

Condom use as part of the wider HIV prevention strategy: Experiences from communities in the North West Province, South Africa

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Abstract

Correct and consistent condom usage remains a pivotal strategy in reaching the target set by the South African government to reduce new HIV infections by 50% in the next 5 years. Studies have found that there has been an increase in condom usage by some categories of the population, but usage has not yet reached the desired levels in order to meet the target. This article reports on the findings of a study on condom usage in eight communities in the North West Province, which was part of a wider HIV and AIDS programme evaluation commissioned by the North West Provincial Department of Health. The main aim was to assess accessibility to condoms, and knowledge, attitudes and practices around condom use by four sampled communities in the North West Province. Eight focus group discussions were held and 50 households were interviewed.

The study found positive results regarding accessibility and awareness of condoms. However, this often did not lead to the desired behavioural change of using condoms in risky sexual interactions. The majority of respondents still resisted condom usage, used condoms inconsistently, or were not in a position to negotiate protected sexual intercourse. The main reasons reported for this were: reduced pleasure, perceived and real physical side-effects, myths, lack of information, status, financial reasons, distrust in the efficacy of condoms, family planning, cultural reasons, gender-related reasons and trust. Many of the barriers to consistent condom use cannot be overcome by strategies that target the individual. Interventions need to address underlying developmental factors such as the non-biological factors that increase the susceptibility of women to HIV infection. As this falls outside of the scope of the mandate of the Department of Health, various partnerships with other key role players need to be established and/or strengthened, such as with local government, non-governmental organisations and faith-based organisations.

Keywords: HIV and AIDS, condoms, behavioural change, South Africa, development.

Résumé

Le bon et consistant usage du préservatif reste une stratégie pivot en vue d'étendre l'objectif du gouvernement sud-africain de réduire les nouvelles infections par le VIH de 50% dans les 5 ans à venir. Les études ont montré qu'il y a eu une augmentation de l'usage de préservatifs parmi certaines catégories de la population. En revanche, cet usage n'a pas encore atteint le niveau désiré afin de satisfaire l'objectif prévu. Cet article présente les résultats d'une étude sur l'usage du préservatif dans huit communautés de la Province du Nord-Ouest. Cette étude a fait partie d'un programme étendu d'évaluation du VIH/SIDA commandé par le Département provincial de Santé du Nord-Ouest. Le but fut d'évaluer l'accessibilité des préservatifs et la connaissance, les attitudes et les coutumes entourant l'usage du préservatif auprès de quatre communautés échantillons dans cette Province. Au total, huit discussions de groupes de foyer ont eu lieu et 50 foyers ont été interviewés.

L'étude a démontré des bons résultats en ce qui concerne l'accessibilité et la prise de conscience de préservatifs. Cependant, ceci n'a pas souvent mené au changement de comportement voulu, qui est d'utiliser un préservatif lors des rapports sexuels à risque. La plupart de participants soit résistaient l'usage du préservatif, soit utilisaient le préservatif de manière inconsistante ou bien ne pouvaient pas négocier avoir des rapports avec protection. Les raisons de non-usage ou l'usage inconsistant du préservatif furent les suivants: le plaisir réduit, des effets secondaires perçus et réels, les mythes, le manque d'informations, le statut, des raisons financières, le manque de confiance au préservatif, la limitation de naissances, des raisons culturelles, les raisons liées aux sexes et la confiance en autrui. Un bon nombre de barrières à l'usage consistant du préservatif ne peut être surmonté à travers des stratégies visant l'individu. Il faut plutôt des types d'intervention qui aborderont les facteurs développementaux plus profonds, comme les facteurs non-biologiques qui augmentent la vulnérabilité des femmes à l'infection par le VIH. Puisque ceci est au delà du mandat du Département de Santé, il va falloir forger des partenariats avec le gouvernement local, les organisations non-gouvernementales et les organisations de foi.

Mots clés: VIH et SIDA, préservatifs, changement de comportement, Afrique du Sud, développement.

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Introduction

One of the primary aims of the new National HIV and AIDS and STI Strategic Plan for South Africa 2007 - 2011 (NSP) (2007) is to reduce the rate of new HIV infections in South Africa by 50% by 2011. Condom use is a major strategy to reach this aim, as condoms provide 80% protection against HIV, compared with non-use, if used consistently (Weller & Davis, 2002). While the new NSP states that reported levels of condom use are high in South Africa, it also recognises that this has not translated into reductions in antenatal HIV prevalence over the past 5 years. The final report of the assessment of the NSP for 2000 - 2005 further concludes that the level of HIV and AIDS awareness has increased, but behaviour has neither changed proportional to this level, nor to the availability of prevention methods such as condoms (NSP, 2007).

Several studies of different methodological approaches present similar findings. A national quantitative study conducted among youth in 2004 found that, among 15 - 24-year-olds, only 52% of sexually active males and 48% of sexually active females indicated they had used a condom the last time they had sex. Only 33% of all youth reported they had used a condom consistently in the past 12 months (Pettifor *et al.*, 2004). A qualitative study among youth in Kimberley and Cape Town (Da Cruz, 2004) found that only 24% of sexually active female participants had ever used a condom. And while the South African national HIV prevalence, national incidence, behaviour and communication survey by Shisana *et al.* (2005) revealed that condom usage had increased in the 15 - 24 age group to 72.8% for males and 55.7% for females, compared with the similar household survey in 2002 (Shisana & Simbayi), this was not the case for the other age groups. Furthermore, of respondents with more than one current partner, 60% indicated having used a condom at the last sexual intercourse. This means for those who did not use a condom, a large group of the population is at a particularly high risk of HIV infection.

Despite progress being made, it is therefore evident that the desired levels of consistent and correct condom usage, in order to help reach the 50% target as stipulated by the NSP, have not yet been reached. Correct and consistent condom usage is part of a wider behavioural change strategy (UNAIDS/UNFPA 2004). It is well known that accessibility to condoms and awareness of the risks of unprotected sex are no guarantee of behavioural change. There are numerous social, economic and behavioural factors standing in the way of safer sexual practices. These factors influence peoples' ability to use condoms when engaging in risky sexual behaviour. Poverty, gender inequality and cultural practices have been identified as important barriers to correct and consistent condom usage by several studies (e.g. Da Cruz,

2004; Kalipeni, Oppong & Zerai, 2007; Shisana *et al.*, 2005; UNAIDS/UNFPA, 2004). The role of gender inequality was also emphasised by the former South African Deputy-Minister of Health, Mrs Madlala-Routledge, when she stated that the 'Action against HIV and AIDS that does not confront gender inequality is doomed to failure' (South African Government Information, 2004, p. 1).

The new NSP of South Africa has identified the strengthening of behaviour change programmes as one of the major objectives for the prevention of sexual transmission of HIV. In order to further our understanding of the personal stories behind the statistics, and to give input to behaviour change programmes, this article discusses the findings of a qualitative survey on condom usage by adults living in rural and peri-urban areas in the North West Province. The study was commissioned by the North West Department of Health (NWDoH) in 2005. The management of condom distribution was one of the key HIV prevention strategies applied by the NWDoH at the time of the survey. Other prevention strategies aimed at behavioural change included the promotion of VCT in the great majority of primary health care clinics, the establishment of support groups, NGO funding, and AIDS awareness days at community level. Yet, statistics and research on sexually transmitted infections (STIs), teenage pregnancy and HIV and AIDS raised concerns regarding the extent to which people at risk were using condoms and, if so, whether they were used in a correct and consistent manner. Teenage pregnancy increased from 11% in 2001 to 18.4% in 2003 (NWDoH, 2004), whereas HIV prevalence among women attending antenatal clinics in the province increased from 26.2% in 2002 to 29.9% for 2003 (NDoH, undated), and reached 31.8% in 2005 (NDoH, 2006). While it subsequently decreased back to 29.0% in 2006, this remains unacceptably high (NDoH 2007).

The Department of Health therefore identified the need to assess whether the applied condom distribution strategy was effective, and whether there was a need to intensify education on condom usage in the province. As the number of condoms distributed is not a good indicator alone of success of any condom strategy (UNAIDS/UNFPA, 2004), the main aim of the study was to assess accessibility of condoms, as well as knowledge, attitudes and practices around condom use among people in the North West Province. In order to obtain rich information, the methodology was qualitative of nature, and one community in each district was sampled. This gave valuable insights into the extent of condom usage, and the issues influencing this in these particular communities. The characteristics of the communities sampled represented the majority of the population in North West Province, namely Setswana people living in lower socio-economic settings in rural and peri-urban areas. Therefore

the findings, together with the available statistics on teenage pregnancy, STIs and HIV, gave an indication of the level of success of the provincial Department of Health's strategy to promote condom usage as a prevention strategy against HIV.

This condom research component was part of a broader evaluation of the HIV and AIDS programmes of the North West Department of Health, which consisted of a random sample of all HIV- and AIDS-related services in the four districts in the province. In each district a regional hospital, two district hospitals, two community health centres, two clinics and several household interviews were done. The survey included questionnaires and interviews with patients, management and staff members at health facilities and other key informants involved in HIV- and AIDS-related services. Numerous aspects were assessed including the ability of each district and facility to render HIV- and AIDS-related services.

Methodology

The present article reports only on the results pertaining to condoms as a prevention strategy. The focus is not on the condom management programmes at the visited facilities. Instead it presents the perceptions of community members regarding the availability and accessibility of condoms, as well as their knowledge, attitudes and practices towards condom use, and personal experiences about condom usage patterns in their communities. These data were attained through focus group discussions and structured open-ended door-to-door interviews in all of the four districts in the province. The principle of individual written informed consent was applied in both the group discussions and interviews. A total of 50 households in rural and peri-urban communities in lower socio-economic settings were randomly visited, covering 10 - 15 households per district. As a random sampling strategy, the fieldworkers interviewed the first mature person who opened the door. Demographically, the interviewed households can be summarised as in Table 1.

Table 1. Demographics of households interviewed

Age group	Female	Male	Total
16 - 20	2	2	4
20 - 29	12	1	13
30 - 39	11	1	12
40 - 49	9	1	10
>50	8	3	11
Total	42	8	50

Separate gender-based focus group discussions were held in the same communities, with one per gender in each district. In total eight such discussions took place, with an average of five participants per focus group. In some cases, the focus group

discussions took place at clinics, while in other cases they took place at the offices of HBC organisations and HIV and AIDS support groups. Participants were invited with the help of clinic nurses and coordinators of the HBC organisations and HIV and AIDS support groups. One focus group consisted of members of an HIV and AIDS support group. All discussions took place in the local language of the participants. All respondents were black, most of whom were Setswana, ranging in age from youth (minimum age 17) to elderly (maximum age 70), with the majority being between 20 and 50 years of age. All were from lower socio-economic backgrounds. A set of key questions was used to guide the discussions:

For men:

1. What do you know about condoms?
2. Are condoms easily available and if so where?
3. Are you happy to use condoms? Why/why not?
4. Do you always use condoms? Why/why not?

For women:

1. What do you know about condoms?
2. What do you think of condoms?
3. Do men use condoms?
4. How do men respond to condoms?

The focus group discussions were audio taped and research assistants took notes during the discussions, which were transcribed and then translated into English. Content analysis was applied to both focus group discussions and household interviews, with coding and drawing of themes. The different focus group leaders and the researchers were involved in the analysis of the findings.

Limitations

The survey had limitations to the extent that the demographic background of the participants was limited to black people in lower socio-economic settings in rural and peri-urban settings. The survey did not include other racial groups or communities in more affluent areas in the province.

Findings

Condom supply/use management

A successful strategy aimed at condom supply and use consists of: getting condoms to the people; getting people to the condoms; and getting people to use condoms correctly as well as consistently (Hearst & Chen, 2004; UNAIDS/UNFPA, 2004). The findings will be presented under these three main themes.

Getting condoms to the people

The demography of the North West Province poses distinct challenges when it comes to the distribution of condoms

to the population. North West is a developing province, characterised by its rural setting, low population density, high poverty and unemployment and relatively low literacy rates. It has a population of 3.6 million people according to the 2001 population census (Statistics South Africa, 2001). The most recent national HIV and syphilis antenatal seroprevalence survey (National Department of Health, 2003) at the time of the study estimated that 5.6 million South Africans were HIV positive by the end of 2003, 3.1 million of whom were women, 2.4 million were men and 96 228 were babies. HIV prevalence among pregnant women attending antenatal clinics in the North West Province was estimated at 29.9% in this year. This made the North West Province the province with the fourth highest HIV/AIDS prevalence in South Africa at the time of the survey.

In the prevention of the spread of HIV and AIDS, condom distribution is one of the key strategies applied by the North West Department of Health. At the time of the survey much progress had been made in making condoms accessible. A condom logistics management information system was developed and implemented and male and female condoms were distributed free of charge from a variety of outlets such as clinics, taverns and petrol stations. In line with the national trend (Shisana *et al.*, 2005), the results suggest that the Department of Health has achieved success in getting condoms to the people. By far the majority (90%, $N=50$) of the randomly chosen interviewees taking part in the door-to-door survey were of the opinion that condoms were easily accessible in their communities. When asked where condoms were available, the outlets most referred to were clinics (78%), taverns (24%) and hospitals (22%). Other distribution points named were pharmacies or chemists, spaza shops, shebeens, bottle stores, the workplace, home-based care organisations, support groups, police stations, churches and garages.

Participants in the group discussions confirmed that male condoms were easily available and most indicated that they could obtain condoms from their local clinics. A few reported that the clinics sometimes ran out of stock.

In contrast to the accessibility of male condoms, female condoms were found to be less attainable. In all female focus groups it was found that the availability of female condoms was poor, and participants argued that they sometimes ran out of stock at the clinic.

Getting people to the condoms

The component of 'getting people to the condoms' refers to the process of building awareness about the value of condoms as a

preventive measure to reduce the risk of sexually transmitted diseases, and increasing demand.

Participants were generally well informed about condoms and their benefits. Men and women both referred to the prevention of STIs, pregnancies and HIV, but generally women seemed to be more informed than men. The elderly taking part in the discussions were by and large less well informed or had not heard of condoms at all.

Several women indicated that they felt reluctant to ask for female condoms at the clinic due to negative attitudes of sisters. As one woman explained: *'Every time when you go to the clinic you have to write down your name. Some might view it in a way that the nurses might think that you sleep around, especially when you collect every month. That causes stigma.'* Some women indicated they bought female condoms elsewhere.

In conclusion, the great majority of community members sampled seemed to know where to get condoms, and were aware that they could be used as a preventive measure to minimise the risk of HIV infection. This coincides with the Nelson Mandela Household survey (Shisana *et al.*, 2005), which concluded that the country has an excellent condom distribution system. It further stated that the country has successfully implemented condom use as an HIV prevention strategy. However, this qualitative study found that regarding actual usage, many respondents reported not using condoms when engaging in risky sexual behaviour, i.e. in the case of multiple and/or concurrent partners, and in marriage/steady relationships where there was suspicion of unfaithfulness on the side of one or both partners.

Getting people to use condoms correctly and consistently

There are several indicators that suggest that people in the North West Province are not using condoms when they engage in risky sexual behaviour. As reported earlier, teenage pregnancy rates increased (NWDoh, 2004a) and HIV prevalence in the 25 - 29-year-age group increased from 31.4% in 2001 to 35.4% in 2003 (NWDoh, 2004b). Results of other studies add to the concern. A survey among 400 people in a community in the Madibeng Sub-District in the North West Province found that 43.3% of respondents felt at risk of contracting HIV. Unfaithfulness, multiple partners and unprotected sex were among the main reasons (Couper Van Deventer, 2003).

These worrying statistics were echoed in the perceptions of the community members of the present sample: only 20% of respondents believed that people in their community used

condoms. Respondents gave several reasons for this perceived state of affairs. One person reported that: *'I usually use a condom every time. But everybody isn't like that. Like when someone is drunk, they don't use it, they lose control.'* Another respondent stated: *'There is a misuse of condoms by the community. They receive them and throw them away. They are lying all around the streets and this happens at night. Young children use condoms as balloons.'*

Respondents were specifically asked if they thought young people used condoms: 48% of people responded by saying that youth did not use condoms, 24% were of the opinion that some youth used condoms, 20% said they did use condoms, and 8% did not know (N=50). Reasons mentioned for the lack of condom usage among youth included youth wanting to experiment, alcohol abuse, and youth selling sex for money. One respondent observed: *'They just play with it and throw them away.'*

Reasons for not using condoms

While condoms were available and most respondents were well informed about the risks of unprotected sex, the majority of men and women indicated they often did not use condoms. In this section we elaborate on the reasons people mentioned for not using condoms.

Condoms reduce pleasure

Respondents indicated that condoms reduced pleasure, had a negative impact on the ability of men to perform the sex act, and that people wanted 'meat-to-meat', 'flesh-to-flesh' and 'skin-to-skin': *'Condoms weaken your erection. With a condom you don't reach orgasm. It is so difficult to take the condom out. You have the condom in your pocket but you don't take it out. You can't bring your hand to your pocket. You don't want to take it out because you want flesh-to-flesh ... and the other thing ... after penetration I can't just do it again and again and the lady she is satisfied. You can't just take it off and go to round two. That's why most of us like flesh-to-flesh – to be satisfied. When you use a condom you will not be satisfied. That is why most of our people don't use condoms. Flesh-to-flesh is alright with someone where you have seen their certificate.'*

This illustrative comment was made by a young man of 26 who was well informed with regard to the usage and protective function of condoms. In spite of his knowledge he declared that he was still not able to always use a condom. At the time of the interview the respondent told the researchers that it was his second visit to the clinic for an STI. He reported that he received counselling concerning his condition on his first visit to the clinic just more than a year ago. From the discussion it

appeared that he understood the consequences of his disease, but this did not lead to condom usage. The result was that he contracted a new STI. The respondent's report is an example of the challenges faced in bridging the gap between knowledge and behaviour change.

From other reports it became evident that alcohol could impact negatively on the self-control necessary to use a condom in a sexually risky situation. One respondent stated: *'Many women and men say that when they use condoms they don't enjoy sex. That is true; and when I am drunk I will never use a condom. Maybe you are sober when you make the appointment. But twenty to two (1:40) in the morning when it is time you will find there are no condoms; and if you ask her to use a condom she will say to you: "Do you say I am sick? Don't you trust me?" And you sleep once with the lady and you can die some or other time.'*

Condoms have physical side-effects

Some respondents were of the opinion that condoms caused a rash, cause inflammation, had a bad smell, could make you sick, and could 'make you urinate':

'The reason why young girls don't want to use condoms is that they cause sores on their private parts.'

They (men) say they make them sick, or they make air inside them. Men say that condoms make them develop sores because of the ointment on them. The condoms should be distributed immediately, not to be stored for a long time because they can really cause infections like sores on the private parts. My child uses condoms and I monitor them as I take them home for them to protect themselves. But later he complained about rashes and when we went to the clinic the sister gave him treatment and said he is allergic. So now we are confused. We don't know if it is because the condoms are expired or not. I am very concerned. ... We got them from the clinic. We have discovered that all these stories (worms, kidney failures, no satisfaction) that people say are not true. Myself, I have never ever felt the difference nor seen the worms that they are talking about. People like making negative comments about things, not only about condoms (HIV support group member). They (young girls) say that the CHOICE condoms make them smell. She says she will smell for another 2 days. Why don't the government put a flavour in like granadilla?'

From the quotes above it can be concluded that a number of respondents reported physical side-effects caused by condom usage. While it is possible that condoms can cause certain allergic reactions, the findings give the impression that the extent of this phenomenon is exaggerated through rumours in

the community. There is also the possibility of men and women using this argument of 'being allergic' as an excuse for not having to use a condom because it 'reduces pleasure'.

Myths

A few respondents indicated that people did not want to use condoms because they could cause HIV, could trigger pain in the kidneys, and that they had worms:

'People started to say many things about this condom use. So I said ... no ... I don't know them and I am not prepared to use them. Someone said if your woman passed away and you slept with someone else ... this is what causes AIDS ... It's like during the mourning period of a woman ... at night she takes off the mourning clothes and she goes into the streets. Do you know that Apartheid still exists? I mean that white people want to get rid of us by means of these condoms. It may be another way of prevention and on the other hand killing us. They want their government back. If you use a condom it means you have AIDS. People think they (government condoms) have worms and that the lubricant is the one that brings rashes. I say anything for free is not good. I heard people talking that the condoms have worms. They say you must put some water in it, lift it high up in the air, look through it and you will see the worms swimming around.'

The men participating in the focus group discussions were generally more inclined to refer to myths than women. The belief that condoms have worms was persistent and came up in all the focus group discussions.

Lack of information

A number of respondents named a lack of information as a possible cause of people not using condoms:

'Some girls believe that they can't fall pregnant as long as their boyfriend withdraws before he ejaculates. People say condoms burst but I don't agree. What they do is they don't handle them properly. They know about them but they don't know how to use them Men sometimes tend to pull the condom too tight and it can burst. Old people should really be taught how to use condoms. Young ones are educated at the schools by their teachers. If you ask her to use a condom she will say to you: "Do you say I am sick? Don't you trust me?" And you sleep once with the lady and you can die some or other time.'

The women were found to be better informed about condoms than the men. A few men asked questions relating to how a condom should be used, and how and where one should dispose of a condom. However, according to some of the female participants, men were not interested in condom usage and

therefore they did not listen. As one woman commented: *'Men must be given education and especially peer education ...; but some men choose to be ignorant yet they are well informed.'*

Status

Using condoms that are free of charge could make you look cheap, as different respondents reported:

'There is a box of condoms in the tavern, but the thing with the box it is always full. People don't want to use the free condoms. The ladies will say you are weak when you use those condoms, you have no money. They ask: what is the name of your condom? If it is CHOICE they think you are cheap. Free choice is like the medicine, the tablets. No one will take the condom in front of other people. I trust them. They protect from diseases. But the way they are all over. It makes one think that they are not of quality. Always things that are for free are always having a problem.'

Despite the re-branding of government condoms, precisely to change the 'cheap' image, it appears that in the communities sampled this image had not changed for some people. One respondent, who explained that he normally lied about his job at the shebeen in order to impress women, argued that presenting a 'cheap government condom' would not impress women. Interestingly, the male respondents referred to women being opposed to the use of free condoms, while no woman interviewed confirmed this. It is not clear from this study whether some women indeed linked free condoms to a 'cheap image', or whether this was mostly a perception among men.

Financial reasons

Linked to the above theme of 'status', there are financial and socio-economic reasons why some people would reportedly not use condoms. A direct link between poverty and the increased risk of becoming infected with HIV came to the fore in a number of cases: one respondent said that men 'won't give money (for sex) if you insist on condom usage' and another stated that young women deliberately fell pregnant in order to qualify for government grants:

*'I use a condom, but those who sell sex for money don't want to use a condom. Young people do not want to use condoms. Most of them become pregnant because they think of government grants. That is why these young people, most of them are HIV positive. They didn't use a condom. One thing a lady will always ask you is "where are you working?" We are always lying. You will say: "I am a magistrate", then she knows we can f**k without a condom. Sex with a condom will never satisfy; but it's dangerous, if you don't get sick you'll get a baby. Those who do*

use them (condoms) carry them in their pockets because they say that some girls fall pregnant on purpose so they don't want unplanned pregnancy. The other thing that worries me is more and more old men that take the young ladies. I don't know if they enjoy the little ladies or what.'

The phenomenon of transactional sex for material gain was still very much alive. The much-debated concern that young women might deliberately fall pregnant to receive government child grants also came up in this study, although from a secondary source. More research into the nature and extent of the phenomenon is required, taking into account that keeping youth HIV-free is one of the major HIV prevention strategies of the new NSP 2007-2011 for South Africa.

Distrust in efficacy of condoms

Respondents had a variety of comments on the efficacy of condoms:

'Condoms stay behind. (Government condoms) are of no value. Condoms don't fit. Condoms burst.'

Especially the men interviewed complained about the efficacy of condoms. It is important to take note of the above complaints because the distrust in the efficacy of condoms is likely to influence decision-making on the use or not of condoms; at the same time one should be aware of the possibility of some individuals using the 'efficacy' matter as a reason not to use condoms.

Family planning

Couples who want to raise a family will at some stage stop using condoms. Several respondents stressed the importance they attached to raising a family and having children. Some asked the facilitator of the interviews what to do if one was HIV positive and wanted to have children. There seems to be a need for more engagement on this issue with people living with HIV and their partners, HIV positive or not, in order to assist couples in making informed decisions regarding family planning, and in a manner that will not jeopardise the health of either partner.

Cultural reasons

Some participants referred to cultural reasons for not using condoms:

'We don't know anything of condom usage because it is mainly for and used by the white community. Because of the cultural practice of having many women, not using a condom makes them feel like real men. Some men still believe that for one to

prove his manhood he has to have many girlfriends, as many as possible.'

As the NSP 2007-2011 indicates, the link between culture and HIV is under-researched. Some of the reasons mentioned above would need more research to validate or contradict. For instance, the statement that culture is the reason for having many girlfriends is something with which not every Tswana person might agree. It is also questionable whether 'culture' does indeed inhibit people from using condoms. It may be used, again, as a convenient excuse against condom use. Yet, the link between culture and the risks of HIV infection does exist, namely through gender inequalities in patriarchal societies, which may influence the individual choices women make to use condoms or not (Meyer-Weitz *et al.*, 1998).

Gender-related reasons

In a patriarchal context men are often the decision-makers when it comes to when and how sexual intercourse takes place. As part of the household survey, respondents were asked whether men wanted to use condoms or not: 50% replied that some men wanted to, 34% that men did not want to use condoms, and only 16% that they did (N=50). When asked why men would use condoms, respondents replied by saying men would use a condom if they did not trust their partners, to avoid pregnancy, because of multiple partners, and to prevent HIV/AIDS. Female respondents, both in the household survey and focus group discussions, were negative about the role of men in condom usage. The dominant view was that men did not want to use condoms. While women complained about men refusing to use condoms, resistance among some women, especially young women, was reported as well: *'Many of the girls they say that they find condoms not comfortable when they have to use them.'*

According to some male and female participants, some women who were not on contraceptives were more worried about falling pregnant than getting infected with HIV. However, more research is required, as it is possible that avoidance of pregnancy was an easier way in which to convince a partner to use a condom than referring to STIs and HIV.

One female respondent in a focus group discussion explained how her condom usage was simply a matter of getting used to it:

'I use them and I don't feel any difference when we use it. You need to concentrate on the mood and not on the condom in order to enjoy your partner. At first I did not enjoy it but because I was worried about my wellbeing we agreed on using them frequently and thus we became used to it.'

Trust

Sometimes a person in a sexual relationship was convinced that his or her partner was faithful and therefore did not consider it necessary to use a condom:

'I have never used a condom because I don't look around for other men and I trust my husband and I know him. He has been my husband for 12 years and I have never had an STI. Condoms are important for health to prevent HIV and transmission of STIs. It can also be used to prevent pregnancies. My relationship with my woman is a long-distance relationship and therefore I don't trust her. That's why I use a condom. Most of the time you find that men are the ones who cheat. Sometimes women do cheat, but not like men. I have never used it (condoms) because my husband doesn't want me to use it ... Sometimes he goes away for two weeks where he is working, and I am not sure if he is seeing other women. I tried to explain to him about the importance of condoms but he would not agree to use them. I feel my life is at risk. Sometimes you will ask him, we must use a condom. He will say to you, you think I am cheating?'

Condom usage within marriage is known to be problematic, which makes married women a high-risk group for HIV infection. An estimated 60 - 80% of HIV-positive women in sub-Saharan Africa have been infected by their husbands or their permanent partner (UNFPA, 2005). Some married female participants argued they did not use condoms because they trusted their husbands. However, the majority of female respondents indicated they did not trust their husbands and would prefer to use a condom if their partners would agree. Yet they were reluctant to ask, as they feared their husbands would interpret this as a lack of trust, loyalty and/or disrespect.

Shisana *et al.* (2005) found that people who are single and have more than one current partner are more likely to use condoms than those in steady relationships. A similar theme came to the fore in the focus group discussions, where a difference was made between steady partners and occasional partners when it came to condom usage. A number of respondents indicated that the use of condoms was more acceptable and common with non-steady girlfriends:

'If I live with my wife and we trust each other I don't see any necessity of using them (condoms). We know that we are planning for the future. But you see when I go to my mistress ... that's when I use protection in order not to get sick. If you have a steady relationship with a girl or you are married then you don't have to use a condom. Condoms can be used when you pick up a girl from the local tavern and like the ones you pick up from the streets.'

Discussion and recommendations

We first present the discussion of the findings, followed by recommendations made by respondents themselves, and recommendations for further research.

Discussion of findings

The findings show that easy accessibility to condoms is no guarantee for success, if people do not use the condoms, or not consistently (Hearst & Chen, 2004). For the people in the communities sampled, many barriers stand in the way of safer sexual practices, including consistent condom use. Accessibility to condoms was not a barrier in this survey. On this level, the prevention strategy has succeeded. While increased HIV and AIDS awareness efforts would be helpful in countering some of the gaps in knowledge and myths, it must be taken into account that there will be some opponents of condom usage who are not interested in this message, as myths are conveniently drawn on to avoid using condoms. This is also where the Department of Health's influence tends to stop and where other stakeholders come into play.

Indeed, the real barriers are much more fundamental and complex in nature, and not all within the Department of Health's influence area. The findings have shown that many people, both men and women, were aware of the risks of unprotected sex, but nonetheless did not use condoms in risky situations. While mostly men indicated that reduced pleasure was more important than risk of HIV infection, for women the picture seemed more complicated. While respondents reported some women not wanting to use condoms, the extent to which this was out of free will need further research. As found in many other studies, socio-economic and gender factors inhibit many women from living in safe sexual relationships (Da Cruz, 2004; Kalipeni *et al.*, 2007; UNFP, 2005). Also, as Kalipeni, Oppong and Zerau argue (2007), the success or failure of health programmes is affected largely by sociocultural factors. In this regard, the disempowered position in negotiating for safer sexual practices in which many women find themselves remains a huge challenge. The nationwide phenomena of inter-generational sex and transactional sex for material gain between younger women and older men, also found in the communities taking part in this particular study, is proof thereof (see also NSP 2007-2011 and Shisana *et al.*, 2005). As one respondent reported: *'Sex without a condom is often part of the deal'*, placing this new generation at particular high risk of HIV infection. Other factors, such as access to child grants and perceived or real lack of job and educational opportunities, also need to be taken into account when studying reasons why girls would not want to use condoms.

The usage of condoms is further complicated by the dynamics of trust in permanent relationships. While it is understandable that

the insistence on using a condom in a monogamous relationship can create suspicion and a break in trust, the findings show that the issue of trust can also be used in manipulative ways to pressurise partners to have unprotected sex. Some of the married women were reluctant to demand condom usage for fear of showing a lack of trust in their partner, but also for fear of being seen as unfaithful by the partner. Interestingly, a different situation was found among women in Malawi. A qualitative study conducted in 2001 showed that women were equally concerned about contracting HIV through the extramarital affairs of their husbands as the women in this study. However, instead of negotiating condom use *within* marriage they would urge their partners to use condoms *outside* of marriage, or as one respondent had stated, file for divorce (Chimbiri, 2007). Furthermore, some of the women interviewed disliked condoms for the same reasons often quoted by men, namely reduced pleasure. Condoms were furthermore seen as incompatible with marriage, due to the nature of marriage as an institution: 'If condoms are used, the marriage is not a real marriage' (Chimbiri, 2007, p.1113).

These views did not come to the fore during the discussions with women in the North West Province. The reasons why are not clear. However, whereas condoms may undermine the institution of marriage and reduce pleasure, for some women there is no real option to leave their marriages if they fear for their health, as many are economically dependent on their husband, without formal education, and often with small children. This might have been the case for the women taking part in this study, as the group discussions took place in communities of lower socio-economic status often far from the economic centres. Furthermore, there is a 5-year difference between the two studies, and possibly the women in Mali had had less exposure to AIDS-related mortality than the South African women in 2004. This might have led to the South African respondents taking a more pragmatic stance: as one cannot really leave the marriage, and cannot be sure if the partner uses a condom outside the marriage, rather initiate condom use within marriage. Yet, more research is clearly needed to give empirical answers to the differences between these findings.

Whereas consistent condom use in permanent relationships was found to be limited, both in the South African and Malawi studies, be it for different reasons, the fact that condom use is more acceptable in non-steady and extramarital affairs is at least some good news. Rising figures in condom use outside a permanent relationship were also found in the South African national HIV prevalence, HIV incidence, behaviour and communication survey (Shisana *et al.* 2005) and by Da Cruz (2004). The latter study looked into the use or non-use of condoms among youth in Kimberley and Cape Town, and found a practice of 'originals and spares' linked to the usage of

condoms (pp. 152-155). While condom usage in the secondary relationship is obviously better than not using a condom at all, the behaviour of having multiple partners remains risky, and the use of condoms can give a false sense of safety if not applied consistently in all sexual encounters. This is especially so given that many studies have found that inconsistent users are at higher risk of HIV infection than those who never use condoms at all (Hearst & Chen 2004). This could be the case where non-users stick to one partner only, while inconsistent users may have concurrent and/or multiple relationships in a sequence.

Altogether, unfaithfulness remains a key problem. As the findings have shown that men are generally the final decision-makers on condom usage, the ABC formula is indeed still faced with a huge challenge: it can only apply where men and women have an equal say in their sexual relationship (UNFP, 2005).

Another theme that came to the fore was the stigmatisation of condom usage, referring to the perception that condoms are used by people who are HIV positive. Proposing to use a condom can be interpreted as if the person who asks for a condom is HIV positive, or believes his/her sexual partner is HIV positive.

What do these findings say about the success of condom distribution as part of the wider HIV prevention strategy of the North West Department of Health, and the need for more education messages? Taking into account that respondents in the household survey as well as the focus group discussions reported that condoms were easily accessible, it can be concluded that the distribution strategy has worked well in the communities sampled. Regarding 'getting the people to the condoms', i.e. raising awareness of the protective value of condoms, the majority of respondents also appeared to be well informed. Yet, it is at the last crucial step, 'getting people to use condoms consistently and correctly', that much has yet to be achieved. This brings us back to a key question raised in a number of other studies (eg Hearst & Chen, 2004; UNAIDS/UNFPA 2004): Can people really change behaviour? They can, but under certain circumstances. Thailand, for instance, gained international recognition for its successful condom promotion strategy in brothels, while Uganda is known for its success in reducing the number of partners among the general population (UNAIDS/UNFPA 2004). In the case of the communities sampled, there was clearly large resistance against condom use, and therefore it can be concluded that condom use as part of the wider HIV prevention strategy is not yet very successful. However, when looking at the various obstacles for poor use of condoms, it is apparent that many cannot be overcome by the Department of Health on its own. Indeed, there is a need for ongoing promotion of condom use among people who engage in risky sexual behaviour, countering of myths and filling of gaps in knowledge. But at the same time the underlying factors

that cause some people not to use condoms are of a nature that lies beyond the Department of Health's scope of work. This is a typical example of the much-proclaimed 'multi-stakeholder partnerships' required to counter the HIV epidemic. Poverty, gender inequality and economic dependence are all developmental problems that make individuals more susceptible to HIV infection (DPLG, 2007; Kalipeni *et al.*, 2007). They can inhibit women from leaving unsafe relationships, delaying or limiting sexual activity at a young age, and negotiating condom use, and therefore require developmental solutions.

One of the key stakeholders in this area is obviously developmental local government (DPLG, 2007), which is tasked with ensuring the promotion of the social and economic development of communities, and with the empowerment of marginalised and disadvantaged groups (Constitution of the Republic of South Africa, 1996; DPLG: 2007; Ministry for Provincial Affairs and Constitutional Development 1998). For many local authorities, however, much confusion still exists with regard to the roles and responsibilities in responding to HIV and AIDS as a governance and development issue (DPLG, 2007; South African Cities Network, 2004; Versteeg & Khan, 2007). While it is imperative that the Department of Health and local authorities work hand-in-hand, respondents of the study rightfully also identified other key stakeholders, who are included in the discussion in the next section.

Recommendations

Promote condom use within a developmental approach

There is a need for ongoing raising of awareness of HIV, and the promotion of condom use, including the discrediting of myths, remains pivotal. However, this should be part of a developmental approach which tackles the underlying conditions that inhibit some people from using condoms, despite good awareness of HIV and AIDS. As the Department of Health cannot do this on its own, as it not part of its core mandate, partnerships with other governmental and non-governmental bodies need to be sought, built and maintained. Developmental local government is a key role player. Many respondents also referred to the importance of the involvement of other stakeholders in society. Emphasis was placed on the use of role models and institutions with authority in behavioural change messages, and in particular those aimed at men. These messages would not only include the promotion of condoms, but also other key issues such as delayed sexual debut, faithfulness to one's partner and reduction in the number of sexual partners. Suggestions were made regarding the involvement of traditional leaders, the role of churches, and the role of fathers:

'Some men still believe that for one to prove his manhood he has to have many girlfriends, as many as possible. Places like tribal places can help in that regard because it is where most of them gather. I think education should be given to our leaders, especially traditional leaders, as they say it is against tradition to talk about sexuality with our children. They think they encourage children to be engaged in sex at an early age. You know ... times have changed, so is life in general. Condoms should be available at churches and priests should be involved actively. If they could call a meeting for priests to talk to them about spreading the word about HIV&AIDS. The role of fathers is also important when it comes to young boys. If a father would tell his kids that they should use a condom, as a parent, they would listen to him.'

The role of parents has already been earmarked by the NSP 2007-2011. To what extent and in what way do parents discuss sexuality with their children and how can they best be supported in this? One respondent voiced his concern with regard to the influence of the media:

'Boys start at 8 or 9 years to have sex. They see their parents do that. The government says we have to talk to our children but how would I do that? Shall I say, my baby, use a condom if you want to make sex and then he is 7 years old? They see sex on TV; everyone watches TV from the firstborn to the last. It is better to put the TV off.'

Strengthening the position of women

Within the developmental approach, a special focus needs to be placed on strengthening the position of women and reducing economic vulnerability. The study has unsurprisingly confirmed the fundamental role of strategies and interventions aimed at promoting equality among men and women, in the household as well as in the job market. Economic and educational opportunities, not only for married women, but especially also for young girls, is a general strategy to alleviate poverty, but these findings have once again shown the direct linkages with HIV susceptibility. As mentioned, the Department of Health cannot address this matter on its own, but would need to forge strong collaboration with especially local authorities, for instance in pointing out to local municipalities which areas are most affected by HIV and AIDS, and prioritising these in interventions addressing gender inequity and inequality and (DPLG, 2007). The partnership with local government should not only be limited to the focus on gender inequality, but also address other developmental matters such as poverty reduction in general and protecting marginalised groups, such as people living with HIV and AIDS.

Conclusions

In order for behaviour change to take place, the conditions under which a person is to change his/her behaviour need to be conducive to the change. Some of the findings of this study indicated that this is often not the case for the individuals living in the sampled communities. Condom use was not an individual choice for all respondents.

In conclusion, accessibility to condoms in the communities surveyed was found to be good. Furthermore, besides some persistent myths and gaps in knowledge, most respondents were aware of the risks of unprotected sex and the protective nature of condoms. The problem remains the actual usage of the condoms. The majority of respondents in multiple sexual relationships (concurrent or subsequent), or in relationships where there was doubt with regard to the faithfulness of the respondents' partner, did not use condoms in a consistent manner. Rising teenage pregnancy rates and an HIV prevalence of 29% give a similar indication that the desired levels of condom use have not been reached yet. This is a situation that the Department of Health will not be able to change on its own. It requires the partnerships reconfirmed by the NSP 2007-2011. Solutions to many of the causes for non-use and inconsistent condom use are developmental. Reducing poverty, creating economic opportunities and promoting gender equality are more aligned to the mandate of developmental local government and other stakeholders. The recommendations by respondents for the Department of Health to work with various stakeholders within local communities further confirm that more vigorous collaboration between societal sectors is required to ensure a more successful HIV prevention strategy.

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