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Postpartum sexual abstinence in the era of AIDS in Ghana: prospects for change

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Abstract

Postpartum sexual abstinence for females has been identified as one of the socio-cultural factors with the potential for creating conditions for the sexual spread of HIV in areas where it is practised. In general, women are expected to abstain from sex after childbirth in order to ensure the survival of the mother and child. Men are not similarly expected to abstain and that has been used to rationalize polygyny.

With changes in socio-economic conditions making it more difficult now than before to maintain two or more wives, particularly in urban areas, some men will abstain like their wives for fear of HIV infection; but such men may press their wives to resume sex early. Some women, on the other hand, may give in to the demands of their husbands by reducing the prescribed duration of postpartum abstinence. If this happens without the use of effective modern contraception, fertility may be affected. Some may also enter short or long-term relationships outside marriage, hoping that they will be safe from sexually transmitted infection.

Using data from the Ghana segment of the Social Dimensions of AIDS Infection Survey, the study examines the responses of women who reported postpartum sexual abstinence and that of their partners. Both men and women reported abstaining, but some women were aware that their partners did not abstain as they did. Some of the women knew the sexual partners of their partners. Mostly it was men who made the first move to resume sex. For any behavioural change to occur, attitudes towards socially-constructed practices such as postpartum sexual abstinence will need to be changed by intensive education of both men and women and also through community support.

Before the first case of HIV seropositivity was reported in Ghana in March 1986, most Ghanaians thought that AIDS was a disease that affected white Americans and their high-flying Ghanaian counterparts. The disease was considered to be far removed from the daily lives of ordinary Ghanaians. A decade later we know better, but this realization has come at a cost to some individuals and families. Since then the disease has been reported from all parts of the country and in the middle of 1995, 15,980 people had been officially diagnosed HIV-positive out of an estimated population of 16.5 million (Ghana Ministry of Health 1995).

With heterosexual contact as the main source of HIV infection in sub-Saharan Africa, the outbreak of the disease has brought into the open a number of issues in interpersonal relationship that had hitherto been taken for granted. For instance, there is now a continuing discussion on issues such as the implications of long postpartum sexual abstinence for females but not for males for the spread of sexually transmitted diseases, including HIV (Caldwell, Caldwell and Orubuloye 1992; Orubuloye, Caldwell and Caldwell 1993), the social status of

females (Mason 1994), the circumstances surrounding the sexual debut of females and premarital sex (Anarfi and Awusabo-Asare 1993; Ankomah and Ford 1993; Ahlberg 1994).

This paper discusses postpartum sexual abstinence in Ghana, how it is perceived and some reactions to the practice in the era of HIV infection.

Context

At the core of the heterosexual transmission of HIV/AIDS in sub-Saharan Africa is the nature of rules governing sex for men and women both within and outside marriage. Most societies, at different times, have had different sexual rules for men and women, an observation which has been labelled the 'double standard' in sexual practices. Among the various ethnic groups in Ghana such a double standard operates, with men allowed a lot more freedom in sexual behaviour than women. One example is the difference in expectations for men and women during the period of postpartum sexual abstinence (Caldwell and Caldwell 1977; Lesthaeghe, Page and Adegbola 1981; Page and Lesthaeghe 1981). Since one of the objectives of postpartum sexual abstinence for women is to safeguard the health of mother and child, sexual abstinence for a man is expected to be from his lactating wife and not from all other women. Within the traditional system, one of the options was to have a second wife, thus making it possible for the health purpose of postpartum sexual abstinence to be achieved (Caldwell et al. 1992). The concern now, though, is that long postpartum sexual abstinence for women but not for men and late age at first marriage for men are likely to contribute to the heterosexual spread of HIV in areas in sub-Saharan Africa where the disease has been introduced.

In Ghana, the expected duration of postpartum abstinence varies considerably among the various ethnic groups. Available ethnographic data, mostly dating from the 1960s, indicate that postpartum abstinence ranges from three months among the matrilineal Akan and the Ga to periods of over one year, which are indicated by physical markers such as till the child is weaned or able to walk or take simple instructions, among the Ewe and Mole-Dagbani (Gaisie 1981; Schoenmaeckers et al. 1981; Ghana 1983). The short duration among the Akan, however, varies by parity, with abstinence after the first birth being around six months. This short to medium duration of postpartum sexual abstinence among the Akan does not fit into Murdock's classification which associates short postpartum abstinence with pastoral societies; therefore, it has been attributed to the effects of modernization (Schoenmaeckers et al. 1981).

Within the traditionally prescribed period, couples were expected to honour the code of discipline of long postpartum abstinence. One of the ways by which the practice was enforced was through physical separation whereby the pregnant woman spent the last month or so before delivery and some time after delivery in her natal household, whether in or away from the same settlement. Where the woman continued to stay at the husband's house or compound after delivery, her mother, the head female in a household, the first wife of the man or a relation of the lactating mother came to stay with her not only to help her with household chores but also to ensure that the couple observed the period of abstinence. In cases of breach of the code of ethics, the couple were implicitly sanctioned. Among the various ethnic groups in Ghana, there were (and still are) derogatory names for mothers with short birth intervals and children who are closely spaced as a result of the early resumption of sex.[1] Thus, for example at Aburi, an Akan town in the Akwapem area, Kaye noted that in the case of early resumption of sex, 'public opinion turns against the parents, especially the father; people say that he cannot control himself, that he is a wicked and greedy person' (Kaye 1962 cited in

[1]Among the Akan a woman who has births close together is considered to be breeding like a pig; among the Ewe such children are referred to as *kpedevio* 'like staircases'.

Schoenmaeckers et al. 1981:57). Society was harsh on the man because it was generally accepted that the postpartum period was meant for the woman to recuperate and secondly it was tacitly accepted that the man could take care of himself somewhere else and therefore did not have to resume sex early with his wife.

According to Caldwell et al. (1992) in the traditional system in Southwestern Nigeria, there were at least five sources of premarital and extramarital sex for men. Single or married men had sexual relations with women married into the family lineage; other men's wives, especially young wives in polygynous marriages; single girls from poor families who had not been betrothed; widows and divorced women; and commercially available 'strangers'. These were possibly some of the avenues for sex for a man in a monogamous marriage whose wife was lactating and who could not afford a second wife.

The practice of long postpartum abstinence worked well for females in the past when migration was limited or over short distances so that wives could travel to and from their natal homes, where separate rooms or sections existed for couples even in the same compound, accommodation was not a problem for a visiting in-law and other controls such as ridicule had an effect on people's behaviour. With modernization, urbanization and migration, some of these safeguards have broken down. For instance, it is not possible for mothers working in modern establishments such as the ministries to take long leave of absence from work to recuperate or breastfeed, or for a visiting in-law to stay for a long period with a couple who can afford only one room in an urban area. It is more difficult now to marry and maintain more than one wife in the urban setting; it is not possible for some women to go to their maternal home to deliver and stay away from the husband for months. Thus, it is important to assess the socio-cultural context and the implications of changes in practices such as long postpartum abstinence for the spread of diseases. Such information is needed for the development of intervention programs to limit the sexual spread of HIV.

Source of data

The data for this study are from a survey on the Social Dimensions of HIV/AIDS Infection in Ghana conducted in March-April 1992. Among the objectives of the survey were to study the knowledge and attitudes of Ghanaians to STDs, HIV/AIDS and seropositive persons, and to assess their perception of practices such as postpartum abstinence and extramarital sex. The study covered a sample of the general population and a sample of HIV-seropositive persons and some of their relatives. This paper presents results from the survey of the general population.

The study of the general population was a three-stage sampling of six districts in Ghana. The first stage involved stratifying the ten administrative regions into three according to the level of reported HIV/AIDS cases at the end of June 1990. These were high, medium and low reported regions. One region was selected from each of the categories by simple random sampling. The Eastern, Volta and Northern Regions representing respectively the high, medium and low-incidence areas were selected. At the second stage, the districts (the smallest administrative unit in the country) in the selected regions were also grouped into high and low HIV/AIDS reported areas. Two districts were then selected to represent low and high reported areas in each region.

The third stage involved the choice of settlements in each of the districts for interviewing. At this stage a number of settlements, including the capital of the selected districts, were purposively chosen. Each interviewer was allocated a quota of respondents distributed by age and sex, and people were interviewed as they were encountered in their homes. Therefore, the sample does not follow a strict probability sampling procedure. The total target was 2,400 respondents, but in the end 2,398 were interviewed. The sampling process and preliminary results from the survey are described in Awusabo-Asare and Anarfi 1995.

After the selection of regions and districts, letters were sent to political heads of all the selected districts and regional medical officers of health. Community and opinion leaders were also consulted before the study was started. The idea was to inform them of the impending survey and to solicit their assistance. Appealing to significant persons at the local level on such delicate issues as sexual practices has been found to enhance co-operation in data collection in Ghana (Agyeman, Brown and Awusabo-Asare 1990).

Although random, the selection of regions reflected the socio-economic and cultural variability in the country. The Northern region is one of the least developed areas in the country and dominated by Muslims and traditionalists. Descent is patrilineal for all the indigenous population, although the region is ethnically heterogeneous. A few migrants from the south have settled in the region. Its regional capital, Tamale, serves as one of the major stopping points for migrants to southern Ghana from Burkina Faso, Mali, and other neighbouring countries to the north. The Eastern region on the other hand has a long history of Western education and tree-crop cultivation, and is highly urbanized by Ghanaian standards (Dickson 1969; Dickson and Benneh 1988). It is also ethnically heterogeneous and contains both matrilineal and patrilineal groups. The Volta region is located on the eastern border of Ghana and Togo; the majority speak Ewe and practise patrilineal descent and inheritance. The region also has a long history of formal education associated with the Bremen missionaries (McWilliam and Kwamenah-Poh 1975). Over the last 40 years, it has experienced net out-migration. It was among these groups that the survey was conducted to provide an overview of some socio-cultural practices which are likely to have implications for the sexual spread of HIV in the country.

Findings

Socio-demographic background of respondents

Table 1 shows the demographic and socio-economic background of respondents. Of the 2,398 respondents interviewed, 1,364 were males, giving a sex ratio of 132 males to 100 females. Overall, the male respondents were slightly older than the female respondents, with 50 per cent of the males but 45 per cent of the females aged 25-39 years. Median ages were 33.9 years for males and 29.7 years for females. The study population is better educated than the overall Ghanaian population, with over 40 per cent of the males and about 30 per cent of the females having had secondary school education or higher. Only a quarter of the females and 18 per cent of the males had not had any formal education, proportions far lower than those reported for similar age groups in the Ghanaian population (Ghana 1989b). Twenty per cent either were economically inactive or did not indicate their occupation. The majority, however, worked in clerical and sales occupations, farming and fishing and crafts.

The Akan who constitute 45 per cent of the total population of Ghana accounted for only 22 per cent of the sample. About a third of the respondents were Ewe and 14 per cent were Ga-Adangbe. As a result of the choice of regions and districts, the Ewe and Mole-Dagbani are over-represented in the sample. Sixty-six per cent of the males and 76 per cent of the females were Christians, about a quarter of the males and 17 per cent of the females were Muslims. Only five per cent reported traditional religion and 2.4 per cent did not report any religion. The pattern of religious affiliation is also a product of the areas chosen.

Table 1
Socio-demographic background of respondents

	Males		Females	
Age	Number	Percentage	Number	Percentage

15-19	42	3.1	94	9.1
20-24	169	12.4	214	20.7
25-29	280	20.5	202	19.5
30-34	216	15.8	161	15.6
35-39	209	15.3	106	10.3
40-44	125	9.2	85	8.2
45-49	100	7.3	65	6.3
50-54	76	5.6	41	4.0
55-59	59	4.1	23	2.2
60+	91	6.7	43	4.2
Total	1364	100.0	1034	100.0
Highest educational level attained				
None	246	8.0	253	24.5
Primary	83	6.1	121	11.7
Middle/JSS	458	33.6	355	34.3
Secondary or higher	576	42.2	304	29.4
Not reported	1	0.1	1	0.1
Total	1364	100.0	1034	100.0
Ethnicity				
Akan	300	22.0	226	21.9
Ga-Adangbe	185	13.6	170	16.4
Ewe	406	29.8	345	33.4
Mole-Dagbani	337	24.7	179	17.3
Other Ghanaians	112	8.2	91	8.8
Non-Ghanaians	22	1.6	17	1.6
Not reported	1	0.1	6	0.6
Total	1364	100.0	1034	100.0
Religion				
Christian	902	66.0	786	76.0
Muslim	330	24.2	175	16.9
Traditional	82	6.0	42	4.1
Other	15	1.1	7	0.7
No religion	34	2.5	21	2.1
Not reported	1	0.1	3	0.3
Total	1364	100.0	1034	100.0

Table 1 continued

Marital status				
Single	429	31.5	275	26.6
Married	821	60.2	583	56.4
Separated	31	2.3	40	3.9
Divorced	58	4.3	73	7.1
Widowed	19	1.4	58	5.6
Not stated	6	0.4	5	0.5
Total	1364	100.0	1034	100.0
Form of current/last marriage				

Customary	638	68.2	495	65.2
Ordinance	19	2.0	13	1.7
Church	59	6.3	41	5.4
Consensual	68	7.3	120	15.8
Islamic	138	14.8	80	10.5
Not stated	13	1.4	10	1.3
Total	935	100.0	758	100.0
Number of times married				
1	565	60.4	543	71.5
2	222	23.7	179	23.6
3	77	8.2	14	1.8
4+	57	6.1	15	2.0
Not stated	14	1.5	8	1.1
Total	935	100.0	759	100.0

Current major occupation	Both Sexes	
	Number	Percentage
Administrative, executive and management	13	0.5
Clerical and sales	591	24.6
Fishing/farming	336	14.0
Mining	6	0.3
Transport and communication	70	2.9
Craft	328	13.7
Services	105	4.4
Unemployed	54	2.3
Other	251	10.5
Not economically active	236	9.8
Total	2398	100.0

Sixty per cent of the males and 56 per cent of the females were married; 32 per cent of the males and 27 per cent of the females had never married. The rest were either separated, divorced or widowed. Of those ever married, about two-thirds contracted their first marriage under customary law, only 13 per cent under Islamic marriage law and ten per cent were in consensual unions (7% for males and 16% for females). Consensual union has no legal backing and also has the potential of developing into a polygynous union. The distribution by form of marriage is similar to those observed in other studies in Ghana (Awusabo-Asare 1990). Sixty per cent of the males and 72 per cent of the females ever married reported being in their first marriage. Fewer females (27%) than males (37%) had married more than once, indicating a fairly high level of plural marriages among the males due to either polygyny or remarriage. High levels of remarriage were observed in the Ghana Fertility and the Demographic and Health Surveys (Ghana 1983; 1989a).

Postpartum sexual abstinence

The duration of actual and expected postpartum abstinence for women is shown in Table 2. For both the expected and actual duration after the birth of last child, the modal period was 12-23 months, similar to those observed in the Ghana Fertility Survey of 1979/80. It is possible that some people reported their actual as the expected duration in order to justify their action, a feature of rationalization which has been observed in a number of demographic studies (Pritchett 1994).

Table 2
Expected and actual duration of postpartum abstinence reported by female respondents

	Expected duration		Actual duration	
Month	Number	Percentage	Number	Percentage
Less than 3 months	44	6.2	23	3.3
3-5 months	109	15.3	104	15.1
6-11 months	203	28.5	199	28.9
12-23 months	251	35.3	214	31.1
24+ months	105	14.7	149	21.6
Total	712	100.0	689	100.0

A multiple classification analysis of reported duration of postpartum abstinence gave a mean of 13.8 months. This is close to 12 months and might have been affected by heaping at 12 months (Table 3). Nonetheless, the results show interesting patterns. Mean duration between those aged less than 25 and over 25 years of age did not show any difference. In terms of current residence, the longest duration was reported by females in large urban areas, contrary to observations from the Ghana Fertility and the Demographic and Health Surveys (Ghana 1983; 1989a).

On the other hand, the pattern by ethnicity is similar to that observed in other studies in Ghana: the highest duration of postpartum abstinence was reported by the Ewe (14.2 months) and Mole-Dagbani (17.3 months) and the lowest by the Fante, an Akan group (9.7 months). The results were significant for both the unadjusted and adjusted duration. Level of education attained by reported duration was also significant although the pattern was not monotonically consistent. The highest duration was reported by females with no formal education and the lowest before adjustment among those with only primary school education and after adjusting for other factors, among those who completed basic (middle school) education.

The reason given by three-quarters of the responding females for abstaining (Table 4), was the health of mother and child whilst 12 per cent acknowledged the family planning component of the practice. Just over one per cent of the females reported that a husband should not be deprived of sex, indicating their willingness to innovate to satisfy the sexual needs of their husbands.

Table 3
Mean duration of postpartum sexual abstinence (in months)

		Unadjusted		Adjusted for independents	
Variable/Category	N	Mean	Eta	Mean	Beta
Age					
Under 25	100	13.72		13.84	
25 and above	581	13.80		13.78	
			0.00		0.00
Residence					
Rural	273	12.77		12.49	
Urban	333	13.99		14.69	
Large urban	75	16.59		14.52	
			0.10		0.10
Education					
None	191	16.06		15.76	

Primary	88	12.07		12.71	
Middle/JSS	234	12.65		12.41	
Higher	168	13.71		14.03	
			0.14		0.12
Ethnicity					
Twi	86	10.64		10.34	
Fante	25	9.68		8.88	
Other Akan	49	11.33		10.81	
Ga-Adangbe	110	13.64		13.55	
Ewe	226	14.19		15.15	
Mole-Dagbani	121	17.27		16.46	
Other Ghanaians	54	13.50		13.04	
Non-Ghanaians	10	15.20		14.60	
			0.19		0.20
Grand Mean	**13.79**				
Multiple R^2	**0.60**				
Multiple R	**0.245**				

Two distinct kinds of postpartum sexual abstinence for females have been observed in West Africa (Adeokun 1983 cited in Lockwood 1995). One links pregnancy with breastfeeding while the other links sex and breastfeeding. In the former, resuming sexual intercourse after childbearing is not interpreted as polluting breastmilk. Therefore, with this pattern, it is pregnancy which is considered to be incompatible with breastfeeding and not sex itself. This is characteristic of societies with short postpartum abstinence such as the Akan and Ga. Among the Akan, the postpartum period of 80 days is meant to help the woman recover from her confinement.[2] In this case the woman can resume sex while the child is still breastfeeding since the society does not link sex and pollution of breastmilk. However, in this regime it is expected that the woman will stop breastfeeding when she becomes pregnant. The pattern of linking sex and the pollution of breastmilk is the typical 'abstinence taboo' found in the literature (Lockwood 1995). Societies which believe that breastmilk is polluted by sexual intercourse tend to practise long postpartum abstinence in order to avoid this, a situation found among the Ewe and Mole-Dagbani.

Table 4
Reasons for practising postpartum abstinence (females only)

Reasons	Number	Percentage
To space births	61	8.7
Health of child	201	28.7
Health of mother	324	46.3
Avoid unwanted pregnancy	87	12.4
Avoid depriving husband	10	1.4
Other	17	2.4
Total	700	100.0

[2]The Akan terminology used for resumption of sex after postpartum abstinence is the woman 'going to harvest her pepper': an activity compared to people leaving their pepper on the tree to be harvested when it has ripened. The implication is that the woman has ripened, i.e. is healed enough to resume sex.

An important aspect in the era of HIV infection, though, is whether a woman expects her sexual partner to also abstain from sex through the fear of contracting STD from the man when she resumes sex. This is important for our understanding of some of the mechanisms likely to promote the heterosexual spread of HIV. In the study, female respondents who reportedly abstained were asked if they thought their partners also abstained. Of the 716 females responding to that question, only 22 per cent were certain that their partners abstained (Table 5). The rest reported that their partners did not abstain or they could not tell whether their partners abstained. Of those who answered 'no' or could not tell if the partner abstained, 36 per cent were in polygynous unions so for them it was obvious that the husband did not abstain. For the rest, some of the women either knew the man had a girlfriend or caught him with a girlfriend. The 'other' category in Table 5 includes a woman reporting that the man informed her (2%), that the man lived in another town (2.5%), and that he travels a lot (2.2%).[3]

Among the women who responded that their husbands or partners also abstained, 17 per cent attributed the men's abstinence to the encouragement they gave them (Table 6). The encouragement such women reported included being helpful (whatever that meant) and assuring them of their love. Others reported using negative sanctions such as threatening to seek divorce and fighting with the man (Table 6). Although few women reportedly took action to assist or coerce the man to abstain, it is evident that some women tried to ensure that the men also abstained. Such actions are likely to succeed if they are backed by societal support. Other available evidence indicates that, where possible, men have used the traditional system to condemn the behaviour of women who refused to have sex with their men because the men had other sexual partners (Awusabo-Asare, Anarfi and Agyeman 1993).

Table 5
Abstinence of husbands/partners

Do you think your partner also abstained?	Number	Percentage
Yes	160	22.3
No	299	41.8
Can't tell	257	35.9
Total	718	100.0
If no/can't tell, basis for answer		
Has another wife	131	36.1
Knows he has girlfriend	88	24.2
Caught him with a woman	14	3.9
Don't trust him	22	6.1
Realized from actions	18	5.0
We are separated	47	12.9
Other	43	11.8
Total	363	100.0

Table 6
Reasons for husband/partner abstaining (females only)

Did you do anything to ensure husband/partner abstained?	Number	Percentage

[3]One is not sure of the circumstances under which such admissions were made by the man to the wife.

Yes	110	17.0
No	510	78.8
Can't tell/ no response	27	4.2
Total	647	100.0
If yes, basis for answer		
Kept him company	47	41.2
Became helpful	13	11.4
Always advised him	32	28.1
Told him of my love	2	1.8
Threatened divorce	3	2.6
Sometimes fought with him	4	3.5
Other	13	11.4
Total	114	100.0

Knowledge of partner's partner

As indicated in Table 5, about two-thirds of the women who were aware or felt that their partners did not abstain knew the sexual partners of their partners. In Table 7 knowledge of partner's partner is examined for both males and females. Over 70 per cent of the males but 38 per cent of the females reported being the only sexual partner of their regular partner. But 38 per cent of the females and ten per cent of the males were aware that they were not the only sexual partner.

Of those reporting that their sexual partner had other partners, fewer than half of the males but 79 per cent of the females knew their sexual partner's partner. This is not surprising since 37 per cent of the married females were in polygynous unions. The males whose sexual partners had other partners were either single, divorced or widowed. Half of the females knew two or more of their sexual partner's partners.

Identifying and tracing partner's partners will be one of the critical areas in the management of STD and HIV infection. Orubuloye et al. (1992) considered the tracing of partner's partners in sexual networking and concluded that the process is fraught with problems. In this study the tracing of partner's partners was not pursued to ascertain the 'interlinking chains' (Caldwell, Orubuloye and Caldwell 1994:viii). The approach, if it is to be used further, will need some thought because it has moral and ethical implications. It will also be necessary to adopt other methods and strategies of data collection such as the local network technique. Local network analysis is one of the potential methods for studying sexual networking (see for instance Morris 1995).

Table 7
Knowledge of sexual partner's partner

Only sexual partner	Males		Females	
	Number	Percentage	Number	Percentage
Yes	826	72.0	322	37.5
No	111	9.7	328	38.2
Uncertain	198	17.3	192	22.4
Not stated	12	1.0	16	1.9
Total				
Knowledge of partner's partners				
Yes	63	48.5	290	79.0
No	67	51.5	77	21.0

Total	130	100.0	367	100.0
Number known				
1	31	26.5	158	49.2
2	23	19.7	76	23.7
3	8	6.8	24	7.5
4+	29	24.8	29	9.0
Not stated	26	22.2	34	10.6
Total	117	100.0	321	100.0

Resumption of sexual relations

One of the aspects of postpartum sexual abstinence which has not been pursued is the dynamics involved in the resumption of sex at the level of the two people involved (see footnote 2). In the study, both the males and females were asked to indicate who made the first move to resume sex. The results, shown in Table 8, are very consistent for both the males and females. In both cases most men made the first move to resume sex. Over 80 per cent of the males reported that they initiated the move while 80 per cent of the women also reported that the first move came from the partner. Thus, while the women were able to abstain, the men were not and requested sex very early. It is partly to forestall such situations that society was harsh on the men in cases of early resumption of sex after childbirth. Possibly the women who 'were helpful' tried to meet the men half-way in their advances. Perhaps it is necessary to find out more about some of these dynamics, especially with the outbreak of HIV.

Table 8
Partner who made first move to resume sex after birth of child

	Males		Females	
Made first move	Number	Percentage	Number	Percentage
Myself	558	81.0	61	9.6
My partner	71	10.3	507	79.5
Both of us	53	7.7	60	9.4
Can't remember	7	1.0	10	1.6
Total	689	100.0	638	100.0

Discussion

The outbreak of HIV/AIDS has exposed our lack of understanding of some aspects of the interpersonal relationships and dynamics associated with sex. For instance, not much is known about the dynamics of postpartum sexual abstinence and the issues associated with the resumption of sex. A woman whose partner wishes to resume sex early is in a dilemma since men are always more anxious than women to resume sex. If a woman opts for a long postpartum abstinence the husband is likely to seek sex elsewhere and if she allows her husband to stray there is the risk of being infected with STD by the husband. But, if she resumes sex early she puts herself at risk of early pregnancy if she does not use effective contraception, and also at risk of societal ridicule or sickness.

In the circumstances some women may shorten the duration of postpartum abstinence, with all the possible consequences, to satisfy the sexual demands of the men. Some women will be torn between satisfying the husband in order to keep him at home and sticking to the rules of abstinence and creating conditions for him to seek sex elsewhere. With the outbreak of AIDS these may be hard choices for women.

But women alone should not be burdened with these choices. Public health approaches to limit the sexual spread of HIV focus on individuals, particularly women, for behavioural change on the assumption that it is important to empower the individual to make informed decisions and for women to take control of their lives. However, available evidence suggests that some of the public health strategies are more likely to succeed if couples and communities, as well as individuals, are targeted for behavioural change. This is because practices such as postpartum abstinence and the differing sexual standards for men and women are rooted in the society. Community norms create conditions for the type of practices observed, and dealing with the community helps to generate support and necessary reinforcement for behavioural change initiated by individuals or couples.

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