UNIVERSITY OF NATAL

KNOWLEDGE, ATTITUDES, RISK PERCEPTION AND CONDOM USE AMONG MARRIED MEN AND WOMEN IN NTUZUMA AND KWADUMISA, KWAZULU NATAL.

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2003

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DECLARATION

This Masters dissertation represents original work by the author and has not been submitted in any form to another university. Where use has been made of the work of others it has duly been acknowledged and referenced in the text.

The research for this dissertation was performed in the School of Development Studies at the University of Natal, Durban. Research was undertaken under the supervision of Dr Chiweni Chimbwete and Pranitha Maharaj during the period of March 2002 to January 2003.

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ABSTRACT

One of the greatest and unresolved challenges that faces mankind today is HIV/AIDS and the effects that it has on people as well as society as a whole. South Africa is one of the countries worst affected by HIV/AIDS, with KwaZulu Natal being one of the hardest hit provinces in the country. So, this pandemic is having a destructive effect on all spheres of life, and until a cure is found for this pandemic, it will continue to pose a threat to all of humankind.

The aim of this study was to look at knowledge, attitudes, risk perception and condom use in two sites in KwaZulu Natal. The reason for doing this was because a study of this nature has not been done in these areas. A pre-existing dataset was used and data were analysed using the Statistical Package for the Social Sciences (SPSS). The analysis was done using crosstabulations, frequencies and multivariate logistic regression. The major findings of this study are: (i) both men and women of all ages are knowledgeable about HIV/AIDS and condoms, as well as condom use; (ii) more women perceive themselves to be at risk than do men; (iii) women view condoms more positively than men; and (iv) respondents indicated knowledge and risk perception, but majority of them were not practising safer sexual behaviour. In conclusion, it was observed that knowledge about HIV/AIDS and condoms are universal, however, people perceiving themselves to be at risk are not practising safer sexual behaviours i.e. they are not using condoms.

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LIST OF ACRONYMS USED

ARC	-	Aids Related Complex
ARRM	-	Aids Risk Reduction Model
FHI	-	Family Health International
HBM	-	Health Belief Model
HIV	-	Human Immunodeficiency Virus
HSRC	-	Human Sciences Research Council
IEC	-	Information, Education and Communication
KZN	-	KwaZulu Natal
NGO	-	Non-governmental organisation
SPSS	-	Statistical Package for the Social Sciences
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
TRA	-	Theory of Reasoned Action
UNAIDS	-	Joint United Nations Program on HIV/AIDS
WHO	-	World Health Organisation

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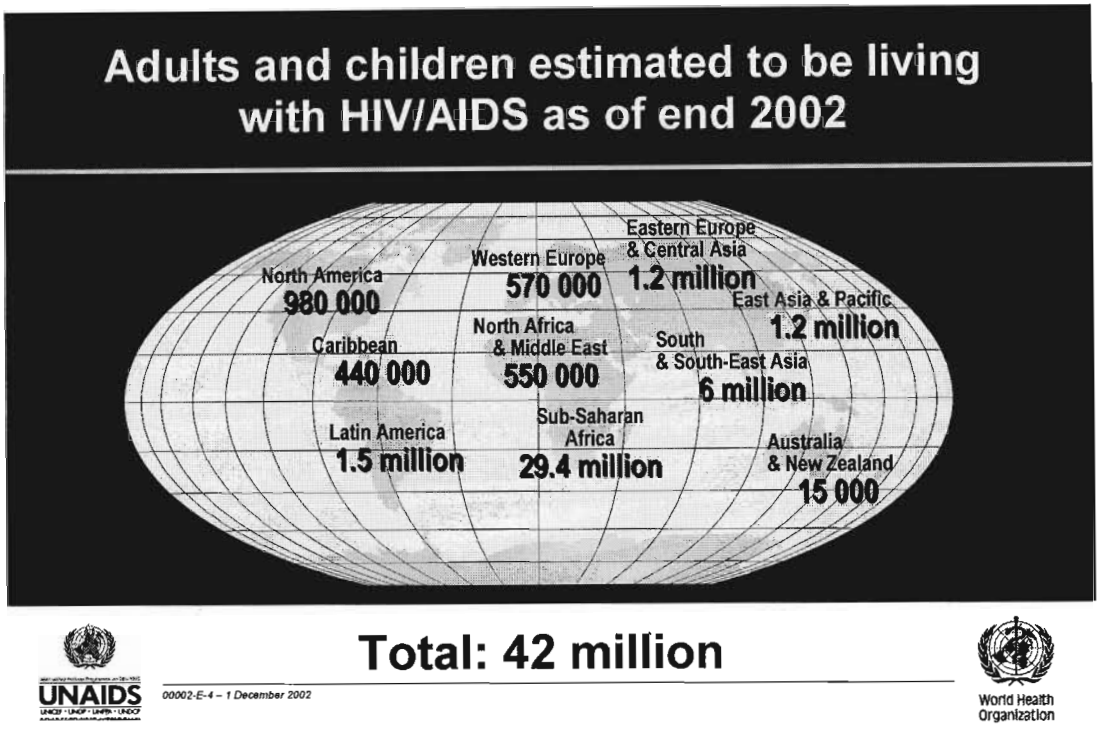
CHAPTER ONE: INTRODUCTION

HIV is no doubt a deadly, infectious, parasitic and distressing virus to have hit the world. It has been the cause of scores of deaths, both in adults and children; and has also resulted in a huge number of orphans.

Recent estimates put forward by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) show that at the end of 2000, there were 34.7 million adults and 1.4 million children worldwide living with HIV/AIDS. The epidemic has produced a sum of about 13.2 million AIDS orphans. Most of the infections i.e. 95 percent of them are of people living in the developing world (Lovelife, 2001).

An estimated 5 million people became infected with HIV around the world in 2000. Of this 5 million, 800 000 were children. Without effective treatment, these people will be in the same predicament as the more-than-20 million people who have died of AIDS since it was first detected. Two of the greatest challenges facing humans today are: firstly to enable people to protect themselves against HIV and secondly, to provide them with affordable treatment and care (UNAIDS, 2002b).

Figure 1: Adults and Children estimated to be living with HIV/AIDS as at end 2002



Source: UNAIDS, 2002a.

As can be seen from the above map of world infections, sub-Saharan Africa is where the epidemic has most prevalence. It was estimated, at the end of 2002, that 29.4 million people in sub-Saharan Africa are living with HIV/AIDS. The number of new infections in sub-Saharan Africa at the end of 2002 was approximately 3.5 million. The epidemic claimed the lives of an estimated 3 million people in sub-Saharan African in the past year. About ten million young people i.e. aged between 15 and 24 and almost 3 million children under 15 years are living with HIV (UNAIDS, 2002a).

The following are some frightening statistics about HIV in sub-Saharan Africa. Firstly, in the past decade, 12 million people in sub-Saharan Africa have died of AIDS – one quarter of these being children. Secondly, AIDS claims another 5500 men, women and children each day. Thirdly, AIDS was the largest killer in 1998, accounting for 1.8 million deaths in sub-Saharan Africa. This is

nearly double the one million deaths from malaria and eight times the 209 000 deaths from tuberculosis. Finally, a 15 year-old in Zambia has a 60 percent chance of dying from AIDS (Whiteside & Sunter, 2000).

There has been an exponential growth of HIV infections in South Africa during 1994 to 2001 (Lovelife, 2001). South Africa, at the start of the new century, probably had the largest number of HIV-infected people of any country in the world. The only other nation that comes close to South Africa's figures is India. However, India has a population of one billion compared to South Africa's population of a mere 42 million (Whiteside & Sunter, 2000). According to Whiteside and Sunter (2000), this did not have to happen. In their book: *"AIDS: A Challenge for South Africa"*, they point out that South Africa was aware, as early as 1985, of the dangers posed by AIDS. There was a national survey done in 1991 of women attending antenatal clinics. This survey found that only 0.8 per cent were infected with HIV/AIDS. When the new government took over in 1994, the national survey results found 7.6 per cent of infected women. By 1999, this figures escalated to 22.4 per cent (Whiteside & Sunter, 2000).

HIV prevalence rates are alarmingly high and are also on the rise in every part of South Africa. This could be attributed partly to the long latency period of HIV in the human body. The effects of those people who were infected years ago are only now beginning to show (Akwara et al., 2001).

An interesting point about South Africa is that there does not appear to be much difference in the urban and rural areas with regards to the epidemic. South Africa is a country that has experienced one of the fastest growth rates of the epidemic in the world (Whiteside & Sunter, 2000).

A major national antenatal clinic survey was conducted which tested blood samples from women attending antenatal clinics in 1997-1998. The results show that HIV prevalence has risen from less than 1 percent in 1990 to nearly 22

percent in 1998. Approximately 3.6 million people were living with HIV by the end of 1998, compared with 2.7 million in 1997, and about one in eight South African adults was thought to be infected with HIV (Kenyon et al., 2001).

In particular, HIV/AIDS is most prevalent in KwaZulu Natal (KZN). KZN has a population of more than 8.4 million. Of this, more than 4.4 million are female and about 4 million are male. It is the province in South Africa that has the highest population – it has one fifth of the country's population. KZN has the highest level of HIV infection in the country and the world (KZN-Health, 2002; Statssa, 2002). However, in a recent report released by the Human Sciences Research Council (HSRC) in the latter part of 2002, they argue that KZN is no longer the province with the highest HIV rate (HSRC, 2002).

According to Whiteside (1990), the reason for the high and rising levels of infections is as a result of widespread migrant labour in the province and its association with distrust between partners and a lack of cleanliness; high value placed on multiple partnerships by men; high levels of poverty in the province; and poor health care services.

There does seem to be hope though since there is evidence that adolescent prevalence rates have decreased slightly since 1998. The carrying out of large-scale information campaigns and condom distribution seems to be paying off. However, this positive is accompanied by a negative with regards to people aged between 20 and 34. In this group, there is a rise in the prevalence of infection. Hence, there needs more prevention efforts to be targeted at these people, which should take into account their particular concerns and realities (UNAIDS, 2002a).

The number of sexual partners women and men have, and protective practices such as condom use, can have a direct effect on their risks of contracting sexually transmitted diseases including HIV. Many factors are at play

that can affect the chance that an individual will encounter an infected sexual partner. These factors are biological, epidemiological and behavioural. The biological and epidemiological factors include the prevalence of particular STDs in communities, the STD status of partners, the ease with which specific organisms are transmitted, the effectiveness and availability of medical treatment and susceptibility of uninfected partners. The behavioural factors include multiple sexual partners, the type of sexual intercourse or behaviour practiced and the use of a condom or some other protective measure. The likelihood of a person encountering a partner who is infected, and who can infect him/her, increases as the number of partners the person has increases. However, even if a person has only one partner, he or she may be at indirect risk if their partner is infected or has multiple partners (Finer et al., 1999).

Currently, in sub-Saharan Africa, there are three main intervention strategies available to reduce heterosexual HIV transmission. They involve: increasing the use of condoms, reducing the number of sexual partners, and seeking prompt and appropriate care for sexually transmitted diseases (STDs) (Kengeya-Kayondo cited in Kengeya-Kayondo et al., 1999). The above strategies are reliant for the most part upon the modification of behaviour, which includes a major component, which is the individual's belief that he or she is indisputably at risk. However, this concept of personal risk or vulnerability is what underlies the theoretical and practical aspects of behaviour change programs for HIV/AIDS prevention, (Kengeya-Kayondo et al., 1999), and has not being studied in these two populations before.

This study aims to look at sexually active men and women and their perceived risks of HIV/AIDS. It also aims to look at how these perceptions affect their protective behaviour. With regards to protective behaviour, the use of condoms will be discussed at length. What is hoped to be accomplished from this study is a better understanding of risky behaviour and perceptions of risk and how better to understand the resulting protective behaviour.

Strunin (1991) points out that studies of risk perception have tried to come up with ways for people to understand what is meant by perceptions of risk and what the underlying factors are. Douglas & Wildavsky (cited in Strunin, 1991) say that perceptions of risky behaviours are influenced by social and cultural factors. They also argue that people base their decisions about what to view as risky based on the environment that they are in. Hence, risk is seen to be "socially embedded" (Strunin, 1991:221). Lagarde et al. (1996) state that as a result of the absence of effective treatments and vaccines, convincing people to change their behaviour can be used as a method to prevent infection.

There have been many studies done of the relationship between perceived risk and condom use among young adults. One of these show contradictory results (Baume, 2000). Hence, individuals understand or perceive themselves at risk but do not practice safer sexual behaviour. In this dissertation, an attempt is made to see if the above is in fact true with regards to the data used.

There are four main objectives to this research:

- To identify knowledge and behaviour among men and women with regards to HIV/AIDS.
- To look at perceptions of risk of infection of HIV/AIDS among a sample of men and women.
- To examine the association that exists between perceived risk and behaviour to avoid HIV/AIDS; and
- To study factors of condom use behaviour.

This dissertation contains six chapters. This first chapter introduces the topic and looks at statistics and highlights how HIV/AIDS affects the world, then sub-Saharan Africa and then South Africa, and in particular KwaZulu Natal. Chapter two is the chapter in which the theoretical framework for this study is discussed. Chapter three reviews the literature. Chapter four discusses the methodology

and data used in this study. Chapter five includes the results. The discussion of the results is found in Chapter six. Finally, Chapter seven is the concluding chapter, which includes recommendations as well.

CHAPTER TWO: THEORETICAL FRAMEWORK

Perceived risk refers to: "one's perception of the extent to which he or she is at risk for a given disease or condition." (Baume, 2000:33). This concept of perceived risk is an essential element in many behaviour theories, especially those that try to identify the determinants of health behaviour (Baume, 2000). There are many theories/models that could be used to structure/shape this dissertation. The theories/models below display some similar components that will be used in this dissertation. What follows is a description of the theories.

2.1 Health Belief Model

The Health Belief Model (herein referred to as HBM) is a psychological model (Janz & Becker, 1984). This model was first put forward by Becker and Rosenstock in 1974. It attempts to explain health-related behaviour (Wilson et al., 1991). It focuses on the attitudes and beliefs of individuals, and in so doing, it tries to explain and predict health behaviours (Baume, 2000; Family Health International (FHI), 1996; Healthknowledge, 2002; Pitts et al., 1991).

The following are the key variables of the HBM (Rosenstock et al. cited in FHI, 1996):

2.1.1 **Perceived Threat**: This consists of two parts: perceived susceptibility and perceived severity.

2.1.1.1 Perceived Susceptibility: this is one's subjective perception of the risk of contracting a health condition.

2.1.1.2 Perceived Severity: this is feelings that are concerned with the seriousness of contracting an illness or of leaving it untreated

2.1.2 **Perceived Benefits**: This is the belief in the effectiveness of strategies that are designed to reduce the threat of illness.

2.1.3 **Perceived Barriers**: This is the potential negative consequence that may result from taking particular health actions. This can include physical, psychological, and financial demands.

2.1.4 **Cues to Action**: This includes environmental (e.g. media publicity) or bodily (e.g. physical symptoms of a health condition) action that motivate people to take action. However, this has not been studied extensively.

2.1.5 **Other variables**: These include demographic, psychosocial and structural variables that are responsible for an individual's perceptions and in so doing influence health-related behaviour.

2.1.6 **Self-Efficacy**: This is the belief that one is able to successfully carry out the behaviour that is required in order to obtain the desired outcomes (FHI, 1996; Janz & Becker, 1984; Wilson et al., 1991).

The HBM has been used to better understand sexual risk behaviours (Rosenstock et al. cited in FHI, 1996). The most influential variable for predicting and explaining health-related behaviours is perceived barriers. It was pointed out more recently by Bandura (1986 cited in FHI, 1996) that an individual's perceived ability to carry out a health strategy successfully influences his/her decision and the ability of him/her to sustain a changed behaviour (FHI, 1996; Janz & Becker, 1984).

2.2 Aids Risk Reduction Model (ARRM)

The Aids Risk Reduction Model (ARRM) came about in 1990. This model overlaps with some of the aspects of the HBM. It provides a framework for predicting and explaining the behaviour change efforts of individuals, especially with regards to the sexual transmission of HIV/AIDS. The ARRM is a three-stage model. It includes several variables from the HBM and other behaviour change theories. The hypothesized influences are the hypothesized factors that influence the successful completion of each stage (Baume, 2000; Catania et al., 1990; FHI, 1996; Lindan et al.,1991).

The first stage in this model is recognition and labelling of one's behaviour as high risk. The hypothesized influences in this stage include: knowledge of sexual activities associated with HIV transmission; believing that one is

personally susceptible to contracting HIV; believing that having AIDS is undesirable; and social norms and networking (FHI, 1996; Lindan et al., 1991).

Stage two is making a commitment to reduce high-risk sexual contacts and to increase low-risk activities. The hypothesized influences in this stage include: cost and benefits; enjoyment (e.g. will the changes affect my enjoyment of sex?); response efficacy (e.g. will the changes successfully reduce my risk of HIV infection?); self-efficacy; and knowledge of the health utility and enjoyability of a sexual practice, as well as social factors (group norms and social support), are believed to influence an individual's cost and benefit and self-efficacy beliefs (FHI, 1996; Lindan et al., 1991).

Stage three is taking action. Here, there are three phases: (i) information seeking; (ii) obtaining remedies; and (iii) enacting solutions. Phases may occur concurrently, or may be skipped, depending on the individual. The hypothesized influences in this stage include: social network and problem-solving choices (self-help, informal and formal help); prior experiences with problems and solutions; level of self-esteem; resource requirements of acquiring help; ability to communicate verbally with sexual partner; and sexual partner's beliefs and behaviours (FHI, 1996; Lindan et al., 1991).

There are also other internal and external factors that are present to motivate individual movement across the stages. An example is aversive emotional states (high levels of distress over HIV/AIDS or alcohol and drug use that blunt emotional states). These may hinder or help the labelling of one's behaviours. Then, we have external motivators, which may also cause people to examine and maybe change their sexual activities. These include: public education campaigns, informal support groups, and images of people dying from AIDS (FHI, 1996).

2.3 Stages of Change Theory

There are four original components of the Stages of Change Theory. These are: firstly, Precontemplation which refers to the stage where the individual has the problem (whether he/she recognizes it or not) and has no intention of changing. The processes here include: Consciousness raising (information and knowledge); dramatic relief (role playing); and environmental re-evaluation (how the problem affects physical environment). Secondly, Contemplation, which refers to the stage where the individual recognizes the problem and is seriously thinking about changing. The process here is self-re-evaluation (assessing one's feelings regarding behaviour). Thirdly, Preparation for Action, which refers to the stage where the individual recognizes the problem and intends to change the behaviour within the next month. Behaviour change efforts may be reported. The process includes: self-liberation (commitment or belief in ability to change). And finally, Action, which refers to the stage where the individual has enacted consistent behaviour change for less than six months. The processes include: reinforcement management (overt and covert rewards); helping relationships (social support, self-help groups); counterconditioning (alternatives for behaviour); and stimulus control (avoid high-risk cues). A stage that was later added is maintenance, which refers to the stage where the individual maintains new behaviour for six months or more (FHI, 1996).

Recently, this theory has been applied to research on sexual behaviours and HIV/AIDS. An example of this theory in use is in the Center of Disease Control and Prevention (CDC). Here, the theory is being used in an HIV/AIDS Counselling and Testing Study at sexually transmitted disease (STD) clinics (FHI, 1996).

2.4 Theory of Reasoned Action (TRA)

Since 1967, the Theory of Reasoned Action (TRA) has been used to explain and predict a variety of human behaviours. This theory is based on the premise that humans are rational and that the behaviours being explored are

under volitional control. The theory provides a construct that links individual beliefs, attitudes, intentions, and behaviour (Fishbein et al. cited FHI, 1996). The variables in the theory are: firstly, Behaviour which is defined by a combination of four components: action, target, context, and time. An example of this could be: implementing a sexual HIV risk reduction strategy (action) by using condoms with commercial sex workers (targets) in brothels (context) every time (time). Secondly, Intention. This is the best predictor of whether a desired behaviour will actually occur. Attitudes and norms influence one's intention to perform a behaviour. Thirdly, action, which refers to a person's positive or negative feelings toward performing the defined behaviour. Fourthly, norms, which refer to a person's perception of other people's opinions regarding the defined behaviour (FHI, 1996).

Each of the above variables is linked by a framework, which is provided by the TRA. The behavioural and normative beliefs, which are referred to as cognitive structure, influence individual attitudes and subjective norms respectively. Thereafter, attitudes and norms shape a person's intention to perform a behaviour and finally, person's intention remains the best indicator that the desired behaviour will occur. In sum, the TRA proposes a linear process where changes in an individual's behavioural and normative beliefs will ultimately affect the individual's actual behaviour (FHI, 1996).

The above four theories/models have similarities within them and these are what will be used to structure the arguments for this dissertation. So, in sum, what the above theories/models posit is that the higher the perceived risk, the more likely it will be for people to carry out protective behaviour, for example using condoms. Furthermore, the more knowledge or positive attitudes people have regarding condoms and HIV/AIDS, the higher their chances will be of using condoms. This implies that peoples' behaviours will be shaped by the rational decisions that they make.

However, according to Hulton et al. (2002:36) "These models are inadequate because they assume a logical pattern of decision making and a degree of control that is unrealistic in the complex field of sexual relations." I agree with the view put forth by Hulton et al. (2002). In this day and age when sex is seen as the be all and end all, one cannot be left to rely on one's "rational" decisions. Hence, this is the gap that I have also found in the theories/models discussed above. However, as was mentioned earlier, some of the points help to shape this dissertation.

CHAPTER THREE: LITERATURE REVIEW

This chapter reviews the literature on HIV/AIDS risk, perception and behaviour. It starts off with a brief introduction on HIV/AIDS and its origin and goes on to provide an introduction of HIV/AIDS in South Africa. Antenatal surveys, risk, perceptions, followed by condom use, gender inequalities and behaviour change are then discussed. Thereafter, a conclusion will follow.

3.1 Introduction

There has been great progress in understanding the disease. The virus has been identified; the ways in which it is transmitted have been isolated, the epidemiology is being exhaustively studied; and there is now a continued search taking place for a vaccine. Unfortunately, the pandemic has spread rapidly especially in Africa (Whiteside, 1990).

3.2 Stages before AIDS

There are a number of stages a person will pass through once he/she is infected. Immediately after infection, there is a period during which the person is infected and infective, but does not have sufficient antibodies for the virus to be detectable through laboratory testing. This period is known as the seroconversion phase. This is followed by a phase during which the virus is detectable, the person is healthy but infective. However, the virus is replicating and beginning its attack on the immune system. This is known as the latent phase (Sabatier, 1987; Visagie, 1999). It is followed by the onset of the disease, possibly initially through 'AIDS related complexes' (ARC) and then full-blown AIDS, ending in death (Whiteside, 1990).

To date, two strains of the virus have been identified. These are HIV-I (the most common in the west and most of Africa). The HIV-II virus is more difficult to detect and may take longer to affect the carrier (Sabatier, 1987; Visagie, 1999; Whiteside, 1990; Whiteside & Sunter, 2000).

3.3 Introduction-South Africa

The major cause of HIV infection in South Africa is through sexual transmission (Donovan & Ross, 2000; Klepinger et al., 1993; Whiteside & Sunter, 2000). One notch lower than that comes mother-to-child transmission (MTCT). A child can be infected prenatally with HIV, at the time of delivery, or postnatally through breastfeeding (Whiteside & Sunter, 2000).

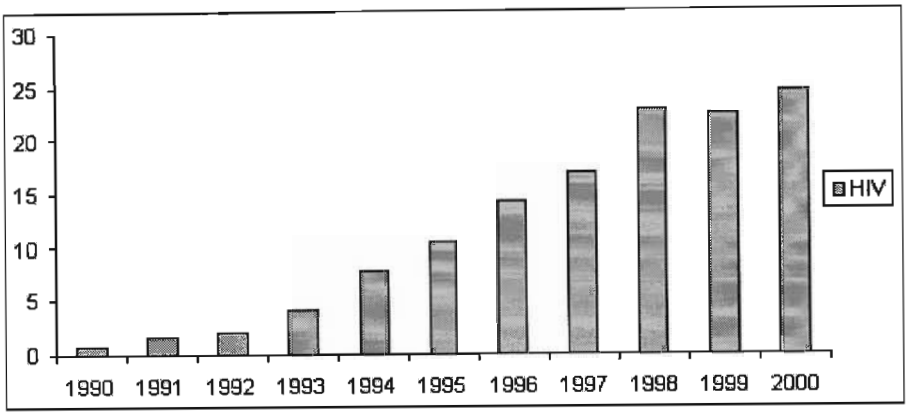
In South Africa, HIV flourishes most in areas that have high rates of unemployment, homelessness, welfare dependency, crime, prostitution, high-school dropout rate and social unrest. Hence, it is no surprise that the areas of KwaZulu Natal have the highest incidence of HIV in South Africa since KwaZulu Natal has been most affected by political conflict, violence and poverty (Kustner cited in Whiteside et al., 1995).

3.4 Antenatal Surveys

Antenatal clinic surveys are seen as being the best method available to measure HIV prevalence among the adult population. These surveys have been (and still are) conducted, since 1990 in October and November, each year. KwaZulu Natal has the highest prevalence in South Africa (Whiteside et al., 1995).

The HIV/AIDS epidemic can be characterised by the following: firstly, in terms of HIV infections. In South Africa in October 2000, antenatal HIV prevalence survey showed that 24.5% of all pregnant women were HIV positive, i.e. approximately 4.8 million South Africans and almost 20% of all 15-49 year olds are infected with the virus (Mann cited in Kenyon et al., 2001). By this it can be seen how disastrous this epidemic is.

Figure 2: National HIV prevalence trends among antenatal clinic attendees in South Africa: 1990-2000



Source: Department of Health, 2000.

However, by looking at the above graph, it can be seen that the prevalence of HIV may be levelling off. While this may be seen to be optimistic, these positive trends do not negate the fact that the epidemic is still severe. There are challenges that face countries, not only in sustaining and expanding prevention, but also to provide adequate treatment, care and support to the millions of HIV/AIDS sufferers and children orphaned as a result of HIV/AIDS.

3.5 Risk

The risk of exposure of an individual to HIV depends on a combination of the following factors: number and type of lifetime sexual partners, the HIV status of the sexual partners, consistency of condom use with each partner, and the level of HIV/AIDS that is prevalent in the population. So, as an example, an individual who reports having had many sexual partners may not be at high risk of HIV infection by virtue of him/her having had many partners since the individual might have used protection each time. Hence, risk depends on a combination of the above factors (Akwara et al., 2001).

Studies of risk perception have tried to come up with techniques to understand what is meant by people's perception of risk and what factors underlie these perceptions. According to Douglas and Wildavsky (cited in Strunin, 1991), perceptions of risky behaviour are influenced by social and cultural factors. They also argue that decisions about what to consider risky is made by people based on the nature of the social organisation in which they live. Hence, risk can be seen as being socially embedded (Strunin, 1991).

There is one possible interpretation of the study done by Finer et al. (1999). This is that the two types of exposure to multiple partners i.e. direct and indirect, impact differently on an individual's perceptions of his or her own risk. People may be more aware of their risk level if they have had, or still have multiple partners. Hence, they will desire to use condoms more strongly. On the other hand, if a person's risk is based on his or her partner's behaviour, then perceptions of risk may not be as evident and the impetus to use condoms may not be as strong. In this study, overall, the levels of risk among women and men were high, with condom use among those at risk being relatively low. According to Finer et al. (1999), this suggests a need for increased and continued emphasis on public education about STDs and about HIV and AIDS. Also included should be information on risk factors, and preventive measures that can be taken, particularly the use of the male and female condom (Finer et al., 1999; Magnani et al., 2002). It has also been argued that preventive interventions in South Africa should be directed at people below the age of 16 years. The reason for this is because it was shown in the study done by Williams, Campbell and MacPhail (cited in MacPhail & Campbell, 2001) that HIV infection was almost non-existent in the 13-16 year age group, which was then followed by a huge increase in the 16-18 year group, and then followed by the peak infection rates for their particular study sample at the age group 21-25 years.

3.6 Perceptions

In a Nigerian study, many participants reported feeling "a sense of vulnerability to STDs and AIDS" (Temin et al., 1999:187) when discussing the risks of having sex with multiple partners. Some participants even took STDs for granted. According to participants in this study, a common perception about behaviour is that people try to spread their HIV infection (Leclerc-Madlala, 1997; Temin et al., 1999). Participants felt that the best method of STD prevention is the condom. The next most commonly used method of prevention was abstinence. The following method was monogamy, then antibiotics and locally available preparations that were thought to be effective in treating people who were infected with HIV (Temin et al., 1999).

In Harare (Zimbabwe), a small study was conducted to examine perceptions of personal risk of HIV infection, and the way they relate to perceptions of more general risks to members of the population and how they relate to decisions about behaviour change. In the above study, there was a belief that a single act of intercourse with an infected person will result in the person contracting AIDS (Pitts et al., 1991).

For the study by Wilson et al. (1991), the most consistent predictor of safer sexual behaviour was perceived social support for behaviour change, followed by accessibility of health care/advice. Many factors may be associated with perceptions of risk of HIV. These include: social, economic and demographic characteristics of individuals, societal norms and attitudes towards HIV/AIDS and the acquisition of knowledge (Akwara et al., 2001).

The following are important in assessing people's risk perceptions and sexual behaviour: specific knowledge of transmission and prevention, for example, thinking that a healthy looking person cannot have AIDS; mother to child transmission; knowing someone who has died of AIDS or who is sick with AIDS; and the knowledge of ways to avoid getting AIDS (Akwara et al., 2001;

Hulton et al., 2000; Weisman et al., 1989). These relate to people's own interpretation of illness and severity. Also, people may believe that certain things like sharing of eating utensils transmit HIV. This could lead to careful behaviour to the point of obsession, or could also lead to fatalistic attitudes i.e. no attempts to practice safer sexual behaviours are carried out (Akwara et al., 2001).

HIV risk perceptions are not stationary and can vary depending on the context and time. It can be referred to as stages or states as opposed to levels of perceived risk. People who are exposed to the same, or a similar situation may have different perceptions of risk at different stages of their life course i.e. a person might change from one state to another, for example, from low perceived risk to high perceived risk or vice versa, even with continued exposure to the same type of risk. With regards to sexual relationships, people might change their behaviour, for example, from risky to safer sexual behaviour. However, there is a strong likelihood that they may relapse to risky behaviour with increasing intimacy in the partnership. Researchers have found that people may adopt the use of condoms at the beginning of a relationship but as trust becomes established within the couple, they stop using condoms (Fapohunda & Rutenberg, 1999; Geringer et al., 1993); Ingham & Van Zessen, 1992; MacPhail & Campbell, 2001). The opposite scenario may also occur where a person with low risk perception at one stage may progress to a high level of perceived risk as a result of intensive exposure to HIV/AIDS information and hence may adopt safer sexual practices.

Akwara et al. (2001) suggest that there are different categories or states of perceived risks, which might lead either to low or high-risk sexual behaviour. People who feel that they might be infected and that there is something that they can do about it might have high HIV/AIDS awareness levels and risk perceptions. They can actually practise low-risk sexual behaviour. A second category of people might feel that they may become infected but there is nothing that they can do about it. This group have knowledge of AIDS and feel at personal risk,

however, they think that it is beyond their control to avoid it. These people usually develop fatalistic attitudes and leave it up to fate, and consequently engage in risky sexual behaviour. These fatalistic attitudes may be present as a result of high HIV/AIDS prevalence in the area or a belief that any other source (e.g. mosquito bites) can infect people with HIV (Akwara et al., 2001; Donovan & Ross, 2000). Joseph et al. (1987), have brought up the point in their paper that people who feel that they are at high risk are generally less likely to practice safer sex or try to reduce their risk.

There are several factors that affect the chance that an individual will come into contact with an infected sexual partner, and hence become infected with an STD. These factors are biological, epidemiological and behavioural. The biological and epidemiological factors include: the prevalence of particular STDs in communities, the STD status of partners, the ease of transmission of specific organisms, the availability and effectiveness of medical treatment and the susceptibility of uninfected partners. The behavioural factors include: multiple sexual partners, the type of sexual intercourse and behaviour practiced, and the use of a condom or some other protective measure. It follows then that the more sexual partners a person has, the higher is his or her likelihood of coming across a partner who is infected and who subsequently infects him or her. It needs to be understood though, that an individual who has one partner can also be placed at risk indirectly, through his or her partner's actions (Finer et al., 1999).

Freudenberg (cited in Akwara et al., 2001) states that ordinary people do not usually use their "factual experiences" but rather they use their "mental knowledge" to estimate their levels of risks. Decisions about risk that are based on mental knowledge may be valid in some situations. However, they can also be biased in other situations and can hence lead to under-estimations or over-estimations of personal risk and can subsequently influence sexual behaviour (Mbizvo et al., 1997; Akwara et al., 2001). Slovic and his colleagues (cited in Akwara et al., 2001) found that the perceptions that people had of dying in an

accident were much higher than perceived risks of dying from a disease. This was found despite mortality figures that showed that illnesses/diseases claim more lives each year as opposed to accidents. The reason for people perceiving themselves at high risk was as a result of the extensive coverage of accident-related deaths in the media (Akwara et al., 2001).

Sexual behaviour is more likely to be based on subjective perception of risk rather than actual risk since people's feelings are in fact subjective. Similar positive associations between perceptions of risk and risky sexual behaviour were found by Cleland (cited in Akwara et al., 2001) and Ingham and Holmes (cited in Akwara et al., 2001). Also, Sheppard et al. (cited in Akwara et al., 2001) found that perceptions of risk were also positively associated with changes in sexual behaviour.

Strunin (1991) has argued that life events not only affect risky behaviour, but they also shape perceptions of risky behaviour. According to Akwara et al. (2001:2), it is rather obvious that the reason for the increase in prevalence of HIV infections and AIDS-related deaths is due to risky sexual behaviour and the "antecedent perception of risk".

The forms of risky sexual behaviour can be viewed in the context of number and types of partnerships, sexual acts and orientations and sexual beliefs and practices (Cohen & Trussell; Dixon-Mueller cited in Akwara et al., 2001; Finer et al., 1999). Early age at first sexual intercourse with commercial sex workers, multiple sexual partners, non-use or inconsistent use of condoms, and untreated sexually transmitted infections are some elements of risky sexual behaviour (Akwara et al., 2001).

The following sexual practices are seen to be risky and high-risk sexual activities: engaging in anal or vaginal sex with an infected partner and not using a condom (this is seen as the highest-risk practice); having sex with multiple

partners, or with someone who has multiple partners; having sex without a condom with people who use drugs intravenously, or with their sex partner; using drugs, which may lead to risky sexual behaviour; anal or vaginal sex without using a condom, and where there is direct contact between mucous membranes and body fluids; not using a condom during oral sex i.e. fellation or 'blow job' with ejaculation in the partner's mouth; not using a condom or protection (e.g. using a slit open condom or thin plastic) during oral or vaginal sex during menstruation; oral-anal contact without protection; not using latex gloves during 'fisting' i.e. insertion of a fist into the vagina or rectum; and not using a finger cot during 'fingering' i.e. insertion of a finger into the vagina or rectum (Visagie, 1999:24-28).

Participants included having multiple partners and engaging in sex with unknown partners as high-risk behaviours. However, they did not recognise the potential health risks of intercourse with a known, regular partner. Hence, this suggests that familiarity with a sexual partner is accompanied by a perception of lower/decreased risk (Temin et al., 1999). However, if individuals associate AIDS with only certain groups of people, then they may perceive themselves at low risk of infection even though they may have multiple sexual partners (Akwara et al., 2001).

Alternatively, there are those people who might not feel that they are at risk of contracting HIV and hence may not practice safer sexual behaviour. A possible reason for people to feel this way could be as a result of their beliefs in their own or their partners' behaviour, hence they feel at a lower risk of contracting HIV. Ingham and Van Zessen (1992) point out that these people feel that their partners can be trusted and believe that they are not promiscuous, that they are faithful, that they have had few previous partners, that they always use condoms when they know they need to, that they have undergone tests for HIV and that they abstain from high-risk sexual behaviour. By a person believing that

his/her partner is HIV negative, he/she might take sexual risks, even though he/she would not have in other circumstances (Agha, 2001; Akwara et al., 2001).

The HIV/AIDS/STD Strategic Plan (2000-2005) was developed early in 2000. It mentioned that this document will be used by government departments, organisations and stakeholders to formulate their own strategic and operational plan. This plan is intended to guide South Africa's response to this pandemic (DOH, 2002; Gow & Desmond, 2002). Despite this comprehensive national HIV/AIDS/STD Strategic Plan for South Africa, HIV prevalence has continued to increase. This can be seen as an indication of inadequate implementation of the plan. Some of the reasons for this include: poverty and inequality; the restructuring of the public sector; a high turnover of staff; lack of effective leadership; and the failure of HIV activities to be mainstreamed at all levels of society (Kenyon et al., 2001).

In the study done by Romer et al. (1994), it was found that the rates of sexual activity confirmed their assumptions that many youths that live in poverty represent a particularly high-risk population for exposure to HIV and other sexually transmitted diseases. That study also showed that the hypothesis about there being differences in the onset and progression of sexual activity and it being related to social influences did in fact come out as being true. In this particular study, the older the children the more knowledge they had about hazards of sex and the benefits of condoms. However, even though the above was true, their sexual activity increased as age increased. This was so especially when these risky behaviours were seen to be acceptable to their peers (Hulton et al., 2000; Romer et al., 1994).

The following are some points that surfaced with regards to reducing high-risk sexual behaviour among young people in Nigeria and controlling the spread of STDs including HIV and AIDS: education of adolescents about risky behaviour by using media campaigns, education of parents about reproductive health and

communication with adolescents, training medical providers in low-cost diagnosis and treatment techniques, and the establishment of youth-friendly services that emphasise sensitivity and confidentiality (Macdonald & Smith, 1990; Temin et al., 1999).

The adoption of safer sex behaviours have also being as a result of the fact that self-perception of HIV/AIDS risk has been identified as another important intervening cognitive variable. This may be true because knowledge of risky sexual behaviour may not in itself lead to individuals practising safer sexual behaviours (Kelly et al. cited in Minichiello et al., 2001).

Safer sex means the following: to have a long-term relationship with a faithful, uninfected partner; to use a condom regularly and properly; to practice mutual masturbation, provided that there is no exchange of body fluids; touching each other or yourself everywhere; cuddling and hugging; rubbing of each other's bodies, provided that there is no exchange of body fluids; dancing; sexy movements; acting out fantasies; and using an aid, vibrator or sex toys (Visagie, 1999:23).

3.7 Condom Use

A condom is a latex sheath that fits over the erect penis. It acts as a barrier to prevent pre-cum or seminal fluid from escaping while the penis is still inside the vagina or rectum. Only nylon and latex condoms should be used. The consistent and proper use of latex condoms during sexual intercourse can drastically reduce the risk of acquiring or transmitting sexually transmitted diseases including HIV. An unused condom is the only reliable protection against an STD or HIV (Visagie, 1999).

An effective way of preventing transmission of STDs including HIV is by correctly and consistently using latex condoms (Mayaud & McCormick, 2001; Finer et al., 1999). Hence, it is crucial to consider condom use in the analyses of

the impact of partnership patterns on STD risk. Many strategies acknowledge the condom's important role as a source of STD prevention. They do this by examining the condom use of individuals at different levels of risk (Finer et al., 1999).

It has been documented that many people thought that condoms decrease the enjoyment of sex (Boulos et al., 1991; Geringer et al., 1993; Kelly & Parker, 2000; Leclerc-Madlala, 1997; Temin et al., 1999). This view was more popular among females than males. In the study by Temin et al. (1999), participants pointed out strongly that condom use was synonymous with mistrust. Also, in this study, there was the perception among male students that getting an STD is inevitable. Hence, this discouraged them from taking precautions in this regard (Temin et al., 1999). Also, condoms were associated with immoral sexual behaviour and hence individuals are likely to find it difficult to discuss the use of condoms with their partner and subsequently may feel embarrassed to obtain them (Agha, 2001).

There still exists the misconception that condoms are dangerous and may cause infertility by remaining in the body of the woman. These misconceptions are increased by the lack of experience with condom use (Lindan et al., 1991). Individuals may want to reduce high-risk behaviour but because of social and family pressure for fertility, they may not be able to (Hulton, et al., 2000; Lindan et al., 1991). Lindan et al. (1991) argue that women need to learn how to negotiate condom use and hence to encourage their partners to be monogamous. Men also need to become the focus of public health efforts in order to prevent the further spreading of the epidemic. According to Minichiello et al. (2001), two ways to decrease the risk of STD and HIV infection are abstinence and reducing the number of sexual partners that one has.

The U.S. Agency for International Development (USAID) and other international donors have been supplying condoms to developing countries,

since the early 1960s, as part of both governmental and private family planning initiatives (Boulos et al., 1991). In the public sector, in South Africa, the provision of condoms has increased from 6 million in 1994 to 250 million in 2000/2001. In research done (Myer et al., 2001), it was found that 5 weeks after the distribution of these free condoms, 44% had to been used in sex and 9% had been lost or discarded. Hence, this can be seen as positive. One of the reasons for the low usage of condoms could be the difficulty in accessing them in an inconspicuous manner. Hence, although the condoms that are been distributed are being used, there is still the need to increase the availability and the marketing of condoms. There has been continued piloting of the female condom since 2000. This offers hope and protection to women (Kenyon et al., 2001). Previous studies on condoms have found that they have a negative connotation attached to them (Kelly & Parker, 2000; Lurie et al. cited in Rutenberg et al., 2001). Other studies have found condoms to be distasteful, unnatural, offensive, uncomfortable and awkward (Kelly & Parker, 2000; Varga cited in Rutenberg et al., 2001). The lack of experience with condom use is what leads to common misconceptions that they are dangerous and may cause infertility, believing that it might accidentally remain in the body. In Africa, condoms have been associated with promiscuity and hence have not been well accepted, especially among steady couples (Agha, 2001; Taylor et al. & Goldberg et al. cited in Lindan et al., 1991).

People that were more likely to use condoms were young, never married and well educated. Also, people with a good knowledge of AIDS were more likely to use condoms (Lagarde et al., 1996). Individuals could perceive themselves to be at high risk as a result of their risky sexual behaviour and hence use condoms. Also, the fear of been infected may continue even if the person is practising low risk behaviour (Akwara et al., 2001). It was found in the study done by Magnani et al. (2002) that HIV/AIDS knowledge was associated with a lower likelihood of being sexually active as well as with a higher probability of using condoms.

A report by Rutenberg et al. (2001) showed that 99 percent of the respondents of the study had heard of HIV and 94 percent of them mentioned that HIV can be transmitted through sexual intercourse. Ninety-five percent of the respondents also reported that they think people can do something to protect themselves from getting HIV/AIDS (Rutenberg et al., 2001).

According to Wilson et al. (1991), an improved understanding of factors is needed that motivate safer sexual behaviour in order to reduce HIV transmission. Increasing adolescents' knowledge about HIV/AIDS has been one of the strategies employed to try to decrease the number of adolescent HIV infections. This operated under the assumption that information will increase HIV prevention. However, it has been shown that even where adolescents' knowledge about HIV is high, it did not necessarily translate into safer sexual behaviour (DiClemente; Fisher & Misovich; Roscoe & Kruger; Ross & Rosser cited in Fisher et al., 1992). However, it has been shown that adolescents' knowledge of HIV is necessary, but not sufficient to be translated into preventive behaviours (Fisher et al., 1992; Mbizvo et al., 1997).

Knowledge about disease prevalence within the community or the knowledge of someone with AIDS or someone who has died of AIDS is likely to show differences in self perceived risk and sexual behaviour. Hence, incorrect beliefs exist that lead people to be excessively careful in terms of their behaviour, or lead them to have uncaring attitudes. Also, in terms of socio-cultural factors, subordinate women may not adopt safer sexual behaviour since they feel/believe that such behaviour is beyond their control (Akwara et al., 2001; Geringer et al., 1993; MacPhail & Campbell, 2001).

Studies by Ingham & Van Zessen (1992), have found that safer sexual behaviour is not associated with having proper knowledge about HIV/AIDS transmission and prevention. Some people still remain ignorant of the risk of HIV

and the risk becoming infected by HIV even though there have been widespread educational campaigns about them (Ingham & Van Zessen, 1992).

Finally, there are those people who might not know anything about HIV infections or the risks thereof. These people may include very young people and those people in remote areas where there is absence of public awareness campaigns (Akwara et al., 2001).

3.8 Gender Inequalities

Even though we are now the third decade of AIDS, and global awareness of HIV threat is probably widespread, women may not perceive HIV threat at the personal level, particularly those women who feel "geographically insulated" (Crosby et al., 2002:655) from the AIDS pandemic since they do not reside in or near AIDS epicentres (Crosby et al., 2002).

In most of sub-Saharan Africa, the assumption that men cannot live without sex causes gender inequalities and this subsequently places women in subordinate positions (Gage & Njogu, 1996; Ocholla-Ayayo cited in Akwara et al., 2001). Evidence has suggested that for men to have multiple partners is tolerated, even though it is not acceptable. However, women's infidelity is seen as being greatly sinful and women are highly penalised (Fapohunda & Rutenberg, 1999; Mbizvo et al., 1997; Radeny cited in Akwara et al., 2001). It has been concluded by Ingham and Van Zessen (1992:19), that "sexual conduct is embedded in culture and in social relations", and women find these beyond their control.

With regards to women, a major obstacle in HIV prevention is their limited capacity to exercise control over decisions about condom use (Agha, 2001; Leclerc-Madlala, 1997; Mbizvo et al., 1997; Wilson et al., 1991). Women have limited power in decisions regarding sex and hence are unable to use or vouch for safer sexual practices (Fapohunda & Rutenberg, 1999; Gage & Njogu, 1996).

Often women are unable to make sexual decisions and hence risk perception may not be significant in their sexual behaviour (Akwara et al., 2001).

With regards to equity of women, less condom use among them who are at direct risk may reflect greater inequity in the power balance between partners. It could also reflect less willingness by men with outside partners both to acknowledge that this pattern of sexual behaviour may increase the STD risk of all their partners and also to preventive action, such as using the condom (Finer et al., 1999).

3.9 Behaviour Change

A first step towards behavioural change from risky sexual behaviour to safer sexual behaviour is to understand the context of risk perception in relation to sexual behaviour (Akwara et al., 2001). Perceived risk may be based on a correct identification of very real, actual danger. An individual's possible inaccurate interpretation of personal fears, reality and biases may shape an individual's risk perception (Mbizvo et al., 1997). Behaviour change was associated with perceptions of risk and beliefs about condoms. In a study by Lindan et al. (1999), women who perceived themselves to be at risk of AIDS were much more likely to have taken some action to reduce their risk, or to have to try to convince their partner to change his or her behaviour. According to Lindan et al. (1991), the following were important in predicting women's efforts to reduce their risk: perceived risk, communication skills, knowing someone with AIDS and belief in the utility of condoms (Lindan et al., 1991).

Lindan et al. (1991) argue that improving perception of risk alone is not sufficient. Women should also learn and be able to implement effective ways of reducing high-risk behaviour, and encourage the same in their partners. This can be done by overcoming barriers to the use of condoms and changing accepted patterns of sexuality and behaviours that may have strong cultural traditions (Lindan et al., 1991). It has been quite recently recognised that the

general knowledge and awareness of AIDS is not in itself important with regards to behavioural change. Knowledge and awareness of HIV/AIDS alone is not enough for behaviour change. Available literature suggests that a host of factors, and not just knowledge of risk are responsible for people's judgements about their risk (Akwara et al., 2001; Klepinger et al., 1993).

An example is in Kenya where Agha (2001) found that as a result of the social marketing campaign, an environment was created wherein there was a larger recognition of personal risk for becoming infected with HIV. Also, it strengthened the belief in the efficacy of condoms and increased the level of personal self-efficacy (Agha, 2001).

The paper by Akwara et al. (2001) make the suggestion that for the spread of AIDS to be contained, behavioural change strategies need to take into account the influence of the wider social context on how the young, and in particular, the unmarried people, received and process AIDS prevention information; and how they relate their sexual experience to risks of disease infection. As a result of the strong influence of social context, this can be translated into sexual behaviour being socially constructed and being biologically driven (Akwara et al., 2001; Hulton et al., 2000). Despite individuals' attitudes and skills that are in support of safe sexual behaviour, social norms can influence these individuals to start and continue with risky behaviour (DiClemente; Walter et al.; Furstenberg et al. cited in Romer et al., 1994). Peer behaviour can have a huge impact on condom use. It was found, in the study by Romer et al. (1994) that condom use tended to decline with age except among children who felt that most of their friends were using condoms.

Domains outside of AIDS prevention have supported the notion that adolescent norms can influence levels of risky or safer behaviour. Other studies have found that as a result of not wanting to appear as individuals who are not risky, adolescents practice risky behaviour (Levinger & Schneider; Wallach & Wing cited in Fisher et al., 1992; MacPhail & Campbell, 2001).

3.10 Conclusion

According to Whiteside (1990), initial government reaction was not adequate. In 1987, R1 million was spent on AIDS prevention and in 1989 a mere R5.4 million. Although there is a National AIDS Advisory Group, the response so far is well below that required to tackle the problem realistically, because of the apartheid system with its heritage of labour migration, the disease may be spreading uniformly in rural and urban areas (Whiteside, 1990).

Wilson et al. (1991) state that "planfulness" among men needs to be stressed by AIDS educators. This would involve obtaining condoms, knowing how to use them, carrying them wherever possible and also learning how to negotiate and suggest condom use (Wilson et al., 1991). A similar sentiment is shared by Tweedie (1995) who says that new interventions need to deal with changing social norms, support for condom use needs to be increased, and interpersonal discussions about HIV/AIDS needs to be increased as well.

The myth that AIDS is untreatable is exactly what it is, a myth. There are therapies available, which reduce viral loads and therefore infectiousness. These therapies definitely improve the quality of life of people living with AIDS. The challenge however is to make them affordable to everyone (Whiteside & Sunter, 2000).

This type of research has never been done before in the areas that will be looked at in this dissertation. The above is what available literature says with regards to this topic. Similar arguments come up throughout the review, however, there are gaps in the literature and this dissertation is going to try to fill the abovementioned gaps, well in the particular areas where data have been collected.

In an attempt to analyse the gap in the literature with regards to this topic, the following were found:

Firstly, there has not been real consensus as to why people really go ahead and engage in risky sexual behaviour, even after knowing the consequences thereof. Secondly, if education campaigns are meant to increase condom use, then why has that not happened since there have been numerous campaigns going on in and around KZN. Thirdly, people who are at high risk do not, or are unlikely to practice safe sex. Why does this occur? Is it fatalistic attitudes or perhaps denial? Fourthly, why do people not recognise the potential health risk of sexual intercourse with a known regular partner. Do they know beforehand that their partner is HIV-negative? Finally, are condoms as difficult to access as it has been pointed out, is it that conspicuous to obtain one?

The literature review done here shows that there has been extensive research done on high risk groups who are unmarried, sexually active individuals. However, the level of HIV among married people is also high and apparently rising yet there has not been much research done on these people. Thus, the study will focus on married and cohabiting people.

CHAPTER FOUR: DATA AND METHODOLOGY

This study is an exploratory one in which an attempt was made to identify the relationship among the following variables: knowledge, perceived risk, attitudes towards condom use and condom use.

4.1 Data

A survey was conducted in KwaDumisa and Ntuzuma, two areas in KwaZulu Natal (KZN), during August 1999 and January 2000. The province of KZN is predominantly rural and African with Zulu being the main home language spoken in this province (Maharaj, 2001). Ntuzuma is an area in KZN with a population of about 103 200 people (estimate in 1998). It makes up 0.24% of South Africa's population and 1.22% of KZN's population (Worldatlas, 2002). KwaDumisa is a subdistrict of Umzinto-Vulamehlo District, which is approximately 80 kilometers south-west of Durban. Many parts of KwaDumisa do not have readily available public transport in place and also, there are still large numbers of households that do not have piped water or electricity.

Part of this survey was to examine perceptions of personal risk of HIV infection and how they relate to perceptions of more general risks to members of the population and to decisions about behaviour change. The survey was done using the World Health Organisation Family Planning And Aids Survey. This survey is a 164-item questionnaire that includes both open and close-ended questions. As the name suggests, this survey was developed by the World Health Organisation. There was a separate questionnaire for men and women, however, the questions pertinent to this study are the same in both questionnaires.

This sample comprised of 1145 males and females between the ages of 15 and 55 years. They included 523 males and 622 females. The study was conducted to collect quantitative information on family planning and sexual health

needs (Bauni et al., 1997). The questions that will be analysed for the purposes of this study include those on knowledge about HIV/AIDS, risk, perceptions, and protective behaviour including condom use.

It was initially proposed that an urban and a rural site be selected in each country. The urban site should be a town with 50 000-200 000 inhabitants, the rural site (a district) in the same region/province as the urban site. The aim was to conduct interviews in 400 households in each site. The index subjects were expected to be 200 men and 200 women and their co-resident partners. As a result of household surveys conducted in these countries in the recent past, it was estimated that over two-thirds of men and women live together with their partners. So, in total 340 persons of each sex in each area, were to be interviewed. So, a total of 1 360 interviews in each country was to be conducted (Bauni et al., 1997).

4.2 Selection of sample

Four wards (or other large sub-district locations) were to be chosen within each urban and rural site. Thereafter, 5 smaller areas were to be selected within those wards or locations. The wards, or large sub-district locations were expected to have between 10 and 25 thousand inhabitants. On the other hand, the smaller areas, which should roughly correspond to census enumeration areas, or villages, or urban neighbourhoods, were expected to have between 500 and 3000 inhabitants. Within each of these 20 smaller areas, 23 household visits were to be made. Each of these small areas was expected to generate around 17 male and 17 female interviews. This includes 10 index cases for each sex, and 7 co-resident partners. An allowance was made for refusals or no adults in the age groups of interest in 3 households out of 23 (Bauni et al., 1997).

Simple random sampling was used at each stage of the sampling procedure. This strategy was chosen, even though it is not the most efficient way of drawing a sample, because it had to be ensured that the same design

was used in each country. This was done because it cannot be presumed that reasonably accurate size estimates will be available for the areas to be sampled. This is true of urban areas. Here, census listings of households become unreliable within a few years (Bauni et al., 1997).

4.3 Method of analysis

The data have been entered into the program Statistical Package for the Social Sciences (SPSS). The analysis included only married and cohabiting individuals since there has not been much work done on these individuals as compared to sexually active unmarried individuals. So, the number of cases that was eventually analysed was 543. These data were analysed using frequencies, cross-tabulations and logistic regression. The type of regression that was used here was binomial/binary logistic regression. This form of regression is used when the dependent variable is a dichotomy and the independent variables are continuous variables, categorical variables, or both. In general, logistic regression applies maximum likelihood estimation after transforming the dependent variable into a logit variable. The logit variable is the natural log of the odds of the dependent occurring or not. Hence, in so doing, the logistic regression estimates the probability of a certain event occurring (NCSU,2002).

The variables that were used assessed two categories of independent variables. One category of independent variables focused on knowledge about HIV/AIDS and condoms. A second category explored risk perceptions and attitudes towards HIV/AIDS and condoms. The dependent variable for the logistic regression is condom use

4.4 Limitations

The use of condoms in relation to perceived risk may be inconsistent in certain instances in this study. The reason for this could be as a result of measurement problems since to start with, the term "risk" is still problematic in terms of its definition.

A very important limitation in this dissertation is that an individual can be very aware of the risks AND perceive themselves to be at very low risk AND be using condoms BUT for prevention of pregnancy.

Concern exists with regards to the sensitivities surrounding questions on risk behaviours and sexual behaviours. By virtue of many of the questions being of a sensitive nature, there is the possibility that people could have lied or answered incorrectly as a result of the sensitivity of the questions. Furthermore, as pointed out by Kengeya-Kayondo et al. (1999), risk could be synonymously used to mean chance, in many instances. Hence, there exists a difference in understanding of the word risk, i.e. the layperson and the expert may not view risk as being the same thing.

Furthermore, women may be reluctant to come forth and speak about their sexual behaviour or they may want to conform to the social norms around sexual behaviour; while males on the other hand are known to exaggerate their sexual behaviour. Hence it might not always be the truth in its entirety. Also, courtesy bias may have been present i.e. respondents may have told the interviewer what he/she thought the interviewer wanted to hear.

Another important point to make at this stage is that this study dealt with condom use, which is pertinent to men, and women may feel at times that since they are not the ones using it (condoms), it does not affect them. This could be problematic once again with regards to respondents' answers. Furthermore, since behaviour change cannot be measured in a once-off study, it cannot be looked at here. If this was a longitudinal study, we would be able to measure behaviour change. By measuring behaviour change, it helps to look at how people have adapted what they have heard or learnt about. So, in essence, the final stages of this theoretical framework cannot be measured in this study. With regards to this being solely a quantitative study, it makes it difficult to gain qualitative knowledge. This inhibits one from obtaining important and significant

information regarding the topic. In terms of the sampling, as mentioned earlier, simple random sampling was used. With simple random sampling, there are a number of potential problems. One could be that if the population is widely dispersed, it may be extremely costly to reach them.

CHAPTER FIVE: RESULTS

This chapter contains the results of the analyses that were carried out in this study. It firstly looks at the socio-demographic characteristics of the sample and a brief discussion thereof. This is followed by the analyses regarding knowledge of HIV/AIDS and condoms; Perception/attitudes of HIV/AIDS; and the analysis of Protective Behaviour. Finally, the multivariate logistic regression results of condom use and explanatory variables will be presented.

5.1 Socio-demographic Characteristics of the Sample Used

Table 1 below shows the socio-demographic characteristics of the sample. As can be seen, the sample contained similar numbers of male and female respondents. Furthermore, there were almost similar numbers of individuals from rural and urban areas. With regards to education, it is clearly evident that this sample is educated with a large percentage of respondents who indicated that they have upper secondary education or higher. Occupation was grouped into three categories, employed, unemployed and self-employed; almost half of all respondents indicated that they were unemployed. When looking at the marital status of the entire sample, it was seen (results not shown) that younger people are less likely to be married and cohabiting. From the age of 25 upward, the number of people married and cohabiting increases.

Table 1: Socio-demographic Characteristics of the sample used(n=543)

Variable	N	%
Age		
15-24	42	7.7
25-34	201	37.0
35-44	240	44.2
>44	60	11.0
Sex		
Male	258	47.5
Female	285	52.5
Residence		
Urban	283	52.1
Rural	260	50.8
Education		
Primary	122	22.5
Lower Secondary	104	19.2
Upper Secondary	201	37.0
Higher	60	11.0
No response	56	10.3
Occupation		
Employed	254	46.8
Unemployed	248	45.7
Self-employed	41	7.6

Table 2 presents the relationship between residence and current condom use for males and females. There is a variation by residence: of those living in urban areas, 25.2 percent males and 31.3 percent females mentioned that they are currently using condoms. Of those who are living in rural areas, only 8.1 percent of males and 11.1 percent of females indicated that they are currently using condoms.

Table 2: Current condom use among urban and rural respondents (n=540)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Urban	25.2 %*	74.8 %*	100 %*
Rural	8.1 %*	91.1 %*	100 %*
Female			
Urban	31.3 %*	68.7 %*	100 %*
Rural	11.1 %*	88.9 %*	100 %*

Note: Totals exclude 4 missing cases; *significant at $p<0.01$

Table 3 clearly shows that there is a large difference (almost double) between males and females who are employed and their current use of condoms. Those who are employed are more likely to report current condom use for both males and females. And this is followed by the self-employed group (15.8% for males and 22.7% females).

Table 3: Current condom use by occupation (n=540)

Statement	Currently using Condoms		Total
	Yes	No	
Male			
Employed	32	138	170
	18.8 %	81.2 %	100 %
Unemployed	8	58	66
	12.1 %	87.9 %	100 %
Self-employed	3	16	19
	15.8 %	84.2 %	100 %
Female			
Employed	27*	54*	81*
	33.3 %	66.7 %	100 %
Unemployed	30*	152*	182*
	16.5 %	83.5 %	100 %
Self-employed	5*	17*	22*
	22.7 %	77.3 %	100 %

Note: Totals exclude 3 missing cases; *significant at $p<0.01$

5.2 Knowledge of HIV/AIDS and Condoms

Respondents were asked to state whether they agreed, had mixed/no opinion or disagreed with specific statement about HIV/AIDS. Some of the statements referred to the respondents' knowledge about HIV/AIDS. The first statement that was analysed was: "There is no cure for AIDS." Table 4 shows that the people, even though they agreed with this statement, are currently using condoms. For females there was no statistically significant association.

Table 4: Responses to statement about there being no cure for AIDS, by current condom use (n=538)

Statement	Currently using Condoms		Total
	Yes	No	
Male			
Agree	32**	186**	218**
	14.7 %	85.3 %	100 %
Mixed/no opinion	3**	10**	13**
	23.1 %	76.9 %	100 %
Disagree	8**	15**	23**
	34.8 %	65.2 %	100 %
Female			
Agree	50	187	237
	21.1 %	78.9 %	100 %
Mixed/no opinion	6	16	22
	27.3 %	72.7 %	100 %
Disagree	6	19	25
	24.0 %	76.0 %	100 %

Note: Totals exclude 5 missing cases; **significant at $p<0.05$

Information was also obtained about routes of HIV transmission. A statement that needed to be answered by either agreeing, disagreeing or having mixed or no opinion was: "Only irresponsible or immoral people get AIDS; it cannot reach normal people who are careful." It is interesting to note that of those males who agreed to this statement, a small percentage of them (12.2 %) indicated that they are using condoms, while the rest of them (87.8 %) said that they are not using condoms. A similar pattern is evident with regards to those respondents who had mixed or no opinion. Of those males who disagreed to this statement, approximately one-fifth (21.7 %) of them mentioned that they are

currently using condoms. For females there was no statistically significant association.

Table 5: Responses to statement about only irresponsible/immoral people getting AIDS, by current condom use (n=536)

Statement	Currently using Condoms		Total
	Yes	No	
Male			
Agree	12.2 %**	87.8 %**	100 %**
Mixed/no opinion	30.4 %**	69.6 %**	100 %**
Disagree	21.7 %**	78.3 %**	100 %**
Female			
Agree	19.6 %	80.4 %	100 %
Mixed/no opinion	15.4 %	84.6 %	100 %
Disagree	23.6 %	76.4 %	100 %

Note: Totals exclude 7 missing cases; **significant at $p<0.05$

Overall, knowledge of condoms is high. This was clear with regards to the question about having ever heard of condoms. Most of the respondents in this study mentioned that they had heard about condoms. This is indicative of the fact that prevention programmes have been successful at raising awareness of condoms. It is understandable that those who had not heard of condoms would not be using them at present. It is very evident from the results obtained (not shown) that AIDS knowledge is universal. Most respondents had heard of AIDS, while only 0.4 percent of all respondents had not heard about AIDS. Furthermore, respondents were asked at what age they had first heard about AIDS. Most of the respondents had heard about condoms more than 5 years ago.

A subsequent statement that individuals had to respond to was whether they thought that using condoms was an effective way of preventing AIDS. Overall, 89.8 percent of all respondents agreed with this statement. This indicates that majority of respondents understand the effectiveness of condoms in terms of serving as a barrier against becoming infected with HIV. With regards to them putting their knowledge into practice, it can be seen from Table 6 below, that of those respondents who agreed that condoms are an effective way of preventing AIDS, 25.2 percent females reported they are currently using condoms.

Table 6: Responses to statement about condoms being an effective way of avoiding HIV/AIDS, by current condom use (n=518)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Agree	17.6 %	82.4 %	100 %
Mixed/no opinion	21.4 %	78.6 %	100 %
Disagree	0 %	100 %	100 %
Female			
Agree	25.2 %**	74.8 %**	100 %**
Mixed/no opinion	0 %**	100 %**	100%**
Disagree	15.4 %**	84.6 %**	100 %**

Note: Totals exclude 25 missing cases; **significant at p<0.05

5.3 Attitudes toward HIV/AIDS and condoms

The following statement was put forth to respondents: "If a wife/husband gets HIV or STD from outside the marriage, there is nothing the wife/husband can do to avoid getting infected herself/ himself." Here, quite a sizeable percentage of male and female respondents (42.9 % and 38.0 % respectively)

disagreed. However, 48.8 percent male and 48.6 percent female agreed. This shows that fatalistic attitudes are existent among some of the respondents in this sample. When looking at those that disagreed with the statement, approximately one-quarter (22.9 %) of males and 31.5 percent of females mentioned that they are using condoms. Of those respondents who agreed with the above statement, only 13.7 percent of males mentioned that they are currently using condoms, while 17.4 percent of females mentioned that they are using condoms. Of those respondents who had mixed or no opinion about the statement, only small numbers (1 male and 4 females) mentioned that they are currently using condoms.

Table 7: Responses to statement about partner not being able to do anything to avoid AIDS, by current condom use (n=538)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Agree	17**	107**	124**
	13.7 %	86.3 %	100 %
Mixed/no opinion	1**	20**	21**
	4.8 %	95.2 %	100 %
Disagree	25**	84**	109**
	22.9 %	77.1 %	100 %
Female			
Agree	24*	114*	138*
	17.4 %	82.6 %	100 %
Mixed/no opinion	4*	34*	38*
	10.5 %	89.5 %	100 %
Disagree	34*	74*	108*
	31.5 %	68.5	100 %

Note: Totals exclude 5 missing cases; **significant at p<0.05; *significant at p<0.01

Another statement that was analysed was: "There is not much use in trying to prevent AIDS: if you are going to get it, you will get it eventually no matter how you try." Here, over half of all respondents (62.7 % male and 58.7 % female) disagreed with the statement. On the other hand, quite a substantial percentage (31.4 % male and 33.6 % female) of all respondents agreed with this statement. These figures show that there is still a large percentage of males and females who feel that AIDS is not preventable in that they feel that there is nothing they can do to protect themselves against HIV infection. Similar percentages of male and female (5.9 % and 7.8 % respectively) had mixed or no opinions. Of those who disagreed with the above statement, only 16.9 percent males and 24.1 percent females mentioned that they are currently using condoms. Of those who agreed, 17.5 % males and 22.1 percent females indicated that they are currently using condoms. The low usage in this category is understandable and in line with what was expected. Of those who had mixed or no opinion, 13.3 percent males and 4.5 percent females indicated that they are currently using condoms.

Table 8: Responses to statement about there being no use in preventing AIDS, by current condom use (n=538)

Statement	Currently using Condoms		Total
	Yes	No	
Male			
Agree	14	66	80
	17.5 %	82.5 %	100 %
Mixed/no opinion	2	13	15
	13.3 %	86.7 %	100 %
Disagree	27	133	160
	16.9 %	83.1 %	100 %
Female			
Agree	21	74	95
	22.1	77.9 %	100 %
Mixed/no opinion	1	21	22
	4.5 %	95.5 %	100 %
Disagree	40	126	166
	24.1 %	75.9 %	100 %

Note: Totals exclude 5 missing cases

Another statement put forth was: "To protect themselves against HIV/AIDS or sexually transmitted infections, a married couple can use condoms every time they have sex." In total, more females (59.5 %) than males (40.9 %) agreed with the statement. This shows that women are more likely to agree that condoms can help against contracting HIV. Once again, this points to women viewing condoms as been positive and something that helps rather than hinders health. By looking at Table 9 below, it can be seen that of those who agreed, approximately one-quarter (26.9% males and 23.7 % females) of all respondents indicated that they are currently using condoms. Of those who had mixed or no

opinion, 15.4 percent males and 25.0 percent females stated that they are currently using condoms. Of those who disagreed with the statement, 8.9 percent males and 13.6 percent females mentioned that they are currently using condoms. This is an interesting point and will be explored in greater detail in the following chapter.

Table 9: Responses to statement about married couples and condom use, by current condom use (n=538)

Statement	Currently using Condoms		Total
	Yes	No	
Male			
Agree	28**	76**	104**
	26.9 %	73.1 %	100 %
Mixed/no opinion	4**	22**	26**
	15.4 %	84.6 %	100 %
Disagree	11**	113**	124**
	8.9 %	91.1 %	100 %
Female			
Agree	40	129	169
	23.7 %	76.3 %	100 %
Mixed/no opinion	14	42	56
	25.0 %	75.0 %	100 %
Disagree	8	51	59
	13.6 %	86.4 %	100 %

Note: Totals exclude 5 missing cases; **significant at p<0.05

The next statement was: "Condoms encourage promiscuous behaviour." Here 47.8 percent males and 35.3 percent females agreed whilst 31.5 percent males and 44.7 percent females disagreed. This suggests that many people

(especially males) still believe that condoms are synonymous with promiscuity. More males (47.8 %) than females (35.3 %) agree that condoms encourage promiscuous behaviour. Here, as is the case in other instances, where condoms are viewed negatively, these beliefs may serve as barriers to condom use. In terms of current condom use, it can be seen from Table 10 below that of those respondents who agreed that condoms encourage promiscuous behaviour, 9.2 percent males and 14.9 percent females are currently using condoms. Of those who disagreed with the statement, 29.1 percent males and 35.3 percent females mentioned that they are currently using condoms.

Table 10: Responses to statement about condoms indicating promiscuous behaviour, by current condom use (n=517)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Agree	9.2 %**	90.8 %**	100 %**
Mixed/no opinion	17.3 %**	82.7 %**	100 %**
Disagree	29.1 %**	70.9 %**	100 %**
Female			
Agree	14.9 %*	85.1 %*	100 %*
Mixed/no opinion	11.3 %*	88.7 %*	100 %*
Disagree	35.3 %*	64.7 %*	100 %*

Note: Totals exclude 26 missing cases; **significant at p<0.05; *significant at p<0.01

The next statement was: "The only reason to use a condom is because you don't trust your partner." Here 58.6 percent males and 63.8 percent females agreed to the above statement. On the other end, 26.9 percent males and 27.2 percent females disagreed with this statement. Hence, there is still a large number of people who view condom use as being synonymous with distrust. As

has, and still is the case in many parts of sub-Saharan Africa, norms/values/beliefs about HIV/AIDS are synonymous with distrust, promiscuity and the like. There have been studies done by Agha (2001), Lindan et al. (1991) and Temin et al. (1999) that support the above statement which have already been discussed in Chapter three. When looking at respondents who are currently using condoms, it can be seen from Table 11 below, that 34.3 percent of males who disagreed with the statement are currently using condoms while 34.2 percent of females who disagreed are currently using condoms. Of those who agreed with the statement, 11.0 percent males and 18.7 percent females indicated that they are currently using condoms.

Table 11: Responses to statement about condoms indicating distrust, by current condom use (n=517)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Agree	11.0 %*	89.0 %*	100 %*
Mixed/no opinion	8.3 %	91.7 %*	100 %*
Disagree	34.3 %*	65.7 %*	100 %*
Female			
Agree	18.7 %**	81.3 %**	100 %**
Mixed/no opinion	20.8 %**	79.2 %**	100 %**
Disagree	34.2 %**	65.8 %**	100 %**

Note: Totals exclude 26 missing cases; **significant at p<0.05; *significant at p<0.01

The following was asked of respondents: "Is it acceptable or unacceptable...For a married couple to use a condom?" Here, 53.4 percent female respondents and 41.0 percent male respondents agree that it is acceptable, while 49.4 percent males and 33.5 percent females say that it is

unacceptable. This shows that more females than males feel that it is acceptable for a married couple to use condoms. Of those who said that it was acceptable, 29.1 percent males and 30.3 percent females mentioned that they are currently using condoms while of those who said that it was unacceptable, 5.6 percent males and 7.9 percent females are currently using condoms. Of those who had mixed or no opinion, 25.0 percent males and 34.3 percent females are currently using condoms.

Table 12: Responses to statement about married couples and condom use, by current condom use (n=517)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Acceptable	30*	73*	103*
	29.1 %	70.9 %	100 %
Mixed/no opinion	6*	18*	24*
	25.0 %	75.0 %	100 %
Unacceptable	7*	117*	124*
	5.6 %	94.4 %	100 %
Female			
Acceptable	43*	99*	142*
	30.3 %	69.7 %	100 %
Mixed/no opinion	12*	23*	35*
	34.3 %	65.7 %	100 %
Unacceptable	7*	82*	89*
	7.9 %	92.1 %	100 %

Note: Totals exclude 26 missing cases; *significant at p<0.01

Respondents were asked about the use of condoms at the beginning of relationships, and were asked to say whether they think it is acceptable, unacceptable, or whether they have mixed or no opinion about it. In total (results not shown), 91.5 percent of all respondents stated that it was acceptable, while 2.7 percent said that it was unacceptable and 5.8 percent said that they had mixed or no opinion.

5.4 Perceived risk of HIV/AIDS

The following question was asked to respondents: "Before today, have you ever thought about your own chance of contracting HIV/AIDS?" Of all the respondents, 28.2 percent males and 60.1 percent females said that they have thought of their chance of contracting HIV/AIDS. Here, almost twice as many females said yes. Of those who said that they had thought of their chance of getting AIDS, only 16.7 percent males and 29.4 percent females indicated that they are currently using condoms. When looking at those who said that they had not thought of their chance of getting AIDS before today, 16.9 percent of the males and 10.6 percent or the females said that they are currently using condoms.

Table 13: Responses to the statement about having thought of chance of getting AIDS, by current condom use (n=538)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Yes	16.7 %	83.3 %	100 %
No	16.9 %	83.1 %	100 %
Female			
Yes	29.4 %*	70.6 %*	100%*
No	10.6 %*	89.4 %*	100 %*

Note: Totals exclude 5 missing cases; *significant at p<0.01

A question was asked: "Considering all things, do you consider your chance of getting HIV to be high, medium, low or no chance at all." 40 percent of males and 29.3 percent of females perceive themselves to have no chance at all of getting HIV. On the other end of the scale, 2.7 percent males and 11.7 percent females perceived themselves to be at high risk of getting HIV. As can be seen from Table 14 below, those who said that they perceived themselves to be at high risk of getting HIV, only about one-quarter (28.6 %) of males and 27.3 percent of females mentioned that they are currently using condoms. Of those who perceived themselves to be at medium risk, 20.7 males and 29.1 percent females are currently using condoms. 17.0 percent males and 19.8 percent of females who perceive themselves at low risk are currently using condoms, while 13.7 percent males and 14.5 percent females who perceive themselves at no risk are currently using condoms.

Table 14: Responses to question about perception of risk, by current condom use (n=538)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
High	28.6 %	71.4 %	100 %
Medium	20.7 %	79.3 %	100 %
Low	17.0 %	83.0 %	100 %
No chance at all	13.7 %	86.3 %	100
Female			
High	27.3 %	72.7 %	100 %
Medium	29.1 %	70.9 %	100 %
Low	19.8 %	80.2 %	100 %
No chance at all	14.5 %	85.5 %	100

Note: Totals exclude 5 missing cases

5.5 HIV testing

The following question was asked to respondents: "Have you ever talked with <partner> about getting a test for HIV/ AIDS?" There is a small variation in the responses from males and females. 52.2 percent males and 42.4 percent females indicated that they had discussed HIV tests with their partners, while 47.8 percent males and 57.6 percent females said that they had not. Of those who mentioned that they had spoken to their partner about getting a test for HIV, only 21.1 percent males and 30.0 percent females mentioned that they are currently using condoms, while, of those who said that they had not discussed getting a test, 12.3 percent males and 15.3 percent females are currently using condoms.

Table 15: Responses to statement about having talked with partner about getting a test for HIV, by current condom use (n=538)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Yes	28	105	133
	21.1 %	78.9 %	100 %
No	15	107	122
	12.3 %	87.7 %	100 %
Female			
Yes	36*	84*	120*
	30.0 %	70.0 %	100 %
No	25*	138*	163*
	15.3 %	84.7 %	100 %

Note: Totals exclude 5 missing cases; *significant at p<0.01

Another question asked in the questionnaire was: "Have you ever had a test for HIV/AIDS?" 28.9 percent males and 41.9 percent females said that they had had an HIV test while 71.1 percent males and 58.1 percent females said that they had not had an HIV test. More females than males said that they had been tested. Of those who said that they had had a test for HIV, only 24.3 percent of males and 31.1 percent of females mentioned that they are currently using condoms, while of those who mentioned that they had not had a test for HIV, 13.8 percent males and 15.2 percent females indicated that they are currently using condoms.

Table 16: Responses to question about having ever had a test for HIV, by current condom use (n=539)

Statement	**Currently using Condoms**		**Total**
	Yes	**No**	
Male			
Yes	24.3 %**	75.7 %**	100 %**
No	13.8 %**	86.2 %**	100 %**
Female			
Yes	31.1 %*	68.9 %*	100 %*
No	15.2 %*	84.8 %*	100 %*

Note: Totals exclude 4 missing cases; **significant at $p<0.05$, *significant at $p<0.01$

5.6 Multivariate Logistic Regression Model of current condom use

Table 17 below shows the frequencies of the variables used in the logistic regression. Table 18 shows the results of the multivariate logistic regression analysis that was carried out for this sample. Here, condom use is the dependent variable and the following independent variables were used in the regression: age of respondents; their residence, which is either urban or rural; their perception of risk of getting AIDS; whether it is acceptable for married

couples to use condoms; and finally; whether respondents agreed or not about the statement that there is nothing a partner can do to avoid becoming infected by his/her partner. The multivariate logistic regression model presents the odds ratio of current condom use for each category of a covariate, whilst holding all other covariates constant.

To begin with, the reference category here is the age interval 45 and over. This age group will be used as a means to compare the other age groups. As can be seen from Table 18 below, in the first age group (i.e 15-24), individuals are approximately 3 times more likely to use condoms as opposed to the reference category. Going on to age group 25-34, these individuals are approximately 5.9 times more likely to use condoms as opposed to the reference category. Respondents in age group 3 i.e. ages 35-44 are approximately 3.1 times more likely to use condoms. Discussion of these values will be done in the next chapter.

The next significant variable is residence. It can be clearly seen that urban residents are approximately 5 times more likely to use condoms than rural residents. Differences in perception of risk were also important and significant in explaining the use of condoms. Table 18 below shows that people who perceived themselves to be at high risk of getting HIV/AIDS were approximately 3.3 times more likely to use condoms. Those perceiving themselves at medium risk were approximately 3 times more likely to use condoms, while those perceiving themselves at low risk were approximately 1.5 times more likely to use condoms. Respondents who said that it was acceptable for a married couple to use a condom were approximately 2.4 times more likely to use condoms, while those who had mixed or no opinion were approximately 2.3 times more likely to use condoms. The last variable that was used in the logistic regression was opinion about there being nothing a person can do to protect themselves if their partner is infected with HIV. Here, people who agreed had odds ratio of 67, and

those who had mixed or no opinion had odds ratio of 77 less likely to report current condom use than those who disagreed (reference category).

Table 17: Frequencies of Variables Used in Logistic Regression (n=537)

Variable	Frequency	Percentage
Age Group		
15-24	42	8
25-34	201	37
35-44	236	44
>44	58	11
Residence		
Urban	280	52
Rural	257	48
Perception of Risk		
High	40	7
Medium	144	27
Low	169	32
No chance at all	184	34
Married couple - condom use		
Acceptable	274	51
Mixed/no opinion	82	15
Unacceptable	181	34
Nothing partner can do		
Agree	262	49
Mixed/no opinion	58	11
Disagree	217	40

Table 18: The Probability of Using a Condom (n=537)

Variable	Odds Ratio
Age Group	
15-24	3.070
25-34	5.895**
35-44	3.133
(>44)	1.0
Residence	
Urban	4.820*
(Rural)	1.0
Perception of risk	
High	3..343*
Medium	3.082*
Low	1.534
(No chance at all)	1.0
Married couple-condom use	
Acceptable	2.426**
Mixed/no opinion	2.285**
(Unacceptable)	1.0
Nothing partner can do	
Agree	0.328*
Mixed/no opinion	0.232*
(Disagree)	1.0

Note: Reference category in parenthesis. *Significant at $p<0.01$; **Significant at $p<0.05$

CHAPTER SIX: DISCUSSION

This chapter is made up of discussions of the results that were obtained in Chapter 5. At the outset, the socio-demographic characteristics of the sample are discussed. Thereafter, knowledge of HIV/AIDS and condoms are discussed. This is followed by a discussion of Attitudes toward HIV/AIDS and condoms and then Perceived risk of HIV/AIDS is discussed. HIV testing is then discussed, followed by protective behaviour. Finally, results of the multivariate logistic regression are discussed.

Even though knowledge about HIV/AIDS influences behaviour change, it is by no means the sole factor that is influential. People initially need to assess their own behaviour and establish whether they engage in sexual activity that puts them at risk of contracting HIV/AIDS. Thereafter, using their knowledge together with their personal risk assessment, people can make decisions regarding their behaviour and may or may not decide to change their behaviour.

As mentioned earlier, the analysis looked at married and cohabiting men and women only. Reason being is that there has not been much research done in this area. This analysis provides some useful insight into knowledge about HIV/AIDS, perceived risk awareness, and use of condoms in two sites in KZN: KwaDumisa and Ntuzuma.

6.1 Socio-demographic Characteristics of the Sample Used

The sample contained almost equal numbers of male and female respondents. The ages ranged between 15 and 55 years. There were also similar numbers of urban and rural respondents. Respondents in this sample were relatively well educated with almost all of them (except for the 10 missing cases) having had some level of schooling. There were almost equal percentages of people who were employed and unemployed. Looking at age of respondents, it was clear that age did not come up as been a factor that

contributed drastically to attitudes and perceptions around HIV/AIDS and condom use. It was clear that both at the beginning and at the end of the age range, respondents perceived themselves at about the same risk. So, in this analysis, age is seen as having very minimal influence.

In looking at education, it is evident that in the sample used in this analysis, three quarters of respondents had education levels higher than primary school. By looking at this sample, it is clear that we are dealing with a relatively educated sample. So, looking at the results we would expect that their education would play an integral part in them being rational individuals. However, the above does not hold true in its entirety in this instance. There is still, as indicated above, a significant number of individuals who have knowledge about HIV/AIDS and condoms but still do not behave the way they are supposed to i.e. they do not change their behaviour and practice safer sexual behaviours. So, it can be seen that education level is not a true, sole and accurate predictor of rational behaviour i.e. it does not mean that the higher the level of education, the more individuals will conform to the logic put forth in the theories. However, it needs to be borne in mind that surely it does affect, to a certain extent, the behaviour of some of the individuals but is not the sole predictor of behaviour change. So, it can be seen that the more educated people still do make incorrect and harmful choices. Hence, it can be seen that behaviour change is a multi-faceted response and is not only dependent on education and level of education.

Looking more in depth at the residency of the respondents, there appeared to be a variation in the number of respondents who use condoms by virtue of them living in a rural or an urban area. It was seen that those living in rural areas were less likely to use condoms as opposed to those living in urban areas. There could be a number of reasons for this. Maybe IEC programs are not reaching these rural areas, or there is insufficient condoms being supplied to them. Whatever the case may be, in response to this worsening epidemic, people need to start using condoms more. In the study done by Wilson et al.

(1991), it was observed that the second most consistent predictor of safer sexual behaviour was accessibility to health care/advice. Hence, in this case, to echo the above point, it can be suggested that the reason for people in rural areas to be less likely to use condoms could be as a result of knowledge and practice about condoms not being easily and readily accessible, or that condoms themselves are not readily available. Also, this is in line with what Akwara et al. (2001) pointed out in their article: they mentioned that people in remote areas i.e. rural areas might not know anything about HIV infection or the risks thereof as a result of public awareness campaigns not reaching them. So, in this study the above could be the reason why people in rural areas are using condoms much less as opposed to those living in urban areas.

When looking at occupation, it was seen that women who were employed used condoms more often than men who were employed. A similar pattern was observed between those men and women who were unemployed and self-employed. So the question then is why do women who are employed use condoms more than men who are employed do? It makes one wonder if perhaps employment here could include prostitution and the like, which then would force women, who are careful, to use condoms.

6.2 Knowledge of HIV/AIDS and Condoms

With regards to knowledge, it was seen that HIV/AIDS knowledge is universal. Every person knows about HIV/AIDS. Furthermore, majority of the respondents had heard about condoms. Majority of the respondents in this sample knew that AIDS was incurable. This could mean that IEC campaigns are successful in spreading the message about condoms. However, how successful are they in ensuring that people actually use them? When looking at the results, it is evident that even though people know that AIDS is preventable, they are not using condoms. It has been documented elsewhere (Fisher et al., 1992; Klepinger et al., 1993; Lagarde, et al., 1996; Mbizvo et al., 1997) that knowledge is not enough to make people practice safer sexual behaviours. Other factors

need to be taken into account when looking at knowledge and how it is translated into safer sexual behaviours. When looking at the gender differentials here, it is clear that women tend to agree more that AIDS is incurable, than men.

People in this study have universally heard of condoms. This indicates that IEC programs are reaching majority of the people that they are targeting. How much of information or knowledge that is disseminated is a separate issue and is beyond the scope of this study. Of those who have heard of condoms, not all of them use condoms. Furthermore, majority of respondents indicated correctly that condoms are an effective way of preventing AIDS. Hence, people in this study correctly identified that condoms are effective in preventing HIV/AIDS. This is in line with what was found in other studies (see Finer et al., 1999; Mayaud & McCormick, 2001; Temin et al., 1999). However, yet again, the same scenario exists as above about having heard of condoms i.e. majority of the respondents are not using condoms albeit knowing and believing that it is effective. However, it is an interesting point and a point worth exploring about the issue that surfaced in the results about disagreeing with the above statement. Of those women who disagreed, there is a significant number of them who mentioned that they are currently using condoms. This is not in line with them disagreeing, and one explanation of this is that the partner i.e. the male wants to use the condom and feels that it is effective and hence she is forced to "use" it.

It was seen at various points in the results that women tend to view condoms in a more positive light as opposed to men. However, by virtue of disagreeing that condoms are synonymous with irresponsibility or immorality, does not increase condom use. It can be predicted with 95 percent confidence that majority of men who disagree with the statement about condoms being associated with irresponsibility or immorality, will not use condoms. The above is in line with what Agha (2001) mentioned with regards to condoms being synonymous with immoral sexual behaviour.

6.3 Attitudes toward HIV/AIDS and condoms

In many parts of sub-Saharan Africa, there exist pluralistic and fatalistic attitudes towards death (Akwara et al., 2001; Donovan & Ross, 2000; Joseph et al., 1987). Almost one third of the people in this study agreed that there is no use in preventing HIV/AIDS "since you will get it no matter how you try" (as per survey question). This suggests that educational campaigns such as media campaigns have not reached all the people in sub-Saharan Africa or have not been understood in its entirety. Whatever the case may be, this apparent "lack" of information needs to be translated into campaigns to help educate the uninformed about this deadly virus that has claimed millions of lives. Hence, education can be seen as a form of primary prevention mechanism to educate the population about HIV/AIDS, it's transmission, preventive behaviour with regards to it, mechanisms to stabilise infection and the like.

Fatalistic attitudes were evident when looking at the results in this study, especially with regards to responses to the statement about there being nothing a person can do to protect himself/herself if his/her partner is infected with HIV; and you will get AIDS no matter how hard you try since it is inevitable. Some of the respondents agreed that there was nothing he/she could do to protect himself/herself from becoming infected with HIV if his/her partner was infected. 87 percent of men and 83 per cent of women were not currently using condoms. Another instance where fatalistic attitudes are confirmed to be in existence in this study is when responses to the statement about there being no use in trying to prevent AIDS since you will get it no matter what you do, were analysed. Here, more than half of the respondents agreed with this statement. This creates concern since, if people believe that they are going to die no matter what they do, they will not think twice about promiscuity and the like. This then becomes a dangerous situation and the risk of infection is drastically increased. If all people felt this way, all people will be infected in a matter of a few months let alone years.

The above is in line with the literature discussed in Chapter three. Various studies (Akwara et al., 2001; Donovan & Ross, 2000; Joseph et al., 1987; Temin et al., 1999) point out that the above is as has been found in other studies where mention was made about fatalistic attitudes and their effect on condom use. Hence, the results obtained in this study confirm what has already been found with regards to fatalistic attitudes and condom use.

The responses to the statement regarding married couples and condom use was analysed and once again, there was the surfacing of gender differentials. More women than men said that it was acceptable for a married couple to use a condom in order to protect themselves against HIV/AIDS. Of those people who said that it was not acceptable, there was still a significant proportion of women who said that they were currently using condoms. The reasons for this could be that her partner does not share her belief in the acceptability of condoms within marriage; or he has his own reasons for using a condom. He might want to use a condom to protect himself from her or to protect her from himself. The woman might feel that it is not acceptable to use condoms in a marriage since if she wanted to use it, it would appear as if she was being unfaithful to her husband or she might be infected. So, to guard against any half-truths, she would rather find it unacceptable to use condoms in a marriage. With regards to men in this study, of those who agree that a couple can use a condom to prevent HIV infection, approximately 27 percent would actually use it.

In addition to the above, over half of the females indicated that they felt that it was acceptable for a married couple to use a condom. Fewer males felt that it was acceptable. Hence, more females than males said that it was acceptable for a married couple to use a condom. However, this does not translate into use. Once again, people feel something, but their behaviour is not consistent with the way they feel. Many studies, (Agha, 2001; Lindan et al., 1991; Mbizvo et al., 1997) have pointed out that what women need to do is to improve their negotiating skills when it comes to negotiation of condom use.

With regards to gender differentials, it has been documented elsewhere (Akwara et al., 2001; Gage & Njogu, 1996; Geringer et al., 1993; Ingham & Van Zessen, 1992; Macphail & Campbell, 2001) that as a result of socio-cultural factors, women are made to believe that they should be subordinate. By virtue of them being subordinate, they feel that to ask to use condoms (or any other method) is beyond their control.

About condoms and promiscuity, it was observed that almost half of the men agreed that condoms translate to promiscuity. When looking at the women, quite a substantial number of them as well agree that condoms equal promiscuity. Of those who agreed, a small number of them mention that they are currently using condoms. This is an interesting point to note, since if they believe that condoms are synonymous with promiscuity, they ought not to be using them, but they do. This suggests that they could see themselves as being promiscuous, or they could be forced to "use" condoms by their partner.

In addition to the above, it was observed, by looking at the results, that more than half of all respondents agreed that condoms were synonymous with distrust. This was expected since this had been documented elsewhere (Agha, 2001; Leclerc-Mdalala, 1997; Lindan et al., 1991; Temin et al., 1999; Whiteside, 1990). However, of those who agreed that condoms are used because you do not trust your partner, there is still a significant number of both men and women who are currently using condoms. Here, with regards to men and power differentials, it can be understood why they say one thing and do another i.e. they agree that condoms and distrust are synonymous yet they use condoms anyway. This could be because he knows that he is unfaithful and hence he will want to use a condom. With regards to women, the issue of power differentials still stands, where as above, she agreed that condoms are synonymous with distrust yet she mentions that she uses them. Maybe she is forced to use them by her partner and hence she mentions using them. We can predict with 99 percent confidence that of those men who agree to the above, approximately 90 percent

of them will not use condoms. With regards to women, it can be predicted, with 95 percent confidence, that of those who disagree with the above statement, almost three-quarters of them will not use condoms. Hence, it can be seen that there exist inconsistencies with regards to belief and practice (as outlined in the literature in chapter three). Furthermore, with regards to trust, it was found that as trust in a relationship increases, condom use decreases (Fapohunda & Rutenberg, 1999; Geringer et al., 1993; Ingham & Van Zessen, 1992; MacPhail & Campbell, 2001).

Apart from distrust, there are other reasons why condoms may not be used. The two most important ones are: condoms are seen as a means to decrease the enjoyment of the act of sex, and also that they dangerous (Agha, 2001; Boulos et al., 1991; Geringer et al., 1993; Kelly & Parker, 2000; Leclerc-Madlala, 1997; Lindan et al., 1991; Temin et al., 1999).

6.4 Perceived risk of HIV/AIDS

More women than men mentioned that they had thought about their chance of getting HIV/AIDS. In this study, women have a legitimate reason for having thought about their chance of getting HIV/AIDS. As has been pointed out in the literature, for men to have multiple partners is tolerated, although not acceptable, but for a woman it is not (Fapohunda & Rutenberg, 1999; Ingham & Van Zessen, 1992; Mbizvo et al., 1997). Hence, by virtue of the above, women know or suspect that their partners are, or may, have other partners and hence this could have made them think about their chance of getting the virus. An interesting point to highlight here is that some people who said that they had not thought about getting the virus, actually mention that they use condoms. This could be explained by the fact that condoms have a dual purpose i.e. to prevent against STIs (including HIV) and to prevent against pregnancy. Hence, those people who had not thought of their chance of getting HIV/AIDS might be using condoms to guard against pregnancy. With regards to women, it can be

predicted with 99 percent confidence, that approximately 10 percent of them who have not thought about getting HIV/AIDS will use condoms.

There are a small number of men and women who perceive themselves to be at high risk of getting HIV. Of these people, a small number of them are actually using condoms. This is not what is expected. Echoing Joseph et al. (1987), it was also found here, that people at high risk of getting HIV are generally less likely to practice safer sexual behaviour to try to reduce their risk. The higher the perception, the more reason a person has to be using condoms, however, in this case, this does not happen. This is not consistent with the literature presented in Chapter two i.e. people, after knowing about HIV/AIDS and condoms, are expected to use them (condoms). The ideal situation would be that people who perceive themselves to be at risk of getting HIV/AIDS should protect themselves. However, this is not happening and hence these findings are inconsistent with the literature. Baume (2000) highlights why these inconsistencies could be present with regards to condom use and perceived risk. She points out that an important reason is that measures of perceived risk do not consider the fact that perception of risk is both a "cause" and an "effect" of condom use. Hence, a person may interpret a question on perceived risk in various ways (Baume, 2000). She goes on to speak about the fact that measures used in measuring perceived risk are vague and hence could be interpreted from two or more vantage points. Hence, as a result of this study being cross-sectional and quantitative, it is not possible to identify which is the cause and which is the effect in this case. However, Baume (2000) points out that for most correlations, the direction of the relationship is the same regardless of which variable is actually the cause and which variable is the effect.

Individuals were asked if they had discussed having an HIV test with their partner. Almost half of all respondents indicated that they had spoken to their partners about getting HIV tests. Of those who indicated that they had spoken to their partner, a small number of them are currently using condoms. One

apparent reason for not discussing HIV tests with partners is because by bringing it up it could translate into the partner concluding that he/she has been promiscuous or has the virus. It could also mean that the person does not trust his/her partner. With regards to women, it can be predicted, with 99 percent confidence, that of those who said that they had spoken to their partner, at least one third of them will be using condoms. This is an interesting point since, of those people who had spoken to their partners, majority of them are not using condoms. So, it may be safe to say that those people are at risk, since, why would they want to discuss getting an HIV test if they are not worried about their risk of getting HIV. And if they are worried, why not use condoms? Once again, power differentials could come into play here as well as existing attitudes, norms and values with regards to condoms and condom use. Tweedie (1995) mentions that people need to increase interpersonal discussions about HIV/AIDS. This includes HIV testing as well. If this is done, people will feel free to speak their mind and will surely be able to negotiate safer sex and even HIV testing if need be, or if he/she feels that they ought to have one (test).

It needs to be borne in mind that in this country (and in particular in these two sites), the norms, values and attitudes towards sex and condom use has not changed drastically, and negativities about condoms still exist i.e. condoms are still viewed as being taboo in most places along with them (condoms) being associated with promiscuity, distrust, being dangerous and the like (Agha, 2001; Kelly & Parker, 2000; Rutenberg et al., 2001). Hence, it is understandable why people mentioned that they had not discussed getting an HIV test with their partner.

6.5 Protective Behaviour

A measure of protective behaviour is whether a person has had a test for HIV. Here, as has been pointed out by the results, more women than men indicated that they had had tests for HIV. The reason for this could be that they are the ones going to antenatal clinics where they are encouraged to undergo

tests for HIV. However, even though they might have had a test for HIV, they might not know their status because most of them do not go back for their results or sometimes, the results are lost or something just goes wrong and hence the person's status cannot, or is not revealed to her. Hence, it is understandable why more women than men say that they have had a test for HIV. One possible reason for them using condoms after being tested is maybe they are HIV positive and hence do not want to spread the infection to their partner.

6.6 Discussion of the Multivariate Logistic Regression Model of current condom use

A model of the variables was created using the logistic regression. What was seen from performing the logistic regression is the following. Firstly, in terms of ages, in the age group 15-24, people are approximately 3 times more likely to use condoms than those who are 45 years and over i.e. the reference category. However, this value is not significant and this can be explained by people in this age group being at their prime with regards to childbearing and hence, will not want to use condoms as they serve as a barrier to pregnancy. In the following age group, it was seen that people here are approximately 6 times more likely to use condoms than the reference category. This result is significant and this significance can be explained by virtue of people in this age group having probably had children and would now want to space and/or limit their pregnancies (or their wives pregnancies). With regards to the final age group, people here are approximately 3 times more likely to use condoms. However, this result is not significant and can be explained as follows: people in this age group are older now and hence the number of sexual encounters decreases and their ability and/or willingness to have children is low. Hence, by virtue of the above, it can be seen that these individuals will not use condoms as much as those in the previous age group.

What came up as a very significant predictor of condom use in this study was residence i.e. whether the person lived in a rural or an urban area. It was

seen that people living in urban areas were approximately 5 times more likely to use condoms than those people living in rural areas. This result is significant. The reasons for this result being significant could be: maybe the IEC programs in urban areas are more effective since the roads etc. are more accessible to people; also, there may be more IEC programs in urban areas rather than in rural areas; more women in urban areas go to antenatal clinics since they are more accessible to them and hence they are more knowledgeable or have had access to more information than women in rural areas (Akwara et al., 2001; Wilson et al., 1991). Hence, in this study, living in a rural or urban area affects condom use quite substantially.

There were differences with regards to peoples' perceptions of their risk of getting AIDS. This variable (perception of risk) was a significant predictor of condom use. Reason being is that if people perceive themselves to be at risk, they will change their behaviour to alleviate or minimise that risk (Baume, 2000; FHI, 1996; Health knowledge; Pitts et al., 1991; Wilson et al., 1991). Hence, in this case, people perceive themselves to be at risk and hence use condoms (protective behaviour).

Furthermore, those people who had said that it was acceptable for a married couple to use condoms, were 2.4 times more likely to use condoms than those who said that it was unacceptable for a married couple to use condoms. The result obtained here is significant and this significance is to be expected since if they feel that it is acceptable, then they ought to be using it to guard against infection (either HIV or other STIs). Hence, it can be expected that the more people who find condom use within marriage to be acceptable, the more they will use them (condoms). Here, it can be seen that this is in line with the theories put forth in chapter two: people, by having positive feelings toward performing a certain behaviour i.e. condom use, they will practice it (condom use) (FHI, 1996).

Finally, the statement about nothing a partner can do to protect himself/herself from getting infected from his/her partner was used in the logistic regression model. These results are significant and this is to be expected, since by people believing a statement like the above, they are forming a barrier to condom use. Hence, the above show that in this study, condom use is affected significantly by the variables outlined above. According to the various theories/models put forth in Chapter two, if a person feels or believes that something, then he/she will act on this belief. So, in the above statement, people who agreed are those who would not use condoms as a result of their belief that they (condoms) will not guard against infection since, according to their belief, there is nothing one can do to protect oneself against infection.

6.7 Conclusion

The results that are evident from this analysis provide limited support for the theoretical framework discussed in Chapter two. The general outline of the theoretical framework put forth in Chapter two is: the higher the perceived risk, the more likely it will be for people to practice protective behaviour. Furthermore, the more knowledge or positive attitudes that people have regarding condoms, HIV/AIDS and condom use, the more likely they are to use condoms (Baume, 2000; Catania et al., 1990; FHI, 1996; Healthknowledge, 2002; Janz & Becker, 1984; Lindan et al., 1991; Pitts et al., 1991; Wilson et al., 1991).

The results presented in this analysis support, to a certain extent, the theoretical framework presented in Chapter two i.e. if people have knowledge about HIV/AIDS and condoms, if they believe that they are at risk of getting HIV/AIDS and if they feel that condoms are effective and view them positively, they will practice safer sexual behaviour i.e. they will use condoms (Baume, 2000; Catania et al., 1990; FHI, 1996; Healthknowledge, 2002; Janz & Becker, 1984; Lindan et al., 1991; Pitts et al., 1991; Wilson et al., 1991). A large percentage of respondents mentioned that they have heard about HIV/AIDS and condoms while there is a small number of respondents who mentioned that they

have used condoms. However, there still exists a significant minority of respondents who mention that they have not heard about condoms and still a larger proportion who mention that they have not used condoms ever. This creates concern for researchers and government alike. Why are these people not practising safe sex? It is understood that HIV/AIDS knowledge is universal and hence it can be assumed that they know about HIV/AIDS, so why are they not adhering to the warnings out there? As mentioned above, a separate and more comprehensive study needs to be conducted with regards to why knowledge does not translate into safer sexual behaviour.

CHAPTER SEVEN: CONCLUSION

Efforts have, and continue to be made to find a cure and a vaccine for this killer disease. But, sadly the attempts to date have been to no avail. So, it seems that an effective vaccine is still far away from being discovered and a cure the same as well. Harrison et al. (2000) say that in light of the above, the only available "treatment" for this virus is for people to change their behaviour in order to limit the spread of the virus. Worldwide, people are increasingly being made aware of the virus, for example ways that it can be contracted, use of protective behaviour and the like; by using information, education and communication (IEC) programs with regards to HIV/AIDS. In South Africa, there have been major public education campaigns going on to help with curbing the incidence of HIV/AIDS and help to reduce new infections. Examples of these include Lovelife, Soul City and the AIDS Train.

In sum, the results presented in this study provide limited support for the framework discussed in Chapter two, which posits that individuals, upon knowing about HIV/AIDS and its risks, and perceiving themselves to be at risk, would change their behaviour and practice safer sexual behaviour. It was seen that knowledge about HIV/AIDS and condoms are universal, however, people perceiving themselves to be at risk are not practising safer sexual behaviours i.e. they are not using condoms.

As has been pointed out earlier by Weisman et al. (1989) in Chapter three, the use of condoms requires two sets of skills: technical and social skills. So, individuals need to be taught how to increase or obtain the abovementioned skills and by doing this, they will be able to protect themselves and others. So, education can be viewed as been a primary means of promoting safer sexual behaviour in order to prevent the spread of the virus.

7.1 Summary

This dissertation aimed to look at knowledge, risk perception and condom use among married men and women in two sites in KZN. What was evident was that respondents had knowledge about HIV/AIDS and, as expected, knowledge of condoms was high. Some respondents also mentioned that they had been for HIV tests and had spoken to their partners about it. A substantial number of people perceived themselves to be at risk of contracting HIV/AIDS, yet, when asked if they had ever used condoms, majority of them said that they had never used condoms.

It is interesting then to note, in light of the above, that there are people who know quite a bit about HIV/AIDS, and then we get people who say they have never heard of condoms. It is interesting to find out how people in these areas came to know about it and how some of them did not. What does this say about current IEC programs. Are they reaching all people? Clearly they are not.

However, in the midst of all the knowledge and perceptions that are prevalent, there still exist misconceptions about HIV/AIDS such as only immoral or irresponsible people get AIDS, there is nothing a partner can do to avoid getting AIDS from his/her partner, and the major misconception that condoms are dangerous. In light of the above, it can be seen that misconceptions are alive and well in this sample and something needs to be done to eradicate them.

In looking to see whether the objectives of this study have been met, firstly, knowledge about HIV/AIDS was established and it was seen that respondents are, to a certain extent, knowledgeable about HIV/AIDS and condom use. However, there is still a sizeable proportion (almost half) of respondents who claim that if your partner is infected there is nothing you can do to protect yourself; and a relatively large number of respondents (almost half) agreed that only irresponsible/immoral people get AIDS. The above point to the fact that even though there are people who are knowledgeable about HIV/AIDS,

condoms, condom use and the like, there are still those individuals who are ignorant about the above. Perhaps these individuals, as a result of their ignorance, will continue in the manner that they are with regards to their sexual behaviour and hence, fall prey to infections and subsequently be the ones to transmit the infection to others. It needs to be borne in mind that even if as little as four percent of the population have not yet heard about condoms, shows that this could be problematic. Hence, it is imperative that education and media campaigns continue with their programs, for example their IEC programs, to further increase awareness about HIV/AIDS.

Secondly, the perceptions and attitudes of respondents were analysed and it is evident that there still are large numbers of individuals who are not fully aware or do not understand fully how the virus works, how to protect themselves against it, as well as there still is a large number of people who still associate condoms with promiscuity, immorality and the like. There also exist fatalistic attitudes with regards to prevention of becoming infected with the virus. Almost one-third of respondents believe that becoming infected with HIV is inevitable. This is extremely worrying since these individuals feel that there is no use preventing HIV/AIDS. This may lead to extremely large numbers of individuals becoming infected as a result of not practising safe sexual behaviours. This can add to the already towering number of individuals who are living with the virus or who are dead. There is quite a sizeable proportion of respondents who perceive themselves to be at risk of getting HIV. Hence, it needs to be seen what these individuals are doing that makes them perceive themselves to be at high or medium risk of contracting the virus. It is clearly evident then that these people are surely engaging in risky sexual behaviour. The consequences of their actions need to be pointed out to them (if they have not been already) and where possible, alternatives should be provided, for example, provision of free condoms as is the case nowadays.

Thirdly, an attempt was made to find out if people who perceive themselves to be at risk are using condoms. The somewhat high level of reported risk perception (approximately one-third) might indicate that awareness exists with regards to risky sexual practices. Once again, knowledge about the destructive nature of HIV/AIDS exists and its transmission methods are known but people still refuse to do something about it. This previous statement is made in light of evidence that came up during the analysis of this study where it was seen that of the approximately one third respondents who indicated that they perceived themselves to be at high risk of getting HIV, only about 20 percent indicated that they had ever used condoms. So, by virtue of perceiving high risk, people ought to be extra careful and do whatever it takes to reduce their chance of getting the virus. The above is an ideal situation, and according to the theories, it is what should be happening. But, in reality it does not happen as predicted by the theories, and we are left with a significant number of people who are endangering their lives and increasing their chances of getting the virus and infecting others as well. So, what needs to be seen is why this is happening. Why are people not protecting themselves knowing full well what HIV can do to them? To answer the above question is beyond the scope of this study, but will indeed be something for future researchers in this field to look at.

Finally, the use of condoms was viewed and it was found that almost one quarter of all respondents indicated that they had used a condom. This is encouraging to look at in light of trends, mainly in African communities in KZN, of not using condoms because it is believed that it is evil, distasteful, encourages promiscuity and it is unnatural (Agha, 2001; Leclerc-Madlala, 1997; Lindan et al., 1991; Mbizvo et al., 1997; Temin et al., 1999). What needs to be done is we need to continue to run IEC programs and probably all people will recognise the importance and the necessity of condom use and hence will use them. Until that time, we need to make an earnest effort to help with the above mentioned programs so that more people will not be infected as a result of irresponsible or ignorant behaviours by their partners.

There are several findings in this study that are encouraging with regards to future prospects in controlling the epidemic. They include: the level of knowledge about HIV/AIDS and condom use is relatively high; over half of all respondents had spoken to their partner about using condoms; almost half indicated that they had spoken to their partner about getting an HIV test; and majority correctly identified that condoms were an effective way of protection against becoming infected with HIV. The above can be viewed as promising for the future and by encouraging and increasingly making people aware of the dangers of unsafe sexual practices and the protective measures that are available, there is no doubt that infection rates will decrease, as has been the case in so many parts of the world. However, this calls for government, NGO's, churches, youth groups, political parties and the like to pool their resources together and help to fight this vicious infection until a cure is available. However, the downside to this is that almost three quarters of all respondents said that they had never used a condom. This certainly may be cause for concern. However, as mentioned earlier, this study looked at married and cohabiting people only, and hence, the expectation is that condom use would be low. Furthermore, they could be using other preventive measures apart from condom use. However, in this era with HIV/AIDS being so rife, deadly and the like, surely individuals should take more responsibility and change their behaviour i.e. practice safer sex. However, once again, by virtue of results obtained, we see this as been untrue.

The major findings of this study are as follows: (i) both men and women of all ages are knowledgeable about HIV/AIDS and condoms as well as condom use; (ii) more women perceive themselves to be at risk than do men; (iii) women view condoms in a more positive light as opposed to men; and (iv) respondents indicated knowledge and risk perception but majority of them were not practising safer sexual behaviour.

As has been pointed out by Campbell and Mzaidume (2002), the participation of local community members in HIV prevention worldwide is a key

element. What is needed is for HIV prevention to be treated as a social issue as opposed to a biomedical one. Abdool Karim (2000) says that the greatest challenge that faces this country in terms of defeating this deadly virus is to act with common purpose. Hence, government, political parties, youth groups, churches, religious organisations and the like need to pool their resources and help fight this deadly pandemic. It has been pointed out (Sutton cited in Herlitz, 1992) that what is needed to reduce sexual risk behaviour related to AIDS is instilling fear of AIDS into populations and/or to change community norms, values and standards with regards to sexuality. But how does one go about changing these social norms, values and standards, or can they actually be changed. Since it is clearly known that social norms and values are embedded into people from the time they are born, it makes one wonder whether it will ever be possible for them to be changed. But this is beyond the scope of this study.

7.2 Recommendations

The findings in this study have implications both for researchers and program planners. These findings can help to target more effective IEC programs and education campaigns with regards to condom use, perceptions and the risk of contracting HIV/AIDS. Furthermore, increased effort needs to be put into implementing sustainable control measures as opposed to merely raising awareness. With regards to the survey questionnaire itself, it could be helpful if more open-ended questions were asked since this gives more depth to answers, and can also be used to verify some of the close-ended questions.

Macphail and Campbell (2001) point out that as a result of the existing inadequacies in our knowledge, we fail to understand what the driving force is behind increasingly high numbers of younger people becoming infected with the virus. Hence, what is needed is knowledge which will help us better understand the factors that help and hinder existing programs that are in place at present, and could also lead to the formulation of better, more effective programs.

Clearly, the existing IEC campaigns are reaching a substantial number of people, however, people who are not being reached need to be taken into consideration and more effective campaigns need to be put into place, as well as increased geographical cover of all areas. Furthermore, it is quite apparent that knowledge of HIV/AIDS and knowledge on risk reduction does not always translate into behaviour change or the adoption of safer sexual behaviour. As Crewe (2002) points out, what is needed is more talk about sex and sexual behaviours, which is lacking in many parts of sub-Saharan Africa, even today. Hence, what is needed is a multi-faceted approach, which looks more in-depth at changing social norms and increasing social support for condom use, as well as by using strategies aimed at changing negative attitudes towards condoms.

The above findings need to be taken into consideration when designing policies and programs to encourage condom use. Particular attention needs to be given to condom use within marriage, as well as condom use in rural areas. Policies need to be put into place that make certain that rural residents receive the proper care, attention, counselling, information and the like regarding sexual behaviour, risks and protective interventions. These results also underscore the need to challenge the prevailing gendered power differentials that facilitate the rampant occurrence of subordinate behaviour among women, to the extent that they would risk their lives rather than display insubordination. Furthermore, policy and programs need a concerted approach in reducing HIV infection both in rural and urban areas, including both people within marriage as well as out of marriage.

Finally, a possible avenue of research for future researchers is to look at why people are not protecting themselves knowing full well what HIV can do to them.

REFERENCES

Abdool Karim, S.S.(2000). Rising to the Challenge of the Aids Epidemic. *Journal of Science*.96:262.

Agha,S.(2001). *The Impact of the Kenya Social Marketing Program on Personal Risk Perception, Perceived Self-efficacy and on other Behavioural Predictors.* PSI Research Division, Working Paper NO.45.

Akwara, P.A., Diamond, I. and Madise, N.(2001). *Perception of Risk of HIV/AIDS and Sexual Behavioour: Is there a causal link?* Southampton: Department of Social Statistics-University of Southampton.

Baume, C.A.(2000). The Relationship of Perceived Risk to Condom Use: Why Results are Inconsistent. *Social Marketing Quarterly.* 6(1):33-45.

Bauni, E.K., Preston-Whyte, E., Riwa, P., Neema, S., Mushingeh, A.C.S. and Muhwava, W.(1997). Family Planning and sexual behaviour in the era of HIV/STDs: a multi-country study. *Social Science Research on Reproductive Health*.

Beyth-Marom, R., Austin, L., Fischhoff, B., Palmgren, C. and Jacobs-Quadrel, M.(1993). Perceived Consequences of Risky Behaviours: Adults and Adolescents. *Developmental Psychology.* 29(3):549-563.

Boulos, M.L., Boulos, R. and Nichols, D.J.(1991). Perceptions and Practices Relating to Condom Use among Urban Men in Haiti. *Studies in Family Planning*.22(5):318-325.

Caldwell, J.C.(1997). The impact of the African AIDS epidemic. *Health Transitions Review.* 7(2):169-188.

Campbell, C.(2002). How can HIV be prevented in South Africa? A Social perspective. *British Medical Journal.* 324:229-232.

Catania, J.A., Kegeles, S.M. and Coates, T.J.(1990). Toward an understanding of risk behaviour: An AIDS risk reduction model (ARRM). *Health Education Quarterly.* 17: 53-72.

Crewe, M.(2002). AIDS in Southern Africa. *Postgraduate Medical Journal.* 78(917):127-128.

Crosby, R.A., Yarber, W.L., DiClemente, R.J., Wingood, G.M. and Meyerson, B. (2002). HIV-Associated Histories, Perceptions, and Practices Among Low-Income African American Women: Does Rural Residence Matter? *American Journal of Public Health.* 92(4):655-658.

Department of Health.(2000). *National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa 2000.*

http://www.doh.gov.za/facts/index.html

Department of Health.(2000). *The HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (HIVSP).* Pretoria.

Donovan, B. and Ross, M.W.(2000). Preventing HIV: determinants of sexual behaviour. *The Lancet.* 355:1897-1901.

Family Health International.(1996). Behaviour Change -- A Summary of Four Major Theories.

http://www.fhi.org/en/aids/aidscap/aidspubs/ behres/bcr4theo.html

Fapohunda, B.M. and Rutenberg, N.(1999). *Expanding men's Participation in Reproductive Health in Kenya, Nairobi.* Kenya:African Population Policy Research Center. http://popcouncil.org/pdfs/aor/ken15.pdf

Finer, L.B., Darroch, J.E. and Singh, S.(1999). Sexual Partnership Patterns as a Behavioral Risk Factor For Sexually Transmitted Diseases. *Family Planning Perspectives.* 31(5): 228-236.

Fisher, J.D., Misovich, S.J. and Fisher, W.A.(1992). Impact of Perceived Social Norms on Adolscents' AIDS-Risk Behavior and Prevention. In R.DiClemente, *Adolescents and AIDS: A generation in jeopardy* (pp. 117-136). Newbury Park: Sage.

Gage A.J. and Njogu, W.(1996). *Gender inequalities and Demographic Behaviour: Ghana and Kenya.* The Population Council: New York.

Geringer, W.M., Marks, S., Allen, W.J. and Armstrong, K.A.(1993). Knowledge, Attitudes, and Behavior Related to Condom Use and STDs in a High Risk Population. *The Journal of Sex Research*, 30(1):75-83.

Gow, J. and Desmond, C.(2002). *Impacts and Interventions. The HIV/AIDS Epidemic and the children of South Africa*. Pietermaritzburg: University of Natal Press.

Harrison, A., Smit, J.A. and Myer, L.(2000). Prevention of HIV/AIDS in South Africa: a review of behaviour change interventions, evidence and options for the future.*Journal of Science*. 96:285-290.

Healthknowledge. (2002).

http://www.healthknowledge.org.uk/knowledgebase/Part1/Health_Promotion3_models.htm

Herlitz, C.(1992). Condom use due to the risk of AIDS. *Scandanavian Journal of Social Medicine*. 20(2):102-109.

Hulton, L.A., Cullen, R. and Khalokho, S.W.(2000). Perceptions of the Risks of Sexual Activity and Their Consequences among Ugandan Adolescents. *Studies in Family Planning*.31(1):35-46.

Human Sciences Research Council (HSRC).(2002). *Nelson Mandela/HSRC Study of HIV/AIDS Household Survey 2002.*

http://www.hsrcpublishers.co.za/hiv.html

Ingham, R. and van Zessen, G.(1992). Towards an alternative model of sexual behaviour: from individual properties to interactional processes. Chapter prepared for *New Conceptual perspectives for understanding sexual behaviour and the risk of HIV infection*. EC concerted action on sexual behaviour and the risks of HIV infection.

Janz, N.K., and Becker, M.H.(1984). The Health Belief Model: A decade later. *Health Education Quarterly*. 11(1):1-47

Joseph, J.G., Montgomery, S.B., Emmons, C., Kirscht, J.P., Kessler, R.C., Ostrow, D.G., Wortman, C.B. and O'Brien, K.(1987). Perceived Risk of AIDS: Assessing the Behavioral and Psychological Consequences in a Cohort of Gay Men. *Journal of Applied Psychology.* 17(3):231-250.

Kelly, K. and Parker, W.(2000). *Communities of Practice. Contextual mediators of youth response to HIV/AIDS*. Sentinel Site Monitoring And Evaluation Project.

Kengeya-Kayondo, J.F., Carpenter, L.M., Kintu, P.M., Nabaitu, J., Pool, R. and Whitworth, A.G.(1999). Risk Perception and HIV-1 prevalence in 15000 adults in rural south-west Uganda. *AIDS*. 13(16):2295-2302.

Kengeya-Kayondo, J.F.(1996). Strategies for HIV/AIDS control in Adults in sub-Saharan Africa. *Journal of Epidemiology*. 6:S121-S123.

Kenyon,C., Heywood,M. and Conway, S.(2001). *South African Health Review 2001*. Durban: The Press Gang. http://www.hst.org.za/sahr/2001/chapter9.htm

Klepinger, D.H., Billy, J.O.G., Tanfer, K. and Grady, W.R.(1993). Perceptions of AIDS Risk and Severity and Their Association with Risk-Related Behavior among U.S. Men. *Family Planning Perspectives*.25(2):74-82.

KZN Health.(2002). *Report on the global HIV/AIDS epidemic - June 2000.* www.kznhealth.gov.za/aids%strat.pdf

Lagarde, E., Pison, G. and Enel, C.(1996). Knowledge, attitudes and perception of AIDS in rural Senegal: relationship to sexual behaviour and behaviour change. *AIDS*. 10(3):327-334.

Leclerc-Madlala, S.(1997). Infect One, Infect All: Zulu Youth Response to the AIDS Epidemic in South Africa. *Medical Anthropology*. 17:363-380.

Lindan, C., Allen, S., Carael, M., Nsengumuremyi, F., Van de Perre, P., Serufilira, A., Tice, J., Black, D., Coates, T. and Hulley, S.(1991). Knowledge, attitudes, and perceived risk of AIDS among urban Rwandan women: relationship to HIV infection and behaviour change. *AIDS*. 5(8):993-1002).

Lovelife, 2001. *Impending Catastrophe Revisited. An update on the HIV/AIDS epidemic in South Africa*. Henry J. Kaiser Family Foundation 2001, p2-36.

Macdonald, G. and Smith, C.(1990). Complacency, risk perception and the problem of HIV education. *AIDS CARE*. 2(1):63-68.

MacPhail, C. and Campbell, C.(2001). 'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a Southern African township. *Social Science and Medicine*. 52:1613-1627.

Magnani, R.J., Karim, A.M., Weiss, L.A., Bond, K.C., Lemba, M. and Morgan, G.T.(2002). Reproductive Health Risk and Protective Factors Among Youth in Lusaka, Zambia. *Journal of Adolescent Health*. 30(1):76-86.

Maharaj, P.(2001). Male Attitudes to Family Planning in the Era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. *Journal of Southern African Studies*. 27(2):245-257.

Mayaud, P. and McCormick, D.(2001). Interventions against sexually transmitted infections to prevent HIV infection. *British Medical Bulletin*. 58:129-153.

Mbizvo, M.T., Siziya, S., Olayinka, J. and Adamchak, S.E.(1997). *Knowledge of STIs and AIDS, Condom Use, and Risk Awareness.* USA:Macro International Inc.

Minichiello, V., Marino, R. and Browne, J.(2001). Knowledge, risk perceptions and condom usage in male sex workers from three Australian cities. *AIDS CARE.* 13(3):387-402.

North Carolina State University (2002). *Logistic Regression.*
http://www2.chass.ncsu.edu/garson/pa765/logistic.htm

Pitts, M., Humphrey, M. and Wilson, P.(1991). Assessments of personal and general risks of HIV and AIDS in Harare, Zimbabwe. *Health Education Research: Theory and Practice*. 6(3):307-311.

Romer, D., Black, M., Ricardo, I., Feigelman, S., Kaljee, L., Galbraith, J., Nesbit, R., Hornik, R.C. and Stanton, B.(1994). Social Influences on the Sexual Behavior of Youth at Risk for HIV Exposure. *American Journal of Public Health.* 84(6):977-985.

Rutenberg, N., Kehus-Alons, C., Brown, L., Macintyre, K., Dallimore, A. and Kaufman, C.(2001). *Transitions to Adulthood in the context of AIDS in South Africa: Report of Wave 1.* New York: The Population Council Inc.

Sabatier, R.(1987). AIDS in the Developing World. *International Family Planning Perspectives.* 13(3):96-103.

Statistics South Africa.(2002). www.statssa.gov.za/default3.asp

Strunin, L.(1991). Adolescents' Perceptions of Risk for HIV Infection: Implications for Future Research. *Social Science and Medicine*. 32(2):221-228.

Temin, M.J., Okonofua, F.E., Omorodion, F.O., Renne, E.P., Coplan, P., Heggenhougen, H.K. and Kaufman, J.(1999). Perceptions of Sexual Behaviour and Knowledge About Sexually Transmitted Diseases Among Adolescents in Benin City, Nigeria. *International Family Planning Perspectives*. 25(4):186-190.

Tweedie, I (1995). *Evaluation of the "We are all at Risk" HIV/AIDS Prevention Campaign in Ghana, 1994-1995: Key Findings*. Baltimore: John Hopkins University (Center for Communication and Program).

UNAIDS.(2002a). *A Global Overview of the Epidemic*. www.unaids.org/epidemic_update/report_july02/english/chapter2.pdf

UNAIDS.(2002b). *Global Summary of the HIV/AIDS epidemic, December 2002*. www.unaids.org/worldaidsday/2002/press/update/epiupdate2002_en.doc

Visagie, C.J.(1999). *HIV/AIDS. The Complete story of HIV and AIDS. A practical guide for the ordinary sexually active person*. Pretoria: J.L. van Schaik Publishers.

Walter, H.J., Vaughan, R.D., Gladis, M.M., Ragin, D.F., Karsen, S. and Cohall, A.T.(1992). Factors Associated with AIDS Risk Behaviors among High School Students in an AIDS Epicenter. *American Journal of Public Health*. 81(1):528-531.

Weisman, C.S., Nathanson, C.A., Ensminger, M., Teitelbaum, M.A., Robinson, J.C. and Plichta, S.(1989). AIDS knowledge, Perceived Risk And Prevention Among Adolescent Clients Of a Family Planning Clinic. *Family Planning Perspectives.* 21(5):213-217.

Whiteside, A.(1990). *AIDS in Southern Africa*. Durban: University of Natal-Eonomic Research Unit.

Whiteside, A., Wilkins, N., Mason, B. and Wood, G.(1995). The Impact of HIV/AIDS on Planning Issues in KwaZulu-Natal. *Town and Regional Planning Supplementary Report.* Vol.42:25-37, Pietermaritzburg: Natal Town and Regional Planning Commission.

Whiteside, A. and Sunter, C.(2000). *AIDS: The Challenge for South Africa*. Cape Town: Human & Rousseau.

Wilson, D., Dubley, I., Msimanga, S. and Lavelle, L.(1991). Psychological predictors of reported HIV-preventive behaviour change among adults in Bulawayo, Zimbabwe. *The Central African Journal of Medicine*. 37(7):196-201.

World Statistics and Atlases (2002).
http://www.worldatlas.brinkster.net/asp/sett.asp?settid=3826

APPENDIX

WORLD HEALTH ORGANIZATION
FAMILY PLANNING AND AIDS SURVEY
INDIVIDUAL WOMEN'S QUESTIONNAIRE

IDENTIFICATION

COUNTRY (Kenya=1, S. Africa=2, Tanzania=3, Uganda=4, Zambia=5, Zimbabwe=6).....	
RESPONDENT ID _____	
CLUSTER NAME _____	
CLUSTER NUMBER.....	
HOUSEHOLD NUMBER.....	
RESPONDENT LINE NUMBER	
SEX OF RESPONDENT (Male=1, Female=2).....	2
URBAN/RURAL (urban=1, rural=2).....	
NATIVE LANGUAGE OF RESPONDENT? _____	

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY
LANGUAGE OF INTERVIEW				MONTH
				YEAR
INTERVIEWER'S NAME				NAME
RESULT*				RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:

1 COMPLETE
2 INCOMPLETE
3 REFUSED INTERVIEW
4 NO RESPONDENT PRESENT OR ABLE TO ANSWER QUESTIONNAIRE
5 HOUSEHOLD NOT FOUND

SUPERVISOR		OFFICE EDITOR	KEYED BY
NAME _____		NAME: _____	NAME: _____
DATE _____			

PARTNER INTERVIEW STATUS (CIRCLE APPROPRIATE CODE)

NO ELIGIBLE PARTNER IN HH.....1
RESPONDENT INTERVIEWED BEFORE PARTNER.....2
RESPONDENT INTERVIEWED AFTER PARTNER.....3
ELIGIBLE PARTNER NOT INTERVIEWED.....4

HH LINE NUMBER OF ELIGIBLE PARTNER

SECTION 1. BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME. Thank you for taking the time to talk to me. I would like to ask some questions about you and your household	HOUR..... ☐☐ MINUTES..... ☐☐	
102	In what month and year were you born?	MONTH..... ☐☐ DON'T KNOW MONTH.....98 YEAR..... ☐☐ DON'T KNOW YEAR.....98	
103	What was your age at your last birthday? COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.	AGE IN COMPLETED YEARS..... ☐☐	
104	Have you ever attended school?	YES.....1 NO.....2	→ 107
105	What is the highest level of school you attended: primary, lower secondary, upper secondary or higher?	PRIMARY.....1 LOWER SECONDARY.....2 UPPER SECONDARY.....3 HIGHER.....4	→ 108
106	Did you complete that level?	YES.....1 NO.....2	
107	Can you read and understand a letter or newspaper easily, with difficulty, or not at all?	EASILY .....1 WITH DIFFICULTY .....2 NOT AT ALL.....3	
108	What is your religion?	ROMAN CATHOLIC.....10 PROTESTANT.....20 BORN AGAIN.....21 PROTESTANT, SPECIFY.....22 PROTESTANT, SPECIFY .....23 PROTESTANT, SPECIFY .....24 PROTESTANT, SPECIFY .....25 MUSLIM.....30 HINDU.....40 TRADITIONAL.....50 NO RELIGION.....60 OTHER_____96 (SPECIFY)	
109	What is your native language? ALTERNATIVE: What is your mother tongue?	COUNTRY SPECIFIC CODES.....01 .....02 .....03 .....04 .....05 OTHER_____96 _____	
110	What other languages can you speak easily?	English.....10 French.....20 Kiswahili.....30 COUNTRY SPECIFIC CODES_____01 _____02 _____03 _____04 _____05 OTHER_____96	
111	What is your main occupation, that is, what kind of work do you do most of the time?	(SPECIFY)_____ _____ ☐☐ _____	
112	Do you receive any payment in cash or kind for this work?	YES.....1 NO.....2	→ 115

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
113	Do you receive payment in cash or kind for any other work besides your main occupation? IF YES:what kind of work?	YES.....1 _____ (Specify work) NO.....2	— 115
114	Who mainly decides how to spend the money that you earn? You, your partner, or someone else?	SELF.....1 PARTNER.....2 TOGETHER WITH PARTNER.....3 PARENTS.....4 OTHER _____6 _____	
115	Are you currently married or living with a man?	MARRIED.....1 NOT MARRIED BUT LIVING WITH.....2 NO.....3	— 120 — 117
116	Do you normally live with your husband?	YES, LIVE WITH.....1 NO.....2	—120
117	What is your current marital status?	NEVER MARRIED.....1 ENGAGED.....2 WIDOWED.....3 DIVORCED.....4 SEPARATED.....5	—120
118	Have you ever had sexual intercourse with a man in your life?	YES.....1 NO.....2	— 802
119	Do you currently have a regular sexual partner? That is, someone you have been having sex with for a year or more?	YES.....1 NO.....2	— 201
120	CHECK 115 & 116 ☐ NOT LIVING TOGETHER	LIVING TOGETHER ☐	133
130	When he is not travelling or away at work where does your husband/partner usually live?	SAME HOUSEHOLD.....1 SAME AREA.....2 OUTSIDE LOCAL AREA.....3	— 133
131	How often do you usually stay together?	MOST DAYS OF A WEEK.....1 AT LEAST ONCE A WEEK.....2 AT LEAST ONCE A MONTH.....3 AT LEAST SEVERAL TIMES A YEAR...4 LESS OFTEN.....5	
132	How long ago did you last stay together? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	DAYS/MONTHS/YEARS AGO D M Y ☐☐	
133	What is the first name of your husband/partner?	NAME_____	
134	Does <NAME> have any other wives or regular partners besides yourself?	YES.....1 NO.....2 DON'T KNOW.....8	— 139
135	How many other wives/partners does he have?	NUMBER..... ☐☐ DON'T KNOW.....98	
136	What is your order among his wives? First, second, third, or more?	NUMBER..... ☐☐ DON'T KNOW/CAN'T SAY.....98	
137	Do any of his other wives/partners live in this household?	YES.....1 NO.....2	— 139

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
138	Do any of his other wives/partners know about your relationship?	YES.....1 NO.....2	
139	How old was <NAME> at his last birthday? ESTIMATE	AGE IN COMPLETED YEARS..... ☐☐ AGE ENTERED IS ESTIMATE.....1	
140	Did he ever attend school?	YES.....1 NO.....2 DON'T KNOW.....8	143
141	What is the highest level of school <NAME> attended: primary, lower secondary, upper secondary or higher?	PRIMARY.....1 LOWER SECONDARY.....2 UPPER SECONDARY.....3 HIGHER.....4 DON'T KNOW.....8	144 143
142	Did he complete that level?	YES.....1 NO.....2 DON'T KNOW.....8	
143	Can he read and understand a letter or newspaper easily, with difficulty, or not at all?	EASILY .....1 WITH DIFFICULTY .....2 NOT AT ALL.....3	
144	What is his main occupation?	(SPECIFY WORK)_____ _____ _____ ☐☐	
147	In what month and year did you start a regular relationship with <NAME>?	MONTH..... ☐☐ DON'T KNOW MONTH.....98 YEAR..... ☐☐ DON'T KNOW YEAR.....98	
148	How old were you when you started a regular relationship with <NAME> ESTIMATE CONSULT 103 AND CHECK CONSISTENCY BETWEEN 147 AND 148	AGE..... ☐☐	
149	CHECK 115 ☐ OTHERS	MARRIED ☐	153
150	Has he ever met your parents or family elders?	YES.....1 NO.....2	
151	Have you ever met his parents or family elders?	YES.....1 NO.....2	
152	Are you engaged or do you plan to marry <NAME>?	ENGAGED.....1 PLAN TO MARRY.....2 NO.....3 NOT SURE.....4	201
153	What type of wedding ceremony did you have (do you expect to have)?	CHRISTIAN.....1 MUSLIM.....2 HINDU.....3 TRADITIONAL.....4 OTHER (SPECIFY)_____5 _____ DON'T KNOW.....8	
154	Has any brideprice been negotiated?	YES.....1 NO.....2	201
155	Is\was the brideprice mostly in terms of cash, cattle, or smaller gifts such as clothes, shoes, or food?	MOSTLY CASH.....1 MOSTLY CATTLE.....2 MOSTLY SMALLER GIFTS.....3 Other (specify)_____6 _____	
156	Has the brideprice been completely paid?	YES.....1 NO.....2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Now I would like to ask a few questions about your travel away from home.		
201	For most of the time until you were 12 years old, did you live in a city, a town, or the village?	CITY.....1 TOWN .....2 VILLAGE.....3	
202	How long have you lived continuously in your current residence? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	MONTHS\YEARS M Y ALWAYS.....97	
203	Have you ever travelled away from home for 1 night or more in the last 12 months?	YES.....1 NO.....2	— 206
204	What was the longest continuous amount of time you spent away from home in the last 12 months? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	DAYS\WEEKS\MONTHS D W M	
205	Where did you go at that time? PROBE FOR TYPE OF PLACE IF MORE THAN ONE MENTIONED, INDICATE MOST DISTANT CIRCLE TYPE OF PLACE (TOP PANEL) AND LOCATION (BOTTOM PANEL)	SAME VILLAGE, TOWN, CITY.....0 OTHER VILLAGE/AREA.....1 OTHER TOWN.....2 OTHER CITY.....3 SAME DISTRICT.....1 OTHER DISTRICT.....2 DIFFERENT COUNTRY.....3	
206	CHECK 120 ☐ LIVING TOGETHER	NOT LIVING TOGETHER ☐	— 301
207	Has <NAME> ever travelled away from home for 1 night or more in the last 12 months?	YES.....1 NO.....2 DONT KNOW.....9	— 301
208	What was the longest continuous amount of time he spent away from home in the last 12 months? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	DAYS\WEEKS\MONTHS D W M DON'T KNOW.....98	
209	Where did he go at that time? PROBE FOR TYPE OF PLACE IF MORE THAN ONE MENTIONED, INDICATE MOST DISTANT CIRCLE TYPE OF PLACE (TOP PANEL) AND LOCATION (BOTTOM PANEL)	SAME VILLAGE, TOWN, CITY.....0 OTHER VILLAGE/AREA.....1 OTHER TOWN.....2 OTHER CITY.....3 SAME DISTRICT.....1 OTHER DISTRICT.....2 DIFF COUNTRY.....3	— 301

SECTION 3 FERTILITY HISTORY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Are you currently pregnant?	YES.....1 NO.....2 UNSURE.....3	
302	Altogether how many children have you given birth to? IF NONE, CIRCLE 00	☐☐ NO BIRTHS.....00	— 310
303	How many of your children are still alive? IF NONE, CIRCLE 00	☐☐ NONE.....00	
304	How many of these children is <NAME> the father of? IF NONE, CIRCLE 00	☐☐ NONE.....00	
305	What is the month and year of your most recent birth? ESTIMATE YEAR	MONTH..... ☐☐ DON'T KNOW MONTH.....98 YEAR..... ☐☐ YEAR IS ESTIMATE.....01	
306	CHECK 305 CHILD BORN IN 1997 OR LATER ☐	CHILD BORN BEFORE 1997 ☐	— 310
307	Is this child currently breastfeeding?	YES.....1 NO.....2 CHILD DIED.....3	
308	Have your menstrual periods returned since your last birth?	YES.....1 NO.....2	
309	How long after the birth of this child did you wait before resuming regular sexual relations? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	WEEKS\MONTHS W M ☐☐ STILL ABSTAINING.....97	
310	What do you think is the ideal time for a woman to wait after the birth of a child until resuming sex with her partner? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	WEEKS\MONTHS W M ☐☐	
311	Who usually has the most influence over when to resume regular sex after child birth: the man, the woman, or both have equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 DONT' KNOW/IT DEPENDS.....8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
312	CHECK 303 HAS LIVING CHILDREN ☐ — If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life how many would that be? NO LIVING CHILDREN ☐ — If you could choose exactly the number of children to have in your whole life how many would that be? PROBE FOR A NUMERIC RESPONSE.	NUMBER..... ☐☐ OTHER_____ 96 (SPECIFY)	
313	CHECK 301 NOT PREGNANT OR UNSURE ☐ — Now I have some questions about the future. Would you like to have (a/another) child or would you prefer not to have any (more) children? PREGNANT ☐ — Now I have some questions about the future. After the child you are expecting now, would you like to have another child or would you prefer not to have any more children?	HAVE (A/ANOTHER) CHILD.....1 UNDECIDED.....2 — 315 NO MORE/NONE.....3 SAYS SHE IS STERILE.....4 — 401	
314	How much would it matter if you did have another child?	Very Much.....1 Somewhat.....2 –316 Not Much.....3	
315	CHECK: 301 NOT PREGNANT OR UNSURE ☐ — How long would you like to wait from now before the birth of (a/another) child? PREGNANT ☐ — After the child you are expecting now, how long would you like to wait before the birth of another child? CIRCLE CORRECT UNIT AND ENTER NUMBERS IN BOXES	MONTHS/YEARS ☐☐ M Y OTHER_____ 96 (SPECIFY) DON'T KNOW.....98	
316	What do you think is the ideal time to space between births? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	MONTHS/YEARS ☐☐ M Y OTHER(SPECIFY)_____96	
317	CHECK 119, 120 HAS REGULAR PARTNER/LIVING WITH ☐ NO REGULAR PARTNER/NOT LIVING WITH ☐ — 401		
318	CHECK 301: NOT PREGNANT OR UNSURE ☐ — Do you think <NAME> would like to have a/another child or would he prefer not to have any (more) children with you? PREGNANT ☐ — After the child you are expecting now, do you think <NAME> would like to have another child or would he prefer not to have any more children with you?	HAVE (A/ANOTHER) CHILD.....1 UNDECIDED.....2 NO MORE/NONE.....3 DON'T KNOW PARTNER'S DESIRE....9 — 320	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
319	CHECK: 301 NOT PREGNANT OR UNSURE ☐ — How long would <NAME> like to wait before the birth of (a/another) child? PREGNANT ☐ — After the child you are expecting now, how long would <NAME> like to wait before the birth of another child? CIRCLE THE CORRECT UNIT AND ENTER THE NUMBER IN BOXES	MONTHS/YEARS (M / Y) ☐☐ OTHER _____ (SPECIFY) 96 DON'T KNOW.....98	
320	Have you and <NAME> ever discussed whether or not to have another child or how soon to have the next child?	YES.....1 NO.....2	——323
321	Have you discussed this many times, a few times, or only once in the last year?	MANY.....1 FEW.....2 ONCE.....3	
322	Have you and <NAME> ever disagreed or had arguments about whether or not to have another child, or how soon to have another child?	YES.....1 NO.....2	
323	Have you ever spoken with anyone (else) about whether or not to have another child/or how soon to have another child? (CIRCLE ALL MENTIONED) PROBE: Anyone else?	MALE FRIENDS/NEIGHBOURS.....01 FEMALE FRIENDS/NEIGHBOURS.....02 BROTHERS.....03 OTHER MALE RELATIVES.....04 SISTER.....05 OTHER FEMALE RELATIVES.....06 FAMILY PLANNING/HEALTH WORKERS.07 OTHER (SPECIFY)_____08 OTHER (SPECIFY)_____09 OTHER (SPECIFY)_____10	

SECTION 4. FAMILY PLANNING

Now I would like to talk to you about family planning.
By family planning, I mean methods that you can get at the clinic or drugstore, things or advice that you can get from traditional healers and herbalists, or things that you can do at home with your partner to delay or to avoid a pregnancy.

INSTRUCTIONS TO INTERVIEWER:

1. ASK Q401 FIRST, PROBING FOR ALL METHODS RESPONDENT HAS HEARD OF INCLUDING TRADITIONAL METHODS.
2. AFTER COMPLETING Q401, ASK Q402 AND Q403 IN ORDER FOR EACH METHOD RESPONDENT HAS HEARD OF.

401	What ways or methods have you heard about? PROBE: What other methods? PROBE:What (other) traditional methods? CIRCLE YES or NO IN FIRST COLUMN, IF MENTIONED. IF YES ASK 402 AND 403	Q401 Heard of?	Q402 Have you ever used this method?	Q403 Do you know where a person could go to get this method?
a)	PILL.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
b)	IUD.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
c)	INJECTIONS.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
d)	IMPLANTS.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
e)	DIAPHRAM/FOAM/JELLY.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
f)	CONDOM.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
g)	FEMALE STERILIZATION.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
h)	MALE STERILIZATION.....	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
i)	RHYTHM.....	YES.....1 —— NO.....2	YES.....1 NO.....2	
j)	WITHDRAWAL.....	YES.....1 —— NO.....2	YES.....1 NO.....2	
k)	ABSTINENCE.....	YES.....1 —— NO.....2	YES.....1 NO.....2	
l)	OTHER (SPECIFY)_____ ☐☐	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
m)	OTHER (SPECIFY) _____ ☐☐	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
n)	OTHER (SPECIFY)_____ ☐☐	YES.....1 —— NO.....2	YES.....1 NO.....2	YES.....1 NO.....2

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
404	CHECK 401 NOT HEARD OF CONDOMS ☐	HEARD OF CONDOMS ☐	406
405	Have you ever heard of condoms? I mean a rubber sheath that a man puts on during sexual intercourse? NO ☐	YES ☐ CORRECT THE CONDOM LINE OF 401 AND ASK 402/403	
406	CHECK 402 NEVER USED ANY METHOD ☐	EVER USED AT LEAST ONE METHOD ☐	411
407	Just to check that I have this right, have you ever used any method or done anything to avoid getting pregnant? Yes ☐ ASK FOR METHOD AND AMEND 401, 402, 403, 406	NO ☐	414
408	CHECK 119, 120 HAS REGULAR PARTNER/LIVING WITH ☐	NO REGULAR PARTNER/NOT LIVING WITH ☐	417
409	CHECK 402 g & h MAN AND WOMAN NOT STERILIZED ☐	MAN OR WOMAN STERILIZED ☐	411
410	Are you and <NAME> currently doing something or using any method to delay or avoid getting pregnant?	YES.....1 NO.....2 — 413	
411	Which method are you using? PROBE: Anything else? CIRCLE ALL MENTIONED CIRCLE '07' FOR FEMALE STERILIZATION. '08' FOR MALE STERILIZATION.	PILL.....01 IUD.....02 INJECTIONS.....03 IMPLANTS.....04 DIAPHRAGM/FOAM/JELLY.....05 CONDOM.....06 — 413 FEMALE STERILIZATION.....07 MALE STERILIZATION.....08 — 413 RHYTHM.....09 WITHDRAWAL.....10 — 413 SPORADIC ABSTINENCE.....11 OTHER_____96 (SPECIFY) _____	
412	Does <NAME> know that you are currently using a method?	YES.....1 NO.....2 — 414	
413	Have you ever used any method of delaying or avoiding a birth without your partner's knowledge?	YES.....1 NO.....2	
414	Have you ever discussed family planning methods with <NAME>?	YES.....1 NO.....2 — 416	
415	Did you discuss this many times, a few times, or only once in the last year?	MANY.....1 FEW.....2 ONCE.....3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
416	Do you think <NAME> approves, has mixed feelings or no opinion or disapproves about a couple using a method to delay or avoid pregnancy?	APPROVES.....1 MIXED\NO OPINION.....2 DISAPPROVES.....3 DON'T KNOW.....8	
417	Who usually has more influence over whether or not to use a family planning method: the man, the woman, or both have equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 IT DEPENDS.....4	
418	Would you say that most of the people you know approve of the practice of family planning, disapprove of it, or have no opinion?	MOST APPROVE.....1 MOST DISAPPROVE.....2 MOST HAVE NO OPINION.....3 DON'T KNOW.....8	
419	For the next set of questions, say whether you agree, disagree, or have mixed feelings or no opinion about the following statements: READ OUT It is acceptable for a couple to use a method to space between births.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
420	It is acceptable for a couple to use a method to have no more children.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
421	If a woman gets pregnant but strongly does not want to have another child, she can consider having an abortion instead.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
422	If a couple has more children than they can afford, they can always rely on relatives for help raising children.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
423	It is acceptable for a woman to propose using a method to her partner.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
424	It is acceptable for a woman to use a method without telling her partner about it.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
425	Family planning leads to promiscuous behaviour.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	

SECTION 5 SEXUAL HISTORY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

It sometimes happens that men and whomen have sexual relations with partners other than their regular partners. I would like to ask you about relationships with other men.

INTERVIEWER INSTRUCTIONS: Questions 501, 507-525 are repeated for the last 3 non-regular partners in the last 3 years. Record answers for the most recent partner in the first column below & in answer sheet for 507-525. Then return to Q501 and ask about the previous non-regular partner, recording answers in the second column of the answer sheet, etc.

501 CHECK: 119, 120

HAS REGULAR PARTNER ☐

How long ago did you last have sex with a man apart from <NAME>? (and the one we have just talked about?

NO REGULAR PARTNER ☐

How long ago did you last have sex with a man (apart from the one we have just talked about)?

PROBE AND ESTIMATE AND RECORD ANSWER BELOW

CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXEX

502 CHECK: 501
IF LAST SEX WITH NON-REGULAR PARTNER WITHIN 3 YEARS?

NO.	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKI
501	PARTNER 1 ☐☐ DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95	> 502	PARTNER 2 ☐☐ DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95	> 601	PARTNER 3 ☐☐ DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95	> 60
502	CHECK 501 3 YEARS OR MORE ☐ SKIP TO 601 LESS THAN 3 YEARS ☐	> 507	CHECK 501 3 YEARS OR MORE ☐ SKIP TO 601 LESS THAN 3 YEARS ☐	> 507	CHECK 501 3 YEARS OR MORE ☐ SKIP TO 601 LESS THAN 3 YEARS ☐	> 50

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
503	Just to check that I have this right, have you ever had a sexual relationship that lasted for one night or a very short time?	YES.....1 NO.....2	— 506
504	Have you ever had sex with anyone other than a regular partner when you were travelling away from home?	YES.....1 NO.....2	— 506
505	Have you ever had sex with anyone other than a regular partner at a party or a social or cultural event?	YES.....1 NO.....2	— 506
506	How long ago was the most recent time something like this happened? CORRECT RESPONSE IN 501, GO TO 502	IF NO TO ALL QUESTIONS ☐	— 601

NO.	QUESTIONS AND FILTERS	SKIP
507	What is his first name or initial?	
508	How long have you had a relationship with <PNAME>? ESTIMATE CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	
509	Is your relationship to <PNAME> still continuing?	
510	What was your relationship to this man? PROBE	
511	Was he younger about the same age, or older than you? IF OLDER, more than 5 years? more than 10? more than 20?	
512	Did you ever live with <PNAME>?	
513	Did you have any children with him?	
514	Did (do) you want to have a child with <PNAME>?	
515	During your relationship with <PNAME> were you concerned that you might get pregnant when you did not want to get pregnant?	
516	Did you and <PNAME> ever discuss family planning methods?	
517	Did you or <PNAME> ever use any method to delay or prevent pregnancy? IF YES Always or sometimes?	
518	What was the main method that was used?	
519	Did you and <PNAME> ever use condoms? IF YES Always, occasionally or only at the beginning of the relationship?	
520	Did you ever use condoms together with another method of family planning with <PNAME>?	
521	Who first proposed using condoms, you or <PNAME>?	
522	Did you and <PNAME> ever discuss using condoms?	
523	As far as you know, is (was) he having sex with anyone else during your relationship?	
524	Did you ever talk with <PNAME> about the risk of getting AIDS? IF YES: did you discuss this before you first had sex or later?	
525	During your relationship with <PNAME> were you concerned that you might contract AIDS from him? If YES very or somewhat concerned?	
526	INTERVIEWER NOW RETURN TO 501 FOR OTHER PARTNER (s)	

NO.	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP
507	NAME/INITIAL_____		NAME/INITIAL_____		NAME/INITIAL_____	
508	DAY\WEEK\MONTH\YEAR D W M Y SINGLE TIME.....97	— 510	DAY\WEEK\MONTH\YEAR D W M Y SINGLE TIME.....97	— 510	DAY\WEEK\MONTH\YEAR D W M Y SINGLE TIME.....97	—510
509	YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3	
510	FORMER HUSBAND.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY_____6		FORMER HUSBAND.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY_____6		FORMER HUSBAND.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY_____6	
511	YOUNGER.....1 SAME.....2 5 YEARS OLDER OR MORE.....3 10 YEARS OLDER OR MORE.....4 20 YEARS OLDER OR MORE.....5		YOUNGER.....1 SAME.....2 5 YEARS OLDER OR MORE.....3 10 YEARS OLDER OR MORE.....4 20 YEARS OLDER OR MORE.....5		YOUNGER.....1 SAME.....2 5 YEARS OLDER OR MORE.....3 10 YEARS OLDER OR MORE.....4 20 YEARS OLDER OR MORE.....5	
512	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
513	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
514	YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3	
515	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
516	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
517	ALWAYS.....1 SOMETIMES.....2 NEVER.....3	— 519	ALWAYS.....1 SOMETIMES.....2 NEVER.....3	— 519	ALWAYS.....1 SOMETIMES.....2 NEVER.....3	— 51
518	METHOD_____		METHOD_____		METHOD_____	
519	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 NEVER HEARD OF CONDOM.....3	— 522 — 523	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 NEVER HEARD OF CONDOM.....3	— 522 — 523	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 NEVER HEARD OF CONDOM.....3	— 522 — 523
520	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
521	RESPONDENT.....1 PARTNER.....2 DON'T KNOW.....3		YOU.....1 PARTNER.....2 DON'T KNOW.....3		YOU.....1 PARTNER.....2 DON'T KNOW.....3	
522	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
523	YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3	
524	YES, BEFORE.....1 YES, AFTER.....2 NO 3		YES, BEFORE.....1 YES, AFTER.....2 NO 3		YES, BEFORE.....1 YES, AFTER.....2 NO 3	
525	VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3		VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3		VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3	
526	RETURN TO 501		RETURN TO 501		GO TO 601	

SECTION 6. AIDS KNOWLEDGE AND RISK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	How old were you when you first heard of AIDS?	Years ☐☐ DON'T KNOW.....98 YOUNG CHILD.....97 NEVER HEARD OF AIDS.....99	— 701
602	Has a member of your family or a friend ever suffered or died from AIDS?	YES.....1 NO.....2	
603	In the last 12 months, have you ever attended a funeral of someone who died from AIDS?	YES.....1 NO.....2	
604	How many children, if any, are you supporting whose parents may have died from AIDS? IF NONE, CIRCLE 00	☐☐ NONE.....00	
605	DISPLAY PICTURE: Here is a picture of 6 communities. People in GREY signify carriers of HIV/AIDS. Which picture best describes your community at this time?	1 2 3 4 5 6 (CIRCLE ANSWER)	
606	Before today, have you ever thought about your own chance of contracting HIV\AIDS?	YES.....1 NO.....2	
607	Considering all things, do you consider your chance of getting HIV to be high, medium, low, or no chance at all?	HIGH.....1 MEDIUM.....2 LOW.....3 NO CHANCE.....4	
608	CHECK 119, 120 HAS REGULAR PARTNER ☐	NO REGULAR PARTNER ☐	614
609	During your marriage / relationship with <NAME> do you think that he had sex with anyone else (apart from co-wives)?	YES.....1 NO.....2 UNSURE.....3	
610	Have you ever talked with <NAME> about the risk of contracting AIDS?	YES.....1 NO.....2	
611	During your relationship with <NAME> have you ever been concerned that you might contract AIDS from him? IF YES very or somewhat concerned?	VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3	— 614
612	Did you try anything to reduce the chance of getting AIDS from him?	YES.....1 NO.....2	— 614
613	What did you do? PROBE: WHAT ELSE?	_____ ☐☐ _____ _____ _____ ☐☐	
614	Have you ever had a test for HIV/AIDS?	YES.....1 NO.....2	— 616
615	Do you know where to go for a test for HIV/AIDS?	YES.....1 NO.....2	
616	Have you ever talked with any partner about getting a test for HIV/AIDS?	YES.....1 NO.....2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Say whether you agree, disagree or have mixed feelings or no opinion about the following statements:		
617	There is not much use in trying to prevent AIDS: if you are going to get it, you will get it eventually no matter how you try.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
618	Only irresponsible or immoral people get AIDS; it cannot reach normal people who are careful.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
619	Very few people in this area have changed their behaviour because of AIDS.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
620	There is no cure for AIDS	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
621	If a husband gets HIV or STD from outside the marriage, there is nothing the wife can do to avoid getting infected herself.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
622	A man needs to have more than one partner.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
623	To protect themselves against HIV\AIDS or sexually transmitted infections, a married couple can use condoms every time they have sex.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
624	A man can be satisfied with only one partner.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
625	If a woman fears AIDS but still wants to play sex, what can she do? PROBE What else? A _____ ☐☐ B _____ ☐☐ C _____ ☐☐ D _____ ☐☐ She can do nothing.....98 SKIP	626 Do you know anyone who has done this? A YES.....1 NO.....2 B YES.....1 NO.....2 C YES.....1 NO.....2 D YES.....1 NO.....2 TO 701	627 Have you ever done this? A YES.....1 NO.....2 B YES.....1 NO.....2 C YES.....1 NO.....2 D YES.....1 NO.....2

SECTION 7 CONDOMS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 404/405 EVER HEARD OF CONDOMS ☐	NEVER HEARD OF CONDOMS ☐	801
702	CHECK 119, 120 HAS REGULAR PARTNER ☐	NO REGULAR PARTNER ☐	708
703	Have you and <NAME> ever used a condom?	YES.....1 NO.....2	706
704	Do you use a condom always, occasionally or only at the beginning of the relationship?	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3	
705	Did you and <NAME> ever use a condom together with another method of family planning?	YES.....1 NO.....2	
706	Have you and <NAME> ever discussed using condoms? IF YES: Many times, a few times, or only once in last year?	MANY TIMES.....1 FEW TIMES.....2 ONCE.....3 NEVER.....4	708
707	Have you and <NAME> ever disagreed or had arguments about using condoms?	YES.....1 NO.....2	
708	Do you know anyone who regularly uses a condom and any other family planning method together at the same time?	YES.....1 NO.....2	
709	Who usually has the most influence over whether or not to use a condom: the man, the woman, or both equally?	MAN.....1 WOMAN.....2 EQUAL.....3 DON'T KNOW.....4	
710	Say whether you agree, disagree, or have mixed feelings or no opinion about the statements: Using condoms is an effective way of preventing AIDS.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
711	Condoms encourage promiscuous behaviour.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
712	Using condoms is an effective way of preventing pregnancy.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
713	The only reason to use a condom is because you don't trust your partner.	AGREE .....1 MIXED/NO OPINION .....2 DISAGREE 3	
714	Say whether you think the following actions are acceptable or unacceptable in your own view, or if you have mixed feelings or no opinion. Is it acceptable or unacceptable.... For a married couple to use a condom?	ACCEPTABLE.....1 MIXED/NO OPINION .....2 UNACCEPTABLE.....3	
715	For a married woman to ask her husband to use a condom?	ACCEPTABLE.....1 MIXED/NO OPINION .....2 UNACCEPTABLE.....3	
716	For a woman who is not married to ask her partner to use a condom?	ACCEPTABLE.....1 MIXED/NO OPINION .....2 UNACCEPTABLE.....3	
717	To use a condom with someone at the beginning of a relationship.	ACCEPTABLE.....1 MIXED/NO OPINION .....2 UNACCEPTABLE.....3	

SECTION 8. CONCLUSION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	As a continuation of this research, we would like to conduct a few in-depth interviews over the next few weeks to learn more about how people live in this area. Only a few people will be selected to take part in this follow up phase. Would you be willing to be interviewed?	YES.....1 NO.....2	
802	RECORD THE TIME. Thank you for your answers. Again, we can assure you that all this information about you and your household will remain confidential.	HOUR..... ☐☐ MINUTES..... ☐☐	