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Women and AIDS in Natal/KwaZulu, South Africa: Determinants to the Adoption of HIV-Protective Behavior

by

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Preface

A study of this magnitude would not be possible were it not for the dedication and commitment of many people. We take this opportunity to acknowledge their contribution. Our deep gratitude to Chief Mlaba whose vision and insight made it possible to undertake work in KwaXimba and Mary-Jane Thusini from Nhlungwane whose tireless energy and enthusiasm gave us new insights into challenges facing residents in informal settlements. We thank the residents of Nhlungwane and KwaXimba for welcoming us into their homes and community and for the open and frank discussions. Our heartfelt thanks to the community liaison persons in Nhlungwane and KwaXimba: Nokthula, Nonhlanla, Mandla and Mary-Jane, for not only facilitating the various project activities in both communities but also for the lessons you taught us about participatory research approaches and insights into your communities. We thank all the fieldstaff: Valerie, Vuyiswa, Esme, Siphso, Thandi, Themba and Troy for their enthusiastic and dedicated contributions to the study. To our colleagues at ICRW, Geeta Rao Gupta and Ellen Weiss, for their useful comments, ongoing support and encouragement, and to Sangeetha Madhavan for keeping us up to date with the emerging literature.

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Executive Summary

"A woman may go to look for employment all day and fail. On her way back home she might meet a man that wants to have sex with her. She will accept any amount of money in exchange for sex in order to purchase meals for her and her children. She could get AIDS from that person." (45-year-old woman, Nhlungwane)

Introduction

Although the AIDS epidemic is at an early stage in South Africa, it is progressing rapidly. It has affected all race groups but is most prevalent among Africans. The epidemic is at a more advanced stage in the province of Natal/KwaZulu, where seroprevalence data from a recent community-based survey showed that HIV infection was four times more common among women as compared to men (1.6 percent vs. 0.4 percent).

Objectives

This study was undertaken to determine the factors that influence a woman's ability to protect herself from HIV infection within a broad socio-political context. The study also attempted to gain a deeper understanding of the intermediate steps between knowledge about HIV/AIDS and behavior change, with the goal of using this information in the design of interventions aimed at reducing women's risk of HIV infection.

Methodology

The study was conducted from November 1991 to March 1993 at two sites in Natal/KwaZulu: a peri-urban, informal settlement (Nhlungwane), and a rural community (KwaXimba). A participatory approach was used throughout the study.

This helped to establish a healthy, dynamic relationship between the communities and the research team. In the initial phase of the study, meetings were held with community leaders, representatives from democratically elected structures, and members of the communities to discuss the aims of the project . This process created the opportunity for the communities to have a voice in the manner in which the project was conducted. Furthermore, each community identified two persons to liaise between the research team and the community. These community liaison persons (CLPs) also functioned as resource persons available to answer questions or address concerns people had about AIDS, as well as to distribute condoms.

Qualitative data on community perceptions of AIDS, sexuality, and safer sex practices were collected through group discussions, key informant interviews, and observation. Throughout the course of the study, a total of 78 group discussions were held in both communities—40 in Nhlungwane and 38 in KwaXimba. These discussion groups varied in size, gender make-up, and age. Information from group discussions was supplemented by other qualitative data gathered from field workers who had lived in the communities for extended periods of time. These field workers met regularly with the research team to discuss and interpret their findings.

The qualitative data were used to develop a conceptual framework that guided the design of two separate questionnaires for women and men. The questionnaires included both open-ended and fixed-response questions. Data on AIDS knowledge and attitudes, STDs, perception of risk, sexual behavior, communication with partner, and use of, access to, and acceptability of condoms were collected from men and women of reproductive age. In addition, issues of economic dependence, violence, decision-making, and power within relationships were explored. Questionnaires were administered to 219 women—111 from Nhlungwane and 108 from KwaXimba—and to 99 men—53 from Nhlungwane and 46 from KwaXimba. All of the women and 69 of the men were randomly selected by household. The additional 30 men who were interviewed were selected because they were

identified as the sexual partners of 30 of the women who had been previously interviewed. These data from couples were analyzed both separately and as part of the larger data set.

In-depth interviews also were conducted with ten men and ten women in Nhlungwane specifically to explore their perceptions of women's vaginal secretions and the use of vaginal drying agents.

Using a semi-structured interview schedule, 29 opinion leaders were interviewed to investigate their knowledge of AIDS and their perception of their role in the AIDS epidemic. The opinion leaders were drawn from a variety of sectors: political, culture and media, education, business, labor, and women's organizations.

Results

Group discussions

From the group discussions, it was found that most people in both communities had heard of AIDS. While some understood it to be a distinct sexually transmitted disease, others, especially men, believed that AIDS was a new name for an old illness—*ilumbo*—which is a disease a male contracts if he has sex with another man's wife or partner. Since *ilumbo* can be treated and cured by traditional healers, many believed that AIDS can also be cured in a similar manner. Some people believed AIDS could be transmitted by casual contact, such as the grass sleeping mat. This notion was probably communicated via educational efforts which used indirect references to sexual transmission in order to respect Zulu culture which does not allow the use of explicit sexual terminology. People from KwaXimba, the rural community, felt that AIDS was found only in the urban areas and that foreign sailors and prostitutes were the source of infection. Older people believed that only youth could get AIDS. The older men expressed concern about the breakdown of traditional practices. They said that in the past men were scared to make a young woman pregnant because the man (or his

parents) would have had to compensate (*inhlawulo*) the girl's family and the chief with cattle. Today, they said, young and older men are getting away with no payments and, therefore, continue to have many partners, making many young women pregnant and then abandoning them. According to young men, having many partners made them popular and important in the community.

Although the majority of participants in group discussions had never used condoms, they expressed strong views based on hearsay, about the negative aspects of condom use, such as condoms decrease sexual pleasure and affect the man's sexual performance. Both men and women were reluctant to use condoms because they believed condoms could remain in a woman's vagina and cause her harm, sometimes even leading to death. The contraceptive properties of condoms were undesirable, particularly to younger women who wanted to have children.

In group discussions, women mentioned that they would find it difficult to ask men to use condoms because men were sometimes drunk during sexual interactions and, as a couple, they seldom discussed sexual matters. Some women felt that a lack of education and skills had forced them to become and remain "sexual slaves" to the men.

While condom use was denigrated by men, they felt that if a choice was to be made between reducing the number of partners and condom use, they would rather use condoms. Married men thought it was unacceptable to use condoms with their wives, but that it was all right to use condoms with casual partners.

Women expressed their desire to protect themselves from acquiring HIV infection but found it difficult to convince men to use condoms or reduce their number of partners. Women repeatedly expressed the need for clandestine methods that they could use and control which would serve the dual purpose of preventing pregnancy and protecting them from acquiring sexually transmitted diseases. Some women also called for providing vocational training and jobs so that they could earn money and support themselves and not risk infection by exchanging sex for small amounts of money in order to ensure their children's survival.

Questionnaire

The average age of women and men interviewed in Nhlungwane was 28.2 years and 33.2 years, respectively. In KwaXimba, the average age of the women interviewed was 23.6 years while for men it was 25.3 years. On average, women had 6.3 years of formal education, compared to 7.3 years among men. Only 17 percent of the women from both communities were married, yet 90 percent of the single women reported being sexually active. Of those women having husbands or partners, only 36 percent indicated that they saw them on a daily basis. Daily contact was more common in Nhlungwane, the informal settlement, than KwaXimba, the rural community (47 percent vs. 24 percent). Almost all of the single women with partners (97 percent) reported that they received money from their partner. Nearly half of the respondents believed that it was common for women in their community to have more than one partner for financial and security reasons. The number of women in both communities with multiple partners has reportedly increased. Twenty-four percent of women from Nhlungwane and five percent from KwaXimba indicated that they had had more than one partner at the same time in the past. In contrast, 32 percent of women from Nhlungwane and 12 percent from KwaXimba indicated that they currently had more than one partner.

Ninety percent of the women interviewed were aware that HIV was transmitted sexually. Women's perception of their own risk was low. Among women in Nhlungwane, 22 percent thought that they were at risk of developing AIDS and 44 percent thought their partner was at risk. Among women in KwaXimba, 19 percent thought that they were at risk and 42 percent thought that their partner was at risk. Forty percent of all women believed their male partners had other sexual partners. Of these, about one-half were unhappy about their partner's other sexual partners but did not believe it was their right to insist on their partner's fidelity.

Although condoms were recognized by most women as preventing disease and pregnancy (69 percent), about one-third of female respondents had never seen a

condom and only 13 percent said they had ever used one. The following were reported by women as obstacles to using and negotiating condoms: condoms signify a lack of love and trust between partners (71 percent), condoms are difficult to discuss with a partner (39 percent), condoms raise the suspicion that the woman has AIDS (31 percent), and fear that a male partner will react violently if condoms are suggested (22 percent). Despite these constraints, about half the respondents who had never used a condom indicated they would like their partners to use them. However, only one-third of these women thought their partners would agree. The majority of all women interviewed from both communities did not believe they had the right to insist on condom use.

Responses to the questionnaire from men indicated that about one-half of the men from Nhlungwane saw their partners daily compared to 17 percent of men from KwaXimba. Seventeen percent of men from Nhlungwane and 30 percent of men from KwaXimba saw their partner over weekends. The remainder of the men saw their partners less frequently. About 90 percent believed that it was common for men in the community to have more than one partner at the same time. While 79 percent of men from Nhlungwane and 89 percent from KwaXimba indicated that in the past they had had more than one partner simultaneously, about half the men from both communities indicated that they currently had relationships with more than one partner. Among male respondents in Nhlungwane, 56 percent thought they were at risk of AIDS; in KwaXimba, the figure was 37 percent. With regard to sexually transmitted diseases (STDs), 55 percent of men interviewed reported a history of STDs. While four out of five indicated that they had sought treatment from a clinic or hospital, the remainder had visited a traditional healer. Only one-third of the men from Nhlungwane and 13 percent from KwaXimba who had been treated for an STD encouraged their partner(s) to seek treatment. About one-half of the men indicated that STDs increased one's risk of contracting HIV.

Although condoms were commonly recognized as a preventive measure (84 percent), only one in three male respondents had ever used a condom. Condom

use was more common among men in Nhlungwane compared to men in KwaXimba (45 percent vs. 26 percent). Respondents believed that a female partner would think the man had AIDS if he wanted to use condoms (95 percent), condoms should only be used in casual relationships (83 percent), condoms signify a lack of love and trust between partners (82 percent), a female partner would be angry if condoms are suggested (79 percent), and condoms cause harm to the women (62 percent). Despite these constraints, about one-half of the men would like to use condoms with their partner, but of these respondents, a little more than half thought that their partner would agree. More than three out of five male respondents believed that women did not have the right to insist on condom use.

In-depth interviews

Findings from group discussions as well as in-depth interviews with women indicated that many women believed their vagina must be dry during sexual intercourse, as men perceive vaginal wetness to be related to infidelity. Women went through potentially harmful procedures such as douching with antiseptics, inserting tissue or toilet paper, and applying traditional medicines to ensure that their vaginas were dry and "tight" for sex. These practices were carried out regardless of whether women felt their vaginal secretions were normal or excessive. Men reported considering vaginal wetness as an indicator of a woman's infidelity and associated wet vaginas with STDs and the use of contraceptives. There was strong disapproval of contraceptives by some men. Several women felt that men were reluctant to use condoms because it prevented them from being able to assess vaginal wetness.

Interviews with opinion leaders

The majority of the opinion leaders interviewed were concerned about AIDS and its potential impact on family life and society. Most were willing to play a role (some already were) in AIDS prevention. Although their knowledge of AIDS was reasonable, a substantial proportion believed that AIDS was government

propaganda and not real. Since many had not seen a person with AIDS, this reinforced their perception that AIDS did not exist and, therefore they had not placed emphasis on the issue within their constituencies. Societal risk factors such as migration and the lack of housing and recreational facilities were mentioned as obstacles to controlling the spread of HIV. The migrant labor system creates abnormal social conditions that separate partners and families, thereby encouraging the establishment of sexual relationships in the cities which facilitate the spread of HIV infection. While some felt that women had better opportunities to discuss AIDS because of their recognized roles as care-givers and educators in the household, many felt that men had to be targeted because of their more powerful position within society and relationships. They felt that the following issues needed to be addressed to curb the AIDS epidemic: increasing women's assertiveness, improving the position of women in society, alleviating poverty, increasing the availability of housing, and creating peace and stability in the country.

Conclusions

The AIDS epidemic is still largely a silent one in South Africa but is slowly taking on a human face, as more and more AIDS cases develop. The asymptomatic phase of the disease has contributed to AIDS being viewed with disbelief by many people, thus impeding prevention efforts. This is further exacerbated by the lack of credibility of the current government whose limited efforts are viewed with suspicion. The non-governmental sector has the credibility, but lacks the technical capacity to respond to the epidemic.

Experience from this study indicates that its participatory approach served as a catalyst for mobilizing organizations in the targeted communities to expand their agendas to include AIDS and to spearhead AIDS-related interventions. The data gathering methods of group discussions, questionnaires, and in-depth interviews provided opportunities for individuals and groups to discuss and debate issues of

HIV/AIDS prevention and impediments to the adoption of protective behaviors. Moreover, as a result of intense and ongoing training of CLPs on AIDS education and research techniques, they have become important and recognized resource people within their communities, providing information and counseling as well as distributing condoms. Despite initial doubts expressed by members of both communities about the existence of AIDS and barriers to condom use, requests to CLPs for information on AIDS as well as condoms increased as the study progressed. It is anticipated that these highly respected members will remain a sustainable resource within their communities beyond the lifespan of this study.

With regard to enabling women to protect themselves from HIV infection, the findings from the study showed that there is a need to:

- Develop clandestine contraceptive and HIV/STD-preventive methods for women, as well as disease preventive methods that permit conception;
- Counsel young women to focus on completing their schooling before entering into sexual relations;
- Provide women with vocational training and employment opportunities in order to better enable them to be economically independent; and
- Provide women with communication and negotiation skills so that they can discuss sexual and other issues with their partners.

Interventions targeted at women also need to increase women's power through group support and networks as well as provide basic education about their bodies and reproductive health. In the course of this study, the positive role of group support was demonstrated repeatedly. Women's groups and other organizations play an active role in bringing people together on specific issues in both communities. Their ability to accomplish tasks despite limited resources comes from pooling their expertise and efforts. While at an individual and group level women recognize the factors which place them at risk and impede their ability to

adopt protective behaviors, their ability to utilize their group power for AIDS prevention needs to be tested.

The goal of decreasing women's vulnerability to HIV infection must go hand-in-hand with interventions targeted at broader societal issues such as:

- Addressing the migrant labor system by examining ways that will enhance the social conditions that allow families to live together;
- Re-examining and re-defining the system of *lobola* (bride wealth);
- Improving the status of women in society; and
- Targeting men to take responsibility for AIDS prevention.

All of these are ultimately dependent on a government committed to addressing the issue of AIDS in a concerted and coordinated way, and credible opinion leaders playing a more active and high profile role in anti-AIDS activities.

1. HIV/AIDS in Natal/KwaZulu

Epidemiology of HIV Infection

The HIV/AIDS epidemic is at a more advanced stage in Natal/KwaZulu than in the rest of South Africa. In 1992, the prevalence of HIV-1 infection among women attending antenatal clinics in the Natal/KwaZulu region was 4.8 percent, whereas it was 2.9 percent in the Orange Free State, 2.2 percent in the Transvaal, and 0.7 percent in the Cape Province (Third National HIV Survey 1993). Computer-based projections estimate that Natal/KwaZulu is at least 1 year ahead of other rural and peri-urban areas of South Africa in terms of the progression of the HIV epidemic (Doyle 1991).

While the HIV-1 epidemic has affected all racial groups in Natal/KwaZulu, HIV-1 infection is higher among blacks. Data on blood donors from Natal/KwaZulu screened from August 1985 to April 1989 indicate that the prevalence of HIV infection among blacks was 0.1 percent; it was 0.002 percent among whites, 0.003 percent among Indians, and 0.01 percent among "coloreds" (Prior and Buckle 1990). A 1991 study of black 20-29 year-olds who were autopsied for legal purposes in Durban revealed that 8.3 percent had contracted HIV-1 (Naidoo 1992).

The rate of increase of HIV infection in Natal/KwaZulu appears to be rising as well, as demonstrated by the more than sevenfold jump in HIV-1 infection among black blood donors from 1986 to 1989 (Prior and Buckle 1990). Based on a 1985 serosurvey of rural communities in northern KwaZulu, the prevalence of HIV-1 infection was estimated to be 0.012 percent (Abdool Karim and Abdool Karim 1992). A 1992 survey in the same area showed that HIV prevalence had risen to 2.2 percent (Abdool Karim and Abdool Karim 1992). Anonymous testing of tuberculosis (TB) patients at Ngwelezana Hospital in northern Natal/KwaZulu showed an increase in the prevalence of HIV-1 infection from 5.2 percent in

January/February 1990 to 7.1 percent in January/February 1991, and 9.7 percent in July/August 1991 (Dr. D. Kemp, personal communication).

The risk of HIV-1 infection is three times greater for migrant than nonmigrant individuals in South Africa (Abdool Karim et al. 1992a). As a result of the homeland system and the now-repealed "influx control" laws¹ that were characteristic of *apartheid*, "oscillatory" migration (Nattrass 1983), wherein workers must travel back and forth between their jobs in the cities and their homes in peri-urban and rural communities continues to be common in Natal/KwaZulu. Consequently, migrant workers are more likely to have sex partners in both rural and urban areas--a factor which may contribute to the higher prevalence of HIV-1 in this region.

HIV-1 infection in Natal/KwaZulu is more common among women than men. Findings from a community-based survey in the region (Abdool Karim et al. 1992a) revealed a fourfold difference (0.4 percent vs. 1.6 percent) in HIV prevalence between men and women. Furthermore, there is an age gap between men and women with regard to infection: whereas there was a fivefold difference among women in the 10-14-year and the 15-19 year age groups (0.3 percent vs. 1.65 percent), HIV-1 infection among men is rare under the age of 20 (Abdool Karim et al. 1992a).

STD clinic patients--and in particular, recurrent attendees--have been found to be at increased risk of HIV infection (O'Farrell and Windsor 1988). In 1988, a survey of people attending the STD clinic at King Edward VIII Hospital (the major tertiary hospital in Natal/KwaZulu) revealed a seroprevalence of 2.4 percent and suggested an association between genital ulceration and HIV-1 infection (O'Farrell et al. 1991). In a study of women attending the gynecology clinic at the same hospital, five percent were HIV-positive. Among those women,

¹These laws strictly regulated the movement of nonwhite Africans into and within the cities.

88.0 percent had human papilloma virus infections, 13.0 percent had trichomonas infections, and 15.5 percent had syphilis (Dhai 1992).

Seroprevalence data for prostitutes are not readily available because prostitution in South Africa is illegal. However, one study of prostitutes at a truck stop in the Natal Midlands reported an average of 23 sexual encounters a week, suggesting that they may be at increased risk for HIV and STDs (Abdool Karim 1992). A survey of 55 women working in escort agencies and massage parlors in Durban (Margolis and Mayat 1991) found that 84 percent had sexual contact with their clients. However, none of the 55 women had HIV infection, and only one had serological evidence of syphilis.

A consequence of the increase in HIV-1 infection among women of reproductive age is that vertical transmission of the virus is on the rise as well. However, observations of children at King Edward VIII Hospital suggest that pediatric HIV infection can be easily misdiagnosed as common childhood respiratory and gastrointestinal diseases (Bobat et al. 1990).

AIDS Knowledge and Risk-Related Behavior

The data from several knowledge, attitude, and practice (KAP) studies in Natal/KwaZulu suggest that the majority of people in this region have heard about AIDS and know, at least at a superficial level, the main mechanisms of how HIV is spread (Abdool Karim and Knight 1991). Detailed knowledge such as that relating to breastfeeding or availability of treatment is poor. Most important, these studies (Abdool Karim and Knight 1991; Abdool Karim et al. 1991) have consistently demonstrated two important findings: there is a poor relationship between knowledge of AIDS and the practice of risk-reducing behavior; and there is widespread denial of individual susceptibility to AIDS.

Mutually faithful monogamy is uncommon as a protective mechanism. In a Durban township, only 44 percent of mothers of teenagers had ever been married

and 56 percent had children from more than one partner (Abdool Karim et al. 1991).

In one study, about 47 percent of sexually active school-going adolescents were reported to be using condoms even though condoms are denigrated as a political ploy by certain groups (Abdool Karim et al. 1992b). However, the consistent use of condoms in every sexual encounter is rare. Condom use is equated with a lack of trust and love in a partner (Abdool Karim et al. 1992b). Hence, condoms may be used with casual partners but are seldom used with regular partners.

Responses to the HIV Epidemic

As part of efforts to control the HIV epidemic in Natal/KwaZulu, the Department of National Health and Population Development in Durban, Pietermaritzburg, and Richards Bay created AIDS Training and Information Centers. These centers have trained several hundred volunteer AIDS educators and lay counselors. School education programs have been launched; for example, drama is being used to educate schoolchildren in KwaZulu schools. "STOP AIDS" signboards have been placed in the major daily newspapers in this region, and advertisements have appeared on radio and television as part of the "yellow hands"² campaign. The KwaZulu Department of Health has undertaken a pilot project to provide home-based care to HIV-infected persons and AIDS patients. The outcome of this experiment is likely to play a major role in the organization of health care services in response to the HIV epidemic.

Nongovernmental organizations are also playing a role through, for example, the community AIDS worker programs initiated by the Progressive Primary Health Care Network National AIDS Program and the AIDS education program at the Valley Trust. Several private companies, trade unions, civic bodies, welfare

²international symbol for AIDS awareness

associations, and religious organizations also have become actively involved in AIDS education and counseling.

Of particular note is a major initiative in Natal/KwaZulu by the Regional AIDS Planning Subgroup (RAPS) to bring together the various agencies in AIDS control efforts within the region in an attempt to devise a plan of action to deal with the HIV epidemic in this area (Laton 1992). Over 200 organizations and individuals are involved in seven commissions that cover the following aspects: education, counseling, care, ethics, research, condoms, and traditional healers. This initiative is a regional component of the National AIDS Co-ordinating Committee of South Africa (NACOSA). It provides an opportunity to look beyond the narrow confines of the fragmented health system and is an attempt to develop a comprehensive approach to dealing with the HIV epidemic in a manner that encourages "grassroots" ownership and builds on the collective expertise within the region.

2. Women and AIDS

Globally, women are increasingly becoming infected with HIV. In most countries where heterosexual transmission of HIV is dominant, equal numbers of men and women are already infected and, in some instances, as in the Natal/KwaZulu area, more women than men are infected. Most research on women to date has focused on women attending antenatal clinics or commercial sex workers, creating a perception that it is only "mothers" and "whores" who are infected (Carovano 1992). Increasingly, however, epidemiological data are demonstrating that it is ordinary women, who are neither prostitutes nor pregnant, such as our neighbors, friends, sisters, grandmothers, and colleagues at work, who are at risk of HIV infection.

Furthermore, the focus of studies on antenatal clinics has been limited to issues surrounding transmission of HIV from infected mother to child, rather than the consequences of transmitting infection to the mother. The complete absence of data on vertical transmission of HIV by the fathers of babies, or on clients of commercial sex workers, has contributed to a perception that women are the reservoirs of HIV infection.

Current messages to reduce the risk of HIV infection, such as use of condoms, reduce the number of partners, practice mutual monogamy, abstain from sex, and seek treatment for STDs, assume that all is equal in sexual interactions. It is well recognized that this is not true for the majority of women (Worth 1989; Elias and Heise 1993).

How does this situation, together with differences in economic, social, and political power, especially in light of the lack of barriers or other options that women can use and control, influence their ability to protect themselves? This study was initiated when information on most of these issues was almost nonexistent. However, as the study progressed, gender differences regarding the HIV epidemic have been given increasing attention by researchers and policy-

makers, and the amount of information on women and AIDS has increased greatly.

In South Africa, HIV/AIDS research efforts have been limited to descriptions of knowledge about AIDS, attitudes toward it, and sexual beliefs and practices. These studies have repeatedly demonstrated a poor correlation between knowledge of AIDS and the adoption of safer sex practices. Very little is known or understood about the complexities that affect the adoption of safer sex practices. Moreover, ways of mobilizing and building on community structures to encourage and support the adoption of safer sex practices have not been explored.

3. Purpose and Objectives

The findings from two earlier studies on HIV/AIDS in Natal/KwaZulu guided the design of this study. The first important finding was that gender analysis of data collected from the anonymous, population-based, cross-sectional HIV seroprevalence surveys in Natal/KwaZulu (Abdool Karim et al. 1992a) indicated that HIV infection was four times more common among women than men (1.6 percent vs. 0.4 percent). The second finding, which emerged in interviews with urban women, was that women would like to adopt safer sex practices, but felt powerless to do so with their partners (Abdool Karim et al. 1991).

This study was undertaken to determine within a broad sociopolitical context the factors that influence a woman's ability to protect herself from HIV infection. It was an attempt to gain a deeper understanding of the steps between knowledge and behavior change so that this understanding could be used in designing interventions that reduce women's risk of HIV infection.

The specific objectives were to:

- Explore community and individual perceptions of AIDS, sexuality, and safer sex practices.
- Identify behavioral, social, and cultural factors that increase women's vulnerability to HIV infection and impede their ability to adopt safer sex practices.
- Explore the feasibility of getting men, women, and couples to adopt safer sex practices.
- Determine the acceptability and use of condoms, and impediments to their use among men, women, and couples.
- Make recommendations to appropriate decision-makers to guide the formulation of targeted interventions.

4. Study Sites

The study was conducted at two sites (Appendix 1): an informal settlement (Nhlungwane) and a rural area (KwaXimba). The nature of sexual relationships and the context within which they are formed are central to the spread of the human immunodeficiency virus. These sites in a way represent the extremes of the types of relationships within African communities in South Africa.

The rural families are representative of the social and political effects of apartheid on family life. In many of these families, males have migrated to the cities for jobs and live in male-only hostels. In the era of AIDS, how does the prolonged separation of partners influence risk of infection, and in particular, a woman's ability to protect herself? When moments together are rare and precious, can time be spent discussing issues that threaten the possibility of these infrequent episodes?

In contrast, the informal settlements represent attempts to reconstruct family units to undo the years of injustice perpetrated by the system. However, within the informal settlements there are a large number of households headed by women who have been abandoned by husbands and partners and have come to the cities in the hope of finding employment and a better life for themselves and their children. To what extent do women's survival strategies in both communities extend to sexual practices that increase their risk of HIV infection and influence their ability to adopt safer sex practices?

Nhlungwane

Nhlungwane is a relatively recent, informal squatter settlement north of Durban. It is characteristic of the many informal settlements that are mushrooming in and around all major cities in South Africa. They usually adjoin stable African townships and compete with the residents of these townships for already scarce resources.

Among Africans in South Africa, the acute housing shortage, overcrowding in the existing four-room township houses, the abolishment of influx control, high unemployment rates, abandonment, and poverty are factors that have influenced and continue to influence the establishment of informal settlements.

Nhlungwane borders three major African townships: KwaMashu, Ntuzuma, and Newtown. The area is under the jurisdiction of the Department of Development Aid (DDA). Nhlungwane is divided into five sections, each having approximately 1,000 shacks. The total population in the area is estimated to be 30,000.

The residents of Nhlungwane live in homes hastily built of mud, timber, and galvanized roofing. Basic infrastructure in the area is almost nonexistent: there are no roads--the residents use footpaths to get in and out of the area; there is no electricity and no sanitary facilities or telephones. The residents purchase water from two standpoints. This often involves walking long distances for daily water.

There is one private general medical practitioner in the area. Most residents use the health services at the KwaMashu Polyclinic, the clinic at Newtown C, or the Osindisweni Hospital in Verulam. The health care needs of the residents are also met by the numerous traditional healers in the area. Often the help of the traditional healer is sought before that of medical personnel.

Children attend the schools in the neighboring areas of Inanda, Newtown, KwaMashu, and Ntuzuma. Public transport is very poor; although there is an irregular public bus service, most residents use the informal minibus service.

Low levels of formal education and training, together with high unemployment rates, limit the employment opportunities of the residents. The majority of them are women who are single parents and the sole breadwinners for the family. Many women generate their income in the informal sector by selling fruit and vegetables, refreshments, etc. Some women are involved in a communal income-generating project that includes sewing, basket-making, crocheting, and knitting. Men tend to be employed in construction and in light industry.

In some instances the abolishment of the influx control laws has provided an opportunity for people to reconstruct family units and conjugal stability in the city, and many have brought their families and settled in shacks. Marriage among the residents is uncommon, however, and many partners simply live together. One of the biggest impediments to marriage is the traditional bride price, *lobola*, which demands that the groom pay the bride's father the equivalent of five cows [R15 000-00; \$1(US)=R3] before marriage.

Despite its problems, the community has many democratic structures through which community needs and issues are raised and discussed. These include civic structures, women's groups, youth groups, religious groups, and extraparliamentary organizations. Residents are informed about forthcoming activities and events through these meetings. Information is usually passed on through informal communication networks or a loud speaker.

KwaXimba

KwaXimba is a rural area in the Natal Midlands, about 80 km west of Durban. In 1987, the area experienced intense political violence. Since 1990, there has been peace and stability in the area and the community is attempting to rebuild itself after years of unrest and instability. Families separated through the periods of violence are being reunited. Vegetable gardens and cattle are once more to be seen. There are large community efforts to improve living conditions and services. KwaXimba is classified as tribal land. It is under the authority of a tribal chief and has tribal structures that administer the area. The chief is well liked and widely accepted by his people.

The community is very involved in the decision-making process for the area and each area is represented at the tribal court meetings. Wide consultative processes are undertaken before decisions are finalized. There are approximately 120 organizations in the area, including civic, women's, youth, religious, funeral, and extraparliamentary organizations.

KwaXimba is divided into seven areas, each having approximately 970 homesteads constructed from mud and ash bricks. The total population is estimated to be approximately 10,000. The unemployment rate is high. Most employed men work either in Durban or in the neighboring towns of Hammersdale and Inchanga during the week, and return home over weekends.

In 1991 a major project to install running water and electricity was started, creating employment opportunities for the residents. The project was completed in December 1992 and many people are once again unemployed. Most women in the community are involved in a communal gardening project. The informal sector is an alternative source of limited employment. Men are involved in building homes for people where no formal plans are necessary. Women earn money by selling fruit, vegetables, or old clothes, or by child-care and domestic work, but many depend on remittances from the men working away from home.

The infrastructure in the community is only just starting to be developed. Residents have had access to water and electricity since January 1993. Water costs R2 for 150 liters and this lasts an average family about 2 days. The electricity works on a card system; people buy electricity when they need it and can afford it.

There is no public transport and transport is a major problem, both in and out of the area. A private bus owner provides transport off the main road. The bus leaves KwaXimba for Pinetown at 4:30 a.m. and 2:00 p.m. from Monday to Friday. An informal minibus service provides alternative transport. This is, however, an expensive option.

There is one health clinic in the area that serves the entire community of KwaXimba. The closest hospital is Edendale, a secondary referral hospital in Pietermaritzburg. The only telephone in the area is at the clinic. There are three primary schools and one junior secondary school in KwaXimba. Pupils attend the senior secondary schools in the neighboring tribal authorities.

Extended families are typical in the area. Traditional customs are still observed and enforced in this community, including bride price. Some families

accept payment after the wedding ceremony. Children born out of wedlock are generally registered under the mother's surname. These children are supported and accommodated by the mother or her parents and brothers, but the mother still has to provide as much financial support as she can possibly afford. Widows have to dress in black and it is rare for them to remarry. Generally decisions in the family are made jointly, but in most families, even though the father is away from home for the most part, he still dominates the household.

Information on community activities and events is communicated through letters and neighbors passing messages to each other. There are two loud speakers. One belongs to the Organization of Churches and the other to the tribal court. These are also used to announce upcoming events and activities in the community.

5. Methods

Research Team

This study was conducted by a team of researchers that included epidemiologists, anthropologists, sociologists, and medical scientists (Appendix 2). In addition, the team was advised and guided by an advisory board that included experts on community issues, sociologists, epidemiologists, and health care providers. The use of a multidisciplinary approach was considered crucial to developing a broad understanding of the complexities of the issues under investigation.

Setting Up the Study

A participatory approach was adopted throughout this study. In the initial phase this involved discussing the aims of the project with community leaders, representatives from democratically elected structures within the community, and members of the community. These meetings took the form of group discussions that presented information on AIDS; clarified issues relating to the project; and explored perceptions of AIDS, the role of women within the community, and problems women encounter in suggesting safer sex practices. Although it was slow, this process created an opportunity for community organizations to have a say in the way the project was conducted.

In KwaXimba this entailed wide consultation, starting with the traditional leader or chief. The chief facilitated a meeting with the approximately 120 democratic structures. These included the members of the tribal court, and the

civic, women's, youth, and political organizations. These meetings culminated in an *imbiso*.³

This consultative process with the community took about three months. During this time we were able to obtain community consent for the study and introduce to almost every family in the area the topic of AIDS prevention. The community chose the civic organization and the clinic as the links between it and the research team.

The meetings between the civic organization, clinic staff, and research team made it clear that a person from the community should be part of the research team. This community liaison person (CLP) would receive a salary and would be involved in facilitating research activities in the community. We directed our request for a CLP through the civic organization. Two candidates were suggested to us who were chosen by the community. The candidates agreed to share the job and the remuneration. In retrospect, the community was wise in giving us two people, because their combined skills and expertise made an invaluable contribution to the study.

In the informal community, although the process used to introduce the study and obtain community consent was similar to that used in KwaXimba, the entry point was the women's group. The research team started with a big meeting with the women from the area at which there were discussions on the project and on the importance of preventing and controlling the further spread of AIDS. We also asked the group to elect a person from the community to be part of the research team. In the initial stages, our interaction in the community was restricted to women. As the study progressed, more and more men were drawn in and, by the time we were constructing the male questionnaire, the community had appointed a male CLP in addition to the earlier female.

³An *imbiso* is a public meeting in a chief's area that varies in frequency from monthly to quarterly. Every family in the area has to be represented at that meeting. It is a mechanism for the chief to pass on important information to his community and for the community to raise issues and concerns with him.

Community Liaison Persons

The function of the community-elected liaisons, two women in KwaXimba and one woman and one man in Nhlungwane (Appendix 2), was threefold:

- To take care of the logistics of setting up meetings in the community, that is, finding mutually satisfactory times and venues, and inviting residents to participate in interviews and group discussions.
- To be a continuous link between the research team and the community.
- To act as AIDS resource persons within their communities, that is, to be able to answer any queries or address concerns people had about AIDS; this included counseling and distribution of condoms.

The CLPs assisted the researchers in developing the sampling frame. They also informed the researchers of days that were suitable for interviewing because they were aware of specific days which were spent in the communal gardens or attending community meetings.

Once the households were selected, the CLPs visited the household and informed the occupants about the study and the forthcoming interview. On the day of the interview, the CLPs escorted the interviewer to the selected household, introduced him or her to the household, and left.

The training of the CLPs started immediately upon their appointment. Initially they attended a formal 2-week course on AIDS information and counseling. This course is run by the AIDS Training, Information and Counselling Center (ATICC) in Durban and includes lectures, discussions, and role playing. Training in general research methods took place as appropriate during the different phases of the study. At the outset the CLPs were trained in qualitative methods that included observation and informal interviews and writing field notes. The CLPs also were trained to demonstrate the correct use of condoms and the research team regularly provided them with supplies for distribution in the community.

Subsequently, the training became much more informal and took place over half a day on a fortnightly basis. One of these fortnightly meetings coincided with the monthly research team meeting. Discussions at these meetings were facilitated by the project coordinator (N.M.) who is also a volunteer counselor at the Durban ATICC. Initially she led the discussions, but as the study progressed, the CLPs would arrive with a list of concerns or questions that they wanted addressed and by working together, would resolve these problems.

During the course of the study, the CLPs became more and more valuable to the research team, providing us with superb logistic support and new insights into the community with regard to AIDS prevention. They were able to continuously monitor the community response to the research team and gave us regular feedback about what people were saying about the research team, the research, AIDS, and emerging issues that were relevant to the project. In addition, they alerted the team to general community issues and concerns not directly related to the project.

Community-Based Qualitative and Quantitative Field Studies

We collected data in both Nhlungwane and KwaXimba from November 1991 to March 1993, using a combination of qualitative and quantitative techniques. Initially, data concerning community perceptions on AIDS, sexuality, and safer sex practices were collected through group discussions, interviews with key informants, and observation. The make-up of the group discussions varied in size, gender, and age.

In Nhlungwane there were 40 group discussions involving 908 people; 200 men and 708 women. They consisted of:

- 10 meetings with a total of 75 women between the ages of 15 and 44 years;
- 8 meetings involving a total of 520 women between the ages of 25 and 60;
- 6 meetings with a total of 120 men between the ages of 25 and 50;

- 16 meetings involving a total of 193 men and women between the ages of 15 and 60.

In KwaXimba there were 38 group discussions involving 979 people; 383 men and 596 women. They consisted of:

- 10 meetings with a total of 83 males between the ages of 17 and 55;
- 15 meetings involving a total of 300 women between the ages of 20 and 60;
- 13 meetings involving a total of 596 men and women between the ages of 15 and 60.

The information generated from these discussions was supplemented by one of the research assistants living in the community for extended periods of time, a fortnightly debriefing of all field-workers, and monthly meetings with the entire research team. These discussions and our earlier observations formed the basis for a conceptual framework (Appendix 3) that was used to guide the construction of the questionnaires that were administered in both communities.

Questionnaires

Quantitative data were collected using different questionnaires for men and women. The questionnaires were translated into Zulu and back-translated to English to assess their accuracy. They were pilot tested and modified, where necessary, before wide-scale field implementation. The questionnaires were scanned daily to monitor proper completion and to identify any problems and issues that arose during this phase. A total of 318 questionnaires were administered. Questionnaires were administered to 219 women (111 from Nhlungwane and 108 from KwaXimba) and to 99 men (53 from Nhlungwane and 46 from KwaXimba). All of the women and 69 of the men were randomly selected by household. The additional 30 men who were interviewed were selected because they were identified as the sexual partners of 30 of the women who had been previously interviewed. These data from couples were analyzed both separately and as part of the larger data set.

Women

Questionnaires were first administered to women in both communities between May and August 1992. The women were between the ages of 16 and 44 and were drawn from a 10 percent systematic sample of households. The number of women in each house was determined and one was randomly selected. The questionnaire (Appendix 4) was administered by a trained female field-worker who is both a qualified nurse and a sociologist. English or Zulu was used, depending on the respondent's choice of language.

Once the interviewer had been introduced by the CLP, she then chatted with all the members of the household and selected one woman whom she interviewed privately. At the end of each session, the interviewer answered any questions regarding AIDS, and corrected misconceptions. Although the questionnaire was completed in privacy, other household members joined in the discussions that followed. Often the interviewer had to provide respondents with advice regarding social benefits and medical care, and this assistance enhanced the relationship between the researchers and the community.

The CLPs returned the following day to get feedback from respondents on how they felt about the interview, for example, the conduct of the interviewer and the nature of the questions, and provided feedback to the researchers.

Men

After the questionnaire-based interviews with women were completed, a random sample of men between the ages of 15 and 50 in both communities was drawn in a way similar to that for women. The men were interviewed between November 1992 and February 1993. The questionnaire (Appendix 5) was administered by two male field-workers, one an environmental health officer with extensive experience in AIDS research, and the other an experienced AIDS counselor. A process similar to that for the interviews with women was followed for the men. The CLPs left after introducing the interviewer to the respondent and made a follow-up visit the next day.

The interviews with men had to be conducted at night and over weekends and the lack of electricity in both areas made interviewing at night extremely difficult. This was further exacerbated in the rural area, where most men only visit their families and partners over weekends or once a month.

Couples

The continuing group discussions in both communities, and the questionnaire-based interviews with women, indicated that a lot of blaming was going on between men and women, with men saying that their partner would not accept the use of condoms and women saying the same of their partners. It was as though each wanted to adopt protective behavior but thought their partner would object. We needed to verify these assertions by obtaining the same information independently from each partner in a relationship. Therefore a second group of men was interviewed. These men were partners of women who, during the questionnaire-based interviews, agreed to continue with the research process. The community liaison persons contacted these women to identify their partners, reassuring them that any information they had shared with us would remain confidential and that their partners would not be told that the women had been interviewed earlier. The CLPs then contacted the partners and asked them to participate in the study. If the partner consented, a male interviewer made an appointment and administered the questionnaire to the male subject.

With the dyad interviews, in addition to the general problems of interviewing men, several other problems were encountered. For example, about 30 percent of the women interviewed approximately three to four months earlier had changed partners, had no partner, or their partner could not be traced at the time that the male questionnaires were administered. The men interviewed were not necessarily from the same household as the women interviewed. Some men were, therefore, difficult to locate even after several attempts. All of these factors resulted in fewer interviews being conducted with men than was initially planned. Furthermore, it became apparent in the analysis phase that while some women

had regarded the identified person as their regular partner, the man had several other partners and did not regard the woman as his regular partner.

In-Depth Interviews on Vaginal Secretions

The topic of vaginal secretions, among others, was explored through in-depth interviews with young men and women in Nhlungwane in February 1993 who had not been previously interviewed. Twenty in-depth interviews were held: five each with men aged 15-20 years and 20-35 years; five each with women aged 15-20 years and 20-35 years. All interviews were conducted by the male and female community liaison persons from Nhlungwane, using an informal, conversational style. The issues were brought up as part of casual conversation so that the responses would more accurately reflect how the respondents felt about this sensitive issue.

Views of Opinion Leaders

"People respect their leaders. If they (the leaders) were to tell the people that there is no cure for AIDS, the people would be made aware of the seriousness of AIDS." (30-year-old male, KwaXimba)

In the initial discussions in both communities, the idea of credible and influential leaders highlighting the issue of AIDS was raised as a possible way of increasing awareness. It was within this context that an exploratory study was undertaken to determine the perceptions of these leaders on a range of issues relating to AIDS prevention, and through discussion, to convince them that they could play a role in promoting an AIDS prevention campaign.

Using convenience sampling, data were collected between February and June 1992 from a range of opinion leaders. They were from different sectors (e.g. political, cultural, education, business, labor, etc.) from Natal/KwaZulu; other

provinces and self-governing states; and included individuals from government, nongovernment, and liberation organizations.

All interviews were conducted by Dr. Nkosazana Zuma,⁴ using a semistructured interview schedule which included five areas:

- Knowledge and attitudes toward AIDS
- Opinion about where prime responsibility for anti-AIDS efforts should lie
- Perception of the adequacy of current efforts
- Activities undertaken by the interviewees' own organizations
- Perception of their role in anti-AIDS efforts

The interviews were conducted in an informal, conversational style. The lengthy discussions that ensued resulted in a constructive dialogue and a sharing of ideas and knowledge. Misconceptions were corrected at the end of the interview.

Data Management and Analysis

The field-workers made detailed notes after each group discussion and in-depth interview. The field notes were analyzed using standard ethnographic techniques, and selected members of the research team independently analyzed their content. The final interpretation stemmed from consensus among the researchers.

Quantitative data were managed using DBase IV and analyzed using EPIINFO. Where appropriate, open-ended questions were coded for content and analyzed as categorical variables.

⁴Currently the Minister of Health for the Republic of South Africa, at the time of the study Dr. Zuma was a member of the research team and the chairperson of the ANC Women's League and the chairperson of the National AIDS Committee of South Africa (NACOSA).

Ethical Issues

The study was approved by the Ethics and Professional Standards Committee of the Faculty of Medicine, University of Natal. At the community level, permission to undertake the study was sought from recognized leaders and existing democratic structures in both communities.

At the individual level, processes that ensured confidentiality, rights, and the welfare of each subject were adhered to at all times. Confidentiality was guaranteed to respondents. All field notes and questionnaires that contained identifiers were maintained in a locked file and were accessible only to selected members of the research team.

6. Results of Field Studies

Group Discussions

AIDS

"AIDS is deadly and sleeping around should be avoided." (40-year-old woman, Nhlungwane)

"AIDS is the same as ilumbo." (25-year-old man, KwaXimba)

Most people had heard of AIDS, either from friends, at work, or through the media. While some understood it to be a sexually transmitted disease, others, especially men, believed that AIDS was a new name for an old disease, *ilumbo*. *Ilumbo* is a disease a male contracts if he has sex with another man's wife or partner. Since *ilumbo* can be treated and cured by traditional healers, many believe that AIDS can also be cured in a similar manner. This has major implications for education and the adoption of safer sex practices. The fact that many participants had not seen anyone with AIDS during the time of the group discussions reinforced their perception that AIDS does not exist.

Long-standing reservations that men in both communities had about women using contraceptive methods were now being related to AIDS, and the blame for the disease was being placed on women.

"AIDS is caused by the family planning treatment such as tablets and injections. They say that this (AIDS) is coming from the woman as sometimes she is found very dry and sometimes very wet." (35-year-old man, Nhlungwane).

The rumors built on these theories were quite widespread in both communities, and in discussions with young women we were often asked: "Is the discharge the cause of AIDS?" or "Do contraceptive methods cause AIDS?" The

issue of dryness and wetness, practices that have developed in response to these theories, and their implications for HIV transmission were subsequently explored more extensively and the findings presented in the section on taboos (see p. 32).

Most group participants were unable to distinguish between HIV and AIDS. While many were aware that AIDS was a sexually transmitted disease, many also stated that it could be caused by casual contact. Some of the responses have to be interpreted with some caution since Zulu culture does not allow the use of explicit sexual terminology. Some people, therefore, explained that one gets AIDS from the grass sleeping mat. This indirect method of indicating sexual transmission may have reinforced, especially among young children, the notion that AIDS can be caused by casual contact.

"Most men in rural areas work in cities where they have girlfriends...they come back home and infect their partners." (34-year-old woman, KwaXimba)

People from both Nhlungwane and KwaXimba felt that the urban areas were the source of infection. Interestingly, while the people from KwaXimba thought that this was because people from urban areas are more promiscuous, people from Nhlungwane felt that foreign sailors were the source of infection and that prostitutes from the urban townships, who had sex with foreigners, brought AIDS into the townships. Young men in Nhlungwane thought that the government was promoting the spread of AIDS in townships by not prosecuting the prostitutes. This belief, along with the failure to acknowledge that multiple partners are the real risk factor, impedes the adoption of safer sex practices.

"AIDS is the young people's disease--it does not concern me." (50-year-old man, KwaXimba)

Attitudes about being at risk varied from men to women and between older and younger people. Some women said that while they were faithful, their

partners had many girlfriends and thus placed them at risk. The older people believed that only the young could get AIDS and were therefore confident that they were not at any risk of contracting the virus.

A few mothers were concerned about their teenaged children and the risk they faced of getting AIDS. Some recommended that the school educate children about the danger of AIDS. However, some teachers said that parents did not like them to discuss sexual matters at school even though they felt it was important.

Relationships

Young women. Our informants indicated that most young girls start having boyfriends when they are 14-15 years old. Having a boyfriend invariably means having penetrative sex. These relationships may be with boys who are three to five years older than the girls are, or with much older men. There is some status associated with having a boyfriend who is in his final year of schooling. This type of relationship with an older pupil lasts from two weeks to a month. If the girl sees her boyfriend with another girl, she will terminate the relationship. Sometimes to "fix" her boyfriend she will find herself another boyfriend. Friends unconsciously pressure young girls to have a boyfriend.

"You feel excluded when the others are talking about their boyfriends. To be part of the group you find yourself a boyfriend." (Schoolgirl, Nhlungwane)

Schoolgirls may have boyfriends for financial reasons; these relationships are usually with much older men.

"A schoolgirl may have a taxi conductor or driver as a boyfriend so then she gets a free ride to and from school." (Schoolgirl, KwaXimba)

"Some schoolgirls seek older men who may buy them gifts or Kentucky Fried Chicken." (Schoolgirl, KwaXimba)

Interestingly, young women see these relationships with older men as opportunities to learn about sex so that they can have long-term, stable relationships in the future with men of an age similar to theirs.

By age 20, a woman may have had five boyfriends. After 20, many women start settling down because they may have had children or are planning their weddings. By age 30, relationships are more stable. A woman may get married or enter into serial monogamous relationships and partners are changed less frequently compared with women who are 15-20.

Young Men.

"My father and his father had many women" (23-year-old man, KwaXimba)

Men felt that they had to keep up the tradition of their fathers and grandfathers by having as many partners as they did. Young men felt that having many partners made them popular and important in the community.

"Our minds are preconditioned in the sense that a man must take a leading role in life as such and that woman must be subordinate. For a man to take that role, he must have more experience in life than a woman." (25-year-old man, KwaXimba)

Such explicit sentiments have guided men in their relationships with women. Most young men equate love with sex and perceive sex to be a fundamental prerequisite for love. They pressure young girls to have sex with them by telling girls who don't want to have sex that they must be abnormal.

Older Men and Women on the Sexual Behavior of Youth. Older people were concerned about the levels of sexual activity among the youth, the high rates of teenage pregnancies, and how shoddily men were treating young women. An older man from KwaXimba said that parents indirectly encourage boys to have

sex at an early age by giving them their own rooms: "This gives the boys freedom to bring their girlfriends regularly into their room and to do as they please with them."

The older people, especially in KwaXimba, acknowledged that in the past men had many partners but they also made the point that these men were more responsible than men nowadays. According to one informant:

"In days gone by a man felt very proud if he had many girlfriends. But these isokas [ladies' men] did not father countless illegitimate children. Married men did not fool around with young girls, impregnate them and then leave them. If a married man saw another woman he was interested in, he usually took her as his second or third wife." (50-year-old man, KwaXimba)

There were many suggestions from older people for a return to tribal law, which was very strict about pregnancies outside of marriage. These days, with the breakdown in tribal law, there is no mechanism to protect young women from impregnation and abandonment. The issue of teenage pregnancies was of great concern in both communities and in most instances was seen as a bigger problem than AIDS. Some older people were hopeful that, in addressing the issue of AIDS, this issue will also be solved.

They felt that the traditional practice of remuneration (*inhlawulo*) to the woman's family should be enforced. If a girl became pregnant, then the boy's parents must compensate the girl's parents either financially or with cattle. They felt that this would create fear in the males and prevent them from having casual sex, and this would help not only in reducing teenage pregnancies but also AIDS. Older people also felt that the traditional practice of femoral (thigh/nonpenetrative) sex should be reintroduced because it safeguards virginity and thereby avoids pregnancy outside of marriage.

The Dynamics of Sexual Relationships

"We [women] have to listen to them [men]." (30-year-old woman, Nhlungwane)

"We only have sex with our husbands but we could be infected." (33-year-old woman, Nhlungwane)

According to our informants, women feel that they have little power in relationships and therefore, are not in a position to negotiate safer sex practices with their partner. Although the situation is changing, especially with younger women, most often the men decide when they will have sex and the women (mostly older and married women) passively submit to the men's needs. It is very rare for a woman to refuse her partner sex, especially if she is married or in a permanent relationship. While it is important for her to satisfy her partner sexually, sexual matters are rarely discussed between partners. It also was pointed out that most mothers do not discuss sex with their children, even daughters, because they are embarrassed to talk about sex. Group participants in both communities felt that most married women and women in permanent relationships accept that their husbands or partners have other partners. Some of the women felt that a lack of education and skills has forced them to become and remain "sexual slaves" to the men.

Economic Factors and HIV Risk

"So many women are unemployed. Some women are married but most live together without a legal marriage contract. Some women sell fruit and vegetables in the spaza shops. Others fall in love with more than one partner to get money to supplement their income." (Woman, Nhlungwane)

"When a woman has financial problems she may find herself sleeping with anyone maybe for R10-00 just because she needs the money." (Woman, Nhlungwane)

Women saw their limited economic options as putting them at risk because poverty was forcing them to risk infection for small amounts of money that ensured their children's survival. Some of the options they suggested for decreasing vulnerability to HIV included vocational training and jobs so that they could earn money and support themselves. A number of the younger women said they wanted to first complete school, earn diplomas, and then start a relationship with a man; they did not want to get pregnant and have to look after children.

Condoms

"I cannot perform well with a condom." (22-year-old man, KwaXimba)

Although the majority of the participants in group discussions had never used condoms, they expressed strong views, based on hearsay, about the negative aspects of condoms. Many said that they decreased sexual pleasure for both partners and affected the male's sexual performance. Men said that their partners would not accept the use of condoms and women said their partners would not use condoms.

There were many myths about condoms. Some women expressed fear of condoms remaining in their vagina and causing them harm. Some went so far as to say that if a condom was left in the vagina, major surgery would be needed to have it removed. Some women expressed little confidence in condoms, saying they might break or burst, causing the woman to become pregnant. For a relatively small number, the contraceptive properties of condoms were undesirable because they wanted to have children.

"I want flesh to flesh contact." (Men in both communities)

Throughout the discussions it was clear that using condoms and reducing the number of partners was not acceptable to men. The men said that women do not

like them to use condoms because women do not get sexually satisfied. If they used a condom then it implied that they were having casual sex ("sleeping around") and the women would not have any trust in them. Men who were married did not see any need to use condoms. Some men complained that condoms are not comfortable and do not fit properly.

"Men wear the condom. If women introduce condoms the men get angry...they eat you alive." (38-year-old woman, Nhlungwane)

"Men don't agree to use condoms. You people [research team] should come up with advice for us to use when men refuse to use condoms." (35-year-old woman, KwaXimba)

Women find it difficult to ask the men to use condoms because the men are sometimes drunk, but more important, because sexual matters are rarely discussed.

"It is difficult to go to your partner with a condom because she will think you are not trusting her." (Man, KwaXimba)

While men denigrated the use of condoms, they felt that if a choice had to be made between reducing the number of partners and using condoms, they would rather use condoms. Married men thought it was unacceptable to use condoms with their wives but acceptable with casual partners. Although sex outside of marriage or permanent relationships is common, a facade of fidelity with wives and permanent partners is maintained. These continuing multiple-partner relationships place both men and women at risk of contracting HIV.

"Women condoms should be made as soon as possible." (Many women, Nhlungwane and KwaXimba)

"We must be taken as human beings and if there is something we must be informed right from the start and not when things get serious." (35-year-old woman, Nhlungwane)

Many women expressed the need for female condoms so that they could have their own protection even if their partner refused to use condoms. Some respondents expressed the need for clandestine barriers that they could use and control that would serve the dual purposes of preventing pregnancy and protecting them from acquiring STDs. Women, especially from KwaXimba, also strongly expressed the need to be informed about any development that had the potential of increasing their options to protect themselves.

Taboos and Beliefs About Vaginal Secretions

Women raised many issues regarding vaginal secretions during group discussions and interviews. They felt that their vaginas must be dry during sexual intercourse because men do not like wet vaginas. When women were asked about vaginal secretions and methods used to dry the vagina, many were initially hesitant and embarrassed to talk about this. The issue of "dry sex" was explored during in-depth discussions after establishing rapport with subjects who had not been interviewed previously.

The women felt that they understood the difference between normal vaginal secretions and discharges as a result of diseases, but felt that men did not understand this difference. They were too frightened to explain this difference to their partners. On exploring what the women understood as normal and (nondisease-related) excessive vaginal secretions, it appeared that they could not make a distinction. Regardless, many women were engaging in a wide range of potentially harmful practices, mainly on the advice of their peers, to keep their vaginas dry.

The women said that they kept their vaginas dry by douching with Jik (bleach) and Dettol (an antiseptic), inserting tissue or toilet paper, inserting snuff, applying

traditional medicines, and inserting medicines (e.g., Eskamel - a sulfa drug) purchased at pharmacies. They did this regardless of whether they felt their vaginal secretions were normal or excessive.

They expressed taboos surrounding "vaginal wetness." It is believed that a woman who is wet during sex is engaging in sexual intercourse with other men. Therefore, women considered it a matter of trust and integrity to keep themselves dry. To this end, women kept their efforts to maintain a dry vagina a secret from their partners. Many women expressed fear of repercussions should their partners discover the substances they were using to keep themselves dry.

Several women expressed the importance that men attach to the dryness of the vagina. They felt that men did not use condoms because this prevented them from being able to assess "vaginal wetness." If the men were not able to establish whether their partners were dry, they would not be able to determine whether the women were being faithful to them.

Some of the women explained that men do not enjoy sexual intercourse with women who are wet during sex because they believe that "vaginal wetness" is associated with "loose" vaginal walls. Thus many women consult traditional healers to keep their vaginas dry and tight so that their partners will be sexually satisfied. Although many of the women understood the risk they ran by using various substances to dry their vaginas, they felt that their partners' sexual satisfaction was more important.

The women explained that when the men did not get an erection, they blamed the women, saying that they were "too wet." Some women believe this and feel that it is their responsibility to ensure that their partner gets an erection; they therefore use a variety of substances to keep their vaginas dry. The young girls learn about these practices from older girlfriends or school friends.

Both men and women also use traditional medicines to ensure that no one else sleeps with their partners. For example, some women apply a "medicine" inside their vaginas before having sex with their partners; they think that if the man attempts to have sex with another woman thereafter, he will not be able to

because his penis will remain flaccid. Men use a similar traditional medicine to keep other men from having sex with their partners. Interestingly, the CLPs also had a strong belief in these medicines.

The men who were interviewed said that they were aware that women inserted "things" into their vaginas to keep dry, but they believed that their own partners did not practice this. They said that if they found their partners using snuff, tissue paper, or any substance, then they would know that their partners were sleeping with other men. They felt quite strongly that they would stop having sex with such a woman for fear of getting a disease (*ilumbo*) from her. This fear was so strong that some men inserted their fingers into their partner's vagina to see if she had inserted anything.

Some men related "vaginal wetness" to STDs, which can cause copious vaginal discharges. This association is of particular interest in view of the findings at King Edward Hospital that 60 percent of the women who complained of vaginal discharge had *Trichomonas* infections; the next most common causes were vaginal candidiasis and *Gardnerella* infections (personal communication, Head, Family Planning Services, King Edward Hospital). Of particular concern was the widespread belief among men that traditional healers could treat STDs using various mixtures and creams.

Although most men were unable to differentiate between normal and excessive vaginal secretions, many believed that excessive vaginal secretions were caused by the contraceptives women used. There was strong disapproval of contraceptives because some men believed that when a woman took contraceptives, her body would accumulate water and this would cause her vagina to be wet.

In conclusion, women go through potentially harmful procedures to ensure that their vaginas are dry and "tight" for sex. Men use "vaginal wetness" as an indicator of a woman's fidelity and associate wet vaginas with contraceptive use and STDs.

Interviews with Men and Women

*"I am not educated and am therefore not qualified to answer any questions."
(35-year-old women, KwaXimba)*

Questionnaires were administered to a total of 219 women (111 from Nhlungwane and 108 from KwaXimba) and 99 men (53 from Nhlungwane and 46 from KwaXimba). Initially women with no formal education were hesitant to participate in the interviews but, after some discussion, they were reassured that they were "qualified" to answer any question. No one refused to participate in the interview. Responses to most questions were very similar among men and among women in both communities, therefore aggregate data by gender are presented. In instances where significant differences exist between respondents from the two study sites, these are presented.

Sociodemography

Sociodemographic characteristics of the sample are listed in Table 1. The average age of women interviewed in Nhlungwane was 28.2 years (SD=8.6) and in KwaXimba was 23.6 years (SD=7.3). The average age of men in Nhlungwane was 33.2 years (SD=9.9) and 25.3 (SD=6.9) in KwaXimba. On average women had 6.3 years of formal education, compared to 7.3 years among men. About a third of the women in both communities were seeking employment compared to 24 percent of men. Approximately twenty percent of both men and women were students; eight percent of both men and women were self-employed. None of the employed women had professional jobs, but four percent of the total sample of women were post-matric students;⁵ in comparison 18 percent of men had professional jobs and none of those interviewed were post-matric students. Seventeen percent of women were housewives. The remainder of the men and

⁵currently obtaining a post-secondary education

women were either in unskilled or semi-skilled jobs. Of note is that 14 young women under the age of 18 who were interviewed said they had to abandon their schooling because of pregnancy. In Nhlungwane 52 percent of the women were members of a Women's Organization, compared to 25 percent in KwaXimba. Five percent of respondents from both communities held an executive position in these organizations.

Table 1: Sociodemographic Characteristics of Female and Male Respondents by Community

| | Nhlungwane | | | | KwaXimba | | | |
|-------------------------------------|------------|-------------|-----------|-------------|------------|-------------|-----------|-------------|
| | Women | | Men | | Women | | Men | |
| | N | % | N | % | N | % | N | % |
| Age | | | | | | | | |
| 16-19 | 25 | 23.8 | 3 | 6.4 | 39 | 36.1 | 10 | 22.2 |
| 20-24 | 20 | 19.0 | 7 | 14.9 | 35 | 32.4 | 16 | 35.6 |
| 25-29 | 10 | 9.5 | 8 | 17.0 | 12 | 11.1 | 9 | 20.0 |
| 30-34 | 17 | 16.2 | 9 | 19.1 | 9 | 8.3 | 5 | 11.1 |
| 35-39 | 17 | 16.2 | 6 | 12.8 | 6 | 5.6 | 3 | 6.7 |
| 40-44 | 16 | 15.2 | 8 | 17.0 | 7 | 6.5 | 1 | 2.2 |
| >44 | 0 | 0.0 | 6 | 12.8 | 0.0 | 0.0 | 1 | 2.2 |
| TOTAL | 105 | 100% | 47 | 100% | 108 | 100% | 45 | 100% |
| Number of Years of Schooling | | | | | | | | |
| 0 years | 12 | 11.6 | 0 | 0.0 | 18 | 16.7 | 0 | 0.0 |
| 1-6 years | 47 | 45.7 | 18 | 46.2 | 40 | 37.0 | 12 | 27.3 |
| 7-9 years | 36 | 34.9 | 16 | 41.0 | 29 | 26.9 | 22 | 50.0 |
| 10 or more years | 8 | 7.8 | 5 | 12.8 | 21 | 19.4 | 10 | 22.7 |
| TOTAL | 103 | 100% | 39 | 100% | 108 | 100% | 44 | 100% |

| | Nhlungwane | | | | KwaXimba | | | |
|-------------------------------------------|------------|------|-----|------|----------|------|-----|------|
| | Women | | Men | | Women | | Men | |
| | N | % | N | % | N | % | N | % |
| Occupation | | | | | | | | |
| Employed: | | | | | | | | |
| Unskilled | 8 | 7.9 | 10 | 20.4 | 5 | 4.7 | 7 | 15.2 |
| Semi-skilled | 4 | 4.0 | 0 | 0.0 | 6 | 5.6 | 3 | 6.5 |
| Professional | 0 | 0.0 | 14 | 28.6 | 0 | 0.0 | 4 | 8.7 |
| Self-employed | 11 | 10.9 | 8 | 16.3 | 5 | 4.7 | 2 | 4.3 |
| Unemployed, but seeking employment | 39 | 38.6 | 9 | 18.4 | 29 | 27.1 | 15 | 32.6 |
| Housewife | 13 | 12.9 | 2 | 4.1 | 23 | 21.5 | 3 | 6.5 |
| Student: | | | | | | | | |
| Up to secondary | 19 | 18.8 | 6 | 12.2 | 24 | 22.4 | 12 | 26.1 |
| Post-matric | 5 | 4.9 | 0 | 0.0 | 3 | 2.8 | 0 | 0.0 |
| School-leaver due to pregnancy | 2 | 1.9 | 0 | 0.0 | 12 | 11.2 | 0 | 0.0 |
| TOTAL | 101 | 100% | 49 | 100% | 107 | 100% | 46 | 100% |
| Marital Status | | | | | | | | |
| Single | 84 | 77.8 | 24 | 50.0 | 84 | 77.8 | 35 | 77.8 |
| Married | 16 | 14.8 | 23 | 47.9 | 18 | 16.7 | 10 | 22.2 |
| Divorced | 0 | 0.0 | 1 | 2.1 | 1 | 0.9 | 0 | 0.0 |
| Separated | 4 | 3.7 | 0 | 0.0 | 3 | 2.8 | 0 | 0.0 |
| Widowed | 4 | 3.7 | 0 | 0.0 | 2 | 1.8 | 0 | 0.0 |
| TOTAL | 108 | 100% | 48 | 100% | 108 | 100% | 45 | 100% |

Relationships

As shown in Table 1, only 16 percent of the women interviewed from both communities were married, compared to 48 percent of men in Nhlungwane and 22 percent of men in KwaXimba. Although marriage was uncommon, 90 percent of single women and 92 percent of single men were sexually active. The majority (97 percent) of these single women indicated they receive money from their partner. About half the women and men from Nhlungwane saw their partner everyday, compared to 24 percent of women and 17 percent of men interviewed in KwaXimba. In Nhlungwane, 26 percent of women and 17 percent of men saw their partner over weekends, compared to 36 percent of women and 30 percent of men from KwaXimba. The remainder of men and women in both communities saw their partner less frequently. The majority of respondents, both men and women, reported they were happy in their current relationship. In both communities day to day household decisions such as the purchasing of groceries were made by women, whereas major decisions such as the purchase of household appliances or furniture were made by men.

AIDS and STDs

AIDS knowledge was high among both men and women surveyed and probably reflects the ongoing educational activities of the CLPs and the research team: 90 percent of women and 98 percent of men were aware of sexual transmission, and 79 percent of women and 94 percent of men were aware of vertical transmission. There were some misconceptions such as that transmission could occur through casual contact (37 percent), and that AIDS could be cured (6 percent of women and 16 percent of men).

About a third of the women from both communities had discussed AIDS with their partner. On average the women who had discussed AIDS with their partner had about nine years of schooling compared to 6.3 years for the total sample. Male respondents from Nhlungwane were twice as likely to have discussed AIDS with their partner compared to men from KwaXimba (60 percent vs 30 percent).

Men who had more than 10 years of schooling were more likely to have discussed AIDS with their partner than men with less education. Women and men who saw their partner at least daily or over weekends were more likely to have discussed AIDS than those individuals who saw their partner less often.

Of the 66 percent of respondents with children, only six percent had discussed AIDS with them; eight of these respondents were from Nhlungwane and one from KwaXimba. These were all women older than 36 years, therefore their children were likely to be adolescents.

Among women interviewed in Nlungwane, 22 percent thought that they were at risk of getting AIDS, 21 percent were uncertain of their risk compared to 19 percent of women in KwaXimba who thought that they were at risk and 27 percent who were uncertain of their risk (see Table 3). Among those who perceived themselves to be at risk, 79 percent from Nhlungwane and 85 percent from KwaXimba thought their partner also was at risk of infection. About half of these respondents from both communities had discussed AIDS with their partner. Approximately two out of three women who perceived themselves at risk of HIV infection believed they had a right to insist on condom use or to refuse to have sex with their partner if he refused to use condoms. Only one out of two women in the total sample believed that women had such rights. Women who perceived themselves at risk were more likely to see their partners either daily or on weekends as compared to women who saw their partners less often.

Table 2: Perception of Risk Among Female and Male Respondents by Community

| | Nhlungwane | | | | KwaXimba | | | |
|-------------------------------------|------------|-------------|-----------|-------------|------------|-------------|-----------|-------------|
| | Women | | Men | | Women | | Men | |
| | N | % | N | % | N | % | N | % |
| Perception of Own Risk | | | | | | | | |
| At risk | 24 | 21.6 | 29 | 55.7 | 20 | 19.0 | 17 | 37.0 |
| Not at risk | 64 | 57.7 | 16 | 30.8 | 57 | 54.3 | 21 | 45.6 |
| Don't know | 23 | 20.7 | 7 | 13.5 | 28 | 26.7 | 8 | 17.4 |
| TOTAL | 111 | 100% | 52 | 100% | 105 | 100% | 46 | 100% |
| Perception of Partner's Risk | | | | | | | | |
| At risk | 47 | 43.9 | 22 | 42.3 | 40 | 42.1 | 15 | 31.9 |
| Not at risk | 40 | 37.4 | 15 | 28.8 | 23 | 24.2 | 16 | 34.0 |
| Don't know | 20 | 18.7 | 15 | 28.8 | 32 | 33.7 | 16 | 34.0 |
| TOTAL | 107 | 100% | 52 | 100% | 95 | 100% | 47 | 100% |

Among women who did not perceive themselves to be at risk of HIV infection, 44 percent from Nhlungwane and 58 percent from KwaXimba thought that their partner was at risk of HIV infection.

Among men in Nhlungwane, 56 percent thought they were at risk of getting infected with HIV, because, as they noted, they had many partners, one of whom might be infected. A smaller number of men (42 percent) thought their partner was at risk of getting infected. In comparison 37 percent of men in KwaXimba thought they were at risk of getting infected, and 32 percent thought their partner was at risk.

Only 12 percent of women thought that there were people with AIDS in their community, compared to 11 percent of men in Nhlungwane and 51 percent of men in KwaXimba.⁶ Among women, four percent indicated that they had seen a person with AIDS, compared to 11 percent of men in Nhlungwane and 46 percent of men from KwaXimba. Two out of three men indicated that AIDS was more common among young people compared to older people, and one out of three men felt that AIDS was more common among women than men.

Data on sexually transmitted diseases were only collected from men. More than half the men (55 percent) indicated a history of sexually transmitted diseases. About 80 percent indicated that they had sought treatment from a clinic or hospital and the remainder had visited a traditional healer for their most recent episode of STD. Only a third of the men from Nhlungwane and 13 percent from KwaXimba who had a history of an STD indicated that they encouraged their partner to seek treatment. About half the men from Nhlungwane and 65 percent from KwaXimba indicated that STDs increased one's risk of getting AIDS.

Condoms

As illustrated in Table 3, about a third of the women from both communities had never seen a condom, compared to seven percent of men. Condoms were recognized as a way of preventing disease and pregnancy by 69 percent of women and 84 percent of men.

⁶A young man had died of AIDS in KwaXimba just before the male questionnaires were administered. This young man had chosen to disclose his diagnosis to the community and subsequently received a great deal of support from the community.

Table 3: Condom Awareness and Use among Female and Male Respondents by Community

| | Nhlungwane | | | | KwaXimba | | | |
|--------------------------------------------------|------------|------|-----|------|----------|------|-----|------|
| | Women | | Men | | Women | | Men | |
| | N | % | N | % | N | % | N | % |
| Seen a Condom | | | | | | | | |
| Yes | 84 | 75.7 | 47 | 88.7 | 68 | 64.8 | 45 | 97.8 |
| No | 27 | 24.3 | 6 | 11.3 | 37 | 35.2 | 1 | 2.2 |
| Have Used a Condom | | | | | | | | |
| Yes | 16 | 14.4 | 24 | 45.3 | 12 | 11.1 | 12 | 26.0 |
| No | 95 | 85.6 | 29 | 54.7 | 96 | 88.9 | 34 | 74.0 |
| Would Like Partner to Use a Condom | | | | | | | | |
| Yes | 46 | 48.4 | 12 | 41.4 | 50 | 52.1 | 17 | 51.5 |
| No | 30 | 31.6 | 14 | 48.3 | 37 | 38.5 | 14 | 42.4 |
| Don't Know | 19 | 20.0 | 3 | 10.3 | 9 | 9.4 | 2 | 6.1 |
| If Yes, Would Partner Agree to Condom Use | | | | | | | | |
| Yes | 10 | 21.7 | 4 | 36.4 | 20 | 40.0 | 11 | 68.7 |
| No | 25 | 54.4 | 3 | 27.3 | 9 | 18.0 | 4 | 25.0 |
| Don't Know | 11 | 23.9 | 4 | 36.4 | 21 | 42.0 | 1 | 6.3 |
| Who Should Initiate Condom Use | | | | | | | | |
| Woman | 16 | 17.0 | 4 | 8.5 | 24 | 23.8 | 2 | 4.4 |
| Man | 35 | 37.2 | 29 | 61.7 | 37 | 36.6 | 36 | 80.0 |
| Joint Decision | 21 | 22.3 | 10 | 21.3 | 14 | 13.9 | 7 | 15.6 |
| Don't Know | 22 | 23.4 | 4 | 8.5 | 26 | 25.7 | 0 | 0.0 |

Among the women interviewed, 14 percent (N=16) from Nhlungwane and 11 percent (N=12) from KwaXimba had had sex with a condom, compared to 45 percent (N=24) of male respondents in Nhlungwane and 26 percent (N=12) in KwaXimba. Of the female condom users, 57 percent said they always used condoms; the remainder used condoms less frequently. Among women, condoms were used with their regular partner primarily as a method of contraception, with the added benefit of protection against AIDS and STDs. Among the male condom users, 17 percent said they always used condoms, 42 percent used them most times, 33 percent sometimes and 19 percent rarely. Among men, condoms were used most frequently with new partners (50 percent), casual partners (31 percent), and to a lesser extent with regular girlfriends (11 percent). Men indicated that they used condoms most often as a barrier to AIDS and other STDs (65 percent).

The majority of condom users (57 percent) were less than 20 years old. Condom users were more likely to see their partner everyday or on weekends as compared to less often, and had, on average, about nine years of schooling. In Nhlungwane all the condom users were single; in KwaXimba 83 percent were single. The majority of women said they used condoms with their regular partner. In Nhlungwane and KwaXimba few of these women perceived themselves to be at risk of HIV infection (13 percent and 17 percent respectively) most likely because they were using condoms.

Among women who had used condoms (N=28) seven indicated they had initiated condom use. In the case of another 14, the male partner had initiated use, and the rest reflected joint decision-making. Among men who had used condoms (N=36), eight said that condom use was initiated by the women and the remainder had initiated condom use themselves.

All the women who said they had initiated condom use were young, single, either in school or employed, and had no children. None of these women perceived themselves to be at risk of HIV infection because they were using condoms. They had all discussed AIDS with their partner and all believed that

women had the right to insist on condom use and to refuse to have sex with their partner if he refused to use condoms.

Family planning clinics were the main source of condoms for both men and women in both communities, and the majority of users indicated no difficulty in either obtaining or using condoms. Among both men and women who used condoms, one out of four had a condom with them at the time of the interview.

About half (47 percent) the women who had never used condoms indicated that if their partner suggested using condoms they would agree; the remainder indicated that there was no need to use condoms because they were in faithfully monogamous relationships. Although 50 percent of the women who had never used condoms indicated that they would like their partner to use condoms, only a third thought that their partner would agree.

With regard to who should initiate condom use, among women, 20 percent indicated that women should initiate condom use, 37 percent that men should initiate condom use, and 18 percent that it should be a joint decision, and the rest were undecided or did not respond to the question. Among men, 71 percent indicated that men should initiate condom use, seven percent that women should initiate condom use and 18 percent that it should be a joint decision.

Barriers to condom use mentioned by women included not having seen a condom (24 percent in Nhlungwane, 37 percent in KwaXimba), the belief that condoms signify a lack of love and trust in the relationship (72 percent Nhlungwane, 69 percent KwaXimba), the perception that a condom can remain in the women and cause her harm (eight percent Nhlungwane, 25 percent KwaXimba), fear of violence from partner (11 percent Nhlungwane, 32 percent KwaXimba), difficulty in obtaining condoms (21 percent Nhlungwane, 13 percent KwaXimba), the perception that her partner would think she has AIDS (29 percent Nhlungwane, 32 percent KwaXimba), and difficulty in negotiating use with her partner (35 percent Nhlungwane, 45 percent KwaXimba).

Among men, barriers to condom use included the belief that condoms signify a lack of love and trust in the relationship (79 percent Nhlungwane, 85 percent

KwaXimba), the perception that a condom can remain in the women and cause her harm (68 percent Nhlungwane, 57 percent KwaXimba), the perception that his partner would think he had AIDS (89 percent Nhlungwane, 100 percent KwaXimba), the belief that condoms should only be used in casual relationships (72 percent Nhlungwane, 93 percent KwaXimba) and the perception that his partner would be angry if condom use was suggested (78 percent Nhlungwane, 80 percent KwaXimba). Despite these constraints, about half the men indicated that they would like to use condoms with their partners. Of these respondents, a little more than half the men in both communities thought their partner would agree.

Multiple Partner Relationships

Nearly half the women indicated that it was common for women in the community to have more than one partner at the same time, for financial and security reasons. The majority of men (89 percent) indicated that it was common for men in the community to have multiple partners, for sexual reasons, and because it was an acceptable norm.

In Nhlungwane, 32 percent of the women interviewed indicated that they were currently in relationships with more than one partner compared to 12 percent of women in KwaXimba. This is in contrast to 24 percent of women from Nhlungwane and five percent from KwaXimba who indicated that they had had in the past multiple partner relationships. Of the women who reported that they currently had multiple partnerships but did not have them in the past, most were between the ages of 16 and 22 years. While 79 percent of men from Nhlungwane and 89 percent from KwaXimba indicated that they had in the past, had relationships with more than one partner simultaneously, 46 percent of men from both communities indicated that they currently had relationships with more than one partner.

Ability to Adopt Protective Behaviors

About a third of women from Nhlungwane and 47 percent of women from KwaXimba thought their partner currently had other partners. However, about half of them indicated that they would not object to their partner's multiple partners because they considered such behavior acceptable. About a third of women who indicated they would object to their partner's multiple partners would do so because they were worried about AIDS and other STDs.

About half the women from both communities indicated that women had the right to insist that their partners use condoms (52 percent Nhlungwane, 44 percent KwaXimba) and the right to refuse sex if their partners refuse to use condoms (51 percent Nhlungwane and KwaXimba). On average these women had about eight years of schooling.

But only about one-third of the women indicated that they would be able to discuss using condoms with their regular partner (32 percent in Nhlungwane, 42 percent in KwaXimba). About 90 percent of these women from both communities were single.

Fewer women said they would be able to refuse sex. Among women in Nhlungwane, 14 percent indicated that they would be able to refuse to have sex with their regular partner if he did not use condoms compared to 21 percent in KwaXimba. On average these women in Nhlungwane had nine years of schooling compared to 12 years in KwaXimba. The vast majority of these women were single (93 percent in Nhlungwane, 87 percent in KwaXimba).

Among men, about two out of three from both communities indicated that women did not have a right to insist their partner use condoms or refuse to have sex with their partner if he refuses to use condoms. Of these men in Nhlungwane 45 percent were single compared to 74 percent in KwaXimba. Older men were more likely than younger men to feel that women did not have these rights.

Among women from both communities, 39 percent indicated that their friends approve of condom use, 58 percent indicated that their friends approve of talking about AIDS with one's partner, and 78 percent indicated that their friends

disapprove of multiple partner relations. Among men, only 22 percent indicated that their friends approve of condom use, 28 percent indicated that their friends approve of talking about AIDS with one's partner, and 52 percent indicated that their friends disapprove of multiple partner relations.

The proportion of women from both communities who felt that they would be able to implement protective behavior with their regular partner is as follows: 41 percent indicated that they would be able to ask their regular partner if he had other partners, 37 percent would be able to discuss condoms, 24 percent would be able to ask him to be tested for the AIDS "germ", 69 percent would agree to having sex only with him, 60 percent would be able to ask him to have sex only with her, and 36 percent would be able to use a condom.

The proportion of women from both communities who felt that they would be able implement protective behavior with a first or new partner is as follows: 58 percent indicated that they would be able to ask him if he had other partners, 50 percent would be able to discuss condoms, 47 percent would be able to ask him to be tested for the AIDS germ, 65 percent would agree to having sex only with him, 62 percent would be able to ask him to have sex only with her, and 53 percent would be able to use a condom.

Among women, other impediments to the adoption of protective behavior included fear of a violent reaction (22 percent) or the possibility of a violent reaction (13 percent) by their partner for insisting on condom use. In addition, about a third of the women interviewed indicated that their partner was sometimes drunk when they had sex.

Factors that made it difficult for women to terminate relationships that continued to place them at risk of getting AIDS included financial dependence (31 percent), love (16 percent), the children needing a father (17 percent), that her family would be angry (27 percent of married women), and that she needed the protection of a man (11 percent).

Controlling the Spread of AIDS

Men and women in both communities made several suggestions as to what needed to be done to control the spread of AIDS. These included the promotion of monogamy (24 percent women, 40 percent men); the use of condoms (17 percent women, 38 percent men); no casual sex (20 percent women, five percent men); education of the community, youth and men (37 percent women, 20 percent men); and that scientists should come up with a cure (11 percent of men).

Interviews with Couples

A total of 30 couples (30 female respondents and 30 male respondents) were interviewed independently of each other in both communities. Ten of the couples were from KwaXimba and 20 of the couples lived in Nlungwane. Eight of the couples were married to each other. In 14 instances both partners were single, in one the woman was married to someone other than the partner who was interviewed, and in seven the man was married to someone other than the woman who was interviewed.

Data will be presented on married couples, married men and single women, and single men and single women. Data on perception of risk were either categorized as "at risk" or "not at risk"; in instances where only one-half of the relationship (i.e. either the man or the woman) perceived him/herself or the other to be at risk, both were regarded as at risk.

Married Dyads

The eight married couples interviewed were from Nlungwane. All couples were over 29 years old (Range: Women: 29-40; Men: 36-67). The average age difference between men and women was 13 years. With the exception of one couple who saw each other only over weekends, the remainder saw their partners daily. Knowledge of AIDS in terms of modes of transmission and methods of

prevention was high. None of the eight couples was using condoms with each other. Two men were using condoms with casual partners only, one always and the other half the time.

Both partners in three of the couples perceived themselves to be at risk of getting AIDS. In four couples, the women perceived themselves at risk but the men did not, and in one couple the man thought that they were at risk but the woman did not.

Although half of the men interviewed had been treated for an STD, only one man encouraged his partner to seek treatment. Given, however, that he had multiple partners, it is unclear which partner he encouraged to seek treatment!

All the women who perceived themselves to be at risk of getting AIDS would like their partners to use condoms but did not think that they would agree. All the men thought it was unacceptable to use condoms with wives or regular girlfriends, but alright to use them with casual partners. At the time of the interview six male respondents did not see a need to use condoms with their wives because they believed their wives were faithful. Although four men perceived themselves to be at risk of getting AIDS because of multiple partners, only two were using condoms with casual partners.

While five women thought that they had a right to insist on condom use and refuse to have sex if their partner refused to use condoms, only three men shared these sentiments. Further, only three women said that they would object to their partner having other partners, while five thought it was acceptable behavior.

Two case studies from the eight married couples interviewed are described below:

Case Study 1. She is a 40-year-old housewife, with no formal education. She has one child and sees her husband every day. Day-to-day household decisions, such as purchasing groceries are made by her. Decisions on major purchases such as household appliances are made jointly with her husband. Her level of AIDS knowledge was high and she thought that both she and her husband were at risk

of getting AIDS because her husband may have other sexual partners. They had had discussions about the risk of getting AIDS. Although she would like her partner to use condoms they were not using them currently, and had never used condoms. She did not think that women had the right to insist on condom use if they thought their partner put them at risk of getting AIDS, nor did she think they had the right to refuse sex if their partner refused to use condoms. She was scared of objecting to her partner having other partners because he was very aggressive.

He is a 50-year-old self-employed man with no formal education. His AIDS knowledge was high and he did not think he was at risk of getting AIDS because he is faithful to his wife and has never had sex with anyone else. He did not think his wife was at risk of getting AIDS or placed him at risk because he trusts her and does not think that she has had sex with anyone else. He did not think that women had a right to insist on condom use or refuse to have sex if their partner refused to use condoms. He believes quite strongly that the best protection against AIDS is mutual monogamy.

Case Study 2. She is a 29-year-old unemployed woman with four years of schooling, has two children and sees her partner daily. She thinks that both she and her husband are at risk of getting AIDS because he has other partners. They have not discussed AIDS. Although she would like her husband to use condoms, he refuses. She believes that women have the right to insist on condom use or refuse to have sex with their partner if they don't use condoms. However, she is unable to ask her partner about his other partners, insist on condom use or refuse to have sex with him although she thinks he places her at risk of getting AIDS.

He is a 43-year-old employed man with six years of schooling. He makes the major decisions in the household while his wife takes care of day-to-day management. He thinks that he could get AIDS because he has many partners but that his wife is not at risk because she is faithful to him. He has previously been treated for an STD and usually encourages his partner to seek treatment,

although it was unclear which partner he was referring to. He said that he always uses condoms with casual partners and believes that women have a right to insist on condom use as well as refuse to have sex if their partner puts them at risk.

Single Men, Single Women

Of the 14 single couples who were interviewed, nine were from KwaXimba and five from Nhlungwane. The women ranged in age from 16 to 36 years and the men from 19 to 42 years, with an average age difference between men and women of 4.7 years (SD=6,6). Only differences in age and frequency of seeing partners existed between respondents from Nhlungwane and KwaXimba. The respondents from Nhlungwane tended to be over 25, compared to KwaXimba where they were under 25. Couples from Nhlungwane saw each other every day in contrast to the couples from KwaXimba who saw their partners over week-ends, once a month or less frequently.

Knowledge of AIDS in terms of modes of transmission and methods of prevention was high. In seven couples both perceived themselves to be at risk of getting AIDS; in three couples the woman thought that they were at risk but the man thought that they were not at risk; in three couples the woman thought that they were not at risk but the man thought they were at risk; and, in one couple both the man and the woman did not perceive themselves to be at risk.

None of the 14 couples were using condoms with their primary partner; eight men were using condoms with casual partners only and on an irregular basis. While half of the women would like their partners to use condoms, only two men indicated that they would agree to using condoms with this partner.

Of the nine men who had been treated for an STD, only two encouraged a partner to seek treatment.

About half of the men (six) and half of the women (seven) interviewed thought that women had a right to insist on condom use and to refuse to have sex if their partner refused to use condoms. Eight of the women would object to their

partner having multiple partners, compared to the remainder who thought it was okay for men to have multiple partners.

Case Study 1 (KwaXimba). She is a 27-year-old self-employed woman with four years of education. She has one child and sees her partner over week-ends. She thinks she and her partner may be at risk of getting AIDS because her partner may have other partners. They have not discussed AIDS. They do not use condoms and she does not want her partner to use condoms. She does not think that women have the right to insist on condom use or refuse to have sex if their partner does not use condoms. She says, however, that she would object to her partner having other partners.

He is a 25-year-old unemployed male with 11 years of schooling. He did not think that he was at risk of getting AIDS. He thought his partner might be at risk because she may have other partners. They have discussed AIDS. He uses condoms with his casual partners; he currently has three casual partners. He has been treated for an STD but has not encouraged his partner to seek treatment. He believes that women have a right to insist on condom use and refuse to have sex if their partner refuses to use condoms.

Case Study 2 (Nhlungwane). She is a 19-year-old female scholar. She has one child and sees her partner over week-ends. Her partner gives her money. She thinks she is not at risk of getting AIDS because she is faithful but that her partner is at risk because he has more than one partner. They have not discussed AIDS. They do not use condoms nor does she want her partner to use condoms. She does not believe that a woman has the right to insist on condom use or to refuse to have sex if her partner does not use condoms. She would not object to her partner having other partners.

He is a 21-year-old unemployed male with 12 years of education. He does not think he could get AIDS because he always uses condoms with casual partners. He does not think his partner could get AIDS because she is faithful to him. He

has never been treated for an STD. He thinks that women have the right to insist on condom use and to refuse to have sex if her partner refuses to use condoms.

Married Men, Single Women

All seven couples in this type of relationship were from Nhlungwane. The women ranged in age from 16 to 39 years and the men from 27 to 42 years. The average age difference between men and women was 13 years. With the exception of one couple who saw each other only over week-ends, the remainder saw each other every day. The wives of the men were usually at their rural homes with their children and the men usually visited this family once a month. Two of the women interviewed were scholars, one was self-employed and the remainder were unemployed, compared to six of the men who were self-employed and one who was a teacher. All the women received money from their partners. The extent of the financial assistance given to the women was not measured.

Knowledge of modes of transmission of HIV and methods of prevention was high among both men and women. While five women did not perceive themselves to be at risk of getting AIDS, their partners thought that they were at risk, one couple thought that both were at risk of getting AIDS and one couple did not perceive themselves to be at risk of getting AIDS.

Three couples were using condoms with each other. This included the two female scholars who were using condoms as a contraceptive method and as a barrier to STDs. With the exception of one couple, condom use in these relationships and with other partners was irregular.

Of the seven men interviewed, four had previously been treated for an STD. However, none of them encouraged his partner to seek treatment. Only one man who was interviewed said he did not have casual partners.

Five women thought that they had a right to insist on condom use, refuse sex if their partner refuses to use condoms and would object to their partner having other partners. In contrast, only two men interviewed, one of whom indicated

that he had no casual partners, thought that women had a right to insist on condom use and refuse to have sex if their partner refused to use condoms.

Case Study 1. She is a 19-year-old scholar, has no children and sees her partner every day. She receives money from her partner. They jointly decide about household matters and major purchases. She does not think that either she or her partner are at risk of getting AIDS because they always use condoms. They have discussed AIDS. She thinks that women have a right to insist on condom use and refuse to have sex if their partner refuses to use condoms. She would object if she heard that her partner had other partners.

He is a 33-year-old schoolteacher whose wife lives in Empangeni, a three-hour drive north of Nhlungwane. He sees his wife once a month. He indicated that he has two stable partners, his wife and the scholar described above. He thinks that he and both these partners are at risk of getting AIDS because he has casual partners with whom he does not use condoms all the time. He has discussed AIDS with his stable partners. He has previously been treated for an STD but has not encouraged his partners to seek treatment. He does not believe that women have the right to insist on condom use or refuse to have sex if their partner refuses to use condoms.

Case Study 2. She is a 16-year-old scholar, has no children and sees her partner over weekends. She does not think that she is at risk of getting AIDS because she has one partner and they frequently use condoms, but her partner may be at risk because he may have other partners. They have discussed AIDS. She initiated the use of condoms for protection against STDs and to prevent pregnancy. She believes that women have the right to insist on condom use and refuse to have sex if their partner refuses to use condoms. She would object to her partner having other partners.

Her partner is a 42-year-old self-employed man. He thinks that he and his partner are at risk of getting AIDS because he has other partners. He has been

treated for STDs but does not encourage his partner to seek treatment. He does not think that women have the right to insist on condom use or refuse sex if their partner refuses to use condoms.

Woman Married, Man Single

As there was only one such combination of a couple, only a brief profile of the man and woman is presented.

She is a 34-year-old housewife with no formal education, has two children and sees the partner described below over weekends. Her knowledge of modes of transmission and methods of prevention of AIDS was high. While she perceived both herself and this partner to be at risk of getting AIDS, they had not discussed AIDS. She had tried to get this partner to use condoms but had not been successful. She did not think that women had the right to insist on condom use or refuse to have sex if their partner refused to use condoms. She did not think that she had a right to object to her partner having multiple partners.

Her single partner is a 28-year-old unemployed man with 11 years of formal schooling. He also perceives both himself and her to be at risk of getting AIDS because he has other partners, currently three, and he never uses condoms. He has been treated for STDs but does not encourage his partner/s to seek treatment. Although he has never used condoms he would agree if the need to use condoms was discussed. He felt that women have a right to insist on condom use and refuse to have sex if their partner refused to use condoms.

These case studies illustrate similarities and differences in attitudes and beliefs between partners, especially with regard to perception of risk and condom use. While some couples use condoms and have discussed AIDS, others have not, despite at least one partner having other sexual relationships. These case studies also highlight the disturbing finding reported previously of men who were treated for an STD but did not encourage their partners to seek treatment.

Opinion Leaders and Anti-AIDS Efforts

Of the 31 opinion leaders approached, only one declined to be interviewed. Interviews were conducted with 29 individuals and one group from different sectors. Six of the 29 were women. Among the respondents, 24 were based in Natal/KwaZulu, three in Johannesburg, one in the Transkei, and one in Kangwane. While the majority were based in Natal/KwaZulu, they were also influential at the national level. The sectors represented included political (eight), religious (five), culture and media (five), education (four), business (four), labor (two), and women's organizations (two). The sample included the president of the African National Congress, and the heads of the state of Transkei and the KwaZulu Legislative Assembly.

Most of the respondents had been briefed by their organizations in preparation for the interview. This unexpectedly had the beneficial effect of sensitizing these influential people to AIDS issues. They were concerned about the potential impact of AIDS on family life and society. They felt that families would be further disrupted and impoverished through prolonged ill health of parents and breadwinners, and that many children would be orphaned. They also expressed concern about vertical transmission of HIV from infected mother to infant. The respondents from the business and political sectors were concerned that economically active people would be most affected by AIDS and that this would negatively influence economic growth.

While their knowledge about AIDS was reasonable, there were many misconceptions, and a substantial number of leaders believed that AIDS was government propaganda and not real. Since many had not seen a person with AIDS, this reinforced their perception that AIDS is not real and therefore they have not emphasized the issue within their constituencies. For some, the government AIDS campaign was equated with family planning, which had been viewed as a means of controlling the black population. Some opinion leaders, despite high levels of basic knowledge about AIDS, did not believe it was real or

that they could be at risk. The need for locally produced audiovisual material that showed asymptomatic and symptomatic people was raised repeatedly.

Among the more enlightened, there was a substantial debate on whether prevention messages should emphasize condom use or a reduction in the number of partners. The majority did not believe that condoms were a long-term solution but that more emphasis should be placed on mutually monogamous relationships.

Many expressed the need to target youth. Some leaders even suggested youth be targeted in their preteens, before they become sexually active or are influenced by peers to experiment with sex. The lack of parental guidance and the need for parents to reinforce positive values were highlighted. They mentioned the need to address the lack of recreational facilities so that the energy and time of young people could be directed to alternative activities. The continuing violence was also mentioned several times as contributing to the dislocation of communities and the breakdown in family cohesion and discipline. It was felt that, among youth, the threat of AIDS has become irrelevant and remote because the threat of violent death is more imminent.

Societal risk factors such as migrancy, and other socioeconomic conditions such as lack of housing and recreational facilities were mentioned as obstacles to controlling the spread of AIDS. The migrant labor system creates abnormal social conditions that separate partners and families, and further encourages men to establish relationships in the cities, facilitating the spread of HIV infection.

While the majority of the leaders felt that both men and women should be targeted for AIDS education, some felt that women should take a leading role in anti-AIDS efforts. They recognized that women play a key role in health care and education in the household. While some felt that women are more organized and therefore have a better opportunity to discuss AIDS issues and even implement changes or influence behavior, many felt strongly that men had to be targeted because of their more powerful position in the society and in relationships. Some respondents, mainly from the liberation movements, said that

women needed to be more assertive and needed an improved position in society, in order to protect themselves, their families, and future generations.

The respondents also pointed out that strategies to address poverty, the lack of housing, and creating peace and stability were issues that need to be addressed to curb the AIDS epidemic.

Of great concern to most respondents was the lack of a national AIDS strategy at the time of the interviews. They felt that a comprehensive strategy should include a far more aggressive awareness campaign and dissemination of information that reached people at the grassroots level. There was unanimous agreement that it was the government's responsibility to curb the AIDS epidemic and that not enough was being done by the government to curb the spread of AIDS in South Africa. The government's lack of credibility among the majority of the population was also raised, and many participants said that they were willing to play a role (some already were) in preventing AIDS if resources were made available to them.

This portion of the study had a broad impact, resulting either directly or indirectly in Dr. Zuma's participation in the following activities: preparation of an AIDS video by COSATU (the largest trade union in the country), a discussion with members of the KwaZulu Legislative Assembly, and being invited to address an AIDS seminar organized by the business sector.

7. Lessons from the Research Process

Undertaking research in situations where respondents/participants are wary of sharing intimate and sensitive information with strangers for fear of victimization or discrimination poses many challenges. The participatory processes used in this study enabled us not only to obtain important insights into this community which otherwise would not have been possible but also to raise the community's awareness of AIDS. Further, it initiated a critical examination by community members of HIV risk and catalyzed a dialogue among individuals about how to reduce their risk of HIV infection.

Group Discussions

"This is the first time our community has gained and learnt such a lot from research." (Women's group, Nhlungwane)

"AIDS has become much clearer to me." (Young female teacher, KwaXimba)

The group discussions brought home for some participants for the first time the reality of AIDS and the risk they possibly face. For others it was an opportunity to discuss fears and have misconceptions corrected. What is important is that for most participants it was the first time there was an opportunity to discuss and debate issues relating to sexual behavior, risk of AIDS, and adoption of protective behaviors. The group discussions not only gave the researchers better insight into the realities of the communities, but also provided members of the community with opportunities to reflect on various aspects of their sexual interactions, and the health implications of their behavior.

Involvement of Community Organizations

In the time that we worked in KwaXimba we were asked to address numerous organizations. The requests came from almost all the sectors of the community--the youth, pupils, teachers, women's groups, the churches, and men. In Nhlungwane, initially our interaction was confined more to women and the requests for talks came from women's groups rather than groups which represented the general population. However, as the study progressed, these organizations were drawn in. Moreover, the process of conducting research served as a catalyst for organizations in the targeted communities to expand their agendas to include increasing AIDS awareness and to spearhead other AIDS-related interventions.

Community Liaison Persons

The contributions of the CLPs, who were not originally included in the study design, cannot be overstated. These individuals became a valuable source of guidance and information, not only for the research team, but for the community itself.

During the early phase of the study, the majority of men and women had never seen, let alone used, a condom. However, by the end of the study, the CLPs were being inundated with requests in both communities, mainly from young men and women, for more AIDS information and condoms. It is apparent that the barriers to condom use can be broken down by information and education.

"I spoke to a young man who had come to me previously for information on AIDS and condoms and instructions on how to use condoms. He has been using condoms since and has had no problems. His girlfriends were saying that by using condoms he was very thoughtful as he was helping to protect them. He said that he first discussed AIDS and condoms before they used condoms." (CLP, Nhlungwane)

In KwaXimba, the CLPs alerted the research team to the perception that was growing in the community that AIDS is a "woman's disease." This perception was based on the fact that the research team consisted only of women; the first phase of the research focused on women; and at that stage all the CLPs and field-workers were women. It was exacerbated by the fact that a few months into the study, a woman in KwaXimba died of AIDS. We then tried to recruit more men onto the team and to involve men in activities in order to counter this perception. This issue would not have been documented or addressed were it not for the CLPs.

In Nhlungwane, in contrast, men felt discriminated against because of our initial focus on women. Often they would join the group discussions and were very articulate in their concerns about AIDS. As we entered the male component of the study, the men played a more active role, largely through the efforts of the male CLP. In Nhlungwane, we were more successful than in KwaXimba in getting men and women to enter into debate and discussion.

The CLPs are highly respected within their communities and it is anticipated that they will remain a sustainable resource within the community beyond the limited life span of this short-term research project.

AIDS Intervention - Part of a Wider Process

"AIDS goes hand in hand with development. The people who are trying to combat AIDS must firstly uplift the standard of living in that particular area before they can make people hear what they want to say." (35-year-old man, KwaXimba)

"In our community people are not concerned about their health. They concentrate on political issues and things that are affecting them directly now such as the lack of water and shelter. They have to see an issue as critical before they concentrate on it. Now they have come to realize that AIDS is of critical importance." (Civic leader, KwaXimba)

As the research progressed, we continued to be inundated with requests from the members of the community for assistance on issues that ranged from AIDS counseling to welfare benefits. Some issues were relatively easy to address, such as providing counseling support to two people with AIDS and their families. Others, such as welfare and disability benefits, were more difficult and these were referred to the appropriate bodies. We were continually challenged by the social reality of these poor and marginalized communities.

Participatory Research

"We appreciate your having come to Nhlungwane. It means we are important in our own right." (Member of the women's group)

Participatory approaches are difficult and time consuming. The benefits derived, however, in terms of what can be achieved and sustained, far outweigh these constraints. In concrete terms, the benefits of this study at both the community and individual level included information on AIDS and safer sex practices, allaying of fears stemming from misconceptions, and access to condoms. However, there were many intangible benefits, as the quote and the following example indicate.

Over the period of the study, a healthy, dynamic relationship developed between the research team and the community. Recently in KwaXimba a big ceremony was held to celebrate the peace that the area has enjoyed in the past few years. More than ten cows were slaughtered for the feast, and the research team felt very honored to be part of this celebration. The invitation came through the liaison people from the chief himself. We attended, and in addition to making special mention of us, together with many other dignitaries in his speech, the chief presented us with a thank-you note.

Having worked in two very different communities, we have learned that, although there is no standard approach to eliciting community consent or

participation, one needs to have a fairly good understanding of the community and the power bases within the community, and try to see what works best, learning from mistakes along the way. Participatory approaches require researchers to be flexible about the specific objectives of projects. While the overall purpose remains, researchers need to be aware of what is emerging in a dialogue with the community, and listen and adjust research questions so that they are relevant and appropriate.

8. Conclusion and Recommendations

The AIDS epidemic is still largely a silent one in South Africa but is slowly taking on a human face as more and more cases develop. The unusually long asymptomatic phase of the disease has impeded prevention efforts because many people do not believe AIDS exists. This has been exacerbated by the lack of credibility of the government, whose limited efforts have been viewed with suspicion.

At this point in the HIV epidemic in South Africa, large-scale, credible, imaginative, and innovative prevention programs are urgently needed if they are to have any significant impact on enabling individuals at risk to alter their behavior. Such programs should go beyond the confines of merely informing and address the more difficult issues, such as making condoms more accessible, increasing personal power to control one's vulnerability to HIV infection, and building community support to encourage risk-reducing behavior.

The findings from this study reaffirmed the poor correlation between factual knowledge of how HIV is transmitted and how it can be prevented, and the adoption of behavior that will reduce HIV risk. Despite factual knowledge about sexual transmission of HIV and confidence in condoms as an HIV preventive measure, high levels of unprotected, multiple-partner relationships continue. The reported increase in the number of young, single women in both communities having multiple partners may be cause for concern. In addition, although responses on the male questionnaire indicated that fewer men were now involved in multiple partners relationships than had been in the past, current levels are still very high.

Of greater concern is the poor internalization of knowledge and translation of knowledge into an assessment of personal risk. Perception of one's own risk, especially among women, was low. In this study it was difficult to ascertain to what extent some form of denial was operating among those women who, despite

high levels of factual knowledge and perception of their partner's risk of HIV infection, did not perceive themselves at risk for HIV infection.

There is sufficient evidence linking the presence of other STDs with an increased risk of HIV infection. In this study we established that sexually transmitted diseases among men are common. While the men seek treatment, they rarely encourage their partner(s) to do so. We were unable to explore the issue of STDs with women because they appeared to have little knowledge of their reproductive systems or the symptoms of STDs. Given the extent of STDs among men and the fact that very few inform their partners, women could have other treatable STDs of which they are unaware.⁷

Limited economic opportunities force men to seek employment away from their rural base. This creates abnormal social conditions that separate partners and families for varying lengths of time and further encourages sexual relationships in the cities, facilitating the spread of HIV in both urban and rural areas. About half the women in KwaXimba see their partners less often than daily or over weekends. This separation most likely makes it difficult for women when they do see their partner to discuss AIDS or the use of condoms when there are more pressing household decisions such as the purchase of food, school fees, and issues relating to the children. It is interesting to note that women who saw their partners more frequently were also more likely to perceive themselves to be at risk of HIV infection, to use condoms, to have discussed AIDS with their partner, to believe that they had a right to insist on condom use and to refuse to have sex with their partner if he would not use condoms, and to feel that they can discuss the adoption of protective behaviors with their partner.

Despite many impediments, women in both communities have been able to organize themselves into a variety of interest and activity groups to address their

⁷Routine screening of first-time attendees at an antenatal clinic in a large tertiary hospital in Natal indicated that 10-15% of the women had syphilis (personal communication, J. Moodley, Department of Obstetric and Gynecology, King Edward Hospital).

material needs and political aspirations. However, their perception of their own power to protect themselves from HIV infection is poor. The possibility of using their group support and power has not been explored as a mechanism to protect themselves from HIV infection. Although issues such as dependence on men for material and financial support and fear of a violent response influence their ability to insist on safer sex practices (such as fidelity and condom use), many women also do not believe that they have the right to do so.

While the lack of communication between men and women about sexual matters may not have been a major issue in the pre-AIDS era, it is central to the adoption of behavior to reduce the risk of HIV infection. The current low levels of communication between men and women are a cause for concern. Many women perceive their partner to be at risk of HIV infection and many men perceive themselves to be at risk of HIV infection, yet married couples and partners in a permanent relationship are reluctant to raise and discuss the issue of protective behaviors. In addition, the overcrowding in both urban and rural areas makes the act of sex a hurried and furtive matter, with limited opportunities to negotiate or discuss HIV-protective behaviors.

A very disturbing finding in this study was that of women going through potentially harmful procedures to ensure that their vaginas are dry and "tight" for sex. Men use "vaginal wetness" as an indicator of a woman's fidelity and associate wet vaginas with contraceptive use and STDs. This issue needs to be explored more carefully and systematically before generalizations can be made. We also need to get a better sense of how widespread douching and use of intravaginal substances is, and what implications such practices have for the transmission of STDs and for HIV in particular.

It is noteworthy that despite the many constraints to using them, about one in ten women and a third of the male respondents had already used condoms. Although only a few used them consistently, the men and women who were using them were also from the age groups in which HIV seroprevalence is currently the highest; that is, condoms were being used by women under 20 years and men

between the ages of 25 and 35. These condom users could be an important influence on their peers. Among condom users, more consistent use needs to be encouraged. About half the respondents indicated that they would like their partner to use condoms or would be agreeable to condom use if it was suggested by their partner. As noted previously, the CLPs were inundated with requests for condoms, mostly by younger people.

Women's vulnerability to HIV infection is directly linked to their status in society and in the family. Men are in a more powerful position both in society and in the family. They need to acknowledge that unprotected sex with multiple partners not only puts them at risk, but also their partners and unborn children, and has implications for the entire family. The responsibility for caring, protecting, and nurturing has traditionally fallen on women but, with the sexual nature of HIV transmission, men have to take more responsibility in this regard.

Many respondents saw the promotion of monogamy as one solution to limiting the spread of HIV. However, marriage is rare in both communities, largely as a result of the system of paying a bride price (*lobola*). Sex outside of marriage or permanent relationships is common, with a facade of fidelity to wives and permanent partners. This facade is evident in men who think the use of condoms should be restricted to casual partners, although they use them infrequently. Here again it is the responsibility of men to avoid unprotected, multiple-partner relations. There is also a need for traditional leaders to reexamine the system of *lobola* as one way of reducing the spread of HIV.

The women participants in the study recognized that while they can continue to challenge the status quo which is at the root of their vulnerability, right now the options for HIV protection that they can control need to be increased. They repeatedly asked for the rapid development of a method that they could use and control. The perception of this method was "something clandestine" that would serve the dual purpose of preventing disease and controlling pregnancy. The women also indicated that they need to be kept informed of new developments in this area.

Traditional leaders need to play a bigger role in ensuring that traditional laws which protected women in society and which have been eroded, are again enforced as one way of reducing the spread of HIV. An example of such a law is the system of compensation (*inhlawulo*) to the family and chief if a women is made pregnant outside of marriage. This could help control the soaring teenage pregnancy rates and protect young women from being impregnated and abandoned. Men would be less likely to pressure young girls into having sex if they had to pay for the consequences.

The system of *lobola* offers protection to a woman through the extended family by providing her with a channel for complaints about her husband. This system does not allow her husband to have another wife or partner without her permission. However, the high bride price has resulted in marriage being unaffordable for most people. This has resulted in a permissiveness that has actually reduced the power women had in relationships. New ways of payment need to be negotiated so that family units can be constructed again through marriage as one way of reducing the spread of HIV.

Opinion leaders from a wide range of sectors have indicated a willingness to play or are already playing a role, in anti-AIDS efforts. They need to be encouraged to place AIDS on their agenda at every opportunity. They need to use the power their position brings to ensure that recommendations are implemented and that appropriate policy is developed at the highest level.

In summary, the qualitative and quantitative findings from this study indicate that for women to control and protect themselves from HIV infection there is a need to:

- Provide women with information about reproductive health issues and sexually transmitted diseases in particular.
- Explore ways of translating factual information on HIV into personal risk.
- Help women to develop communication and negotiation skills so that they can discuss sexual and other issues with their partners.

- Pay special attention to targeting younger women, who may be especially vulnerable to HIV infection because of multiple partners. The younger women in both communities who have already succeeded in negotiating safer sex practices could serve as an important peer influence. The fact that young women who have more years of schooling think they can demand safer sex practices is one more reason to encourage young women to focus on continuing their education.
- Explore ways to enable women to be economically independent, possibly through vocational training, creation of job opportunities, and improved credit facilities.
- Find ways to increase women's power through group support and networks such as women's groups. In the course of the study, the positive role of group support was demonstrated repeatedly. Women's groups and other organizations play an active role in both communities in bringing people together on specific issues. Their ability to accomplish tasks despite limited resources comes from pooling their expertise and efforts. So far, the use of this strength in preventing AIDS has not been explored to any extent. While women recognize at an individual and group level what places them at risk and impedes their ability to adopt protective behavior, their ability to use their group power as leverage remains to be tested.
- Teach parents how to communicate with their children about the dangers of unprotected sex and encourage them to do so.
- Increase efforts to develop inexpensive, clandestine methods that women can use to prevent pregnancy and protect themselves against sexually transmitted diseases, as well as disease preventive methods that permit conception.
- Familiarize women with condoms and their proper use.
- Explore ways of creating opportunities for men and women to discuss AIDS and other issues that surround sexuality.

Efforts to decrease women's vulnerability to HIV infection need to go hand in hand with interventions targeted at broader societal issues. These include:

- Addressing social issues, such as the migrant labor system, by examining ways that will allow families to live together.

- Reexamining and redefining the system of *lobola*.
- Improving the status of women in society.
- Getting men to take responsibility for their role in the transmission of HIV.

All of these are ultimately dependent on a government that is committed to addressing the issue of AIDS in a concerted and coordinated way, and on credible opinion leaders playing a more active and high-profile role in anti-AIDS activities.

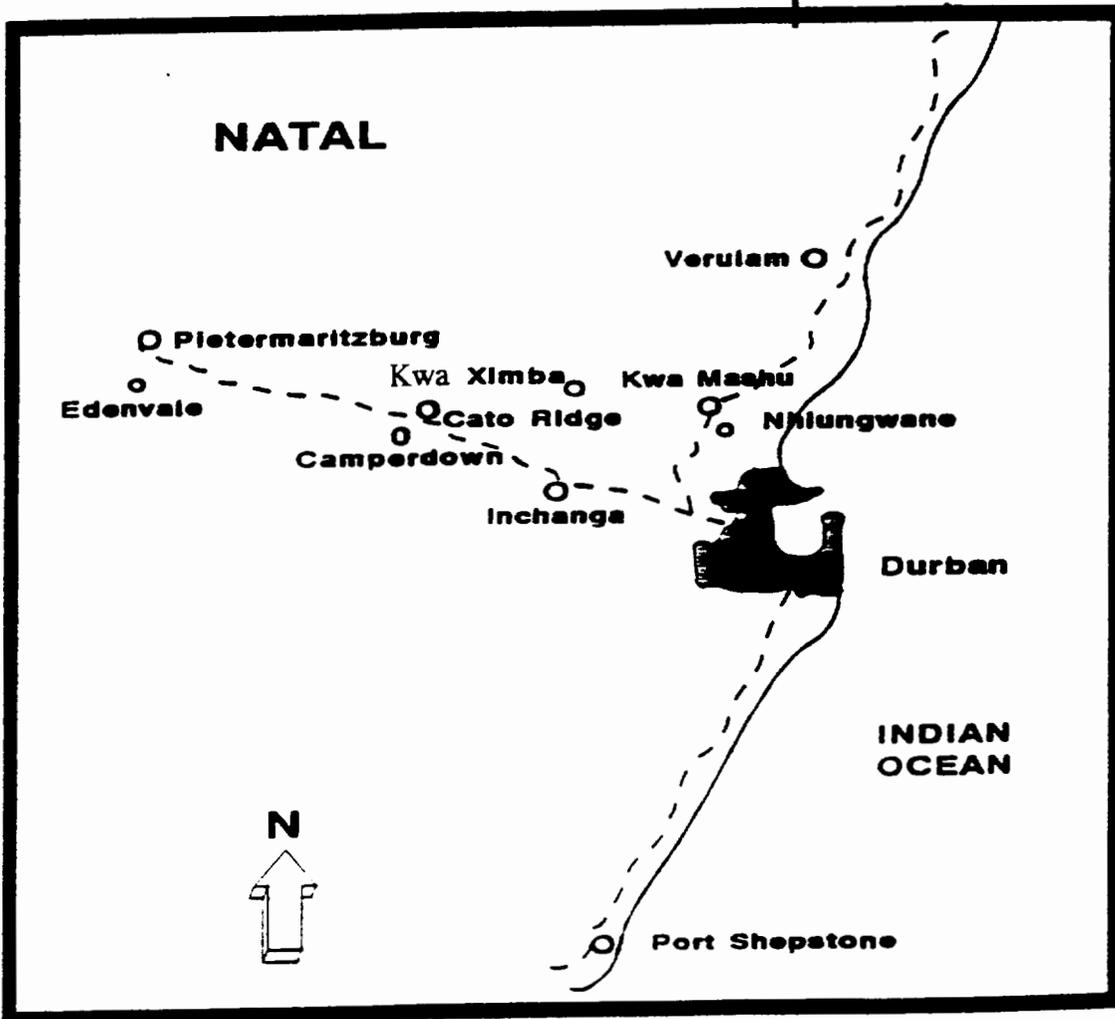
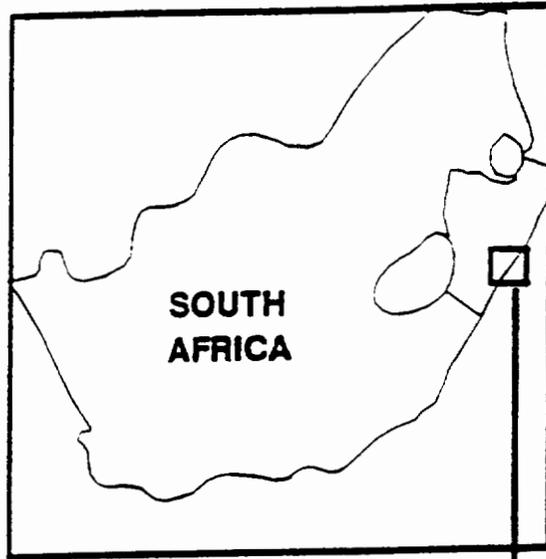
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APPENDICES

APPENDIX 1



APPENDIX 2

Project Team

Q ABDOOL KARIM

E PRESTON-WHYTE

N ZUMA

Z STEIN

I SUSSER

Advisory Board

J COOVADIA

F DLAMINI

P ZULU

M RICHTER

SS ABDOOL KARIM

Project Co-ordination

N MORAR

Research Assistants

V MTHEMBU

E CAKATA

V NAIDOO

S NGXONGO

T MDLULI

T PHILI

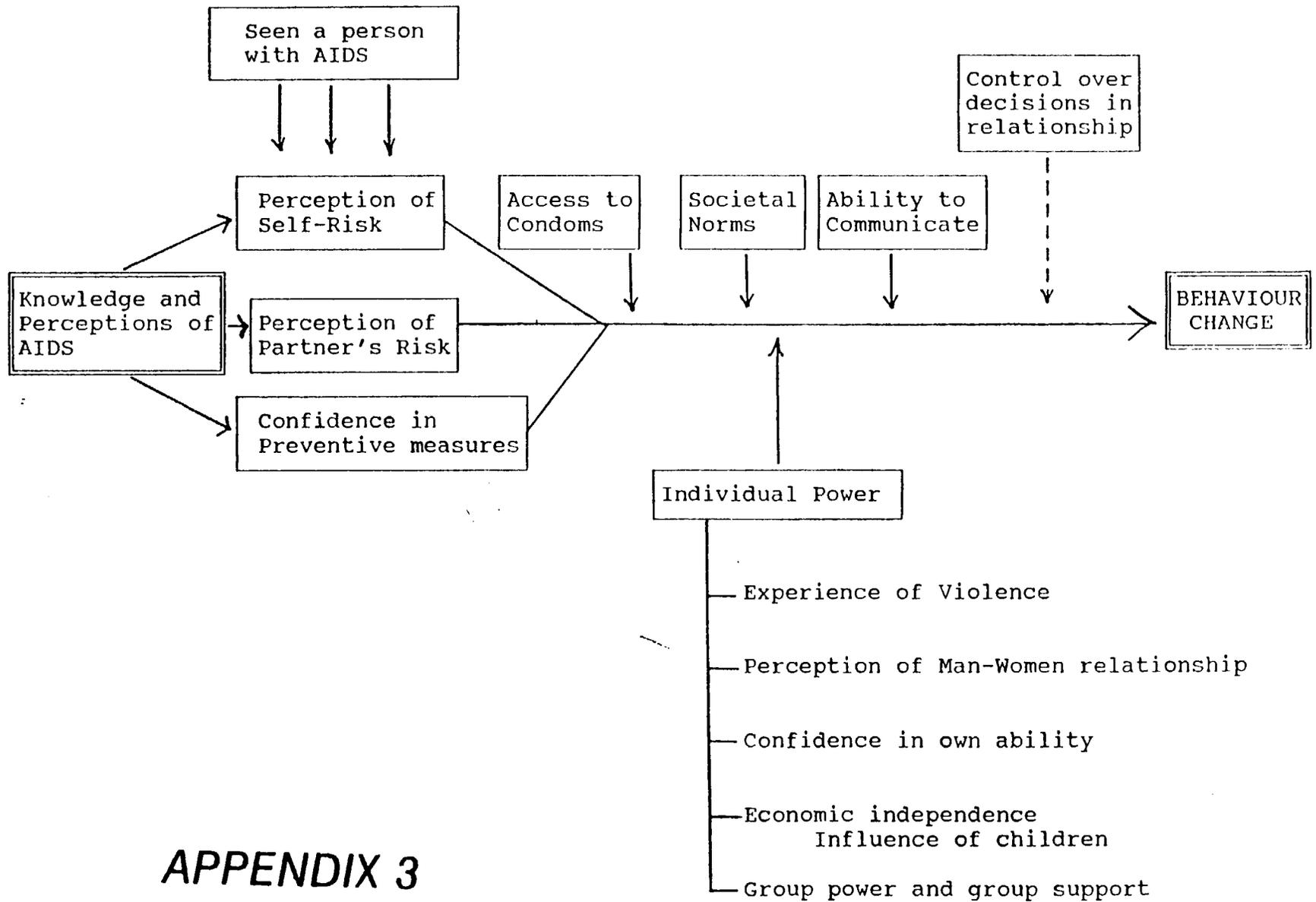
Community Liaison Staff

M MBOKAZI (N)

MJ THUSINI (N)

N DIMBA (KX)

N NTANZI (KX)



APPENDIX 3

APPENDIX 4

WOMEN AND AIDS STUDY

NB. TO BE ADMINISTERED TO WOMEN AGED 16 - 40 YEARS ONLY

Questionnaire Number:

| | | |
|--|--|--|
| | | |
|--|--|--|

Interviewer's Initials: _____

Date of Interview: _____ / _____ /92

Area:

| | | |
|-------|----------|-------|
| URBAN | INFORMAL | RURAL |
|-------|----------|-------|

A. SOCIO-DEMOGRAPHY

A1. Age or estimated age of respondent:

| | |
|--|--|
| | |
|--|--|

 years

A2. Highest standard passed: _____

Post-Matric training:

| | |
|---|---|
| Y | N |
|---|---|

 Specify: _____

Attendance of non-school vocational courses:

| | |
|---|---|
| Y | N |
|---|---|

Specify: _____

A3. Respondent's Occupation:

| | | |
|--------------------------|-----------------------------------|--------------------|
| <input type="checkbox"/> | Employed | Specify: _____ |
| <input type="checkbox"/> | Unemployed but seeking employment | |
| <input type="checkbox"/> | Housewife/not seeking employment | |
| <input type="checkbox"/> | Self-employed | Specify: _____ |
| <input type="checkbox"/> | Scholar | Specify Std: _____ |

If respondent is unemployed, how long has she been unemployed:

| | |
|--|--|
| | |
|--|--|

 months

What work did she do in her last job: _____

A4. Marital status:

| | | | | |
|--------|---------|----------|-----------|---------|
| Single | Married | Divorced | Separated | Widowed |
|--------|---------|----------|-----------|---------|

A5. If single, do you have a permanent partner:

| | |
|---|---|
| Y | N |
|---|---|

A6. How often do you see your husband/partner:

| | | | |
|---------------------------------|-----------|--------------|-------------|
| Everyday | Week-ends | Once a month | Once a year |
| If other, please specify: _____ | | | |

18

7. Partner's occupation: _____

8. Do you have any children:

| | |
|---|---|
| Y | N |
|---|---|

If yes, how many children do you have:

| | |
|--|--|
| | |
|--|--|

9. If married or in a permanent relationship, what role do you play in making the following decisions:

Planning the family budget: _____

Spending your income (if applicable): _____

Spending money earned by your partner: _____

Purchasing groceries: _____

Major purchases in the house eg TV, furniture: _____

10. Does your partner give you any money:

| | |
|---|---|
| Y | N |
|---|---|

11. What organisations (community/ professional) do you participate in: _____

12. Is there a women's group in your area:

| | |
|---|---|
| Y | N |
|---|---|

If yes, do you participate in the group:

| | |
|---|---|
| Y | N |
|---|---|

What issues are taken up by this group: _____

Are you an office-bearer:

| | |
|---|---|
| Y | N |
|---|---|

B. UNDERSTANDING OF AIDS

1. What is AIDS? _____

2. What is HIV? _____
(If a respondent does not know, explain that HIV is a germ that causes AIDS)

3. How is the AIDS germ (HIV) spread from one person to another: _____

4. How can a person prevent him/herself from getting AIDS: _____

B5. Does a person with HIV infection have any characteristics which can be used to identify him/her:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

If no, how can you tell who has HIV: _____

If yes, what characteristics can be used to identify a person with HIV: _____

B6. Once someone is infected with HIV how long does it take for them to get sick with AIDS: _____

B7. What does a person with AIDS look like? _____

B8. Can AIDS be cured:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

If yes, do you think that AIDS could be cured by a:

| | | |
|--------|-----------------|------------------|
| Doctor | Inyanga/Sangoma | Other (specify): |
|--------|-----------------|------------------|

B9. Do you think that AIDS can be spread by:

| | | | |
|-----------------------------------------------------|---|---|----|
| Being in the same room as a person with AIDS | Y | N | DK |
| Having sex with someone who has the AIDS germ | Y | N | DK |
| From a mother with the AIDS germ to her baby | Y | N | DK |
| Coughing and sneezing | Y | N | DK |
| By donating blood | Y | N | DK |
| Sharing utensils with someone who has the AIDS germ | Y | N | DK |
| By receiving a blood transfusion | Y | N | DK |

B10. Can the spread of the AIDS germ be prevented by:

| | | | |
|-----------------------------------------|---|---|----|
| Eating good food | Y | N | DK |
| Always using a condom during sex | Y | N | DK |
| Having sex with only one person/partner | Y | N | DK |
| Having only a few boyfriends (2-4) | Y | N | DK |
| Avoiding casual sex | Y | N | DK |

B11. Do you think that there are people in your area with AIDS or HIV infection:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

B12. Have you seen anyone with AIDS:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

B13. Do you think that you could get AIDS:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why: _____

Are you doing anything to protect yourself against AIDS:

| | |
|---|---|
| Y | N |
|---|---|

If yes, what: _____

B14. Do you think that your partner could get AIDS:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why: _____

B15. Have you discussed AIDS with your partner:

| | |
|---|---|
| Y | N |
|---|---|

If yes, what have you discussed: _____

B16. Have you discussed AIDS with your children (if applicable):

| | |
|---|---|
| Y | N |
|---|---|

C. Condoms

1. Have you ever seen a condom:

| | |
|---|---|
| Y | N |
|---|---|

2. Have you ever used condoms during sex:

| | |
|---|---|
| Y | N |
|---|---|

If no to C2 proceed to C5

If yes to C2

3. How often do you use condoms:

| | | | |
|--------|------------|-----------|--------|
| ALWAYS | FREQUENTLY | SOMETIMES | RARELY |
|--------|------------|-----------|--------|

What are your reasons for using condoms: _____

What has been your experience using condoms: _____

4. The last time you used a condom, who suggested the use of the condom:

| | |
|-----|---------|
| YOU | PARTNER |
|-----|---------|

If partner broached the subject of use of condom, what was your reaction: _____

If you broached the subject of condom use, what was your partner's reaction: _____

Who obtained the condom: _____

Where was the condom obtained from: _____

Was there difficulty experienced in obtaining condoms:

If yes, specify: _____

Do you have a condom with you now:

| | |
|---|---|
| Y | N |
|---|---|

Proceed to C6

If no to C2

C5. Would you like your partner to use a condom:

| | |
|---|---|
| Y | N |
|---|---|

If yes, do you think your partner will agree:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why: _____

Where would you get the condoms from: _____

Which partner do you think should initiate the use of condoms: _____

If your partner asked you to use a condom, how would you respond: _____

C6. Do you think that women have the right to insist that their partners use condoms:

| | |
|---|---|
| Y | N |
|---|---|

C7. Do you think that women have the right to refuse sex if their partners refuse to use a condom:

| | |
|---|---|
| Y | N |
|---|---|

C8. What do you think would assist you in being able to

convince your partner to use a condom: _____

29. Do you think that:

- i. Condoms are difficult to obtain
- ii. Condoms decrease sexual pleasure
- iii. Condoms protect you from idrop:
- iv. Condoms are needed only if you do not trust your partner:
- v. Condoms protect against AIDS
- vi. Condoms get left in the women and cause her harm

| | | |
|---|---|----|
| Y | N | DK |

30. My partner would:

Be angry if I asked him to use a condom during sex

Leave me if I refused to have sex with him without a condom

Think I have AIDS if I asked him to use a condom

Think I have other partners if I asked him to use condoms during sex

Beat me if I insist he uses a condom with me

| | | |
|---|---|----|
| T | F | DK |

D. SEXUAL BEHAVIOUR AND COMMUNICATION WITH PARTNER

1. Why do some women have more than one partner: _____

2. Have you ever had more than one partner at the same time:

| | |
|---|---|
| Y | N |
|---|---|

3. Do you think that your partner has other girlfriends:

| | |
|---|---|
| Y | N |
|---|---|

4. If you heard that your partner had other girlfriends would you object:

| | |
|---|---|
| Y | N |
|---|---|

Why: _____

If yes, how would you object: _____

D5. Have you ever refused to have sex with your partner until he agreed with you on a matter:

| | |
|---|---|
| Y | N |
|---|---|

If yes, what happened: _____

D6. My friends are supportive of the following:

Using condoms during sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Talking about AIDS with our partners

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Having more than one partner

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

D7. Would you be able to do the following with a first or new partner:

Ask how many partners he has had

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Discuss using condoms before having sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Ask him to be tested for HIV before having sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Agree to have sex only with him

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Ask him to have sex only with you

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Use a condom

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Refuse to have sex if he won't use a condom

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

D8. My partner puts me at risk of getting AIDS but I continue my relationship with him because:

I need the financial support for my children

| | | |
|---|---|----|
| T | F | DK |
|---|---|----|

I am financially dependent on him

| | | |
|---|---|----|
| T | F | DK |
|---|---|----|

My children need a father

| | | |
|---|---|----|
| T | F | DK |
|---|---|----|

My family will be angry with me if I leave him

| | | |
|---|---|----|
| T | F | DK |
|---|---|----|

I won't be able to protect myself

| | | |
|---|---|----|
| T | F | DK |
|---|---|----|

79. What do you think needs to be done to control the spread of AIDS: _____

End of interview

Thank you for your time and co-operation

Do you have any questions you wish to ask about AIDS

Would you like to continue with the research process on the

following aspects:

- i. How can women protect themselves against AIDS - group and individual discussions
- ii. Trying out interventions based on research findings and reporting on your experiences
- iii. Using condoms with your partner and sharing your experience with us

If yes, Name: _____

Address: _____

95

APPENDIX 5

WOMEN AND AIDS STUDY

NB. TO BE ADMINISTERED ONLY TO MEN (15 - 60)

Questionnaire Number:

| | | |
|--|--|--|
| | | |
|--|--|--|

Interviewer's Initials:

Date of Interview:

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

Area:

| | | |
|-------|----------|-------|
| URBAN | INFORMAL | RURAL |
|-------|----------|-------|

A. SOCIO-DEMOGRAPHY

A1. Age or estimated age of respondent:

| | |
|--|--|
| | |
|--|--|

 Years

A2. Length of stay at this address: _____

A3. Length of stay at previous address: _____

A4. Highest standard passed: _____

Post-Matric training:

| | |
|---|---|
| Y | N |
|---|---|

 Specify: _____

Attendance of non-school vocational courses:

| | |
|---|---|
| Y | N |
|---|---|

Specify: _____

A5. Respondent's Occupation:

| | | |
|--------------------------|---------------------------------------|--------------------|
| <input type="checkbox"/> | Employed | Specify: _____ |
| <input type="checkbox"/> | Unemployed but seeking employment | |
| <input type="checkbox"/> | Unemployed but not seeking employment | |
| <input type="checkbox"/> | Self-employed | Specify: _____ |
| <input type="checkbox"/> | Scholar | Specify Std: _____ |

If respondent is unemployed, how long has he been unemployed:

| | |
|--|--|
| | |
|--|--|

 months

A6. If respondent is employed,

Where does he work: _____

Does he travel to work daily:

| | |
|---|---|
| Y | N |
|---|---|

If no, where does he live while at work: _____

A7. Marital status:

| | | | | |
|--------|---------|----------|-----------|---------|
| Single | Married | Divorced | Separated | Widowed |
|--------|---------|----------|-----------|---------|

18. If single do you have a permanent partner:

| | |
|---|---|
| Y | N |
|---|---|

19. Does your wife/ partner work

| | |
|---|---|
| Y | N |
|---|---|

Wife/ Partner's occupation: _____

Where does your wife/partner live: _____

How often do you see your wife/ partner:

| | | | |
|---------------------------|-----------|--------------|-------------|
| Everyday | Week-ends | Once a month | Once a year |
| If Other, please specify: | | | |

110. Do you have any children:

| | |
|---|---|
| Y | N |
|---|---|

If yes, how many children do you have:

| | |
|--|--|
| | |
|--|--|

Do you plan to have any more children:

| | |
|---|---|
| Y | N |
|---|---|

111. What role does your partner play in making the following decisions:

Planning the family budget: _____

Spending her income (if applicable): _____

Spending money earned by you: _____

Purchasing groceries: _____

112. How do you feel about your relationship with your partner:

| | | | | |
|------------|-------|------------|---------------|--------------|
| VERY HAPPY | HAPPY | AVERAGE/OK | NOT TOO HAPPY | VERY UNHAPPY |
|------------|-------|------------|---------------|--------------|

113. What organisations (community/ professional) do you participate in: _____

What issues are taken up by this group: _____

Are you an office-bearer:

| | |
|---|---|
| Y | N |
|---|---|

B. UNDERSTANDING OF AIDS

1. What is AIDS? _____

2. What is HIV? _____
(If a respondent does not know, explain that HIV is a germ that causes AIDS)

B3. How is the AIDS germ (HIV) spread from one person to another: _____

B4. How can a person prevent him/herself from getting AIDS: _____

B5. Does a person with the AIDS germ in his/her body have any characteristics which can be used to identify him/her:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

If no, how can you tell who has the AIDS germ: _____

If yes, what characteristics can be used to identify a person with the AIDS germ: _____

B6. Once someone has the AIDS germ in their body how long does it take for them to get sick with AIDS: _____

B7. What does a person who is sick with AIDS look like: _____

B8. Can AIDS be cured:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

If yes, do you think that AIDS could be cured by a:

| | | |
|--------|-----------------|------------------|
| Doctor | Inyanga/Sangoma | Other (specify): |
|--------|-----------------|------------------|

B9. Do you think that AIDS can be spread by:

Being in the same room as a person with AIDS

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Having sex with someone who has the AIDS germ

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

From a mother with the AIDS germ to her baby

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Coughing and sneezing

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

By donating blood

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Sharing utensils with someone who has the AIDS germ

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

By receiving a blood transfusion

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

310. Can the spread of the AIDS germ be prevented by:

Eating good food

| | | |
|---|---|----|
| Y | N | DK |

Always using a condom during sex

Having sex with only one person/partner

Having only a few boyfriends (2-4)

Avoiding casual sex

311. Do you think that there are people in your area sick with AIDS or who have the AIDS germ in their body:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

If yes, how do you think most of them got the AIDS germ:

312. Have you seen anyone with AIDS:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

313. Do you think that you could get AIDS:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why: _____

Are you doing anything to protect yourself against AIDS:
If yes, what: _____

| | |
|---|---|
| Y | N |
|---|---|

314. Do you think that your partner could get AIDS:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why: _____

315. Have you discussed AIDS with your partner:

| | |
|---|---|
| Y | N |
|---|---|

If yes, what have you discussed: _____

316. Have you discussed AIDS with your children (if applicable):

| | |
|---|---|
| Y | N |
|---|---|

C. SEXUALLY TRANSMITTED DISEASES

317. What STDs are you aware of: _____

318. Have you ever sought treatment for an STD:

| | |
|---|---|
| Y | N |
|---|---|

If yes, approximately how many times:

| | |
|--|--|
| | |
|--|--|

C3. Where did you go the last time for treatment: _____

C4. Do you usually inform your partner if you are being treated for an STD:

| | |
|---|---|
| Y | N |
|---|---|

C5. Do you do anything to protect yourself against STDs:

| | |
|---|---|
| Y | N |
|---|---|

If yes, what: _____

If no, why: _____

D. Condoms

D1. Have you ever seen a condom:

| | |
|---|---|
| Y | N |
|---|---|

D2. Have you ever used condoms during sex:

| | |
|---|---|
| Y | N |
|---|---|

If no to D2 proceed to D5

If yes to D2

D3. How often do you use condoms:

| | | | |
|--------|------------|-----------|--------|
| ALWAYS | FREQUENTLY | SOMETIMES | RARELY |
|--------|------------|-----------|--------|

With whom have you used condoms since last Christmas:

Wife

| | |
|---|---|
| Y | N |
|---|---|

Regular girlfriend

| | |
|---|---|
| Y | N |
|---|---|

New girlfriend

| | |
|---|---|
| Y | N |
|---|---|

Casual partners

| | |
|---|---|
| Y | N |
|---|---|

What are your reasons for using condoms: _____

What has been your experience using condoms: _____

D4. The last time you used a condom, who suggested the use of the condom:

| | |
|-----|---------|
| YOU | PARTNER |
|-----|---------|

If partner broached the subject of use of condom, what was your reaction: _____

If you broached the subject of condom use, what was your partner's reaction: _____

Who obtained the condom: _____

Where was the condom obtained from: _____

Was there difficulty experienced in obtaining condoms:

If yes, specify: _____

Do you have a condom with you now:

| | |
|---|---|
| Y | N |
|---|---|

Proceed to D6

If no to D2

D5. If your partner asked you to use a condom, how would you respond: _____

Would you like to use a condom:

| | |
|---|---|
| Y | N |
|---|---|

If no, why: _____

If yes, do you think your partner will agree: Y N DK

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why: _____

Where would you get the condoms from: _____

D6. Which partner do you think should initiate the use of condoms: _____

D7. Do you think that ~~women~~ have the right to insist that their partners use condoms:

| | |
|---|---|
| Y | N |
|---|---|

D8. Do you think that ~~women~~ have the right to refuse sex if their partners refuse to use a condom:

| | |
|---|---|
| Y | N |
|---|---|

D9. What do you think would assist you in being able to convince your partner to have sex with you using a condom:

D10. Do you think that:

- i. Condoms are difficult to obtain
- ii. Condoms decrease sexual pleasure
- iii. Condoms protect you from idrop:
- iv. Condoms are needed only if you do not trust your partner:
- v. Condoms protect against AIDS
- vi. Condoms get left in the women and cause her harm

| | | |
|---|---|----|
| Y | N | DK |

D11. Would your partner:

Be angry if you asked her to use a condom during sex

Leave you if you refused to have sex with her without a condom

Think you have AIDS if you asked her to use a condom

Think you have other partners if you asked her to use condoms during sex

| | | |
|---|---|----|
| Y | N | DK |

D12. Which option best describes the way you and your partner handle disagreements:

We discuss the problem calmly

We quarrel and shout

We don't discuss the problem

| |
|--|
| |
| |
| |

D13. How easy or difficult is it for you to:

i. Get condoms:

| | | | | |
|----------------|-----------|----|------|-----------|
| Very Difficult | Difficult | OK | Easy | Very Easy |
|----------------|-----------|----|------|-----------|

ii. Tell your partner to use a condom:

| | | | | |
|----------------|-----------|----|------|-----------|
| Very Difficult | Difficult | OK | Easy | Very Easy |
|----------------|-----------|----|------|-----------|

iii. Convince your partner to use a condom:

| | | | | |
|----------------|-----------|----|------|-----------|
| Very Difficult | Difficult | OK | Easy | Very Easy |
|----------------|-----------|----|------|-----------|

iv. Dispose of a condom after use:

| | | | | |
|----------------|-----------|----|------|-----------|
| Very Difficult | Difficult | OK | Easy | Very Easy |
|----------------|-----------|----|------|-----------|

E. SEXUAL BEHAVIOUR AND COMMUNICATION WITH PARTNER

E1. Is it common for men in this community to have more than one partner:

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Why do some men have more than one partner:

E2. Have you ever had more than one partner at the same time:

| | |
|---|---|
| Y | N |
|---|---|

How many partners do you have at present:

| | |
|--|--|
| | |
|--|--|

How long have you been with each of them:

| | | | |
|-----------|--------|--|--|
| Partner 1 | months | | |
| Partner 2 | months | | |
| Partner 3 | months | | |

Add if needed: _____

E3. Do you think that your partner has other boyfriends:

| | |
|---|---|
| Y | N |
|---|---|

E4. If you heard that your partner had other boyfriends would you object:

| | |
|---|---|
| Y | N |
|---|---|

Why: _____

If yes, how would you object: _____

E5. Have you ever refused to have sex with your partner until she agreed with you on a matter:

| | |
|---|---|
| Y | N |
|---|---|

When you and your partner have sex, how frequently are you drunk:

| | | | | |
|--------|------------|-----------|--------|-------|
| ALWAYS | MOST TIMES | SOMETIMES | RARELY | NEVER |
|--------|------------|-----------|--------|-------|

E6. My friends would approve of the following:

Using condoms during sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Talking about AIDS with our partners

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Having more than one partner

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

OB

Do most of your friends:

Use condoms

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Talk about AIDS with their partners

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Have more than one partner

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

E7. Would you be able to do the following with your regular partner:

Ask how many partners she has had

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Discuss using condoms before having sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Ask her to be tested for the AIDS germ before having sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Agree to have sex only with her

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Ask her to have sex only with you

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Use a condom

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Refuse to have sex if she won't agree to my using a condom

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

E8. Would you be able to do the following with a first or new partner:

Ask how many partners she has had

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Discuss using condoms before having sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Ask her to be tested for the AIDS germ before having sex

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Agree to have sex only with her

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Ask her to have sex only with you

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Use a condom

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

Refuse to have sex if she won't agree to you using a condom

| | | |
|---|---|----|
| Y | N | DK |
|---|---|----|

E9. What do you think needs to be done to control the spread of

AIDS: _____

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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.

Publications from the Women and AIDS Research Program

ICRW Policy Series

Women and AIDS: Developing a New Health Strategy by G. Rao Gupta and E. Weiss.

Research Report Series

AIDS Prevention Among Adolescents: An Intervention Study in Northeast Thailand by E. Thongkrajai, J. Stoeckel, M. Kievying, C. Leelakraiwan, S. Anusornteerakul, K. Keitisut, P. Thongkrajai, N. Winiyakul, P. Leelaphanmetha, and C. Elias.

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Strengthening Intergenerational Communication: An AIDS Prevention Strategy for Adolescents (Mexico) by M. Givaudan, S. Pick de Weiss, M. Alvarez, M.E. Collado, E. Weiss, and G. Rao Gupta.

Strengthening Intergenerational Communication: An AIDS Prevention Strategy for Adolescents (Zimbabwe) by D. Wilson, J. McMaster, M. Armstrong, N. Magunje, T. Chimhina, E. Weiss, and G. Rao Gupta.

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