From Policy to Practice: The Anthropology of Condom Use

By

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Abstract

AIDS and HIV infection rates are climbing amongst young people in South Africa in the last decades, despite various intervention initiatives by National Government and Non-governmental organisations alike. This dissertation explores the knowledge, beliefs and attitudes towards condom use amongst young people in the Northern and Western Cape in an attempt at understanding some of the cultural factors that inform sexual behaviour. It aims to explore issues of knowledge and the institutional culture of the clinic that invariably impacts on the sexual practices of individuals being targeted by such policies. It also hoped to investigate and offer an insight into the persistence of high-risk sexual practices amongst young people despite their having access to barrier contraceptive methods; condoms.

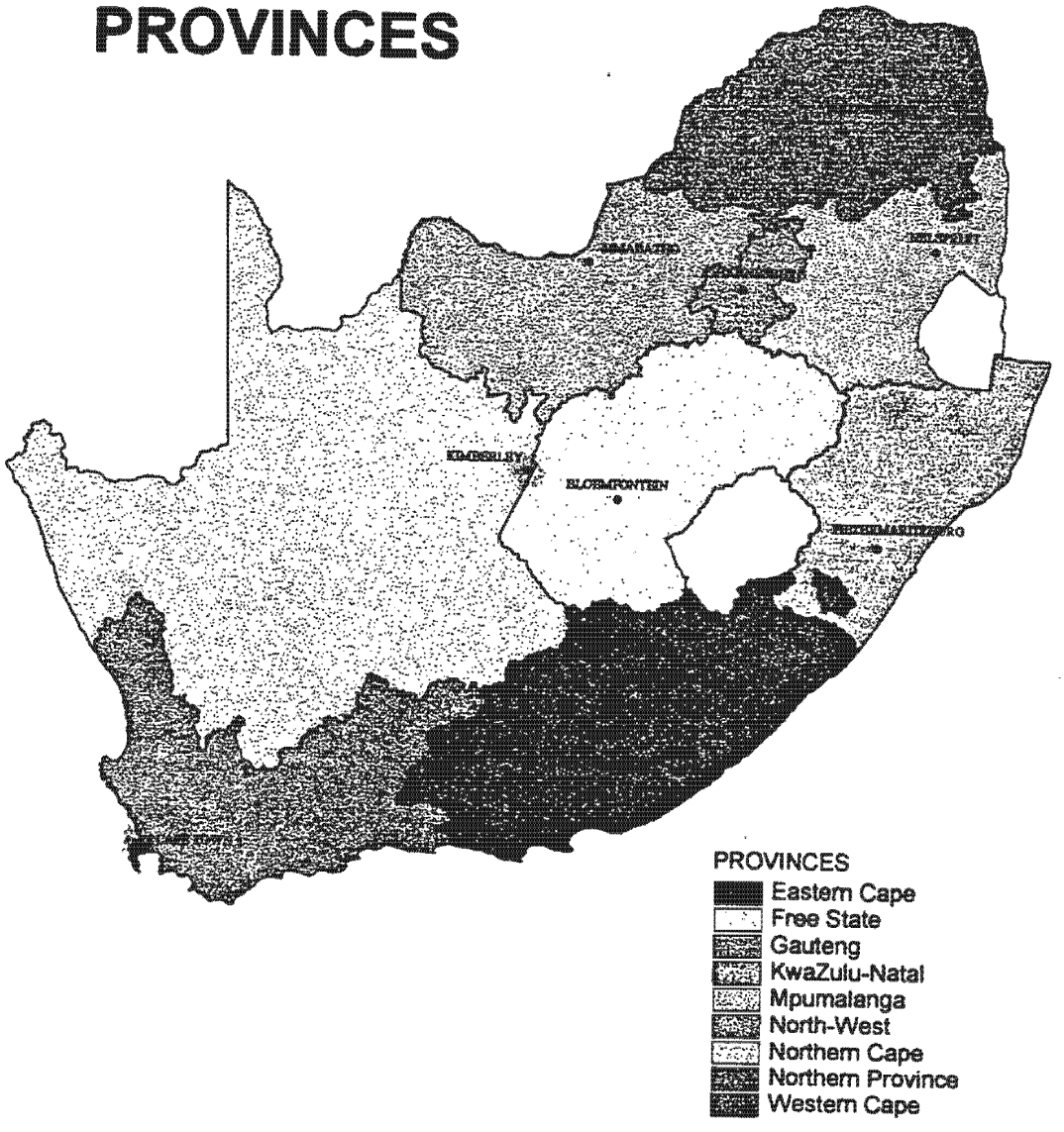
I illustrate my argument through the analysis of data acquired in fieldwork carried out in two government clinics through the use of multi-faceted methodologies. The research applied anthropological, qualitative and quantitative research methods including focus group discussions, participant observation and in-depth follow-up interviews through the use of a detailed questionnaire. The questionnaire lent itself to the collection of both quantitative and qualitative data, through its structured, semi-structured and open-ended questions.

The overall findings of this research show that firstly, young men chose to use condoms selectively and the type of relationship they find themselves in appears to impact directly on this selection process. Secondly, younger women in this study seem to use condoms more regularly than their older counterparts and there appears to

be a general dis-use of condoms within 'stable' relationships. Thirdly, lack of empowerment amongst women has a direct impact on their ability to negotiate condom use within sexual relationships. This research has also shown that there are some real and perceived challenges and constraints facing intervention strategies in terms of condom procurement and overall access to reproductive health services.

Lastly, the overall aims of this research attempts to highlight the important contributions applied anthropology can make to the understanding of the various beliefs, practices and culture of condom use so as to better inform existing policies in the field of AIDS and HIV.

Map of South Africa



The above map shows the two cities where fieldwork took place.

1.0 Introduction

There are more than one billion adolescents in the world and their number in developing countries – 800 million- will increase by 20% in the next 15 years (UNAIDS, 1997). Latest statistics show that the HIV prevalence rates are highest among adolescents and young adults. In South Africa heterosexual transmission is predominantly responsible for the spread of HIV infection, and the virus appears to be spreading most rapidly among young people between the ages of 15 and 30 with women most at risk (NPPHCN, 1996;Abdool Karim et al 1992). Based on these statistics it is obvious that AIDS constitutes a severe threat to the well being and productivity of youth in South Africa. The impact of the HIV/AIDS epidemic in South Africa can be reduced, for although HIV prevalence is high, and rates of new infections continue to climb, there is still an important role for prevention programmes to play.

It has been noted that young people can be a great asset to helping prevent HIV and bringing the epidemic under control. As they - the youth - are still developing sexual behaviour and experimenting with sexual matters, they can adopt safer practices more easily than adults can (UNAIDS, 1997). Due to the fact that young people are usually starting to experiment with sexual matters at this stage of their lives, they are particularly vulnerable to HIV and AIDS, as well as various other sexually transmitted diseases. A number of behavioural and social characteristics of adolescents are thought to determine their high- risk status. These include: the onset of sexual activity during the teen years; the probability of multiple partnerships; general non-use or inconsistent use of condoms and the reported tendency of young

people to perceive themselves to be both physically and psychologically invulnerable, which in turn, is related to the conduct of a variety of risk behaviours (Moore & Rosenthal, 1991; DiClemente, 1990;Hein, 1992 as cited in Swart-Kruger, J. & Richter, M., 1997:957).

In October 1992, nearly 450 people representing the widest possible range of organisations attended the launching conference of the National AIDS Co-ordinating Committee of South Africa (NACOSA). A draft AIDS strategy was formulated which culminated in the publication of a comprehensive and detailed National AIDS Plan in June 1994 (Schneider & Stein, 1997).

The department of Health has made intervention against AIDS one of its top priorities. The provision of free contraceptives, condoms and STD's treatment services nationally has been one of the main steps towards the prevention of HIV/AIDS. One of the goals out of the three main goals formulated for dealing with the prevention of HIV/AIDS and STD's is the introduction of the Barrier Methods Programme. The table below shows one of the goals of the government Operational Plan for dealing with the prevention of HIV/AIDS and STD's.

Goal no. 2: To prevent HIV and STD Transmission Strategies

Barrier Methods	Objectives	Progress
Barrier Methods	**Distribution of male condoms** • Provinces to take over the tender from national Government so that successful ordering of condoms occurs on provincial tender. • Improved condom distribution to all regions with the aims of increasing the number of condoms distributed. • Distribution to all spaza shops/taxi industry, night clubs with the aims of increasing distribution at non-conventional outlets. • Improved condom usage encouraged with the aim of improving behaviour seeking patterns.	6 Million condoms were distributed annually in the W. Cape and 98 million Nationally (1995 figure)

Source: Operational Plan Report 1999-2000, Government Publications

The provision of free condoms to the public via government clinics, community health centres, hospitals and non-conventional outlets, such as spazas, clubs and taxis, is one of the goals of the AIDS Plan policy for the prevention of HIV and STD in South Africa. The goal of this type of intervention is to increase condom usage with the aim of improving high-risk sexual behaviour patterns. In 1995, 98 million

condoms were distributed nationally to all provinces in South Africa (Government Publication, 1995).

However, relatively little information is available concerning the usage of condoms by the youth in this country. This study will shed some light on the various perceptions surrounding condom use and dis-use as perceived by the youth making use of government clinics. It also attempted to analyse some of the barriers or challenges met by youth in terms of accessing condoms, information and health care in the clinics under study. In addition this research aimed to provide useful insights into ways of improving existing government policies on barrier methods. Despite the fact that the result of many prevention programmes has been disappointing, they still have important benefits. The assumption is that if people do not have knowledge and understanding of HIV/AIDS and how to prevent it, they will not be able to change behaviour effectively (SA Health Review, 1997). However, despite the relatively high levels of knowledge and information young people have about AIDS/HIV in South Africa, they still engage in a range of high-risk sexual behaviour (NPPHCN, 1996).

It therefore becomes apparent that there is a great need to change sexual behaviour amongst young people who are most likely to be at high risk of getting infected with HIV. This thesis will explore some of the knowledge, belief and attitudes of young people who make recourse to particular government clinics in order to try and understand the various reasons young people behave in the ways that they do.

1.1 Objectives of the study

As already indicated above a large amount of condoms are distributed in South Africa. However, relatively little information is available on the actual use, non-use, misuse or abuse of these condoms. In addition, very little information pertaining to how current policies of barrier methods are being implemented is currently available. Although there are numerous evaluations available on the training of teachers for the life skills programmes targeted at youth, there are none evaluating the preventative strategies through the use of barrier methods. Despite the implementation of these Barrier strategies, relatively little research has been carried out on whether these strategies have improved condom usage and behaviour seeking patterns of the youth in question. It is a known fact that condoms are 'freely' available to young people in South Africa, but what is less known is some of the challenges that these young people face in terms of both procuring condoms, negotiating condom use and general condom use practices.

I set out to explore condom distribution, issues of knowledge and the clinic cultures that invariably impact on the sexual practices of individuals being targeted by such policies.

It hoped to gather data that would provide a clearer understanding of the knowledge, attitudes and beliefs underlying condom use and disuse amongst youth in a particular setting and in so doing investigate the persistence of high risk sexual practices. It also aimed to look beyond the condom distribution policy and to explore the various beliefs, practices and culture of condom use so as to inform said policy.

1.2.0 Research Setting

Research material pertaining to this study was drawn from three different research sites over a period of eight months from the middle of 1998 to March 1999. The fieldwork sites included a community health clinic situated in the southern suburb of Cape Town; a government clinic in the high density area of Kimberley called Galeshewe and numerous meetings with a diverse set of people involved in the field of policy implementation in regards to AIDS and HIV in South Africa.

1.2.1 Wynberg Community Health Clinic

The fieldwork carried out in Wynberg was conducted in a Cape Town government clinic. The study explored issues surrounding condom use patterns amongst women clients seeking health care at the Community Health centre in Wynberg. The fieldwork carried out in this particular clinic investigated knowledge, attitudes and beliefs underlying condom use and non-use amongst women patients. It explored women's relationships and some of the reasons for the high-risk sexual practices within particular relationships. Issues concerning multiple sex partners, condom use within new and permanent relationships and issues of empowerment regarding negotiation of condom use were explored through the voices of women participants. From this exercise, many complex questions came to the fore relating to issues of condom use that due to various methodological constraints could not be fully explored. This study served as the pilot study for subsequent research in which further attempts to address these questions were made. This thesis is a result of all these exercises.

The Wynberg Community Health Clinic is situated within metres of the Wynberg train station; its urban location meant that large volumes of patients made use of the existing medical services. One of the health care workers pointed out that all government clinics along the Southern Suburbs line tended to be situated as close as possible to the train stations. This was done so as to ensure that clinics were accessible to people wanting to make quick use of the clinic's services on their way to work, school or shopping.

The Wynberg Community Health clinic has a neat and agreeable feel to it with a distinct lack of 'hospital coldness' usually associated with such service providers. Although it was sparsely furnished, the waiting rooms were large, airy and bright with various educational posters decorating its walls. There were several table displays scattered along the clinic walls covered with pamphlets, condom dispensary jars and general health information booklets. There were three condom procurement points available to patients. Below one of the many STD/AIDS and STD posters there was a jar containing condoms for those who wanted to acquire them whilst waiting to see the health care workers. The second point of distribution was with the receptionist who dispensed ten condoms at a time wrapped in a brown paper bag and lastly the health care workers within the consultation room gave condoms freely.

Fieldwork took place within the clinic in the midst of these various waiting rooms. Time was spent sitting and observing women patients and health care workers during various times of the day. Although no health provider interviews were carried out on

the health workers, quite a few informal conversations around various topics elicited vital information concerning condom use patterns amongst patients. Issues pertaining to logistics around condom purchasing, distribution and procurement were discussed with various health workers in order to obtain a clearer picture of the condom distribution system.

1.2.2 Galeshewe clinic, Kimberley, Northern Cape

As part of a wider project looking at the *Social aspects of Condom Use in South Africa*, I spent six weeks in Kimberley as a research assistant looking at condom use amongst residents making use of a government clinic in Galeshewe. This period of fieldwork was carried out over six weeks from the beginning of November to middle of December 1998.

Much like the issues explored in the Wynberg clinic research site, fieldwork carried out in Kimberley also aimed to gather data on the fate of condoms once out of the distribution point. The fieldwork pertaining to this site aimed to incorporate all applicable quantitative and qualitative approaches necessary to the collection of relevant data. It offered an excellent follow up on the research carried out in Wynberg, as besides offering the quantitative aspect to the study, it also drew on the qualitative aspects of research necessary to explore the complex attitudes, practices and behaviours of the informants in question. It also enabled me to address some of the shortcomings experienced in the pilot study at the Wynberg clinic and to explore in more depth some of the issues that had cropped up in the previous research site.

Some of these shortcomings included the issues of limited time spent with informants and problems related to privacy. The research carried out in Galeshewe, was conducive to qualitative research methods, such as follow-up interviews with participants, the use of journals and in-depth interviews with particularly interesting case studies and as a result offered good sets of qualitative data necessary for the understanding of the issues of condom use. The use of separate rooms allocated for the purpose of interviews through out the time in the field also ensured privacy for all participants taking part in the study.

The clinic in which I carried out fieldwork was situated in a high-density area of Kimberley called Galeshewe. Situated in the heart of the township, it was proudly considered by its health workers as the biggest government clinic in Kimberley. The interior of the clinic was somewhat severe and impersonal in its feel. The clinic housed two big waiting rooms on each end of its interior and the dispensary shared an open space with one of the waiting rooms. Hard and worn wood benches lined the entire waiting rooms and there were very little adornments of any sort on the walls. Although the clinic was clean, there was a distinct 'hospital' smell and feel to it. A few posters and pamphlets portraying the dangers of HIV and TB covered the entrance of the clinic, but there was no condom dispenser available to patients wanting to procure privately. Clients wanting to procure condoms in this clinic had to either ask for them at the dispensary or wait to see a health worker.

The participants in this research were recruited from all those people who had come to the clinic to procure condoms and were willing to take part in our study. For the period of the research the health worker in charge of the dispensary and all

contraceptive nurses were asked to refer condom procurers interested in taking part in the study to us.

Procurement interviews and follow-ups, took place in an allocated, private consultation room. A representative of the Ministry of Health introduced us, as researchers, to the various research sites, and as a result the health care workers made every effort to accommodate our study into their existing routine and even treated us as officials. Besides the procurement and follow-up interviews, I also interviewed a health care provider working at the clinic. The health care provider interviewed was chosen based on the rapport we had established and her perceived involvement with the pertinent health care issues under study.

My inability to speak the two major languages, Setswana and Afrikaans, meant that I had to make use of a translator for some of the more in depth interviews. In some cases, all questions in a particular interview took place via the translator and as a result she played an active and key part of my study. The rapport established between the translator and myself was exceptional and in many ways she became not only a translator but also a friend and key informant. As a member of that particular community, since she lived in Galeshewe and was my translator, she would often provide additional information or anecdotes relating to a specific answer or comment made by our informants. Due to the length of time spent together she offered me an insight into the more intricate workings of both the clinic and the patients that made use of its services. These insights included snippets of local gossip on particular clients or local stories dealing with interesting constructions around the contraction of HIV or even her perspective on the health care system as a whole. This continuous

insight into her community enabled me to access information and understanding round issues that would otherwise never surface within the formal environment of interviewing.

1.2.3 Cape Town

A third area of fieldwork took place in the form of gathering literature for a specific brief in the field of AIDS/HIV in South Africa. Data gathered for this brief drew on both fieldwork and archival research.

During my two-month internship with the Department of Psychiatry, at the University of Cape Town from February to March 1999 I compiled a health report on the state of youth in South Africa. The report had an emphasis on Youth and HIV/AIDS and was based on a literature review for the Youth Development Trust. I was responsible for work dealing with intervention strategies and programmes presently being implemented by government and non-governmental organisations in South Africa. The fact that this type of information is often unpublished and thus unavailable in libraries meant that the collection of material often involved actual meetings with those presently involved with policy making and implementing. One month of the internship involved the setting up of meetings and formal interviews with various government and non-governmental personnel on issues pertaining to HIV/AIDS intervention programmes. Data relating to the availability and evaluations of such programmes were put together in the form of a report document for the Youth Commission of South Africa.

1.2.4 Methodology

This study attempted to reach the set objectives by implementing a multidisciplinary methodology, which incorporated a range of techniques in an attempt to generate complementary sets of qualitative and quantitative data simultaneously. Some of the techniques implemented included the use of semi-structured questionnaires, secondary sources of all sorts, focus group discussions, and provider interviews and in depth interviews with relevant participants. This multidisciplinary approach to data collection on policy offered an interesting insight into the unintentional consequences of government policy, which will be discussed in later chapters.

1.2.5 Literature Review

Much of the literature and studies pertinent to this research topic were obtained by carrying out library and archival searches. These searches included the use of the CD-ROM, the Internet and the University of Cape Town's cataloguing system (Boris) searches in various libraries including the UCT main library and Medical School library. Hand searches were carried out on various South African journals in an attempt at ensuring that all South African studies were represented. A search for governmental publications and evaluations on existing policies was also carried out through the use of key informants in relevant ministries and NGO's.

As part of my brief for the literature review carried out for the Department of Psychiatry, extensive literature searches were made in the field of AIDS/HIV and

Youth in South Africa. Besides gathering general information around the topic, certain aspects of health and youth had to be investigated.

My brief included the highlighting of the existing available literature on the following issues:

- Key health service providers available to youth;
- Quality of service provision; and
- Challenges faced by youth accessing health service;
- Extent to which the sector is meeting the needs of youth;
- Constraints faced by the health sector in meeting the needs of youth; and
- Highlighting successful intervention programmes and approaches.

This brief drew on a variety of journals for the available studies carried out on youth and HIV/AIDS in South Africa. Information was gathered from a range of journals ranging from medical, anthropological and psychological spheres. Including *AIDS CARE; Development Southern Africa; Agenda; South African Medical Journal Curationis; Medical Anthropology; Journal of Adolescent Health; School Psychology International; Journal of Adolescents; Urbanisation and Health Newsletter; Paediatrics.* These journals and various evaluations obtained from NGO personnel and government officials offered a sound basis for attempting to understand some of the gaps in needed research.

1.2.6 Research: Interviews with Key informants

1.The Pilot research: Condom use amongst women clients in Wynberg, Cape Town

Fieldwork carried out in the Wynberg clinic drew on a limited range of research methods to research condom use (dis-use) patterns in women patients. Issues surrounding condom use, dis-use and non-use were explored through the use of a questionnaire and observation. A sample was obtained by using a random sampling approach, which resulted in an accidental or random sample of women participants.

The questionnaire used in this study investigated condom use practices and therefore excluded non-users. The questionnaire included questions pertaining to the demographic profile of the participants, semi-structured questions dealing with condom use, non-use and dis-use as well as some open-ended questions to explore issues regarding knowledge, attitudes and beliefs of participants regarding condoms (see appendix).

Although this research was intended to be also qualitative in nature, it soon became apparent that the research site was not conducive to this methodology. The amount of time participants had available was limited and the amount of privacy even more so. Participants often had time constraints and thus were rarely willing to be interviewed

after their consultation with the health workers. As a result interviews were administered prior to the participants consultation. Most interviews took between fifteen and twenty minutes and often the participant was unwilling to go into a private room to be interviewed in case they missed their turn in the queue. This had obvious repercussions in terms of time shortages and lack of privacy. As a result this study became very quantitative in nature. Although there were various constraints around the research methods implemented in this research site, many issues around youth and condom use arose which I felt needed to be further explored using a more appropriate methodology. The fieldwork carried out in Kimberley offered an ideal opportunity to explore some of these issues in more depth, whilst presenting data, which could effectively be used to compare, and contrast issues regarding condom use amongst youth.

1.2.7 Kimberley, Galeshewe: The social aspects of condom use in South Africa.

Fieldwork carried out in Kimberley Galeshewe also drew on a range of methods, though it tended to be more comprehensive in its approach. Firstly, the research aims of this project were to try and obtain outputs that would help to inform policy decisions around the most rational approach to condom distribution around the country and as a result incorporated a wider and more comprehensive methodology. Secondly, this research site was part of a wider project that was commissioned by the Ministry of Health and the Medical Research Council of South Africa, and as such had to adhere to stringent parameters associated with such substantial research

project. The methodology implemented was multi-faceted with a focus on combining both qualitative and quantitative approaches to the research questions. Quantitative questions were used to gather demographic information relating to age, educational backgrounds, employment status, number of sexual partners, and so on. The qualitative aspects of the study aimed to explore some of the reasoning behind knowledge, attitudes and behaviour related to condom use.

In order to achieve the aims of this research, procurement interviews, follow-up interviews, coital journals, provider interviews, and focus group discussions were used to generate a range of qualitative and quantitative data sets. Individuals making use of the clinic facilities and procuring condoms were approached and asked to take part in the study. Willing participants (who had procured condoms on the given day) were administered procurement interview in an attempt at building a profile of condom procures and condom users and non-users. Procurement interviews are a useful technique that can provide valuable information towards constructing a profile of condom procurers (an important contrast to the profile of condom users) as well as an understanding of the issues of condom availability and access (Meyer *et al* 1998:8). In addition it is a valuable source of information on the intention s of condom procures, even though intention can vary considerable from behaviour.

These interviews made up part of a set of two interviews; with the second being the follow-up interview.

The procurement interviews took between 25 and 45 minutes on average. Throughout the research period, I worked with a translator, as many of the informants were unable to speak fluent English. The time taken to carry out interviews was often dependant

on the participant's level of understanding of the questions at hand and whether the translator had to be used to translate all questions. These questionnaires were mainly quantitative in nature covering topics such as demographic background, number of condoms procured on the particular day, frequency of condom procurement, brand preference and so on. An example of a procurement questionnaire can be seen in Annex 1. Subsequent to participating in the procurement interview informant were invited to take part in the follow-up interviews and to keep a coital journal.

The participants were asked to use their coital journals to diarise their condom use, non-use, breakage and 'sharing' (giving out condoms to friends or family members). According to Meyer *et al*, 1998, the most obvious benefit of this method is its capacity to investigate a sensitive and highly personal topic on a regular basis during an extended period of time. The journals were used to obtain data pertaining to both condom use and sexual activity (with and without a condom). Participants were asked to return four weeks after the procurement interviews to take part in the follow-up interview and to return their coital journals. The follow-up interviews consisted of fully structured questions that investigated fate of originally procured condoms and number of sexual acts for the four-week period. A comprehensive set of open-ended questions made up the bulk of this questionnaire so as to fully investigate the various attitudes, beliefs and knowledge that has informed condom use, dis-use or non-use of the participant. Incentives were used to ensure that journals were filled in properly and returned and that participants came back for follow-up interviews.

Besides these three approaches to the research, provider interviews were also administered to health care givers with whom good rapport was established. These

interviews aimed to explore some of the same issues under study, but from the perspective of the provider.

This research site was more conducive to qualitative research as all interviews took place in allocated private consultation rooms. Firstly, unlike Wynberg clinic, participants were more willing to discuss sensitive issues at length due to the private nature of the interview, and this allowed for the collection of in depth qualitative data. Secondly, the time spent in the field (double that of the Wynberg study) allowed for the establishment of rapport of sorts with participants that had to return for follow-up interviews.

1.2.8 Interviews with other key informants

During my period of internship, I had various meetings with key informants in the field of AIDS/HIV policy makers and implementers. Meetings with those responsible for the drawing up of provincial AIDS policy and implementing of such polices, resulted in a wealth of information from a different perspective. Formal interviews with those working in the Ministry of Health in the Western Cape, offered invaluable insight into both the National AIDS Plan and the current implementation status of the various policies. The informant interviewed included those in health research, NGO practitioners and policy implementers.

1.2.9 Other Research Methods

Another research method that offered a wider scope of investigation was the use of focus group discussions. A focus group is a discussion in which small groups of informants ranging from six to twelve people, guided by a mediator, talk freely and spontaneously about themes considered important to the research (Scrimshaw, 1987:15). Focus group discussions for target groups within a population offer a qualitative approach to gathering relevant information about a certain target group. Three focus groups were carried out on three targeted groups, namely: Sex workers in a local escort agency; Tertiary students at the Teachers Training College and High School students in a designated high school. The focus group sizes varied with target group and for the Sex workers focus group the number of participants was five whilst in the Teachers Training College fifteen.

2.0 Method of Data Analysis

Sampling

The random sampling used in this research yielded a total of 82 participants ranging from 14 to 27 years of age. 34(41.4%) of the total sample were male and 48 (58.6%) were female. The participant mean age was 22.5 years. A majority of informants interviewed had completed standard 8 (grade 10), others had matric while a few had post high school education.

At the time of interviews 74.2% of the participants were in a relationship (non-cohabiting and cohabiting) while 23.5% were married. Only 2.3% of the participants were single.

40% of the participants were employed with jobs ranging from manual, part-time work to teaching professions. In general though the majority of participants held low-paid, unstable work. 24% of the sample was made up of students and scholars and 35 % were unemployed.

In response to various quantitative questions relating to condom use and knowledge relating to HIV/AIDS the respondents commented as follows;

To the question of whether it was difficult to procure condoms from the clinic, 86.2% responded no and 13.8% said yes. It is important to note that the figure relating to difficulty in procuring condoms seemed to rise with further conversations held with

participants. Although they often commented on the fact that they were 'freely available' some would later point out that this did not automatically translate into 'easy to obtain'. Very often issues relating to privacy and confidentiality had an impact on this perception but more on these issues will be discussed later in this study.

Women who responded positively to the question 'have you ever used condoms', 47.6% said that they used condoms as a contraceptive, 21.4% used them for protection against STD's and HIV/AIDS and 31% used them as both a contraceptive and barrier method of protection. It is important to note that condom use amongst women seemed to be as a result of STD treatments or as a backup to their regular contraceptive. 69% of the women said that the reasons for ever using condoms were a direct result of the intervention of a health worker and condoms were used as a temporary protection against STD's and for the unreliable periods of their normal contraceptive (the pill or the injection). Men participants said that they used condoms primarily for the protection of STD's and as a 'double protection' against pregnancy.

In response to various questions pertaining to knowledge, education levels and behaviour change participants offered a range of responses. In response to the question of **where informants had first learnt about HIV/AIDS and STD's** there was a variety of responses, though over 80% did say that they had gathered the bulk of their information from the media (which included radio, television and newspapers). Some of the responses are recorded below. The words in Italics throughout this dissertation are verbatim and I have not corrected grammatical errors so as to accurately reflect the manner of speech of my informants.

' I first heard about these diseases at school and from the television'.

(19-year old male student)

' I heard about it in an AIDS awareness workshop'. (27-year old unemployed man)

'We first learnt about it at school with magazines and we found out that the disease is real and not a government propaganda. We also learnt how to protect ourselves'.
(21-year old student)

'I first learnt about it from a friend who caught 'drop' (a STD*). He told me that he got it from a girlfriend he did not know very well and he told me to protect myself by using condoms'.* (19-year old male student)

'I learnt about them in Johannesburg from newspapers and the clinics. They said that people sell their bodies and then they die from these diseases. I understood that it only attacked prostitutes and women who have many boyfriends. (27-year old female)

As can be gathered from the above-mentioned responses, participants had first learnt about HIV/AIDS and STD's from a variety of sources, though a majority mentioned that they had also learnt about them through the media in addition to other sources.

In response to the question of **whether the knowledge of HIV/AIDS and STD's had changed the way informants thought about sex,** some of the responses included:

'Yes, I keep only one partner and always use a condom'. (19-year old male student)

'Yes, therefore I realise the importance of using condoms because I know my husband can bring diseases home'. (22-year old married woman)

'No, I always believed in one partner'. (21-year old female)

' Yes, I do not sleep around anymore'. (21-year old male)

'*Yes, I meet different girlfriends so I must try and be safer'*. (23-year old male)

'*No, because I always protect me at all time'*. (21-year old male)

'*Yes, I now always use a condom with my spare because I am scared of catching diseases*'. (24-year-old male)

'No, because I always use a condom so I can still go around as much as I wish' (27-year old with multiple sex partners)

'*I never discuss these things with my boyfriend as I do not believe these diseases exist. But I do want to use condoms, but he refuses so we sleep without one'*. (20-year old female student)

'Yes, I still have many girlfriends but I am very careful to always use a condom with them'. (18-year old student)
'*No, because I know that there are pills available to cure it and this is why I have not changed my behaviour'*. (19- year old student)

The above responses highlight some of the differences in attitude and behaviour towards the acquisition of knowledge round HIV/AIDS and STD's. An in depth and full analysis of these beliefs, attitudes and behaviour will be outlined in later sections of this thesis.

In response to **who initiates condom use within the relationship** the following responses were elicited:

'*I tell her to use a condom to protect us and she agrees'*. (19-year old male)

' We negotiate condom use within our relationship'. (21-year old male)

' I initiate condom use as I don't want the ladies to fall pregnant'. (22-year old unemployed male)

'She asks me to use a condom as she does not trust me and she always tells me about the diseases'

'I always decide to use a condom. If a girl asks me to have sex I tell her I am a man and use condoms. All my girlfriends, except my original, understand. My original is on the injection'. (20-year old male)

'I decided to use them as I do not trust my husband. I think that he has other women and has sex with them without my knowledge'. (23-year old married woman)

In response to the question of **why do you or your partner not like to use condoms,** the following responses were obtained:

"My boyfriend does not like to use condoms as he says that it does not feel the same. He says that it is like eating a sweet with a wrapper on it." (22- year old student)

" I do not like to use condoms with my wife as we trust each other and so I do not believe it is necessary". (27- year old married man)

" My boyfriend does not want to use condoms with me because he says he likes 'flesh on flesh' and that it does not feel the same as having sex without one". (19-year old Schoolgirl)

" My boyfriend complains that the condoms are not pleasurable and that they are too tight for him. We both feel that we do not need to use them because we trust each other." (24-year old woman)

" We believe that to use condoms within our relationship is like saying that we do not trust each other. We have tried to use them because my wife was unprotected by her contraceptive for a while, but we both did not enjoy them." (26-year old man)

" We always use a condom and I am on the pill, because we want to make sure we are 'double' protected against pregnancy." (18-year old girl)

" Condoms are crucial for my business. They represent a boundary between work and play and they are the only way we have to protect ourselves from HIV and STD's. I always use a condom with my clients, but never with my boyfriend". (27-year old sex worker)

" My girlfriend and I do not mind using a condom, but it is mainly for the protection of pregnancy, as we are too young to be having children". (19-year old male student)

"Condoms are unnecessary. I do not like them as they do not feel like a man is really having sex." (28-year old male)

These responses show that there are firstly more than one reason attributed to condom use and secondly that condom use is not tied up to purely physical barriers but also symbolic barriers of distance. Condom use, for many of the informants, is for the protection against STD's and HIV, whilst for others they act as a ('double') protection against pregnancy. Condom use to others is symbolic of a particular type of relationship and become associated with these particular contexts.

This collage of responses has attempted to demonstrate some of the variation in attitudes and knowledge regarding condom use by the young people making up this sample. Some of these responses in addition to the qualitative information gained from in depth follow up interviews offered some interesting insights into the social issues that shape the knowledge, attitudes and behaviour of these young people.

3.0 The challenges and constraints facing Intervention strategies

There is presently very little research available in South Africa relating to the challenges faced by young people trying to access reproductive health services. Conversations held with key researchers in the field of education and health highlighted the fact that very little studies have been commissioned pertaining to challenges faced by young people accessing health services. However, the few studies available emphasise the need to address this shortage. It was based on this assumption that some of these issues were explored in relation to the participants taking part in this study.

One of the greatest challenges of working with HIV prevention, unsafe sexual behaviour and STD treatment is finding ways to offer health services to the target populations and to provide them with appropriate prevention information. Besides the physical accessibility challenges faced by young people seeking health care services, such as distance from clinics, high transport costs and inappropriate clinic hours, young people also face the real challenges in the form of barriers to actual clinic use.

Many South African youth are sexually active, but many of those who face problems of HIV/STD infection fail to consult a health care worker. According to the HSDU, part of the problem rests with a lack of reproductive health knowledge amongst young people, as often the information they have is unreliable or inaccurate. Based on the statistics gathered from the response of informants at the Galeshewe clinic over 72% of the informants said that no nurse or anyone working at the clinic had ever shown them how to use a condom.

However, young people also experience significant problems in accessing reproductive health services. They often have extremely negative perceptions of the health services and this acts as a barrier to their use (HSDU Booklet, 1998:3). Some issues of concern that arose out of this study will be discussed under the below mentioned sub-headings:

Confidentiality/privacy issues

Poor relations between health worker and patients

Fears of asking for contraceptives and being found out

3.1Confidentiality/privacy

Based on the literature review it was found that many young people fear going to clinics to speak about sensitive issues related to reproductive health/HIV/AIDS and STD's because they fear that their problems will not be kept confidential. The manner in which the Galeshewe, and to some extent the Wynberg clinic were laid out did not seem conducive to privacy. In Galeshewe, condom distribution points were often an issue of contention for many of the participants. It was found that many of the participants felt embarrassed and fearful of obtaining condoms from the existing distribution points. This particular clinic only had two points of distribution. One could procure condoms from the dispensary jar (which was situated in the main waiting room and did not offer any privacy from those waiting for their clinic

appointments) or from the contraceptive nurse. There was no jar or box of condoms anywhere in the clinic that offered potential procurers an opportunity to fetch condoms without interaction with a health worker. As a result many informants voiced their reluctance at coming alone to the clinic to procure condoms and tended to procure in a group of three or more. Due to the privacy offered by our interview office, young people would often ask us during their follow up interviews, to fetch them more condoms for them. When questioned about this reluctance to fetch condoms, some of the informants replied:

"I sometimes feel shy to fetch more condoms at the dispensary because the people sitting there seem to be looking at me in a funny way".

And another said

" I have to come back to the clinic often because the sisters do not like it if I take a lot of condoms at a time".

Many young clients felt uncomfortable asking for condoms as they said that the 'old people waiting to see the sisters watched them and seemed to judge them'. This lack of privacy meant that young men would often wait to procure condoms from the local 'Spaza's' or night -clubs in an attempt at keeping some anonymity.

According to HSDU report (1998), in many community clinics there is insufficient space to guarantee privacy; as a consequence it is easy for the conversations between nurses and their clients to be overheard. In a study carried out by Abdool Karim, Q. *et al*, 1992, in Durban, it was found that the lack of privacy could lead to the inhibition of the youth in relation to the health worker. This same study found that although

rooms were available in most permanent clinics, students wanting to procure condoms were not usually taken into them. In the Galeshewe clinic, only young women seeing a contraceptive nurse or partners seeing STD nurses were able to obtain condoms within the privacy of a consultation room.

3.2 Poor relations between health workers and patients

Despite the fact that a majority of young people (72.2%) disagree with the statement that the clinic staff were generally unfriendly, many of these same informants later went on to say that they had sometimes encountered hostility from health workers. Many informants felt that the relationship they formed with health care workers was both inadequate and wanting. Some young people perceived nurses as being hostile and judgmental towards them and as a result often avoid going to clinics. These types of negative stereotypes associated with health care workers can be problematic, as they will only serve to discourage young people from seeking care at clinics.

Conversations held with various participants contradicted the high statistic showing that young people find the staff friendly and helpful. Some of the young girls interviewed on condom use practices complained that the sisters were 'unfriendly and unhelpful' and that they would 'scold them for sleeping around'. They said that often they felt scared to come to the clinic for a pregnancy test as they felt that the nurses would judge them and pass comment on their sexual practices. One 17 –year old girl commented:

" Last time I came to the sister for a pregnancy test she screamed at me and told me that I just slept around and then wanted to come to the clinic for a pregnancy tests".

Another young woman (with a sexually transmitted disease) came to our office crying because she said that the sister would not treat her unless she brought her boyfriend. Although this is part of the new policy on STD treatment, this particular girl felt that the nurse was 'short–tempered and impatient with her and not understanding of her problems'. Some of the informants also complained that some of the health care workers 'discussed their private and confidential problems loud enough for the elders in the waiting room to hear'. One 20-year old man pointed out that he did not feel comfortable seeing a health care worker in this particular clinic because of this perceived lack of privacy.

" My friends and I do not come to this clinic to get treated for STD's as the nurses are unfriendly and ask all sorts of questions of us if we come here. Sometimes they also embarrass us by speaking very loudly at the entrance of their offices so that all those people in the waiting room can hear our problems. When we need advice for STD's, or 'drop' treatment we go to the clinic in town where no one knows us".

Besides these very real barriers to health care services, young women also complained it was 'too embarrassing' to ask for condoms and as a result their partners were relied on to bring the condoms into the relationship. One or two of the informants who wanted to procure condoms, felt that if they were seen taking condoms at the clinic they would be labelled 'cheap or those kind of women', and as a consequence very few procured condoms from their local clinics.

Very often adolescents are afraid of asking clinic staff for contraceptive advise, especially when the client is very young. According to Wood *et al* (1997), teenagers seeking contraceptives without parental permission was frequently a source of conflict

between staff and clients (pg.3). Based on the conversations held with young women in Wynberg and Galeshewe, it was found that these same conflicts were often a source of frustration for young clients.

It is also interesting to note that some health care workers perceive that it is their responsibility to discourage young people from being sexually active. According to a very young participant (16-year old) some of the nurses treated young girls who seek contraceptive advice with contempt.

'In some clinics I get strange looks because I am so young. The nurses make me feel as if I am too young to be sexually active; they are abrupt and sometimes not that helpful. I believe that no one but myself can look after my body, so I simply ignore them. I still come and get my injection and condoms regularly. The problem is that I have many friends that feel too intimidated to come the clinic and as a result they often practice unsafe sex. I think that they believe we are too young and should not be having sex, but I know lots of girls my age who are regularly having sex..."

This type of attitude towards young people who are sexually active only serve to isolate young people from obtaining contraceptives and barrier methods necessary to protect them from contracting HIV/ Aids or STD's. In a study carried out in the Northern Province, teenagers said that nurses would not provide the method (contraception) until they had asked 'funny questions' about whether they had told their mothers, and had lectured them that they were far too young to be sexually active and must 'stop going around with men' (Wood *et al*, 1997:3). Teenagers who refused to answer these questions were reportedly scolded. 'Scolding' provoked emotions of shame, unhappiness and fear in the teenagers and many stopped using contraceptives as a result (ibid).

3.3 Fears of asking for contraceptives and of being found out

Very often young people are afraid of asking clinic staff for contraceptive advice, especially if the clients are very young. At two clinics in rural areas of the Northern Province, nurses reported that they asked teenagers whether their mothers knew that they wanted to use contraception, explaining that this was because the client was a 'minor', and because 'some cultures don't like contraceptives so we can't just give them to a child without their parents permission' (Wood *et al*, 1997:27).

Based on conversations held with various participants in Galeshewe and Wynberg, some of these issues of contention arose. Very young clients complained that they found it hard to procure condoms and contraceptives because of the attitude of health workers towards their age. One fifteen-year old girl said that often the health workers were reluctant to issue condoms to her and would often ask 'funny questions about my relationships'. Another sixteen- year girl said that she felt that it was this type of attitude that stopped her friends from coming to the clinic to procure condoms despite the fact that they were sexually active. In another case, a seventeen-year old girl complained that not only did some of the health workers 'pass judgement' on her requests for a pregnancy test, but they also discussed her problems in front of other patients that were known to her. This type of behaviour seems to be tied up to the conflict health workers seem to have between their professional and moral role in society. It may also be tied up the fact that in close-knit communities health workers often know the parents of these clients and might fear their anger (Wood *et al*, 1997:4).

In Galeshewe in particular, the fear of being found out seemed to be a problem with some of the males coming not only to procure condoms but also to see a health worker in connection with a sexually transmitted disease. Due to the nature of the community in this 'high density area', very often the health workers were known to their clients outside the professional sphere. A few participants knew the nurses from church or in other social contexts and quite a few of them even knew the health workers by first names. The effects of a close-knit community on the relationship formed between client and health worker had obvious implication. To add to this, the presence of other clients in the clinic known to these participants made anonymity virtually impossible. This often resulted in young clients looking for health care in other clinics away from their area of residence. In particular young men said that they avoided seeing a health worker in Galeshewe if they suspected a sexually transmitted disease due to fear of being stigmatised by the other clients or even the health workers. They no doubt also fear that their medical problems will reach the ears of their parents. These perceptions around the lack of anonymity and professionalism are only conducive to push away the young person most in need of contraception or barrier protection.

The nurse has an important role to play in this field. She acts as a counsellor and decision-maker. She must guard against value bias rooted in her own cultural or religious background (Kunene, 1995). Some nurses have been known to resist giving teenagers contraceptives because they believe it encourages pre-marital sexual relationships (Welman, 1986). This has been found to be the case in more than one study in South Africa, where health workers regard moral guidance of young people

and discouraging of sexual activity as part of their social role. Often health workers struggle to put their professional ethics above their moral ones and as a result they often do not fulfil their role as professionals.

4.0 Gender as a barrier to safer sexual practices

Although the promotion of condom use by various intervention programmes aims to empower people with a means of protection against AIDS/HIV and STD's, often the simple access to free condoms does not automatically translate to consistent use. To date many of these programmes have promoted the use of the male condom, based on a 'knowledge leads to action' model. The condom is seen as a simple protective device to be introduced into the sexual act at the 'right' moment (Wood & Jewkes, 1997:39). This implies that the individual is an independent person who can make decisions regardless of the opinions and behaviour of others, and of the wider social context (Campbell, 1995). This ignores the realities of power dynamics, not least of which are the gender inequities, which structure heterosexual relations (ibid).

In South Africa, besides the very real biological factors contributing to women's vulnerability to HIV, this vulnerability tends to be compounded by the 'context of their lives within a patriarchal society'. Male dominance pervades every aspect of women's lives including family, social, religious, legal and institutional and influences their ability to be assertive and to protect themselves (Abdool Karim, 1998:19). Very often women, but especially Black women, find themselves in relationships where they have very little power and are therefore unable to negotiate safer sexual practices with their sexual partners. This lack of power is often due to a variety of complex issues that directly impact on a woman's life. In particular contexts, such as in cases of extreme poverty, lack of education and the ingrained belief that women should be subordinate to men, sexual interactions are often dominated and controlled by men. These factors, worrying in themselves, often

translate into issues of violence and coerciveness in relation to sexual relationships. Especially in Black communities it is common for young women to be forced into sexual intercourse by boyfriends who believe it to be their right (Richter, 1996; Varga & Makubalo, 1996). Young women who find themselves in sexual relationships, often seem unable to control the nature and safety of their sexual encounters with their partners. This is due to the fear of negative response, or 'worse, reprisal in the form of anger and rejection'.

In general, women's attitudes towards condom use, in this study tended to support these assumptions about the relevance of cultural factors when negotiating condom use with their sexual partners. The younger women of the sample (from 14 to 19) tended to be far more assertive and suggested that they had a sense of empowerment where issues of safer sex were concerned. These issues included the protection from unplanned pregnancies, sexually transmitted diseases and HIV. However, issues pertaining to male partners who had multiple sex partners did not seem to be as well negotiated. A few of these women, who found themselves in very new relationships, or were single at the time of research, suggested that they felt confident and assertive enough to negotiate condom use with new partners. Nevertheless, quite a few commented on the fact that condom use within a sexual relationship was symbolic of a very new relationship and that the importance placed on condom use declined with increased time within a relationship.

Nonetheless, even in this age group there were quite a few young women who felt that they were unable to suggest condom use with their partners for fear of being labelled 'loose' and 'forward'. Very often these women said that they were aware of the

dangers of unprotected sex with a new partner or a partner who had other 'girlfriends' but were afraid to discuss issues relating to safer sex practices for fear of rejection.

Those women who found themselves in stable relationships seem to have a different attitude to condom use that were often related to perceived issues of 'trust' and 'love'. Some of the women who had regular partners were often aware that their partner had other girlfriends but seemed to accept this as some sort of 'cultural norm'. Based on the findings of this study it became apparent that stable relationships were the primary motivation for the disuse of condoms with a regular partner. According to Abdool Karim (1998), we are observing through research and health services that it is monogamous women who are mainly being infected. Male condom use within a regular relationship seems to be rare and influenced by issues of love and trust and perceived to be negatively associated with casual partners and not regular partners. The pattern shown by this particular sample seems to suggest that women perceive condom use as a negative experience for men and many of them just seemed reluctant to push the issue with their primary partners in case it resulted in conflict or embarrassment.

A few of the women who found themselves in a relationship where it was known to them that their partner had sexual relations with other women indicated that they would like their partner to use condoms. However, like the attitudes of women in other studies, who found themselves in similar situations, these participants did not believe that they had the right to insist on condom use (Abdool Karim *et al,* 1994).

Older, married or those participants involved in a long term relationship seemed to fit in with the traditional idea that women should be submissive and dependant on their primary partner. Some of them commented on their primary partners 'having affairs and pointed out the fact that they did not trust their partners, but they seemed resigned to the fact and seemed to simply accept this behaviour. Many other participants pointed out that although crucial in this day and age to use some form of barrier protection with new sexual partners, this becomes unimportant once they have established long term relationships. Some participants pointed out that steady relationships symbolised faithfulness and trust to those involved and thus condom dis-use symbolised a step towards 'true commitment'. From the various discussions with participants, women and men, it became apparent that stable relationships and marriage was a primary motivation for the lack of condom use.

Regardless of the fact that many women do not use condoms within their relationship due to reasons associated with 'trust' and 'love', many of them know that they are at risk of HIV/AIDS and STD's from their primary partners. Four of the women interviewed found out that their partners were being unfaithful through the fact that they had on occasion been infected with a sexually transmitted disease. Numerous others simply suspected their partners were being unfaithful. One black woman's story was particularly disturbing because despite being re-infected on various occasions, this woman was still unable to negotiate regular condom use with her partner.

" Yes, I am using condoms right now, but usually I am on the injection as a regular form of contraception. My partner does not like condoms. He says that they do not feel the same and that we should not use them as we are in a long-term relationship. He says that he likes 'flesh on flesh' and that condoms are for

those who are not in serious relationships. This is the second time I come to STD clinic as I have become infected with some diseases. I do not have other partners, but I know he does because he brings these diseases home. He does not come to the clinic with me to get treated, maybe he goes elsewhere for treatment, but when I become infected is the only time he will use condoms with me. The nurse here gave me medication and condoms and told me to use them while I am on treatment. My partner is only willing to use condoms during this period and only because he does not want to catch the disease again. After I am cured he again will not allow condom use in our sexual relationship..."

This scenario clearly illustrates how firstly, some women have little room for negotiating safer sexual practices and secondly, how their perception of the situation is one of resignation to the perceived inevitability. Reasons for lack of negotiation abilities seems to be directly related to the fact that many Black women experience unequal access to power, as previously discussed. African men - through the payment of *Lobola* or maintenance for their children - assume they have certain perceived rights over their partners. According to Ramphele (1993), the cornerstone of 'traditional' control of women by men among Africans in most part of South Africa is the system of *lobola* (bride-wealth), which is used to secure control of the reproductive power of women. She goes on to point out that unwillingness to change is not a reflection of lack of 'gender consciousness' so much as a deliberate decision not to upset well-tested and established social structures (Ramphele, 1993:70).

This particular case study shows that this lack of negotiating power might be influenced by her partner's view of the relationship in terms of ownership. Some partners seem to consider women as 'property' and often fall back on tradition to justify their needs and wants. As a social worker in Virginia van der Vliet's study on tradition points out " the man is so selfish and arrogant that he will go along with change when it suits him and will resist change and hide behind tradition when he cannot defend a particular practice (van der Vliet, 1991:223).

It is strikingly evident that this woman, like many others, finds herself in a powerless situation where she is unable to protect herself from sexually transmitted disease and at times even pregnancy. As a result condom use is far from being a possibility in their sexual lives (Wood & Jewkes, 1997:41). Condom use becomes the decision of the male sexual partner and then only when he feels his health is at risk. In this particular context of unequal power, it is invariably men who determine the timing of sexual intercourse and its nature, including whether a woman should try and conceive, and whether or not condoms will be used (ibid).

In other situations women find themselves not only in relationships where they are powerless in terms of their reproductive bodies, but this powerlessness is often tied up to the violent and coercive nature of their sexual relationships. One particular woman, who took part in this study with some initial reluctance, broke down in tears in her follow up interview.

"I met my partner three years ago when I came from Johannesburg for a visit to my family who live in Kimberly. We met at Club 2000 (an area in Galeshewe) and within five days he made me have sex with him and quit my job in Johannesburg. I did not want to have sex with him but he forced me. One night he came to my house and demanded that I stay away from work and that I have sex with him. I said no and went to spend the night with my friend across the road. That night he came to that house and started knocking on the door. My friend went to open it and he told my friend to go buy him some beer. My friend said no it is late and we are sleeping. He ran into the house and started shouting and throwing saucers around and when he got hold of me he threw me down too. Then he dragged me outside and stabbed me. He had taken a knife from my friend's house and stabbed me because I did not want to go with him to his house. My friend went to call the police at a friend's place but my boyfriend told me that I must come with him or he is not finished with me. I went, because I was scared he was going to do something. We are now together three years and he does hit me, but especially if he is drunk. I only ever refused to have sex with him that first time...when he is drunk he acts violent. When he starts to get violent with me I run away. I was so many times at the police station, but they told us to stay together. He often hits me when he is drunk. When he is drunk he is like someone who is unhappy.

He just wants to fight and he touches other girls, as he likes. Sometimes he touches my friends in front of me and if I complain he threatens to hit me. So I keep quiet..."

Not unlike the study carried out by Varga & Makubalo (1996), where the majority of girls interviewed stated that they were usually unsuccessful in refusing sex with their partners, this example demonstrates that any attempt at refusal resulted in physical abuse. Sexual coercion amongst black women is not unusual. Wood *et al.* (1997), in a study carried out in Khayelitsha amongst young teenagers have shown that in most cases men were reported to use violent strategies from the start of the relationship, forcefully initiating partners who often had no awareness about what the sex act involved.

It has also been noted in numerous studies carried out in a South African context, that males seem to have an 'unnatural' control over female sexuality and that in many Black communities it is expected and accepted that men will dominate heterosexual relationships. There is a belief, put forward by men but unchallenged by women, that romantic relationships must necessarily involve full penetrative sex when the male partner wants it (Eaton, 1999). As a result young women, if they want to have a partner or boyfriend, are often unable to have any real control over their sexual behaviour.

In other studies carried out in South Africa, it has been found that by contrast to the above findings, some women are able to draw on cultural traditions to ensure that their virginity remains intact. Studies carried out on Xhosa women in East London, show that in the days when Xhosa girls were regularly inspected by senior women to ascertain if their virginity was still intact, the word *intombi* meant both girl and virgin (Mayer, 1971:253). The object of inspection was to discourage girls from indulging in

full sexual intercourse as against *ukumetsha,* external intercourse (ibid). In *ukumetsha* – intercourse 'between the thighs' as Xhosa say- the girl is not supposed to take off her undergarments, and technical virginity should be safe (Mayer, 1971:253). Despite the fact that these practices were almost obsolete in urban areas, at the time this study took place, there have been attempts at reviving the practice in recent times, which might offer a young woman a means to control their sexual bodies.

In the current case study, the participant in question had come to the clinic to see a nurse in connection with a sexually transmitted disease. She said that she was faithful to her partner so she believed that he must have other sexual partners. She commented on the fact that within their relationship no discussion relating to contraceptives had ever taken place and that she was now using condoms, with his permission, only because the nurse had told her to do so.

"My partner said to me that if I ever mentioned pregnancy or contraceptives with him he will throw me out of the house. So I never talk about these things with him. We have never talked about AIDS/HIV and I do not even know if I have experienced these STD's before...I found out that he had one because he told me that he had a sore on his penis and I told him to the clinic. He came back and told me that the doctor wanted to see both of us together. I asked him if had other girlfriends because I was not infected but he was, but he said no. I know he has others.. I want to use a condom always now because I won't know when he is clear of that. "

Based on the existing coercion and violence that seems to take place within this participant's sexual relationship, it seems highly unlikely that she will be in any position to negotiate regular and consistent condom use with her partner. The threat of violence or rejection effectively means that she might be unable to insist on the use of condoms or to demand fidelity from her partner (Meyer-Weitz *et al, 1998;* Varga & Makubalo, *1996*). Despite having the information related to safer sex as well as freely

available condoms, this particular woman, like many others in the same situation, will still be unable to protect herself within a sexual context. This is one of the main reasons that heterosexual women in South Africa are at high risk of HIV infection. Based on the findings of this study it has been noted that issues of gender and unequal power relations play a crucial, if destructive, role in the shaping of women's reproductive and sexual lives. It has made clear that these issues are contributing to women's vulnerability to HIV. The above evidence suggests that a theoretical insight into gender constructions within a South African context is crucial for a clearer understanding of how this discourse impacts on women's lives. Below I will review some of the necessary attempts at theoretically constructing gender within a South African context.

Many writings about AIDS and safer sex have suggested that safer sex may be especially difficult for women to implement because of the way sexuality is constructed in many cultures (Miles, 1992:23). Gender constructions are related to issues of power and in particular contexts, sexuality. Lesley Miles, (1992) carried out research exploring issues of power, AIDS and heterosexual negotiations on a group of University of Cape Town students. She found that masculine sexuality is thought to be characterised by sexual aggressiveness and competitiveness and driven by biological need. Feminine sexuality on the other hand, seems to still be defined by ideas of passivity, submissiveness and emotional need.

When issues relating to the negotiation of condom use within relationships were explored with a group of black girls, it was obvious that gender constructs were impacting on young women's perception of their partners. The women tended to feel

that it would be difficult to suggest the use of condoms to their lovers because there would be a number of consequences.

> "These are connected to the loaded and negative connotations of AIDS. AIDS has the fundamental meaning of deviance, which includes connotations of promiscuity, delinquency and pollution. Therefore, if a woman asks a man to use a condom as a means of self-protection, he may think that she is suggesting that he has AIDS. What follows from this suggestion is that the man is not trustworthy, which in the canons of masculinity, is unacceptable. Trustworthiness implies authority and control. Men must be seen to be trusted and trustworthy. Their authority must be taken at face value and not questioned." (Miles, 1992:34)

In another study carried out in South Africa on constructions of marriages and relationships between Black Xhosa- speaking couples in the Eastern Cape, South Africa, Virginia van der Vliet (1991) explored gender construction in terms of 'traditional Xhosa culture. Her findings suggest that masculine sexuality is thought to be characterised by certain perceived rights, by men, to be promiscuous because 'Xhosa culture and tradition' seem to be reason enough to justify this behaviour. In her study she shows that men often used the 'tradition' of polygamy to justify their relationships with other women (van der Vliet, 1991:231). Despite adopting various 'modern' ways of life, these men were able to rationalise their promiscuous behaviour in a manner that appealed to their own interpretation of 'tradition'. As so well put by Spiegel and Boonzaier;

'The normative prescriptions implied by the idea of " tradition" derive from the ways in which people appeal to an image of their past to give legitimacy to presently preferred beliefs and practices'. (Spiegel & Boonzaier, 1998 as cited in van der Vliet, 1991).

Van der Vliet goes on to argue that whether Xhosa men were ever as dictatorial as some of her informants suggested was not the issue; what mattered was that they used this construction of the past to justify their present behaviour (ibid).

The arguments presented above offer an understanding of some of the ways in which young, Black men validate the contention that 'they have the right to be promiscuous'. On the one hand a young man may draw on the 'biological need' theory to rationalise his philandering; on the other he may simply draw on 'his tradition'.

These ideas around masculinity and authority came through quite clearly with various conversations held with male participants. Many of the positive responses to the question pertaining to violence or arguments within a relationship seemed to be tied up to issues of authority and 'maleness'. A few men admitted that they had hit their partner. They were quick to add, however, that they did so either because they were drunk or because their partner had initiated sex within their relationship. One young man pointed out that it was not 'the women's place to ask for sex, but that it is up to the man'. These sorts of response seem to be tied up to ideas around what constitutes a 'males role'. In a society where the negotiation of safe sex takes place with imbalanced gender power relations, successful female negotiation of condom use is generally low (Holland *et al,* 1991)

Besides the fact that in almost all cultures (in most 'first world' countries, mainly prior to the sexual revolution of the 60's) women have been traditionally expected to be 'passive and demure' and not actively initiating sexual contact (Eaton, 1999), it is

also still felt to be problematic for a woman to carry condoms in anticipation of sexual intercourse. If a woman is prepared there might be an assumption that accords with existing social stigmas that she is promiscuous or 'loose'. According to Miles, (1992) there just does not seem to be the space to openly acknowledge the issue of safer sex in a sexual encounter or relationship without one or the other partner being forced to take up a position of 'bad person'. This position invariably (although not necessarily) seems to be projected onto women and as a result it seems very difficult for women to negotiate safer sex without a whole range of defensive emotional responses being engendered in men (Miles, 1992:34). In developed countries such as in Europe, women seem to be better able to express their sexuality and to demand an equal role within their sexual relationships. Women who are able to acknowledge their sexuality despite the restrictive messages from society have usually had extremely open relationships with their mothers who actively encouraged discussions of all aspects of sex and sexuality (Thomson, 1990). These women who are able to openly assert their needs in a sexual relationship have better chance of being able to insist on safe sexual practices in these same relationships.

Although the women in this study faced true barriers to their attempts at practising safer sex, the younger ones seemed to be more empowered when it came to issues of condom use within a new relationship. While the younger women (14 –20) in this study placed a high value on their relationship with a primary partner, their attitudes were not all congruent with traditional gender role characterisations of the submissive women. These young women were not only vocal about their perceived rights to protect themselves, but also offered explanations for the various reasons they had decided to protect themselves.

As voiced by an 18-year old girl:

> *" I always make my boyfriend use a condom, even though I am in a steady (5 months) relationship. It is very easy, he either uses one or he does not get any sex"*

Another 20- year old added:

> *" I am presently between relationships, but have kept on with the pill. Actually I am seeing a guy on and off and since we are not going steady we have decided to always use condoms. I mean, if he does not want to use a condom with me, then can you imagine who else he did not use one with?"*

The above two case studies offer an interesting, if contrasting view around issues of responsibility and negotiation. The first example illustrates the fact that there does not seem to be any sense of sharing of responsibility or pleasure within the relationship. The young woman in this particular case seems to have decided to take full control over what she perceives to be the protection of her sexual body. The male partner seems to have no choice on the matter and there is no sense of shared responsibility over their sexual practices. By contrast, the second example demonstrates that some form of shared responsibility exists within this relationship. She argues that *both* her and her partner have decided to protect themselves within the relationship. This suggests that both sexual partners have a sense of shared responsibility and pleasure within their relationship. It is interesting to note that based on the data obtained from this study, a majority of men said that they were the ones who initiated condom use within the relationship while quite a few informants said that it had been a mutual decision. The few exceptions where women said that they had initiated condom use were usually tied up to younger, often assertive participants or older women who were unable to rely on their regular contraceptive for short periods of time throughout the year.

The 19% of the women who regularly used condoms were between the ages of 16 and 22. This demonstrates an important relationship between age and condom use. There seems to be a distinct drop in regular condom use with a rise in age in women participants in this study. This relationship points to a direct correlation between condom use and age of participant. Those younger women, who voiced an ability to successfully negotiate condom use within a relationship, might be able to do so because they are not directly dependant on their sexual partners in any way. It is also interesting to note that condom use for the young women mentioned above, seems to be associated with new or non-stable sexual relationships. Based on the lack of regular condom use within a stable relationship for the 'older' participants, it might be safe to assume that these young women will follow the same pattern of condom dis-use once they find themselves in a stable and long- term relationship. In order to ensure that young women continue to actively strive for safer sexual practices, intervention programmes need to look at ways to ensure that these young women do not stop using condoms once they find themselves in stable relationships.

It is obvious from the preceding arguments that despite the availability of condoms and high levels of AIDS education, a majority of women still find it exceedingly difficult to protect themselves from HIV infection. If women are held subordinate to men and sexual interaction is dominated and controlled by the male partner (as found in this particular study), women's sexual health is, and will continue to be, at risk (Eaton, 1999).

5.0 Relationship Dynamics: Condom use and multiple sex partners

The previous section showed how gender can often be a barrier to safer sexual practices and attempted to deconstruct some of the reasons for the perceived lack of negotiation powers amongst some of the participants in this study. In this section I will attempt to explore some of the relationship dynamics that seem to inform condom use or disuse amongst my informants.

Various studies carried out in South Africa have found that the majority of young people's sexual activity starts in the mid-teens. According to a recent study the national average age is 15 years for girls and 14 years for boys, though there is great variability around these figures (Eaton *et al,* 1999). Besides starting to have sex earlier than women, men also tend to do so in greater numbers. According to various studies the following characteristics of sexual risk taking among young people has been well documented: high levels of sexual activity, a tendency towards multiple partnering and non-use or inconsistent use of condoms (Hein, 1989 Moore & Rosenthal, 1991; Rollins, 1989; Lerner & Spanier, 1980; Sorenson, 1973 as cited in Macphail, 1999). These behaviours obviously have implications for risks of HIV/AIDS and the contraction of sexually transmitted diseases.

HIV/AIDS intervention strategies currently being implemented by the South African Government and various NGO's recognise that young people need to be one of their

main priorities in order to empower them with the necessary knowledge and barrier methods necessary to protect themselves from infection.

Generally, young men report beginning sexual activity earlier than young women because premarital sex is accepted for males, whereas women are expected to postpone the initiation of intercourse until they marry (Eaton *et al*1999). This observation seemed to hold true in this particular study, though the average age of first sexual encounter for women was not postponed till marriage. The most interesting point to note – when it came to the discussion of sexual encounters between genders- was the striking difference in behaviour of young men and women. Although both seemed to be equally knowledgeable about the various aspects of HIV/AIDS, the men seemed to be more aware of the various types of sexually transmitted diseases one could contract. The male interpretation of what constitutes safe sexual encounters also seemed to be skewed in favour of condom use without a drop in the number of sexual partners rather than fidelity and/or one partner. Women in contrast, knew that condoms would protect them but also felt that a monogamous relationship would offer greater protection from HIV infection than condom use alone. Women in this study tended to favour monogamous relationships and no woman mentioned having more than one partner at the time of interview.

Various women who were asked if they used condoms within their relationships reported that they did not need to do so as they were presently in a monogamous and stable relationship. As already noted, condom use to these women symbolised a lack of trust and love within a relationship and condoms were only used in cases where their regular form of contraceptive was unreliable. Other women felt that although

they would be willing to use condoms within their relationship, their partners were not as keen to do so. Condom use seems to be symbolic of 'distance and barriers' and according to Meyer-Weitz *et al*, 1998, implies a lack of love or care between partners. Other women said that they did not like condoms and that they were for the use of 'those kind of women'. Confronted with the fatal and frightening diseases such as AIDS, people often create defence mechanisms to shield themselves from the reality of the disease. People will often, due to the lack of exposure to those infected, perceive AIDS to be remote, only affecting others, especially subgroups such as homosexuals or prostitutes (Roos *et al*, 1995). Besides associating condoms with sex workers, some of the women informants also said that they were only used by 'loose or cheap girls who had many partners' and that because they did not behave in this manner themselves, they saw no need to use them. In addition some adolescents appear to justify their non-use of condoms, with the belief that they are unnecessary because their current relationship is monogamous and promises to be long term (Akande, 1997).

Based on the conversations and interviews held with women in this study, it was interesting to note that women tend to use 'trust' as the yardstick to deciding when it is safe to start using another form of contraceptive (as opposed to condoms). Trust, as defined by the participants, is a 'feeling of belonging to' and the knowledge that they are now in a 'stable' relationship. In addition, social norms internalised by young women encourage them to adopt elements of trust and assumed monogamy into relatively new relationships so that they can be viewed as permanent and therefore sexually justified (MacPhail, 1999). There seems to be a clear correlation between

'length of time within a relationship and condom use. The yardstick, which decides condom use within a relationship, is based purely on subjective measures.

According to one young woman:

> *"When we first start a relationship with a new guy we insist on condom use as we do not know each other well yet. However, after a few months or so you start feeling as if you trust the guy and then you stop using condoms."*

Another young women said;

> *"When one stops using a condom within a new relationship one know that the relationship is now serious and that you really love one another."*

An older woman commented on condom use as thus:

> *'I do not believe in using condoms if I am in long-term relationship and if one trusts and knows their partner. Condoms are for those who are not in serious relationships and for those who have many sexual partners'.*

Another women offered her opinion:

> *' I believe that condoms do not really apply to those who find themselves in long-term relationships. Yes, they should be used if one is not sure about ones partner and maybe when one is just starting out with a new partner, but after one makes a commitment than it is better to use another form of contraceptive, because seriously, men do not really like them.'*

There seems to be a clear trend between condom use and the type of relationship women or men find themselves in. Many women that found themselves in a steady relationship voiced their reluctance at regular condom use within the relationship. They believed that to suggest condom use to their partners – or if their partners were to suggest it – might imply 'mistrust and lack of true commitment'. They felt that trust and 'knowing' their primary partner was a good enough indicator of when to stop

using condoms. As an indication of the trust in relationships, partners tend to terminate condom use and in this way expose themselves to greater risk of both HIV and STD infection (Holland *et all* 1990; as cited in Macphail, 1999).

The definitions around 'trust' seem to vary with different cultural contexts. Some of the women said that they trusted their partners but still felt that they were in danger of contracting a sexually transmitted disease from them. Others said that they trusted their boyfriends but suspected that they might have other 'girlfriends'. However, some did say that they did not trust their partners as they suspected that they were 'seeing' other women. After some discussion around the issues of trust carried out in focus groups, it became clearer that trust for many women does not necessarily translate into purely issues of 'being faithful or monogamous', but rather seems to be tied up to long term commitments and even financial dependency. Although condom use for many of women who found themselves in steady relationships appeared to be for the protection of pregnancy, there were some women who argued that they needed protection from STD's and AIDS/HIV too. Amongst women who took part in the focus group carried out in the Teacher Training College, there was an overall sense that condom use, although not always practised within a long-term relationship, should be considered.

The majority of the women present said that they worried more about unplanned pregnancies than contracting sexually transmitted diseases. All the women in this group were on family planning and often used other forms of contraceptives along with condoms. Condom use seemed to be reserved for very new relationships, where a non-barrier contraceptive and condoms were used. One or two of the participants,

after much discussion in the presence of their male counter parts, felt that they might not be as safe as they previously thought within their sexual relationships. One young, but assertive, woman pointed out that although she feels uncomfortable suggesting condom use to her long-term partner, she feels that she has to do so in order to protect herself.

"My boyfriend does not stay in Kimberley and we only see each other a couple of times a year, on holidays. I do not know what he gets up to in my absence and since I am worried about catching HIV or disease. I have started asking him to use condoms when he comes home for the holidays, even though I do not have other sexual partners. I do not think he likes this very much, but he ends up using them anyway."

When the group at large were asked about issue of risk, some interesting if disturbing responses were elicited. Most of the participants felt that casual relationships posed a higher risk to the contraction of HIV/AIDS and sexually transmitted diseases. They felt that the nature of this particular sexual encounter constituted a high-risk practice because one did not know the partner in question sexual history. Most of the participants felt that individuals involved in casual relationships would be at higher risk for HIV due to the fact that they had multiple – and often casual- sex partners.

However, a few of the women participants disagreed with this theory based on the fact that they thought that there were more dangers associated with long-term relationships where condom use was not the prescribed norm. They felt that within these relationships, it might be very common for one or both of the partners to have 'spares' (casual girlfriends) and due to lack of condom use within a stable relationship the 'original' partner might be in more danger of contracting HIV/AIDS or sexually transmitted diseases. The majority of women interviewed in this study, however, felt that they fell within a low risk group for the contraction of HIV/AIDS because they

found themselves in 'stable' relationships. Issues surrounding risk behaviour associated with monogamous relationships will be further supported in later discussions.

Based on a literature review carried out for this study, it was found that almost all studies show men reporting significantly more partners than women, whichever way the figures are measured. Fewer men than women in these studies reported only one partner over their life times. Two studies found that more young men reported four or more partners than two or three partners (Naidoo, 1994; Goliath, 1995as cited in Eaton *et al* 1999). A further noteworthy finding (Du Plessis *et al,* 1993) is that more men than women report having a regular sexual partner as well as other regular or casual partner. Data pertaining to the research carried out in the two clinics in this research suggest that the findings are congruent to past research. Young men in this study reported in overwhelmingly higher numbers than their female counterparts of being involved with more than one sexual partner at the time of research. The NPPHCN national study suggests that multiple concurrent partnering is more common and accepted among Black youth than among others. In this study, young Black men frequently stated that it was boring to have only one sexual partner, and that having many sexual relationships at the same time was necessary for sexual satisfaction (Eaton, 1999).

From the viewpoint of this study, it is apparent that many of these contentions hold true and that the male informants often alluded to their relationships in terms multiple sex partner 'affairs'. Drawing on the data gathered from the various interviews and focus groups a clear scenario of multiple concurrent partnering emerged.

From the male perspective it became apparent that peer pressure to have sexual intercourse plays a big role deciding when a young man becomes sexually active or at least starts claiming or boasting to do so.

Based on the statistics gathered from this study, the majority of men interviewed started having sex at an average age of 15.5 years. Male participants seemed more worried about contracting sexually transmitted diseases and HIV/AIDS then about unplanned pregnancies. They were also more likely to find themselves in casual relationships more frequently than women in this study.

According to the statistics gathered from questions pertaining to number of sexual partners, 59 % of the total male participants had more than one sexual partner and of these, 22% had 3 or more sexual partners at the time the interviews occurred. This information was supplied with no 'coyness' or 'embarrassment' and often I, as the researcher, got the distinct feeling that these numbers were offered with pride. Despite the fact that men would often describe in great detail how they 'pursued' their 'original girlfriends' (original signifying long-term partner or "true love") in contrast little detail was offered on how men met their 'spares' (casual sexual partners). It is also interesting to note that men appear to construct a clear definition round what constitutes an 'original' and 'spare' girlfriend. The original girlfriends are the women these men feel are their 'true girlfriends'. These relationships symbolise love, 'trust', romance and emotional involvement. Most of the men interviewed said that they had waited 'at least a few months to have sexual relations with these girlfriends'. A clear ritual of 'romancing' was often voiced with intense detail whereas 'spares' seemed to only offer a physical outlet. However, when these same men described the process

that led to meeting of 'spares' the scenario was often by contrast strikingly different. One informant described how he met his 'other girlfriends' below:

" Spares are easy to meet. We just go to the tavern and buy some of the girls drinks. I have a saying that goes like this: Two beers and panties down!"

Although this particular 18-year old male showed a very contrasting scenario of how men meet their spares and one night stands, there were those who said that they met spares in the same manner they met their original girlfriends. The only difference, according to many of these informants was the length of time one waited to have sex with them. As a rule it was apparent that it was acceptable to wait a longer period to initiate a sexual relationship with an original than with a spare. More importantly, a glaringly obvious difference in the manner in which these young men construct the two relationships is through the perceived need to use a condom with all other partners but their original girlfriend.

" I have a long term, original girlfriend. I have been seeing her for two years and we met at a school play. I pursued her for a few months and then we became partners. I love my girlfriend and trust her, but I also have three 'spares'. I met them at the tavern. It is easy to meet these girls there. I have never discussed HIV/AIDS and diseases with these spares as I always wear a condom with them. I have spoken to my original about it though, and I told her not have other boyfriends because of diseases. She (the original) is not willing to use condoms with me – she was angry when I once suggested using a condom with her. I have spoken about contraception with my original and about pregnancy, but not with my originals, because I always use condoms with them. I am safe from pregnancy with my original as she uses contraception."

(19-year old student)

And:

" I have many partners, but only one original. I always use condoms with the others (spares) but not with my girlfriend who is on the injection and I trust her.

(20-year old unemployed male)

Another commented:

"I have two girlfriends and I always struggle to make the one use a condom".
(16-year old student)

And in response to whether his increased knowledge of HIV/AIDS had altered the way he thinks about sex, a 21-year old commented:

> *" Yes, I now always use a condom with my spare because I am scared of catching diseases. I only do not use them with my original as I trust her."*

By contrast, a much older informant who spoke to us said:

'I am always travelling and I have many women wherever I go. I am not scared of AIDS or HIV because I know that it can be cured. I only use condoms when the sister says that I have 'drop', but otherwise I do not believe it necessary. There are 'doctors' who can cure AIDS by cleaning your blood, so I am not worried.'

And another:

> *"No, I think the same way about sex, because I always use a condom I can still go around as much as I please."*
>
> (25-year old male)

And still another:

'Yes, I am very careful to be with only one or two girls at a time, but not more than that and I always try and use a condom'. (17-year old student)

It is clear that in particular contexts- in this case in the context of young Black men- that multiple partners are seen as acceptable and even desirable though not safe –

which may mean that risk taking is part of the 'game'. Other studies support this finding. Meyer-Weitz *et al* (1998) and Wood and Jewkes (1997/98) report that young Black men commonly claim that it is "natural" for them to seek casual sex outside their steady relationships – and that their girlfriends or wives cannot challenge this attitude. Although Black women do also have concurrent partnerships (though none admit to it in this study), there seems to be a double standard operating in many communities (Eaton *et al* 1999). Men openly claim the prerogative of having outside relationships, while expecting their partners to be monogamous. Women sometimes support this double standard: they agree that it is inappropriate for women to have many partners, and accept the notion that men's sexual urges are uncontrollable (ibid).

In another case study, an 18-year old student explained how the construction of different types of relationships took place:

' I have two girlfriends. I met my first girlfriend on the street and asked her if I could talk to her. She seemed to like my approach so she became my girlfriend. With the first girlfriend, she wanted to wait six months to have sex with me, but I told her that I loved her and so we only waited one month before we had sex. The second girlfriend I met at a school play. We had sex after a week of seeing each other. The second girl knows about my first girlfriend, but the first does not know about the second one. I have never discussed HIV/AIDS with either of them, as I am more worried about pregnancies. I always use a condom, though sometimes I do not use one with my original (first girlfriend) as we have been together for over a year. I am the one who brings the condom to the relationship and I do so because I need to be protected from unplanned pregnancies'.

This multiple concurrent partnering, in this particular context, seems to be accompanied by selective condom use. A high value is placed on condom use with casual sex partners. A majority of men in this study said that they were willing to use condoms 'regularly' with their 'spares' but that they would not be eager to do so with their stable partners. This attitude seems to be tied up with negative perceptions

surrounding condom use, including symbolic meanings associated with their use (Varga, 1997).

Due to the nature of the casual relationships, which to most seem to be tied up to physical need in absence of emotional involvement (though some would argue that they have emotional bonds with their spares) the introduction of condoms in such a context does not seem inappropriate. However, the introduction of condoms into what is perceived to be a stable and long-term relationship symbolic of trust and love, might be seen as suggestive of distrust and infidelity. This perhaps is the reason that some women, as can be seen from the case study previously mentioned, might be opposed to the use of condoms within their relationships. To accept condom use with their stable partner might be symbolic of the acceptance that ones partner is being unfaithful. As a result to resist condom use a woman might be asserting her position as an 'original' girlfriend or negating the fact that her partner is involved in multiple partnering. This of course, is assuming that a woman has the power necessary to negotiate condom use or dis-use within a relationship. In the majority of cases where a woman's partners dedicates the nature of the sexual encounter, a woman may simply be forced to accept the decisions made for her.

This has obvious implications for the risk factors associated with HIV infection in women who find themselves in long-term relationships. Ideas surrounding trust coupled with issues pertaining to empowerment, place women in stable relationships in an extremely vulnerable situation.

Men who find themselves in multiple partnering scenarios also place themselves at high risk for HIV contraction despite the fact that they may often be in control of their sexual relationships. It was beyond the scope of this study to try and offer an insight

into the knowledge and attitudes of these so-called 'spares'. The women taking part in this study all said that that they were either in a monogamous relationship -albeit that some did suspect that their sexual partners had partners outside this relationship- or that they were single. If the women in this study believed that they were all 'original girlfriends or partners', then who are the spares that make up the 'other' within these multiple partnering scenarios?

Although the data gathered from this research was limited in terms of exploring these constructions of 'spares and 'originals' and it seemed to indicate that only the 'original' partners were interviewed, I would like to suggest that the scenario might not be this simple. Despite the limitations related to the 'types' of participants we were able to interview, I believe that some of the women interviewed might in fact have been party to a multiple partnering relationship where she may not have been the only 'original'. Although the men interviewed suggested that they used condoms with their spares, some did mention that they often did not use them with all their 'spares'. Another scenario might be the fact that with time a 'spare' might become an 'original' and as a result a multiple partnering relationship might in fact be made up of more than one original. The existence of more than one original within a multiple partnering relationship effectively means that the male in the equation is discontinuing condom use with more than one partner, whilst having sexual relations with spares simultaneously.

In another scenario it is also possible that some young men exaggerate the number of partners they have and that some young women under-report their partners, as a result

of social stereotypes that approve of male sexual experience while disapproving of female sexual activity.

This could help account for the disparity in the data that as it stands, suggests that there were more females than males in the areas of study.

6.0 Conclusion

The overall findings of this study suggest that AIDS knowledge is good amongst young people and that some individuals, particularly males, do choose to make use of condoms in specific contexts. This study has also shown that intervention strategies cannot simply assume that knowledge and condom availability will lead to overall safer sexual practices amongst young people in specific social contexts. Wider social and cultural factors have to be taken into consideration if meaningful change in behaviour is to be evidenced. Intervention has to encompass more than just pure education, it has to be sensitive to the cultural and social contexts which impact on an individual's way of life and it has to realise that people's behaviour is not simply governed by what they know. Very often simply knowing something is dangerous does not necessarily mean that young people are empowered enough to act upon this knowledge, as was clearly illustrated in the chapter that dealt with women's barriers to safer sexual practices. Education alone cannot hope to compete with the various forces impacting on individuals' lives; it needs to be sensitive to the social norms, existing peer pressures, socio-economic and cultural taboos that play a crucial role in shaping the knowledge that individuals chose to internalise. To add to this there is a need to ensure that health care provision and accessibility of condoms is as user friendly as possible in order to ensure high levels of condom procurement.

Based on the discussion of challenges faced by young people seeking health care at clinics a few assumptions can be made. Firstly, it is clear that although condoms are free and 'available' to all, their availability is hampered by certain constraints. The percentage of young people who were offered instructions on how to use a condom in these government clinics by professional health workers was strikingly low. This in

itself is problematic, but what is more disturbing is the fact that even accessibility is dubious. This inaccessibility, according to various informants, is influenced by factors such as embarrassment, lack of privacy and limits relating to number of condoms that one is allowed to procure at one time. Although no informant complained of ever being refused condoms, they did mention that they found it embarrassing that almost all procurements involved the interaction with a health care worker. Secondly, young people often found that the clinic staff had negative attitudes towards young people who are sexually active and quite a few young men objected to their critical comments in connection with sexually transmitted diseases services. Quite a few of the informants voiced their reluctance at making use of these particular clinics for STD treatment and as a result seek health care in other areas where confidentiality might be better ensured.

It is also interesting to note that staff fail to encourage regular condom use to young people within these two clinic settings. It is particularly disturbing to note that this failure seems to have a greater impact on young women. Family planning staff tends to focus on the prevention of pregnancy – and since condoms are not as reliable as other contraceptives, they may discourage their use. Condom use amongst most women participants in this study was a direct result of health worker intervention and only seemed to be recommended in contexts relating to STD treatment or failure of regular contraceptives. Existing facilities 'with personnel necessary to provide the required services already in place', are letting opportunities for intervention slip through the system. Health care workers need to capitalise on these opportunities and offer young people more than simply the easiest or most reliable contraceptive for solely the prevention of pregnancy. Interventions of this kind would be imperative in

terms of providing young people with accurate and reliable reproductive knowledge and appropriate prevention information.

This study has also brought to light the need to create a user-friendly environment for those who are attempting to protect themselves. It is clear that it is not always easy for individuals to access appropriate contraceptive services, procure condoms un-obstructively and obtain adequate STD treatment. The perceived (and real) lack of privacy acts as a barrier to young people seeking reproductive health services. Some youth fear the attitude of health workers and communication between health workers and their clients is often not adequate. Some health care workers struggle to put their professional ethics above their moral ones and this acts as a barrier to the provision of adequate health care.

Issues relating to confidentiality, poor relations between care givers and their clients, condom accessibility and health worker ethics need to be re-assessed if adequate and adolescent friendly services are to be realised.

Although there is an assumption in many quarters that 'knowledge determines attitudes and attitudes govern behaviour' (Eaton, 1999), this study has clearly shown that there is a gap between what people know about prevention and what they actually do (how they behave). This study has also shown that despite the fact that most young people have the knowledge 'necessary' to protect themselves from high-risk behaviour, very often this does not translate into low risk sexual practices. It is clear that knowledge on its own is not enough to guarantee safer sexual practices. It has also been found that HIV-related information obtained from the media is only used

when it corresponds with and is reinforced by social beliefs and norms (Martin & Vance, 1984; Perkel, 1991 as cited in Wood, 1994).

The availability of free condoms in government clinics and the provision of sexually transmitted diseases services do not necessarily translate into regular and consistent condom use practices amongst young people, despite high levels of awareness. Attitudes towards HIV/AIDS prevention and condom use are complex and in order to understand the forces that shape these attitudes one needs to look to the social and cultural constructions that inform these attitudes. Attitudes towards condom use found in this study appear to be directly related to the individual's perception of risk and these perceptions did not necessarily translate into condom use. It was found that despite having misgivings about issues of their partner's promiscuity, young women were often unable to act upon these perceptions of risk. As previously outlined in this study, young women showed that intention alone is not sufficient to predict condom use but that there are broader more complex issues that impact and inform these intentions. It is important that interventions which target young people, but especially young women, should not concentrate only on passing on knowledge but also enabling women to translate their AIDS knowledge into risk reducing behaviour (Karim, A. 1991).

The young men who took part in this study appear to be using condoms for sexual relations at a higher rate than young women. Condom use- in almost all cases- was within a casual relationship scenario, rather than within stable, long-term relationship. The 24% of the women who ever used condoms (regularly and irregularly) said that in almost all cases condom use had been a result of health care worker intervention for

periods of the year when their contraceptives did not offer enough protection. The perception that condoms are used only for contraception, when being treated for an STD, or when a partner cannot be trusted needs to be changed, according to Karim (1991). There were very few young women (10) who said that they regularly used condoms out of their own perceived need to protect themselves.

According to the young men in this study, condom use is a 'norm' and acceptable with casual sex partners or 'spares. To many of the male participants, condom use within a stable relationship is not as acceptable due to the negative connotations associated with condom use. These connotations included real and perceived feelings about condoms. Issues relating to 'lack of pleasure', wanting 'flesh on flesh' and closeness with their partners was some of the negative feedback associated with condom use and regular partners. Other negative stereotypes included symbolic associations with a lack of trust, love or feelings within the relationship.

Young women, who voiced their willingness to use condoms within a stable, long-term relationship, clearly illustrated that it is wrong to assume that behaviour change lies solely with the individual. It is not simply the decision of the individual because in order for a person to use a condom they will have to have reached an agreement to use one with the partner in question. Although this argument applies to both the sexes, it is clearly harder for negotiation to take place for women who find themselves in dis-empowered positions. If these women are really unable to challenge or change their dis empowered positions, then they need to devise coping strategies that enable them to pay lip service to male supremacy, but still advance their own position (Ramphele, 1993:73).

The inability to discuss sexual matters with parents and older members within their community also impacts negatively on Black young people. Many of the participants in this study felt that it was inappropriate to discuss sexual matters with their parents and as a result relied on their peers for information regarding sexual matters and contraceptives. Very often the information obtained from other young people led to misconception and confusion around issues of contraception and barrier methods of protection. For young women especially, the lack of negotiating powers and the inability to discuss sexual matters due to existing cultural norms, does nothing to facilitate the conversion of knowledge into safer sexual behaviour practices.

The young men alluded to the fact that very often it was they who determined the manner in which sexual practices took place. To many of the young men it was felt that the introduction of condoms into a relationship was up to the male partner. They also showed through their various comments, that they were selective in their condom use. There was a clear pattern of selective condom use, which in most cases was tied up to casual sexual encounters. The perceived negative stereotypes associated with condoms, has an enormous impact on the manner in which men select to use condoms. These perceptions are tied up to whether a sexual partner is perceived to be promiscuous, whether the potential partner's history is known and the construction of the relationship in terms of 'an original' or 'spare'.

I believe that in many ways, young women's attitudes towards condom use were much more positive than their male counterparts. Quite a few of the young women, most of them in relationships, felt that condom use within a stable relationship would be a positive step towards protecting themselves from HIV/AIDS and sexually

transmitted disease. Others felt that condom use was inappropriate within a stable relationship due to their suggestion of promiscuity. According to Wood (1995), AIDS seems to be associated with promiscuity and therefore this set of beliefs impacts on those individuals who construct a sense of safety in their perceived lack of promiscuity.

Issues around trust within relationships offered some insight into the ways in which people constructed the need to use or dis-use condoms. Trust, as defined by participants, was tied up to issues of 'belonging', 'love' and 'stability'. It was not always tied up to issues of fidelity, however. Definitions around trust seem to vary with different cultural contexts, for although some women said they trusted their partners, they still felt at risk for HIV/AIDS or STD's. Trust, therefore, appears to be tied up to long-term commitments and in some cases financial dependencies rather than simply fidelity. As a rule there appears to be a direct correlation between time within a relationship and decreased condom use. The introduction of condoms into a stable and long-term relationship would be construed as inappropriate and furthermore might be suggestive of a lack of trust between partners. Within the context of a stable relationship, the introduction of condoms would be viewed in a negative light as an indication of promiscuity. As a result, as an indication of the trust in relationships, partners tend to terminate condom use and in this way expose themselves to greater risk of both HIV and STD infection (Holland, *et al*, 1990 as cited in MacPhail, 1998).

The responses gathered from the males in this study highlighted the selective nature of condom use within relationships. Where men perceive the type of relationship to be purely physical and casual in nature, the introduction of condoms does not seem inappropriate and is in fact encouraged by their male peers. Condom use within the context of promiscuity is seen in a positive light. I believe that some of the misconceptions around condom use arise at the intervention level. Many of the slogans preaching for the protection of individuals from AIDS/HIV and STD's create the impression that if you cannot have a single partner, use condoms with these multiple partners and you will be 'safe'. As previously discussed, the male response to the risk of contracting HIV has not met with a drop in number of sexual partners. The male interpretation of what constitutes safe sexual practices includes condom use with multiple partnering relationships rather than a drop in number of sexual partners.

Based on the findings of this study, the problem does not appear to lie with a lack of knowledge about issues regarding protection but rather with the manner in which individuals have selectively internalised this information to suit their particular cultural and social beliefs. The information individuals chose to act upon seems to depend on its ability to fit in with accepted practices within a particular context. Many of the Black men in this study were able to appropriate practices, such as condom use, because they offered no resistance to 'usual' social practices. This study has shown that it is relatively common for Black men to have more than one partner at a time and condom use viewed in a positive light in the context of casual sex, is easily incorporated into existing practices. It was hard to ascertain the levels of regular condom use within these relationships, but it was obvious that there is regular 'dis-use' with original or long-term partners. This has certain implications for the safety of

the partner involved in a long-term relationship. By dissociating themselves from a 'casual relationship' or 'one night stand' and attempting to give their relationship a sense of permanency through the dis-use of condoms, individuals place themselves at higher risk for the contraction of HIV and STD's. I believe that in certain cases, casual sex partners are often involved in lower risk sexual practices than those who find themselves in stable relationships.

The women in this study who find themselves in long-term relationships and wished to use condoms do not do so because of the perceived negative connotations and stigmas associated with condoms in these particular contexts. In some cases women do not insist on condom use within a relationship because of the fear of rejection or anger at their suggestions. It was found that despite the small age gap between the youngest and oldest women in the sample, there were some clear patterns of difference in the way in which condom use was constructed. The younger women in this study (14 to 23 or so) seemed to show a more positive attitude towards both the negotiation and assertiveness in dealing with condom use matters than their older counterparts. Regardless of age, this study has shown that there are still various negative stereotypes surrounding attitudes concerning condom use. These women have demonstrated that in a majority of cases there is a lack of condom use due to a partner's dislike of this form of protection.

This study has also brought to light a very clear pattern in condom use; that is that there seems to be a clear correlation between time within a relationship, and drop in condom use levels. The older women, who did not believe in condom use within their

stable relationship, felt that trust was the yardstick used to decide when to discontinue condom use. Condom use, to many of these women, is symbolic of a 'new' or casual relationship and therefore to discontinue condom use within a relationship is symbolic of 'permanence' and even a declaration of ones commitment to a particular relationship. From various conversations held with women it became clear that the general attitude is that condom use somehow interferes or lessens the pleasure of sexual acts. Because of these perceptions, which in many cases are reinforced by their men's attitude towards condoms, women feel that to have a meaningful, loving and long-term relationship would necessarily involve the dis-use of condoms, which might be suggestive of a casual encounter.

In essence, the use and dis-use of condoms within relationships seems to be tied up with the various stages of a woman's life. Despite starting off a relationship with the protection of condoms, she invariably decides or agrees to terminate its use with both time and perceived stability of the relationship in question. This is problematic in itself, but more problematic is the fact that young people tend to have many of these perceived permanent relationships in their search for the partner who may become their life long partner. Intervention strategies need to focus on ways to promote continued condom use within a perceived 'monogamous or permanent' relationship. . There is a need to promote and encourage the practice of condom use within a relationship that has passed the stage where trust becomes the deciding factor for condom dis-use. This can only be achieved if we go to great lengths to re-orientate the negative perceptions surrounding condom use in society at large (Eaton *et al,* 1999). We need to have educational initiatives that facilitate a platform from which men and

are able to communicate around the issues of condom use and offer a means to overcome the stigmas associated with condoms.

In relation to multiple sex partnering relationships it is obvious that the risks involved for both the male and the various females involved are high. Despite alleged condom use practices with all 'spares', the boundaries that divide a spare from an original do not seem to be as clear-cut as men seem to suggest. These sexual practices are high risk despite condom use and need to be highlighted as thus. It is not enough to recommend condom use, there is a need to emphasise the importance of monogamy amongst young people today. Intervention initiatives need to promote a 'new morality' that values equality between the sexes, monogamy and respect. We also need to dispel the notion that condom use alone will protect young people in multiple partnering scenarios, for young people place themselves at risk precisely because they internalise the aspects of AIDS education, which do not overly interfere with their usual acceptable notions of sexuality.

It seems to me that we need to look at not only why young people do not use condoms, but also at why some do. Issues relating to condom use amongst young men who found themselves in multiple partnering relationships need to be further explored, in order to ascertain who are the individuals who make up these relationships and to better understand the many factors that inform condom use within these particular contexts. We need to develop interventions that both address existing barriers to behaviour change and replicate the elements that make young people in this study and others like it, committed to regular condom use, whatever the context.

7.0 Recommendations

AIDS prevention needs to encompass more than just factual education, since people's behaviour is rarely governed by simply what they know. More attention needs to be paid to the de-stigmatisation of HIV/AIDS and sexually transmitted diseases and existing stereotypes need to be broken down in order to create an environment that is conducive for the discussion of matters pertaining to HIV/AIDS. Suggestions on how to de-stigmatise current negative sterotypes associated with HIV and AIDS are outlined below.

The following are some of the issues that need to be recognised and if possible addressed by future policies in the field of HIV/AIDS prevention.

- The provision and accessibility of condoms to all is not enough to ensure safer sexual practices. Health care workers need to provide guidance in terms of promoting condom use within a contraceptive context, provide information regarding proper use of condoms and counselling where appropriate. All health care workers who have contact with young people should be trained to advocate for safer sexual practices. The authority that comes with being a health care worker should be channelled towards offering young people advice and information necessary to protect themselves from HIV and STD's.

- Health care services need to offer clear and concise information on correct condom usage and should take every opportunity to advocate for safer sexual practices.

- Health care workers, especially in contexts where they are known to most of their patients outside a work environment, should place their professional ethics above their personal ones. They should ensure that young people have access to the information and barrier methods necessary to protect themselves within a sexual context, regardless of their own negative attitude towards youth that are sexually active. Further training in dealing HIV/AIDS prevention and the provision of professional STD treatment is needed to create user-friendly health care services. The training of health care workers needs to address attitudes of young people towards sexual practices that interfere with service provision.

- There is a need to recognise that AIDS prevention cannot be seen in purely a biomedical light in isolation of broader socio-economic, cultural and social conditions that impact on an individual's life.

- Negative stereotypes associated with condom use need to be deconstructed with the help of media, workshops and overall positive attitudes of those connected with condom dispensing. Those individuals in powerful positions in society need to actively voice their support and involvement in the dispelling of existing negative stereotypes associated HIV and AIDS.

- The issue of unequal power relations between women and men in society needs to be dealt with on many levels. Women need to be empowered to deal with the endemic violence within sexual relationships and need to openly assert their needs within a sexual relationship. Those women who are able to openly assert their needs in a sexual relationship have a better chance of being able to insist on safe

sexual practices in these same relationships (Holland *et al*, 1990, as cited in MacPhail, 1998). There needs to be a platform established where women are able to discuss their situations and look to role models for the speaking out against unequal power dynamics. Women have to be empowered to be assertive and confident enough to be able to negotiate condom use within relationships where they feel they are at risk. On another, more important level, women's role in society needs to be given more recognition and their economic status needs to be lifted, so that they are not solely reliant on men for everyday survival.

- The social norms entrenched in society, though hard to change, need to be altered so that ideas based on what constitutes 'femininity' or 'masculinity' is addressed in such a way as to construct condom use in a more positive light. Women need to be taught to be more demanding, assertive and confident in their approach towards safer sexual practices. For while HIV interventions may promote the use of condoms, they run counter to social dogma which entrenches the risk of bad reputation among condom carrying women and take little heed of young women's lack of assertiveness and confidence to insist on condom use in sexual relationships (MacPhail, 1998). The constructions round masculinity too need to be rethought so that macho constructions of man do not hinder HIV prevention through maintaining gender imbalances in power and encouraging risk-taking behaviour among young men (ibid).

- Research into ways to overcome the cultural and social taboos that create an environment unaccustomed to the discussion of sexual matters between elders and youngsters needs be promoted. An important skill for condom use is that of

communication and negotiation between partners involved in a relationship. However, very often due to an environment where young people are discouraged from openly discussing such matters, negotiation and communication are lacking. Opening channels of communication between sexual partners would ensure that those who have the intention of using condoms are better able to ensure they do so through negotiation.

- Condoms should be promoted and marketed so as to reframe condom use in positive terms (Eaton, 1999), and the positive effects of safe sex for relationships and the enjoyment of sexual activity should be stressed. Current television adverts and overall media promotion of condom use needs to be re-assessed in order to make them more sensitive to target populations and their cultural contexts. The stigmas associated with condom carrying and women also need to be dispelled in order to make it acceptable for women to be a full partner in introducing condoms into a relationship.

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Appendix

Relationships

Tick when section is complete: ☐

(A) How long have you been in your current relationship(s)? How did you meet your partner(s)? If you are not in a relationship, how do you meet your partners generally?

3 yrs. Met at the disco - Kimberley.

(B) How long did you know each other before you had sex? What were the circumstances the first time it happened?

After six months - Both had something to drink - sexual event just happened.

(C) When did you first discuss HIV/AIDS & STDs with your partner(s)? What did each of you say? What did you think? If you are not in a relationship, when do you first discuss HIV/AIDS & STDs with your partner(s) generally?

When they met - they were with alot of friends and they spoke about HIV/Aids.

(D) Did you discuss using a condom or another form of protection against HIV/AIDS and STDs? What was said? Why?

Yes. Because she has a child - he don't trust her and always use condoms.

(E) When did you first discuss pregnancy with your partner(s)? What did each of you say? What did you think?

Never.

(F) Did you discuss using a condom or another form of contraception? What was said? Why?

No!!!

(G) Are you happy with the decisions you and your partner have made around pregnancy and/or HIV/AIDS & STDs? Why?

Not sure whether he wants children with her.

(H) What if you wanted to change your decision about contraception or protection against HIV/AIDS & STDs? What would you say to your partner? How would he/she react?

Don't know / Not sure.

(I) Have you ever refused to have sex with your partner when she/he wanted to? Why did you refuse? What happened when you did?

Yes. She was angry and dissappointed.

(J) Do you or your partner ever drink alcohol before sex? If so, how does this change the way you or your partner behave(s)?

Yes. He'll be going on wild and wants to try all sorts of sex styles.

(K) Have you or your partner ever been violent towards each other? What happens? When does this happen? Why do you think this happens?

Never.

Questionnaire for Follow-Up Interviews

The Social Aspects of Condom Use in South Africa Research Project

Lost	Avail	Throw	Give	Break	Used	#take	ConSex	ConSex	# Sex	Relig	Lang	Work	Edu	Live	Prov	Local	M/F	Age	Idcode
0	0	1	2	1	6	10	0	10	10	1	10	1	16	8	4	1	1	23	4080

c/o: Department of Social Anthropology
University of Cape Town
Private Bag, Rondebosch 7700
tel. (021) 650 2139

Department of Community Health
University of Cape Town
Anzio Road, Observatory 7925
tel. (021) 406 6535

erviewer Code: 1 0 4

e of Interview *(dd–mm–yy)*: 0 6 — 1 1 — 9 8 (16 / 11 / 98.)

: 0 7

Province: KwaZulu-Natal ☐ Western Cape ☐ Gauteng ☐ Northern Cape ☑

e: 0 9 3 0

roduction & Consent:

name is .... I am working on a project sponsored by the Department of Health to stigate what happens to the condoms given free to the public within South Africa. We conducting research across the country, talking to people who come to clinics about their wledge and attitudes towards condoms and other related topics.

part of this work, I would like to ask you a few questions about yourself and your sexual ctices. It is important that these questions be answered as accurately as possible. As in last interview some of these questions are very private, but your responses will be kept nymous. No one except the members of our research team will see these names, and n we are finished in this area your name will be removed from our records.

rything you say is completely voluntary—you do not have to answer any questions if you not want to. Participation in this interview will have absolutely no effect on your access to kind of health care.

s interview will last approximately 45 minutes. I will tell you more about our work at the of the interview, and how you can earn money for participating in our study over the next weeks. As agreed upon, you will receive R25 for participating today.

you consent to participating in this interview? *(Tick one)* **Yes** ☑ **No** ☐

nk you.

erview Number: 4 0 2 0

erviewer Comments: Participant [illegible] partner [illegible] from [illegible]

4 0 8 0

I. General

1	During the time that has just passed since the last interview, have you gotten any other condoms from anywhere? Yes= 1 No= 2 → IF NO, GO TO 6	01 [0][2]
2	If yes, from where? This outlet= 1 Clinic/hospital= 2 Pharmacy/chemist= 3 Other *(specify)*= 99 Shop= 4 Partner or friend= 5 Don't know= 00 _____	01 [1][ ]
3	How many did you get? *Probe for number*/Don't know= 00	10 [ ][ ]
4	Did you pay money for these condoms? Yes= 1 No= 2	02 [ ][ ]
5	If yes, how much? *Enter amount*	[ ][ ] . [ ][ ]

I would like to ask you about your love life during the past few weeks and what you've done with the condoms you received at the clinic...

6	During the time that has passed since the last interview, did you have sexual intercourse with anyone? Yes= 1 No= 2 → IF NO, PROBE TO VERIFY → IF NO, SKIP TO III: CONDOMS	01 [0][1]
7	If yes, how many times have you had sex since the last interview? *(Interviewer, probe for exact number)* Enter 1-98 (10)	04 [0][6]
8	How many partners have you had sex with since the last interview? Enter 1-98 same person as before →	01 [0][1]
9	At any time during the past period did you try to avoid or refuse sex with any of your partners because it was not possible to use a condom? Yes = 1 No = 2 → IF NO, GO TO 11	02 [0][2]

Follow-Up Interview Summary Sheet

	1st Follow-Up	1st-2nd Follow-up	Total
Number of Sexual Events	06	04	10
Number of Sexual Events using a condom	06	04	10
Number of Sexual Events without a condom	/	/	/

4 condoms 'USED' at follow ups - 1 broke / 3 used on esc. of 10 taken at 1, 12 & 2nd F/U

Total Number of Condoms Taken Originally	10	10	10
Number of Condoms **Used in Sex**	6	/	6
Number of Condoms **Broken during Sex**	1	/	1
Number of Condoms **Given Away**	2	/	2
Number of Condoms **Thrown Away**	1	/	1
Number of Condoms **Remaining/Still Available**	0	/	0
Number of Condoms Unaccounted for	0	/	0

at 16/11/98.

Total Number of Participant Days in the Study (from Procurement Interview to Second Follow-Up)	24 DAYS.

Participant Number 4080

Open Ended Questions: General

Tick when section is complete: ☑

In your sexual relations over the past period, who intiated condom use? How does this happen?

Participant ~~initiate~~ initiate condom use - don't trust girl. She already has one child - he first discussed it with her.

If you or your partner use condoms regularly, who brings the condoms? How often do they do this? Where do they get the condoms from?

Participant brings condoms - regular condom users - Take condoms from clinic.

If you used condoms that were not involved in the study, what brand of condoms were these? Where did you get these from?

Only condoms involved in study - but participant prefer condoms from Hustler Shop

At any time in the past period did you want or try to use a condom during sex but did not for some reason (i.e., wanted to but couldn't, or partner refused, etc.)? What happened?

Yes. Only had one condom, but it broke - did not have sex at all.

At any time during the past period did you refuse or try to avoid sex with any of your partners because it was not possible to use a condom?

If yes, what happened? What was your partner's response?
If no, what do you think would have happened if you had tried?

A lot of times. Participant was not in the mood - girlfriend was very cross and they'll argue

Knowledge and Attitudes

Tick when section is complete: ☐

(A) How did you first learn about sex? Who did you talk to? How old were you?

Spoke with friends, ± 19 yrs old. Knew about sex before – from films.
↳ In this case – basically how to have sex.

(B) How did you first learn about sex? Who did you talk to? How old were you?

(C) When you were young did you discuss sex with anyone else? Parents? Brothers/sisters? Friends? Why (or why not) these people? → Why not → doesn't trust them to treat such matters confidentially.

Yes, but not with parents / siblings but c̄ friends. / family situat. such that he feels that he is unable to communicate with them → tense – argue.

(D) When was the first time you heard about condoms? Who from? What did they say?

At school → onderwysers ± STD. 9. ± 1991
↳ guidance teachers.
/ Said :- nothing special just if one was sexually active one was to use condoms.

(E) Who do you talk to about sex with now *[in the present]*? Parents? Family? Friends? Partners? What kinds of things do you talk about?

With friends, cousins + with partner now & then. Pregnancy etc. → nothing else.
+ with cousin etc. about STD.
↳ all married people.

(F) If you don't talk about sex with anyone, or with only your partner, why not with other people?

4 0 8 0

(G) Where did you first learn about HIV/AIDS & STDs from? What did you learn?

At school. → had an AIDS advisor at school → should be careful. → he spoke about the use of condoms to prevent the contract of AIDS/HIV.

(H) Have you ever seen or heard information about HIV/AIDS & STDs at clinics, on TV/radio, in newspapers and magazines, or anywhere else? Where, and what did these sources say?

Newspapers. → never watches TV. → does have an interest in reading magazines & bought. ⇒ pictures of AIDS sufferers. ↳ descriptions of the disease.

(I) Has knowledge of HIV/AIDS & STDs changed the way that you think about sex? Has it changed the way you behave around sex? Why or why not? became aware of these issues before he became sexually active. (Unclear whether he thinks that media has influenced his subsequent sexual behaviour, but he seems eager to show that he would use a condom in any case, thus suggesting that he might have been heavily influenced by the

(J) What do you think could help to make people (or certain groups, like students) use condoms more often? feels we can do something. → eg) give out condoms at key points eg. schools → To talk about the diseases that are spread

) media, or places great value on its influence.

Economics

Tick when section is complete: ✓

(A) Including you, who contributes money to your household each month? What do these people do for a living? all work. Mom → left of finances - ass. director, brother - a warden at the prison in Kimberley. (says "aboard affair") → data capturer. sister → nurse at Kimberley hosp. He works in the gat

*Probe for estimate of **participant's income:*** R 6000 100 gross R3500 NET.

(B) Approximately how much money do you spend yourself in an average week—on everything (ex. food, drink, housing, recreation, etc.)? What or who is this spent on? → NOT especially on ± R200 R300/week → perhaps alcoholic beverages → spent on friends / his partner. clothing/accio. ± R1600/month.

*Probe for estimate of gross **individual spending:*** R ± 2800 100

(C) Approximately how much money do you spend a week purely on recreation: entertainment, snacks, coke, etc.? What types of things do you spend this on? → seems pos. that drinks (alcohol) ± R80-R100/week. → Movies, drinks etc. so def. from this.

*Probe for estimate of **recreational spending:*** ± R 300 100

(D) If you had an extra five Rand each week, what would you do with it? If you would spend it, what on? Why this? R5 means nothing in his eyes. would give it to those who possibly need it.

(E) How much do you think public ('free') condoms are worth (in Rand)? ONE CONDOM

*Probe for estimate of **public condom value:*** ± R 2,89

(F) What would you do if you could not get condoms for free from a clinic or hospital? Will automatically buy them → at a Hustler shop / Chemist.

(G) What would you think of paying for condoms? How much would you pay for one condom? perhaps the best. - all condoms are not the same. believes condoms that are sold, are of a better quality than those that are given out at clinics

Public Sector Condoms

Tick when section is complete: ☐

(A) What are condoms worth to you? What value do they have for you?

→ means protect.

(B) Do you think that all condoms are the same? What about the condoms for sale compared to the free ones? What about different brands?

Some are better than others.

refer to previous pg ⇒ pos. durex.

that pink condoms with knob on it. R13,50.

(C) Which of these condoms do you like the most? Why? *Display condom varieties/Probe* What makes some kinds better than others?

→ more rubber-like qualities.

available at.

(D) Have you ever heard of Lovers Plus condoms? Where did you hear about them? What do you think of them?

Yes, saw it in a Hustler shop ⇒ Won't use Lovers Plus. not strong enough this pink condom is his choice →heard from a friend that you can use it 3X before ...

One of the things that we are trying to study is the waste of free condoms—condoms being thrown away, or never used, etc.

(E) Have you ever heard of condoms being thrown away before use, or just never being used? *(Probe for examples, anecdotes)*

Yes.

(F) Do you think that many people throw away or do not use the free condoms they get from clinics? Why do you think people do this?

(they are now divorced)

Yes - his mom came to fetch + his dad threw them away. Dad → says he doesn't use nonsense.

(G) What do you think could be done to encourage people to use the free condoms they get from clinics?

→ link it c̄ AIDS educat. → Scare tactics.

(his idea)

Follow-Up Questionnaire
98/10/04

4 0 8 0