, 2004, 2007; Mah & Halperin, 2010; Mudingayi, Lutala, & Mupenda, 2011) which documented that the perceived risk of contracting HIV coupled with the correct knowledge on the misconceptions did not result in lower risky sexual behaviour among women. A tendency to engage in risky sexual intercourse was observed among women who are unsure about the misconceptions around HIV. Women may have good knowledge of HIV mode of transmission, but their attitudes to safer sex practices do not reflect the depth of knowledge about HIV and its implications. In addition, qualitative data provoked some concerns about the attitude of women to engage in risky sexual intercourse as resentment for extramarital affairs, which is consistent with other studies (Previti & Amato, 2004; Treas & Giesen, 2000; L. R. Williams & Hickle, 2011). This may partly account for the high prevalence of HIV/AIDS among women in Mahikeng.

As found in this study, procreation is the main reason reported by women as influencing them to engage in sex if their husband or partner has an STI. The importance attached to having children as a priority for women rather than protection against sexually transmitted infections is consistent with earlier studies in different parts of South Africa that childbearing is prioritized rather than protection against risky sexual engagement of the potential mother (Dyer et al., 2002; Wood et al., 1997; Varga & Makubalo, 1996; Langen, 2007). Messages about safer sex practices must be streamlined to address ethnic and cultural views on child-bearing. The cultural view of fertility as evidence of womanhood can shape the attitude of women on decision-making about safer sex. It could be surmarized that the high prevalence of HIV/AIDS among pregnant women in North-West (Setswe, 2009) may be linked to the interest of women in having children rather than their sexual health. Women who engage in sex for health and happiness demonstrated an unexpectedly positive attitude to safer sex practices. It would appear that these women also consider STIs including HIV and their implications. Hence they may practice safer sex to protect their sexual health.

Women were more likely to avoid risky sexual intercourse if the man had an STI, especially when the couples engage in spousal communication about sex, and when women perceived sexual engagement as a means to enhance their health. The importance of communication as a strategy to avoid risky sexual intercourse also emerged in the qualitative study. Other studies have also documented that spousal communication increases women's decision-making about safer sex (Hamid et al., 2011; Klomegah, 2006). Women believe that education and communication on their sexual rights through workshops could empower them in practicing safer sex.

7.4 CONCLUSION

The results of the study indicate that empowering women through education and improving spousal communication are needed for decision-making on safer sex. Despite the assumption that South Africa is in the fore front of empowering women in Africa, women lacked the knowledge of their fundamental human right to sex, which disposes them to sexual risk-taking. Furthermore, attitudes and misconceptions about HIV/AIDS still remain driving forces behind risky sexual decision-making in South Africa. Increasing women's awareness of their higher risk by following traditional sexual practices could become part of the current HIV/AIDS prevention programmes in South Africa. The fact that women can avoid risky sexual intercourse suggests that women are not completely powerless in protecting themselves from being infected by their intimate partners as some earlier studies have indicated. However, this ability needs to be exercised in other scenarios such as sexual inequalities which expose women to risky sexual practices.

CHAPTER EIGHT: CONDOM USE

8.0 INTRODUCTION

This chapter presents information on the prevalence of condom use among married women. The male condom is the most widely used and also provides dual protection against unwanted pregnancy and disease prevention. It presents the perceptions, levels and determinants of condom use among the women in the study.

8.1 DEPENDENT VARIABLE

Current condom use is the dependent variable. That is, married or cohabiting women who report that they are using or not using condoms at the time of the survey. Respondents were asked "Are you currently using condoms?" The response to this question was "Yes" or "No". Respondents who reported that they are currently using condoms were coded as 1, while those who did not were coded as 0.

8.1.1 Analyses

Some of the categories in the independent variables were zero at bivariate analysis. These include number of living children which is grouped into three categories (None, 1-2, and 3+). Knowledge that condom use prevents STI/HIV/AIDS was transformed into dichotomous variable (No and Yes). Knowledge that an STI is a risk factor for HIV infection was transformed into a binary variable "No" or "YES".

Three models were fitted for the women who reported current use of condoms. In the first, the effects of demographic characteristics were controlled on condom use. In model 2, the demographic characteristics, knowledge and attitudes to STIs were used. In the final model, the effects of demographic characteristics, knowledge and attitudes to STIs and reasons why women engage in sexual activities on condom use were examined.

8.2 RESULTS

8.2.1 Knowledge of sexually transmitted infections and use of preventive measures: Univariate Analysis

Table 8.1 presents the knowledge of STIs and use of preventive controls. Almost all respondents (99%) had heard of STIs and HIV/AIDS (97%). Ninety-five percent of the respondents knew that sexual intercourse is one of the modes of HIV transmission and STIs and their transmission can be prevented by using condoms (91%). It seems married women in Mahikeng are well aware of the existence of STIs, including HIV/AIDS in particular. Ninety-seven percent of the women reported television and radio (91%) as the main source of information. However, there was a mismatch between knowledge and practice. Although the majority of married women know that the mode of HIV transmission is through sexual intercourse and many know that condoms can be used to prevent STIs, about 16% were users. The main reason for not using condoms is that the respondent and the husband/partner trust each other (60%). But there are cases where either the respondent opposes using condoms (38%) or the husband/ partner opposes (44%).

Table 8.1: The percentage distribution of women by knowledge and source of information about STIs

Knowledge and attitudes toward STIs	N=568	Percentage
Ever heard of STIs		
Yes	561	98.8
Types of STIs heard about		
HIV/AIDS	542	97.1
Gonorrhea	282	50.1
Candidiasis	161	28.9
Herpes	164	29.4
Syphilis	279	50.0
Total	**1428*	*100.0*
Source of information		
Radio	512	91.1
TV	545	97.0
Newspaper	367	65.3
Posters	290	51.6
Partners	166	29.5
Others (clinics, Doctors, nurses)	185	32.9
Total	**2065*	*100.0*
Mode of HIV transmission		
Sexual intercourse	538	94.7
Shaking of hands	13	2.4
Unsterilized needles	348	62.9
Blood transfusion	342	61.8
Total	**1241*	*100.0*
Condom use		
Yes	93	16.4
Reasons for not using condom		
Husband/partner opposed	177	44.3
Respondent opposed	150	37.5
Not accessible	16	4
Sterile	61	15.3
We trust each other	240	60
Am afraid of my partner	17	4.3
Total	***661****	***100***

Source: same as Table 4.1Note: * Respondents were allowed to state more than one condition.

8 .2.2 Women's condom use: Bivariate analysis

Cross tabulation between demographic characteristics of the women and condom use is shown in (Table 8.2). Women in the age group 30-34 and those who commenced their relationship at the age of 30 and above showed the highest percentage in reporting

condom use. Urban dwellers and women with secondary formal education showed higher percentages (17% and 21%) in reporting condom use compared to rural and women with no formal education. Those who speak Setwana as their home language showed the highest percentage in reporting condom use. In terms of type of union, cohabiting women showed the highest percentage in condom use (24%). Women who were unemployed showed a lower tendency of reporting current use of condoms compared to women who were employed. Number of living children was negatively associated with women reporting current use of condoms. Low percentages in condom use were reported by women who follow traditional religion, commenced their marriage between the ages of 25-29 years and those in union for 10 years and over.

Women who freely discuss sex with their spouses were more likely to report use of condom compared to those who considered discussion about sex to be very difficult. Women who reported that husbands/partners have no right to use force for sex showed higher condom use compared to those who said that husbands/partners have right to sex. Lower condom use was reported by women who indicated they were forced to have sex sometimes compared to those that were not forced. Women who claimed that their spouses accepted condom use were more likely to report current use of condoms compared to those whose spouses rejected condom use. Government workers, women who chose their partners and those who were satisfied within their relationship showed highest condom use within their categories.

Table 8.2: Proportion of women who are currently using condoms by demographic characteristics

Demographic characteristics	Condom use (%)	Total (N)
Total	**16.4**	**567**
Age group		
< 25	15.6	64
25-29	15.1	106
30-34	17.5	114
35-39	16.0	119
40-44	16.7	90
45-49	16.2	74
Residence		
Rural	16.0	444
Urban	17.1	123
Home language		
Setswana	19.5	375
Afrikaans	9.5	21
IsiXhosa	10.0	50
Sesotho	12.2	74
IsiZulu	6.4	47
Type of union		
Civil	19.0	211
Religious	9.8	112
Traditional	12.1	149
Cohabiting	24.2	95
Highest educational level		
No education	15.2	112
Primary	15.1	179
Secondary	21.2	156
Tertiary	12.5	120
Occupation		
Unemployed	8.9	169
Business/trading	13.2	76
Government worker	16.5	133
Teaching	10.2	59
Student	46.8	47
Domestic worker/security	20.5	83
Religious Affiliation		
Roman Catholic Church	15.3	72
Methodist	16.4	146
Pentecostal	19.2	213
Seventh Day Adventist	13.8	94
Other religion*	7.1	42
Number of living children		
None	35.1	77
1-2	17.6	289
3+	7.0	201

Table 8.2 Continued

Demographic characteristics	Condom use (%)	Total (N)
Age at marriage		
< 25	16.7	234
25-29	13.2	197
30+	19.9	136
Duration of the union		
<5	18.3	218
5-9	16.6	157
10+	13.5	192
Husband/Partner Occupation		
Unemployed	17.9	39
Farming	16.7	24
Set up private business	13.5	141
Government worker	21.4	192
Teaching	9.5	63
Miner/gardener	17.4	46
Others	11.3	62
I chose my partner		
No	7.5	40
Yes	16.9	527
Satisfied in the union		
No	9.1	44
Yes	17.9	463
Don't Know	8.3	60
Discuss sex with husband		
Very difficult	2.7	73
Difficult	11.3	133
Not difficult	20.8	361
Husband has right to use force for sex		
No	18.7	434
Yes	6.4	47
Don't Know	9.3	86
Husband sometimes force you to have sex		
No	19.3	290
Yes	13.0	277
Husband accepts condom use		
No	6.5	185
Yes	20.9	382

Source: same as Table 4.1

Knowledge and attitudes related to STI/HIV/AIDS and condom use is show in Table 8.3. Women who perceived that they were at risk of contracting an STI were more likely to report condom use than other women. Women who had ever suggested condom use to their spouses were more likely to report current condom use than those who never suggested condom use to their partners. Women who knew that an STI is a risk factor for HIV which can be prevented by the use of condoms showed higher tendency of reporting current condom use compared to women who did not know. Women who knew that a healthy looking person can have HIV/AIDS, and cannot be infected by

sharing food with a person who had AIDS were more likely to report condom use compared to those who did not know. Low percentages in condom use were reported by women who did not know whether HIV cannot be transmitted by mosquito bite or through supernatural means.

Table 8.3: Proportion of women who are currently using condoms by knowledge and attitude related to STI/HIV/AIDS

knowledge and attitude related to STI/HIV/AIDS	Condom use (%)	Total (N)
Total	**16.4**	**567**
Respondent at risk of contracting STI		
No	17.4	270
Yes	22.3	121
Don't Know	10.3	156
STIs/HIV/AIDS can be prevented by condom use		
No	4.0	50
Yes	17.4	517
Ever suggested the use of condom to your partner		
No	5.0	238
Yes	24.3	329
Do you know that STIs are a risk factor for HIV/AIDS		
No	5.2	58
Yes	17.5	509
Do you know the HIV status of your partner		
No	16.0	125
Yes	16.6	398
Don't Know	16.7	24
A healthy looking person can have the HIV/AIDS virus		
No	12 0	25
Yes	17.2	495
Don't Know	6.7	30
HIV cannot be transmitted by mosquito bite		
No	25.0	72
Yes	15.9	408
Don't Know	10.4	67
HIV cannot be transmitted by supernatural means		
No	25.3	95
Yes	18.7	273
Don't Know	9.1	175
Person cannot be infected by sharing food with a person who has AIDS		
No	9.5	42
Yes	17.2	482
Don't Know	10.0	20

Source: same as Table 4.1

Reasons for engaging in sexual activities and condom use were indicated in table 8.4. Women who claimed that procreation was not the reason for engaging in sex showed a higher likelihood of reporting condom use than those who reported procreation as important. Those who considered sex for enjoyment to be very important (14%) showed a lower percentage in reporting condom use compared to those who asserted that sex

for enjoyment was not important. The highest percentages in reporting condom use were observed among those who considered sex for love/closeness (22%) and confirm desirability (21%) to be important. Women who reported that sex was considered to be very important for health enhancement and to be important to keep and satisfy partners showed highest percentages in reporting condom use within their categories. The lowest percentages in condom use were observed among those who considered sex to be very important (14%) as a natural meaningful experience as well as for the purpose to control partner or show strength (13%) compared to their counterparts.

Table 8.4: Proportion of women who are currently using condoms by reasons for engaging in sexual activities

Reason for sex	Condom use (%)	Total (N)
Total	**16.4**	**567**
Procreation		
Not important	34.8	66
Slight important	18.6	97
Important	9.8	205
Very important	15.7	197
For enjoyment		
Not important	24.0	25
Slight important	21.4	56
Important	16.7	221
Very important	14.0	265
To show love and be closer to partner		
Not important	19.2	26
Slight important	6.5	46
Important	22.1	190
Very important	13.8	305
Confirm my desirability		
Not important	12.1	157
Slight important	13.3	135
Important	20.9	191
Very important	19.5	77
For my health and happiness		
Not important	12.0	117
Slight important	16.3	80
Important	17.1	210
Very important	18.8	158
To keep my partner/ to satisfy my partner		
Not important	14.3	49
Slight important	15.1	86
Important	17.7	203
Very important	15.8	228
Natural and important meaningful experience in my life		
Not important	14.7	34
Slight important	19.2	52
Important	18.8	234

Very important	13.6	243
To control my partner and show strength		
Not important	15.2	343
Slight important	20.5	73
Important	18.8	101
Very important	13.3	45

Source: same as Table 4.1

8.2.3 Multivariate analyses of the factors related to condom use

Table 8.5 shows separate models of women who reported current condom use by selected characteristics. In model 1, occupation and number of living children, spousal discussion and acceptance of condom were significant predictors of condom use among the women. Compared to unemployed women, students and domestic workers/female security workers were 3.6 times and 2.2 times likely to report condom use. The odds of condom use decreased with increasing number of living children. Women who stated they discuss sexual issues without difficulty were more likely to report condom use than those who found it very difficult to discuss sex with their partners. Women who reported husbands/partners' acceptance of condom use were more likely to use condoms than other women whose partners rejected condom use. In model 2, respondents at risk of contracting STIs, knowledge of partner's HIV status and ever suggested condom use were significant predictors of condom use among women. Women who were unaware of their risk state and those who knew HIV status of their partners were less likely to report condom use than other women. Compared to those who had never suggested the use of condoms to their partner, those who have suggested were 5.9 times more likely to report condom use. All the significant variables in model 1 maintained their significance in model 2 with the exception of husband acceptance to use condoms.

In the final model, students and domestic workers/female security workers were 4.9 times and 2.9 times likely to report condom use as unemployed women. The odds of condom use decreased with the increasing number of living children. Women who were unsure whether they were at risk of contracting STIs or not were less likely to report condom use compared to those who reported they were not at risk. The odds of reporting condom use were significantly higher among women who had suggested

condom use to their partners than those who never suggested it. Of particular importance, the odds of reporting condom use were significantly higher among women who discuss sexual matters without difficulties than those who find discussion on sex issues to be very difficult. Women who know the HIV status of their husband were less likely to report condom use compared to those who do not know it. Women who were not sure of transmission of HIV by supernatural means showed lower likelihood in reporting condom use compared to those who did not know. Women who stated procreation to be important or very important reason for sex showed lower likelihood in reporting condom use compared to those who reported it unimportant.

Table 8.5: The parsimonious logistic regression model showing the women who reported current use of condom by selected characteristics

Variables	Model		Model 2		Model 3	
	OR	95% CI	OR	95% CI	OR	95% CI
Demographic characteristics						
Occupation						
Unemployed (ref)	1.000		1.000		1.000	
Business/trading	1.634	0.663-4.027	1.775	0.690-4.566	2.083	0.777-5.586
Government worker	1.49	0.697-3.185	1.403	0.630-3.124	1.507	0.649-3.498
Teaching	0.782	0.275-2.227	0.768	0.260-2.265	0.724	0.236-2.225
Student	3.578**	1.522-8.410	3.941**	1.533-10.126	4.990*	1.803-13.807
Domestic worker/security	2.252*	1.013-5.005	2.752*	1.184-6.401	2.980*	1.222-7.272
Number of living children						
None (ref)	1.000		1.000		1.000	
1-2	0.422**	0.223-0.796	0.437*	0.216-0.884	0.483	0.225-1.037
3+	0.213**	0.094-0.482	0.182**	0.075-0.445	0.189*	0.074-0.487
Discuss sex with husband						
Very difficult (ref)	1.000		1.000		1.000	
Difficult	3.706	0.782-17.55	4.082	0.817-20.394	3.862	0.746-19.995
Not difficult	4.776*	1.062-21.477	6.403*	1.344-30.512	5.483*	1.099-27.347
Husband accepts to use condom						
No (ref)	1.000					
Yes	3.278**	1.666-6.452				
Knowledge and attitude to STI/HIV/AIDS						
Respondent at risk of contracting STI						
No (ref)			1.000		1.000	
Yes			0.838	0.459-1.533	0.802	0.423-1.522
Don't Know			0.339**	0.157-0.731	0.418*	0.185-0.949
Know the HIV status of partner						
No			1.000		1.000	
Yes			0.472*	0.226-0.986	0.413*	0.188-0.906
Don't Know			2.223	0.557-8.867	2.378	0.554-10.207
Ever suggested the use of condom to partner						
No (ref)			1.000		1.000	
Yes			5.998**	3.030-11.874	6.349**	3.116-12.933
HIV cannot be transmitted by supernatural means						

No (ref)	1.000	
Yes	0.704	0.357-1.387
Don't Know	0.376*	0.166-0.852
Reasons for sex		
Procreation		
Not important (ref)	1.000	
Slight important	0.418	0.171-1.02
Important	0.197**	0.086-0.450
Very important	0.399*	0.180-0.885

Source: Same as Table 4.1; Note: * significant at 0.05 level; ** significant at 0.01 level; 1.000 reference category.

8.2.4 Knowledge of condom use: Qualitative study

Most of the participants have heard about condoms as well as having access to them. Two issues that were discussed were perception about condoms and barriers to condom use.

Perceptions about condoms

Respondents were aware that condoms can prevent sexually transmitted infections, including HIV, and unwanted pregnancies. A participant said: "*It is good as it prevents both diseases and unwanted pregnancy and it helps us to plan our family properly*" (urban woman, aged 32, married 8 years).

A few said that condoms have side effects and are not 100% effective. A participant said: "*They have side effects because it gives me rashes and inflammations to my husband. It is not 100 % safe and can burst during sexual activity. So we stopped using it for a long time*" (urban woman, aged 34, married 9 years).

Barriers to condom use

All the participants stated that condom use was important. Some have used condoms whereas a few have never used. However there were some limitations to condom use.

Concerns about sexual pleasure: All the respondents acknowledged the importance of condom throughout the interview. However reduction of sexual pleasure was a negative effect which they were concerned about. Most of the women responded that they would not be able to use condoms consistently because sex needs to be enjoyed. In the words of the participants: "*I used condoms when I was dating but now that we are married I don't think I can use it anymore except in emergency like during my period*

(rural woman, aged 39, married 10+ years). *"I can use condoms to prevent pregnancy but I also need to enjoy sex"* (urban woman, aged 28, married 6 years). *"I knew it prevents diseases and unwanted pregnancies, it also reduces satisfaction but we have been together for 12 years, I trust my husband, we do not want it"* (urban woman, aged 37, married 10+ years).

Fear of accusation: Some of the participants responded that they would not be able to ask their partners to use condoms because of fear of accusation. A few acknowledged that their partners had already accused them of cheating for asking them to use a condom. Some stated that they would ask for condom use as pretence to prevent unwanted pregnancy. Some of the views of the participants on fear of accusation are:

"We did not use it from the beginning and it will be difficult to ask for it now. He will ask me why all of a sudden I want to use it. I trust him as he trusts me. I have not dated anyone since I met him but I know that men do cheat" (urban woman, aged 32, married 8 years)

"It is going to be a battle as we never used it for a long time" (rural woman, aged 28, married 7 years).

"It is not easy, I can't, he will think that I am cheating and we have never used it before" (rural woman, aged 30, married 8 years).

Trust: A few had never used condoms and have no intention to use them because they trust their partners. However, some of the women were of the opinion that there is no need to use condom because relationships must be based on trust. One participant said: "*We do not want to use condoms because we trust each other and we have never used it"* (rural woman, aged 28, married 7 years).

A few reported irregular use of condoms because men should initiate condom use. In the words of a participant: *"I have never asked him, he uses a condom when he wants" (rural woman, aged 43, married 10+ years).*

8.3 DISCUSSION

Condom use has emerged as one of the promising strategies in the global fight against sexually transmitted infections including HIV/AIDS. Since the introduction of condoms purposely for disease prevention, easy supply and accessibility is evident from research findings in South Africa (Shisana, 2005; Shisana et al., 2009). The present study gives support to the earlier observations on knowledge and efficiency of condoms in preventing the spread of STI/HIV/AIDS. Despite the prospects of condoms in HIV/AIDS prevention, the reported usage in the study is low. The study revealed that while over 90% knew that an STI is a risk factor for HIV and condom use prevents STI/HIV/AIDS, only 16.4% of the women reported current use of condoms. Other studies in South Africa (DoH, 2004; Maharaj & Cleland, 2004) have reported that married and cohabiting women were less likely to use condoms. This indicates a high level of mismatch between knowledge and condom use. The study indicated that condom use in marital or cohabiting relationships is influenced by a complex interaction of structural, cultural and individual factors.

The result is similar to studies in Free State province (Chandran et al., 2012) and Cape Town (Hargreaves et al., 2009) which indicated that students were more likely to report condom use compared to unemployed women. This is not unexpected because safer sex practice programmes through condom use have been promoted in institutions of learning and communities where there are students. This finding is in consonance with previous studies in Nigeria (Ogunjuyigbe & Adeyemi, 2005), where a job earning an income enabled women to make decisions on condom use. Irrespective of limited skills and meagre salaries, their economic state bestows self-esteem on women.

One of the findings is in sharp contrast with recent studies in South Africa (Peltzer, 2013; Vu et al., 2012) and other countries (Bunnell et al., 2008) which reported that

knowledge of partner's HIV status is associated with high condom use. The discrepancy may be attributed to the fact that previous studies considered married and unmarried women, whereas the present study focused on married or cohabiting women. Knowledge of partners' HIV status may offer unlimited opportunities to women to decide whether to use condoms or to reject sex outright. The present study did not focus on knowing either the HIV status of the women or that of their partners. However, over 90% of the women in the survey reported that they would reject sex if a partner has an STI. However, recent studies have shown unprotected sex among discordant couples in which the woman is HIV-positive (Bii, Otieno-Nyunya, Siika, & Rotich, 2008; Peltzer, 2013; Villar-Loubet et al., 2013). There was evidence that these women knew that their partners were HIV-negative (Bunnell et al., 2008). The reason why women who knew the HIV status of their partners showed low condom use in this study is not clear from the data. The low condom use among women reporting knowledge of their partners HIV status may represent trust as observed from the qualitative data.

Considering the recent reports on early sexual initiation, unplanned pregnancies with risky sexual behaviour among women in South Africa (Peltzer, 2013; Villar-Loubet et al., 2013), women with knowledge of their partners HIV status and may yet have sex represent potential risk to their male partners. Studies have shown that some young women commenced marriage and cohabitation after they have already been infected by HIV virus (Kaiser et al., 2011). Under this condition, reluctance to use condoms may occur. From the in-depth interviews, the major impediment to use condom was fear of accusation because condoms were not introduced at the beginning of the union. Interventions that encourage couples to know their HIV status at the inception of a relationship may increase adoption of condoms in steady relationships and subsequently overall wellbeing of sexual and reproductive health.

The result is consistent with other studies in South Africa (Langen, 2007; Maharaj & Cleland, 2004) that showed that the use of condoms decreases with increasing number of children. This may suggest that the use of condoms may be related to prevention of pregnancy rather than disease. The importance women place on having children is

higher than the need for protected sex and health risks, a finding similar to a study in Uganda (Beyeza-Kashesya et al., 2009). Sex for the purpose of childbearing will involve unprotected sexual acts. In the African context childlessness might certainly have negative effects on condoms use within marriage because childbearing is the symbol of a good marriage and womanhood to women. In addition, husbands and male partners may resist use of condoms in marital and steady relationships because sex ought to be natural and based on trust. Women may engage in unprotected sex as a way of discouraging their husbands or male partners from having children outside marriage or their relationship. Juxtaposing the interest in having children which a natural sexual act provides, consistent condom use may be unattainable especially when women desire more children. The importance of procreation may have an impact on the spread of HIV/AIDS in marital relationships because of inconsistent condom use.

The findings of the study are in agreement with other studies (Exavery et al., 2012; Hamid et al., 2011; Jones et al., 2013; Perrino et al., 2006) that reported spousal communication about condom use is associated with a rise in condom use. Our study showed that women who discuss sex without difficulties with their partners were more likely to adopt protective measures by using condoms. Women who have ever suggested the use of condom to their partners had higher odds of using condoms, a finding that is documented in previous studies (Mon & Liabsuetrakul, 2012; Muhwava, 2004). Spousal discussion about sex promotes use of condoms in marital relationships without fear of accusation. This result revealed that women may prefer to use condoms but fail to communicate the desire, a finding similar to another qualitative study in the North-West province (Versteeg & Murray, 2008). The fact that women want to use condoms but could not voice out their intentions suggests a communication gap between couples. Furthermore, women using condoms as a pretence to prevent an unwanted pregnancy instead of diseases cannot be a sustainable strategy to avert risky or unprotected sex. Empowering women through spousal communication may emerge as one of the strategies to promote condom use in marital relationships.

Finally, one of the findings gives support to some extent to earlier studies in South Africa (Kalichman & Simbayi, 2004; Prince, Denis, & van Dijk, 2009) and elsewhere (Behrend, 2007; Tenkorang, Gyimah, Maticka-Tyndale, & Adjei, 2011) that reported supernatural transmission of HIV/AIDS influences attitudes to condom use. About thirty-two percent (32.2%) of the women were not sure about transmission of HIV by supernatural means. Considering the traditional beliefs that supernatural forces or malicious spirits inflict diseases in South Africa, this particular group of women may not perceive the need to use condoms to prevent sexually transmitted infections. The assumption is that humans cannot contend with malicious spirits if they play role in the spread of HIV/AIDS. AIDS does not have a name in Setwana, which created doubts about its existence (Scott, 2010). Denying AIDS existence because it has no local name may separate HIV transmission from unprotected sex which may result in low condom use. Uncertainty about HIV transmission by supernatural means is associated with unprotected sexual behaviour. The findings of the study underscore the relevance of local beliefs in promoting condom use in marital relationships.

Apart from socio-cultural and structural barriers to consistent condom use identified in the study, qualitative findings reveals that women may not use condoms because of sexual pleasure despite the knowledge of the benefits. This indicates that women may place sexual pleasure above health risks. The claim that condoms can break is enough to have a negative attitude to condom use. Women's negative attitude to condom use may compromise safer sex measures which is consistent with previous findings (Awusabo-Asare et al., 1993; Dixon-Mueller, 1993).

8.4 CONCLUSION

The study revealed that the risk of unprotected sex and the implications are clear to the women. Since fertility is intertwined with marriage and womanhood in the African context, condom use within marriage may continue to influence safer sex practices. The misperception and dislike of condoms because of trusting one's sexual partner, fear of accusation, and sexual pleasure among women suggest that married and cohabiting women may continue to represent a high risk population for sexually transmitted

infections. Personal attitudes of disliking condoms and trusting partners leading to non-condom use needs further investigation. Strategies to increase condom use in marital relationships may focus on providing women with income earning jobs and improvement of spousal communication as these two factors play a role in consistent usage.

CHAPTER NINE: SUMMARY AND RECOMMENDATION

9.0 OVERVIEW

Reproductive health emphasizes the ability to have a satisfying and safe sex life, and the right to reproduce and the freedom to decide if, when and how often to do so (Fathalla, Sinding, Rosenfield, & Fathalla, 2006). Reproductive health, therefore, is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and, care related to reproduction and sexually transmitted infections (Glasier et al., 2006).

In line with the (Fathalla et al., 2006; Glasier et al., 2006) definitions of reproductive health and sexual health, there is a growing body of literature on sexual and reproductive decision-making in developing and developed countries. However, such studies in South Africa have concentrated on youth and unmarried women of reproductive age with a neglect of those in marital and cohabiting relationships. Of particular importance, little is known about the factors that shape sexual and reproductive decision-making among married and cohabiting women. The essence of this study is in line with the United Nations reproductive health declaration in Cairo 1994 (Fathalla et al., 2006).

Marriage is a respectable union endowed with cultural, social and religious values and the major context for childbearing. Cultural, social and religious values on heterosexual marriage within South African take precedence over national law leading to behaviours between men and women (Boonzaier & de La Rey, 2003). There is 'ownership of wives' by their husbands which violates women's sexual and reproductive health rights. Studies in South Africa have shown that men dominate reproductive decision-making in marital or cohabiting relationships (Jewkes *et al.*, 1999; Hargreaves *et al.*, 2009; Ragnarsson *et al.*, 2009 Mantell *et al.*, 2009).

Realizing the Cairo definition of reproductive health among married women may entail knowing and addressing the factors that influence sexual and reproductive health decision-making within marital or cohabiting relationships. Hence the main purpose of the study was to assess sexual and reproductive health decision-making among married or cohabiting women aged 18-49, in Mahikeng, South Africa. Effects of demographic characteristics, husband/partner related factors, STI/HIV/AIDS related knowledge as well as attitude and reasons for engaging in sexual activities on sexual and reproductive decision-making among married or cohabiting women were investigated using mixed methods approach.

9.1 SUMMARY OF THE FINDINGS

The lack of empirical studies on the factors influencing sexual and reproductive decision-making among married or cohabiting women compelled the assumptions stated in this study. It was conceptualized that demographic characteristics, knowledge and attitude to STIs and reasons why women engage in sexual activities affect sexual and reproductive decision-making among married or cohabiting women. Linking the theory of gender and power with the conceptual framework some hypotheses were tested.

9.1.1 Effects of socio-demographics characteristics on sexual control

Women's control over their sexuality was assessed on their ability to demand and to reject sexual advances from their husband/partner. Eight-one percent and 58% of the women reported that women can demand and reject sex respectively from their husband/partners. In the model estimating the effect of demographic characteristics of the women on control over sexuality, the hypothesis that women in a traditional union were less likely to agree that women can demand sex from the husband than those in a civil union was confirmed. This finding found support from the theory of gender and power on societal norms about gender roles within the structure of the cathexis. Other socio-demographic characteristics such as age of the woman, education, and number of living children were significant predictors of a woman's ability to demand sex from her

husband/partner. On the other hand, ability to demand sex from husband/partner was not significantly associated with place of residence, home language, age at marriage, religion and duration of the union.

The hypothesis was confirmed by the findings that unemployed women were less likely to state that women can reject sex from their husbands/partners compared to employed women. This finding is in agreement with the theory of gender and power sexual division of labour. In addition the age, education and number of living children are other variables that are significantly associated with the ability of women to reject sex from their husband/partner. However, there was no significant relation between ability to reject sex and place of residence, home language, religion, age at marriage and duration of the union.

9.1.2 Effects of socio-demographics characteristics on sexual and reproductive health decision-making autonomy

Sixty-one percent of the women exhibited partial autonomy in decision-making on when to have sex; 21.8% and 45.2% reported full autonomy and partial autonomy respectively in the decision on when to use contraception. Over two-thirds reported full autonomy in decision-making on family size. In the model of women's autonomy in decision-making on when to have sex, the hypothesis that women in arranged marriages were less likely to participate in decision-making on when to have sex compared to those who chose their husbands/partners was confirmed. Support for this hypothesis is found within the structure of cathexis. Furthermore, type of union, occupation, number of living children and perception that husbands have the right to sex were significant predictors of decision-making on timing of sex. There was no significant association between decision on when to have sex and education, place of residence, duration of union, home language, religion, husband's occupation, satisfied in the relationship and partner's uses of force for sex.

Significant associations between the decision on when to use contraception and the socio-demographic factors home language, education, duration of union, religion and

occupation, spousal discussion about sex and use of force for sex by husband/partner were observed. However, place of residence, number of living children, occupation of the husband/partner, I chose my husband/partner, husband's approval of family planning and satisfied in the relationship were not significant predictors of decision-making on contraceptive use.

The hypothesis that rural women were less likely to exercise autonomy in decision-making on family size compared to their urban counterparts was endorsed. The theory of gender and power was validated on account of non-participation of rural women in decisions on family size. Furthermore, age of the women, use of force for sex by the partners, type of union, number of living children and perception that husbands have right to sex were significantly associated with decision-making on family size. However, education, occupation, duration of union, religion, occupations of the husband/partner, choosing a husband/partner, satisfaction in the relationship were found to be non-significant predictors of decision-making on family size.

9.1.3 Factors associated with sexual risk- taking behaviour

About 39% of the women in the study reported that they would engage in risky sexual activities if they had STI. Sexual risk- taking when a woman had an STI was associated with education, husband's occupation, perception that husband has a right to sex, husband uses force for sex and his acceptance of condom use. Perceived risk of contracting STIs and misconception of transmitting HIV by a mosquito bite were significantly related to sexual risk-taking if a woman had an STI. Of all the reasons for engaging in sexual activities, only sex for health and happiness was associated with sexual risk-taking. Sexual risk taking when the woman has an STI was found to be unrelated to the age of the women, age at marriage, place of residence, type of union, home language, number of the living children, choice of husband/partner, satisfaction in the union, discussing sex with the partner and the partner's approval of contraception. Other variables that were not associated with sexual risk-taking when the woman has an STI were HIV/AIDS-related knowledge and attitude like condom prevents STI, suggesting condom use to partner, STI is a risk factor for HIV/AIDS, knowledge of

partners HIV status, healthy looking person can have HIV/AIDS virus, and HIV transmission by supernatural means.

Fourteen percent of the women in the study reported that they would engage in risky sexual activities if their partners had an STI. Sexual risk-taking if the partner had an STI was associated education, husband's right to sex, and spousal discussion about sex. Among the reasons for engaging in sexual activities, sex for procreation, health and happiness were related to sexual risk-taking if the partner had an STI. Sexual risk-taking if the partner had an STI was not related with demographic characteristics such as age of the women, age at marriage, place of residence, home language, occupation, religion, number of living children, the duration of union, husband's occupation, choosing the husband/partner, satisfaction in the union, husband's use of forces to have sex, husband/partner approval of contraception, and his acceptance of condoms. None of the variables measuring knowledge and attitude towards STI/HIV/AIDS was associated with sexual risk-taking if the partner had an STI.

9.1.4 Factors associated with current condom use

In the study only 16.0% of the women reported current use of condoms. It was hypothesized that women who stated that spousal discussion on sexual matters to be 'very difficult' were less likely to report condom use compared to those who stated it to be 'not difficult'. The theory of gender and power sexual division of power was validated by finding low condom use among women who found communication on sexual matters very difficult. Other predictors of condom use were in the model estimating the effects of socio-demographic characteristics on condom use, occupation, number of living children and husband accepts use of condoms. However, age of the women, age at marriage, place of residence, type of union, duration of union, education and religion were not related to condom use. Furthermore, association between condom use and husband/partner's occupation, choosing a partner, satisfaction in the union, husband has a right to use force for sex and being forced to have sex was not significant.

STI/HIV/AIDS related knowledge and attitude, which include respondent at risk of contracting STI, knowledge of the partner's HIV status, ever suggested use of condom

and HIV cannot be transmitted by supernatural means were significant predictors of condom use. On the other hand, knowledge that condom use prevents STIs/HIV/AIDS, knowledge that STIs are a risk factor for HIV/AIDS, a healthy looking person can have the HIV/AIDS virus, HIV cannot be transmitted by mosquito bite and a person cannot be infected by sharing food with a person who has AIDS were found to be unrelated to the dependent variable.

Of the several reasons for engaging in sex, only procreation is significantly associated with condom use. Sex as a natural and an important meaningful experience in women's lives, for enjoyment, affection and be closer to partner, to control my partner and show strength, for health enhancement, for health and happiness and to keep/satisfy a partner were not related to condom use.

9.2 DISCUSSION AND CONCLUSION

Despite the cultural values and social-political views on the appropriate behaviours of women in marital relationship, demographic factors, STI/HIV/AIDS-related knowledge, attitudes as well as the purpose for sex were found to have influences on women's sexual and reproductive health decision-making. These were confirmed by the variables found to be significant predictors of sexual and reproductive health decision-making in the multivariate analysis. Since a spectrum of factors related to reproductive health issues were investigated, the summary represents key findings of the study.

Mahikeng women in the study were found to have control over their sexuality. They had control over a wide range of dimensions of sexual control and ability to demand or to reject sex from their husband/partner. The women further showed variations in reporting their level of autonomy in sexual and reproductive health decision-making. However, traditional attitudes to decision-making on sex and reproductive matters have not changed significantly. These were confirmed by the findings that some women cannot reject sex, inability to use contraception or decide on the number of children they want. Given the range of socio-cultural and structural factors which affect family sexual and reproductive health, married women are still faced with challenges in making decisions

with regards to their sexual lives. It seems that patriarchal norms have remained resilient on issues of sexual and reproductive health of women. This study documented that women in a traditional union conceived it indecent for a woman to demand sex from her husband. This can be simply explained by the cultural influence on the marriage institution.

From the study, it was observed that home language, socio-economic status and place of residence are associated with women's participation in sexual and reproductive health decision-making. Sexual division of labour construct and the conceptual framework of the study indicated that lack of economic resources have negative effects on women's sexual control. It was conceptualized that traditional norms would limit the ability of women to reject sexual intercourse from their husband/partners. The findings of this study supported the conceptual framework. In line with previous studies, the poor status of women as well as traditional norms in a marital union has continued to challenge the emancipation of married women to exercise their sexual and reproductive rights. Poor status of women is associated with low self-esteem, economic and social insecurity. The inability of unemployed women to reject sexual advances from their husband/partner may be to avoid economic insecurity which is consistent with the findings in previous studies (Awusabo-Asare et al., 1993; Mathews & Abrahams, 2001). Invariably, the cultural norm which enforces submissive sexual behaviour of a woman to her husband is persisting. It appears that women in a traditional union fear divorce or rejection by their husbands.

An arranged marriage was conceptualised as a traditional practice, where marriage is imposed on women. Consistent with previous studies women in arranged marriages have limited decision making power in sexual and reproductive health issues (Orisaremi & Alubo, 2012; Santhya et al., 2010). However, the desire to be in a heterosexual marital relationship is esteemed in African society. However, an arranged marriage could be perceived as sexual slavery as the choice to be in marriage did not stem from the woman. It has already been documented that men claim 'ownership of their wives' in Southern African black society (Garbus & Khumalo-Sakutukwa, 2003). Notwithstanding

the circumstance that led to arranged marriages, the findings of this study indicate that such women are merely used as sexual objects by the husband/partner. Other studies have shown that arranged marriages take advantage of poverty, low self-esteem, and young age of women in favour of older male partners (Orisaremi & Alubo, 2012; Santhya et al., 2010). Hence such women hardly exercise any control over their sexual lives.

Within this study framework, it was anticipated that due to the patriarchal traditional norm, rural women may not participate in decision-making on family size. Rural women seem to be trapped in relationships where reproductive health decisions remain the domain of the husband. Having a large family is a source of pride to men. Dyer et al. (2004) note that having children is what makes you a 'man'. One of the observations of this study was covert contraceptive use. This is an indication that women have found themselves in relationships where they are denied autonomy over their reproductive lives due to persisting cultural values about large family size.

Limited communication on sexual matters was conceptualized to be a hindrance in the ability of women to use condoms. Within the theory of gender and power, poor communication is an element of sexual division of power which limits the women from taking control of their sexual and reproductive health. Difficulty in spousal communication about sexual matters suggests low sexual relationship power, which manifests as non-use of condoms. It is apparent that the respondents had knowledge of STIs, mode of transmission, STIs as risk factor for HIV as well as condom use prevents STIs. However, the magnitude of the knowledge on issues of STIs cannot be equated to condom usage as it should be among people who are concerned about health risks. This finding is consistent with the low prevalence of condom use among married and cohabiting couples reported in KwaZulu-Natal, South Africa (Langen, 2007; Maharaj & Cleland, 2004) and elsewhere (Iyayi et al., 2011; Nyanzi et al., 2005). Apart from women who reported personal dislike and husband opposition to condom use, some do not use because of trusting their partners.

It is not clear to what extent fear is confused with trust. Some women have never asked their husband to use condoms because their husbands use when they want. A negative attitude to self-protection gives men leverage over women's bargaining power in the sexual arena which may have some implications on the spread of HIV/AIDS. We have no doubts that the inability of women to exercise control over condom use is translated to the art of trusting their partners. The high prevalence of HIV/AIDS and other STIs among married women compared to single women appeals for the verification of sexual trust in marital or cohabiting relationships.

Some women were willing to use condoms however non-receptiveness of condom use by their husbands/partner remains a challenge. Having difficulty to engage in spousal communication about condom use suggests that women are afraid of being accused of infidelity. This is evident from the qualitative findings; women lamented that failure to initiate condom use from the beginning has affected their courage to ask for it currently despite suspicion of partner's infidelity. This is consistent with the report of women's desperation that men have not changed their sexual attitudes and were very reluctant to use condoms (Ogunjuyigbe & Adeyemi, 2005). Lack of spousal communication about condom use in marital relationships has many implications for the sexual health of couples. Recent studies have indicated that the proportion of married women living with HIV is increasing dramatically (Peltzer, 2013; Villar-Loubet et al., 2013). The intervention programmes meant to educate both men and women on the risk they are taking if they do not use condoms will go a long way in combating HIV/AIDS.

9.3 RECOMMENDATION

Decision-making on sexual and reproductive health is improving women's reproductive health especially in Africa. This study is to guide policy makers on reproductive health strategies useful to married or cohabiting women. It seems there is still room for the South African government in general and the North-West provincial government in particular to continue addressing the issue of improving the status of women. The group of women who disagree that married women can reject sexual intercourse with their

husband/partners under any circumstances needs serious consideration in terms of reproductive health policy.

Occupation increases women's participation in sexual and reproductive decision-making, but job insecurity may have negative effects on their participating ability due to lack of skills. Although women prioritize occupation more than education, the latter is capable of equipping them with life time skills. Education may supersede occupation in terms of women empowerment, as it provides opportunities to enter into high income occupation and self-sufficiency. Having observed that a considerable proportion of the women reported being abused sexually by their husbands or partners, programmes of empowerment should integrate their partners as a way of bridging the gap of gender-based inequality. There is a need for the government to embark on community-based programmes for the rural and unemployed women for the purpose of giving them income yielding skills. Programmes initiators should involve community and religious leaders in the campaign of women empowerment because of cultural or ethnic diversity of the rainbow nation.

Strategies to prevent STIs in marital relationships need to look beyond the civil, religious and cultural sexual obligation of women in marital or cohabiting relationships. HIV prevention and intervention strategies which take note of cultural sexual behaviour may be the most efficient to induce behavioural changes. The government should initiate information education communication programmes that emphasize knowledge about sexual rights and clarification on the misconceptions about HIV/AIDS. HIV misconceptions leading to risky sexual behaviour may be corrected through simple educational programs that specifically address the particular belief. In addition, there is a need to emphasize that an individual's fate hangs on their attitude to safer sex practices and never on astral forces. Furthermore, strategies that improve spousal communication may hold the potential for consistent condom usage and safer sex practices in marital or cohabiting relationships. There is a need to continue disseminating information through media programmes to empower women to take control of their sexual lives. Furthermore, steering community meetings and public

education is necessary to reorient women's perception on husband's conjugal rights to sex.

9.4 FUTURE PROSPECTS

This study was not able to examine the couples' decision-making because only women were interviewed in line with study design and objectives. The study revealed a clear picture of husband/partner's influence in the sexual and reproductive decision-making of the women. Subsequent studies should take into consideration interviewing the couples. The data of the study were cross sectional and cannot establish the definitive sequels of decision-making patterns. Future prospects should be to undertake a longitudinal study which will enable documentations of the dynamics in sexual and reproductive decision-making as the relationship matures. Nevertheless, concrete identification of association between the dependent and independent variables were observed, which motivate for further studies in sexual and reproduction health decision-making in the study area. Finally this research needs to be expanded to other municipalities in the North-West province which are also very rural.

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APPENDICES

Appendix 1: Structured individual questionnaire

NORTH-WEST UNIVERSITY
MAFIKENG CAMPUS
POPULATION TRAINING AND RESEARCH UNIT

DECISION-MAKING ON SEXUAL AND REPRODUCTIVE HEALTH ISSUES AMONG WOMEN IN HETEROSEXUAL MARITAL RELATIONSHIPS IN MAHIKENG, SOUTH AFRICA

Please you do not need to identify your name. The researchers will uphold anonymity so that there will be no trace of you the respondent being identified or linked in any way to the research findings in the final research report. The information collected for the study will be analyzed to present the accurate picture of the research objectives. Furthermore, the proceedings of the study will be for the purpose of improving sexual and reproductive health of women. We solicit that you answer all the questions as honestly as possible.

CONSENT TO PARTICIPATE IN SURVEY

Please sign/thumb print below if you agree to participate in the study.

The above document describing the benefits, risks and procedures for the research title (Population, Health and Poverty in Accra) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Respondent's Signature/Thumbprint..... Date.....

Interviewer Signature.....

Date.....

START TIME FOR INTERVIEW HOURSMINS

IDENTIFICATION	
RESEARCH REF. NO.:..... *RESPONDENT'S PLACE OF RESIDENCE:..... * 1= UNIT 2=VILLAGE 3=URBAN 4= SUBURB 5=OTHER (SPECIFY) _____ **MODE OF INTERVIEW..... 1=FACE-TO-FACE 2=SELF-ADMINISTERED	☐☐☐☐☐☐☐ ☐ ☐

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐ NAME ☐☐ RESULT ☐
INTERVIEWER'S NAME	_____	_____	_____	
RESULT*	_____	_____	_____	
Next visit: Date	_____	_____		
Time	_____	_____		TOTAL NO. OF VISIT ☐

***RESULT CODES:**
1 COMPLETED
2 NOT AT HOME AT THE TIME OF VISIT
3 POSTPONED
4 REFUSED
5 OTHER (SPECIFY)

LANGUAGE IF FACE-TO-FACE INTERVIEW	
LANGUAGE OF QUESTIONNAIRE: **ENGLISH** LANGUAGE OF INTERVIEW**_____ NATIVE LANGUAGE OF RESPONDENT** WAS TRANSLATOR USED? (YES=1, NO=2) ..... ****LANGUAGE CODES**: 1= ENGLISH 2 =SESTWANA 3= OTHER (SPECIFY)	1 ☐ ☐ ☐

SUPERVISOR ☐☐	FIELD EDITOR ☐☐	KEYED BY ☐☐
NAME_____ DATE _____	NAME_____ DATE_____	

SECTION A: DEMOGRAPHIC CHARACTERISTICS

Now, I would like to ask you some background information about yourself.			
Q NO.	**QUESTION**	**RESPONSE**	**SKIP**
101.	How old were you at your last birthday?	☐☐	
102.	Which language do you speak at home? 1= Afrikaans 2=English 3=IsiXhosa 4=Sesotho 5=Setswana 6=Zulu 7=Other Specify.....	☐	
103.	What is your highest Education qualification? 1=No Education 2=Primary 3=Secondary 4=Tertiary	☐	
104.	What is your Occupation? 0=Housewife/unemployed 1=Agric./Faming 2=Trading 3=Set up private business 4=Government worker 5=Teaching/Lecturing 6= Others (specify)_____	☐	
105.	What is your Husband's/partner's Occupation? 0=Unemployed 1=Agric. /Farming 3=Trading 4=Set up private business 5=Government worker 6=Teaching/Lecturing 7=Others (specify)_____	☐	
106.	Which of these Religions are you affiliated to? 1=Catholic 2. Methodist 3. Evangelical church 4. Anglican 5. Adventist 6. Pentecostal & Apostolic 7. Other church 8. ISLAM9.Hindu 10. Traditional 11. Others (Specify)_____	☐	
107.	At what age did you get married?	☐☐	
108.	Did you choose your husband by yourself? 1= Yes 2=No	☐	
109.	What type of marriage was it? 1=Civil 2=Religion 3=Traditional 4=Cohabiting	☐	
110.	How long have you been married? Month Year	☐☐ ☐☐	
111.	Have you ever given birth? 1= Yes 2= No How many are they? How many are still alive?	☐ ☐☐ ☐☐	

112.	Are you satisfied in your relationship?	☐	

	1=Yes 2= No 3=Don't know		
	LEVEL OF WOMEN'S SEXUAL CONTROL		
113.	Can women demand for sex? 1=YES 2=No	☐	
114.	Under what circumstances? (You may circle more than one)	**Mentioned** / **Not Mentioned**	
	i. It is natural	1 / 0	
	ii. When another child is need.	1 / 0	
	iii. To satisfy the husband	1 / 0	
	iv. Others (Specify)_____	1 / 0	
115.	Does Husband/partner has right to use force for sex? 1=Yes 2=No 3=Don't know/Depends	☐	
116.	Can women reject sex? 1=Yes 2=No	☐	
117.	Under what conditions can a woman reject sexual intercourse?	**MENTIONED** / **NOT MENTIONED**	
	i. During breastfeeding	1 / 0	
	ii. During pregnancy	1 / 0	
	iii. During menstruation	1 / 0	
	iv. She is not in the mood	1 / 0	
	v. She does not want to get pregnant	1 / 0	
	vi. She is ill	1 / 0	
	vii. She suspect he has sexually transmitted infection	1 / 0	
	viii. He does not support the children	1 / 0	
	ix. He does not support her	1 / 0	
	x. He has sex outside marriage (Cheats)	1 / 0	
	xi. He is drunk	1 / 0	
	xii. He beats her	1 / 0	
	xiii. Others specify.....	1 / 0	
118.	How difficult is it to talk about sex with partner? 1=Very difficult 2=Difficult 3=Not difficult	☐	

	REPRODUCTIVE HEALTH DECISION-MAKING		
119.	Can woman decide the number of children to have? 1=Yes 2=No	☐	
120.	Does your partner sometimes force you to have sex?	☐	

	1=Yes 2=No					
121.	Who has more say about the following decisions? 1=Husband 2=Wife 3=Both 4=Others					
	i. When to have sex	1	2	3	4	
	ii. When to use contraceptives	1	2	3	4	
	iii. Family planning method(s) to use	1	2	3	4	
	iv. When to have more children	1	2	3	4	
	v. Desired family size	1	2	3	4	
	vi. Final say on own health care	1	2	3	4	
	vii. Major household purchases	1	2	3	4	
	viii. Purchases for daily household needs	1	2	3	4	
	ix. Visit to her own family or relatives	1	2	3	4	
122.	What are the reasons why women engage in sex activities? 1=Not important 2=Slightly important 3=Important 4=Very important					
	i. It is natural and important meaningful experience in my life	1	2	3	4	
	ii. Procreation	1	2	3	4	
	iii. For enjoyment	1	2	3	4	
	iv. To show love and be close to partner	1	2	3	4	
	v. To control my partner and show my strength	1	2	3	4	
	vi. To confirm my desirability	1	2	3	4	
	vii. For my health and happiness	1	2	3	4	
	viii. To keep my partner/to satisfy my partner	1	2	3	4	
	KNOWLEDGE AND ATTITUDES TO STIS					
123.	Have you ever heard of STIs? 1=Yes 2=No					☐
124.	Which STIs have you heard about? ***(You may circle more than one)*** 1=HIV/AIDS 2=Gonorrhea 3=Candidiasis 4=Herpes 5=Syphilis 6= Others (specify)_____					☐
125.	What is the mode of contacting STIs? ***(You may circle more than one)*** 1=Sexual intercourse 2=Shaking of hands 3=Unsterilized needles 4=Blood Transfusions					☐

126.	Do you know that STIs is a risk factor for HIV/AIDs? 1=Yes 2=No 3=Don't know			☐
127.	What are the sources of your information? ***(You may circle more than one)***	**MENTIONED**	**NOT MENTIONED**	

	Radio	1	0	
	TV	1	0	
	Newspaper	1	0	
	ix. Posters	1	0	
	x. Partners	1	0	
	xi. Other specify.....	1	0	

128.	What are the reasons why women engage in sex activities?	Yes	No	DK	
	i. A healthy looking person can have the HIV/AID virus				
	ii. HIV/AIDS cannot be transmitted by mosquito bite				
	iii. HIV/AIDS cannot be transmitted by supernatural means				
	iv. A person cannot become infected by sharing food with a person who has AIDS				
	v. HIV can be transmitted by breastfeeding				
	vi. Risk of MTCT can be reduced by mother taking special drug during pregnancy				
129.	**Attitudes toward negotiating safer sexual relations with partner**	Yes	No	DK	
	i. Can safer sex practice stop transmission of STIs				
	ii. Do you think you are at risk of contracting HIV				
	iii. Do you know the HIV status of your partner?				
	iv. Would you have sexual intercourse with your partner if you have STI				
130.	If my partner has STI? 1=I will refuse sex with partner if he had STIs 2=I will ask him to use condom if he had STI 3=I will not refuse sex to my partner if he had STI				

KNOWLEDGE AND USE OF FAMILY PLANNING

131.	Do you know of any contraceptive methods? 1=Yes 2=No		

132.	What methods do you know ***(you may circle more than one)***	**Yes**	**No**	
	i. Rhythm	1	0	
	ii. Withdrawal	1	0	
	iii. Washes out	1	0	
	iv. Pills	1	0	
	v. Injectables	1	0	
	vi. IUD	1	0	
	vii. Sterilization	1	0	
	viii. Condom use	1	0	
	ix. Foam	1	0	

	x. Others (Specify)_____	1	0	
133.	Are you currently using any contraceptive method? 1=Yes 2= No		☐	IF CODE 0 SKIP TO Q136
134.	Method are you currently using?***(You may circle more than one)***	**MENTIONED**	**NOT MENTIONED**	
	i. Pills	1	0	
	ii. IUD	1	0	
	iii. Injectable	1	0	
	iv. Diaphram	1	0	
	v. Condom	1	0	
	vi. Sterilization	1	0	
	vii. Periodic abstinence	1	0	
	viii. Withdrawal	1	0	
	ix. Female condom	1	0	
	x. Foam/Jelly	1	0	
	xi. Others (Specify)_____	1	0	
135.	Is your Husband/partner's aware that you are using contraceptives? 1=Yes 2=No 3=Unsure whether he knows		☐	
136.	What are the reasons for not using any contraceptive method?***(You may circle more than one)***	**MENTIONED**	**NOT MENTIONED**	
	i. Do not know any method	1	0	
	ii. I want to get pregnant	1	0	
	iii. Not accessible	1	0	
	iv. Sterile	1	0	
	v. Fear of side effects	1	0	
	vi. Husband does not permit	1	0	
	vii. I don't want	1	0	
	viii. Religion prohibits	1	0	
	ix. Others (Specify)_____	1	0	

137.	Have you ever used condom? 1. Male condom 1=Yes 2= No 2. Female condom 1=Yes 2=No		☐ ☐	
138.	Have you consistently used condom for 12 months: For 6 months 1. Male condom 1=Yes ☐ 2=No ☐ 1= Yes ☐ 2= No ☐ 2. Female condom 1=Yes ☐ 2=No ☐ 1=Yes ☐ 2= No ☐			
139.	What are the reasons for not using condoms? ***(You may circle more than one)***	Mentioned	Not Mentioned	
	i. Partner doesn't want condoms	1	0	

	ii. I don't want condoms	1	0	
	iii. Not accessible	1	0	
	iv. Sterile	1	0	
	v. We trust each other	1	0	
	vi. Am afraid of him	1	0	
140.	Have you ever suggested the use of condom to your partner? 1=Yes 2=No		☐	
141.	Did your partner accept to use male condom? 1=Yes 2=No 3=Don't Know		☐	
142.	Did your partner accept to use female condom 1=Yes 2=No 3=Don't Know		☐	

Appendix 2: In-depth interview guide

NORTH-WEST UNIVERSITY
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NOORDWES-UNIVERSITEIT

POPULATION TRAINING AND RESEARCH UNIT **Individual In-depth Interview guide**

Thank you for acceptance to be interviewed in the research project. I am (name of field worker) from the North-West University. I am conducting interviews as part of the research project **"Decision-making on sexual and reproductive health issues among married women in Mahikeng"**. The interviews are intended to understand from women all aspects of sexual negotiation and decision-making and what could be done to improve women's sexual negotiation in marital relationships.

I request that notes and tape recorder will be used to overcome information loss. The information gathered will be strictly used for the purpose of the research and will be discarded immediately after the project completion. Your name will not be used in the research report. You are not required to tell us your name because we would like you to feel free to share your opinions without fear of intimidation.

NOTE: All information will be kept confidential, meaning no person will have access to it except the researcher.

Participant: Please fill in blanks to first 5 questions –

- Number of years married to current spouse: _____
- Number of living children _____
- Highest level of education attained: ___No Education __ Primary ___ Secondary __ tertiary_
- Language: _____ Employed ____Yes ___No
- Residence _____ Partner living in the same house ---- Yes ---No

A. CULTURAL IMPACT ON SEXUAL CONTROL

1. How does culture affects your ability to demand sex from her husband.

2. How does culture affects your ability to reject sexual advances from her husband.

B. DEMOGRAPHIC IMPACT ON REPRODUCTIVE HEALTH DECISION-MAKING

1. How does your education affect your participation in decisions making on when to use contraception and family size?
2. How does having children give you power to participate in decisions on when to use contraceptive use and family size.
3. How does your economic status affect your participation in decisions on when to use contraception and family size?

C. SEXUAL RISK TAKING

1. What is your view about engaging in risky sexual intercourse with your partner when they know they had STIs"?
2. How they perceive the risk of contracting STIs in within their stable unions. And if so, can women be empowered to avoid engaging in risky sexual intercourse.

D. PERCEPTIONS ABOUT CONDOM

1 What they know about condom.

2 How they feel about asking their partners to use condom.

3 Would they be able to use condom for the rest of their life

Thank you for your participation in this study.

Appendix 3: Ethical clearance

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Ethics Committee
Tel +27 18 299 4850
Fax +27 18 293 5329
Email Ethics@nwu.ac.za

ETHICS APPROVAL OF PROJECT

- Project title: Decision-making on sexual and reproductive health issues among women in heterosexual marital relationships in Mahikeng, South Africa.
- Project leader: Prof AJ MTURI Student on project: Goodwill Osuafor
  Ethics number: NWU-00048-12-A9 Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation Expiry date: 04 May 2017

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal Ethics approval certificate will be sent to you as soon as possible.

Yours sincerely

Me Marietjie Holgryn
NWU Ethics Secretariate
Private Bag X6001, Potchefstroom South Africa 2520
Tel: (018) 299-4900 Faks: (018) 299-4910 Web: http://www.nwu.ac.za
Ethics Committee
Tel +27 18 299 4850
Fax +27 18 293 5329

Appendix 4: Informed consent for individual

Decision-making on sexual and reproductive health issues among women in heterosexual marital relationships in Mahikeng, South Africa.

Principal Investigator:

Address:

We have been commissioned by the North West University to undertake a study on Decision-making on sexual and reproductive health issues among women in heterosexual marital relationships in Mafikeng.

The goals of the study are to:

- To explore the demographic characteristics of married women in Mahikeng;
- To understand the reproductive decision-making;
- To contribute to the understanding of spousal communication on reproductive health matters;
- To access married women's risk perception of contracting STIs including HIV;
- To explore the factors influencing condom use; and
- To recommend strategies that will likely increase women's reproductive decision-making and safer sex practices.

The main objective of this study is to examine the extent to which women have control over their sexual negotiation and its implication in the spread of HIV/AIDS as cultural and economic dependency clout dwindle.

The information we get from you will help us to advice on programs and policies that enhance women's capacity to negotiate safer sex practices. The information we require from you will be confidential and sensitive. We therefore solicit that you answer the questionnaire as fairly and honest as possible. The interview will not take more than 30 minutes.

Are you willing to provide us with information about your sexual decision-making?

If willing, sign here .....

Signature of research assistant.....

Thank the participant for agreeing to give information

Appendix 5: Publication and Presentations at Conferences

Published article

Osuafor, G. N. & Mturi, A. J. (2014). Attitude towards sexual control among women in conjugal union in the era of the HIV/AIDS epidemic in Mahikeng, South Africa. *African Population Studies*, 28(1), 538-550.

Some of the results of this study were presented at the following conferences

Presentation titled: "Attitude towards sexual control among women in conjugal union and its implication for HIV infection in Mahikeng, South Africa". XXVII IUSSP International Population Conference to 26-31 August 2013 in Busan, Korea

Presentation title: "Decision-making on modern contraceptive use among married and cohabiting women in Mahikeng, South Africa". 3rdInternational Conference on Family Planning: Full Access, Full Choice, 12-15 November 2013 in Addis Ababa, Ethiopia.

African Population Studies, Vol. 28, No. 1, April 2014

Attitude towards sexual control among women in conjugal union in the era of the HIV/AIDS epidemic in Mahikeng, South Africa

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Abstract

Husbands continue to be the greatest source of sexually transmitted infections including HIV to their wives. Using a survey of 568 respondents and 33 in-depth interviews, this study examined the attitudes of women in marital and steady relationships towards sexual control in Mahikeng. Data analysis using logistic regression showed that age, type of union, education, occupation, and number of living children were significantly associated with attitudes towards rejecting sex. Additionally, age, type of union, education, and number of living children were found to be significantly associated with demand for sex. Qualitative data revealed that social-cultural factors influence the disposition of most women regarding demanding or rejecting sex from their husbands. Their attitudes to sexual control are intertwined with cultural, religious belief and perception that husbands have sexual right over their wives. Women empowerment initiatives should continue to be considered as a means to assist women to control their sexuality.

Keywords: Sex; Sexual control; HIV/AIDS; sexually transmitted infections; South Africa

Résumé

Les maris (hommes) continuent à être la principale source d'infections sexuellement transmissibles (STD) y compris le VIH à leurs épouses. Un échantillon de 568 femmes a été interviewé lors de 33 entrevues pour évaluer leur attitude face aux relations conjugales et la maîtrise sexuelle dans Mahikeng, Afrique du Sud. L'analyse des données par régression logistique a montré que l'âge, le type d'union, l'éducation, la profession et le nombre d'enfants vivant était significativement associée aux attitudes envers le rejet du sexe. En outre, l'âge, le type d'union, l'éducation, et le nombre d'enfants ont été significativement associés à la demande pour le sexe. Les données qualitatives ont révélé que les facteurs socio-culturels influencent la disposition de la plupart des femmes en matière d'exiger ou de rejeter le sexe de leurs maris. Leurs attitudes à l'égard au contrôle sexuel sont étroitement liées avec la croyance religieuse, culturelle et la perception que les maris ont le droit sexuelle sur leurs femmes. L'initiative de la promotion et responsabilisation sociale des femmes doivent être considérées comme un moyen d'aider les femmes à contrôler leur sexualité.

Mots clé: sexe; contrôle sexuelle; le VIH / sida; les infections sexuellement transmissibles; l'Afrique du Sud

Introduction

Marriage[1] takes place to formalize sexual relationship of couples. A couple can choose to have a civil (or Christian) and customary (or traditional) marriage in South Africa. Whilst the civil marriage is a straight forward exercise involving getting a marriage certificate from the government (i.e. the Department of Home Affairs), the customary marriage is a process which can take a short duration of few weeks or as long as ten years or more. Common to Black South Africans, customary marriage is concluded by payment of lobola (bride price) which symbolizes the joining of the two (bride and groom) families (Peart, 1983). Many couples still go to the government after payment of lobola to get a marriage certificate, but some decide to get a marriage document from the Chief. Cohabitation happens when a man and a woman decide to live together like a husband and wife but do not have a legal document. Cohabiting relations are generally

[1] This paper deals with only opposite sex marriages.

accepted in South Africa (Matshidze et al., 1998; Swart-Kruger & Richter, 1997; Mindry et al., 2011). For the purpose of this paper, married and cohabiting women are studied together because they have more or less similar experiences on sexual control.

The main purpose of this paper is to assess the attitudes toward sexual control among currently married or cohabiting women. It is very important to understand the extent to which women in stable sexual relationships are able to negotiate for matters pertaining to their sexuality in this era of the HIV/AIDS epidemic. The factors related to sexual control of these women are also investigated. The specific objectives are to explore about knowledge on STIs transmission and prevention methods; to examine the extent of women's control over sex with their husbands/partners; to investigate the justification women give for their position on having or not having sexual control; and to analyze the factors related to women's attitudes toward having sexual control.

Literature Review

Gender equality was the expectation for the South African socio-political environment with the demise of apartheid. However, studies have shown that culture and patriarchal values (Jewkes et al., 1999; Morrell, 1998; Hargreaves et al., 2009; Mogale et al., 2012) continue to shape reproductive attitudes and behaviour in South Africa. Jewkes et al. (1999) reported the cultural acceptability that a man owns his wife when he pays lobola. Thus, the perception of women as men's property compromises their power in decision-making on sexual and reproductive health matters. Culturally accepted norms in marital relationships with regards to roles of men and women certainly contribute to poor sexual negotiation (Orisaremi & Alubo, 2012; Balmer et al., 1995).

Concerns about married women's control over their sexuality were reverberated by the HIV/AIDS epidemic in developing countries. The higher susceptibility of women to sexually transmitted infections (STIs) including HIV has been attributed to the African patriarchal norms of men dominating family decision-making and biological vulnerability of women (Magadi, 2011; Ackerman & de Klerk, 2002; Coombs et al., 2003; Phyllis, 2013). Given the tempo of the HIV/AIDS epidemic in South Africa, understanding the extent social values influence the vulnerability of women to HIV infection in marital relationships carries some sense of urgency. It has been shown also that married women in Africa are becoming infected with HIV at higher rates than single, sexually active young women of the same age (Glynn et al., 2001). Ogunjuyigbe and Adeyemi (2005) documented that women who took part in their qualitative study lamented that they are being infected with STIs by their husbands. These findings suggest that women do not have the control over their sexual lives even with threats of infidelity in sexual relationships (Schoepf, 1992; Langen, 2005; Varga & Makubalo, 1996). The alluded powerlessness of women in sexual control seems to be entrenched in protracted cultural tenets (Langen, 2005; Jewkes et al., 1999; Jewkes & Morrell, 2010), socio-economic dependency on men and limited education to women (Wodi, 2005; Ackerman & de Klerk, 2002; Mindry et al., 2011).

Studies in some African countries have shown mixed reports on the ability of women to control their own sexual lives. Awusabo-Asare et al. (1993) reported that married women have limited control over their sexuality in Ghana despite the fact that tradition accorded them sexual rights. They found that 60% of the women felt that they did not have right to refuse sex. In addition, poor control over sexual lives was exacerbated among women with no formal education. Awusabo-Asare and his colleagues concluded that inability of women to refuse sex was on the premises that male fidelity is not a cultural expectation. On the contrary, the findings in Nigeria revealed that women have considerable control over their sexuality especially when there is evidence of infidelity and disease infection (Orubuloye et al., 1993; Ogunjuyigbe & Adeyemi, 2005; Wusu & Isiugo-Abanihe, 2008). It was observed that increasing ability of women to exert controls on their sexual lives was associated with their economic independence.

Socio-economic dependency of women on men has uncompromisingly conferred on men the decision-making power in reproductive issues and may continue to be a challenge to women's sexual control (Jewkes & Morrell, 2010; Mindry et al., 2011). Financial dependence on men was the reason for uneducated and jobless women in Cape Town (South Africa) to remain in a relationship that tramples on their sexual dispositions (Mathews & Abrahams, 2001). It was also found in KwaZulu-Natal (South Africa) that women's ability to negotiate sex was incapacitated because of poor

education (Langen, 2005; Varga, 2003). These give credence to economic status of women as the determinant of their bargaining power in sexual issues (Folbre, 1986; McElroy, 1990).

There are studies that contradict the relevance of economic independence in enhancing sexual control and sexual decision-making of women. For instance, ownership of income generating ventures did not improve women's bargaining power in reproductive decision-making in Ibadan, Nigeria (Odebode, 2004). Another study showed that possession of economic assets by women may not increase their control power in reproductive decision-making (Omeje et al., 2011). In fact, economic independency of women led to their spouse relinquishing financial responsibilities in the household without any effect on sexual empowerment (Odebode, 2004; Nyanzi et al., 2005). Nyanzi et al. (2005) concluded that economic independence of women only avails them greater opportunity to enter and exit relationships than their counterparts who are not economically independent. This suggests that the economic status of women may not entirely explain the inequality in sexual negotiation and sexual decision-making in marriage.

Data source and Methods

The study uses a mixed methods approach. The survey was carried out in Mahikeng municipality, where the capital city of the North-West province of South Africa is located between May and July, 2012. North-West is the fourth province with the highest HIV prevalence and people living with HIV/AIDS in South Africa (Department of Health, 2011). The majority of people in Mahikeng are Tswana speakers who have patriarchal culture and traditions towards marriage and other sexual matters. However, Tswana marriage system like other African societies has undergone profound transformation due to westernization. But some scholars still argue that culture continues to be an important force in daily life of Tswana people particularly in rural areas (Nkomazana, 2008; Gulbrandsen, 1986). So this area is a perfect setting for investigating how married women feel about their culture and traditions on sexual matters against religious teachings and westernization. In addition, Mahikeng municipality is one of the few places in the North-West province which has a large urban setting (25% of the area) surrounded by various rural areas (75%).

The sampling frame for each of the selected areas consisted of the enumeration areas provided by Statistics South Africa (2012). These enumeration areas were treated as clusters. The clusters from both rural and urban areas were sampled with probability proportional to size. A total of 800 households were randomly selected from the selected clusters. A structured questionnaire was developed and pretested before administering to 600 eligible respondents identified from the households in those clusters. A total of 568 married or cohabiting women aged 18-49 years (i.e. 95% response rate) filled in the questionnaire. For details on the sampling design see Osuafor (2014). Fieldworkers were students registered at the North-West University (Mafikeng Campus) under the population studies and social work programmes. There was training and pilot study before fieldworkers were dispatched to the field.

Most of the variables used in the analysis were obtained from direct responses from the questionnaire. However, aggregate knowledge about HIV was created by asking women the various ways of HIV transmission and prevention in addition to a number of misconceptions including: whether a healthy person can have HIV/AIDS; whether HIV can be transmitted through mosquito bites, supernatural means or through food. Respondents who were able to identify sexual intercourse, mother to child transmission at delivery or through breastfeeding as ways of HIV transmission and condom use as a method of HIV prevention in addition to rejecting all the four misconceptions were recorded as having comprehensive knowledge. Women were classified as having moderate knowledge if they were able to identify condom use as one of the ways of HIV prevention and sexual intercourse, mother to child transmission or breastfeeding as possible ways of HIV transmission in addition to rejecting at least two of the misconceptions while little knowledge was classified as knowledge of only one method of HIV transmission and rejecting of at least one misconception or none. Furthermore, women who did not know any method of HIV transmission or prevention and failed to reject any of the misconceptions were classified as having no knowledge on HIV/AIDS.

Quantitative data were analysed by using both descriptive and multivariate statistical techniques. At multivariate stage, the logistic regression models were used to determine the predictors of respondents' opinion on married women's demand

for sex and rejection of sexual intercourse from husbands or partners. The logistic regression was used because both dependent variables are dichotomous in nature.

For the qualitative study, individual in-depth interviews (IDIs) were conducted on the experiences regarding to sexual control. The study employed phenomenological approach (Jerrett 1994). This approach is concerned with the study of experiences from the perspective of the individual. Hence there is no single reality. Given that sex is a conservative matter in an African setting, only individuals who are willing to describe their experience in sexual control were interviewed. The study also aimed at interviewing women with different background characteristics such as place of residence, age, duration of union, education and occupation. Since questions asked have much to do with women's experience in marriage, only women who were married for at least five years were considered. In all, 33 women in marital/cohabiting union participated in the IDIs. Interviews were conducted using a semi-structured interview guide. Information from IDIs, which was collected in Setswana, was transcribed and translated to English and organized under broad headings that depict different aspects of the thematic area manually. Content analysis was used to analyse the qualitative information.

Any study on sexuality in Africa is subject to some limitations because discussion on sexual matters is a taboo in many African settings. The first limitation is that data collected were based on self-reporting and there was no method that was used to verify the responses. This limitation was minimized in the survey by asking about opinion of respondents rather than their personal experiences. The second limitation is that the in-depth interviews were conducted to only Black people whose main home language is Setswana. So opinion of other ethnic groups residing in Mahikeng is not reflected. We take note of these limitations when interpreting the findings.

Table 1 presents the socio-demographic characteristics of the respondents. The findings revealed that the chunk of the respondents dwell in the rural areas. The age distribution shows that women are fairly distributed in all age groups with a mean of 34.5 years. As expected, Setswana is the major language people speak at home (66%). The table also shows that 51% of the respondents had primary or no education. Occupational distribution reveals that well over a quarter of the respondents were unemployed, the next category being government employees (24%). Examination of the type of union shows that civil marriage is the most popular followed by traditional marriages. Cohabiting women forms the lowest percentage of the respondents (17%). In terms of religious affiliation, the majority of the respondents are Christians. Despite the fact that most of the respondents are Christians, only 20% of the union is contracted under religious rite. About two-thirds of the respondents have been in a relationship for nine years or less and the mean duration of relationships is close to 9 years. The majority of respondents (87%) have living children.

Table 1: The percentage distribution of respondents by socio-demographic characteristics

Characteristics	N	%
Residence		
Rural	445	78.3
Urban	123	21.6
Age group		
< 25	63	11.1
25-29	108	19.0
30-34	114	20.1
35-39	120	21.1
40-44	89	15.7
45-49	74	13.0
$\bar{x} \pm \sigma$	34.4 5	7.96
Home language		
Setswana	376	66.2
Afrikaans	21	3.7
IsiXhosa	50	8.8
Sesotho	74	13.0
Zulu	47	8.3
Type of union		
Civil	212	37.3
Religion	112	19.7
Traditional	149	26.2
Cohabiting	95	16.7
Highest educational level		
No education	112	19.7
Primary	179	31.5
Secondary	156	27.5
Tertiary	121	21.3
Occupation		
Unemployed	165	29.0
Business/trading	80	14.1

Government worker	134	23.6
Teaching	59	10.4
Student	47	8.3
Domestic worker/security	83	14.6
Religion		
Roman Catholic church	72	12.7
Methodist	146	25.7
Pentecostal	213	37.5
Seventh Day Adventist	95	16.7
Other religion	42	7.4
Duration of union		
< 5	229	40.3
5-9	145	25.5
10-14	88	15.5
15-19	31	5.5
20+	75	13.2
$\bar{x} \pm \sigma$	8.72	7.63
Number of living children		
None	77	13.6
1-2	290	51.1
3-4	168	29.6
5+	33	5.8
Total	***568***	***100.0***

Source: Mahikeng Sexual and Reproductive Health Survey, 2012.

Note: Other religions include traditionalist and other religious affiliations whose sample was too small to stand alone in the analysis.

The age range of the IDIs respondents is between 26 and 46 years. About 64% have been married for less than 10 years. Fifty-five percent of them have primary or no education. Slightly above half of respondents (52%) are employed and 61% reside in the rural areas.

Results

Knowledge of sexually transmitted infections and use of preventive measures

Table 2 presents the knowledge of STIs and use of preventive controls. Almost all respondents (99%) have heard of STIs and HIV/AIDS (97%). And the majority (95%) of respondents knows that sexual intercourse is one of the modes of HIV transmission and STIs can be prevented by using a condom (91%). In addition, most of the respondents (90%) know that STIs are a risk factor for HIV. It seems married women in Mahikeng are well aware of the existence of STIs in general and HIV/AIDS in particular. Other types of STIs are not so familiar. Television and radio are the main source of information. However there is a mismatch between knowledge and practice. Majority of married women know that the mode of HIV transmission is through sexual intercourse and many know that condom can be used to prevent STIs, only 58% of respondents ever suggested use of condom to their partners and only 16% are currently using condoms. The main reason for not using condoms is that the respondent and the husband/partner trust each other (60%). But there are cases where either the respondent opposes using condoms (38%) or the husband / partner opposes (44%). These reasons are very problematic hence a need for advocacy programmes.

Table 2: The percentage distribution of women by knowledge and attitudes toward STIs and preventive controls

Knowledge and attitudes toward STIs	N	%
Ever heard of STIs		
Yes	561	98.8
STIs is a risk factor for HIV		
Yes	510	89.8
Types of STIs heard*		
HIV/AIDS	542	97.1
Gonorrhoea	282	50.1
Candidiasis	161	28.9
Herpes	164	29.4
Syphilis	279	50.0
Source of information*		
Radio	512	91.1
TV	545	97.0
Newspaper	367	65.3
Posters	290	51.6
Partners	166	29.5
Others (clinics, Doctors, nurses)	185	32.9
Aggregate knowledge of HIV		
Comprehensive knowledge	188	33.9
Moderate	336	60.5
Little	23	4.1
None	8	1.4
Currently using condom with partners		
Yes	92	16.2
Reasons for not currently using condoms*		
Husband/partner opposed	177	44.2
Respondent opposed	150	37.5
Not accessible	16	4.0
Sterile	61	15.2
We trust each other	240	60.0
Am afraid of my partner	17	4.2

Source: Same as Table 1.

Note: * Respondents were allowed to state more than one condition.

Control and attitude over sexual issues

Table 3 presents the distribution of women's control and attitude over sexual issues. Whilst 81% of respondents reported that a married woman can demand sex from her partner, 59% asserted that a woman can reject sexual intercourse. For those who approved that a woman can demand sex, an overwhelming majority (93%) reported that it is just natural to do so. In addition, about half of them reported that a woman should demand sex in order to satisfy the husband and a quarter reported that a woman should demand sex when a/another child is needed. The reasons given for a woman to reject sexual intercourse from her husband are many that a woman should reject sexual intercourse if the husband beats her, if she is ill or if she suspects that the husband has an STI. Three-quarters or more reported that a woman should reject sex if she is not in the mood, if she knows that the husband has extramarital affairs, if she is menstruating, or if he does not support her.

Table 3: The percentage distribution of women's control and attitude over sexual acts

Evaluation criteria	N	%
Can women demand for sex?		
No	107	18.8
Yes	461	81.2
Condition women can demand sex*		
It is natural	427	92.6
To satisfy the husband	249	54.0
When another child is need.	116	25.2
Can women reject sexual intercourse?		
No	234	41.2
Yes	334	58.8
Conditions women can reject sex*		
He beats her	306	91.6
She is ill	302	90.4
She suspect he has sexually transmitted infection	301	90.1
He has sex outside marriage (Cheats)	255	76.3
She is not in the mood	252	75.4
During menstruation	249	74.6
He does not support her	241	72.2
He does not support the children	211	63.2
He is drunk	206	60.2
She does not want to get pregnant	181	54.2
During breastfeeding	135	40.4
During pregnancy	71	21.3

Source: Same as Table 1.

Note: * Respondents were allowed to state more than one condition.

Multivariate analysis of the factors related to sexual control

The respondents in the study demonstrated variations in their ability to demand or reject sex by background characteristics. However, it is still not clear how these variables influence the respondents' sexual control in a multivariate perspective. Therefore, as stated in the 'methods' section, the binary logistic regression analysis is used for this purpose. Table 1 presents the distribution of all variables and number of cases for their corresponding categories used in this analysis. Two other variables were selected from Table 2 namely aggregate knowledge of HIV and currently using condom with husband/partner.

Table 4 presents the odds ratios and standard errors of two parsimonious binary logistic regression models. The two dependent variables are can demand sex and can reject sex. The models examine opinion of married women to sexual control. Of the independent variables selected, age, type of union, education and number of living children were found to be significantly related to the respondents' opinion for women to demand sex. Women who had tertiary education were more likely to approve a woman to demand sex than women without education. Women who were 40 years old or over were less likely to approve married women to demand sex than those aged 24-29. And respondents who were traditionally married and those who had five or more living children were less likely to approve that married women can demand sex compared to those without living children. The findings also show that women who were having traditional/customary marriage were less likely to suggest that a woman can demand sex from her husband compared to those with civil marriages.

Table 4: The parsimonious logistic regression model showing the factors related to attitude towards woman demanding or rejecting sex from her partner

	Can demand sex		Can reject sex	
Variable	**Odds Ratio**	**SE**	**Odds Ratio**	**SE**
Age				
< 25	3.716	0.811	0.414*	0.450
25-29 (RC)	1.000	1.000	1.000	1.000
30-34	0.902	0.417	0.837	0.354
35-39	0.528	0.406	0.371**	0.365
40-44	0.377*	0.445	0.551	0.419
45-49	0.346*	0.447	0.597	0.429
Type of Union				
Civil (RC)	1.000	1.000	1.000	1.000
Religion	0.694	0.336	1.166	0.313
Traditional	0.296**	0.296	0.686	0.271
Cohabiting	0.539	0.413	0.269**	0.338
Education				
None (RC)	1.000	1.000	1.000	1.000
Primary	1.396	0.334	5.742**	0.318
Secondary	1.699	0.530	8.137**	0.346
Tertiary	2.073*	0.729	11.932**	0.511
Occupation				
Unemployed (RC)	-	-	1.000	1.000
Business/ Trading	-	-	2.605**	0.333
Government worker	-	-	3.375**	0.394
Teaching	-	-	4.331*	0.592
Student	-	-	4.178**	0.467
Domestic worker	-	-	2.029*	0.320
Number of living children				
None (RC)	1.000	1.000	1.000	1.000
1-2	0.601	0.556	1.356	0.386
3-4	0.562	0.586	0.729	0.448
5+	0.262*	0.684	0.270*	0.668
Constant	14.107**	0.640	0.298*	0.511

Source: Same as Table 1

Note: * significant at 0.05 level; ** significant at 0.01 level; – not significant; SE standard errors; and RC reference category

All the significant variables are related to approval for demand for sex in the expected direction. Older women, those with traditional marriages, less educated and those with large family sizes were more likely to feel inferior and abide to traditional customs and beliefs which are discussed below. This has negative implication on their attitude to demand sex.

The variables that are significantly related with the respondent reporting that a woman can reject sexual intercourse include age, type of union, education, occupation, and number of living children. Women who were below 25 years old and those aged 35-39 were less likely to report that women can reject sex compared to women aged 24-29. Cohabiting women were less likely to report that a woman can reject sex from her husband/partner compared with women who had civil marriages. It is not surprising for cohabiting women to disapprove a woman rejecting sex as their relationship is not very secure. As expected, the higher the educational level the more likely the respondent approved a woman can reject sex. Women who were doing any type of work or

students were more likely to approve rejecting sex than women who were unemployed. Women with five or more living children were less likely to reject sex than those without a living child. Whilst occupation was only significant in the 'reject sex' model, age and type of union gave a different picture. The pattern depicted for age is not very clear. However, aggregate knowledge of HIV and condom use were neither significant in the 'demand sex' model nor in the 'reject sex' model.

Findings from the qualitative study

The general views portray that social and cultural atmosphere still influence the disposition of most women on the issue of demanding or rejecting sex from their husbands/partners. Their opinion on rejecting sex is influenced by cultural belief that husbands have right to sex, religious belief and consequences of rejecting sex. With such strings attached to women's sexuality, their attitude to sexual control is embedded in fear of losing their husbands/partners.

Women were asked how their culture affects their ability to reject sexual advances from their husband. Over half responded that their culture does not support them to reject sex from their husband. However a quarter of them claimed that their culture supports them to reject sex from their husbands especially when a woman has a new-born baby. In other words, a woman cannot just reject sex from her husband without a valid reason. Below are some of the responses of the participants on their ability to reject sex from their husbands.

Woman can reject sex, but it has some consequences like rape, physical abuse, divorce, cheating, patronizing commercial sex workers and polygamy etc (urban woman, aged 39, married 10+ years)

From human rights perspectives, I have the right to reject sex from my husband. But the Bible says husbands and wives should not deny one another sex except when they are fasting (urban woman, aged 37, married 7 years)

Yes, I have the right to reject sex, but our culture disagrees with that. Nowadays the law can protect you. If you take the matter to court that he forces you to have sex, it will be a different story. But I will not take my husband to court I love him (laugh) (urban woman, aged 29, married 5 years)

According to the society you are not supposed to refuse sex from your husband and my culture does not support me as he is my husband who has fulfilled cultural requirements for marriage (rural woman, aged 44, married 10+ years)

No, when he wants it (sex) nobody will stop him even if it is red (menstruating) he does not care. I know it belongs to him, he got right to have it anytime, unless he shares me with somebody, so I think I have no right over sex to him (rural woman, age 28, married 9 years)

Most women have greater ability to demand sex from their husbands. Majority responded that there is nothing wrong for a woman to demand sex from the husband except if there are marital problems. However few respondents reported that culture is set back to their ability to demand sex. For a woman to demand sex suggests she is not cultured. Below are the responses of the participants on the influences of culture on their ability to demand sex from their husbands.

For a married woman to demand for sex, your husband and family can regard you as disrespectful wife. They will call you names along the lines of being a slut. (rural woman, aged 42, married 10+ years)

Yes I demand sex if am not getting it. Usually it is us women who are often tired and would deny the men sex. If am in the mood for sex and it has not been happening, I will tell him and make sure I get it (Urban woman, aged 35, married 9 years)

Culturally a woman is taught how to make her husband happy sexually. You are taught about sex and other important things in marriage during initiation. We do not demand sex but you seduce him. Men would not miss opportunity for sex (laughter) (rural woman, aged 46, married 10+)

The reason why I should demand sex is for my man to be secured. Men are very insecure. He may think you are getting it somewhere if you do not ask. (urban woman, aged 31, cohabiting for 6 years)

Women were asked if they consider themselves at risk of contracting STIs. Most of the women were of the opinion that marriage still accord protection against STIs. This view is consistent with Langen (2005) findings that marriage is a safe haven for STIs. About two-thirds did not consider themselves at risk because they trust each other, one-fifth considered themselves to be at risk and only one-tenth said they always use a condom. Some of the responses of the participant are

My husband does not show me any sign not to trust him (urban woman, aged 34, married 10+ years)

I see myself at risk as men are not trustworthy and my husband is working outside Mahikeng (rural woman, aged 35, married 8 years)

Yes, as men are not trustworthy, you will never know what they do when they are out there (rural woman, aged 31, married 10+ years)

The quantitative results concur with the findings of the qualitative study on the use of condom. On the question about how do you feel about asking your husband to use a condom, about two-thirds said they can ask comfortably. A few responded they are currently using condom. Women can ask their husbands to use condom but it remains unknown whether the husband can accept the request. In addition, women were afraid of accusation of infidelity if they suggest condom use. Some of the reasons for the inability to ask include:

It is going to be a battle (asking to use a condom) as we never used it for a long time (rural woman, aged 28, married 7 years)

Because we did not use it from the beginning, it is a bit difficult, because he will ask me why all of a sudden I want to use it. I trust him and he trusts me as well. Because I have not dated anyone since I met him. But I know that men do cheat (urban woman, aged 32, married 8 years)

It is not easy. I can't. He will think that I am cheating (rural woman, aged 28, married 6 years)

I have never asked him, he uses a condom when he wants (rural woman, aged 43, married 10+ years)

Discussion

This study has examined the attitudes toward sexual control among women in marital or cohabiting relationships and what it portends for the control of HIV/AIDS. The level of control women have over their sexuality is the prerequisite of sexual and reproductive health decision-making outcomes. In general, the study indicates that women have considerable control over their sexuality. On operationalizing the dimension of sexual control, the overwhelming majority of the respondents approve demanding sex from their partners. The stand of women to demand sex because it is natural, to satisfy their partners and for procreation indicates a shift from societal norm of women passiveness in sexual and reproductive matters which contrast with previous studies in Uganda (Nyanzi et al., 2005). Women are socialized to satisfy their husbands sexually but not to express their desirability by demanding for sex. It is expected that older women, uneducated, those in traditional marriages and those with large families did not approve women to demand for sex. This inability to demand sex may be linked to the cultural socialization of married women to be submissive in sexual relations to their husbands or partners. This concurs with the evidence from the qualitative findings. It is obviously that culture plays out in the realms of older women, women with limited education, those who are traditionally married and those with large families.

The majority of the respondents asserted that a woman can reject sex from her husband/partner during menstruation, illness or when not in the mood. With no doubts there are circumstances under which sex cannot occur. The study to a good extent concurs with the report in Ghana (Awusabo-Asare et al., 1993) where over four-fifth of women would reject sex with husbands known to suffer from sexually transmitted infections. The result differ with a recent report among Edo women in Nigeria who cannot reject sex because of the fear of been beaten (Iyayi et al., 2011). On the other hand, consistent with the conclusion of Wusu and Isiugo-Abanihe (2008) that fear of been beaten is not a normative practice in marital relationship because of mutual respect. This suggests that women are not treated as sexual objects as earlier findings in women sexuality indicated. Indeed fear of violence may suppress the courage of women to exercise control over their sexuality.

Salient findings of the study are the influence of the nature of the union on the sexual control of a woman. Cohabitation has negative effects on a woman's sexual control ability which concur with the findings in Honduras (Speizer et al., 2005).

Cohabitation is becoming a norm in South Africa, but the consciousness that it is void of cultural recognition subjugates the ability of the woman to reject sex. It is in the instinct that for a man and woman to be together and indulge in sexual activities, there are certain criteria to be met. Since cohabitation is devoid of such criteria, cohabiting women do not feel secured to exercising control over their sexuality.

Consistent with numerous findings (Awusabo-Asare et al., 1993; Langen, 2005; Ogunjuyigbe & Adeyemi, 2005; Iyayi et al., 2011; Delbiso, 2013) women with socio-economic advantage exercise greater control over their sexuality compared to those who are socio-economically disadvantaged. The state of being uneducated and unemployed is the main factor that stifles the mandate of Mahikeng women over their sexuality. Such women always nurture the fear of losing their husbands to other women which may aggravate their state of poverty and hopelessness. The impact of economic dependence is corroborated with the qualitative findings where a considerable percentage of women agreed that depending on husbands for support deterred them from exercising their sexual control to avoid some domestic sanctions. Even in cultural discretion, there are some circumstances where women have some right to refuse sex. However, it is uncertain that such right could exist among women who have no source of income coupled with their state of being uneducated. The absolute dependence of women on their partner for support presents a massive impediment on their attitude to sexual control. This has some implication in the control of HIV/AIDS in Mahikeng.

It is apparent that the respondents have knowledge of STIs mode of transmission, STIs as risk factor for HIV and condom use prevents STIs. However, the magnitude of the knowledge on issues of STIs cannot be equated on condom usage as it should be among people concerned about health risks. This finding is consistent with the low prevalence of condom use among married and cohabiting couples reported in KwaZulu-Natal, South Africa (Maharaj & Cleland, 2004; Langen, 2005) and elsewhere (Iyayi et al., 2011; Nyanzi et al., 2005). Apart from women who reported personal dislike and husband opposition to condom use, a greater majority do not use because of trusting their partners. One of the major challenges in the research on sexual control is the quantification of sexual trust in marital or cohabiting relationships. The high prevalence of HIV/AIDS and other STIs among married women compared to single women, appeals for the verification of sexual trust in marital or cohabiting relationships.

It is not clear to what extent fear is confused with trust. We have no doubt that fear is translated into trust at best. From the qualitative findings, woman lamented that failure to initiate condom use from the beginning has affected their courage to ask for it currently despite suspicion of infidelity and at risk of being infected. Some women have never asked their husband to use condom because their husbands use when they want. A similar attitude of whether to use condom or not is always up to the men was document by Mantell et al. (2011). We have no doubts that the inability of women to exercise control over their sexuality have translated to the art of trusting their partners. This kind of blithe attitude to self-protection gives men leverage over women's in sexual arena and may bear heavily in the spread of HIV in steady relationships. Ogunjuyigbe and Adeyemi (2005) noted that women lamented that men have not changed their sexual attitudes and are very reluctant to use condom. Previous studies were conducted in a setting that may be considered to have lower HIV prevalence compared to South Africa (UNAIDS, 2010) where condom use is low on the premises of trust on partner. We posit that the trust women have on their husband or partner may have some implications on the spread of HIV/AIDS in South Africa.

Indeed, Mahikeng women who participated in the study have demonstrated considerable control over their sexuality, in addition to knowledge of HIV prevention. This is consistent with the findings in KwaZulu-Natal, women are not powerless to take preventive measure when infection looms in the relationship (Maharaj & Cleland, 2004). However, the attitude of women to HIV preventive measures is disturbing having demonstrated good knowledge about mode of infection and prevention. In South Africa, the spread of HIV/AIDS is through unprotected sex. Thus the major restriction to safer sex practices is defined within the sexual relationship and the conduct of the women (Worth, 1989; Dixon-Mueller, 1993). What stood out clearly in the study is that education, economic empowerment and the nature of the union are critical determinants of women's mandate over their sexual control. The present study suggests that vulnerability of women

to STIs including HIV may be linked to their attitude to sexual control and negligence of preventive measures. The use of condom does not show good potentials for curbing HIV infection among women in marital or cohabiting union in Mahikeng.

Conclusion and Recommendations

Knowledge of STIs including HIV is very high among married women in Mahikeng, South Africa. However, use of condoms is very low. It is striking to note that married women themselves disapprove of the use of condoms because they believe that there is a high degree of trust with their husbands/partners. This finding has a lot of implications especially because, as noted above, the proportion of married women living with HIV is increasing dramatically. But there are women who are willing to use condoms however non receptiveness of condom by their husbands/partners remains a challenge. The intervention programmes meant to educate both men and women on the risk they are taking not to use condoms will go a long way in combating HIV/AIDS.

On the issue of sexual control, it is encouraging to find out that most married women approve demand for sex from their husbands/partners and they report that it is just natural to do so. However, a significant proportion of married women do not approve that married women can reject sexual intercourse with their husband/partner under any circumstances. This is the group of women that needs serious consideration in terms of policy. It boils down to empowering married women to have control over their sexuality. This is confirmed by the variables found to be significant in the multivariate analysis. It seems there is still room for the South African government in general and the North-West provincial government in particular to continue addressing the issue of improving status of women. Addressing the specific issues affecting the women's status in their locale requires programme of empowerment through job provision. Since it is clear that having income gives women an edge in sexual control, there is need for informal training with the aim to give them employment. It should be noted also that married women should not be taken for granted when it comes to sexual and reproductive health services as the focus in the past has only been to young and unmarried women and men.

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