SOCIO-CULTURAL RELIGIOUS CONSTRUCTIONS ON WOMEN FERTILITY AND THEIR IMPLICATIONS IN THE CONTEXT OF HIV AND AIDS IN SWAZILAND[49]

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ABSTRACT

The latest Swaziland HIV Incidence Measurement Survey, or SHIMS 2, funded by the United States President's Emergency Plan for AIDS Relief shows that Swaziland has nearly halved the number of new HIV infections among adults since 2011. This achievement is largely attributed to the rapid scaling up of the number of people accessing antiretroviral therapy, (ART). While new HIV cases are declining generally, women are at least three times more likely to contract the disease than their male counterparts (UNICEF 2017). This is attributed to high levels of sexual violence, widespread poverty and patriarchal norms that limit women's decision-making on their sexual health. This paper therefore argues that socio-cultural religious constructions on women fertility, embedded in patriarchal structures and systems that uphold and reinforce inequalities between women and men, put Swazi women at a health risk. It is these constructions that are largely responsible for the high prevalence of HIV and AIDS amongst women. Shaped by the patriarchal worldview, Swazi society places a high value on childbearing as a means to perpetuate the bloodline of the father, and for social cohesion; hence the importance of women fertility. Framed within an exploratory and critical feminist research paradigm, the paper advocates for a reorientation of the patriarchal thinking on women fertility, as a means to effectively deal with the high prevalence of the virus amongst Swazi women.

Key words: Patriarchy, socialisation, fertility, communitarian ethic, socio-cultural religious constructions, reproductive abilities

Introduction

The first HIV infection was identified in Swaziland in 1986 (SHAPE 1996; SNAP 1999). The government responded by establishing the National AIDS Prevention and Control Programme (NAPCP), later renamed the Swaziland National AIDS/STI Programme (SNAP), with support

[49] In April 2018, King Mswati III changed the name of the country from Swaziland to Kingdom of Eswatini. The initial rendition is retained in this article.

[50] This paper draws on my PhD thesis,*'Sowungumuntfu ke nyalo' – "You are Now a Real Person":* A Feminist Analysis of How Women's Identities and Personhood are Constructed by Societal Perceptions on Fertility in the Swazi Patriarchal Family, completed in 2013. Data collected from participants of this study, in both FGDs and separate interviews revealed that traditionally it is expected that a woman must be fertile in order to bear children for the in-laws, such that in childless unions conclusions are reached, without any medical diagnosis, that it is the woman who is infertile and she is blamed for the predicament. The man is assumed to remain fertile for the rest of his life; low sperm count, varicose veins in the testicles, sexually transmitted diseases and other causes of male infertility are never considered in a traditional family.

from the WHO's Global Programme on AIDS. By the end of the 1990's a standard package of interventions had been put in place (FLAS 2001). As in most countries this was done through the Short Term Plans which evolved into Medium Term Plans. The interventions included mandatory screening of all donated blood; information, education and communication programmes (IEC); condom promotion and distribution; and the establishment of AIDS Information and Support Centres. In February 1999, His Majesty King Mswati III declared HIV andAIDS a national disaster (UNDP 2002). Two new committees: the Cabinet Committee on HIV and AIDS; and the Crisis Management and Technical Committee were then created and launched to carry out the King's mandate.

The Kingdom of Swaziland has long had a severe HIV epidemic with the world's highest national HIV prevalence and incidence (rate of new infections). However, the country has demonstrated a commitment to turning the tide of the epidemic by dramatically scaling up HIV testing and treatment as well as other prevention efforts. Thus, between 2011, when SHIMS1 was conducted, and SHIMS2 in 2016, HIV incidence among adults fell by nearly half (2.5% to 1.4%) and the percentage of HIV-positive adults with viral load suppression (VLS), as a measure of control of the virus, doubled (35% to 71%)[51]. The improved treatment according to a report to the International Aids Society Conference in Paris has made Swaziland, the country with the highest national rate of new infections, as well as the highest proportion of people living with HIV to have dropped infections. The latest data, based on blood tests from about 11 000 people aged 15 and over, showed that 27% were HIV-positive in 2016. This translated to an infection rate of 1.39% among 18- to 49-year-olds, down from 2.58% in 2011 - a 46% reduction. Notably, "incidence was higher among women than in men," said the report to the International Aids Society Conference. The decline was also steeper for men at 52% than for women at 40%[52]. In Swaziland, as in many African countries, women are the backbone of the communities; they maintain the household, generate income, and shoulder the burden of caring for sick family members. However, as shown in the statistics Swazi women continue to suffer a double dose of the HIV burden, even when the rate of new infections has been halved in five years.

Socio-cultural religious expectations of a woman's mandate, that of begetting children in their families, together with other social drivers, contribute to women's vulnerability to HIV and AIDS. For instance, Swazi society expects women to be subordinate and submissive, thus allowing men to control their sexual health. This is blamed on the conventional patriarchal discourse, embedded into the psyche of most Swazi women, such that they readily internalise it in defining themselves as worthless without fulfilling the "motherhood mandate" (Ngcobo, 2007). So, even when basic information on HIV and AIDS is available to women, this knowledge does not assist them in making decisions to avoid risky sexual behaviour.

[51] These are recent findings from the Population-based HIV Impact Assessment, or PHIA surveys, funded by the U.S. President's Emergency Plan for AIDS Relief. The Swaziland HIV Incidence Measurement Survey (SHIMS), which is a nationally representative population-based survey, has collected demographic and HIV-related measures twice. It was the first national-level survey to measure HIV incidence through direct observation of new infections in 2011 (SHIMS 1), and it did the same in 2016 (SHIMS 2).

[52] These statistics were given by a research team led by Dr Velephi Okello of the Ministry of Health in Swaziland in a written presentation to an HIV science conference in Paris in 2016, titled; "Since 2011, national HIV incidence in Swaziland dropped by almost half. Accessible at https://www.dailymaverick.co.za/article/2017-07-24-swaziland-turns-around-worlds-highest-hiv-infection-rate-report/#.Ws3iTKJrnIU

Unfortunately, this waters down efforts like condom promotion, meant to discourage women from indulging in unsafe sex and also getting pregnant.

Patriarchal Context of Swazi Society

Swazi society is patriarchal[53] in its nature, and by extension its fundamental unit, the family whose basis is marriage, is also patriarchal (Nyawo and Nsibande, 2014; Mofolo, 2011). According to Swaziland Action Group Against Abuse (*hereafter* SWAAGA) Report (2012),[54] which confirms the national study conducted by UNICEF on 'Violence Against Children and Young Women in Swaziland' in the IRIN Report (2010),[55] the patriarchal nature of the Swazi society often fuels behaviour where women are seen as subordinates to men. Even within the legal system, women are considered minors for most of their lives. These studies point at patriarchy in the household, having multiple intimate partners and infidelity, poverty and economic issues, alcohol and substance abuse, harmful customary practices, inaccessibility to key resources such as land and credit, and the misuse of culture to justify harmful actions toward women, as all having contributed to gender inequality and male superiority in Swaziland. Despite its exposure to modern socio-political and economic transformation, the Swazi society has upheld its conventional gender dynamics whereby subservience, deference towards males and asymmetrical gender roles are purported in essentialist terms (Unger, 1970:14). The family unit is central to the reproduction of patriarchal relations and women's subordination. Family members in the Swazi society are positioned in hierarchical power relations where males have authority over women; they are obligated to comply with the authority that has been defined within these relationships. The husband is therefore culturally accepted as the ruler of the family, and is regarded as the formal authority to whom the wife and children owe their allegiance. Whitehead (1993:72) has labeled this a pervasive ideology of male superiority which shapes women's views of themselves and their capabilities (Giddens, 2005; Kneel 1981; Horner, 1972).

The male dominance also extends to control over women's reproductive abilities. Studies undertaken by Ngcobo (2007), Mdluli (2007), AWEPON (2007), WLSA (2001), Daly (2001), Russell (1993) and Nhlapho (1992) on the dynamics of the Swazi society have shown that the Swazi family is pro-natal, and the ultimate purpose of marriage is procreation; hence women's fertility is highly regarded. Similar findings by Isiugo-Abanihe (1994) in a different African context further reveal that it is the family structure in a patriarchal society that shapes and influences individual reproductive decision making and women's fertility. As we have shown in a previous publication emanating from this study, it is the communal and familial ethic of Ubuntu which takes precedence over the (largely feminist) ethic of self-determination (Nyawo, Nadar and Reddy, 2013, pp.105-118).

The ethic of Ubuntu taking precedence over the ethic of self-determination as shown by Nyawo, Nadar and Reddy is confirmed in Mpofu's (1983) assertion that the dowry that is paid when a Swazi woman gets married is to bind her to her husband and in-laws as the price that

[53] Patriarchy is a social system in which the role of the male as the primary authority figure is central to social organization, and where fathers hold authority over women and children, and property. There have been controversies about the term 'patriarchy', but in recent years most forms of feminism tend to agree that patriarchy is a general descriptor of male dominance.

[54] http:www.swagaa.org.sz/?page-Id=32 [accessed 10 September 2014]

[55] http://www.irinnews.org/report/73057/swaziland [accessed 10 September 2014]

acquires her procreative capacity. It is also obligatory that she bears children, preferably an *'heir',* for the patriline she marries into. Swazi patriarchy dictates that children belong to their fathers, both culturally and legally, thus they assume the father's identity; "it is through bride wealth that men acquire the right to children and to fertility of their wives" (Russell, 1984, p.50). Women are therefore valued for their ability to produce children who would continue the heritage and name of the family, and to guarantee perpetual lineage (Donkor, 2008; Nukunya, 2003; Buor, 2002). Hence studies such as those conducted by the Women and Law in Southern Africa (*hereafter* WLSA) –Swaziland Chapter in 2004 and the African Women's Economic Policy Network (*hereafter* AWEPON, 2005) demonstrate that in the Swazi family, patriarchy promotes group rights over individual rights. In other words, a man marries a wife for the family, and that assumes that women's interests are subsumed and protected within the wider community. Marriage being so closely linked to women's fertility and sexuality becomes a seedbed for HIV, which disappropriately affects women as a result of their unequal socio-cultural status. Being inhibited to make decisions about their sexuality heightened their vulnerability to HIV.

Notwithstanding the above, Swaziland has made some effort to protect the rights of its citizens. For example, international conventions related to fair the treatment of women, independent of categorical judgments, have been signed. Despite these initiatives an androcentric view which dominates familial and social relations, including women's reproductive abilities, remain captive to the legislative developments which have taken place.

Theoretical Considerations: African Feminist Theological Anthropology

At the heart of this paper is the consideration that women's reproductive capabilities or fertility are believed to be the essence of a married woman's personhood as implied in several studies (Donkor, 2008; AWEPON, 2005; Ginindza, 1989). Thus, as dictated by socio-cultural religious constructions, women view themselves as "fully human" when they are able to reproduce offspring for their families. How Swazi women experience these religious and socio-cultural beliefs and how they make sense of them, determines their response towards HIV reduction campaigns. In order to theorise the implications of the religious and socio-cultural constructions of fertility and women's personhood, in the context of HIV and AIDS, theories of theological anthropology framework best inform the argument.

An African feminist approach takes cognisance of culture as an indispensable variable within gender discourse and argues that culture shapes and influences the experiences of African women (Kwok,2004; Oduyoye, 2001). As noted by Phiri (2004, p.17), culture is a social construct which assigns roles to women and men based on how the society understands the identities of women and men. Whilst Phiri acknowledges that culture is important because it gives people their identities, she also asserts that; "unfortunately African cultures have viewed women as less important than men, thereby making it difficult for women to have valid relationships with self, others, creation and God" (2004, p.17). Hence, culture can provide women with a communal identity and a sense of belonging, while at the same time it can be manipulated and be used as a tool of domination (Kwok, 2004). Kanyoro (2002), Oduyoye (2001), Phiri and Nadar (2006) have theorised on the humanity of African women and how it is so intricately tied with religio-cultural and social expectations of women's subordinate status. The paper employs these theories to interpret the Swazi society's socio-cultural and religious beliefs on women's fertility and how they subsequently frame women's constructions of personhood, which contradict with some HIV reduction strategies.

Gender, Power and the Family

The structure of families is closely guarded and maintained by culture as many scholars have shown (Giddens, 2005; Russell, 1993). "It is within the family that social construction of womanhood is engineered and perpetuated, and in which process women become unwilling partners to even critique culture", argues Zigira (1998, p.35). Hence, the family is a crucial agent of socialisation, where girls are socialised to be passive, soft-spoken and tolerant throughout their lifespan (Nyawo and Nsibande, 2014). In the same spirit WLSA Swaziland has asserted that the interest and position of a family member are compromised by being born a female. From birth a girl is perceived to be a temporary member of the family and when she gets married she occupies an inferior position as a newcomer, an outsider and a non-blood member (1998, p.64).

Within the global discourse feminists have been analyzing conventional relations which favour men in the intra-familial distribution of power and resources and they have linked this power to how families are constructed. They have further observed that within patriarchal systems, the family is viewed as an important societal institution conceptualised as essential - and this underscores the exalted position of men, whilst condoning women's inferior positions. This power differential is also clearly evident in the Swazi context as well. For example, many studies undertaken in Swaziland show that although the number of women in Swaziland is larger than that of men, their power is far less than that of men; women continue to be a minority group as a subordinate segment of society (Kioli, 2013; Mofolo, 2011; Mpofu, 1983), yet they are expected to prove their "high quality" (Vitrovitchi, 1997, p.26) through childbearing. Sexual activity and behaviour are considered to be the man's domain, and a woman is expected to be always at the receiving end in order to fulfill her 'duty' of procreation. She must not deny her partner sexual relations, nor should she take the initiative to invite him to sexual intimacy; or else she is labelled as 'loose' and suspected of infidelity. Thus, a woman is rendered more vulnerable to HIV, due to lack of control over her body.

Socio-Cultural and Religious Beliefs and Practices Regarding Fertility

Feminist literature shows that patriarchy allows a male superiority ideology to control female sexuality and procreation through cultural beliefs and practices (Rakoczy, 2004; Oduyoye, 2001). In cultures similar to Swaziland where the paying of "bride price"[56] is practiced, it becomes the price for acquiring the wife's reproductive capacity (Russell 1993). The woman is obliged to produce children for her husband's lineage; hence WLSA's (2001) observation that marriage in a patriarchal society serves specific major functions which are the perpetuation of the woman marital lineage and the provision of her domestic labour. Walker (1990) and Carter and Parker (1996), who share similar sentiments, add that sons are preferred; at least one male child in the family is regarded as absolutely necessary. It is therefore true, as Oduyoye (1995:142) would argue, that motherhood in most African societies is a highly valued role open only to women, but desired by both women and men, as the channel by which men reproduce

[56] The phrase 'bride price' is no longer used in scholarship in African theological discourse but I have used it here and in other sections to illustrate the point that when *lobola* is paid it is often assumed that something is being bought.

themselves and continue the family line. So, the actual prestige of reproduction goes to those who 'own' or control the reproductive capabilities of women, such that women are not valued in themselves, but only as valuable objects or means to an end. Other than the continuity of the family name, sons are important for economic support and their permanent residence near the ancestral home, unlike girls who would join their husbands' families after marriage (WLSA, 2008; Ngcobo, 2007; Russell, 1993).

Daly's study also made some important conclusions about socio-cultural beliefs regarding the value of women's fertility within Swazi society (2001:46). He argues that procreation is one of the most highly valued cultural obligations in Swazi communities. In terms of beliefs, among others, he cites three major reasons why Swazi society values procreation so much. First, he notes that the birth of a child brings hope in families that parents will be cared for in their old age. Second, fertility is perceived by society as a sign of wealth and prosperity. Third, it is an indication that one's ancestry is sufficiently pleased to allow the couple successful childbirth. Furthermore, Daly cites (2001:49) several examples of how these beliefs are entrenched within cultural practices. He notes that it is customary if the union is childless that a substitute wife stands in for her sister and bears a child for the spouse. In instances where the man has died before his wife has given birth, the brother of the deceased 'inherits' the wife to facilitate procreation (Daly, 2001; Nhlapho, 1992). All these cultural practices breed behaviours that foster HIV risk, in a context where a woman is socially obliged to accept any gender constructed decision her natal family makes on her behalf. Women have no choice but to suppress their autonomy and embrace these cultural practices that unfortunately expose them to a health hazard.

In addition to the actual socio-cultural practices which enforce women's subordinate status within marriage, another means of entrenching these beliefs are through folk-songs and other traditions. Mdluli (2007) in her article entitled "Voicing their Perceptions: Swazi Women's Folk Songs", has shed an illuminating insight on how patriarchy shows its face in songs. She has categorized the songs into various themes, but for the purposes of this discussion I will only focus on the love and marriage theme. In her exploration of the love folk songs she reveals the patriarchal traits of a Swazi family in that it grooms a girl child for her final destination which is marriage. She is indoctrinated to believe through these songs that her father's house is not her permanent home, although her father would one day be a wealthy man through the exchange of *lobola* cows for her. Through socialisation which she receives primarily from her mother and grandmother, she emerges to fit into the patriarchal society as a 'full' woman. So, marriage becomes the transitional stage each Swazi girl looks forward to as she grows up in her family (Ngcobo, 2007), which is;

> An institution that bears responsibility for the physical reproduction of society and for the ideological reproduction of its citizens as gendered subjects with certain beliefs, skills and expectations. It is of primary importance in socialising children into specific socially produced heterosexual norms of femininity and masculinity (Mdluli, 2007, p.88).

Fertility is therefore crucial in any African community for the survival of the clan names and for the incarnation of family ancestors; hence the "child factor" syndrome in African families (Oduyoye, 1999). In response to the societal pressure, Swazi women would bargain with their reproductive health in this era of HIV and AIDS just to meet societal expectations. Despite the government's interventions to promote condom use as a primary preventive measure against HIV transmission, gender related barriers sometimes limit their use. Some women view the use

of condoms as being in conflict with their own or their partners' desire to continue the patrilineal descent. This increases chances of them being infected with the virus.

Hegemonic Control over Women's Sexual Health

Hegemony is explained as the social dominance of a group, exercised not through brute force, but through a cultural dynamic which extends into private life and social realms (Giddens, 2005, p.119). The National Gender Policy of Swaziland (2010, p.10) has defined sexual health as an aspect of health that enhances personal relations, respect for the security of the person and the physical integrity of the human body, and the right to make decisions on sexuality and reproduction free of discrimination, coercion and violence. Societal perceptions, including those of the women themselves are shaped by hegemonic constructions of sexuality that establish hierarchal relationships between femininity and masculinity. "Male centeredness" places men in an inherently superior position, whilst declaring their experiences as the norm. These hegemonic constructions provide scaffolding for skewed relationships between women and men to be accepted as "natural" whilst inevitably legitimising dominance and submission (Connell, 2000). Such mentalities are characteristic of hegemonic control in gender regimes, where women live their lives to serve and satisfy the interests and ascendancy of the dominant group. This gender order is accepted by the subordinates as natural, divine and unchangeable (Nganga, 2011; Oduyoye, 2001). As also noted by Schippers (2007, p.87), hegemony legitimates ascendancy, and also inspires everyone to consent to and go along with social dominance. Failure to fit into this hegemonic 'jacket' results in misery, as the woman would feel like she owes society some debt or "treasure". Yet, women's sexual health embraces reproductive rights which are supposed to grant women freedom to decide on issues that pertain to their sexuality, and not to be deprived of their rights by any cultural undercurrents. The hegemonic control can also be noted in the paying of the 'bride price', which in actual fact purchases her womb from her father, not the body (Nhlapo, 1992, p.48), and ownership of her womb now transfers to her marital home. This is evident in the rituals families perform to redeem childless unions. For example, when elders in her marital family have proven that their son is sterile, arrangements can be made with close relatives to surreptitiously give service to their property, the 'bought womb'. Though not forced, the woman would submerge her dignity and ethics and comply with the 'deal'. Given that the woman is not forced into the arrangement, what then leads her to consent with it yet it works against her favour?

Women willingly accept hegemonic control as a result of gender socialisation. Socialisation according to Clifford (2001), Riley (1989), Ruether (2002, p.1985), and Lerner (1983), trains women to understand themselves in terms of patriarchal super-ordination and subordination of being in the center or being on the fringes. Further it leads them to internalise that they have to accept and adapt to things as they are. Gendered social norms then become formal and informal rules which govern the women's behaviour. They construct fertility in such a way that it is perceived as a societal value that defines a *'real'* woman in Swazi marriages. Through socialisation, which is chiefly supported by biological essentialism, women are taught to accept patriarchal norms, values and beliefs about their fertility as 'natural', 'divine' and obligatory. Failure to fulfill this expectation results in social sanctions which may range from verbal violence to social alienation.

In contrast, socialization of men takes a different path from that of women. With men there is no social pressure to preserve their virginity till marriage as compared to women; neither is there a stigma attached to pre-marital sex. At the same time society pressurizes men to continue

the family line through procreation. Many men would therefore want to prove their sexual prowess through having multiple partners, and this puts women at the center of the storm of the HIV and AIDS pandemic.

Tensions between the 'Motherhood Mandate' and mitigating Strategies against HIV and AIDS

The paper has established that traditional socialisation of females and males runs on gender lines in traditional context. As it is the case in other African cultures, socialisation in the Swazi society is reinforced through traditional initiation ceremonies where girls are taught sexual education which includes how to satisfy the sexual needs of their future partners. They therefore grow up conscious of their mandate as wives, which is also instilled through sexual rules. Regrettably, these rules often enhance women's risk of HIV; hence the high prevalence of the virus with women. Dennis (2003:70) and Haddad (2002:95), remarking on these rules in African societies assert that men prefer dry sex, and women would therefore use herbs that would make the vagina to be dry, tight and warm, yet the dryness cause small tearing during sexual intimacy which increases chances of infection. The 'motherhood mandate' would also debar women to negotiate for safe sex through the use of condom. This kind of teaching is often supported with Scripture, where women would be taught not to deny their husbands sexual advances except for prayer' (1Corinthians7:5-15). Biblical cultures which present women as belonging to either their fathers or husbands are often exaggerated, and are applied as the norm. As noted by Phiri (2003), Scripture is sometimes misinterpreted and misused to serve selfish ends that put women at risk. For instance, women and men will be presented as becoming one flesh in marriage, and that would be the basis for refusing the use of condoms, and that when one is infected they need to share the virus and die together.

Conclusion

The paper has worked from the premise that culture has polarised genders, allowing men to be portrayed as inherently superior, and women to fatalistically accept the societal constructions of their personhood. This poses a threat to the advancement of mitigating strategies against HIV and AIDS, meant to rescue women from the claws of the virus. Constrained by a communal reality or the communitarian ethic to live accordingly to societal expectations, this is when women can only ever make sense of their existence within the community. That said, it is not enough to blame Swazi women's diminished sense of self with regard to fertility only on the communitarian ethic. We have to go further to recognize that this communitarian ethic is founded on patriarchy. Hence African feminists challenge societies to question the lopsided status quo that seeks to safeguard the interests of men, whilst pushing women to the bottom of the pyramid. They argue that women should not passively accept their 'fate' and prop up patriarchy; rather with bruised and anguished voices, women should shout to recover their full humanity (Nganga, 2011). As Oduyoye (1995: 81) has noted; "unlike beauty, oppression does not lie in the eyes of the beholder; it tags at the soul of the one who feels it". Put differently, the reorientation of the traditionally socialised mindset should start with the women themselves, as people that are at the centre of the storm of the HIV and AIDS pandemic (Phiri 2003). They must learn not to put value on socio-cultural religious constructs at the expense of their health; 'they should seek ways to empower themselves and their sisters and daughters with knowledge to overcome situations that expose them to the HIVirus' (Phiri, 2003:16).

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