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### **Sociocultural Factors Favoring HIV Infection and the Integration of Traditional Women's Associations in AIDS Prevention in Kolda, Senegal**

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## **Executive Summary**

In southern Senegal, the Dimba (a well-respected traditional women's association) and women of the Laobe ethnic group provide advice about reproductive health and sexuality. The Dimba focus on problems of sterility and miscarriage, while the Laobe, experts in eroticism, make and sell products to enhance sexual pleasure. In an effort to address the rapid rise of HIV infection rates among women in the region, this study examined the potential for using the Dimba and Laobe as communication channels for HIV/AIDS prevention messages.

### **Objectives**

The specific objectives of this study were to:

- Determine the knowledge, beliefs, attitudes, and behaviors associated with sexuality, STDs, and HIV/AIDS among women and men in Kolda, a town in southern Senegal;
- Identify sexual, reproductive, and therapeutic practices that increase women's risk of STDs and HIV/AIDS;
- Describe the structure and functions of the Dimba and Laobe as well as the advice given to Kolda residents by both groups;
- Identify ways to integrate STD/HIV prevention messages into the traditional interactions between the local community and Dimba and Laobe groups.

### **Methodology**

This action research project utilized a variety of qualitative and quantitative methods of data collection. Participant observation and discussion groups were conducted with purposive samples of Dimba and Laobe women. Individual interviews were conducted with key informants in the community and members of the Dimba and Laobe groups. A

questionnaire was administered to a random sample of 250 women and 250 men of reproductive age who were residents of five neighborhoods in Kolda representing different ethnic groups including the Fulbe, the Manding, the Wolof, the Diola, and the Balant. Following administration of the questionnaire, 11 men and 14 women over the age of 40 were selected based on their willingness to participate in in-depth sexual life history interviews.

At the beginning of the research period, the sample consisted of one Dimba group from the Sikilo neighborhood in Kolda. This group was chosen because its members included women from all of Kolda's ethnic and religious groups and it was considered to be one of the most dynamic and influential Dimba groups in the city of Kolda. Later in the study, the sample was enlarged to include a second Dimba group from the Bouna Kane neighborhood.

In order to collect data on the Dimba and involve them in the intervention process, the research team had to be fully integrated into the Dimba group by participating in a number of traditional ceremonies. A woman of proper age and standing in the community was found to make the necessary introductions to the hierarchical leaders of the Dimba. The research team was then accepted as a legitimate "sub" group within the Dimba, and was therefore allowed to take part in all Dimba activities.

Integration of the Laobe into the research process began with the identification of Laobe women in the marketplace. Female researchers purchased Laobe products from these women and requested information on the use of the products. Through repeated visits, the researchers were able to establish an informal dialogue with the Laobe women, and by using a "snowball" sampling technique, the researchers were able to interview additional Laobe women.

## Results

### *Risk Factors for STDs and HIV/AIDS*

According to the study's informants, indigenous therapeutic belief systems do not generally acknowledge a link between transmission of STDs and sexual relations. The most frequently cited causes of transmission of illnesses whose symptoms would be identified as STDs included urinating or walking barefoot on the urine of someone who already has the disease, encountering a "bad wind," and being the victim of a curse. It was recognized, however, that men can place "traps" in their wives' genitals that can cause a wife's lover to contract an STD-type illness. However, it is believed that the husband as well as the wife are protected from infection.

Women may be at increased risk of HIV infection due to sexual practices aimed at enhancing sexual pleasure. According to informants, people in the community believe the vagina is not a simple natural object but must bear the mark of artistic "work." These "works" may be perfumed scents (certain women place incense between their legs so that the smoke can perfume the vagina) and plant-based products, powder made from rocks, or small stones which are inserted into the vagina before sexual intercourse. The Wolof call the insertion of these substances into the vagina, *safal*, which means "to increase the quality of the taste." Among the 196 women who responded to the survey question about the use of vaginal erotic substances, nearly 40 percent indicated that they had taken part in the practice. Married women were more likely than single women to have engaged in the practice. More respondents who were between the ages of 31 and 40 years practiced *safal* than women of other age groups. According to local perceptions, this age range is considered to be the time of sexual maturity for women.

In addition to putting substances into the vagina which can cause irritation and inflammation, another practice that may make a woman more vulnerable to HIV infection is the cutting of bumps and warts that are in and around the vagina with a blade. According to informants, such vaginal incisions are done for the pleasure of the

husband by allowing easier penetration of the penis into the vagina. When asked about this practice, none of the woman who were administered the questionnaire admitted to having practiced vaginal incision. About one-third of married women and one-fifth of single women had heard of the practice, however. During group and individual discussions with Laobe women, three acknowledged that they had growths removed from their vaginas.

Data from the study suggest that multiple partnerships and frequent partner change are common as a result of polygamy, divorce and remarriage, extramarital sexual relationships, and migration. Polygamous marriages are common in Kolda. For example, men may acquire an additional spouse by inheriting the widow of an elder brother. Among certain ethnic groups, one form of secondary marriage involves girls who are seasonal migrant workers. In some Diola villages, girls who return to their native villages at the beginning of the rainy season are pressured into temporarily choosing a husband, who is usually married. When these girls migrate to larger cities at the end of the rainy season, they are once again considered to be unmarried women.

According to findings from the survey, only 2 percent of men were divorced, while nearly 20 percent of the women were divorced. The low number for men is due to the fact that men generally remarry faster than women. Divorced women are relatively free from any family supervision—a factor which may facilitate casual sexual relationships. It is interesting to note that the Wolof word *caaga* means both divorce and prostitute.

About half of survey respondents believe that many married men and women have extra-marital sexual relationships. The reason most frequently cited by respondents for married women engaging in extra-marital relationships was the need for clothes, personal items, and food for the family. Traditionally, the woman has been responsible for providing food for the household. Economic, agricultural, and ecological crises have impeded women's traditional role as food providers, therefore, many have had to adopt

survival strategies that include exchanging sex for money or food. Another motivation for women engaging in extramarital relations which was acknowledged during interviews was the need for money to satisfy social obligations related to family ceremonies, which are a woman's responsibility. If a woman does not meet these obligations, her social status is demeaned in the eyes of other women.

Migration is a common and necessary occurrence in the lives of young adult men in Kolda. One of the main reasons men migrate is to earn enough money for wedding expenses. Since many men cannot marry until later in life, they may have sexual relationships with married women. Analysis of the sexual life histories collected in this study showed that a woman's first sexual partner was usually her husband, while a man's first sexual partner was often a married woman.

The vast majority of the survey sample had never heard of condoms, yet higher levels of education were associated with increased awareness of condoms. Ever use of condoms was more common among divorced and single women than among married women. Some women expressed the fear that if they asked their male partners to use condoms, they would run the risk of being considered a sex worker. According to one itinerant female merchant:

*I don't need condoms because I am not a prostitute. I have a husband and children. It is rare that during my travels I fall to the advances of a man. When I do, it is with someone that I trust. I only choose to have sexual relations with men who are clean and visibly healthy, polite, and capable of respecting me. These men know me, trust me and know that they don't need to use condoms with me.*

Although modern contraceptives are rarely used, traditional methods of birth control are widely used. The most common means of birth control are conjugal postpartum abstinence, which lasts for as long as the wife is breastfeeding (about two years), and the use of a belt made by traditional doctors that is worn by both women and men and is believed to have mystical properties that negatively affect fertility.

Despite newspaper, radio, and television campaigns to increase awareness, 10 percent of the survey sample--the vast majority of whom had no schooling--had never heard of HIV/AIDS. Among those who had heard of the disease, misconceptions about modes of transmission were common.

### **The Dimba**

The Dimba are a membership organization that includes all ethnic groups. Membership is restricted to women who have experienced problems of infertility or repeated miscarriages, had children who died at a young age, gave birth to twins, or adopted orphans--all of which are considered to be hardships that empower a woman. The Dimba's duty is to ensure the fertility of the woman and protect the health and well-being of the mother and her newborn. The Dimba are also a solidarity group whose members help each other socially, financially, and in farm-related work.

The Dimba conduct community rituals and ceremonies as well as provide therapeutic advice to women and couples. The organization constitutes a well-known and powerful force in the community. During ceremonies, they may use derision, mockery, nudity, and indecent language to challenge male dominance and ridicule moral, political, or religious authorities.

The Dimba are divided into groups which are responsible for organizing various activities. The groups are generally made up of members living in the same neighborhood. Each group has as its head an elderly woman considered to be the spiritual leader. She has a thorough knowledge of the treatment of women's and infant's illnesses. She visits women who have problems with fertility and provides follow-up for prenatal and post-natal care. Next in rank is the "mother" who is in charge of organizing Dimba sub-groups and dividing administrative duties among them. She is surrounded by a group of three to six senior members who are her advisors and participate in decision-making. There is also a lower body of members that includes all

the Dimba women of a neighborhood. The “mother” and her group of senior members call the lower body together for neighborhood meetings.

Each Dimba group includes men who have various responsibilities. The “father” takes care of all spiritual and therapeutic tasks that call for a man’s presence. He treats individuals or couples who suffer from sexual or reproductive diseases, and has two assistants. The “father” gets a second opinion, when necessary, from a traditional doctor. The drummer is in charge of music during ritual ceremonies and often has three or four assistants.

Results from the survey showed that the influence of the Dimba in Kolda is extensive. Kolda has four main Dimba groups located in four neighborhoods of the city. Eighty-three of the 250 women surveyed (33 percent) said they were Dimba members. Twenty-two percent of males surveyed acknowledged being married to a Dimba woman. Nearly forty percent of the entire sample said they had close relatives that were Dimba. Among non-Dimba women, more than half said they had participated in Dimba ceremonies.

Because the research team was officially integrated into the Dimba hierarchy and acknowledged as a sub-group of the Dimba, the team was able to take advantage of the Dimba’s ability to mobilize large groups of women to educate the community about STDs and HIV/AIDS. The research team conducted two large group sessions, that included films, role-playing, and discussions, for several dozen Dimba women. After these large group sessions, small discussion groups were organized to further sensitize the women about the topics. There also were discussion sessions with groups of Dimba spouses. During the sessions, the research team highlighted the recommendations advocated by the Dimba to protect the health of the woman and infant, which were congruent with HIV preventive behavior, such as avoidance of extramarital relationships. The team also pointed out that the belt, a traditional contraceptive, would offer no protection against HIV if a breast-feeding mother decided to observe post-partum

abstinence with her husband, yet have sex with another male partner. In this situation, condoms would protect the mother against HIV infection and in this way safeguard her health and the health of her child. Condoms were subsequently given to Dimba therapists to promote among their patients.

### **The Laobe**

The Laobe are an itinerant ethnic group, originally from the northern region of Senegal, but they travel throughout Senegal and to other neighboring African countries as well. They make and sell a variety of products designed to enhance sexual pleasure. These products include incense, perfumed powders, objects to insert in the vagina, necklaces, and belts.

Laobe women decorate pieces of cloth used as lingerie, which serve different functions during foreplay. The cloths have different names that evoke preparation for the sexual act. Some use decorations which are drawings of sexual acts or the male or female genitals.

Laobe women may be at risk of HIV infection for a variety of reasons: Laobe husbands and wives lead migratory lives; Laobe women are highly valued as sexual partners but do not consider themselves to be commercial sex workers; they tend to have poor knowledge of HIV/AIDS; and they seldom use condoms: none of the four Laobe market women interviewed had ever seen a condom.

More than half of the total survey sample of men and women bought products from Laobe women. Nearly three-fourths of the women, representing all age groups and ethnicities, reported buying Laobe products.

Although it was difficult to work with the Laobe because they are an itinerant group, the research team succeeded in introducing condoms as one of the products sold by

Laobe women and in convincing them of the marketability of the condom as an erotic product. This was accomplished by associating the condom with a piece of lingerie that has on it an erotic drawing. The cloth is called “it must be hard” and the Laobe women subsequently gave the condom a name which means “maintain the hardness.”

## **Conclusions**

Women in Kolda are at risk of HIV infection because of low levels of knowledge about STDs and HIV/AIDS, low levels of condom use, their own and their partners’ non-monogamous sexual behavior, and certain sexual practices, all of which are influenced by social, economic, and cultural factors.

Results from this study suggest that the Dimba and Laobe have the potential to serve as communication channels for a community-based HIV prevention program. It is recommended, therefore, that both groups be included in future AIDS prevention efforts in the region.

## 1. INTRODUCTION

### **Epidemiology of HIV/AIDS in Senegal**

The evolution of the AIDS pandemic in Africa is very alarming. According to the World Health Organization (WHO), the reported number of AIDS cases has risen from 230 in 1984 to 152,463 in 1992. However, because many AIDS cases have not been diagnosed or reported, WHO estimates that the total number of AIDS cases in Africa may be closer to one million, which represents two-thirds of AIDS cases worldwide.<sup>[1]</sup>

The number of people who have tested positive for HIV in Africa is estimated to be between 5 and 6 million, a figure which represents more than half of the total cases worldwide. The situation among women and children is even more alarming. Two and one-half million African women (80 percent of seropositive women worldwide) are estimated to be infected with HIV. Children with AIDS in Africa represent 90 percent of pediatric cases worldwide.<sup>[1]</sup>

Although central and southern Africa have received most of the attention because of the extent and the rapidity with which HIV has spread there, the epidemiological picture in west Africa is also serious. Although epidemiological HIV/AIDS data for west Africa is less complete than for central and southern Africa, studies have shown that in some west African villages there are households with high mortality rates due to AIDS.<sup>[2]</sup>

In Senegal, the official numbers--which may be inaccurate because of difficulties in diagnosing and reporting AIDS cases due to the lack of medical facilities--show an exponential increase in the number of AIDS cases from six in 1984 to 911 in June 1993.<sup>[3]</sup> This will worsen if the trend is not reversed.

Among the general population the officially-reported seroprevalence of HIV in Senegal is approximately 1 percent. This figure is likely to be inaccurate due to the fact

that it is based solely on data obtained from different populations. In 1991, the prevalence of HIV infection among 2,995 blood samples taken from different groups was as follows:<sup>[4]</sup>

Blood donors	0.3 percent
Pregnant women	1.2 percent
Men infected with STDs	2.4 percent
People with tuberculosis	4.6 percent
Hospital patients	6.5 percent
Officially-registered Commercial Sex Workers (CSWs)	14.8 percent

A detailed analysis of the CSW data for the southern region of Senegal (Casamance) indicates a prevalence of HIV infection of 30.4 percent. This figure is more than double the national average for this population. The percentage of HIV-positive pregnant women in Casamance is 3.5 percent, which is three times the national average.<sup>[4]</sup> Although the statistics show that in 1987 women with AIDS represented 10 percent of all reported AIDS cases in Senegal, by 1992, this figure had risen to 30 percent.<sup>[5]</sup> These numbers are indicative of the rapid spread of HIV/AIDS, particularly among the younger population, which is more sexually and economically active.

### **The National Socioeconomic Environment**

As in other African countries, the spread of HIV in Senegal often takes place in an environment marked by poverty, poor health and little education, especially among women. Living conditions for the majority of the Senegalese population has worsened over the past two decades. According to the World Bank, per capita income in Senegal, which is \$710, decreased at an annual rate of -0.6 percent during the 1980s. At the same time, the foreign debt, which represented 50.5 percent of the GNP in 1980, rose to 66.5 percent in 1990. In 1990, life expectancy was approximately 47 years, and the mortality rate of children less than 5 years old was estimated to be 189 per 1000 live births.<sup>[6]</sup>

The national maternal mortality rate was estimated to be 600 per 100,000 live births

in the years 1980-1990. Only 50 percent of births were attended by a health care professional.<sup>[7]</sup> Between 1960 and 1986, national health expenditures decreased from 1.5 percent of the GNP to 1.1 percent; population growth, however, increased at a rate of 2.8 percent between 1960 and 1980.<sup>[6]</sup> In 1990 the total fertility rate for women was 6.4, while only 11 percent of married women of childbearing age were using contraception.<sup>[7]</sup>

The illiteracy rate, which is 63 percent for the general population, is 75 percent for women. The girl-to-boy ratio is 72:100 in elementary schools and 51:100 in secondary schools. The gender disparity in the work place is more than double that in education: women represent only 17 percent of the total work force.<sup>[6]</sup>

### **Women and HIV/AIDS: Research Gaps**

Since HIV in Africa is mainly transmitted through heterosexual contact, integrating women into studies about HIV risk factors is essential. However, until very recently research in Africa focused mainly on commercial sex workers and did not acknowledge the need to pay attention to women in the general population. Moreover, the research that was conducted followed a biomedical and epidemiological orientation, and did not pay attention to the social, economic and cultural factors which greatly influence women's roles and thus their risk of HIV infection. As a result, little data are available in Africa, in general, and in Senegal, in particular, about the relationship between women's ethnicity, their sociocultural and economic status, and their sexual behavior.

Furthermore, although research in Africa and from around the world has identified the presence of sexually transmitted diseases (STDs) as a risk factor for HIV infection <sup>[8,9,10]</sup>, little research has been done on how STDs are interpreted and treated by men and women in local communities.

## 2. PURPOSE AND OBJECTIVES OF THE PRESENT STUDY

Typically, HIV/AIDS prevention programs have had difficulty accomplishing substantial risk behavior modification because of limitations in the ways in which target communities are approached and in the knowledge of the endogenous environment. Prevention programs often do not take into account the cultural environment and the economic and social realities of people at risk, especially women. In order to design an effective HIV prevention program, therefore, it is important to design prevention strategies that actively involve the local community and match the characteristics of the local culture.

The main objective of this study was to formulate a community strategy for information and education on HIV prevention. This strategy involved utilizing women's traditional organizations that counsel women in the areas of reproduction, maternal health, and eroticism as communication channels. The two groups studied were the Dimba and the Laobe. The Dimba act as a childbirth and maternity support group for women living in "abnormal" social situations. They are responsible for matters relating to reproduction and the health of the mother and child within the community. Organizations similar to the Dimba exist in all ethnic groups in the southern part of Senegal, as well as in Guinea Bissau, Guinea and Mali.

The second group studied, the Laobe, are a nomadic ethnic group in Senegal, whose women are considered knowledgeable about eroticism and have a quasi-monopoly over matters relating to sexuality in the society. For example, it is socially acceptable for Laobe women to talk in graphic terms about sexual matters and to also be aggressive in pursuing certain men in whom they are interested.

To accomplish our main objective a number of secondary objectives were defined. These were:

1. To describe the structure and functions of the Dimba and Laobe, as well as their social influence on the local community;
2. To determine beliefs, attitudes, and behaviors associated with sexuality and STDs as well as the levels of knowledge about these topics among women and men in Kolda;
3. To identify sexual, reproductive, and therapeutic practices that increase women's risk of HIV infection, and the factors that promulgate their use; and
4. To identify ways to integrate STD/HIV prevention messages into the recommendations of the Dimba and Laobe.

### **The Research Site**

We conducted our study in the city of Kolda, the capital of the region of the same name. The Kolda region is located in the south of Senegal, in the eastern region of old Casamance. Kolda covers an area of 21,011 square kilometers, and has a population of 570,000. The region includes the departments of Sedhiou, Kolda and Vélingara. The department of Kolda has a population of 184,027 spread along main roads and along the borders of Guinea and Gambia. The last national census (1988) shows that the city of Kolda had a population of 34,337, divided into nine neighborhoods. The population's main ethnic groups are: Fulbe (Peul Firdou) (56 percent); Manding (17 percent), Wolof (7 percent); Diola (5 percent); and Balant (1 percent). The standard of living is fairly low. The population is comprised mainly of farmers. The region is marked by ongoing migration to the major cities and to other regions in Senegal.<sup>[11]</sup>

Health and sanitary conditions are very poor in the south of Senegal, particularly in the Kolda region. In 1988, the patient to doctor ratio was 148,300:1 (compared to the national ratio of 13,060:1), the patient to nurse ratio 14,468:1, and the ratio for (modern) midwives was 59,320:1. In 1988, the illiteracy rate was 73 percent for men and 90.1 percent for women. The mortality rate for children under 5 years of age was 191 per 1,000 in the department of Kolda.<sup>[12]</sup>

Many people travel through the Kolda region because many major travel routes between Senegal, Guinea, Guinea Bissau and Gambia, and between the southern, central, northern, and eastern regions of Senegal intersect at Kolda. The Kolda region lacks the technical means for HIV testing, and the region is not incorporated into the national AIDS prevention program. As a result, the impact of migration on the prevalence of HIV in this region is unknown.

The only available HIV/AIDS data for the city of Kolda are the results of blood tests done in Ziguinchor, which were obtained from CSWs working in Kolda in 1990. From these test results, the prevalence of HIV infection among CSWs was established to be one in four.

### 3. METHODOLOGY

The usual qualitative tools and methods used in field research were employed in this study, as well as quantitative methods that utilized questionnaires. Table 1 summarizes the study design and research methods used.

#### Qualitative Research Methods

##### *Participant Observation*

Participant observation techniques have been used in other settings and contexts for sociobehavioral research on sexuality and on sexual behavior <sup>[13]</sup>. The basic idea is to observe the study population as they go about their lives and to share in some or all of their activities. We conducted participant observation with the Dimba, Laobe, and with commercial sex workers.

**The Dimba.** The process of integrating the Dimba into this research project involved introducing members of the research team (3 men and 2 women) to a Dimba group in Kolda. This occurred in several phases and followed traditional introduction procedures. The researchers first had to find an intermediary who was the same age as the Dimba group leader: an intermediary of the same age would have the stature and the ability to discuss matters with the group leader. The role of the intermediary was played by the principal researcher's mother, who resides in Kolda and carried out the necessary introductions.

Second, the research team needed to be introduced first to the male and female hierarchical leaders within the Dimba group followed by the entire Dimba group. These introductions were conducted in accordance with traditional rites and ceremonies. According to tradition, an introduction should always be the occasion for a traditional ceremony. During these ceremonies, the researchers witnessed and participated in dances, chants, offerings, prayers and other Dimba rituals. From this moment on, the

**Table 1. Study Design**

Research	Data Collection Methods	Sample	Type of sampling
Qualitative Research	Participant Observation	2 Dimba groups	purposive
		1 Laobe group from Kolda & Médina Wandifa markets	purposive
		1 nomadic Laobe group moving from one weekly market to another	purposive "snowball" selection
		Sex Workers and Clients from 1 Kolda hotel bar 2 "clandestine" bars	purposive
	Discussion groups	4 Dimba "general assemblies" each gathering included 500 to 1000 people	purposive: natural groupings
		4 small group discussions with 2 groups each of Laobe and Dimba women	purposive: natural groupings
	Individual interviews	5 neighborhood chiefs & their first wives	purposive
		25 key informants: midwife, female nurses, sex workers, elementary school teachers, high school girl customers of Laobe, parents of Dimba, landlord of Laobe, itinerant merchants	purposive: "snowball" selection
		64 Dimba women	purposive
		16 Laobe women	purposive
Life Histories	11 men & 14 women of the Bouna Kane neighborhood	questionnaire respondents	
Quantitative Research	Questionnaire	250 women, 250 men of Bouna Kane, Sikilo, Bantagnel, Sarè Moussa, and Gadapara neighborhoods	simple random sampling
	Review of records, documents	medical records and health service documents (e.g. consultation registry at outpatient STD clinic, 1990 CSW HIV test results, etc.)	

research team was considered a legal subgroup of the Dimba, with the right to take part in all Dimba activities.

At the beginning of the research period, the sample comprised one Dimba group from the Sikilo neighborhood in Kolda. This group was chosen because of the following criteria:

- a) The group's members included representatives from all of Kolda's ethnic and religious groups.
- b) The group was considered to be one of the most dynamic in the city of Kolda. The group was made up of about 50 active members who participated in all the ceremonies that the group organized and about 100 others who only gathered for the larger ceremonies.

Later, the sample was enlarged to include a second Dimba group, which consisted of about 20 women who live in the Bouna Kane neighborhood. The Dimba of the Sikilo neighborhood recommended that we include other Dimba groups in the Bouna Kane neighborhood because they have symbolic alliances and mutual solidarity ties with them. Although there are three Dimba groups in the Bouna Kane, we were only able to work with one of these groups and for a relatively short time towards the end of the research period.

**The Laobe.** In order to carry out participant observation with the Laobe, contact was first established between the female members of the research team and Laobe women in one of Kolda's markets. The members of the team bought goods sold by the Laobe, as is done by other women in the city, and engaged them in informal conversation about the specific use of these goods, as well as sexuality in general.

Contact with the Laobe was maintained by repeated visits and continued purchasing of Laobe products. The team also traveled to weekly markets, as well as other vending areas and places where the Laobe women conduct traditional activities.

Convenience sampling was used to select informants. The availability of Laobe sales women who agreed to collaborate with our research team allowed the team to be introduced progressively to other Laobe groups in a "snowball" effect.

In addition to the Laobe of Kolda, we observed nomadic Laobe groups of women selling at the weekly markets in Diaobe, Salikégné and Saré Yoba, as well as groups of female Laobe restaurant owners in Médina Wandifa (100 km from Kolda) and in Louga in the north of Senegal.

**Commercial Sex Workers.** We also integrated commercial sex workers (CSWs) into our qualitative research sample because they have the same roles and responsibilities as well as share the same social obligations as other women, such as sisters-in-law and mothers. They are sometimes members of the Laobe and the Dimba, as well.

We regularly visited the places where sex workers meet with customers. We observed them in hotel bars, which are considered the meeting place for the well-to-do, and in two "clandestine" bars (that sell illegal drinks), which are considered meeting places for men of modest income.

### *In Depth Interviews*

We conducted in-depth interviews using guides tailored to fit the profile of the interviewees. We administered these interview schedules to the following informants:

1. Community Leaders

- 5 neighborhood chiefs and their first wives resulting in a total of 10 interviewees

2. 25 Key Informants in the Community

- 2 men who "host" the Laobe women when they are in town
- 2 female nurses
- 1 midwife

- 3 sex workers
  - 4 elementary school teachers
  - 2 Dimba spouses
  - 5 Laobe customers
  - 2 sisters of the Dimba
  - 2 high school girls
  - 2 itinerant merchants
3. 64 within the Dimba:
- 2 female spiritual group leaders
  - 2 "mothers" of groups
  - 8 members of a Dimba advisory group
  - 5 elderly Dimba women
  - 22 adult married Dimba
  - 13 young married or divorced Dimba
  - 2 male leaders and traditional healers of the Dimba group
  - 4 traditional healer's assistants
  - 6 griot-musicians having ties with the Dimba group
4. 16 within the Laobe:
- 2 elderly women of the Kolda and Médina Wandifa Laobe groups
  - 14 Laobe women (5 at Kolda, 4 in the weekly market, 2 at Louga and 3 at Médina Wandifa)

### *Group Discussions*

The group discussions which were conducted with the Dimba and Laobe essentially were of two types:

1. With the Dimba, four large general assemblies were organized and served as the setting for research and intervention activities. These assemblies involved Dimba members and women from one or more neighborhoods.
2. Four small groups led by female researchers were conducted with the Dimba and the Laobe. The first group consisted of 9 Dimba; the second of 8 Dimba; the third group consisted of 4 Laobe; and the fourth of 6 Laobe. Two discussion sessions were held with each group.

### *Life Histories*

As described below, a questionnaire was administered to a random sample of male and female residents of Kolda. We focused on the Bouna Kane neighborhood, whose residents we hypothesized were at higher risk for HIV due to the fact that they were poor, included non-registered CSWs and international travellers. After the questionnaire was administered, respondents over the age of 40 years were asked to participate in detailed interviews to retrace their sexual life history. Selected on the basis of their willingness to collaborate, the sample population included 25 adults (14 women and 11 men).

### **Quantitative Research**

#### *The Questionnaire*

A random sample of 500 people (250 women and 250 men) were selected to respond to a questionnaire. The sample was composed of 100 people—50 women and 50 men—from each of five neighborhoods.

We first selected four neighborhoods—Sikilo, Bantagnel, Saré Moussa and Bouna Kane—where organized Dimba groups reside. Then we looked for a neighborhood that did not have any Dimba groups. Three neighborhoods with no Dimba groups were identified and of these we chose the one that included a representation of all ethnic groups in the region. This was the Gadapara neighborhood, which was also advantageous because some Laobe women live there.

The people to be interviewed were selected on the basis of a random selection of houses. The houses were chosen based on an aerial photograph of the city of Kolda. Each house in the neighborhood was assigned a number. Ten houses from each neighborhood were chosen at random.

A man and a woman (of at least 15 years of age) were selected randomly from among the residents of each house. However, bias was introduced into the selection when at times the head of the household would not allow us to interview the person that was randomly selected, saying it was indecent to interview a young person without the parents being present. The head of the household would then designate another interviewee. This occurred 15 times during the time surveys were administered.

### *Clinical Records and other Documents*

During the entire study, we examined medical records as well as diverse health service documents such as the consultation registry at an outpatient STD clinic, 1990 results from HIV tests of CSWs, and HIV data from the registry of officially-licensed CSWs.

### **Analysis**

An analysis of the qualitative research data was performed throughout the research period by using the usual techniques of qualitative analysis:

- The tapes of interviews were transcribed and key messages and themes identified.
- The key messages were ranked in terms of frequency of response. Comparisons were made between groups and between variables to confirm reliability of the answers.

Analysis of the data gained from the questionnaires was done by computer with the MacSS ( Macintosh Statistical System) software package. Statistical techniques were used and allowed us to:

- generate frequency tables
- make comparisons using the Chi square test and the Kruskal-Wallis ANOVA test.

## 4. RESULTS

The results section is divided into two parts. The first presents the findings related to risk factors for HIV infection. The second part describes the structure and functions of the Dimba and Laobe, their influence in the community, and results from the pilot intervention.

### **Sociocultural Risk Factors for HIV Infection**

#### *Transmission and Treatment of Sexually Transmitted Diseases*

According to estimates of doctor's visits for the entire country of Senegal, STDs represent approximately 20 percent of all out-patient visits. Gonorrhea is estimated to be the cause for up to 5-10 percent of all out-patient visits, syphilis accounts for 1.2 percent, and chlamydia accounts for 12 percent of visits. Candida infections, herpes infections, and hepatitis B are other STDs which are prevalent throughout different regions of the country.<sup>[14]</sup>

Epidemiological data about STDs are scarce in the Kolda region. However, analysis of the available outpatient data shows that STDs are the fourth leading cause for doctor's visits, after malaria, diarrhea and dermatological infections. In addition, available data revealed 107 new cases of sterility among women in 1989, and 122 in 1992. It is estimated that throughout the country, 60 percent of sterility cases are caused by STDs.<sup>[14]</sup>

It is difficult to obtain reliable data about the number of consultations made to traditional doctors to treat STDs. According to the questionnaire we administered to 250 men and 250 women, one-fourth of the men and women who were surveyed said that the first time they consulted a traditional doctor who had ties to the Dimba was for a health problem categorized as an "illness of men" or an "illness of women," or because they suspected that either they or their spouse was sterile. (An "illness of men" and an "illness

of women" are illnesses whose symptoms appear on the genitals.)

Observation of one Dimba father and one Dimba spiritual leader showed that each had 3 to 12 consultations a day for "illnesses of men and women" (i.e. STDs). A traditional doctor may be the first person consulted when an individual is sick. They are sometimes seen while an individual is getting treatment from a hospital or health center. The point at which an individual consults traditional doctors depends on the diagnosis the individual, his family members, or the community makes and the severity of symptoms of his/her illness.

Traditional doctors with ties to the Dimba very often have detailed knowledge of illnesses that modern medicine categorize as STDs. During an interview conducted by a male and female physician with the Dimba father and spiritual leader, they gave descriptions of symptoms that the physicians identified as syphilis, gonorrhea, hepatitis B, and herpes. Although the traditional doctors and the physicians offer the same description of the symptoms of these diseases, they differ on the cause, the mode of transmission, and the treatment.

For illnesses which modern medicine categorize as sexually transmitted diseases, particular aspects of the *Peul*, *Balant* and *Manding* therapeutic systems that we studied through our informants found no direct link between transmission of these illnesses and sexual relations in most cases. The most frequently cited causes of transmission of these illnesses are:

- Urinating on the urine of someone who has a disease. This releases vapors from the ground which contain germs from the diseased person.
- Because the toes and heels are very sensitive to penetration by germs, walking barefoot over a soiled area can result in contracting a disease.
- Diseases that pertain to this category are associated with supernatural forces which are carried by the wind at certain times of the day or night within certain areas and are considered dangerous at the mystical level. Therefore, one can

contract these diseases by encountering this "bad wind."

- Curses made by certain people can cause the same symptoms as sexually transmitted diseases.

However, there are cases where the traditional system acknowledges that a disease could be transmitted sexually (for example, some pelvic pains among women) but such cases are rare and considered exceptions. For example, some men are said to place "traps" in the form of medication in their wife's genitals. These "traps" are expected to cause illness to any man who has sexual contact with the wife. The husband, however, is protected against the disease by an antidote. His wife is also protected because the medication was not meant for her.

It is believed that only men can transmit diseases contracted through non-sexual means to the women during sexual intercourse and not vice versa. This explains why men who are treated by the formal health system for sexually transmitted diseases continue to have unprotected sex with their partners. Although the women may be infected, the men do not perceive the women to be a source of re-infection. In the traditional therapeutic system, women may receive different treatments for "women's illnesses" which may help them develop some immunity to reinfection. Although in certain cases sexual intercourse is forbidden during traditional treatment of STDs this sanction is not associated with the possibility of reinfection, but rather with the concern that the effect of the treatment could be neutralized.

The traditional therapeutic systems studied acknowledge that there are some ways reinfection after treatment can be prevented. The means most frequently cited by informants is a belt made of fine cotton thread or of leather, upon which pearls, small pieces of wood, or talismen are attached. This type of belt, which men or women fasten around the waist, is considered protection for adulterous lovers against the "trap" set by the husband who is being fooled into thinking his wife is faithful. They also serve to "immunize" the woman from diseases she may contract from men.

According to Dimba informants, hospitals are more effective in treating certain infections. However, modern medicine cannot cure the most serious illnesses which are those in which supernatural forces intervene or where a curse has been made. These only can be cured by appropriate specialists of the traditional system. So when a modern physician announces that AIDS is an incurable disease, the traditional therapist does not find this to be a novel revelation. For example, among the Diola, there is a disease which cannot be cured by modern medicine. This disease starts among women as pelvic pain. As the disease worsens, the woman experiences extreme weight loss. The disease could lead to death if not treated by a traditional doctor. So if a woman was hospitalized but was diagnosed by the traditional system as having this disease, there is a high probability she would leave the hospital to go to a traditional therapist.

Traditional treatment of certain infections can increase the risk of HIV infection. This is especially true in cases in which surgical operations are performed that cause tears in a woman's genitals. The tears make the woman more vulnerable to viral infection during sexual intercourse with an HIV sero-positive male. For example, a disease known by the Diola and the Manding is diagnosed by lumps of fat or pimples that contain "germs" which develop in the vagina. It is believed that if the pimples are not removed they can obstruct the vagina and lead to sterility, difficulty in child birth or unbearable pain during sexual intercourse. Therefore, therapeutic treatment of this condition, which involves incising the pimples with a blade or knife, may make the women more vulnerable to HIV infection.

### **Risky Erotic Practices**

In every society there are practices that are meant to increase sexual pleasure and excitement, as well as those that make individual sexual acts conform to society's norms. Some of these practices may present risks for HIV infection. This is true of the practice of inserting plant-based products, powder made from rocks, or small stones into the vagina before sexual intercourse. These practices are common in diverse parts of Africa

and may be associated with the rapid spread of HIV. Objects that are inserted into the vagina can irritate the vaginal mucosa and cause infections that could make women more vulnerable to HIV.<sup>[15,16]</sup>

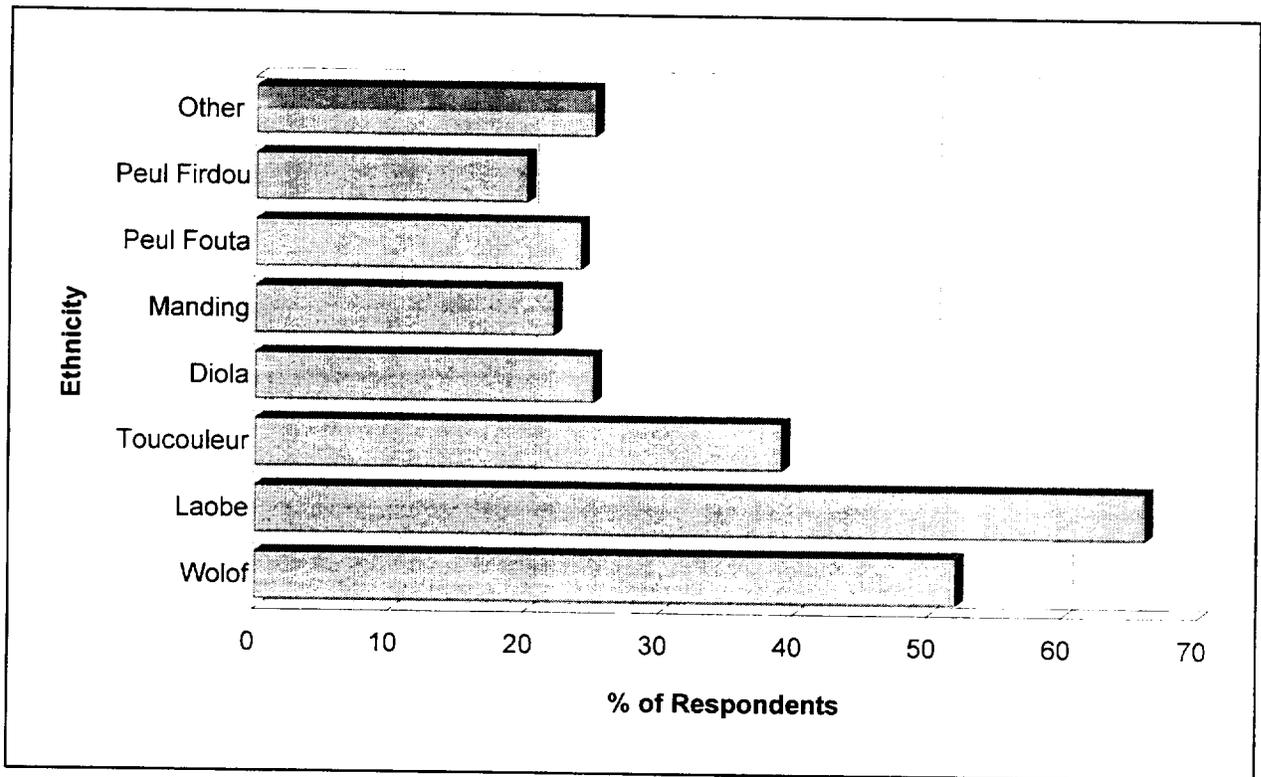
In Kolda, as in various locations in Senegal, these practices are meant to increase the pleasure of the man during sexual intercourse. People believe that the vagina is not a simple, natural object, but must bear the mark of artistic "work". These "works" may be perfumed scents (certain women place incense between their legs so that the smoke can perfume their vagina) and the insertion of erotic substances.

The Wolof call the insertion of these substances into the vagina *safal*, which means "increase the quality of the taste." This notion includes the idea of "making it better" or "improving the nature" of something. The objects inserted into the vagina may be dried roots from certain plants prepared by Laobe women or powder and small stones imported from Mali or the Middle East.

Among the 250 women in our sample, 196 responded to the question about whether or not they inserted erotic substances into the vagina. Sixty-six (39 percent) said they took part in this practice (Figure 1).

Although all ethnic groups were represented among those who responded affirmatively, the degree to which each was represented differed. A slight majority of the women from the ethnic groups originally from the south of Senegal or from Guinea (Diola, Manding, Peul Firdou, and Peul Fouta) responded negatively; while the majority of respondents from the ethnic groups from the north of Senegal answered positively. This was the case for the Laobe (even though the Laobe made up the smallest ethnic group in the sample), and the Wolof. Nearly 40 percent of the Toucouleur women indicated they have inserted substances in the vagina.

**Figure 1.** Percentage of Women by Ethnic Group Inserting Erotic Objects Into the Vagina



We did not find a significant difference with regard to practice of *safal* between women with higher levels of education and lower levels of education. However, there was a significant difference ( $p=.0079$ ) between the percentage of married women (24.1 percent) and single women (20.5 percent) who practiced *safal*. Among divorced women who represented 19 percent of the sample, the practice was more frequent, with 44 percent saying they practiced *safal*.

The following table shows there is also a difference between age groups in practicing *safal*. More respondents who were between the ages of 31 and 40 years practiced *safal* than women of other age groups. According to local perceptions, this is considered the age of sexual maturity for women.

**Table 2. Practice of *Safal*: Percent of Women Inserting Erotic Objects into the Vagina by Age Group**

Age Group (years)	Percent
Less than 20	12.5
21 to 30	34.2
31 to 40	38.6
41 to 50	30.3
51 and older	10.0

One of our Laobe informants explained the relationship between age and marital status with regard to the practice of *safal*. When a girl is young and single, it is the man who does the pursuing, the informant stated. The girl does not have to do much to attract the man besides allowing him to fantasize about what it would be like to make love to her. However, it is up to the divorced or married woman who is in a stable relationship to keep the man interested. She does this by always giving him the impression of rediscovering sexual pleasures every time he has sex with her. This way he will never pursue other women.

According to informants, another practice that makes a woman more vulnerable to HIV infection is that of cutting bumps and warts that are in and around the vagina with a blade. Such vaginal incisions are done at the request of and for the pleasure of the husband by allowing easier penetration of the penis into the vagina. This practice (*socant* to the Wolof) is found among all ethnic groups, but is more prevalent among the Pulaar group that includes the Toucouleur, the Peul Firdou and the Peul Fouta. In accordance with Pulaar tradition, the husband asks for the incision to be done using symbolic language. He does this by placing a razor blade next to a gourd container for water in the bathroom (where the couple takes their bath every morning). Upon seeing this, the wife, knowing what the objects symbolize, finds an elderly woman to perform the operation.

When asked about this practice in our survey, none of the female respondents admitted to having practiced vaginal incision. However, during group and individual discussions, we found three Laobe women who acknowledged that they had growths removed from their vaginas. Women in all age groups who were surveyed knew about this practice, although the percentage of younger women who knew was less than the older group of women. There was a difference between the married women who knew (32.3 percent) and the single women who were aware of this practice (20.5 percent).

The anthropological literature describes female circumcision as a means of decreasing female sexual desire in order to limit her sexual activity and increase sexual repression.<sup>[17]</sup> It allows the man to have control over the woman. Although female circumcision is practiced among the majority of ethnic groups in Kolda, including the Toucouleur and the Diola, most informants had never heard of this explanation of the practice. We only heard this explanation among some informants of the Diola, Laobe and Wolof ethnic groups.

Studies have suggested that female circumcision (excision) can be a risk factor for transmission of the virus from one HIV infected girl to others when the same razor blade is used for an entire group of girls who are undergoing the operation. As a result, cross-transmission is highly likely during the operation.<sup>[17]</sup> With regard to the relationship between female circumcision and the prevalence of HIV infection, Hidry finds that there is no correlation between the practice and higher rates of HIV infection.<sup>[18]</sup> Although this may be true throughout the African continent, at the local level, for instance in Senegal, according to the HIV surveillance data, we found a higher rate of HIV infection among women from the southern region, where female circumcision is practiced extensively, than among women from other parts of Senegal where female circumcision is rarely practiced.

A correlation between the absence of male circumcision and higher rates of sexually transmitted diseases, including HIV has been found among men.<sup>[19]</sup> In Kolda, as

throughout Senegal, adult males are generally circumcised. However, some sub-groups among the Toucouleur practice a symbolic circumcision (a light incision on the foreskin that disappears after a while) in place of cutting the foreskin off. This practice, which is considered taboo in some parts of Senegal is identical in certain aspects to practices in other regions, as well as those mentioned in the ethnographic literature related to sexual mores.<sup>[20]</sup>

## **Sexual Behavior**

Epidemiological data have linked an increased risk of HIV infection with multiple sexual partners.<sup>[21]</sup> The number of partners and the frequency with which they are changed have become variables for studies on the risk factors associated with HIV infection.

Studies of multi-partner sexual relations, or the frequency of changing sexual partners, can be examined within the context of marital and extra-marital sexual activity.

### *Multiple Sexual Partners in Married Life*

**Having Many Wives.** Polygamous marriages are common throughout Senegal, including Kolda. All ethnic groups practice polygamy, although not to the same extent. Islam, which is the predominant religion in Senegal, recognizes polygamous marriages. Islam allows men to have up to four wives. However, it is possible to find traditional or Muslim dignitaries who have up to five or six or more wives. These cases are the exceptions, however.

Census figures show that 59 percent of married women live in polygamous households in Kolda. Among the 40 to 44 year age group the number is even higher (70 percent). Married girls 15 to 19 years of age are the least affected, with only 44 percent of them living in polygamous households.

Other forms of marriages, called secondary marriages, also exist. For example, besides his four wives, an older man may marry an elderly widow whom he visits less frequently than his other wives. The Wolof call this form of marriage *takoo*. These secondary marriages were not investigated in our study, although they seem to be rather common in rural areas and in the cities. They are not platonic relationships between the elderly because they do involve sexual relations.

Local communities exert a lot of pressure on people of a certain age to get married. Among certain Diola sub-groups, a form of secondary marriage exists which involves girls who are seasonal migrant workers in Kolda and other major cities across Senegal. This form of marriage, called *buuji* or *blood* in Wolof, lasts throughout the rainy season, when girls leave the urban areas to work in the countryside. While employed, and under pressure from the community, the girls temporarily choose a husband, who is generally married. It is understood that the girls are there only for the rainy season.

**Changing of Spouses.** Frequent divorce and remarriage is one way people change sexual partners. Data on divorce in Kolda are lacking. Among the sample group in our study, nearly 11 percent of survey respondents were currently divorced. Only 2.4 percent of the men were divorced, while the figure for women was 19.3 percent. The low number of divorced men is due to the fact that men re-marry faster than women. The figure for women may be higher because some societies consider divorced women without value (therefore some women may have been reluctant to disclose their true marital status). According to a 1978 survey on fertility in Senegal, one in 10 marriages ended in divorce after two years and 20 percent ended after six years. The divorce rate among the Pulaar is higher; 33 percent of first marriages ended in divorce. For women living in urban areas the figure is 27 percent.<sup>[22]</sup> Divorced women are relatively free from any family supervision, which makes them available for casual sexual relationships. (The Wolof call this *caaga*, which means both divorcee and prostitute.)

Another way to change partners is by marrying widows. While older men can marry

elderly widows in secondary marriages, it is the young men who are the beneficiaries of inherited widows. Marriages that involve inherited widows are considered real marriages. A man can inherit the wife of his eldest brother, but the eldest brother cannot inherit his younger brother's wife. *Lèvirat* (where a husband dies and the wife is taken by his brother) and *sororat* (where a wife dies and the husband takes the wife's sister) are practiced by all ethnic groups, although the frequency with which they occur cannot be determined. One may notice, however, that marriage by inheritance often is concomitant with polygamy.

### *Extra-Marital Sexuality*

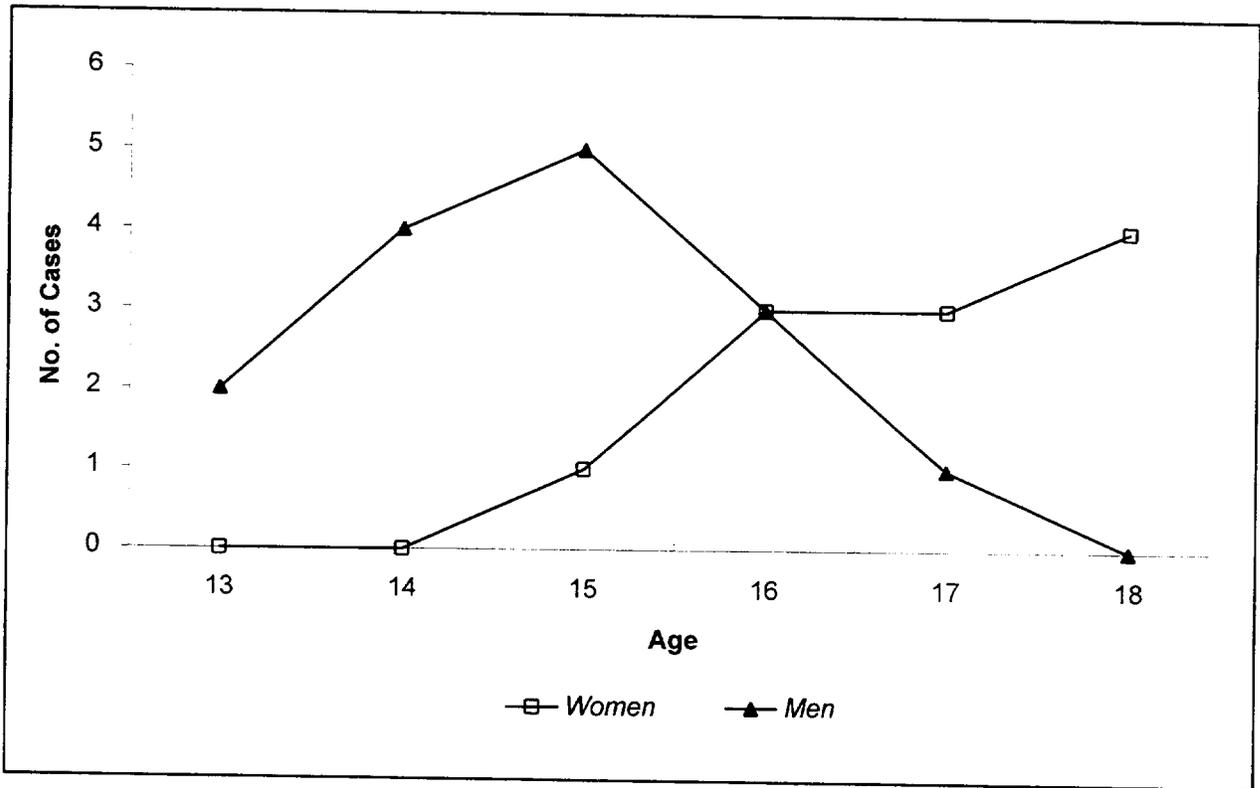
Data about the first sexual experience and first marriage gives some indication about pre-marital sexual behavior among the Peul Firdou.

In the life histories gathered after administration of the questionnaires, most women acknowledged having had their first sexual experience between the ages of 13 and 15, while the men acknowledged to having theirs between 16 and 18 years (see Figure 2). However, official statistics from Kolda show that the age of first marriage for women is 16, while for men it is 26 <sup>[22]</sup>. We cannot affirm that the data based on the life histories, presented below are representative of the general population because of the small size of our sample and the method of sampling used.

An analysis of the responses from the questionnaires about the sexual behavior of young women, young men, married women and married men gives an idea about the extent of partner change and what are perceived to be the motivations for sexual relations.

A majority of those surveyed think that the frequent changing of sexual partners is a phenomenon that is widespread among the younger generation living in Kolda. There were no significant differences according to gender and ethnicity. Table 3 illustrates people's opinions on how many young girls frequently change sexual partners.

**Figure 2. Reported Age of First Sexual Experience Males and Females**



**Table 3. Survey Respondents' Perceptions about the Numbers of Young Girls who Change Sexual Partners Frequently**

Perception	Women's Responses		Men's Responses		Total Responses	
	N	Percent	N	Percent	N	Percent
Almost all young girls frequently change partners	23	9	28	11	51	10
Many	115	46	129	52	244	49
Few	61	25	57	23	118	24
Almost none	14	6	6	2	20	4
None	35	14	29	12	64	13
<b>Total</b>	<b>248</b>	<b>100</b>	<b>249</b>	<b>100</b>	<b>497</b>	<b>100</b>

**Note:** The total sample consisted of 250 women and 250 men. Missing cases excluded.

The analysis of respondents' opinions of how many young men frequently change sexual partners gives a comparable result. The majority from all ethnic and age groups think that many young men frequently change sexual partners.

According to survey respondents, the principal motivation for young girls to change sexual partners is financial -- to buy clothes or personal items and to feed their families. As noted in Table 4, sexual pleasure was not the main reason given by respondents as to why these girls frequently change sexual partners.

**Table 4. Motivations for Frequent Change of Sexual Partners Among Girls: Perceptions of Survey Respondents**

Type of Answers	N	Percent
Satisfy need for clothing & personal items	203	40.9
Help feed the family	97	19.5
Care for children	24	4.8
Satisfy personal pleasure	91	18.3
Have a child	10	2.0
Other reasons	19	3.8
No opinion	53	10.7
<b>Total</b>	<b>97</b>	<b>100.0</b>

**Note:** Missing cases excluded.

Frequent partner change among young women can be seen as a response to a number of phenomena in a rapidly changing environment. One of these is the growing trend away from early marriage. Since girls are marrying at a later age, those who are old enough to get married, but are unemployed, are often embarrassed to ask their parents for money to buy clothes and personal items. With limited education and no marketable job skills, girls who must fend for themselves resort to using their sexuality for financial gain. A girl may have several lovers at the same time in her search for optimum financial gain.

Mechanisms that regulated sexual behaviors of unmarried girls have broken down, resulting in greater freedom of association and increased mobility that removes them from direct control and supervision of their parents.

The majority of those sampled also believe that almost all or many married men and women have numerous extra-marital relationships as illustrated in Table 5.

**Table 5. Survey Respondents' Perceptions about the Number of Married Men and Women who have Extra-Marital Sexual Relations**

Perception	Responses About Married Men's Behavior		Responses About Married Women's Behavior	
	N	Percent	N	Percent
Almost all have extra-marital relations	38	8	23	5
Many	233	47	231	47
Few	137	28	144	29
Almost none	5	1	25	5
No opinion	80	16	71	14
<b>Total</b>	<b>493</b>	<b>100</b>	<b>494</b>	<b>100</b>

Note: Missing cases excluded.

The most frequently given answers about married women's main motivation for extra-marital relationships is the need for clothes and personal items, as well as the need to feed their family. The introduction of a monetary economy, as well as ecological and agricultural crises, have led to a steady disintegration of families' coping mechanisms with a concomitant change in the roles and responsibilities of individual members. The family is often no longer able to provide its own food, a responsibility which traditionally has been that of women. Many women then have developed a kind of "crisis management culture," meaning a set of survival strategies designed to provide food for their families in the face of a precarious food situation.

**Table 6. Motivations for Extra-Marital Relationships Among Women: Perceptions of Survey Respondents**

Type of Answer	Men's Answers		Womens's Answers		Total Answers	
	N	Percent	N	Percent	N	Percent
Satisfy need for clothing & personal items	82	33	61	25	143	28.9
Feed their family	58	23	66	27	124	25.1
Care for children	14	6	13	5	27	5.5
Satisfy own pleasure	50	20	46	19	96	19.4
Have a child	2	1	8	3	10	2.01
Other reasons	14	6	11	4	25	5.1
No opinion	28	11	42	17	70	14.1
<b>Total</b>	<b>248</b>	<b>100</b>	<b>247</b>	<b>100</b>	<b>495</b>	<b>100.0</b>

**Note:** Missing cases excluded.

One motivation for extra-marital relations which was not mentioned by survey respondents, but was mentioned several times during qualitative interviews, was the need for money to satisfy social obligations of various family ceremonies (e.g. baptisms, weddings and funerals) which are women's responsibilities. These ceremonies are the occasions for lavish expenses and gift exchanges, which confer high social prestige on the donor. Family ceremonies are the one place where women exercise leadership and show solidarity, although they are often competing with each other. Depending on her position in the alliance network of women (e.g., sister, sister-in-law, aunt, mother-in-law), a woman (particularly the Wolof, Toucouleur and Laobe) has obligations for gifts and ceremony expenses *vis-à-vis* other women. If she does not meet these obligations, her status is demeaned in the eyes of the other women.

## **Commercial Sex Work**

Commercial sex work in Senegal is legal and has been recognized and regulated by a 1966 law which set conditions for its practice. To be a sex worker one must be an adult, be registered by the Health Service, and undergo periodic medical examinations. In 1991, 53 prostitutes living in Kolda were registered at the Health Center. Most of these women were not native to Kolda, ranged in age from 24 to 35 years, and were divorced mothers who often had primary or secondary education. Some registered prostitutes are Dimba, but rarely are they Laobe because Laobe women do not consider themselves to be prostitutes. One marked characteristic of registered CSWs is their extreme mobility. They often travel throughout Casamance and the rest of the country, stopping at tourist sites and major communication centers. Their clients are considered fairly well-off (tourists, civil servants, traveling managers, etc.).

Registered sex workers represent only "the tip of the iceberg" of sex workers in Senegal. The number of unregistered prostitutes far out-numbers registered prostitutes. These unregistered sex workers often do not view themselves as prostitutes because they usually have other functions and identities (housekeepers, itinerate merchants, high school girls and restaurant workers). Often in local communities, people associate itinerate female merchants with commercial sex workers. It is believed that these women use their buying and selling of merchandise as a cover for sex work and exchange sex for lodging, transportation or administrative transactions.

Commercial sex work is a high risk factor for HIV infection (and transmission) for both the sex workers and their clients. HIV prevalence data for the Casamance region based only on registered CSWs indicates an already high prevalence of 30.4 percent. If, as we have indicated, unregistered prostitutes outnumber registered ones, it can be assumed that the above figure underestimates the extent of HIV infection, not only among women engaged in the sex trade, but also among the general population. The mobile nature of commercial sex workers, and the difficulties in identifying which women

are engaged in the sex trade so that appropriate health services are made available and accessible, present formidable challenges for HIV/AIDS prevention efforts.

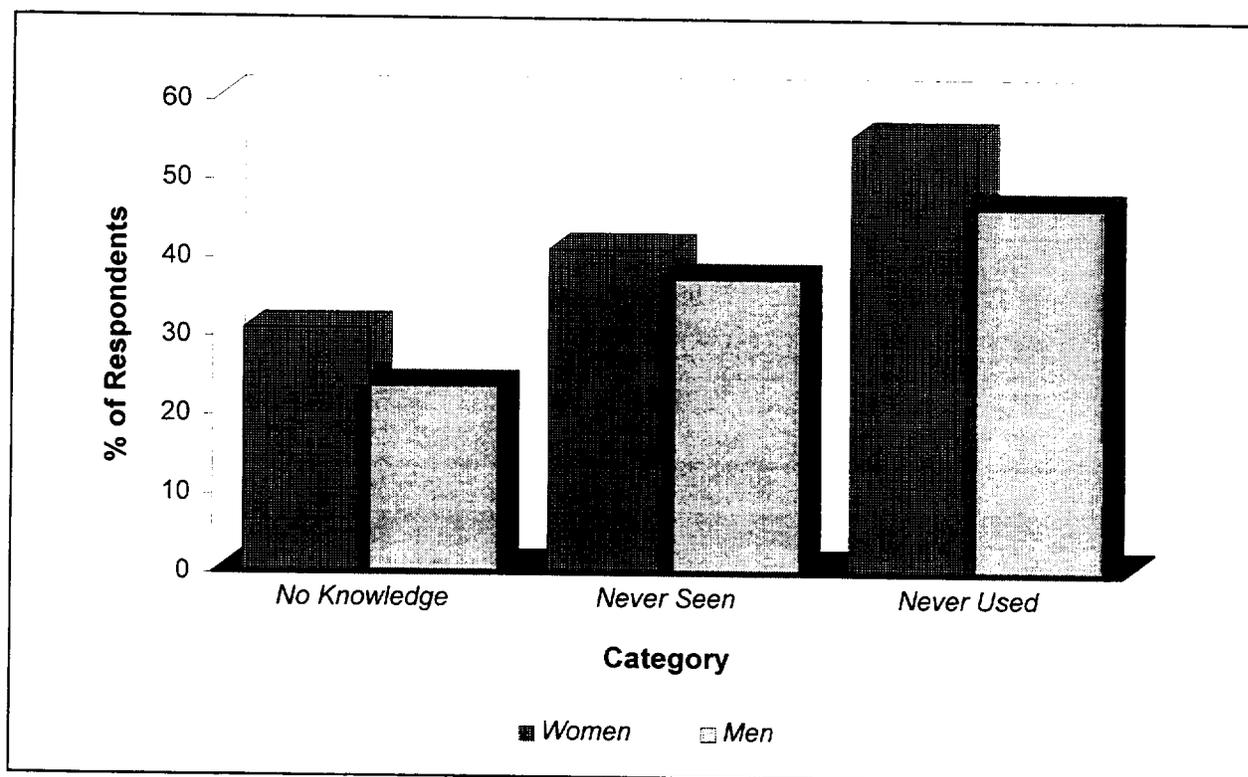
### **Condom Awareness and Use**

Because the condom is the only method known to-date which offers protection from HIV infection we wanted to find out if the study population knew about and/or used condoms. One of the most remarkable findings in our survey was how little people knew about condoms. The vast majority of our sample had never heard of them, and many others had never seen or used condoms during sexual intercourse (see Figure 3). The questionnaire, however, did not explore the frequency and ways in which condoms have been used by respondents.

Women's awareness of condoms was associated with level of education. Women with higher levels of education were more likely to have heard of condoms than women with little or no education. There was not a significant difference between ethnic groups and the ever use of condoms. There was, however, a marked difference between married, single, and divorced women in relation to having used condoms at least once during sexual intercourse. Among married women, one-half acknowledged they had never used condoms, compared to 38 percent for single women and 30 percent for divorced women. Therefore, divorced women were most likely to have used condoms than the other groups of women.

Among male and female itinerate merchants, (those who travel internationally as well as those who travel to in-country weekly markets) numbers were almost equal for those who had never used condoms and those who had used them at least once.

Figure 3. Knowledge and Use of Condoms of Male and Female Survey Respondents



For example, among the female merchants 17 reported they had used a condom at least once, whereas 19 said they had never used a condom. Eight male merchants reported ever use of condoms and nine reportedly never had sex with a condom.

During the in-depth interviews, all of the itinerate female merchants (although few in number) said that when they ask their partners to use condoms, they run the risk of being considered sex workers. One female merchant who travels often to Gambia, Mali and Guinea Bissau said:

*I don't need any condoms because I am not a prostitute. I have a husband and children. It is rare that during my travels I fall to the advances of a man. When I do, it is with someone that I trust. I only choose to have sexual relations with men who are clean and visibly healthy, polite, and capable of respecting me. These men know me, trust me and know that they don't need to use any condoms with me.*

## Traditional Contraceptive Methods

Although modern contraceptives are rarely used, traditional contraceptive use is widespread.<sup>[20]</sup> There are several types of traditional contraceptives including holy water, scarification, abstinence and the "belt". According to informants, the most commonly used traditional contraceptives are the belt made by traditional doctors and used by both men and women, and conjugal postpartum abstinence. The belt is made of a fine leather or cotton thread, from which twigs and talismen are suspended. These belts are thought to have properties that block the "vital principle" that affects fertility. In postpartum abstinence, practiced by the Manding and the Peul Firdou, the husband is forbidden to have sexual intercourse with his wife as long as she is breast-feeding. Breast-feeding usually occurs for about two years. Thirty-four percent of the women in our sample believed in this form of protection. They believed that "antagonism" exists between the sperm and breast milk. The sperm "pollutes" breast milk and exposes the baby being breast-fed to grave sickness, notably fatal diarrhea. Therefore, sexual intercourse is best avoided. Postpartum abstinence is easy to practice since the husband usually does not sleep in the same room as the breast-feeding wife. Among the Manding and the Peul Firdou who are influenced by the Manding, the wife and the infant share the same hut or *bumba*. (*bumba* means "main hut" in Manding.) In polygynous marriages, the wife, whose turn it is to sleep with the husband, joins him in his personal hut where she stays for a part of the night. As a result, when a woman is breast-feeding she experiences pressure from the other wives in the main hut to maintain abstinence and to stay away from her husband's hut. The mother of the one who shares the main hut is considered to be the traditional guardian of this prohibition. In non-polygynous marriages, the wife sleeps in a separate hut, or sometimes goes to her mother's family. Even if the spouses say they observe postpartum abstinence, it is probable that within the same period extra-marital sexual relations will occur.

## **AIDS Knowledge and Awareness**

Although there has been a campaign of HIV/AIDS awareness in newspapers, radio and television, 10 percent of our sample (28 women and 22 men in all age groups) acknowledged that they had never heard about HIV/AIDS. However, there were more people in the 51-year and older age group who had not heard of HIV/AIDS (32 people or 64 percent) than in other age groups. Eighty-eight percent of the people who had never heard about HIV/AIDS had no schooling, while the remaining 12 percent had only primary school education. All who received secondary or higher education acknowledged that they had heard about HIV/AIDS. An analysis of the responses to the question about knowledge of HIV/AIDS shows a marked difference between women with a high level of education and women with no or little schooling and their knowledge of HIV/AIDS. The more educated they were, the better knowledge they had of the disease.

A significant number of people are misinformed and have misconceptions about modes of HIV transmission. Survey responses showed that, of those who had heard of HIV/AIDS, 7 percent said the virus is not transmitted by sexual contact; 13 percent did not know whether the virus is transmitted through sexual contact or not; 10 percent disagreed with the statement that the virus is transmitted through blood; and 10 percent disagreed with the statement that the virus can be transmitted from a mother to her baby.

In addition, 110 of the people we interviewed (24 percent) think that HIV can be transmitted to someone who urinates on the site where someone who has the disease has urinated. Only 14 percent of this group believed the virus could be transmitted by sexual contact. Sixty-five people (representing 14 percent of all respondents who had heard of HIV/AIDS) stated that AIDS could be transmitted through a bad curse directed at someone. Twenty eight percent thought that AIDS is caused by a "bad wind" encountered at night. These data suggest that a significant segment of the study population integrated AIDS into their traditional belief system regarding other STDs.

**Figure 4. Awareness and Knowledge of AIDS by Neighborhood**

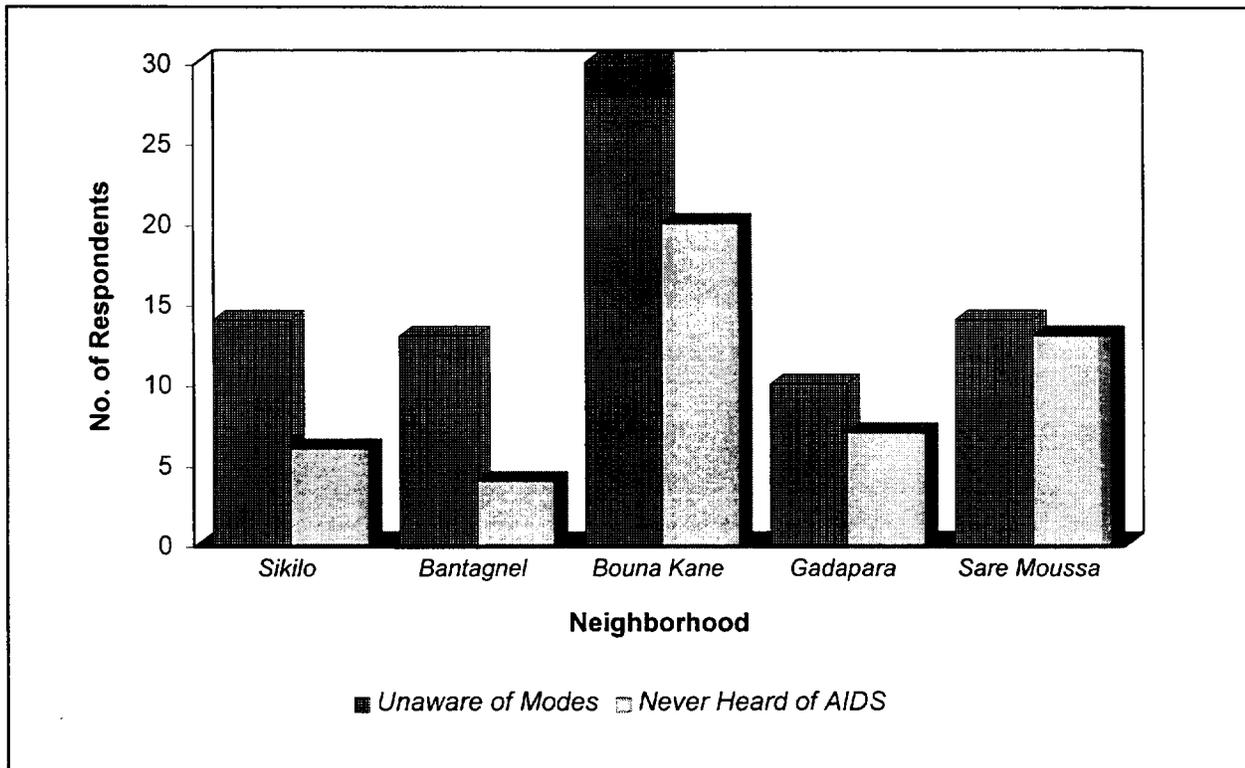
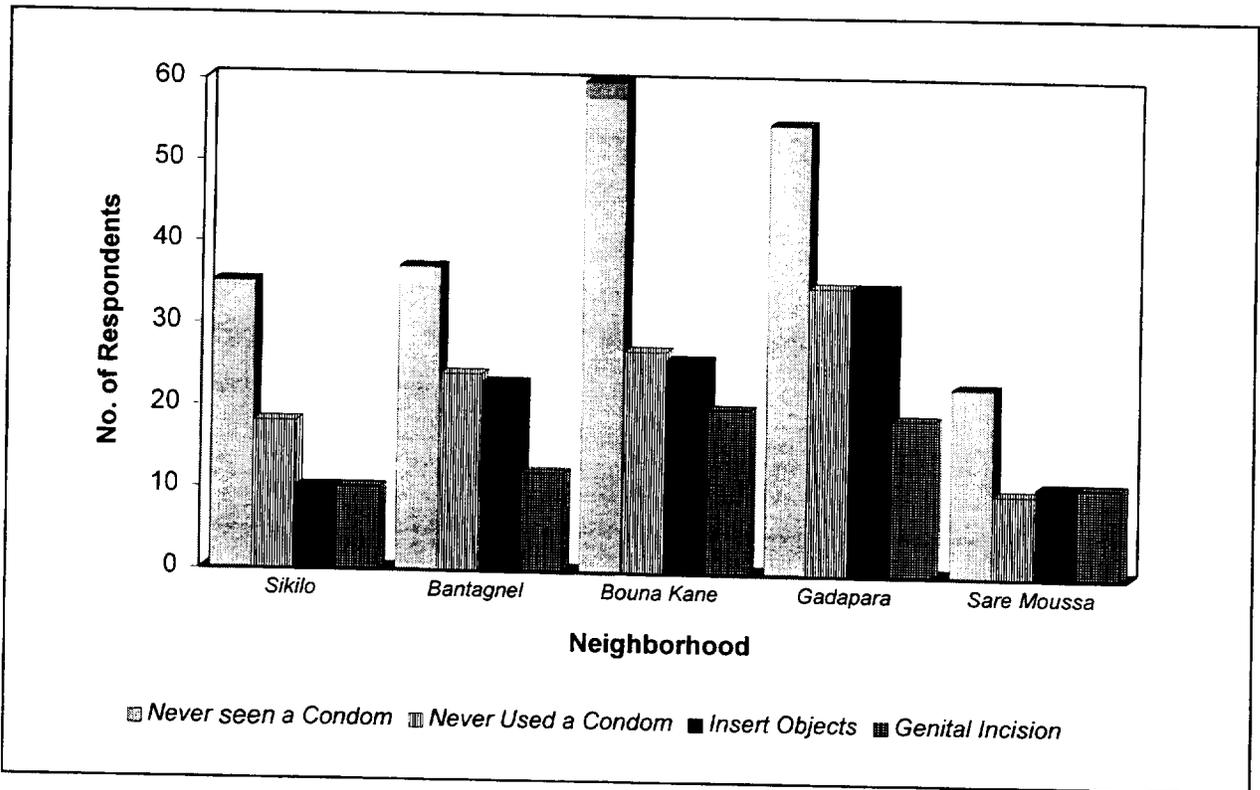


Figure 4 shows that the Bouna Kane neighborhood had the greatest number of people who did not know much about AIDS. Figure 5 shows that this neighborhood also had a large number of people who were ignorant about condoms and were involved in high-risk sexual behavior.

### **Male Migration**

The Peul in Kolda are a migratory culture. Migration is a necessary phase in the lives of young and adult men who must assume multiple responsibilities. They migrate in search of money for wedding expenses, household furniture and appliances, and clothing. Migration carries a meaning of value. It is getting away from daily village activities.

**Figure 5. Numbers Reporting Risky Behavior by Neighborhood**



Migration also may explain why in Kolda there are a greater number of women than men between the ages of 15 to 39, which is considered to be the most sexually active age group for men (Table 7).

In Kolda, men outnumber women from 40 years of age and older. This may be due to a high mortality rate for women in this age group and the fact that the men usually do not migrate at this age. Although men outnumber women in this age group, it does not mean these men are no longer interested in women. On the contrary, because of their polygamous society, older men (men of the age group where the man-to-woman ratio is greater) often have a second, third or fourth wife who is much younger than they are.

**Table 7.** Number of Men per 100 Women in the Departement of Kolda

Age Group	Percentage of Men
15-19	84.9
20-24	86.7
25-29	79.8
30-34	95.4
35-39	95.7
40-44	130.0
45-49	118.2
50-54	144.1
55-59	127.1
60-64	147.7
65-69	129.8
70 and over	124.9

*Source:* Ministère de l'Economie, des Finances et du Plan, Senegal: Recensement Général de la Population et de l'Habitat de 1988, September 1992.

Young men, on the other hand, often cannot afford to get married. They must delay marriage until they are able to gather the necessary funds to pay for marriage. One of the main reasons for seasonal migration is to earn enough money for wedding expenses. Since these men cannot afford to get married until later, they may have sexual relationships with married women. This is supported by data from the "life histories" which show that a woman's first sexual partner was usually her husband (especially in the Peul tradition where it is common for women to marry young and later experience great sexual freedom), while a man's first sexual partner was often was married woman.

Figure 6. Profile of a Woman's First Sexual Partner

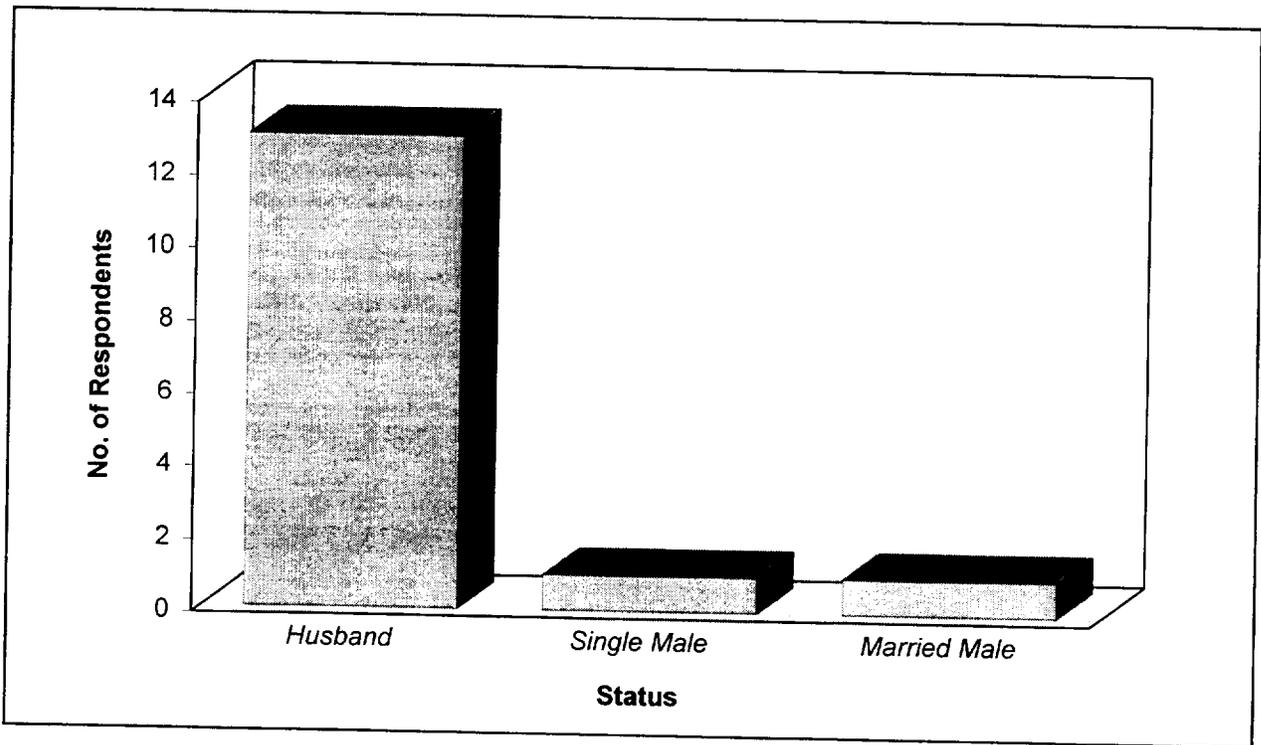
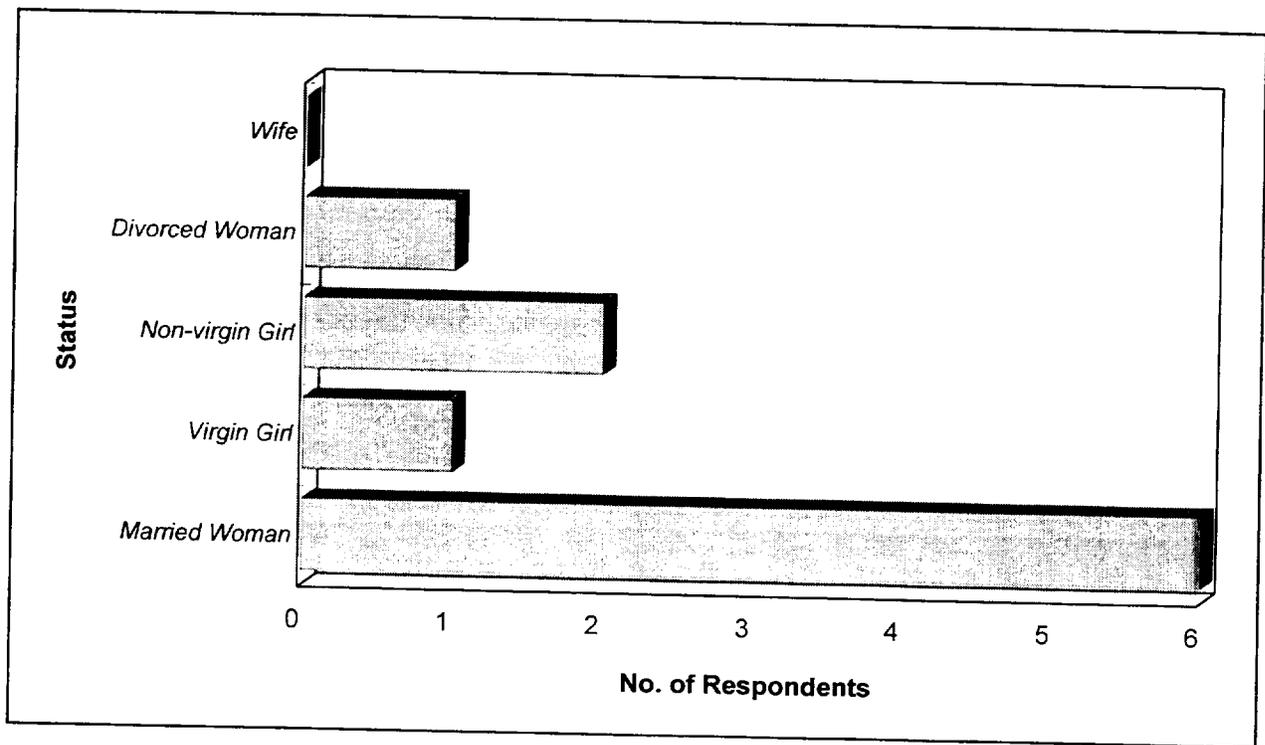


Figure 7. Profile of a Man's First sexual Partner



Since our sample of "life histories" only included adults over the age of forty, the data we collected are not representative of the younger generation. While many girls currently postpone getting married, they often engage in sexual activity which means that increasingly, their first sexual partner is not their husband.

## **The Dimba**

### *General Description of the Dimba*

The Dimba are a traditional women's organization that is found in all ethnic groups, but whose origin is difficult to trace. D. T. Niane traced the Dimba's rituals back to the Mali Empires which existed between the 11th and 16th centuries.<sup>[23]</sup> The Dimba include women living in the same village or neighborhood, regardless of their ethnic origin.

Dimba groups are made up of four categories of women:

- women who never had children due to sterility or repeated miscarriages
- women whose children died very young
- mothers of twins
- women who have adopted orphans

The Dimba's duty is to protect the mother and her newborn against anything that could endanger their health using rituals and prescriptions which they impose upon the entire society, including the men. For example, the Dimba have been known to remove a pregnant woman from her house and place her in another house where she would not have to do household chores or have sexual relations with her husband in order to protect herself and her unborn baby.

The Dimba constitute a powerful counter-force to male dominance. They often use the social weapon of derision to exert their power. The Dimba organize protest marches and use public nudity when there is injustice. They compose chants of mockery to ruin

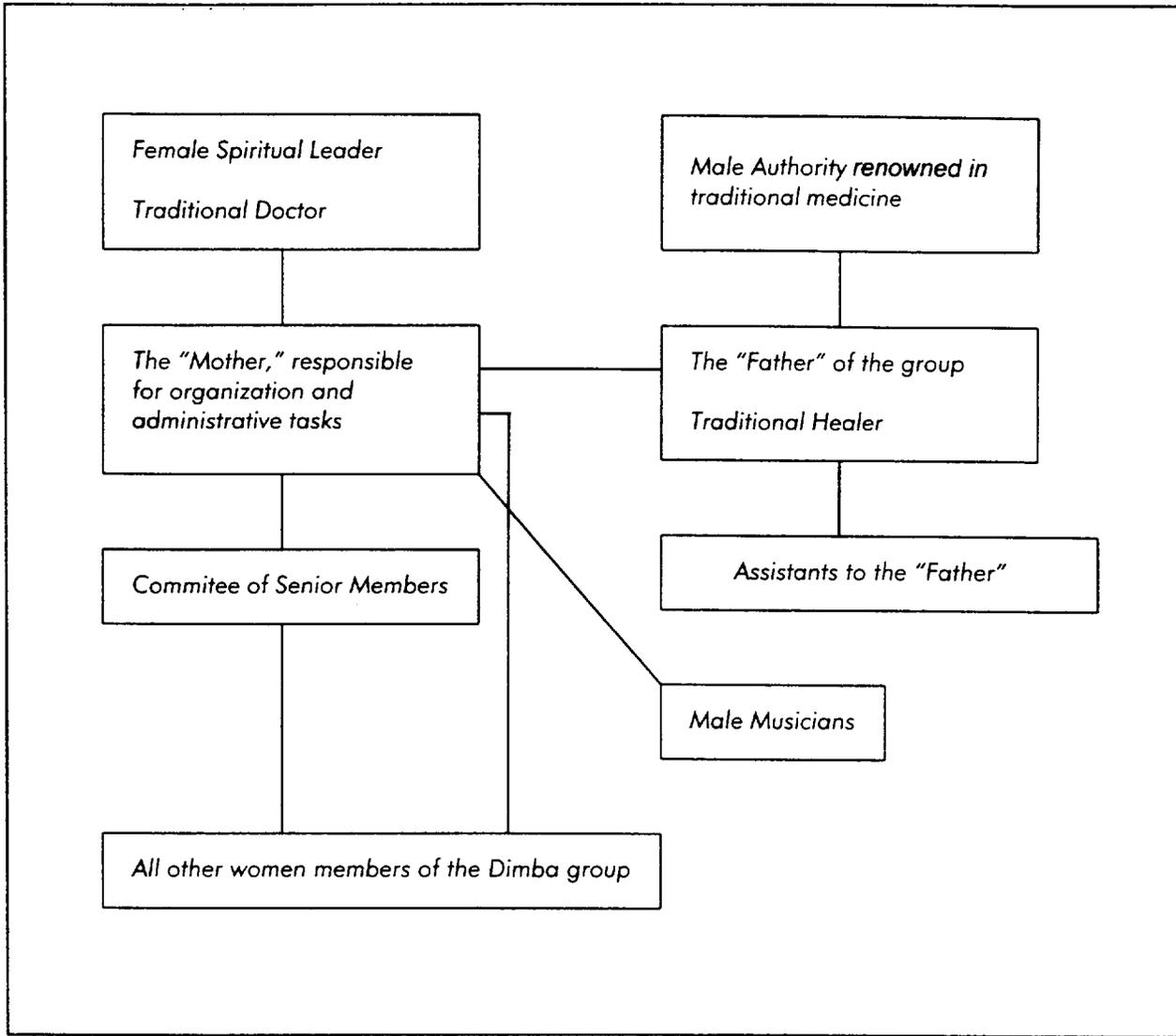
the reputation of the perpetrator of the injustice in the community. They use language that can be considered extremely indecent when used by others in the community and completely ignore all taboos of language for use in ridiculing any moral, political or religious authority.

Besides being well known for safeguarding maternal and child health, including the provision of prenatal care, they also intervene in questions relating to rainfall and soil fertility. Traditionally, the Dimba "open the farm" which is to give symbolic blessing at the start of the farming season. It is believed that the Dimba's prayers can make rain fall during severe periods of drought and ward off epidemics and natural disasters that threaten the community. The Dimba are also a solidarity group for women, who help each other with farming and assist each other socially and financially. Table 8 summarizes the aims and activities of the Dimba.

The Dimba are divided into functional groups, which organize various activities. Groups are generally made up of all Dimba members living in the same neighborhood. Those living in neighborhoods where there are not enough members to form a group join the next neighborhood Dimba.

As illustrated in Figure 8, the group has as its head an elderly woman considered to be the spiritual leader and who commands a lot of respect. She generally has a thorough knowledge of the treatment of women's and infants' illnesses. She visits women who have problems with reproduction or fertility and provides follow-up for prenatal and post-natal care. Next in rank is the "mother," who is in charge of organizing the groups and dividing administrative duties among them. She is surrounded by a group of three to six senior members who are her advisors and participate in decision-making. There is a lower body that gathers all the Dimba members of a neighborhood. The "mother" and the group of senior members call the lower body for neighborhood meetings.

**Figure 8.** Structure of the Dimba Group



Each Dimba group has men who are assigned to different activities:

- The "father" takes care of all the spiritual and therapeutic tasks that call for a man's presence. He treats individuals or couples who suffer from sexual or reproductive diseases. He has two assistants. The "father" gets a second opinion, when necessary, from a traditional doctor who is not a member of the Dimba group.
- The drummer, who is contracted, is in charge of music and animation at ritual ceremonies. He often has three or four assistants and receives instructions from the "mother."

**Table 8. Areas of Intervention and Actions by the Dimba**

Area	Objectives	Actions
1. Women's and men's fertility	Increase the number of live births and the birthrate	Antenatal, pregnancy and postnatal care for women
	Promote the psychological and ontological stability of the couple	Treatment of women for STDs, infertility, pregnancy-and-birth-related illnesses
	Promote harmony	Treatment of the couple for infertility or the death of their children  Psychological counselling of the woman or couple for infertility; temporary removal of infertile woman from her husband's house
2. Protection of women	Preserve women's health and psycho-social stability	Temporary removal of pregnant woman from her husband's house
		Ridicule or scorn the man
3. Protection of children	Prevent infant mortality	Care for infant illnesses
		Spiritual protection and care for newborns
		Temporary removal of newborn and mother from the husband's house
4. Women's solidarity	Promote family, social and economic stability	Help with harvesting, conduct prayers and spiritual actions, provide support system, work together in the community
5. Social action	Fight against injustice	Organize protest marches that may include public nudity and disregard for all political, social and religious norms
6. Soil fertility	Ensure good rainfall	Conduct rituals for rain and soil fertility
	Ensure a good harvest	"Open" the farming season
7. Environment	Respond to epidemics and natural disasters	Conduct prayers and other spiritual actions

### **The Kolda Dimba Groups**

The city of Kolda has four main Dimba groups located in the neighborhoods of Sikilo, Doumassou, Saré Moussa and Bantagnel. These groups are divided into sub-groups and have members living in all the neighborhoods in the city. One third (83) (33 percent) of the 250 women surveyed in our study said they were Dimba members. The distribution of Dimba members by neighborhood in our sample was as follows:

**Table 9.** Distribution of Dimba by Neighborhood

Neighborhood	Number of Dimba (N)	Percent of Female Respondents by Neighborhood
Sikilo	28	56
Bantagnel	4	8
Quartier Bouna	21	42
Gadapara	17	34
Saré Moussa	13	26

**Note:** 50 women were sampled in each neighborhood.

All ethnicities, including the Laobe are represented among the Dimba. All age groups also are represented as shown by the following table:

**Table 10.** Distribution of Dimba by Age Group

Age Groups	N	Percent
Less than 21 years	10	12
21 to 30 years	28	34
31 to 40 years	19	23
41 to 50 years	12	14
50 years and older	14	17
<b>Total</b>	<b>83</b>	<b>100</b>

Only 12 percent of Dimba women in our sample were less than 21 years of age (even though this age group represents 29 percent of our sample population). Their relatively low participation is due to the fact they are of an age when women are expected to experience few problems with childbearing, which is the main reason women join Dimba groups.

The marital status of our sample of Dimba was as follows: 52 were married, 27 divorced and 4 unrecorded cases. There were no "never married" women. Society feels that a woman must be married at least once to experience problems with childbirth. The expectation being that sexual activity and therefore pregnancy and childbirth take place after marriage. Recent data on marital status for women aged 15-19 years from the Demographic and Health Surveys shows that 71 percent reported getting pregnant after marriage, 18 percent before marriage and 11 percent had been pregnant but never married.<sup>[24]</sup>

Even though the majority of Dimba have had no schooling, we found some members who had primary and secondary education. We did not find a notable difference between the professional or commercial activities of Dimba and other women in our sample.

All the Dimba we interviewed joined the group after having difficulty getting pregnant, carrying a pregnancy to term, or keeping their babies alive. However, a woman who has difficulties with pregnancy does not automatically become a Dimba member. She must go through an integration ceremony to become a member.

A woman who wants to be a Dimba member must be sponsored by a member of the group, who introduces her to the group leader. The sponsor must follow a set of procedures (collect food from houses in the neighborhood, talk to the men of the group, etc.) and organize a ceremony of integration rituals for the newcomer. During the ceremony the new member receives the blessings and prayers of the group. Prior to the ceremony, a candidate may have already had therapeutic sessions with the female spiritual leader or the Dimba "father," who probably asked her husband to come for an interview and separate consultation. The goal of the consultation is to find out the cause of the candidate's illness which may be:

- an antagonism between the essence of the two spouses (the vital principles of the man and the woman can repulse each other and prevent impregnation).

- a case of evil forces, supernatural beings or of bad curses that prevent all attempts of impregnation and safeguarding the life of infants.
- a natural illness that can be cured by using plants or other therapeutic products.

In our sample, sterility, miscarriage, and the death of newborns were the most frequently cited reasons Dimba women first sought therapeutic consultation with either the Dimba father or with the spiritual leader (Table 11).

**Table 11.** Reason for the First Consultation with the Dimba Father or Mother

Reason	N	Percent
Infertility, miscarriage, or death of the newborn	65	79
Infertility problems of the spouse	6	7
Sick infant	6	7
Sexually transmitted disease	3	3
Other medical reason	3	3
<b>Total</b>	<b>83</b>	<b>100</b>

Although the question was not asked in the survey, observation revealed that people consulted either the "father" or the woman spiritual leader, for treatment for themselves, their spouses or their children. It was also observed that men would mainly seek advice from the "father" and women from the woman spiritual leader. One should note that Dimba members also consult the spiritual leader or the Dimba fathers for other health problems.

### **Influence of the Dimba**

In total, 38 percent of the sample (71 percent among the Dimba) acknowledged having close relatives who are Dimba (e.g., aunt, sister, mother). Fifty-seven men

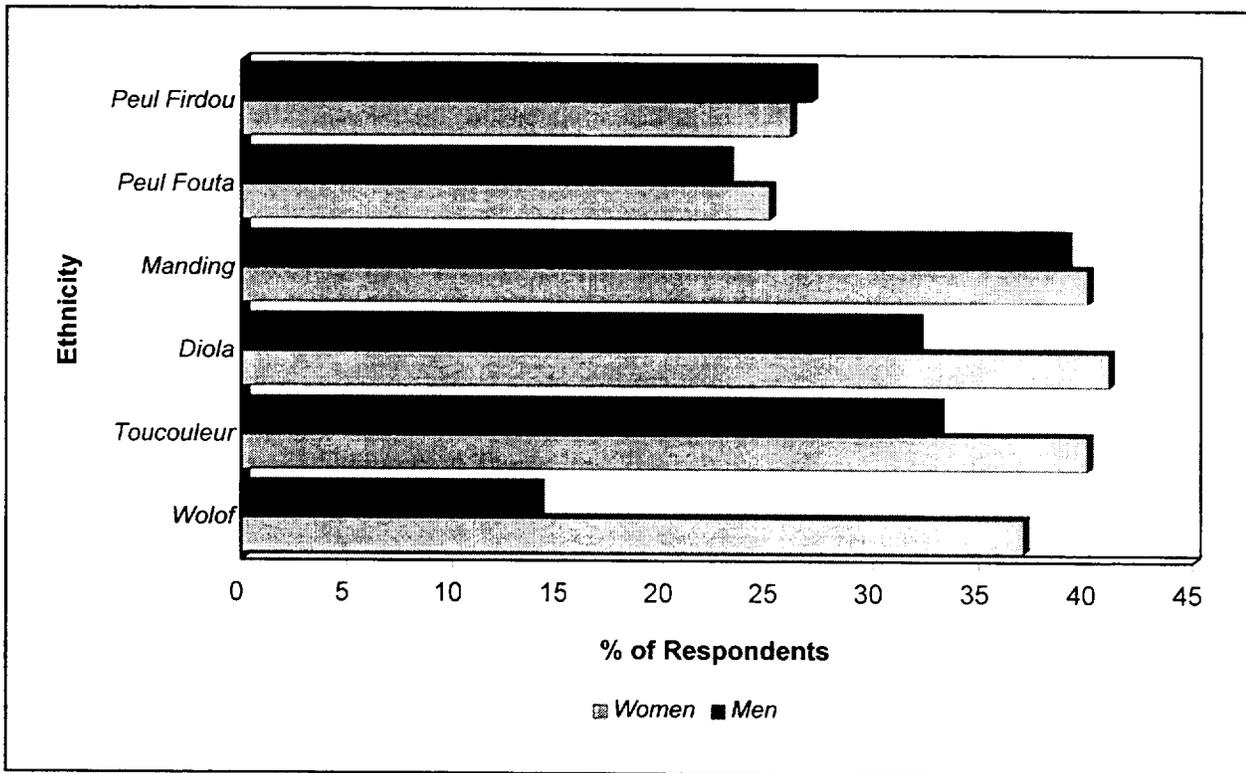
(representing 23 percent of our sample population of men) acknowledged being married to a Dimba woman. Of these men 35 percent acknowledged having consulted the Dimba "father" for treatment because they did not have children while nearly one-third acknowledged consulting a woman spiritual leader for the same reason.

Consultation with a Dimba therapist may be related to an individual's level of education, even though this finding was not corroborated by the data gathered from the questionnaire. According to our interview data gathered from informants, those with little education or no education trust Dimba therapists for infertility problems or "diseases of women," and consult them frequently. The typical educated person only consults Dimba therapists in extreme cases or after the repeated failure of modern medicine.

There was no significant difference between married and unmarried persons regarding consultation with Dimba therapists. However, there were notable differences in consultation with the Dimba between men and women of different ethnic groups. The ethnic groups whose members reported the greatest number of consultations with the Dimba were the Manding, the Toucouleur, and the Diola. The ethnic group whose respondents reported the lowest number of consultations was the Peul Fouta, which may be explained by the fact that Islamic orthodoxy rejects consultation with the Dimba as idolatry.

Among non-Dimba women, 53 percent acknowledged having participated in Dimba ceremonies, whereas 45 percent said they had not and 2 percent were not sure. The ceremonies are marked by chants, dances, prayers and rituals. They often take place in the woods on the outskirts of the city and can last up to a whole day or more, including the preparation of food. While crossing the city to go to the ceremony, the Dimba begin to animate the neighborhood through chants and dances. This tends to mobilize the communities participation in the resulting ceremonies. Data from this study support the idea that the Dimba's influence is Kolda is widespread.

**Figure 9.** Percentage by Sex and Ethnicity of People Who Consulted *Dimba* Fathers



## The Laobe

### *General Description*

There are no sociological studies about the Laobe that we know of. We only found reference to them in certain ethnographic texts,<sup>[25,26]</sup> historical analyses<sup>[27]</sup> and in sociological work about other ethnic groups.<sup>[28]</sup>

The Laobe are known to be from the northern region of Senegal, from whence they travel throughout Senegal and to many countries in Africa, Europe and the Americas. They have developed a very sophisticated nomadic system of seasonal migration and itinerate activities. During the 19th century Mollien compared them to the Bohemians.<sup>[26]</sup>

Some authors, such as A. Bara Diop, classify the Laobe in the Wolof and Pulaar caste systems as wood craftsmen.<sup>[28]</sup> Besides being wood craftsmen, Laobe men engage in itinerate commerce (in particular the commerce of cattle and fabric). In the Wolof and Pulaar social systems, the Laobe are an inferior caste. The members of the so-called superior caste have contempt for the so-called inferior castes and feel obligated to give gifts to the members of inferior castes which serve to boost their superior image in society. Members of the inferior castes have the right to ask anything of the members of the superior caste with whom they have ties, but the reverse is not possible. The caste system relies on a strict endogamy that prevents intermarriage. However, with Laobe women, the stature of the caste's inferiority does not apply. These women are highly valued and have been sought after for marriage within the ruling family. Illustrious Wolof kings were known to be born from Laobe mothers.

The Laobe women have a monopoly over certain products and erotic objects, meaning products destined to enhance the sensation of sexual pleasure and to express sensuality. They are considered the most refined specialists with regard to the erotic and cosmetic beauty. According to ethnographic texts and popular belief, Laobe women have a God-given beauty.<sup>[25]</sup>

#### *Activities and Function of Laobe women*

In Senegal, as in many African societies, it is often indecent to talk of sexual matters in explicit terms. People tend to observe taboos regarding communication about sex or sexuality. In observing a social sense of decency, they use a very complex symbolic language to talk about these subjects. The Laobe women have a quasi-monopoly, especially in the Pulaar and Wolof society, over this language.

The Laobe make and sell a wide variety of incense (*cuuray*) which is used not only to perfume their rooms, but to repel insects as well. Women learn that they must use incense to trigger the sexual desire in men or to create a romantic atmosphere.

According to female Laobe informants, the type of incense that a woman uses in the room where she will receive a male visitor indicates whether or not she wants to see him again.

The perfumed powder (*gongo*) has an important erotic function. Each woman must have a particular style in mixing the perfume to make the *gongo*. Laobe women sell the basic element (powder with a standard perfume) and give women advice on how to make a mixture based on age, stature and circumstances and how to give her perfumed powder a personal seal. According to Laobe women, a perfumed powder made to attract a man will not leave him indifferent.

Laobe women's main specialty is making and selling pearl necklaces and belts. The necklaces are jewelry for women and infants. For infants they also are used as talismen to protect the infants against "bad wind." Pearl belts are made to fit specific waists and have different meanings depending on the woman's age, marital status and the purpose for which she wears them. The symbolic language of sexual relationships often refers to pearl belts, which are considered to be one of a woman's most intimate objects. The noise made by the colliding pearls is considered erotic and capable of triggering strong sexual desire in men. Laobe women learn to manipulate the pearls to make noise when they walk or dance.

The pearls on the belt worn by Laobe women are thought to bring luck to anyone who gets one. This explains why when a Laobe woman's pearl belt breaks in public and the pearls scatter, a crowd of men and women rush to pick them up.

Laobe women decorate small pieces of various kinds of cloth used as lingerie, which assume different functions during romantic preludes. The cloths have different names that evoke the preparation for the sexual act. Some use decorations which are drawings of sexual acts or of male and female genitals. The small pieces of cloth are rarely sold in the market place. Instead, the Laobe deliver them to the house of the customer who

requests them. Laobe women make plant-based drinks and solutions which can be added to bath water to enhance women's sexuality and arouse men's sexual desire. They also sell objects that are inserted in the vagina to enhance male sexual pleasure.

Laobe women are renowned hairstylists, as well as animators for family ceremonies (weddings and baptisms). During the wedding ceremony, particularly the day following the honeymoon, Laobe women lead chant and dance sessions, during which they compose poems. These poems, which praise the bride and her erotic and sensual qualities using very graphic language, are considered to be love-anthems describing male and female sexual organs. With the exception of the musician, men are not allowed to participate in these ceremonies.

Besides attending ceremonies to which they are invited, Laobe women organize their own dance sessions which are occasions for demonstrating erotic talent. Everything in the ceremony refers to the sex act.

According to our questionnaire, 56 percent of our total sample population (men and women) bought products from Laobe women, while nearly three-fourths of the women in our sample reported buying these products. Women of all age groups and ethnicities had purchased products. For each ethnic group, the number of women who bought Laobe products was greater than the number of women who did not report purchasing products. Men and women in the age groups 21 to 30 years and 31 to 40 years were the most frequent purchasers. The Wolof, Toucouleur, and Peul Firdou were the ethnic groups whose members were the most frequent purchasers of products in our sample.

### **The Laobe Women and the Threat of AIDS**

Laobe women may risk exposure to HIV infection due to three factors:

- a) Laobe husbands and wives seasonally migrate to different places which include localities where there is a temporary influx of money favorable to commercial sex

(e.g., peanut season in Kolda, tourist season in Casamance). Meetings between spouses are episodic. During Muslim holidays or the rainy season, they live together in their place of origin. During long periods the couple lives separately and each partner has several opportunities to have multiple extra-marital sexual affairs. For example, the Laobe men who sell wood crafts in Europe and the United States spend years apart from their spouse.

- b) The Laobe women are highly valued as sexual partners, even for occasional sexual relations. Informants have told us, "It is better to have one sexual relationship with a Laobe woman than have a dozen with a non-Laobe." Another informant said, "I save my money for several months to have sexual intercourse only once with a Laobe." Laobe women take advantage of their caste status to make advances to men they consider to be potential customers. Their caste status allows them to be more "aggressive" in taking the initiative to attract customers. They are mostly married women whose marital status is incompatible with officially registered commercial sex.
- c) The Laobe women have very poor knowledge of HIV/AIDS and very seldom use condoms during sexual relationships. None of the four Laobe market women whom we interviewed acknowledged ever seeing a condom.

### **Findings from the Intervention**

The philosophy that guided our research and intervention activities was based on the principle that we must have a thorough understanding of the local culture in order to make the population aware of risk factors associated with HIV/AIDS, and we must utilize and develop local resources in the prevention of the epidemic. Our strategy also utilized other approaches that have been implemented in various African countries, namely the social marketing of condoms, the participation of traditional leaders and healers in the fight against AIDS, and the utilization of traditional structures and communication channels to promote HIV prevention messages.<sup>[29,30]</sup>

#### ***Intervention with the Dimba***

The intervention was conducted at the same time the qualitative data were collected by team members who were of the same gender as the corresponding Dimba being interviewed. By following the internal hierarchy of the Dimba, we utilized their

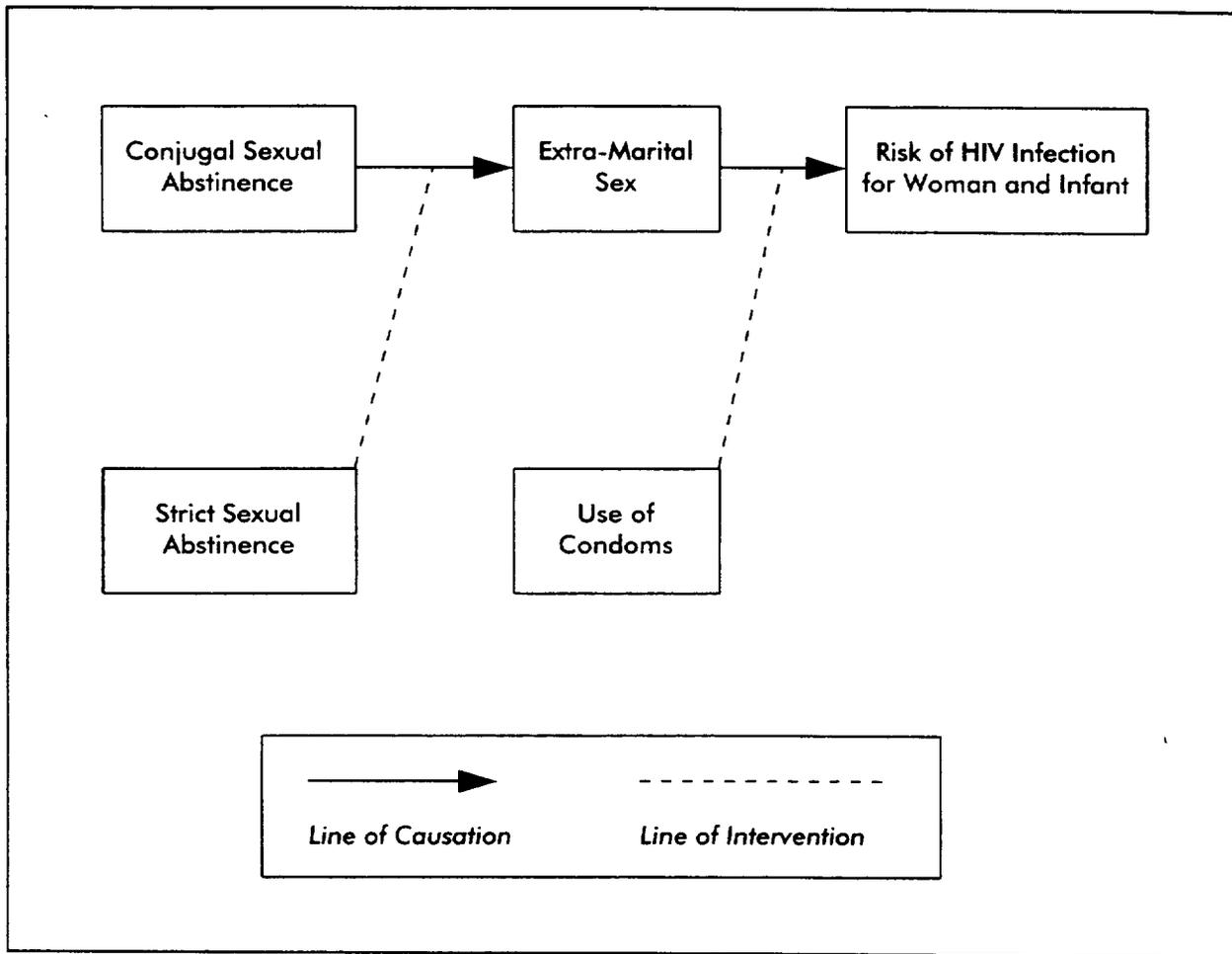
traditional channels of communication and transmission of knowledge for research and intervention purposes. We approached and worked separately with the four key Dimba figures: the male authority renowned in traditional medicine, the "father" of the group, the woman spiritual leader of the group, and the "mother" of the Dimba (see Figure 10). An allopathic physician was brought in to describe sexually transmitted diseases, their symptoms and treatment to Dimba leaders. The information was subsequently shared with Dimba members and others in the community through neighborhood gatherings.

We first worked to identify adverse effects of traditional therapeutic recommendations whose aim was to protect the health of the mother and the infant, and then to justify HIV/AIDS preventive behaviors within the context of the traditional therapeutic belief system.

For example, in analyzing the recommendation that women observe two years of postpartum abstinence, whose aim is the survival of infants, we tried to show the adverse effects that may result when women do not follow this recommendation and engage in extra-marital sex. The women who have extra-marital sexual relations while breastfeeding feel that they are safe (with traditional contraceptive methods such as the belt) because pregnancy is the only thing they worry about. We tried to show how extra-marital sex could put a woman at risk of contracting HIV which in turn could be transmitted to her child, thus endangering the proclaimed goal of abstinence, the survival of the infant. To prevent the risk of infection, the woman should use condoms or observe total abstinence (Figure 10). Dimba therapists have included the rejection of extra-marital sex as part of their treatment of certain reproductive illnesses.

Next, we used the Dimba's system for mobilizing the community to reach a large number of women in the Sikilo neighborhood. According to the traditional system, a person who needs help can solicit the collective aid of the Dimba by making a "request for help" addressed to the leader of the group. If the request is accepted, the candidate

**Figure 10.** Relationship between Conjugal Sexual Abstinence and the Prevention of Mother-to-Infant HIV Transmission



prepares the day's meal for the entire group that will mobilize for the collective task (e.g. farming or prayer to ward off evil spirits). We made two "requests for help" to the Dimba, who then mobilized several dozen women for two large sessions that included films, role-playing and discussions about HIV/AIDS. After these large group sessions, small discussion groups were organized to further sensitize the women about the topics. There also were discussion sessions with groups of Dimba spouses. In addition to this, condoms were given to Dimba therapists and one young Dimba to promote among their patients.

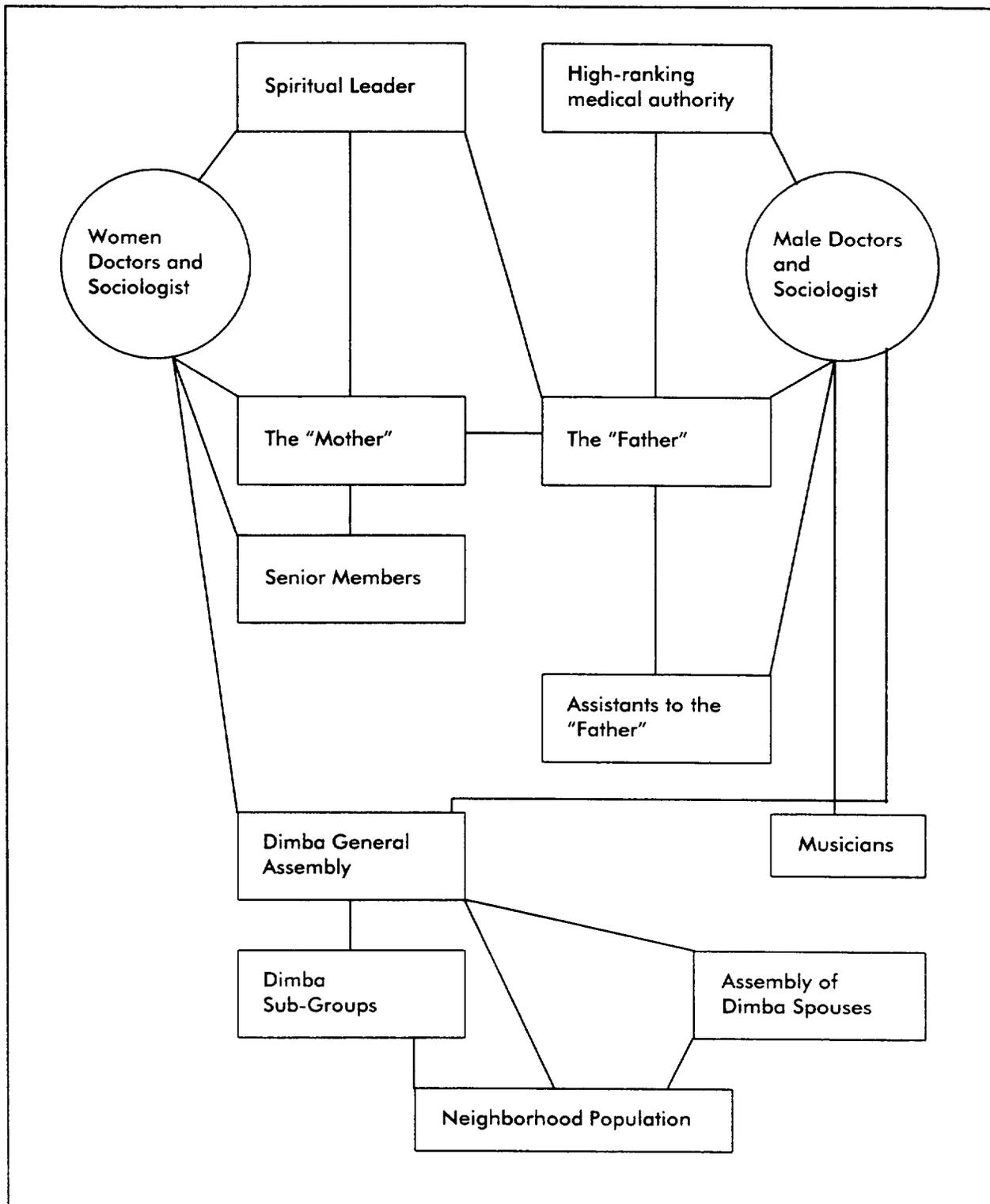
### *Intervention Conducted with the Laobe*

Our work at this level mainly consisted of introducing condoms to the Laobe as a product that could sell. We worked with three Laobe women in order to associate condoms with one of the products sold by the Laobe. The objective of our work was to have the condom be perceived as an erotic object. We did this by associating the condom with a piece of cloth used as lingerie. Subsequently, the local Laobe women named the condom based on the name given to the piece of cloth. The cloth (with the erotic drawings) is called "it must be hard", meaning the man's erection must be hard. The condom now has a name which means "maintain the hardness" or "keep it hard".

Another aspect of the intervention was the promotion of sex without penetration. Traditionally, young Laobe girls are raised to remain virgins until they get married; however, after marriage they experience great sexual freedom. Before getting married, they must practice techniques to attract a man's attention, enhance their eye games, their sexual expressions, and erotic body movements using symbolic language. The Laobe women say that "the entire body of the Laobe woman is sexual," at the same time they must avoid all sexual penetration.

Finally, although we had scheduled a dance ceremony with Laobe women to promote the use of condoms as sex, we did not have enough time to do it because most of the Laobe women left Kolda at the beginning of the rainy season. A tentative plan is to hold the dance when they return during the following dry season.

**Figure 11.** Contacts Made by the Research Team as part of the Intervention with the *Dimba*



### *Initial Assessment of the Strategy*

It is difficult to assess the impact of our pilot intervention activities because of insufficient time. However, the following suggest that our strategy of using the Dimba and Laobe as communication channels has been successful:

- The analysis of the questionnaire data has shown that all the Dimba of the Sikilo neighborhood—with whom we met and worked prior to the administration of the questionnaire—had heard about AIDS and gave us a higher proportion of correct answers about methods of transmission as compared to respondents from other neighborhoods.
- Health workers at the Kolda dispensary have told us a number of times that many women had come to be tested for STDs the day after a general awareness neighborhood gathering was organized by the Dimba group.
- With regard to condom use, the Dimba are showing some success in providing information and education and promoting the use of condoms, but for the moment we are not able to measure what impact, if any, they are having. Laobe women promote the use of condoms not only among the female customers who buy the small pieces of cloth, but also among the men who buy the products for their wives or seek their advice, and the men who want to sleep with the Laobe women.
- Laobe women are also using their own image to promote the condom. They are perceived as being endowed with great physical beauty and knowing a great deal about how to maintain this beauty and good health. In dispensing

advice, the Laobe therefore emphasize that women must use the condom in order to stay beautiful and healthy.

A critical challenge facing the intervention among Laobe women is how much of an impact it will have on existing inequitable gender-based power relations in the social and economic arenas. While women may be interested in the idea of using condoms, for example, they must negotiate condom use with their male sexual partners.

Within marital relations, we found that women seem to have little power to make their partners use condoms although they seem more capable of doing so in extra marital relationships. It is in these situations that Laobe women are promoting condom use.

The next stage of the project will evaluate the immediate impact of the interventions on knowledge of and attitudes towards condoms, STDs including HIV, condom use and health seeking behavior.

## 6. CONCLUSION

Women in Kolda are at risk of HIV infection because of low levels of knowledge about STDs and HIV/AIDS, low levels of condom use, their own and their partners' non-monogamous sexual behavior, and certain sexual practices, all of which are influenced by social, economic, and cultural factors.

Results from this study suggest that the Dimba and Laobe have the potential to serve as communication channels for a community-based HIV prevention program. It is recommended, therefore, that both groups be included in future AIDS prevention efforts in the region.

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## **ABOUT THE WOMEN AND AIDS RESEARCH PROGRAM**

The Women and AIDS Research Program was initiated in August 1990 with support from the Offices of Health and Women in Development of the U.S. Agency for International Development. The objective of the program was to support research in developing countries to identify the behavioral, sociocultural, and economic factors that influence women's vulnerability to HIV infection. The program also sought to identify opportunities for intervention to reduce women's risk of HIV infection.

The first phase of the program supported 17 research projects worldwide: seven in Africa, five in Asia, and five in Latin America and the Caribbean. The studies focused on women and men in rural and urban communities, school-based and nonschool-based adolescents, and traditional women's associations. The focus of the second phase of the program, which began in August of 1993, is to support eight of the original seventeen projects in the design, implementation, and evaluation of interventions developed from the research findings of the first phase of the program. The second phase of the program is expected to be completed by February of 1996.

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