



SCHOOL OF SOCIAL SCIENCES

Cluster: Culture

School: Social Science

**Probing the sociocultural factors influencing female condom use among
heterosexual women in Clermont, Durban.**

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**Submitted in fulfilment of the requirement for the degree of Master of
Social Science the College of Humanities, School of Social Sciences at
the University of KwaZulu-Natal, Howard Campus**

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February 2016

As the candidate's supervisor, I agree/ do not agree to the submission of this thesis.

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DECLARATION ON PLAGIARISM

I, Nelisiwe Mnguni, declare that this dissertation entitled: Probing the sociocultural factors influencing female condom use among heterosexual women in Clermont, Durban is my own work and all the sources used are quoted and acknowledged by means of references. This work has never been submitted to any other University or College.

Signed: _____

Date: _____

DEDICATION

This work is dedicated to all the women of various age groups who are in relationships.

You all possess the power to effect change and that change starts with you. Whether you are in abusive relationships or not, all of you, beautiful women, can make a difference. Never before have women been given a platform to air their voices as it is today. A small step towards a positive change, is every woman's responsibility.

Women can learn from each other's mistakes, triumphs, tears and joys.

We, wonderful women, possess the power to effect change; it is up to each and every one of us to find a voice to express that power within us.

ACKNOWLEDGEMENTS

I would like to express my gratitude to my research participants and to all those who helped me from the beginning of my study including the late Professor Dennis Arbuckle, who motivated and encouraged me to start this process.

My sincere gratitude also goes to my supervisor, Professor Maheshvari Naidu, for her wisdom, guidance, patience and continued reassurance and encouragement and Dr Shenuka Singh for helping me overcome some hurdles along the way.

To my family, my three beautiful children who were with me through out, I would like to express my love and appreciation for your continued support of my endeavours and encouragement during times of self-doubt. To my sisters, who provided the levity and perspective that balanced my crazier moments, I thank you both. To my friends who supported and encouraged me with words of wisdom, thank you.

Also, I would like to thank my fellow students in the Sociology Department, whom I could reach out to for support. They contributed in making my year and this study a success.

Above all, I would like to thank Jehovah, the God Almighty, who carried me through this long journey.

ABSTRACT

Most of the world's women are poor. In Africa, this fact is further compounded by patriarchal influences that permeate traditional African cultures. As such many women occupy the lower ranks in society and often bear the brunt of HIV infections and unplanned pregnancies. In South Africa, out of all HIV infected people, women and children continue to bear a huge burden of this infection. Whilst African culture has undergone considerable change over a period of time with influences from colonization¹, apartheid² (in South Africa) urbanization, Christianity, migrant labour system and acculturation, *cultural ideals* of behaviour related to patriarchy continues. These ideals have influenced and shaped attitudes, beliefs and values that individuals portray in relation to their expectations in heterosexual relationships with regards to sexuality, family life and gender roles. Within this context, men continue to wield tremendous gender power which has diminished women's autonomy, resulting into gender inequalities. These inequalities have hindered most women's ability to insist on condom use or refuse sex. This has put women at a disadvantage and increased their risk of unplanned pregnancies, contracting HIV infection and other sexually transmitted infections. This study was conducted to probe and understand the factors that influence the use or non-use of female condoms where gender inequalities still exist to some degree. Hence the insertion of this study was to contribute to the understanding of broader socio cultural issues that influence the use of female condoms as a women initiated strategy to prevent sexual transmitted infections, HIV and unplanned pregnancies in this community³. It also aimed to find out if males supported women in health initiatives. Understanding these factors can re-shape interventions designed to strengthen women initiated HIV prevention and contraceptive methods including female condoms. The results of the study showed that most women are not powerless to negotiate safer sex practices. The study also found that behaviors towards medical interventions are not only shaped by social prescripts but by knowledge, understanding, perception and beliefs formed around the intervention. The study also revealed that perceived benefits of the intervention can influence acceptability and continued use of female condoms by both males and females. Thus there is fertile ground for continued education and empowerment of both males and females through targeted messaging including male involvement in health initiatives.

¹ A practice of domination politically and economically which involves subjugation of one people by another.

² A policy or system of segregation or discrimination based on race that was practiced in South Africa

³ Community in this study is referred to as mobile or migrant because almost all interviewed participants came from different parts of the country to stay in the area under study and have been moved to temporal settlements to await relocation to government housing.

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Chapter 1

INTRODUCTION AND LITERATURE REVIEW

1.1 INTRODUCTION

The extent of sexually transmitted infections (STIs), awareness of contraceptives and contraceptive use is an essential indicator of sexual health among members of the community in any given society. In South Africa, out of all HIV infected people, women and children continue to bear a huge burden of this pandemic infection (Stats SA, 2013). A high percentage⁴ of infected women are in their reproductive years. Women are seen as the backbone of every society and the children as its future. HIV /AIDS has had a major impact on the core of the society, touching on family life, economy and physical aspects of individuals. Statistically, South Africa continues to have the largest HIV epidemic in the world with an estimated 6,422,179 people living with HIV infection in 2012. This is a significant increase of almost 1.2 million more people living with HIV since 2008 (SA AIDS Report: 2012). Women and children have been recognized as a priority for HIV prevention and care as outlined in the South African Antiretroviral treatment guidelines document. This has resulted in a huge overhaul in the prevention and management of HIV/AIDS in South Africa. Today, amongst other HIV treatment and prevention tools, South Africa has the largest female condom distribution programme in the world, since its introduction in 1998. This programme has made the female condom freely available to everyone in all state owned clinics as well as the private sector. It is available to women mostly free of charge. This programme is designed to empower women to take control of their reproductive health. In 2012, female condoms were listed by the United Nations Commission on life saving commodities for women and children as one of the 13 high-impact, effective, but overlooked tools that could save the lives of millions if widely accessed and properly used (Ahmed and Deperthes, 2012). Regardless of the availability of these protective tools, HIV infection has not been shown to have an impact on the fertility rate of women in the reproductive age bracket. Despite these efforts to empower women, there have been challenges with gender-based inequalities and acceptance of this method – the use of female condoms.

This study sought to investigate social, cultural and behavioural factors influencing the use of the female condoms. The factors in the study define and describe heterosexual relationships - as a normative relationship between males and females in multiple African cultures. Culture has been

⁴ Stats SA (2013) reported women incidence of HIV infection between the ages of 15- 24 years to be 113,000 compared with men's HIV incidence at 26,000 of the same age group.

shown to have positive and negative influences on health behaviours (Airhihenbuwa, 2004). African cultures have undergone considerable change over a period of time with influences from colonization, urbanization, Christianity, migrant labour system and acculturation. *Cultural ideals* of behaviour related to patriarchy (defined as the social system where the men have authority in all aspects of the society) continue. These have been found to influence and shape attitudes, beliefs and values that individuals portray in relation to their expectations in heterosexual relationships with regards to sexuality, family life and gender roles. As revealed in this research and shown through history, men have been the recipients of tremendous power.

The masculinized behaviours though relational, can further be understood through the lens of gender and sexuality. Gupta (2001:1) defines sexuality as ‘a social construct of biological drive’. He further asserts that this construct is multifaceted and ever changing because of influences that the society prescribes on gender, gender roles, economic status, and ethnicity. He also reveals that one of the facets of sexuality is *power*, which has been shown to determine who’s ‘pleasure is given priority and when and how and with whom sex takes place’. He also defines gender as a social and cultural construct that hinges on the shared expectations of behaviour and gender roles that females and males play in society (Gupta 2000). For example, men are expected to work outside the home and bring the ‘bacon’ home whilst females are expected to reproduce and cook the “bacon” in the home. Within this context, men continue to wield tremendous gender power which has diminished women’s autonomy. Some scholars like Ouzagane and Morell (2005) and Naidu (2013) have termed this as ‘masculinized behaviours’. These behaviours have been attributed to male practices that are socially acceptable, promoted and give male their dominant identity in society. These inequalities have put most women at a disadvantage and at a greater risk of contracting the HIV infection from their male partners since they are considered ‘powerless’ in terms of negotiating condom use or refusing sex. Pierotti’s (2013) study on gender attitudes and HIV risk in Malawi shows that social ideologies of gender constructions have a bearing on sexual practices that are often high risk. These high risk sexual practices have resulted in women contracting HIV infection or landed them with sexually transmitted infections and or unwanted pregnancies. Furthermore, the emphasis that African culture places on fertility and family, influences how individuals perceive contraception and informs their decisions to use or not to use any family planning strategies including female and male condoms. The point of insertion of this study was to focus on the socio-cultural factors that influence the use of the female condoms as an HIV prevention and contraceptive method in this community.

1.2 BACKGROUND AND MOTIVATION

HIV/AIDS infection continues to be of public health concern, impacting on social, family, economic and the physical health of individuals. Despite the worldwide decrease in new HIV infections and AIDS related deaths largely due to the availability of antiretroviral medication for treatment which has decreased mortality rates, improved and prolonged lives of people infected with HIV (Hinkin, 2007). South Africa continues to have the largest HIV epidemic with the largest HIV/AIDS programme in the world. Within South Africa, there is a huge geographic variation in the prevalence and incidence of HIV infection.

The Province of KwaZulu-Natal continues to lead South Africa in HIV prevalence (16.9%) with an estimated 38% of women attending antenatal classes infected. (SA AIDS Report: 2012). Although South Africa has reached its Millennium development target for people on HIV treatment in 2015, it still has the highest record of new HIV infection in the world recorded on a daily basis. The South African National Department of Health (NDOH) has reported to have widely distributed male and female condoms between 2012/2013 with approximately 400 million male and nearly 5 million female condoms distributed. In its National Strategic plan on HIV, STI and TB for the period 2013-2016, it aims to distribute one billion male condoms annually (50 male condoms per adult male aged 15 years and older) in 52 districts and to increase the number and the availability of female condoms at its departmental facilities. Through this investment in health, the government hopes to have ‘returns’ from a society that is healthy and economically productive. However, there is a growing concern over the uptake and continued use of condoms especially in long term relationships. McPhail’s (2007) study found that reproductive health among young South African women showed that the use of contraceptives was associated with having previously been pregnant and that young women who had never been pregnant did not use contraceptive methods and were less likely to report using condoms either. McPhail’s study further reveals that the general trend amongst young women who have been pregnant before was to use hormonal methods of contraception rather than barrier methods like condoms which can serve a dual purpose of protection. What is compelling is that young women were using condoms, and making contraceptive trade-offs in which condom use declines as relationship lengthens.

Other studies on women’s reproductive health have confirmed that among South African adolescents who are in established or long term relationships, the issue of trust becomes a significant factor in contraceptive decision making as a result these young couples stop using condoms altogether or inconsistently use condoms. The same trend of inconsistent condom use

has also been observed in married couples or those in long term cohabiting unions (Maharaj, 2006). In the context of the African culture where behavioural ideals are still maintained, women occupy a lower status than that of men hence they continue to be at risk of contracting HIV, sexually transmitted infections and unwanted pregnancies.

Literature on *Cultural norms* highlights the existing cultural norms within communities with regards to sexuality, relationships, health and HIV as important factors in the health seeking behaviour and prevention of both HIV infection and unwanted pregnancies. It further indicates that the context within which individuals make decisions is often determined by cultural influences (Marmot and Wilkinson, 2006; Berkman and Kawachi, 2000). Thus cultural practices, values and norms have a strong influence on individual sexual behaviour and are strong determinants of how prone an individual is to HIV infection (Soskolne, 2002).

In various clinical studies that have been conducted in the use of vaginal microbicides as an HIV prevention tool, there has been challenges with adherence to products that had to be used intravaginal. These trials have cited amongst other reasons for non- adherence such as lack of male partner involvement and the perceived fear by women of being found out by their male partners that they are taking part in a clinical trial (Woodsong C et al., 2013). Studies dealing with women's reproductive health have cited a link between unintended pregnancies, sexually transmitted infections and partner violence. This violence has been shown to take various forms ranging from males controlling women contraceptive and treatment choices, refusal to use condoms to physical, and emotional abuse (Miller, 2010; Stephen, 2008 and McFarlane, 2005). Gender based violence rears its ugly head in almost all societies thus crippling safer sex negotiations and practice because of the fear of repercussions. On the other hand, the South African health statistics shows that the number of new HIV infections and pregnancy rates have not decreased despite all health initiatives on HIV education, prevention and care. Hence the insertion of this study is to contribute to the understanding of broader socio-cultural issues that can re-shape interventions designed to strengthen women initiated HIV prevention and contraceptive methods.

This study is guided by the Structural Violence theory. The findings of this study show that women's health is often determined by numerous social and cultural influences that shape individuals' sexuality perceptions, gender roles, attitude and behaviour. Johan Galtung (1969), referred to a form of violence where social structure may harm people by impeding the realization of their full potential. According to structural violence theory, the violence lies in everyday experiences and is normalized by institutions and the people who are affected are not always conscious of being victims of this violence because it has become part of their lives and it is seen

as normal (Farmer,2009). In the context of African tradition and culture, women have little or no say about their bodies and sexuality. When referring to gender perceptions and roles, Naidu (2013) quotes Foucault (1970)⁵ by stating that within the African tradition and culture most women have been rendered ‘docile’ in that they have given their sexual power, pleasure and say to men and they perceive it a prerogative of males to dictate to them when it comes to sex, fertility and sexuality.

Various studies that were conducted in some African and Indian communities with patriarchal influences show that although women may be knowledgeable about the risks of unprotected sex, they still engage in it. These studies have cited cultural influence as the factor that socialises most women to stereotypical feminine roles, including being subservient, submissive and docile. In the context of heterosexual relationships, these stereotypical feminine roles construct women as powerless individuals who have to please men first at the expense of their health (Leclerc- Madlala, 2009; Gupta, 2000).

In this research, the women interviewed revealed that most men do not display overt violent tendencies and/or force them into a certain behaviour. However, it is the subtle coercion together with a subconscious play out of cultural gender roles that paralyses them into agreeing to risky sexual behaviour in which they hope not to be victims of HIV, sexually transmitted infections and/or unwanted pregnancies. This cultural factor of gender roles is heightened This cultural factor is heightened especially where women lack income or are not economically stable and depend on their male partners for material support where refusal to participate in unsafe sexual practice may spell economic or material withdrawal. The understanding of gender roles and expectations, rooted in perceptions of femininity and masculinity, may an important spring board area for the government to base its resolution to increase the distribution of condoms. Thus both men and women can play a key role in the effective uptake and use of the female condoms as an additional method of protection.

In his study Hunter (2005:393), found that “most Zulu men aspired toward an *isoka* masculinity, which defines ‘real men’ as those who have multiple sexual partners and are sexually successful”. He also argued that this goal encouraged men to engage in risky behaviours, such as having unprotected sex with multiple partners. The women participants also revealed that sometimes they are aware of their partners’ multiple sexual partners and openly acknowledge this fact. However, they felt powerless to insist on the use of female condoms because of patriarchal cultural ‘norms’ that place so much power on masculinity, which makes men more dominant than women. Hence

⁵ It is noted that Foucault’s work was a generalization of certain understandings of truth and rationality.

any women who dare go contrary to these patriarchal norms is often labelled as equating herself to the men or will be given an ‘unpalatable label’ of being a ‘loose woman’. This version of masculinity has also been associated with some men’s use of violence when their partners initiate or suggest condom use.

There is therefore a need to break through situational cultural norms that interfere with:

- Un-inhibited communication in heterosexual relationships regarding safe sexual practices including contraception.
- Women’s ability to determine their fertility choices

It becomes imperative therefore to understand the context within which males and females make health related decisions within the prescribed cultural norms. Accordingly, this qualitative study is one of the many that have been done in government local clinics where female reproductive health is promoted by the South African Department of Health. This study was conducted independently as part of academic contribution in an effort to understand the uptake and sustained use of the female condom in the context of African culture and the threat of HIV, sexually transmitted infections and unwanted pregnancies in a poor community of Clermont, KwaZulu-Natal in South Africa. Data was collected from the Clermont Clinic. This clinic is located about 5km outside of Pinetown in the middle of a peri-urban community. The participants in this study were recruited in the clinic as they came for their reproductive health consultation.

The researcher’s choice to undertake research at this clinic was motivated by the following factors:

1. The clinic serves a diverse, predominantly mobile and poor African community
2. The researcher’s anxiety which came about because of her experience in working with this same community in a discontinued vaginal microbicide clinical trial
3. The researcher’s familiarity with the population and its cultural values.

1.3 LITERATURE REVIEW

1.3.1 Definitions and arguments around socio-cultural influence in the use of female condoms

Female condoms represent an effective, efficient solution as a dual method of prevention to sexually transmitted infections, HIV and unplanned pregnancies. Evidence from Global Health Visions - Business case for female Condoms Report (2014) points to the health gains that have been seen in other countries like Myanmar, Kenya, Cameroon and Nigeria from employing female

condom distribution strategies. This has been based on the general population health indicators following the introduction of the female condom to the contraceptive method mix as an additional strategy.

In South Africa there has been efforts by the government to scale up the availability of female condoms to the greater population masses who are affected by the scourge of HIV/AIDS and to increase the choices of women in the contraceptive method mix. However, there are concerns that this method has not received high acceptability rates amongst the targeted populations because of amongst other reasons, its dependency to both partner mutual uptake and continued use. As a result, despite the high impetus that HIV prevention, treatment and care has been given, fertility rates and incidence of HIV infection continues to grow (SA. AIDS Report, 2012). The necessity of this method that it places on women to negotiate with their male partners has been met with challenges because of socio-cultural dictates that prevail amongst African communities. The dictates that are referred to in the study are social, cultural and behavioral that define and describe heterosexual relationships. Hughes and Koehler (2005: 43-44), defines culture as a “social heritage of a people, those learned patterns of thinking, feelings and actions that are transmitted from generation to the next, including embodiment of patterns in material items”. Airhihenbuwa, (2004) posits that culture can exhibit both positive and negative influences on health behaviors. Studies that have been done around the uptake and continued female condom use have cited gender and behavioral prescripts as inhibiting the sustained and continued use of the female condoms.

Leclerc- Madlala (2009:16) argues that “men in present day South Africa commonly engage in multiple and concurrent partnerships”. This is affirmed by Hunter’s (2005) who argues that this version of masculinity encourages men to have multiple concurrent partners and engage in high risk behaviours. Thus this notion concurs with the observation of Geertz (1973) who argued that “culture acts as template for organization of social and psychological processes such as a genetic system provides such template for organization of organic processes”. Naidu (2013) also argues that these masculinized behaviours serve to enhance the power differentials accorded to males over women. This has also been associated with some men’s use of violence when their partners initiate or suggest condom use.

This study found that violence has not always been overt, it is sometimes subtle and coercive. Women have been subjected to this violence through the prescripts of culture described in gender roles and expectations. McPhail (2007) affirms this as she describes her observation in established

relationships where women are coerced to eventually stop using condoms because of the subtle pressure placed on them in the name of 'trust'. The author observed that couples would assert to use condoms at the beginning of a relationship but when it gets longer, women would be coerced into not using condoms because most men would equate condom use as affirming distrust on the one partner by the other. Gupta (2000) argues that within this cultural construct, the scales of power and decision making authority tips toward male dominance. This translates to unequal power balance where male control and pleasure is favoured over women. This position affects women's sexual autonomy negatively whilst it increases male sexual freedom giving rise to increased risk of HIV infection for both males and females. Naidu (2013) argues that even though this is generally the case, it must be taken into account that there are 'situational' African masculinities and 'situational' femininities that exists within relationships and thus it can be placed upon women as well to choose to practise safe sex. This notion becomes complicated when women express concerns about the outcomes if they suggest condom use with their partners. This suggests that part of the solution to effective female condom use lies in involving male partners and working with young males and females on developing their communication skills in sexual relationships. Furthermore, Gupta (2002:184) argues "that gender inequality compromises the ability of women to protect themselves and this promotes a cycle of illness and death that is threatening the future of households, communities, and entire nations".

1.3.2 Worldwide impact of Condom use

In developed countries condom use has been generally accepted even though the uptake of female condoms has been lower than expected since its introduction in 1994. Over the last decade female condoms have gained popularity through educational promotions (Hoffman, 2004). Worldwide, the change in society structure and behavioural patterns enhanced by the modern lifestyle and unique developmental vulnerabilities has created a number of factors that place today's adolescents' especially young girls at heightened risks of poor health outcomes. Sub Saharan Africa is regarded as the developing region which is still poor and has not attained to the economic and health status enjoyed by the citizens in the developed world. An Economy impact model used in three countries in the Sub Saharan region: Kenya, Cameroon and Nigeria which based its' premise on the notion that consistent female condom use curbs many sexually transmitted infections and abortions, showed that the health systems of various countries can save large

amounts of money from averting morbidity and mortality that can emanate from these (Thurston and Forbes, 2014).

In his study on Commercial sex workers in the State of Nevada, United State of America, Albert (1995) found that there are benefits from condom use if only people were encouraged to use them consistently. He further points out that the experience gained through consistent condom use by individuals enabled them to gain confidence in using the condoms correctly and in turn this increased the likelihood that they will continue to use them. This in effect, she asserts can snowball into tremendous public health pay offs through the population health gains and the aversion of diseases, morbidity and mortality. The World Health Organization also endorsed this notion by asserting that “One of the strategies to mitigate sex worker risk to HIV and ill-health is to ensure access to appropriate and sensitive health care and education” (WHO, 2012).

A study conducted in Zimbabwe among traditional rural women in the use of female condoms, it was found that condom use was associated with “immorality and infidelity among men and women” (Chizororo 2003:102). This findings of the study are similar to some African cultures where patriarchal influences prevail. The study found that men continue to wield tremendous decision making power over women. This is primarily because some women have not yet attained to assertiveness to negotiate condom use even if they suspect their partners of infidelity. Other factors include patriarchal influences associated with the bride wealth payments where men expects to be sexually satisfied from their women, and thus would not want to use condoms (Leclerc-Madlala, 2009). Studies conducted in Papua New Guinea, Jamaica, and India women reported that bringing up the issue of condom use, had an inherent implication that one partner or the other has been unfaithful, which almost all the time resulted in violence (Gupta 2002).

1.3.3 Sociocultural issues that influence Female Condom use - an African perspective

(i) Gender

Gender as a social and a culture specific construct can have implications for women’s access to HIV prevention programs and dictates women’s health seeking behaviour. The cultural practices, values, norms and traditions have strong influence on the individual’s sexual behaviour and can determine the individuals risk to sexually transmitted infections and fertility choices. As such,

sociocultural factors are strong determinants of the uptake of health promotion strategies. Women make up more than 50% of all people infected with HIV, and HIV is now the leading cause of death for women between the ages of 15-49 years worldwide (UNAIDS, 2010). The statistics indicate that women that access health care programmes are not able to use health promoted strategies or products as directed for a host of reasons including economic oppression; disempowerment; limited education and lack of decision making power (Soskolne, 2002). On the other hand some scholars have observed that men seem not as concerned with health issues as evidenced by male responses to and involvement in health initiatives at the community level (Nkosi, 2012). Various scholars have cited that due to patriarchal influences inherent to most African cultures, females have limited to no power to insist on safer sex practices and contraception thus fueling the uneven scales of HIV incidence and prevalence between males and females (Airhihenbuwa, 2004; Leclerc-Madlala, 2009).

Maharaj (2005) argues that when women perceive the risk associated with unprotected sex, this perceived risk can override the man's objections and women can start to insist on safer sexual practices. This has not been seen to be applicable to a greater number of women in this community setting because of a host of reasons including gender role expectations. Gender role expectations refer to what is considered to be appropriate and acceptable behaviour for men and women. These are deeply rooted and enforced in the socio-cultural prescripts of each society (Leclerc- Madlala, 2009) These prescripts have been seen to generate aspects of masculinity and femininity which describes the power relations between women and men in society. Hence communities can hold on to some rigid views about what is acceptable for men and the same applies to women. The gender role assigned to women encourage them to be emotionally and passive whilst men must be strong, silent and powerful. These expectations continue to place women at a subservient level (Wendell, 2009).

(ii) Communities' socio-economic status

Communities' socio-economic status can also have an impact on the health status of its members. Men see themselves as providers of the family and the loss of income can put a strain on the perceived self-worth imposed by the inability to support the family financially. This gives rise to an increase in female headed households and this has also spelt the change in the power dynamics. These changes in the scales of power can put added strain on family relationships in that whilst men in these circumstances may not be able to exercise dominancy in financial control, they may

find ways to regain power and control in some aspect of the relationship in the likes of restriction of movement, access to prevention health care including family planning. These economic and or psychosocial dictates may also have a negative impact on those women who may not be able access health care provisions in a timely manner. Often times individuals may fail to honour scheduled appointments or they may not be consistent in coming for follow-ups (Soskolne, 2002). Gupta (2000) argues that when women economically depend on their male partners, they may not be able to insist on safer sexual practices and end up engaging in risky sexual behaviours because of the fear of being abandoned by their male partners and losing material support. Thus they may knowingly trade 'social death' for 'biological death' where they rather contract diseases and be plunged into misery and slow death than to risk their partners' violence or getting their partner to seek sexual gratification from other women outside of their relationship.

(iii) Sexual Decision making

In the province of KwaZulu-Natal most African communities have been influenced by religion, mainly Christianity even though many people still hold on to traditional beliefs shaped by patriarchal influences and socialisation. Within these communities, many people still continue to perform traditional rituals. Leclerc- Madlala (2009) argues that the combination of these systems continue to have repercussions and influence on the marital and social relations because of the ideals of behaviour that continue to favour men over women. Hence, sexual decision making falls largely in the hands of male partners and thereby compromise the women's position in active sexual decision making.

Gender based violence⁶ has become more common in all societies and greatly increase the vulnerability of women to infections and unplanned pregnancies. Zalewski (2010) reports that within a marriage setting, African men seem less concerned with equality between men and women. To this effect, gender inequality and power differentials increases women's vulnerability to sexually transmitted infections and unplanned pregnancies. Cultural, social and religious norms have been cited as responsible for gender inequalities (Gupta, 2000). Kenyon et al. (2012) argues that Christian influence on the African tradition did not write off the practice of polygamy that was widely practiced in the African continent but served to hide non main partner relationships which have fuelled unsafe and unprotected sexual behaviours.

⁶ The term as used here refers to violence inflicted by men on women and girls.

(iv) Desire for Children

Within the African context, marriage is socially and culturally influenced. The woman loses her autonomy with the transfer of bride wealth from the husbands' family to the wife's family, to legitimize marriage. Leclerc- Madlala (2009) argues that this transfer disempowers women, because now she is not married to her man only but to the family and the community. The wife takes on the husband's family practices and the social way of doing things. She is then expected to attain the status of a member of the family by procreating and having children. Thus with these expectations and pressure from the family, the couple will not be able to practice safe sex and condom use will not be on the cards. Leclerc- Madlala (2009) adds that an individual who does not procreate does not gain status in the community and is regarded as sub-human or as cursed in the family.

Hence in some communities when the wife fails to fall pregnant, a male relative is coerced by the family sometimes without the knowledge of the woman to befriend the wife in order to impregnate her, thus this practice throws light into the cultural practices that are deeply rooted and shape the perception of sexuality and choices that women have in traditional communities. The author further points out that even young females espouse motherhood because of the importance the African culture places on fertility. As such fertility barriers are not commonly used as these young women must prove their fertility before they get married. Similarly, Hunter (2005) states that many young men aspire to an '*isoka*' masculinity in order to prove their virility and potency. This ideology pushes them to engage in unprotected sex and more often these young men end up impregnating women. This places both men and women at a risk of contracting sexually transmitted infections including HIV.

(v) Sexual Satisfaction/ Gratification

Women have been programmed by culture to satisfy men's sexual needs at the expense of their own. Abdool-Karim (2005) argues that women go to great lengths to increase men's sexual pleasure either to maintain a good marriage or sometimes for economic survival and he sites vaginal douching as one of the practices that women engage in so that they may please men sexually. McPhail (2007) pointed out that this practice of vaginal douching or cleansing is not associated with condom use, hence it places women at a higher risk of acquiring sexually

transmitted infections. Naidu (2013) found that men who do not want to use condoms threaten to leave women who insist on condom use and find other women that will have sex without condoms. This has fueled unsafe sexual practices where women trade their health safety to please men.

(vi) Substance and Alcohol Abuse

Substance and alcohol abuse is associated with poor decision making especially when it comes to choices in sexual behavior. Much has been reported in medical literature about the association of substance and or alcohol abuse as one of the determinants of poor adherence to medical treatment and as such this is also true for condom use where intoxicated couples fail to use barrier methods or utilize condom protection and engage in risky sexual behavior. For instance, Braithwaite and Bryant (2008) reported a positive association between non-adherence to antiretroviral medication with alcohol and substance abuse. Thus alcohol and or substance abuse is a socio-cultural factor that negatively impacts on health gains through failure to utilize medical interventions designed to protect individuals.

(vii) Relationship length

There is a link between long term relationships and the lack of condom use. McPhail (2007) observed that at the beginning heterosexual relationships, many couples reported condom use which usually fades as the relationship progresses. This phenomenon is also found to be true especially in adolescents. Sandy (2011) echoed the same observation in the more mature cohabiting couples including adult relationships. This is also been observed in married couples or couples in stable relationships that condom use is reported as low or non-existent due to the belief or perception that a stable relationships is a form of protection against sexually transmitted infections and or HIV. In most African countries, condom use is not expected in a marriage arrangement and is seen as a confirmation of infidelity and lack of trust between the couples (Leclerc-Madlala, 2009).

(viii) Perceived Health Benefits

Knowledge about condoms and the health benefits associated with the protective effect of consistent condom use is necessary and the best condition for acceptance of this strategy. Thus when individuals or groups have access to information about their bodies and about sex, it can contribute to their ability to protect themselves by insisting on condom use. Maharaj (2005) notes that in communities where men have negative attitudes towards condom use, perceived risk of

infection by women can override these objections. However, Gupta (2006) reports that in most cultures women are still powerless to insist on condom use and they need to be protected from sexually transmitted infections, HIV and unplanned pregnancies. On the other hand Maharaj (2006) argues that condom use can be increased in communities by increasing education and awareness of the benefits thereof. Camlin (2008) affirms this by observing that community groups may also have a positive effect on condom use when individual members perceive the health benefits of using these strategies. As such, group norms can guide and govern behaviour, and are particularly relevant in condom use across various contexts in communities that have strong social support systems. This notion is further supported by Saggurti (2013) who discovered that female sex workers and men who have sex with men reported the shared belief in the ability of a group to address problems were more likely to engage in consistent condom use in India.

(ix) Individual Behaviours

The wealth of information around health issues, sexually transmitted diseases and fertility choices that is available through media and is promoted by the department of health does not equal to change of behavior. Cultural norms, peer influence and other social networks have a bearing on individual interpretation of situations and decisions that an individual makes. Coates (2008) argues that together with prevention strategies as in the form of female condoms, individuals' behaviors need to change to effectively combat and break this cycle of illness, and death. He declares that these behavioural strategies can focus on individuals, couples, families, peer groups or networks, institutions, and entire communities. He defines these as those that attempt to delay the onset of first sexual debut, decrease the number of concurrent sexual partners, and increase the number of sexual acts that are protected through the use of condoms.

1.4 PURPOSE OF THE STUDY

The study's intention was to probe the sociocultural factors and behaviour that appear to influence the use of female condoms by African women in a bid to remain HIV free and to exercise their right in controlling their fertility. When these factors are understood, they can help in deriving specific and targeted messages to inform and shape health initiatives and interventions designed to empower and guide women's choices in reproductive health. There are a host of reasons why there are challenges with the uptake and sustained use of female condoms, besides male partner involvement and support issues. The researcher categorized these into service level, and user issues and presented an overview:

1.4.1 User issues:

Like men, women engage in sex for different reasons including pleasure. Thus the discomfort reported by some women in the study when using female condoms, speaks to major issues around uptake and continued use of female condoms. The design of the female condom with both its inner and outer ring has been reported by some women participants to be a ‘put off’ from sex because of its baggy shape and big size. In this community some women practice vaginal douching or cleansing to dry and tighten the vagina so that the penis fits snugly reported some concerns. Some women participants reported that the female condom size leaves the users wondering as to whether its’ size mirrors the size of their vagina. This distorted view has been reported by some women to linger at the back of their minds during intercourse thereby interfering with their sexual pleasure. Studies that have been done in communities where vaginal cleansing is practiced by some women (Mozambique, Tanzania, Uganda and South Africa) have reported minimum or no use at all of condoms following this practice (Smit et al., 2011; Bagnol and Mariono, 2008). Naidu (2013: 30) posits that the design flaws of the female condom that have been reported by the women as inhibiting sexual pleasure perpetuate the ‘docility’ ascribed to some African women and their bodies.

1.4.2 Service level issues:

Provider attitudes are crucial when it comes to promoting any strategy that clients need to buy into. Clients look at the enthusiasm displayed by the provider about the product as to whether the provider believes in the promotional product. If the provider gives a negative hint about the product, uptake thereof is usually not good and doomed to fail. It also is important to ascertain the extent to which the female condom is being promoted at every encounter with each female or male that visits the clinic for any reason. This would speak to the strategies given to women to introduce the female condom to their males and the support that is readily available should the couple experience difficulties in using the female condom (for example, if women are given direction to follow if they have questions or concerns about the female condom). The availability of the product at all times to the targeted population ensures sustained use and the maintenance thereof. The reported stock outs of the female condom in other facilities places the female condom at a disadvantage because the targeted population cannot get the product at all times. The irregularity of the product in the mainstream means that the targeted population cannot always trust on its availability and hence the targeted population may fall in and out of product use (Beksinska, 2013).

1.5 Research Problem and Key Questions

Women continue to bear a huge burden of HIV infection and other sexually transmitted infections and even unwanted pregnancies despite efforts by the government and other women's advocacy groups to empower them through health education, provision of free contraceptive services and access to free condoms. Many clinical trials have also been done to test intravaginal Microbicides in an effort to find solution to high incidence of HIV infection amongst women of reproductive age. However, there has been challenges with these methods because of inconsistent product use and the continued high statistics of HIV, sexually transmitted infections and unplanned pregnancies. Many studies that have been done on vaginal Microbicides, have cited non-adherence as threatening to derail the scientific gains in combating the HIV/AIDS scourge because of among other reasons, not involving men partners (Amico, 2013).

Hoffman et al.(2004) report that the female condom was adopted due to the growing evidence that a great percentage of women contracted HIV mainly through heterosexual intercourse rather than any other manner, hence there was great advocacy for the female condoms in a bid to protect women against sexually transmitted infections including HIV and unwanted pregnancies. It was thought by most female condom advocacy groups that women would readily accept, embrace and use the female condom without having to rely on their partners. However, this has been far from reality as these studies have asserted; partner cooperation is crucial to the effective and continued use of this method. These studies have not paid enough attention to the socio cultural dynamics of the communities from which they recruit their participants instead their focus has largely been clinical. Understanding these cultural dynamics can serve as an entry point for health intervention strategies and can increase on the uptake and efficacy of condom use amongst the targeted groups. The following are the research questions to be answered in the study:

- a) Why do some African women 'choose' to use female condoms?
- b) Why do some African women 'choose' not to use female condoms?
- c) What support if any, do some women receive from their male partners, regarding their choice to use female condoms?
- d) How does the gender powered relationship influence the use of products that have to be used inside the vagina?

1.5.1 Study objectives

The study hoped to contribute to the body of knowledge through understanding of the following:

- a) Factors associated with the uptake and sustained use of the female condoms.
- b) Community knowledge, attitudes and beliefs towards the use of female condom.
- c) Structural barriers affecting the use of female condom,(i.e. is it readily available, promoted at the clinic)
- d) To explore the extent to which these barriers impact upon the use of the female

1.5.2 Propositions

The study has been approached based on the following assumptions:

- a) It is difficult for some women to negotiate female condom use with their partners
- b) Sociocultural factors play a huge role in determining the uptake and continued condom use
- c) Male partner involvement is crucial in realization and promotion of women's health

1.6 DEFINITION OF KEY TERMS

The following terms were used in the study and can be understood to have the following meaning:

HIV prevention strategies: ways or interventions that have been proven to prevent transmission of HIV

Sociocultural Factors: Cultural practices, values and norms that interact with individual ability to make choices

Microbicides: products applied inside the vagina or rectum that are intended to reduce the risk of getting HIV through sex

Isoka/ Casanova: a man with multiple sexual partners

Influence: A determining factor believed to affect an individual's tendencies and characteristics. The influence can be positive or negative.

Structural violence: A form of violence where some social structure or institution may harm people by preventing them from meeting their basic needs.

Behaviour: The way that one acts or conducts oneself, especially towards others.

1.7 CHAPTER OUTLINE

This study is organized into six chapters. Each chapter begins with a brief introduction, followed by a body, which is divided into sub-sections, and all six chapters end with a conclusion which briefly summarizes the discussion presented in each chapter.

1) Chapter One:

Introduction and Literature review

This chapter introduces the background to the study. It is here that the relevant literature which outlines the definitions and the arguments around the socio cultural influence on the use of condoms is discussed. The literature provides the background, arguments and findings from previous work done. It further presents the global and African regional perspectives. The socio-cultural factors that influence condom use in heterosexual relationships are explored.

2) Chapter Two:

Research methodology, design and theoretical framework

This chapter outlines the research methodology, design and the justification of the research methodological techniques used. The sampling design and procedures, data gathering techniques and tools are discussed and justified. The chapter also discusses ethical considerations in conducting research with human participants. It also presents and discusses the relevance of the Structural violence Theory and Structure of Conjuncture and their relevance to my research study and the limitations of the method used is discussed.

3) Chapter Three:

Female condom use in heterosexual relationships

This chapter introduces women participants from low resourced setting, mostly from informal settlements and discusses the meaning of female condoms through the lens of these women. It probes how women from a diverse background, predominantly low resourced, mobile community make health related decisions and how social prescripts, sexual identity influence these decisions.

4) Chapter Four:

Acting on acquired knowledge

This chapter presents the drivers behind condom use or non-use. It explores the attitudes, beliefs and behaviour of individual participants in the study. In this chapter also the structural barriers that impact upon the use of female condoms in this particular community (whether there is enough education and knowledge around the use of the condom) are explored.

5) Chapter Five:

Research findings and discussions

This chapter explores the socio-cultural determinants that influence condom use. It looks into the power differentials and explores women sexuality and their perceived support from male partners.

6) Chapter six:

Conclusion and Recommendations

This chapter presents the findings and summarize them as well as discussing the limitations of the study, conclusion and recommendations.

Chapter 2

RESEARCH METHODOLOGY AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

The previous chapter presented the existing literature that focus on socio-cultural influences on health decision making. This chapter presents the research methodology and design as the behaviours and instruments that were used in the study and the theoretical framework as the guiding principles that enabled the conduct of this research.

2.2 RESEARCH METHODOLOGY AND DESIGN

This study used qualitative research methods. This approach was chosen because it seeks to understand a complex world of reality through the lens of those who live it. Patton (2001:39) affirms that “qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings, such as real world setting [where] the researcher does not attempt to manipulate the phenomenon of interest”. The study used this approach in line with the construction of the social world of individuals that emerged from the interaction between the researcher and the participants. Strauss and Corbin, (1990:17) defined qualitative research, “as any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification”. This interpretive method helped the researcher to get insight and find meaning as to how individuals perceive medical interventions and the sociocultural dictates that spell meaning and shape decision making and behavior for individual community members. This is because the focus was on the subjective experience of individuals and their perception of reality when it comes to medical interventions and the integration thereof into their life. The use of this design made it easier to ascertain how the introduction, uptake and sustained use of female condoms is contingent on interrogating and understanding the sociocultural aspects of communities where these intervention are to be introduced and used continuously. The study also applied semi-structured interviews.

2.2.1 Data Collection

The study was conducted by using in-depth interviews and focus group discussions which made it easier to triangulate data. The field notes, recordings and observation of nonverbal cues were valuable tools and a reliable source of additional information. The researcher used convenience sampling which was cost effective. This meant that the researcher was able to get the sample size from one targeted population which possessed the appropriate characteristics that were needed for the research. The advantages of this method is that the interviewer has one on one interview with the participant after creating a safe environment where the participant could feel at ease to talk to the interviewer without fear of judgement or negative social repercussions. Although the interviewer encouraged free talk sometimes unexpected topics cropped up which necessitated the interviewer to steer the conversation back to the topic under discussion. Some of the participants were not inclined to talk much. Other participants did not take kindly to being recorded and after repeated assurances of how confidentiality would be maintained, they were eventually at ease to carry on and the interview was completed. The use of recording material and notes made it easier to capture the information as the participants narrated their stories.

(a) In – depth interviews (IDIs)

In-depth interviewing is one of the useful qualitative research techniques. It involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation. In this case, the interviews were conducted mostly in Isi-Zulu for approximately 45 minutes with individuals, unless the participant was comfortable and asked to be interviewed in English language. 12 females and 7 males took part in the in-depth interviews. This was done to probe and understand individual views on the use of female condoms. Knowledge of female condoms, general and personal views were probed including how participants felt about using them with their partners. The in-depth interviews (IDIs) were conducted with participants accessed from clinic when they visited and had been informed of the study and were agreeable to participate by symbolizing this through the signing of the informed consent.

The participants were interviewed individually in a private room at the clinic where strict confidentiality was maintained. A semi-structured interview guide was used to keep the conversation on track. Anxiety was allayed through forthright declaration of the use of audio

recorders and the taking of notes. Participants were assured of maintaining strict confidentiality of their names including the information they provided. Guion et al (2011) considers an in-depth interview (IDI) as a conversation where the participant has more say on the topic under discussion. The interviewer can follow up on a question and probe for meaning. Interviews were conducted in isiZulu because this is a predominant language of the people of Clermont unless the participant preferred to be interviewed in English. All interviews were transcribed verbatim. The interviewer is both fluent in IsiZulu and English which made it easier to transcribed using the field notes and the audio tapes.

In-depth interviews were chosen for the study because they employ open ended questions. This has a potential for engaging in an open, honest, truthful and meaningful discussion because of using communication skills like probing, exploring, clarifying and summarizing information to bring out the thought processes and the clarity of information on the topic under discussion. Verbal and nonverbal cues were observed and interrogated to unveil hidden feelings or silent words and these added value to the data collection. This method has its own limitations in that respondents may not be open and honest about sensitive issues of behavior that may be culturally or socially criticised or condemned. This limitation was overcome by conducting individual interviews in a relaxed, comfortable environment and by the interviewer's nonjudgmental demeanor in order for each individual to express his/ her feelings and thoughts.

(a) Focus Group Discussions (FGDs)

Powell et al (1996: 499) define focus group as a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research. The focus group was conducted in a private room where participants attended their scheduled group meeting. 4 participants formed the male focus group which ran for one day and 5 women participants attended their focus group which was held once. A focus group guide was used to serve as a road map directing the course of discussion. Since some women expressed concern to participate in the presence of the opposite sex, females and males had a focus group separately. This method proved convenient as participants were free to express themselves and this created an opportunity for interaction and learning from getting multiple, sometimes divergent responses from a single question.

Kitzinger (1994, 1995) argues that interaction is the crucial feature of focus groups because the interaction between participants highlights their view of the world, the language they use about an

issue and their values and beliefs about a situation. Interaction also enables participants to ask questions of each other, as well as to re-evaluate and reconsider their own understandings of their specific experiences. The limitation of this technique is that individuals in a focus group express their own definitive individual view and they may be speak in a specific context, within a specific culture hence it may be difficult for the researcher to clearly identify an individual's message as sometimes the exploration of questions is controlled as not to step on toes especially when dealing will sensitive issues.

2.2.3. Sampling Technique

a) Convenience Sampling

A sample is a finite part of a statistical population whose properties are studied to gain information about the whole (Webster, 1985). Therefore a sample is a subset of the population. Convenience sampling was used in the study by the researcher. Convenience sampling is a non-probability sampling method that relies on data collection from population members who are conveniently available to participate in study. This method involves getting participants wherever you can find them and whenever they are available. Patton (2002: 137) affirms that availability sampling is appropriate in social research where the researcher cannot access all elements in the target population. In this study, participants were drawn from the group of clinic patrons who had come for contraception, sexually transmitted infections treatment and voluntary HIV counseling and testing. The targeted participants had to be females and males over 18 years, sexually active in a heterosexual relationship and be residents of Clermont area. The researcher chose this sampling method because it is cost effective and an in-depth study of a social event can be achieved using fewer participants with the same characteristics. 29 participants were interviewed as more than this number would have been cumbersome to analyse because of the amount of data that would have been generated. Although this method is not without risk in that it can lean towards selection bias, poor generalizability, and a high level of sampling error, these limitations were catered for through in-depth interviews and focus group discussion as a way of triangulating findings.

b) Participant Selection

The study was introduced to the participants through health presentations at the foyer or waiting area of the Clermont Clinic. Potential participants were recruited using the information sheet that

outlined the study and all those that showed interest and were available for further discussion were requested to come to a separate consulting room where the study was further explained in a confidential setting using the informed consent form. Participants who had time and were available signed informed consent and were interviewed after they had been attended to at the clinic for the purpose of their clinic visit. Those that were in a hurry or wanted some time to think the study over were given the researcher's contact details for appointments at a later date. Some participants who wanted to think about the study did come back whilst a number of them did not. Despite these setbacks, an adequate number was obtained. 12 females and 7 males were interviewed individually however male accrual was painfully slow. The focus group discussion was conducted with different participants from those that participated in the in depth interviews in order to minimize bias and this aided in triangulation of findings. The participants' ages ranged between 18 and 45 and the average age for both males and females was 24.6 years.

2.3 RESEARCH SITE

This research was conducted in Clermont, Durban which is predominantly a 'cosmopolitan' and mobile⁷ peri urban area (black African men and women who had migrated from other cities). This clinic is located about 5km outside of Pinetown. Some residents of Clermont come from as far as the Eastern Cape to settle in the area in search of work. The purpose of this study was to probe the socio-cultural factors that influence the use of female condoms in heterosexual relationships in this 'cosmopolitan' community where there is not one standard culture but a conglomeration of 'borrowed and emergent' cultures as different people come together from different backgrounds and find meaning in the interpretation of the situation they find themselves in at that particular time.

2.4 RELIABILITY AND VALIDITY OF DATA

To ensure reliability of data in qualitative research, examination of trustworthiness, dependability and credibility of data is important. Seale (1999: 266) states that the "trustworthiness of research report lies at the heart of issues conventionally discussed as validity and reliability." Hence, Johnson (1997:282) argue that sustaining trustworthiness of a research report depends on the issues

⁷ Most sections of this community are zoned to receive government housing and as a results residents are often moved to temporal shelters to await reconstruction and development programme houses. This, coupled with the fact that most of the participants have moved to this area from other locations therefore they have been referred to in this study as 'migrant' or 'mobile'.

discussed as validity and reliability which is defensible and establish confidence in the findings. In this study validity and reliability were catered for through triangulation. This method was used to seek accounts from three perspectives, namely individual female interviews, individual male interviews and a focus group. This is affirmed by Mathison (1988: 13) who states that “triangulation has risen an important methodological issue in naturalistic and qualitative approaches to evaluation in order to control bias and establish valid propositions because traditional scientific techniques are incompatible with this alternate epistemology”. Probing participants for deeper understanding on how they view female condoms and how they arrive at decisions to use or not to use them to protect themselves against STIs /HIV infection and unwanted pregnancies helped to construct their reality from their perspective. Crotty (1998:42) defines constructivism as “the view that all knowledge, and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context”. Obtaining data through open ended interviews, probing, observation of non-verbal, communication and audio recording made it easier to peer into the participants’ world. The research tools were able to obtain relevant information and the data that emerged was appropriate for the research question. A strong association between what the participants see as important to them shaped by their cultural beliefs, linked with the concepts under scrutiny and there was consistency in the outputs received from participants.

2.5 DATA ANALYSIS AND INTERPRETATION

Data analysis is the systematic process of applying statistical and/or logical techniques to describe and illustrate, condense and recap, and evaluate data. Thematic analysis was used in this study. This method of analysis is commonly used in qualitative research. It emphasizes examining, and recording patterns or themes within data. Boyatzis (1998:7) describes thematic analysis as a process of "encoding qualitative information". During the process of data collection, the researcher was at the same time involved in analyzing her data through transcribing non- verbal cues, emotional responses and recorded data. As patterns of thoughts emerged, these were coded into categories and grouped.

Thematic analysis can be approached in various ways, but the researcher chose inductive form whereby coding and development of themes emerged from the content of collected data. Reading the data several times made it easier for the researcher to get similar patterns and thereby categorize

these as they develop. Each interview was read and analyzed against the research question. Emergent patterns were defined, named and grouped and thereafter translated in writing. Data was transcribed and all the recorded interviews were coded into themes as they emerged.

2.6 ETHICAL CONSIDERATION

Like any study involving human subjects or participants, Ethical Considerations are crucial to protect the dignity, the rights and respect all participants. The Office of Human Research Participants (2012: 62) states that conducting research with human participants raises a wide range of ethical considerations which all researchers need to address before embarking on any research to prevent harm. Thus research in which human participants are involved is expected to involve three guiding principles of Respect, Beneficence and Justice. Hence permission to conduct research was sought from the Clermont Clinic supervisor to use clinic patrons and ethical clearance was obtained from the University of KwaZulu Natal Social Science Ethics Committee. The District and the Regional Department of Health were notified of the intention to conduct the study at the Clermont Clinic. All participants were required to sign Informed Consent which had all elements of good informed consent document as stipulated by the Office of Human Research Participants. This maintained that participants were engaged in a process of information exchange, comprehension thereof, willingly took part in the study and the whole process culminated in the documented agreement of the informed consent.

In order to maintain the dignity and respect of all participants, all study documents and participant's information was kept confidential in the school of Humanities and Social Science Research Registry for five years and to protect participant's identity, anonymity was observed in all documents, correspondence and write up. Participants were provided with adequate information about the purpose of the study and were informed that their participation would be voluntary hence if they felt like they wanted to withdraw at some point during the study they were free to do so. Risks and benefits of the study were also explained. Fortunately, there were no opt outs after the informed consent was signed. The study results or feedback will be made available to all participants.

(a) Confidentiality

Confidentiality can be defined as an explicit or implied guarantee by a researcher to a respondent in social science research whereby the respondent is confident that any information provided to the researcher cannot be attributed back to that respondent. During the focus groups all participants had to sign the agreement of confidentiality of information that they would not divulge or make reference to information discussed in the room nor any participant involved in the focus group. The researcher protected her participants in that information in their records did not contain their real names. The researcher also explained to the participants the conditional or relativity of confidentiality in exceptional circumstances. Codes were used to identify participants as these were assigned after informed consent signing. Frank (2013:1) affirms that the use of codes or pseudonyms helps in masking the details of interviews during transcription.

(b) Anonymity

In view of the sensitivity of the research content as is especially true when one discusses private intimate information, it was imperative for the researcher to observe anonymity of participants and their research documents by always keeping them away safely and assigning codes and not real names.

2.7. THEORETICAL FRAMEWORK

Individual woman sexual decision making is central to the study as it lays the basis for analysis of the ability for each woman to negotiate female condom use to prevent sexually transmitted infections, HIV and unplanned pregnancies. Notwithstanding, the perception of individuals' worth in the interpretation of gender roles and functions in a changing society influenced by lifestyle and unique developmental changes for both males and females. Thus Structural violence and structure of the Conjuncture will be given fair attention in this study.

2.7.1. Structural Violence

Structural violence theory was first proposed by Johan Galtung during the 1960's and can be defined as a term that describes the macro structures such as social, political, economic, legal, religious, and cultural that impede individuals, groups and societies from reaching their full

potential (Farmer, 2006). Farmer argues that “Every society is shaped by larger- scale social forces that together defines structural violence”. These forces include racism, sexism, political violence, poverty, and other social inequalities that are rooted in historical and economic processes that sculpt the distribution and outcome of HIV/AIDS. According to structural violence theory, the violence lies in everyday experiences and is normalized by institutions and the people who are affected are not conscious of being victims of this violence because it has become part of their lives and it is seen as normal. Therefore the primary objective of this theory is to identify and explore just how these macro forces influence the support that males afford their women partners in health care related matters. This theory suggests that the cultural perception formed around sex and sexuality, gender and gender roles in a given society has an impact on how culture prescribes behavior and distribution of sexual power. In an African society with patriarchal influences women in heterosexual relationships are dependent on their male partners to make health related decisions including fertility choices. Structural violence theory is proposed for this study as it gives light to the actions, behaviors and processes in the individuals’ life that have been prescribed by culture through socialization. This framework provides a mechanism to understand individuals behaviors especially towards health interventions and how these decisions shape and give meaning to observed patterns of behaviors measured against the wealth of health education and health promotion available to all in the community. The concept of ‘structure of Conjuncture’ (Sahlins,1961) has also been employed to better understand how the shift from known social structures enabled by individual movements from one place to another, the change in the systems of meaning and practice develops and emerge as a new trend of behaviour giving identity and meaning to individuals within a community. This could well have an effect in a modern “cosmopolitan” or diverse community with different cultural practices.

2.7.2. The Structure of Conjuncture Theory

The structure of conjuncture theory was proposed by Marshal Sahlin in 1961 and is used to understand the confluence of perceptions in the interpretation of circumstances and events in the individual lives of participants. These perceptions in turn were seen to be projected in behaviour towards medical intervention and how support from male partners can influence the sustained use of medical interventions. The way couples in heterosexual relationships in this mobile community interact and give meaning to their behaviour will help to identify variables that make them to arrive at decision making to accept or reject female condoms. The theory of structure of conjuncture however, has limitations especially because of the fault line between culture and community practices. Viewed from the ‘conjuncture’ lens, where in the African culture, many scholars have

sited that much emphasis is placed on fertility, condoms are viewed as an unnatural and a waste of sperm whilst arguments have been raised to assert that women who perceive the health gains afforded by condom use can negotiate condom use (Maharaj, 2009). Johnson-Hanks (2007) argues that there are apparent social motivations for behaviour that can contradict stated norms. She quotes Weber (1978) that a sufficient understanding “of social behaviour such as getting married, giving birth, moving, or dying—requires “adequacy on the level of meaning” as well as mastery of the rates at which various forms of behaviour occur” This creates a conundrum which benefits the study as it compares individual decision making towards medical interventions as influenced by culture and the community prescripts in an evolving fast paced lifestyle changes dissociated from the known traditions and how these are projected in sexual behaviour as people derive meaning from them.

2.7.3. Significance of theories

Structural conjuncture theory helped the researcher to delve into the world of males and females in heterosexual relationships and to examine how these individuals view themselves, make health related decisions including fertility choices and how others in the community view medical interventions as well. This enabled the researcher to investigate the influences of socio-cultural factors on their decision making. The theory helped the researcher to see how individuals construct their sexual realities, from which they follow their sexual beliefs and practices.

The structural violence theory helped the researcher to understand how individuals position themselves in the community and the distribution of power differentials in heterosexual relationships. It also helped to ascertain how individuals define and describe their gender roles as individual males and females. These theories helped the researcher to answer questions such as: (a) what are the main socio-cultural factors that influence female condom use in heterosexual couples? (b) What are the factors that contribute to the acceptance of the female condoms? (c) What are the factors that contribute to the rejection of the female condoms? (d) What support if any do the women receive from their male partners, regarding their choice to use female condoms? (e) How do gender-powered relationship influence the use of products that have to be used inside the vagina? These questions provided a lens through which the researcher peered into the individuals’ reconstruction of their relationships, the interaction in the reality of their world and thereby come to understand the confluence of perceptions, interactions and interpretation of situations that eventually culminate in health decision making.

2.8 LIMITATIONS OF RESEARCH METHOD USED

Data collection was achieved but with some limitation involved. For example, some participants' response were biased for a number of reasons which included the internal conflict between the individuals' perception of events and the socio-cultural dynamics. For instance, some participants reported increased use of female condoms which did not tie up with the number of condoms that were obtained from the clinic and some women reported the use of female condoms at each encounter even though they had asserted that their partners did not like using condoms. Other female participants were not eager to talk about their sexual practices. The researcher accounted for this limitation by using mixed data collection methods to tap on the individual as well as the group perspective. The researcher herself had to be careful as not to influence the study in any manner either by preconceived ideas or leading the discussion to arrive at the desired conclusion.

The interviewer made the participants comfortable and she appeared interested in what they were saying. She made sure to use effective interview techniques, such as avoiding yes/no and leading questions, using appropriate body language, and keeping her personal opinions in check.

2.9. CONCLUSION

This chapter provided the context within which to examine various socio cultural factors that influence and shape condom use in heterosexual couples. The interviews and interaction with participants showed that the acceptance of female condoms is primarily influenced by increased knowledge and understanding of health benefits of the individuals within the relationship coupled with the ability of women to continue to negotiate condom use with their partners. The chapter also presented structural violence and structural conjuncture theories as a basis for arguments to show how individuals view and make health related decisions. The uptake and continued use of this pregnancy and HIV prevention strategy though hinging on socio cultural factors and the underlying gender dynamics, was seen to be contingent on the interpretation of the benefits by individual participants. The next chapter will closely examine the lived experiences of community individuals.

Chapter 3

FEMALE CONDOM USE IN HETEROSEXUAL RELATIONSHIPS

3.1 INTRODUCTION

The past two decades have witnessed an increase in female circular migration in South Africa. Migration and its' causes, has often been associated with male movements. Little is said about female migration patterns and the conditions under which women migrate. The impact migration has on the health of female migrants has not been investigated as extensively as it has been for men. Hunter (2007) reiterates this notion after observing that the most common data source on women migration is obtained from census or household surveys. The reality though, is that since the democratic dispensation in the country, there has been a freedom of movement for many people in search of 'greener pastures'. The last two decades has seen females, mostly young girls moving away from traditional homes to big cities in search of work.

This has, amongst other things, contributed to the mushrooming of informal settlements in and around townships and suburbs. Clermont, is one of the townships, which has seen the increase of informal dwellers and most of them being females who have come mostly, from rural areas. Most women usually come at the invitation of one of the acquaintances or a relative for a job prospect. This relative or acquaintance would provide a temporal accommodation, with the hope that the one accommodated will find a 'live- in' job or will soon be able to provide for herself. This rapid social change calls for quick adaptation to the new environment and for each individual to make a sense out of it. Migration, on its own is a crucial social vulnerability, where there is lack of back up from known systems of social capital (Soskone 2002: 1298). Here, young girls usually build temporal structures next to each other or live as a group in what is called *Imijondolo* (Informal settlements or Shacks). They depend on each other for safety and support and sometimes share common ideologies as they see life, interpret and make sense of it. This structural transformation with the rapid social change can be overwhelming that sometimes the need for survival can take precedence over all other needs. These young women thus make do with the little they have and as most of them find jobs they start to spread and find their own spaces. Sometimes, individual women find sexual partners who are willing to accommodate and clothe them. These are the 'shanty town temporary families' that are only glued together by circumstance. This poor economic

status and the unfavorable or uneven distribution of power puts these young women in a vulnerable position. This view is strongly shared by Soskolne (2002) who asserts that “migration is linked to a lower socio economic status and to limited power in the new society which are major determinants of elevated risk of HIV infection”, other diseases and or unwanted pregnancies. Thus in these circumstances, it becomes important to interrogate how women arrive at and make health related decisions.

3.2 WHAT FEMALE CONDOMS MEAN TO WOMEN IN THIS COMMUNITY

Kumina iyinto enhle kakhulu ngoba uma ingekho ikhondomu yabesilisa umuntu angasebenzisa leyabesifazane ukuzivikela ekukhulelweni, nezifo zocansi.

Angisho nje, ngake ngazama ukuyisebenzisa kodwa uphathina wami akazange ayithande, ngase ngayiyeka, asikaze ke siyizame futhi.

For me it is a good thing, because in the absence of male condom one can use the female condom for protection against pregnancy and sexually transmitted infections. I must admit though, I tried it once but my partner didn't like it, so I left it. I have never tried it again. (N-K, 23yrs)

Ikhondomu yabesifazane yenzelwe ukuba abasesifazane nabo babe novo kwezocansi, kodwa-ke akusithina sonke esingakhululeka ukuxoxa nophathina bethu ngezocansi

The female condom is meant for women to also have a say in sexual matters, but not all of us can talk freely to our partners about it. (A-B, 18yrs)

Sibonga uHulumeni ngokusenzela into esingazivikela ngayo njengabesifazane, mhlawumbe bekungaba ngcono uma ukwakheka nokushelela kwayo kungenziwa ngcono kunalokhu eyikona njengamanje

We thank the government for creating something for us too as females to protect ourselves, however it would be great if the texture of the condom can be changed and be little bit better than it is at the moment. (T-Z, 19years)

Mhlawumbe uma lamakhondomu abesifazane abengadayiswa abantu banga wasebenzisa, ngoba abantu banomqondo wokuthi amakhondomu adayiswayo angcono kunala wamahhala.

Maybe these condoms should be available for sale too because people have that mentality that the condoms that are sold are better than the free ones. (CIS, 22 years)

The views expressed by some participants bring to the fore the challenges encountered by most women with regards to condom negotiation and use. Although they may be knowledgeable about the risks of non-protection during sex, and not by themselves opposed to condom use, they may face challenges in using them. Knowledge and attitudes related to condom use is crucial to the uptake, correct and consistent use of the female condoms (Beksinska: 2012). However knowledge alone is not always translated to positive actions. There are a host of reasons for the poor uptake and consistent female condom use. Amongst others are social–structural factors, such as extreme poverty, culture, economic factors and peer influences (Morisky: 1998; Outwater: 2000). Included in this mix is the fact that women cannot use condoms independent of their partner. However, other participants expressed a need for innovation to improve the texture and the make of condoms so that they (condoms) can be user-friendly. Whilst some participants expressed the need for expanding the market and communication of female condoms in the community to enhance acceptance, uptake and use by the targeted population.

Z-D 22 years, thinks the female condom is an alternative when there is no male condom. She relates:

*Sasesikulungele ukwenza ucansi, wabheka edroweni lakhe, wangawathola, benginamabili amakhondomu abesifazane esikhwameni, ngakhipha eyodwa, **wamangala.***

Kodwa wangisiza ukuyifaka, kwabamnandi futhi salujabulela ucansi sobabili.

*We were ready to have sex when he looked in his drawer, and he could not find anything, I had two of the female condoms in my bag, I took the female condom out, **he was surprised**. But he helped me put in it, we enjoyed sex with it. (Z-D 22yrs)*

Z-D relates that she caught her boyfriend unawares, and in the heat of the moment, he had to agree to use it otherwise they could have engaged in unprotected sex, like the previous time where he played the same card of “no condoms in the drawer”. She reported that she takes protection seriously as she has recently been treated for sexually transmitted infection (STI) and had a negative HIV test, which is why she had condoms with her. Although her partner was, in a way, as Z-D puts it “trying to slyly force me to have unprotected sex”. Z-D had taken it upon herself to protect herself. The STI treatment has been a wakeup call for her. The subtle coercion to engage in unprotected sex is associated with male partner’s control of women reproductive choices and health which is often linked to partner violence (Naidu 2013:1; Miller 2009: 316). The participant was further probed on why she thinks her partner was surprised, Z-D confirms that her partner does not like condoms. When she brings the condom issue up, he always says she must trust him. The issue of ‘trust’ in relationships irrespective of its length is seen here as a form of mental and subtle coercion which speaks to male dominance and their attitude towards condoms (Macphail 2007:6; Naidu 2013:1). This also brings to light the competing ideologies and attitudes towards condom use experienced by women and their partners in heterosexual relationships. Although most of the female respondents felt it was difficult to negotiate condom use with their partners, the majority of the male participants claimed otherwise. Most males admitted that they would be surprised at first if a female suggest or negotiate condom use even though they are open to condom discussion with their partners.

Z-N a 24yr old had this experience to relate:

Nakuba ngazi ukuthi ayasebenza ukuvikela ezifweni zocansi futhi ngiyalujabulela ucansi ngawo nalawa abesilisa, athatha isikhathi ukuwafaka, kanti kweny inkathi sisuke singekho lesosikhathi, sengivane ngisebenzise lawa abesilisa.

Though I know it works and it protects against infections and I enjoy sex with the female condom as much as I do with

the male condom, it takes time to insert and sometimes I do not have that time, then I stick to male condoms. (Z-N 24yrs)

N-L who likes to be affectionately called ‘Skhokho’ (slang word which carries a connotation of being “with it” or denoting “one who is informed”), had a different view from most women:

Ngicabanga ukuthi ayasebenza ukuvikela kwi HIV nezinye izifo zocansi kanye nokukhulelwa kulabo abakwaziyo ukuwasebenzisa kahle, kodwa kumina, ayisebenzi. Kubukhuni ukuyifaka futhi angiyithandi. Ngimane ngisebenzise lawa abesilisa.

I think it works to protect against HIV, other infections and pregnancy for those who can use it properly, but for me, it does not work. It is difficult to insert and I do not like it. I would rather stick to the male condom.

(N- L, 19yrs)

Unlike N-L, most women respondents did not regard the female condom as a contraceptive tool. They admitted to have been introduced it as a dual protection (as both contraceptive and STI / HIV preventative tool) but for them, it is more for HIV prevention. This raised an important question about the use of female condoms on when one knows does not know her HIV status. It emerged from the responses of most participants that the use of condoms is sometimes compromised when both partners know their status. For those who are positive, they have nothing to prevent since they are already infected. Those that are negative, would not use condoms consistently because of false belief that they are not at risk of infection. This is in keeping with other study findings which showed that knowledge about disease transmission, though empowering, has not always effected positive behavioral change (Zellner 2003; Gilmour 2000 and Varga 1997). Negative attitudes about condoms are also a major barrier to consistent use. For many young couples, suggestions to use condoms spells unfaithfulness and mistrust. Due to such beliefs, personal and emotional concerns often supersede the choice to use condoms. ZNN a 25yr old, reported proudly that she and her partner test for HIV every month. She reported that:

*Siyasazi isimo sethu, ngakho asiwasebenzisi amakhondomu.
Ayazwakala, ngokwami ngikhetha ukushaya isikoon.
Awukwazi ukuzwa lokuya kukitazeka, nokunwayeka okumnandi
lapho esechama uma ufake amakhondomu.*

*We know our status, so we do not use condoms
They are unnatural, personally I prefer sex without it.
With the condoms, you can't feel and enjoy the tingling
sensation that happens as he release himself. (ZNN 25yrs)*

Her friend Z-L 22 years has a negative view of a woman who carries condoms.

*Ungasuke uthi uhlale ekulindele ukwenza ucansi,
ngicabanga ukuthi abesilisa okumelwe baphathe amakhondomu.
Cabanga nje uma iwa eteksini, bonke abantu sebekubuka ngamanye amehlo.
(kkkkk, ehleka). Eqhubeka:
Uma ucinelela ukusebenzisa amakhondomu,
Lo wakho angakushiya aye kulabosisi abengezuwasebenzisa.
Ngiyazi amakhondomu ayasebenza ikakhulu lawa esifazane,
Ngoba enzelwe abesifazane, kodwa sekuyisijwayezi nje
Ukungawasebenzisi, Nabangani bami abawathandi.
Uma sizixoxela ngawo bavele bangihleke.*

*It is like she is always ready for sex, I think it is the males
who must bring condoms. Imagine if you drop the condom
by mistake in the taxi, then all people will look funny at you.
(kkkkk, laughing). She continues:
If you insist on condom use, your boyfriend will leave you for
those girls who want it without condoms.
I know condoms work, especially female condoms because
they are meant for women, but out of habit, I do not use them at
all times. My friends do not like them. When I tell them about my
experience with the condoms, they tease and laugh at me. (B-S 34yrs)*

This highlights the communities' view of condoms and the competing ideals of behavior which are viewed and interpreted as acceptable or normal within the community. Thus this notion portrays Geertz's (1973) observation about culture: 'culture acts as template for organization of social and psychological processes such as a genetic system provides such template for

organization of organic processes. The female condom activists thought that the female condom would readily be embraced and accepted by women in communities with a high burden of unplanned pregnancies and HIV/AIDS infection, because of it being women initiated. (Beksinksa 2012, Hoffman 2004).

3.3 FINDING A HOME AWAY FROM HOME - A conscious choice to use or not to use.

*Ay, sis akubanga lula neze ukufika kwami apha necousin yami
Kwakungokomsebenzi, endafika usuthathiwe,
ndingenandawo yokuhlala, kwafuneka ndithole indawo msinya
ngoba ndingenakuhlala necousin nendoda khe nabantwana
bakhe ababini rumin inye.*

*Ay sister, it has not been easy, when I came with my cousin,
the job that I was promised had already been taken,
I had to find alternative accommodation real quick because
my cousin lived with her boyfriend and her 2 children in a
single room. It was odd for me to be in the same room with them.
(NEM 26).*

These are the words of one participant who described how she ended up cohabiting with a new found boyfriend. She has been in the area for 3 months and her reality to negotiate the use of the female condom she feels is something out of question. She admits to have knowledge of female condoms as she previously had been introduced to them at her home clinic by the health provider. She, however, finds it difficult to introduce them to her partner at this stage of their relationship because they did not use them from the beginning. On this day when I spoke to her, she had come to the clinic for her second dose of contraception. She recently started contraception in preparation for her migration to the city. She continues:

*Ukuqala manje ndithi asisebenzise ikhondomu, kuvele kome umqolo.
Uzawthi kutheni manje bese ndithin mna-ke.
Into ndesabela ukuthi uzawcinga ndiyamgangela,
Usuk' abenomsindo kwenyinkathi. Haai, sisi, noshe!*

*The thought of introducing it now sends shivers down my spine,
he will ask me.. why now, then what will I say?
I fear he will think I am unfaithful and he can be temperamental
at times, no Sisi I can't!*

When the researcher looked at her, she shyly looked away. From her demeanor, the researcher could read from her facial expressions and voice that condom negotiation is not about to happen. She conveyed a shocking predicament that she had found herself in. At this young stage of her life, her health had taken a back sit whilst she struggles with the current need for shelter and being loved. She went on to relate that she had not even tried to talk to him about family planning or any concrete future plans. She conveyed a bleak outlook of helplessness which she nuances as she explains her perceived objection of the female condom use by her boyfriend. She said:

*Ndake ndamncokolisa ngamakhondomu emva kwe advert kuradio,
wathi akaguli yena amakhondomu awabantu abangaphilanga.
Emva koko andizange ndiphinde ndiyiphathe nje eyekhondomu.*

*I once joked about the condoms after an advertisement on the
radio but he said he is not sick, condoms are for sick people.
After that I have never mentioned them again.*

NEM views herself as powerless to negotiate condom use and as a prerogative of her partner to protect her. She is a passive participant in this relationship. The power that she has transferred to and accorded her boyfriend including her economic situation determines whose pleasure will be given priority at the expense of her health. Gupta (2000: 2) observes that “the unequal power balance in gender relations that favours men, translates into unequal power balance in heterosexual relations. This he posits is constructed by a complex interplay of social, cultural and economic forces that determine the distribution of power.”

She seems to have an inconsistent perception of her partner though, because during the course of the discussion, she portrayed her partner as being loving and understanding. She admits that her partner had never been physically violent towards her though during one minor argument, he raised his voice. It is on this basis and the fact that he provides for her that she thinks she can never be able to negotiate condom use. When probed, why she feels this way, she related that:

*Lomntu wandichola ndisenkingeni, wandethemba
Wandifaka endlinakhe, wandenzumntu ebantwini,
Uyandinakekela, andiswelento, so angeke ndamkhathaza
Okuncane endikufumanayo, ndikuthumele khaya*

*This person (boyfriend) rescued me when I was in trouble he took me in and
treated me like a human being, he supports me in every way,
I lack nothing, so I won't cause trouble. The little money I get,
I am able to send home.*

One can read from her voice the commitment she has on playing and carrying out her subservient role. She went on to justify what she felt fulfills her cultural role expectation as she is prepared to be obedient and a good partner in her relationship.

HB, a 23 year old who readily admits to have 2 boyfriends who support her, explained sheepishly why she finds it difficult to use condoms at all times.

*Nophathina wami wangempela, angikwazi ukusebenzisa amakhondomu, ngoba
uhlale ethi asakhe umuzi, angimtholele umntwana. Akacabangi
ukuthi sisebenzise akhondomu. Angimthsheli ukuthi ngifake implant,
ukholwa ukuthi angihleli. (kkkk, ehleka).*

*With my main partner I cannot use condoms because he always speaks about
starting a family, he wants a child from me and he refuses to use them (any type of
condoms). I do not tell him that I have the implant, (contraception inserted under
the skin) he thinks I am not on contraception. (kkkk, laughing). (HB -23 years)*

What HB expresses about male partners' verbal demands has long been observed by various scholars and has been associated with partner violence and unintended pregnancies. The overt pregnancy coercion which sometimes leads to interference with contraception fuels risk taking behavior of non-condom use (Miller 2007, 2010; Lang 2007; Wingood 2001). She goes on to say that:

*Ungisaphotha kukho konke, kodwa kumele ngibhekelele umntanami
nogogo ekhaya.. Angiholi mali, kungakho nginalo makhwaphehi wami.*

*He supports me in everything but I have to see to my child and
grandmother at home. The money I earn is not enough that is
why I have this “roll-on” (meaning her other boyfriend).*

She reported in a low voice as she looked down shyly, with a wry smile as if she was saying “Don’t you judge me, don’t you dare judge me”. I looked on straight, trying hard not to send any vibes that could shut down the conversation or distract her from the conversation. She went on:

*Kwenyinkathi kumelwe wenze izinqumo ezinzima ukuze uphile.
Impilo ubuye ibe nzima ingakuniki thuba
Sometimes you have to make the tough choice to survive.
Life can be hard and leave you no choice.*

It appears that assuming the role of a breadwinner, a woman takes on a new responsibility of maintaining and supporting herself as well as her family left in the rural area. This is the expectation from family members left in the rural homes and such is the predicament that young women find themselves in. She explained her situation as:

*Kodwa naye, (lowesibili) ngisebenzisa amakhondomu.
Kukanye la asiphelela khona, sashaya uskoon kulerawundi yokugcina.
Emva kwalokho ngihleli ngiphethe awami. Ngithatha womabili abesilisa
Nawesifazane eklinikhi futhi sishintshashintsha wona.*

*But with him (2nd boyfriend) I use condoms. It is only once where
we ran out of condoms and I had the last round without a condom.
After that I had to carry my own condoms. I took both female and
male condoms from the clinic and we use them interchangeably.*

Hunter (2002) reiterates this phenomenon clearly when he says ‘unemployed or poorly paid women are forced to engage in transactional sex with men’. Though in this case of girlfriend and boyfriend one cannot explicitly classify this relationship as transactional as you would describe

the exchange of sex with a sex worker for gain but this kind of sex describes gains one partner obtains in exchange for sex. Amongst a few respondents, it seemed acceptable that one partner (especially women) would gain material or monetary awards out of a sexual relationship.

A different view emerged when both partners were immigrants and are new in the area.

CZN a 33 year old female verbalizes that she uses condoms with her partner at all times as she uses them as a means of contraception. She went on to relate that they find the condoms readily available and safe. She seemed content that her partner can find them even in tuck-shops and sports bars. As she puts it:

*Kwakunzima ukuya eklinikhi sisafika ngoba sasingenakheli eliqondile.
Ngishu kuthi xa sifika lapha kwakungelula ukuya emaklinikhi noma
kuphi, kodwa ukuthola amakhondom etuck shop kwenza izinto zaba ngcono.*

*It was hard for us to get to the clinic at first because we did not
have the right address. I mean, when we came in the area we
were not comfortable with going to clinics and so on,
but the condoms that we found in the tuck-shops came in handy.
(CZN – 33 years)*

This assertion brings to light a different perspective that other foreign nationals enjoy in this country to some degree. The fact that male condoms are freely available make it easier for them to continue to use even as she asserts that it is this type of condoms (male condoms) that are freely available, but she has found difficulties in accessing female condoms because they do not get them everywhere except at the clinics. She points out that in her country (Congo) they have difficulties in accessing any type of condoms all the time. She reported that condoms were not promoted in her country as is in South Africa. Her experience with female condoms is only limited to television. The nearby tavern and tuck-shop does not stock female condoms. The clinic does not provide female condoms. This finding concurs with Beksinska (2012: 55) observation that the provider attitudes have much influence in the uptake and continued use of female condoms. Though there is much evidence that female condoms have a pivotal role to play in turning the tides of unplanned pregnancies, sexually transmitted infections, HIV and AIDS, much depend on the promotion and continued availability of this strategy.

3.4 SOCIAL PRESCRIPTS AND COMMUNITY EXPECTATIONS

“Seninesikhathi eside nindawonye, uyamlambisa yini umakoti, usalokhe esesiqu esinjengoba engena kulamagceke”.

Uvele ufunde kwezakho ukuthi kuthiwani kuwe, kulindeleke ukuba ngabe sesinabantwana, kuqondwe ukuthi ngabe usenesisu esikhulu manje.

“You have been together for some time now, are you not feeding her properly, she looks the same as when she entered these premises”.

You know the meaning of these words, their expectation of you to have children. They mean my fiancée must change shape around the waist.

(One participant quoted a family member directing these words to him).

Despite the growing impetus on condom use as a dual method of sexually transmitted infections, HIV and unwanted pregnancy prevention, many couples engage in sex without the use of this strategy. The participants pointed out that the family and community expectations placed upon each couple to have children makes the use of female condoms or any other protection for that matter very difficult.

Isoka lami ilona elivame ukuba namakhondomu.

Uma siseklinikhi ngiyawathatha ngiwanike yena.

Angeke nje ngifane ngifike nawo ngiwathi qithi kuye.

Uzongibuka njengomuntu ophaphayo osefuna ucansi

My boyfriend is the one who usually has a stock of condoms.

I take condoms if we are at the clinic together and give it to him, but I cannot bring it and ask him to use it. He will look at me as though I am forward and want to initiate sex. (NQ, 24)

SK a 23 year old seemed to reiterate what NQ had said:

Lo wami uyena olawulayo ukuthi ucansi silwenza nini, kwesinye isikhathi ngisuke ngingalindele. Kwenye inkathi sishaya uskooni ngoba sisuke singenawo amakhondomu ngoba usuke engawathathanga eklinikhi

My boyfriend decides when to have sex with me, sometimes he takes me by surprise. We sometimes have sex without condoms because

he did not bring them from the clinic.

Most women in the study seemed to think that it is the responsibility of their partners to ensure a sufficient stock of condoms. They felt males did not take lightly to a woman who carries condoms with her. When probed about this perceived objection by males for women to carry condoms with them, it emerged that the discomfort came from the proximity of rooms. Males were suspicious that it would be easier for women to engage in sex with other males. This fear is displayed to women in the form of dominance and restriction of choices and decision making. This community predicament could be explained and understood through the structural conjuncture theory (Sahlin: 1961) as it explains how these couples interact and give meaning to their behavior. This structural barrier to accessing and consistent condom use cannot be seen in isolation. Other factors emerged as the discussion carried on.

The participants explained what they perceived to be another barrier to consistent condom use by sharing the community perception on HIV. The silence that surrounds HIV/ AIDS and care was apparent. Hence, individuals within relationships keep their HIV-positive status confidential. This sometimes means that even in long term relationships, (this is also true for married couples) individuals are not always open to each other about their HIV status because of fear that an open discussion would lead to confrontational arguments and demand to questions that individuals may feel are best left unanswered. As a result of the secrecy surrounding an HIV-positive status and the emphasis placed on fertility, couples in these settings bear a lot of pressure from relatives and family members that expects them to reproduce (Leclerc- Madlala 2009, Gupta 2013). The narrative below gives insight to the extent of silence around HIV status:

Umzala kamakoti wakithi owangihlanganisa nesoka lami ngenkathi ngifika la endaweni. Nakuba wayazi ukuthi lo, kade egula isikhathi impela, akazange ayithi vu leyo. Saqhubeka sizithandanela nje futhi singasebenzisi khondomu ngoba wayethi ufuna ngimzalele umfana. Ngisanda kuthola nje ukuthi lo wami kade azi ukuthi uyagula futhi wayeseqalile nokudla amaphilisi wabuye wawayeka uma esezizwa engcono. Ngaphambi kokuthi ashone wathi ucela ngimxolele futhi uyangithanda kakhulu. Ucela ngimbhekele ingane yethu eyayinezinyanga eziwu 9 ngalesosikhathi, Ngenhlanhla ingane yona ayithelelekanga.

I was introduced to my boyfriend by my sister- in law's 'cousin when

I came in the area. She did not tell me that my boyfriend had recovered from a long term illness. We continued our relationship without using condom because he said I needed to give him a son.

I found out recently that my boyfriend had known his status for a long time. He had been on treatment and he stopped taking it because he felt better. Before he died, he said he was sorry, he loved me so much.

*I must take care of our 9 month old son. Fortunately, my son is not sick.
(NM, 22years)*

This narrative left the researcher emotionally exhausted and helpless, thinking how much work is yet to be done to protect and empower women in the communities. I echo Gupta's (2006) words: "If we are to contain the HIV epidemic we must tackle its root cause—gender inequality. It is this that is compromising the ability of women to protect themselves and promoting a cycle of illness and death that is threatening the future of households, communities, and entire nations". The silence around HIV, the desire to procreate and other structural factors fuels HIV infection, unplanned pregnancies and other social ills.

3.5 WOMEN'S VULNERABILITY VERSUS MEN'S VULNERABILITY

NDU, a 23 year old who had been engaged for 2 yrs. and recently moved to the area describes how she called her engagement off from her abusive fiancée. She relates:

Ngathola ukuthi wayenenye intombi ngathi sekuzofanele sisebenzise amakhondomu, yena wathi angeke asebenzise amakhondomu ekuhambeni nalayindlini. Sasihlele ukuthola umntwana kodwa kwakungelula kumina ukubamba, ngase ngiyezwa ukuthi usemithisile. Ngavele ngaphelelwa, ngezwa ukuthi ingqondo iyama, ukudla kwakungangeni kulezonsuku. Wayethembise ukusebenzisa amkhondomu ngaphandle

*I found out that he was unfaithful and I insisted on condom use
He did not like it, and said he could not use a condom outside of home
and at home with me. We planned to have a baby but it was difficult
for me to conceive, then I got to know that he had impregnated someone
else. I was so devastated, I stopped eating for days.*

He had promised to use the condom with the other women”.

NDU trusted and believed that her fiancé would use the condom with someone else but not her. She fell victim of the circumstance that placed her at risk. She asserted to have prior knowledge that her fiancé was unfaithful but she saw the risk as far away from her because of the prospect of marriage and starting a family. This finding concurs with Adimora (2013:169) who asserts that “gender based violence inside and outside the context of intimate partner relationship is a common experience for women world-wide and increases their risk for HIV acquisition through several biological, behavioral and social mechanisms”.

NH a 29 year old from the Eastern Cape admits that she depended on her boyfriend for her survival. Her boyfriend supports her fully, meaning that he is responsible for shelter, clothing and food. Whatever temporal jobs she finds, she has to send money home. She also falls in and out of condom use. She admitted that her boyfriend was not physically abusive but she had not insisted on condom use.

She admits:

*Kumane nje kuwumkhuba engihlulekayo ukuwuyeka, uyaluthanda
ucansi olumpumpununu futhi ungizwa kangcono,
angincome kabi, nami ngifuna ukukugcina kunjalo.*

*It is a habit that is difficult to overcome, he loves sex without a condom
and he always praises me after sex and I want to keep it that way.*

(N-H, 29yrs)

The participants’ explanation seem to bring to the fore, the various cultural expectations that are prominent amongst Africans where ‘good women’ are supposed to be passive and ignorant about sex. What was highlighted by NDU that even when she was aware that her fiancée was not faithful, she could not successfully negotiate condom use puts her in a vulnerable position (Corovano 1992). NH and other participants in the study who depended on men economically show to have little or no voice to negotiate safer sexual practices. Most women, especially those that see their relationship as ‘protective’ are not able to work their way out of a risky relationship, NDU’s situation shows the choices that women can have if they see the benefit of their decisions. The vulnerability increases where women see themselves as silent participants and continue to put male sexual gratification ahead of their basic health needs (Gupta, 2000; Airhihenbuwa, 2004; Naidu 2013). The socialization that gives males power in sexual relationships creates a

conundrum that puts males at risk as well. The lived experience and social expectation that has been shared by male participants in the study alludes to this fact. MD, a 23 year old male related that:

Kumele ngibe nobuciko ekwenzeni ucansi ukuze angakhali,
uma kungenjalo angingishiya phela, akuyonake into engiyifunayo leyo
akufuneki ukufambula ngesikhathi socansi, kumelwe akuzwe
umshaye wonke amakhona aze akuthakazele
*I need to be skilled in love making so that I can satisfy her;
otherwise my girl will leave me that is the last thing I want.
You cannot fumble during intercourse,
She must feel you, you must do it in the manner that
She starts calling your name as you reach all her corners". (MD, 23yrs)*

He says this as he burst out laughing and all the other guys in the focus group starts to join in. This notion is shared by all. They seem to justify why they need sexual experience with a lot of girls before they settle down with the "one". During discussion it emerges that most males seem to buy into the idea that promiscuity "is the rightful passage to manhood". SP, a handsome immaculately dressed guy, who readily admits to being an *Isoka* /Casanova (a male with many female sexual partners). He expressed his views and explained why he thought it necessary as one grows into manhood, to experience natural sex without a condom first before one can say he knows anything about sex. He states that:

*Ndingathi mna, ukwenzu cansi isipho esivela kumdali
Ngakho kumele ndisebenze ukuze ndenze, ndimshaye kakuhle
Umntu wami, angasokoli.
I can say, engaging in sex is a gift from God
So I need to get skilled so that I can excel in it and
satisfy my partner; so that she does not complain. (SP 26yrs)*

According to Vilakazi (1962: 47) 'Courting behavior among traditional young men is a very important part of their education; for a young man must achieve the distinction of being *isoka* (Casanova)'. This notion holds true even in this day and age where social norms expect men to be more knowledgeable and experienced about sex. Hunter (2005) concurs with this as he points out

that young males aspire to an *isoka* masculinity and thus experiment with various sexual partners. This expression of masculinity encourages risky sexual behavior as males are coerced to engage in unsafe practices to prove their manhood. This, it seems is not isolated to this community as some studies have shared their observation from various males in other societies as well. Mane, (1994) and Heise, (1995) observed that men believed that a variety of sexual partners is part of men's nature.

3.6 SEXUALITY AND FEMALE CONDOM USE

Andikaze ndimbuze ngokusebenzisa amakhondomu
xa efuna uyawasebenzisa, mna ngivuma oko akwenzayo,
ndithokoze nje qha.

*I never question him about the use of condoms
He uses condoms when he wants and it is pleasurable
For me in both ways, I still enjoy sex (LES, 34yrs).*

Unesu lokundenza ndikhohlwe zikhondomu,
Ndiyazi ziyasebenza kodwa andifuni ukuxoka nami
ndiyaluthokozela olungenawo.

*He has a way of getting me not to use it
I know condoms work, but I also enjoy sex without them
I do not want to lie. (ZIN, 19 years).*

The participants seemed to suggest that their partners enjoy a tremendous amount of power in their sexual relationships which inhibits consistent condom use. Gupta (2000) posits that "power determines whose pleasure is given priority in sexual relationship". Clear links also exist between the sexual pleasure that respondents seek and the use of dual method of protection in the form of condoms. This is confirmed by STA who reported to enjoy sex more since she started using female condoms.

She says :

*Angikhathazeki ngokukhulelwa noma ukuthola izifo zocansi
Sisebenzisa amakhondomu nangesikhathi sisadlalisana
futhi lokhu kuyangisebezela.*

*I do not have to worry about getting pregnant or contracting any diseases.
I use the condom with my partner in fore play, and it works for me (STA, 24yrs).*

DE a single 33 year old matured woman who is eloquent in her speech and reasoning, she reported to have stopped having children says:

*Ikhondomu yabesifazane iyisipho kwabesifazane
Ngiyayisebenzisa futhi ngyalijabulela ucansi ngayo
Kunamaphilisi nemijovo egcwele amakhemikhali
Ngincamela amakhondom, usengathi ucansi lwendalo nje.*

*The female condom is a gift for women.
I use it and I enjoy fantastic sex with it.
Instead of pills and injections, which have chemicals
I prefer condoms, really they are next to natural.*

This assertion concurs with findings from various studies conducted in women's health. These studies have shown that participants who have accepted, continued and mastered the correct use of the female condom have reported enhanced sexual pleasure. In addition women's sexual goals have been seen to shape the patterns of female condom use. Higgins (2010: 685) confirms this by asserting that the initiation and continuation of condom use, (male or female condoms) can be influenced by how condoms make sex feel and that sexual experience and reproduction may affect the uptake and continued condom use.

3.7 CONCLUSION

The experiences and the narratives of individual and group participants clearly show how circumstance, culture and social prescripts enforce certain behaviors and decisions making at individual level (Soskolne 2002: 1297). The chapter also brought to light the interpretation of circumstances and situations experienced by 'migrant' informal dwellers and how these shape and give meaning to their lived world. Airhihenbuwa (2004:5) suggests that for any medical intervention to be successful, it is important to understand the culture of communities within which these medical interventions are introduced. Culture has been identified as a central feature to defining and understanding health related behavior. However, in a mobile community with a

confluence of mixed cultures, it becomes exceptionally important to extract and explore the commonalities that are seen to shape and influence health behavior.

An attempt was made to explore and understand how individual participants viewed female condoms and their meaning against the backdrop of unplanned pregnancies and risk of sexually transmitted infections and HIV. The experiences captured from participants in the study suggest that cultural beliefs and practices as well as structural forces influence behavior towards the uptake and continued female condom use. It became apparent that sexuality, social prescripts of behavior and social structures pertinent to a specific community needs to be further explored in association with behavior towards health initiatives. The next chapter presents and discusses study findings.

Chapter 4

ACTING ON ACQUIRED KNOWLEDGE

4.1 INTRODUCTION

An individual's view of life and beliefs can shape one's outlook and behavior in life. A large body of knowledge exists on sexual construction and women sexuality. Often women are portrayed as helpless and powerless to insist on safer sexual practices. Maharaj (2006) sees it differently; she noted that in communities where men have negative attitudes towards condom use, perceived risk of infection by women can override these objections. Soskolne (2002) adds that women migration is a social vulnerability which places women, particularly those that depend on their partners economically in a difficult social predicament. The disempowerment of being new in the community coupled with inherent African traditional socialisation puts an added strain on migrant women. As shown in the previous chapter, various women in different settings have their pre-conceived ideas and notions about condom use. As such, whilst other women participants perceived themselves as unable to initiate, negotiate and insist on female condom use, others seemed comfortable with this. The women's views and perceptions of female condom use is nurtured and fuelled by their cultural beliefs and approaches to reproductive health, sex and sexuality and their social standing in the community. As such whilst other migrant women could enjoy protection afforded by the use of condoms during sexual encounters, others were adversely affected by non-condom use. Female condoms have been promoted in South Africa since 1998 and whilst there is some knowledge of the benefits of its use as a dual method of protection, the effects of its uptake and continued use are yet to be realized. Thurston (2014) points to the health gains that have been seen with the introduction, acceptance and continued use of female condoms to the contraceptive method mix in other countries including Sub Saharan Africa. Thus, the female condom has positioned itself as an affordable and effective tool in contraception and HIV/ AIDS prevention strategy. Its uptake in the context of high prevalence of unwanted pregnancies and sexually transmitted infections could prove beneficial for the communities mostly affected.

4.2 'MIND OVER MATTER'

The first days of my husbands' circumcision were very difficult for me because I was used to my husband. But a few days after his circumcision, he insisted on condom use. I looked at him and said: 'You must be joking' Guess what, he was not! I was really disappointed and wanted it (sex) without the condom since I imagined he was now clean and the chances of infection were minimal. I had to pretend I was enjoying it until the end. I did not want to have sex for a few days thereafter.

(BY, a 32 year old married female)

The crackling in BYs' voice, spelt her disappointment and you could see from her face how her husbands' stance affected her. She had objected to using the male condom that she reportedly was familiar with and had used it several times before, though not at all sexual encounters. Another participant NB a 35 year old married and working woman spoke so strongly about female condoms and admitted that she does not use them at all times.

I really do not like female condom, it is difficult to insert and I can't keep the partner waiting whilst I am trying to make a number eight (referring to the method of inserting the inner ring into the vagina). Me and my husband we do not use condoms at all times, out of habit, we do not use them. We may start with one but the subsequent rounds are mostly without condoms.(NB, 35yrs)

The participant's negative perception of condoms indicate that its use within a marriage setting is unacceptable or undesirable. The use of condoms whether male or female within the marriage arrangement has long been a bone of contention among scholars. The perception that most women have that marriage is a form of protection against sexually transmitted infections, and HIV has fueled the HIV epidemic within the married community (Stats SA, 2013). This notion is multiple dimensional as McPhail (2007:6) argues that the use of condoms among couples still faces resistance as the length of the relationship grows and especially amongst married couples irrespective of the knowledge of the benefits it affords to couples. This points to couples in all age groups regardless of their HIV status.

The participants indicated that the use of condoms in a marriage setting regardless of knowledge of HIV status is largely undesirable and unacceptable. According to the participants, the use of condoms is not morally right to the extent that some of the female participants revealed that they sometimes engaged in unprotected sexual intercourse with their spouses because condoms have no place in a marital bed. It is against this backdrop that the use of the condoms was specifically interrogated in order to gain insight of the extent of its acceptance by married couples. When NB was probed further about introducing female condom and use to her husband, she retorted:

Angithandi ukumlindisa, ngayizama kanye ngahluleka ukuyifaka
kodwa njengoba usho nje, mhlawumbe uma ngimcela ukuba
angfake ngenkathi sisadlalisana, ngingaythokozela ukuuysebenzisa.
*I really do not want to keep him waiting, I tried it once and I
failed to insert it but as you say maybe I can ask him to put
it for me during fore play, perhaps I can enjoy using it.*

Leclerc- Madlala's (2009) observed that the traditional African culture where condom use within a marriage arrangement is compromised is due to amongst other reasons, the emphasis placed on fertility and family. The communities' perception of this dual method of prevention has had an added impact on its uptake and continued use. NBs' asserted that she and her close friends did not like it because it was difficult to use, made the interviewer want to know more about the participant's experience with the female condom. When probed further it emerged that she and her friends had all tried it once and thereafter decided that it was not working for them. This finding alludes to messaging from the provider around the education and introduction to partner of the female condom. This opens a conundrum and brings to question how the education given to the women at the clinic and the support that is given by the provider, should women experience problems using the product.

Hernandez (2006) posits that amongst other variables proper education is a causal variable in improving health because this is associated with understanding and acting on knowledge for better health. This assertion coupled with the fact that some participants reported that after the first use they could not find the female condoms at the clinic because of stock outs creates a gap in the use of this strategy.

Another way of looking into this is through the lens of gendered power within the marriage institution as revealed by the following participant's experience:

He refuses to use condoms saying:

“I am the head of the family, do not tell me how to conduct my affairs, next you will tell me when and how to have sex with you.”

CIS, a 22 year old who recently started taking contraception, confirms to have taken female condoms from the health care provider, she relates:

I took a few condoms from the provider but I have never used them. They look strange and are huge. The look is just a put off. I cannot think of a way to introduce them to my partner, they seem awful to look at. I am embarrassed to take them out and show them to my partner.

On probing this assertion by the participant, it emerged that attitudes against the female condom was formed due to the appearance of the condom which is seen to mimic the size of reproductive cavity or the vagina of women. The introduction and education of the female condom did not address the imagined ideals and the mental pictures of how a vagina should be like. Although the female condom has been championed as the option of choice and a useful tool for prevention of sexually transmitted infection, HIV/ AIDS and unwanted pregnancies, its promotion should speak to the ideals of culture and the vaginal practices of the community in which it is promoted. Thurston (2014: 4) argues that female condoms offer the means of utilization of family planning and HIV prevention strategies that have long been unmet for women, especially because this strategy is women initiated. The participants' views prompted the researcher to probe further in order to get better understanding of the partners' intimate moments behind closed doors in heterosexual relationships. These views and perceptions can be classified into broad categories which include:

1) Perceived reduced sexual pleasure

With a condom, sex feels just dull, and mechanical the sensation is reduced and sex last long. (JB, 24yrs).

I have to hold the female condom so that he does not push it in I always worry that it would get lost inside of me.

Then I cannot concentrate on what I am doing. I do not enjoy sex with it. (AB, 18years).

To be honest, at first I did not enjoy using the female condoms but I persisted because I was afraid of getting infections and I was not ready to have a child. I had been given two types of condom to try: the one with a ring and the one with a sponge. We tried them both, at first it was difficult. But this one, the one with a sponge inside, sex feels different in it, I enjoy it (GGN, 24years).

GGN compares the female condom with wearing a new shoe for the first time. She further reported that it was not comfortable at first, but she persevered and now she actually has discovered that sex was fun as she continued to use the female condom and mastered how to use them properly. She goes on to relate what technique she and her partner have implemented to use the female condom brand that has an inner ring:

Because of the problems I encountered in using the female condom, we decided to remove the inner ring and my partner put the female condom in his erect penis and guided it through, he pushed it gently and touches in all my corners inside. In this way we both enjoy sex and know we are protected. Now we use it most of the time.

This interesting innovative use of female condom intrigued me and made me realize how far individuals who believe in the product and see the benefits of its use were willing to go. This finding concurs with Dimateo's (2007: 525) study which found that the perception of the severity of threat to the individuals' health that has a bearing on the use or not of a medical intervention.

2) Unnaturalness of sex with a condom

ZA a 45 year old who has been cohabiting with her partner for 9 years readily asserted that she knew that condoms were good and had the power to protect but she found it a challenge to use them consistently. She explained that:

We often use condom but sometimes you want to do things differently, you long for that naturalness of sex, that special feeling.

Although ZA was not pressured to have children and has excellent knowledge on the gains of consistent condom use, she views the use of condoms as unnatural and sometimes a barrier to enjoying sex. This notion of unnaturalness of sex with a condom outweighs the health returns that condom use can have. This is confirmed by Azjen (1996) who argues that knowledge does not always translate to positive behavioural change.

BO a 33 year. old who is a Christian had a different view on condom use:

I know as Christians, sex before marriage is wrong, but since we can't help it. We engage in it anyway, marriage is scarce these days and everyone is doing it.

I usually think God will judge me better than having committed a sin, I did in a safe way. (kkkk, laughing)

I am waiting till I am married to engage in sex in a more natural way, only when I am ready to start my own family.

This brings in a very important fact that individuals long for natural intimate sexual encounters. This longing, according to various scholars is heightened when individuals engage in social drinking and sometimes drug use. These longings or desires have been fulfilled when individuals who although use protection when sober, have sometimes engaged in risky behaviour due to altered mental state under the influence of alcohol and or other drugs. For instance Hinkin (2007: 185) observed that drug use and abuse may also be related to poorer medication adherence. This has been a cause for concern in medical adherence of people already infected and has been also observed in various HIV prevention initiatives (Woodsong, 2013; Abdool Karim, 2013).

3) Peer influence

Nabangani bami bazamile ukuyisebenzis kodwa ayibasebenzelanga nabo. Simane sabona ukuthi kungcono sihlale la kweyabesilisa. Hhay, ayejwayeleki le , Yenza ubone sengathi nesitho sakho siwuwaxawaxa nje. Kanti siya monya thina sithule, thaqa. My friends also tried to use the female condom but it did not work for them as well. Like my friends, I have never tried it again. We thought we will stick with the male condom. We cannot get used to the female condom, It makes you think, your private part is huge, but we douche and we know we are tight. (LIN, 23 yrs).

This brings to light the mental picture created by the female condom to individuals and how its use can be compromised by the inadequate knowledge and ill perception of the method. Although the participants admitted that they did not ask the provider about the female condom appearance, their perception and interpretation of how the female condom looks and what it means appears not to have been adequately or never addressed. In this instance peer influence can have both positive and negative connotations in the health behaviour of individuals as attested by one participant:

Me and the circle of my friends, we use condoms because we have set our goals. Pregnancy and HIV is not one of them. We are far away from home, we have to look out for each other. (AYZ, 20yrs).

These participants' perception of protected sex may be understood within the theoretical framework of Structural Conjuncture Theory. The theory interrogates and gives meaning to the individual or group behaviour emanating from interpretation of situations and or circumstances that shape the prescripts of family structure, social prescripts and sexuality in gender roles in this community.

4.3 ACTUAL OR PERCEIVED PARTNER VIOLENCE

*I do not see how I can persuade him to use condoms
He wants a baby from me. Each time I suggest condoms use, he
just brushes that aside. Even if I offer to wear one myself, I am not
ready to have a baby, but he puts pressure on me. He started off by
tearing my Family Planning card into pieces. He really have me
cornered (DU, 23yrs).*

ST a 31 year old seemed to share the same predicament as DU as she also reported that she was in a long term relationship but her partner would not use condoms, saying that asking him to use condoms with her inferred that he was not faithful, ST relates:

*He came home a bit tipsy and he initiated sex I reached for the
condoms. Oh, that was a start of a whole nights' argument. I did
not sleep that night. Ever since that incident, he plainly refuses to
use them.*

This finding concurs with Miller (2010: 316) who asserts that partner violence is associated with direct pregnancy coercion, interference with contraception, verbal abuse and threats of or actual physical violence.

SI reveals that her partner threatens to withhold financial support if she insisted on condom use whilst with BT it is the fear of how he may view the request to use condoms. BT relates:

*We did not use condoms at the start of our relationship,
It would be difficult to ask him now. How will he interpret
this request without thinking I am accusing him of being
unfaithful. (BT, 26yrs)*

This hesitation and pre-empting one partner's response was alluded to by Woodsong (2013). She cited among other contributors to non-adherence to vaginal microbicides by trial participants, the fear women have of being found out by their partners to be participating in clinical trials. This fear was crippling in so much that women would rather, not wear a vaginal ring when

engaging in sex. This was so ironical because the medicated ring was designed to protect the women from infection during sexual intercourse.

SIM a 27 year old, unemployed female participant who lives with her partner had a different experience:

*I had just come back from the clinic and put my bag down.
I went outside of my room to fetch water, when I came back,
without any notice, he slapped me hard on my face, I fell down. He
asked me, what's this? Showing me condoms.
He had been through my bag and found condoms
I had been given at the clinic.*

The interpretation of what it means for a women to carry condoms in their hand bags and how males perceive this can largely depend on the type of relationship the individual has. Sarkar (2008: 117-118) associates the decreased autonomy of women in a relationship with social barriers to condom use. She affirms that when women are in a difficult relationship where there is no dialogue about sexual matters, men always had the final word. She goes on to link the individual capability and emotional intimacy with the power to effectively negotiate condom use. Although SIM was caught unaware she was unable to defend her case in this instance. The violence that was projected towards her made her numb and unable to negotiate condom use at the time. She reported that after this ordeal, she was frustrated and did not talk to her partner for days until he apologized.

She described what transpired next:

*When he wanted to talk things over, I was glad.
I was determined to make my voice heard
I then was able to explain and insist on condom use.
Now we use condoms except by mutual agreement.*

Unemployment and economic dependency on male partners by women interferes with the women's' ability to stand up and protect themselves especially in sexual and reproductive matters as men always see themselves as providers and wield more power. Many scholars dealing with reproductive health describes pregnancy coercion, birth control sabotage as experiences that place women at greater risk of contracting sexual infections and unplanned pregnancies. Unless women are empowered to create a platform for open dialogue with their

partners, and men are informed and recruited as partners in the health initiative, the change in social dynamics will remain static.

4.4 SEXUAL ECONOMY IN INFORMAL SETTLEMENTS

SIB admits to have 3 boyfriends who support her in various ways, as she puts it jokingly:

*I have to have all the ministers lined up
Minister for housing, Minister for Food and water and
Minister for recreation (meaning there is a boyfriend who helps
with rent and the other helps with food whilst the other is for
pocket money and the recreation). Ay sis (she chuckles), what can
you do you have to “shuffle,” work is scarce.*

To survive SIB engages in risky sexual behavior and hope and pray that she does not contract HIV and other sexually transmitted infections. She admits to be on contraception but she falls in and out of condom use. She reported that she did not use a condom with her main boyfriend but does so with her other two boyfriends. She reported to consistently use condoms when with the other two boyfriends. Like others in her case who are away from home, SIB has to survive. ZD, a 34 year a live-in domestic worker with an unemployed husband in her rural home admitted that she had a boyfriend who financially assisted her. She said:

*I usually use condoms when my boyfriend visits me.
He helps me financially and sometimes he does not want to use
condoms. But with my husband at home I do not use condoms
because he is my real partner.*

Exchanging sexual favors for economic gains by women at the risk of their health, has been observed by many scholars (Gupta 2000; Soskolne 2002; Hunter 2005; 2007; Richter 2013). Even though some women move from their rural homes and find some employment in the urban areas, it is found that their everyday existence depends on sexual economy. Poor socio economic status and the added responsibility to care for self and the family at home has been cited as one of the drivers of risky sexual behavior.

4.5 CONCLUSION

This chapter has shown how pleasure and sexual functioning of individual members of the community can promote risky sexual behavior in the community. It explored the attitudes beliefs and practices prevalent in this community. It also shed light on structural barriers that affect acceptance and continued female condom use. It pointed out that knowledge of barriers to female condom uptake and continued use can be positioned against the community knowledge and perception to overcome challenges and promote acceptability and continued use. It also alluded to peer influence as an added cord in strengthening the safe environment within which individuals can interrogate their perception of health initiatives and find examples in the form of their peers with whom they can relate. It also brought to the fore economic pressures as social ills that drive poor uptake of health initiatives that are designed to uplift women's health.

Chapter 5

POWER DIFFERENTIALS AND ACCEPTANCE OF FEMALE CONDOM

5.1 INTRODUCTION

One of the important factors that was noted to have an effect on the uptake and consistent use of female condoms in this study is gender. Gender has always been of interest to HIV prevention programmes and researchers as it speaks to the bargaining power in decisions related to sexual choices and prevention strategies among sexual partners. Gender equality and women's empowerment are necessary for the fulfilment of all health initiatives and promotion of women's health in the Millennial Development Goal (WHO, 2008). In his study findings and previous observations Wendel (2009: 20), found that it was clear that most female participants regarded their role in heterosexual relationship as below that of their male partners. Hence, decisions taken by individual participants were shaped primarily by their cultural prescripts, socialization, social standing, economic power, life experiences and their personal beliefs. As seen in previous chapters, women in general have an understanding of health related issues of illness. This is seen in part to be shaped by their cultural upbringing; thereby giving them particular cultural understandings of health and illness. Thus, understanding the context within which individuals make and carry out their decisions is important.

This chapter explores socio-cultural determinants of decision making as it interrogates females and male roles, perception of female condoms, access to reproductive resources and the decision making authority. Thus, it is in the context of the African culture where behavioral ideals are still maintained placing women at a lower status than men hence women continue to be at risk for HIV, sexually transmitted infections and unwanted pregnancies (Marmot and Wilkinson 2006).

5.2 SOCIOCULTURAL DETERMINANTS OF DECISION MAKING

A female participant was quoted as saying:

When we are together (engaging in sex) I need to show respect for him and his decisions because I love him. If he wants to use condoms, we use. If he does not want to use one, then we do not. He has done so much for me and really, this is the only way that I show him respect and support.

The mindset that many women share can be seen as emanating from sociocultural prescripts where women's position and pleasure takes a back seat and men's pleasure is favored over women's. This is not by chance. This assertion can be seen through the Structural violence theory lens, as most women feel it natural to advance men's desires at the expense of their health. This violence has been masqueraded in the form of "respect" within the structures that describes and are found in heterosexual relationships. This finding concurs with Gupta's (2000) study findings which assert that the standpoint of men is consistently privileged and that of women devalued, as he further asserts that it is an established fact that when a woman depends more on a man or men for money and economic welfare, this dependence increases the vulnerability of a woman in negotiating for safer sex. Gupta goes on to explain that in relationships where women are seen as inferior, it is the men's sexual pleasure that is given priority and the sole reason for women's existence is to please men. Wendell (2009:20) concurs with Gupta's findings where heterosexual relationships with patriarchal influence the gender role expectation for women is that they occupy the lower status than that of men and they are constantly underprivileged and oppressed by men.

NOM a 26 year old further reveals why she is not in a position to use condoms.

When I brought the female condoms from the clinic and showed him, he said: " You will use this condom with those nurses who gave you." He was so angry that by the time we went to bed he was no longer talking to me.
(NOM 26yrs).

She continues to share with me that she had hoped that her partner would like the female condom because he always complains about the male condoms. She further reveals that her partner is violent towards her when she tries to negotiate condom use even though she knows that he has more than one intimate partner. Like many women that depend on their male partners for economic support, NOM is caught in a rut. She does not think this relationship is unhealthy and she seems powerless to do anything about it.

Sarkar (2008:117) associates resistance to condom use by males to emotional sexual fulfillment. He argues that “men’s emotional fulfillment with attainment of satisfaction through direct penile-vaginal contact and ejaculation during natural intercourse is an obstacle to condom use. Women who have reported condom use, at times also yield to men pressure to sometimes have unprotected sex. One participant was quoted as saying:

Ngihlale ngimcela ukuthi sisebenzise amakhondomu kodwa kwenye inkathi ngiyamzwela uma ecela ukungawasebenzisi. Ngiyazi kuzwakala kungenzi mqondo lokhu, kodwa ngibuye ngimdabukele uma ngimbona ukuthi ufuna kanjani ukukwenza ngaphandle kwawo. Ngiye ngicabange ukuthi naye uyangihlonipha uma ngicela siwasebenzise nami kumelwe ngimlalele kwenye inkathi.

I always ask him to use condoms but at times I feel I can give in to his request to make love without condoms. I know it sounds absurd, but sometimes I feel sorry for him because I can see that he really wants to do it without a condom. I usually think, he respects me when I ask him to use condoms and I need to yield as well, at some point.

QD on the other hand lives in her own world where she feels and think it okay for her partner to decide on her behalf virtually on all aspects of her life. She is a 26 yr old engaged to be married female who stays full time with her partner.

She relates :

*Uphathina wami nguye olawulayo kulobudlelwane bethu
Ude andixelele kube ndinxiba ntoni. Andibon into erongo apho
kuba uye othengayo. Mna ndilandela ngemva. Phofu ke uma
ndinga soloke ndicomplainer, kubanoxolo endlwini.
My partner has a greater say in our relationship,
He even tells me what to wear. I see nothing wrong with that
because he is the one who buys things for me. I only follow from
behind and do not complain, there is peace in the house.*

When probed further about her relationship, QD said:

*Ndimane ndimhlonipha kube eyinhloko yekhaya.
Uneright phela yokutsho ukuthi yini ayithandayo
Ukuze siqhube sakh'umuzi. Kutheni sisi, isiko awusalazi yini?
I am only respecting him as a head of the family
He has a right to say what his preferences are
So that we can make a successful family.
Why, sister, don't you follow our culture?*

This question is rhetorical, meaning I should know the packing order of the family in an African cultural context. The control that QD's future husband has, is normalized in the African culture and you can see that as 'the bride to be, she is content with the role she is to play in this relationship. She feels she is obligated to follow after her partner. In the evolving culture with modern living, urbanization and religious influences it is noteworthy to note that some indigenous cultural ideals of behavior that favors men still maintains.

ZO on the other hand presents a different view of her relationship. She and a group of her friends whom she socializes with, share a bond that is traced back to where they come from in the rural area of Canzibe in the Eastern Cape. They grew together and have moved to the area because of their economic circumstance in search of jobs. They continue to stick together and form a social network of their own. They share common ideals of behavior and find strength and support in one another. she relates

*Ayikho into esingayithethiyo ne patina yami kwaye
uyandimamela.xa kuziwa kumakhondomu, sisebenzisa womabini,*

*awesilisa nabesifazane.umntana akekho eziplanini zethu
okwangoku, so siyacophelela njalo ngamakhondomu
We discuss everything with my partner and he respects my point
of view. When it comes to condoms, we use both male and female
condoms. We are not planning to have a child yet, so sex is
always with condoms.*

This points to the role each person plays in a relationship because of social affiliations that have been formed through social networks. She goes on to relate that she and a circle of her friends do things in a similar way. They have formed a group where all the couples spend time together and discuss everything about relationships and their social life. Hence the ability of such friends to have an open dialogue with their partners about their sexuality. This finding concurs with Hernandez (2006) as he points out to the positive physical and mental health outcomes of social networks.

5.3 MALE POWER AND SOCIAL PRESSURE

Numerous men worried about whether they were sexually pleasing their partners; men seemed keenly aware of the social pressures on them to be skilled and experienced lovers. A number of men had formed their attitudes about female condoms based on how they were able to perform sexually when using them. Some men said they liked that they could last longer during sex with female condoms, whereas others struggled to last long while using female condoms and therefore disliked them.

MZ a 23 yr old stated:

Ngamakhondomu esifazane, ngiyadonsadonsa ngoba
ngisuke ngikhululekile, ekugcineni ngisuke ngazi ukuthi
ngiwenzile umsebenzi wami
*With female condoms I last long because I feel “free”
and at the end of it, I know I have done my job.*

TK, 22 years said:

Ukungakhathazeki ngokumithisa noma ukuthola izifo
zocansi, kwenza ngiwathande amakhondomu esifazane.
Ngaphezu kwalokho angikhathazeki ngento enginsinyayo.
Wheeh, ngingathini ngawina!

The fact that I don't have to worry about impregnating anyone or contracting any diseases, makes me love female condoms. What is more is that I do not have the tight male condoms on me. Wheeeh, what can I say, win mina (I have won)!

He says excitedly and seeming relieved. The excitement shared by some male participants highlights the promising future prospects of condom acceptance and use, if more males would buy into female condom use.

ZN a 24 year old male participant viewed it his prerogative to provide condoms had this to say:

*Ngihleli ngiwathenga amakhondomu futhi nginesitaki sawo,
ngoba angikwazi ukusebenzisa lawo atholakala emaklinikhi.
I always buy condoms, I do not engage in sex without them
I always keep a stock as I cannot use these one that are provided
at the clinic.*

ZN spells it with pride that he uses branded condoms not the cheap ones offered at the clinic. He views it a social status to use branded condoms as he and the circle of his friends have attained to an exclusive group. They often talk about different brands and they look down on those who use condoms that are available at clinics. This puts pressure on those males who cannot afford to use these branded types.

NLZ 23yrs and NT 22yrs shared an interesting point about their relationship.

These two young adults valued the support their partners gave them in health initiatives.

Though both of them are in a fairly new relationship, they were able to ask their partners to go for an HIV test before they became intimate. When probed about their ability to negotiate NT reported:

*Ay, sisi, wonk' umuntu uyazi ukuthi kubi la ngaphandle.
Umuntu kumele ngandlela thize azibheke.
Ngamtshela sisaqala nje lokho engikulindele kulobudlelwane
bethu, safinyelela esivumelwaneni. Sobabili saya kohlolela iHIV,
sakhombisana imiphumela. Eklinikhi, emva kokuyalwa sathola
amakhondomu, mina ngathatha awesifazane yena wathatha*

awabesilisa. Kusukela lapho sisebenzisa zozimbili izinhlobo zamakhondom.

*Ay, sisi, everyone knows things are bad outside.
One has to look out for herself, in a way.
I laid down my expectation in the relationship when he was still proposing to me, in that way we came to some agreement. We both went for an HIV test and we shared the results. At the clinic, after counselling, they gave us condoms. He took male condoms and I took female condoms. From then on we have been using them, both types.*

NLZ also had a similar experience like NT, she relates:

Isoka lami likhululekile uma sixoxa ngezempilo
Uyangisaphotha and izinto sizenza ngokuvumelana
Saxoxa ngokuhlela umndeni, nokuzivikela, akanankinga.
Uyangikhumbuza izinsuku zokuhlela futhi siyawasebenzisa amakhondomu noma ke hhayi zonke izinsuku ngokuvumelana.
Ngikhumbula sibuya kohlelela iHIV, sathi namhlanje akesi wabeke eceleni (kkkkk, ehleka).
Ini! Sasizibusisa, laphoke senza ucansi ngaphandle kwamakhondomu. Kodwa ngingasho ukuthi isikathi esingamaphesenti angu 99, siyawasebenzisa.
*My boyfriend is very open when it comes to health related matters. He is very supportive of me, we do things together.
We discussed family planning, protection, he is okay with it
He reminds me of my family planning dates and we use condoms.
Though not all the time by agreement.
I remember, we came back from an HIV test and we thought,
Today, we will give it a break (kkkk, laughing).
What! We were celebrating and we had sex without a condom,
but I must say 99% of the time we use protection.*

NLZ went on to describe how she has been able to appeal to her partners ego by putting it to him that he has the power to protect them both. She goes on to say:

Ngihlale ngikhuluma kabi ngeHIV. Ngimane ngithi umuntu osatheleleka kulenkathi yanamuhla umuntu okhelesi. Namuhla akekho umuntu okusafanele atheleleke. Ngivele ngicinelele ukuthi siyisebenzise, okwamanje siyisebenzisa sonke isikhathi. Asikakulungeli ukuqala umndeni.

I always make it a point to talk negatively about HIV. And point out that, people who get infected through sex at this day and age, are careless people. Nobody should get infected at this age. I insist on condom use and so far we use them at all times. We are not ready to start a family.

These women seem to thrive on support their partners are affording them. What came out of the discussion was that these young women were able to talk and stand up for the decisions they had made. This worked well to their advantage. This can also be true in relationships where women are working and males have been out of work for some time, like in the case of DU and SI who stay together with their partners. They alluded to the respect they show to their partners that makes the relationship work. DU went on to say:

Lapho uphathina wami elahlekelwa umsebenzi, wayekhunganathekile impela, ngazama ngawo wonke amandla ukumsaphotha futhi sixoxisane ngazonke izinto..Ibhajethi siyenza ngokuhlanganyela konke kuqhubeka njengasekuqaleni esasebenza.

When my partner lost his job, he was very depressed but I tried by all means to support him and discuss everything openly. We do the budget together and everything continues as before. (Du, 32yrs)

The shifting economic roles for males in poor resourced communities has become a reality where male employment prospects are low. Though this factor has affected the male ego negatively, it has been noteworthy that some women were able to navigate their sexual lives around these and continue to appreciate health initiatives with their partners support. This

affirms the notion that has been observed by various scholars that partner characteristics and type of a relationship plays a huge role in determining the health status of individuals within a relationship (Sarkar, 2008; Lightfoot, 2005 and Tschann 2002)

5.4 DUAL PROTECTION –WHOSE RESPONSIBILITY?

Whilst most participants both males and females revealed knowledge of the importance of using condoms in all sexual encounters, a number of them did not use condoms consistently irrespective of whether they knew their sexual partners' HIV status or not. Though this topic was not the centre of discussion, participant readily shared their views on HIV statuses and the use of Condoms. It emerged that most participants would go on without using the condoms even if they were not sure of the other partner's HIV status and even if they suspected their partner to be HIV positive.

Kungumthwalo wawo wonke umuntu ukuzivikela ezifweni.

Uma engasho lutho ngekhomu. Ngivane ngizigibelele
ngaphandle kokunanaza.

*It is the responsibility of each individual to protect themselves
against infection. If she does not suggest the use of condoms,
I would just ride on and enjoy myself without thinking twice about
it. (MAD – 28yrs)*

Lerclerc- Madlala (2009) points out that sex is often viewed in African culture as a natural gift and the use of condom as a waste of sperm. Notwithstanding that even those couples that had knowledge of their status and were both on treatment, often engaged in unprotected sex despite counselling received every time they collected their treatment. It is against this background that the use of the condom was specifically discussed with the participants in a bid to understand the support and responsibility that each individual brings into a relationship. One male participant reiterated what most men had already said:

Angisi mawakhe mina, uma engazigcini, indaba yakhe

Mina ngiyazazi isimo sami.

*I am not her mother, if she does not protect herself it is her
business. I know my status.*

This suggests that most men, long for women to stand up for themselves. They view it as the prerogative of women as much it is theirs to protect themselves against infection as well as unplanned pregnancies through condom use. Although this is not always communicated overtly, it became apparent that most men were open to discussion on sexual matters with their partners. Whilst some women suggests that condom use is the responsibility of the male, males as well gave an impression that they saw this responsibility as lying with women. They gave an impression that they were willing to listen and negotiate with women. If she brings a condom and introduce it they would be willing to listen.

LZY, (33) readily asserted that she usually she left the decision to her partner to bring condoms as she is on contraception. She brought an important point that most women seemed to run with, that because they are on contraception, males also need to play their part in the relationship by bringing and agreeing to use condoms. When probed further if this was discussed with her partner, she points out that these are unspoken responsibilities that lie with males. This notion of ‘silence’ is seen by Gupta (2002:183) as placing women at risk because it affects their negotiating skills for safer sex practices. She went on to relate that as in the family, there are different roles for each member. Condom availability and use in a relationship is a “given” or a known responsibility for males. Like most women, LZY admitted that she is always given condoms at the clinic when she goes for contraception even though she does not like the brand of condoms issued there. She prefers the brand that is bought which is not always available to her when she engages in sex with her partner. She was referring to male condoms. She also reported that female condoms were not always available at the clinic and were expensive to buy at the chemist. She admitted that the purchased condoms weree not always available, hence she fell in and out of condom use.

SND a 22 year old slender built and beautiful young woman, who came to live in Clermont while studying at a tertiary institution, said that she used condoms at all times and had been introduced to female condom recently. She readily admitted that she quickly became used to using female condoms as she felt that it is her prerogative to protect herself against pregnancy and sexually transmitted infections as well.

She admits:

Ucansi luyajabuleleka ngamakhondomu esifazane
Ngiwathandel ukuthi ngiyazi ngeke angirobhe enzesengathi
uyigqokile kanti cha.Ucansi luzwakala kahle njengathi awufake

lutho. Ngincamela awabesifazane kunamkhondomu esilisa,
ngyawethemba, ngiwethemba ngempela.
Sex is much fun with the female condoms.
I like them because I know for sure that he can't rob me
and pretend to be wearing a condom meanwhile he is not.
Sex feels natural and I prefer female condoms to male condoms.
I trust them, I really do.

This confirms Hoffmans' (2004) findings that the attitudes of individuals towards a medical intervention plays a huge role into its uptake and continued use.

5.5 THE POWER OF THE VAGINA

Most women in the study have been able to negotiate successfully condom use with their partners and they seem to have their men at their fingertips:

LIN shares what she calls the a trick to getting her partner to use female condoms:

You have to be clever, if he does not want it, lead him on during foreplay, when he is in the point of no return, whisper sweet nothings and take it out put it on his hand and guide him through insertion, you can't go wrong. Personally I do not have any problems in negotiating condom use. He knows, no protection, no play.
I spelled this from the outset, and I have never changed.
He follows through and is happy, I am also happy.

BS also shared her experience by saying that:

I always suggests we use both female and male condoms.
I put it on him and he puts it on me. We both enjoy our play
It has become a habit that we often joke about our stock of condoms.
I want to believe that males respect a woman who knows what she wants.
The use of condoms with us has become second nature.

The views from these women is shared by a few women that were interviewed.

It was noteworthy that these women displayed outgoing personality traits and were not shy to talk openly about their relationships and their sexual encounters. The confidence they displayed was seen as a powerful weapon that they used to negotiate and insist on condom use. Like most women in this community, they depend on their male partners to some degree. It is important to recognize the power of the woman's sexuality that some

women use as a powerful tool, with which to enhance their reproductive health. This also speaks to the shared views, outlook of friends and their determination to continue to protect themselves and use health initiative irrespective of their background and social status.

MX a 29 year old medium built dark handsome man who is a taxi driver by profession, said that in his job he comes in contact with many women. He admitted to have had many girl friends that he had had sex with previously. He reported that his Casanova days came to an abrupt end when he had a terrible sexually transmitted infection, from then on he said he no longer had sex without a condom. He reported that:

*Ngyakthanda ukuba nomuntu wami
Phela kqala bengiyisoka lamanyala, manje sengikhulile
Ngizithandela umanakazi wami nje, ungiqoqile ngempela
Angikhali ngalutho, uyanganelisa.
Ungifundise ukumhlonipha nekhekhe lakhe (kkkk, ehleka)
Weh ngivele ngiduke mese senzucansi*

*I love being with my girl,
I was a dirty Casanova before, now I have grown up.
I only love my sweetheart, she saved me (from being a Casanova)
I don't complain, she taught me to respect her and her cookie (kkkk, giggling)
Now, I just become lost in the love making with her. (MX 29yrs)*

MX admitted that his partner changed him. He has a different view of her as he now respects her and her sexuality. He also added that their relationship was based on mutual respect. He also reported that they used female condoms because her partner introduced them to him. Even though he has money, MX respects a woman who knows what she wants and he thinks that if women respected their sexuality, then men could follow suit.

He said:

*Uma umuntu engawuhloniphi umzimba wakhe, yena qobo
Mina ngizowuhlonipha kanjani? Uyazi ngiye ngthule ngicabange
amandla umuntu wesifazane anawo, ukwehlisa umuntu wesilisa.
Ayamangalisa uma ngicabanga langiphuma khona.*

*If a woman does not respect her body, how can a man do?
You know I sometimes sit and think about the power women possess to tame
a man. It is amazing, when I think where I come from and the now.
(MX, 29yrs)*

*JSB a 45 yr old male had this to contribute:
I am a traditional African man but since Beijing
Most of us man have changed. But, of course the respect must
Be both ways. You cannot tell me that men do not listen to their women.
It is the manner in which we are approached, that matters.
A real women will know how to talk with her partner. (JSB, 45yrs)*

When probed about the woman's way of talking with her man, JSB chuckles and say:

*A woman will know what her mother taught her when it
comes to respect. Also when she is near, here to my chest, I
can give her everything. A woman who knows what a man
wants, always gets what she wants in return. She has power
under her skirt. But that of course coupled with respect.*

Although JSB admits to being a traditional man, he points to the changes to his outlook in life that has been constructed by the dynamics of evolving cultures that are also shaped by experience of lived life within a cosmopolitan community.

5.6 CONCLUSION

This chapter explored the sociocultural determinants of decision making, projected in behavior and response towards medical interventions. I looked into participants experiences through their stories. The chapter revealed that behaviors towards medical interventions are not only shaped by social prescripts but also by knowledge, understanding, perception and beliefs formed around the intervention. It also found that perceived benefits influenced acceptability and continued use of female condoms by both men and women. The findings in this chapter concur with Maharaj's (2006) who found that perceived benefits of female condoms can drive negotiating skills in women who really want to use them. Sexual pleasure, purpose for engaging in sex was also seen as a determinant for increased female condom use irrespective of economic and social status. The chapter also alluded to the power that women have in negotiating safer sexual practices and how males are open to discussion over these matters. This points to need of continued women empowerment and male involvement in health prevention initiatives. In this chapter it became apparent that when males are involved in health initiatives where messages are tailored to meet specific needs in the community, the uptake of the strategy can enjoy much needed support. The next chapter discusses findings and recommendations of the study.

Chapter 6

SUMMARY OF FINDINGS

6.1 INTRODUCTION

This study sought to explore the factors that influenced the use of female condoms in heterosexual relationships in a highly mobile community as a dual protective method for HIV/ AIDS and unplanned pregnancies. From the interaction with participants it emerged that there are complex factors, both intrinsic and extrinsic which are vastly shaped by intricate socio-cultural traits. These were found to have a bearing on the acceptability or rejection of this method. Socio-cultural beliefs and norms were seen to have a significant role in how individuals perceived their health risk. This was evident in individual decision making in health related matters projected through sexual behaviour. Thus, it transpired that despite education, knowledge and effective health initiatives, the perception of all these interventions hinged on the understanding of the community within which the intervention is proposed.

6.2 KEY FINDINGS

From the interaction with the participants three factors emerged as critical for the promotion, uptake and sustained use of female condoms, namely:

- 1) Subtlety and sensitivity
- 2) Capacity building
- 3) Peer education

6.2.1 Subtlety and sensitivity

Successful female condom promotion requires working with peoples' mind set and attitudes. These need to be addressed in order to encourage people to start trying these interventions. As it emerged in several interviews, most females do not regard the female condom as an alternative way of exercising their sexual and reproductive rights. Whether this is related to lack of knowledge or is associated with social prescripts, it remains to be explored further. What was

more revealing is that cultural dictates that rendered women ‘docile’ or placed them at subservient levels were not always enforced by their partners.

This was alluded to by most participants but one female participant stands out:

I do not see how I can ask him to use condoms.

If he wants, he uses them but I do not ask him to.

I trust him because he provides everything for me.

Messages targeted at empowering women to enable them to negotiate safer sexual practices such as the use of female condoms are of utmost importance. Thus, ongoing education and sensitization on its use in a community where conversation on sex is nonexistent or is hushed, is of paramount importance. In addition the creation of a safe environment or space is imperative, especially for young growing males and females. Thurston (2014) posits that female condoms have a potential to uplift the communities health indexes thus contributing to the economy of the country by curbing frequent infections and their treatment. This also Includes family planning and spacing which can contribute towards healthy mothers and babies. This can be achieved through working within the community and with people who understand the community and are familiar with its practices.

6.2.2 Capacity Building

Much impetus is placed on women empowerment and female condom use as a powerful tool to curb unplanned pregnancies and decrease the incidence of new HIV infections and generally, sexual transmitted infections. From the interviews it emerged that most women saw themselves as unable to communicate safer sexual practices with their male partners. Wendell (2009) argues that for women to be able to stand up for themselves, it is important that they, themselves must start to realize their potential. He goes on to say that women need to view themselves as human beings, capable of effecting change by taking responsibility to direct their own lives. On the other hand men felt that they wanted women to stand up for themselves and discuss with them what they wanted in heterosexual relationships. Although African men have been portrayed as concerned with the ideas of equality between men and women (Zalewski 2010:60), this cannot be generalized across the board. From the interviews, it became apparent that some men were willing to listen and be on the equal footing with their female partners. This was seen as an important positive spin that can enhance dialogue and open communication in heterosexual relationships.

For most men and women the idea of experimenting with the female condom was based on communication strategies designed for targeted audiences as these can be useful and have been proven to work. This is affirmed by Ickes (2007: 48) who posits that “gender specific interventions can lead to behavioral changes as it allows the material to be tailored to gender beliefs and associated risk factors”. The need to empower married couples and those in long term relationships became apparent as it had been observed that tradeoff of trust fuel ill health in these categories of women.

6.2.3 Peer Influence

Evidence from the study highlighted that peer influence played a vital role in the world view of individuals and their interpretation of events. This was evident from peers who were positive about the use of female condoms hence the uptake and continued use was obtained and conversely the finding is true where negative perceptions were shared. Furthermore, it was observed that similar behaviors persisted within a group of friends. Ickes (2007) and Coates (2013) agree that peer groups can be helpful in changing the social norms by exposing participants to interventions designed not only to promote safer sex but also to develop individual skills and self-beliefs that would enable risk reduction in the face of counteracting influences

It was evident that peers have the potential to influence behavior and as such the utilization of such avenues in peer education was seen to have a potential of yielding positive results.

6.3. LIMITATIONS OF THE STUDY

The study used a small sample of participants from the community from which it cannot generalize its finding. The inherent conflict between the socio-cultural dynamics and the individual perception and actions were evident in this small study. Viewed through the structural conjuncture theory, the interpretation of events in the life of participants helped the interviewer to peer into, and understand how individuals made decisions. This theory lens was limited because of the fault line between culture and the community practices as seen in the interaction of participants and their partners where there is no gender hierarchy. This is in line with Johnson – Hanks (2007) observation that social motivators can direct behavior regardless of cultural norms. Another limitation came in the data collection where participants reported increased use of protection, some using both female and male condoms interchangeably and consistently. Mantell (2011), (2013), Abdool- Karim (2010) and Baxter 2010) all alluded to the futility of self-reports

by participants in prevention strategies. This has seen reports of inflated use of prevention strategies which usually are not supported by laboratory findings and subsequent health status of participants. Prevention strategies have been shown to be effective in concept but in Sub-Saharan Africa where they are needed the most, they have met with incredible challenges because of their dependent upon reports from participants. Amico (2013) regarded this as a reporting bias where participants would report what they think that the interviewer wants to hear and not the actual facts of what really happens in everyday life thus diluting the facts with fiction.

Another limitation inherent in interviews is that of preconceived ideas by the interviewer. This was counteracted by creating a safe environment where participants became free to trust and thereby express themselves as they wish. The interviewer tried not to ask leading or suggestive questions but also allowed participants to express themselves as they see fit. She remained neutral throughout the interview when asking questions and tried not to send non-verbal cues that would be interpreted as judgmental or affirming any behavior. she tried to employ reflexivity and approach the study with an open mind and not with pre-conceived ideas to the greatest extent possible (Guoin et al. 2011:12)

6.4 RECOMMENDATIONS

For effective uptake and sustained use of health intervention, conditions to optimize their uptake are recommended. This translate to continued targeted messages that are tailor made to specific audiences to attract individuals to use female condoms in order to ensure that these initiatives work. Female condom meant different things to individual women and men. To others it meant freedom of choice, safety and a good addition to the method mix whilst to others it meant the depiction of their sexual organs, oppression and an added burden to their sexual prowess. It is thus important to target communities as autonomous entities and specifically tailor make messages for each community as a separate diverse unit. In order to effect a positive response from individual members of the community, behavioral change can be enhanced by training individuals to exercise influence over their own behaviors and their social environment. This situation is best achieved not only by intervening for heightened awareness and knowledge but also by enhancing resources and social support. The following recommendations are made:

i) Community based Interventions

Realizing the structural drivers within communities of risky behavior through a holistic multi-sectoral approach can have much leverage in attaining to acceptance and buy in from these communities. Thus working from within the community with the people who understands and speak the language of the people can help in selling the messages and the product thus removing hurdles that can hinder acceptance, uptake and use of the female condom. The experiences of individuals who attempted to use the condom but abandoned it due to problems encountered can be addressed effectively through the use and engagement local people as advocates of the female condom who can create a safe environment to enable and promote dialogue at the grassroots level. These advocates can be positioned to address questions, concerns of all members of the community. In addition advocates can create networks that can enable open dialogue and interrogation of the relevance of the female condom within the sexual relationships irrespective of sexual orientation of community members. This notion is affirmed by Coates (2013: 179) who noted that the” biomedical approaches cannot work nor will they have widespread effectiveness if the conditions for their use are not optimized or if individuals fail to use them in ways that are necessary to ensure they work and achieve their intended effect”. So it is important to employ the help of structures within the community which people can relate to including community based organizations, public health facilities and private sectors that are utilized constantly by individuals like spaza- shops, sports – bars to mention a few. These structures can focus on different target groups with specific targeted messages and training initiatives. When individuals know how to use the female condom correctly, this may enhance their sexual pleasure and then be able to use them consistently.

Initiation of community projects that are peer driven and designed to empower women by building capacity for them to discuss sexual matters and negotiate safer sexual practices with their partners without fear of negative repercussions can be utilized. This also calls for male involvement in health related initiatives and skills development so that individuals can be economically viable and empowered, Moore (2014:12) describes empowerment as she borrows from Laverack’s definition as a ‘dynamic continuum ‘which targets individual action that can translate to collective social and political change.

So male involvement in health related issues may go a long way to tackle and change perception of some of the issues that may be socially and culturally sensitive.

ii) School based interventions

Empowerment of young girls through gender equality, HIV training programmes and peer-based participatory education challenging harmful gender norms, particularly among men, women, boys and girls can be implemented. These interventions can help shape the growing minds of both young men and women and orientate them in the pros and cons of sexuality and accepted behavior within a society. The messages can be tailored to be culture sensitive but also designed to address the growing minds of the changing and evolving cultural dynamics and the responsibility laid upon each young girl and boy in the society. Sexual conversation can address the myths and answer silent questions that usually families are not open discuss and it may help to dispel the undertaking of sexual experiments that are risky.

iii) Policy makers and female condom Program

The female condom program has been given priority in South Africa in the 2015 financial year plan. However there is a need to address issues that are seen to challenge the uptake and continued use of this health intervention strategy. When this intervention is measured against the health indexes of communities there is a huge discrepancy between the demands of this strategy and the health outcomes of women in the reproductive age bracket. Thus there is a need by policy makers to provide enablers of the female condom use through the creation of frameworks that stimulate interest from the funders, public and private entities and researchers. These can help to encourage progressive innovation and policies for the expanded female condom initiative programme to counter act harmful and risky sexual behaviour. This is propose can be achieved through the following methods:

a) Policy driven and proper evaluation of the existing female condom programme through the evaluation and proper addressing of the gaps in female condom acceptance, uptake and use at the community levels by addressing the vertical access channels. This calls for attending to procurement procedures, distribution channels and end user characteristics that can enable constant availability, promotion and acceptance of female condoms.

b) Investment on resources for condom promotion –Female condoms have been positioned as the best dual method strategy that promises to increase women’s health and upsurge the current burden of disease in the communities that are hardest hit and ignite social dynamics with far reaching effects. If female condoms are seen in the media and

are promoted widely with various choices, its uptake and use can be unprecedented. There is also a need to improve on the existing type of condom through innovation and market expansion to open a platform for new female condom entry into the market that can be comparable to the wider distribution of the male condom.

- c) **Creation of new and linking the existing distribution channels-** There has been an observation and repeated assertion by participants that spoke to the notion of better quality female condoms as those that are branded and can be obtained through the shops for a fee. Added to this is that unlike the male condom, the female condom is not readily available in shops and local community outlets where it can be accessible to all.
- d) **Developing Communication channels** – sharing of experiences with other sectors or countries with successful female condom uptake and use can create leverage from which to base promotional campaigns and create consumer demands.
- e) **Correct marketing of female condoms-** when the gains of female condom availability and use by communities are seen, appreciated and measured in the long term by increased individuals health indexes, this can lead to increased socio economic status of the communities.

There is room to introduce a carefully developed communication strategy to reach the targeted audience or groups to scale up the acceptance and continued use of this programme. Branding and the acquisition of different types of female condoms to attract different users and add to the choice of a wider variety of people is imperative. It is paramount to maintain and control adequate stocks of female condoms to ensure their availability at all times so that the users do not fall in and out of condom use. This can help with the continued use and sustained uptake of this method.

The female condom programmes can involve community role models to share with the communities the important health messages and increase the desirability of the product. Public figures and local celebrities can wield a strong influence in promoting the female condom use especially where youth is involved. This can be ascertained through the use of music, a language that is readily understood especially if it has the vibe that is catchy to young people. This can also have a tremendous influence on young people who tend to aspire to or mimic someone in life. The media is another avenue that can play a role in the promotion of this health strategy since many people receive thousands of messages through the use of this tool. When well thought and targeted messages that speak and appeal to individuals are disseminated, the results can be overwhelming.

iv) Informal settlers health initiatives

The mushrooming of informal settlements is most of the time associated with poor health conditions and a fertile ground for unplanned pregnancies, HIV and other infections because of various structural reasons. The use of health care facilities has been found to be minimal by the individuals from these communities due to various reasons. Thus it is recommended that these informal dwellers should have access to health initiatives through the visit of mobile clinics to promote family planning and also through the introduction of extended support in the likes of community food banks, and programmes that involve adoption of this communities to improve their socio economic status and thus improve on their health. It has been found by various scholars that in poor resourced communities the need to survive has been seen to far outweigh the benefits of health initiatives (Soskolne 2002; Gupta 2000 and Airhihenbuwa 2004). But when the strategy increases the well –being of community members impact can be readily measured in the form of increased health and socio-economic status.

v) Research

For any health programme to run effectively, there needs to be a community needs assessment and analyses, backed by evidence of health status of the community. Thus a coverage survey to measure the current availability and accessibility of the female condoms in health clinics and other supply spots is important. Further research is needed that would interrogate the suitability and adaptability of the available female condom programme and evaluate the impact of this programme into the knowledge, attitudes and behavior in particular socio-cultural settings. As noted in the study informal dwelling and migration is a social vulnerability that positions individuals at a risky health status thus it would be important to ascertain if the health condition of the individual members of community is peculiarly found in this community or other communities are affected as well.

6.5 CONCLUSION

The study showed that the essence of effective female condom uptake and consistent use lies in continued working with and in the communities. For the female condom to be acceptable, much education and counselling of both females and males need to be strengthened especially the interpersonal communication between partners. In this community of cultural diverse people, understanding the prescripts within which people make health related decision is fundamental to scaling up effective health strategies.

For a health service intervention to be effective, gaining access to communities and bringing the initiative closer to communities so that these interventions can voluntarily be utilized by the targeted community is necessary (Hewer, 2005). Researching actual community perceptions prior to the implementation of these strategies is crucial to the uptake and continued use. Health campaigning is critical especially with an intervention as culturally charged as the female condom. Determining the extent to which protective methods intrude into sexual pleasure and spontaneity is a key factor in ascertaining whether they will be used consistently and correctly, especially in the 'heat of the moment'.

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Appendices

Appendix 1 Information Form in IsiZulu



UNIVERSITY OF KWAZULU NATAL-SCHOOL OF SOCIAL

SCIENCES

Fieldworker: Nelisiwe Mnguni (0719524580)

Supervisor: Dr. Maheshvari Naidu (031-2607657/naiduu@ukzn.ac.za)

Research Office: Ms. P Ximba 031-2603587

Mina Nelisiwe Mnguni, umfundi owenza iMasters enyuvesi ya KwaZulu-Natal ufisa ukuba ubambe iqhaza kucwaningo olusihloko sithi: **Probing the sociocultural factors influencing female condom use among heterosexual women in Clermont, Durban.** Ukhethwe ngesizathu sokuthi usitshela kabanzi ngokuhlangenwe nakho –nangolwazi onalo ngezindlela zokuvikela ukutheleleka ngesandulela ngculazi, nokuvikela ukukhulelwa okungahlosiwe ngokusebenzisa amakhondomu abesifazane. Ngakho kubalulekile ukuzwa uvo lwakho ukuze lolu cwaningo lube yimpumelelo. Lolucwaningo luhlose ukuhlola indlela yokuphila kumphakathi wase Clermont engaba nomthelela ngayo ekufinyeleleni ukuthatha izinqumo ngokusebenzisa amakhondomu esifazane. Ukuba yingxenye yakho kulolu cwaningo kubalulekile kakhulu ukuqonda izimo ezingaba nomthelela ekufinyeleleni komuntu, abesilisa nabesifazane kwizinqumo ngezindlela zokuzivikela kwigciwane lesandulela ngculazi kanye nokukhulelwa okungahleliwe ngokusebenzisa ikhondomu yabesifazane. Ukubamba kwakho iqhaza kulolucwaningo akuphoqelekile. Ungase ukhethe ukuba uhoxe ukubamba iqhaza nganoma yingasiphi isikhathi ofuna ngaso noma ukukhetha ukungayiphenduli eminye yemibuzo uma uzizwa ungakhululekile. Ngeke kube khona isigwebo sanoma yiluphi uhlobo uma uhoxa noma ukhetha ukungaphenduli eminye imibuzo. Ulwazi oluzotholakala kulolucwaningo luyoshicilelwa ezincwadini zezinzululwazi futhi luphinde lwethulwe ngomlomo. Kulolu cwaningo kuyaqinisekiswa ukuthi igama lakho ngeke livezwe. Ngeshwa, ngenxa yesimo sami njengomfundi, ngeke ngikwazi ukukhokhela wena inzuzo yezimali nge qhaza lakho ozolibamba kulolu cwaningo. Ucwaningo luzofaka izingxoxo ezimbili eyodwa noma ngaphezulu uma ufisa. Lezi zingxoxo zizothatha cishe imizuzu eyishumi amane nanhlanu kuya ehoreni, futhi kuzoqoshwa ngemvume yakho. Futhi kuzoba khona amaqembu engxoxo yenhlobo okungathatha ihora nesigamu. Lomhlangano uyoba endaweni ejwayelekile futhi evikelekile. Ngiyethemba uzothatha isikhathi sakho ubambe iqhaza kulolucwaningo.

Uma unemibuzo mayelana nokubamba iqhaza kulolu cwaningo, sicela ukhululeke ukuxhumana nami noma umqondisi wami esebenzisa imininingwane enikeziwe ngenhla. Uma ungaba nemibuzo noma ukungagculiseki ngandlela thize, ungathintana nomnyango wokubhekelela izimiso zocwaningo (Humanities & Social Ethics Committee) kule nombolo: 031-260 3587.

Ozithobayo

Ms. Nelisiwe Mnguni (0719524580)

Abaphenyi Signature: Usuku:

Appendix 2: Informed consent form



**UNIVERSITY OF KWAZULU NATAL
SCHOOL OF SOCIAL SCIENCES**

Fieldworker: Nelisiwe Mnguni

Supervisor: Dr. Maheshvari Naidu (031-2607657/naiduu@ukzn.ac.za)

Research Office: Ms P Ximba 031-2603587

Declaration

I _____ (optional and may be replaced by initials) hereby declare that I am fully informed about the nature of the research titled: **Probing the sociocultural factors influencing female condom use among heterosexual women in Clermont, Durban** by the researcher.

Yes..... No.....

I have also been well informed about the role that I stand to play if I am to participate in this project, which is participating in a one to one interview or in a focus group meeting. I am also aware that participation is voluntary and I can choose to withdraw from the process at any stage without any consequences to my withdrawal.

Yes..... No.....

I am aware that all information obtained from me in the course of this project will remain confidential and that my identity will be well protected in the case of any publication of the obtained information. I am also aware that information shared in the focus groups cannot be divulged or shared with anyone outside of the group for any reason whatsoever.

Yes..... No.....

I agree that the interview process will be electronically recorded and all collected information will be kept with confidentiality and high security. **Yes..... No.....**

I Nelisiwe Mnguni do solemnly declare that I have fully informed the above participant of the nature and purpose of my research and the demands involved in her participation. I also declare to do all in my power to maintain confidentiality and anonymity of the participant as I fully keep to the ethical conduct requested of me as a fieldworker

The study outcomes will be available for those who would like to know about the study. If you would like to know about the study outcomes please provide your contact details below:

Address-----

E-mail address-----

Signature.....

Date.....

Place.....

Appendix 3.: Informed consent form in isiZulu



UNIVERSITY OF KWAZULU NATAL
SCHOOL OF SOCIAL SCIENCES

Fieldworker: Nelisiwe Mnguni (071 952 4580)

Supervisor: Dr. Maheshvari Naidu (031-2607657/naiduu@ukzn.ac.za)

Research Office: Ms P Ximba 031-2603587

Isifungo

Mina _____ (igama noma uyazikhethela ukufaka ama inishiyali)

ngiyavuma u ukuthi ngithole ulwazi ngokugcwele ngalolucwaningo olusihloko: **Probing the sociocultural factors influencing female condom use among heterosexual women in Clermont, Durban**

kumcwaningi. Yebo Cha

Nguye ngachazeleka ngokugcwele ngendima engizoyidlala uma mina ngivuma ukubamba iqhaza kulolucwaningo oluhlanganisa inkulumo mbuzo yomuntu ngayedwa (interview) kanye nasemhlanganweni ngxoxo-mbuzo yeqoqo labantu (focus group). Nginyaqaphela futhi ukuthi ngizibandakanya ngokuzithandela futhi ngiyakwazi ukukhetha ukushiya inqubo yocwaningo noma inini ngaphandle kokuthola imiphumela engemihle ngokuhoxisa kwami.

Yebo Cha

Nginyaqaphela ukuthi yonke imininingwane etholakala kimi kulolucwaningo izohlala iyimfihlo nokuthi akuzadalulwa igama lami lapho sekushicilelwa ulwazi olutholakele. Futhi ngiyaqonda ukuthi yonke imininingwane yengxoxo mbuzo yeqoqo labantu angizukuyidalula kunoma ubani ngaphandle kwaleliqembu noma ngayiphi indlela.

Yebo Cha..... ..

Ngiyavuma ukuthi inqubo yengxoxombuzo ingaqoshwa futhi yonke imininingwane eqoqiwe izohlala ngobumfihlo nokuphepha kwezinga eliphezulu.

Yebo..... Cha.....

Mina Nelisiwe Mnguni ngiyafunga ukuthi nginikele ukwaziswa ngokugcwele kubabambi iqhaza ngezimfuneko, imithetho isimo kanye nenhloso yocwaningo abazihlela kulo. Ngiphinde ngizibophezele ukwenza konke okusemandleni ami ukuba ngilondoloze ubumfihlo nokungadaluli imininingwane yobambe iqhaza njengoba ngiqhubeka ngilandela ngokugcwele imithetho yokuziphatha elawula ukuziphatha kwami ocwaningweni njenge fieldworker.

Isiginesha..... Usuku..... Indawo.....

Appendix 4

131 Valley View Road

Escombe
4093
08 June 2015

The Operations Manager
Clermont Clinic
Clernaville
3610

Request to use Facility to recruit Participants for MA Study

Dear Sir/ Madam

My name is Nelisiwe Mnguni, I worked for PHIVA Project where we conducted a Vaginal Ring Research Study and recruited participants from your Community.

Now, I am a registered Masters student in the school of Social Science at the University of KwaZulu Natal. My topic of study is: **Probing the sociocultural factors influencing female condom use among heterosexual women in Clermont, Durban**. I kindly ask for permission to use your facility when recruiting participants for the study (approximately 24). The study involves individual interviews which will last approximately 45 minutes each. The interviews will be recorded on audio at the consent of the participants. The participants will be given all necessary and relevant information to help them understand the purpose of this study. If the participants are agreeable to join the study and have signed informed consent, interviews will be conducted at the clinic or they may be scheduled to a place and time convenient for the participant.

The study will not include the actual names of the participants in the final write up and all data from the research will be for research purposes. All participants will take part at their own free will and will be allowed to withdraw from the study at any point. Anonymity and confidentiality will be maintained.

I greatly appreciate your cooperation and I look forward to hearing from you.

Yours Faithfully

Nelisiwe Mnguni
(0719524580)

Appendix 5: Interview Schedule (Individual Interviews)

Perceptions/ Attitudes on female condoms

No.	Question	Probes
1.	What is your opinion on Female condoms?	Do they work as intended? User friendly?
2	Have you used them before?	How often? In a week, month How do you find them?
3.	Where do you normally get your stock of female condoms?	Is it always available, easily accessible to you?
4	How important is it for you to protect yourself against HIV infection and or unwanted pregnancy?	Probe based on response
5.	How would you view a partner who always carry female condoms or insist on using one?	Explore reasoning based on the response
6.	Do you think you would be comfortable in introducing female condoms in any relationship you may have in future?	Probe for participant opinion
7.	As far as you know, have any of your friends used female condoms	Challenges Successes
8.	Do you think it is easy for women to want to use Female condoms?	Probe based on the answer
9.	What in your opinion could make women not to use anything that has to be inserted into the vagina?	Why do you perceive it this way?
10.	How important it is for you to do as your peers do in connection with female condoms?	Explore response further
11.	What do you think can encourage women to use anything that has to be inserted in the vagina?	Probe based on answer
12.	What rumours have you heard about individuals who carry condoms with them?	What did you make of them?

13.	In your opinion do you think that men are supportive of HIV prevention methods?	What perception do they have?
14.	What impact does the use of Female condoms have on a) fertility b) sexual pleasure c) sexually transmitted infections	Why do you feel that way?

Sexual Choices, HIV Prevention and Gender Issues

No.	Question	Probe
1.	How easy is it to discuss anything to do with sex and or sexuality with your partner?	a) Condoms b) HIV counselling and testing c) Male circumcision d) contraception
2.	What Encourages you to use female condoms?	Partner, dual protection, clinic staff, other?
3.	What discourages you from using female condoms?	Probe based on the answer
4.	How does gender affect your choice to use female condoms?	Who has power whether you use a condom or not

Thank you for your time and contribution.

Appendix 6: Focus group Interview schedule

No.	Question	Probe
1.	Do you know of any intervention to prevent HIV infection or unwanted pregnancy?	

2.	What does a female condom mean to you?	Why, so?
3.	What is it like to know someone infected with HIV?	Does it affect you
4.	Do you think it important to protect those you love from HIV?	Probe for reasons
5.	What do you think must be done in the community to protect the next generation from HIV?	Explore on attitudes, knowledge and beliefs
6.	What role has gender played in the spread of HIV?	Probe on masculine and feminine issues that affect decisions on Prevention choices
7.	How do you view HIV prevention methods that are offered at the clinic?	Condoms Male circumcision HIV testing and Counselling
8.	How likely is it that men can support women in using female condoms	Explore what the participant say
9.	What encourages/ discourages you from using female condoms	Explore sociocultural issues that influence decision on HIV prevention

Thank you for your time and contribution.

Appendix 7

Demographics of participants

Table 1.0 (IDI and FGDs)

Sequential Number	Participant	Gender	Age in years	Race
1.	NK	Female	23	African

2.	AB	Female	18	African
3.	TZ	Female	19	African
4.	CIS	Female	22	African
5.	Z D	Female	22	African
6.	LYZ	Female	33	African
7.	ZN	Female	24	African
8.	NL	Female	19	African
9.	ZNN	Male	25	African
10.	ZL	Female	22	African
11.	NEM	Female	26	African
12.	HB	Female	23	African
13.	CHN	Female	33	African
14.	MX	Male	29	African
15.	MZ	Male	23	African
16.	MD	Male	23	African
17.	TK	Male	22	African
19.	LES	Male	34	African
20.	ZN	Male	24	African
21.	SK	Male	23	African
22.	GNN	Female	24	African
23.	NH	Female	29	African
24.	NDU	Female	23	African
25.	NIS	Female	29	African
26.	QD	Female	26	African
27.	SP	Male	26	African
28.	JB	Male	24	African
29	JSB	Male	45	African



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address : 83 Kind Cetshwayo Highway, Mayville, Durban, 4001

Postal Address: P Bag X54318, Durban 4000

eThekweni District Office

9 February 2016

Dear Nelisiwe

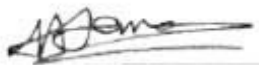
Re: Probing the socio-cultural factors influencing female condom use among heterosexual women

I have pleasure in informing you that, given the existent approval by the KwaZulu-Natal Health Research and Knowledge Unit, full ethical approval, and gatekeeper permission; the district office acknowledges and supports your research at Claremont Clinic.

Please note the following:

- i. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
- ii. logistical details must be arranged with the operational manager of the facility, and
- iii. a report of your findings should be forwarded to the Ethekewini district office on completion of your project.

Yours sincerely



H Somaroo (Dr)

Medical Officer- Public Health Medicine

Fighting Disease, Fighting Poverty, Giving Hope



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Health Research & Knowledge
Management

Reference: 007/16
KZ_2015RP32_138

Date: 19 January 2016

Dear Ms N. Mnguni
Email: masuwe.neli@gmail.com

Approval of research

1. The research proposal titled '**Probing the sociocultural factors influencing female condom use among heterosexual women in Clermont, Durban**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at KwaDabeka Community Health Centre.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 21/01/16.



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

PO Box 371 Clermontville 3602
4 Khululeka Road, Kwa-Dabeka Township
Tel: 031 714 3713 Fax: 031 714 3707 Email: nondumiso.hoqwe@kznhealth.gov.za
www.kznhealth.gov.za

KWADABEKA COMMUNITY HEALTH CENTRE

Reference	Nelly 1/2015
Enquires	Dr. Hoque
Date	13 November 2015

To

Ms N Mnguni

UNIVERSITY OF KWAZULU-NATAL

RE: PERMISSION TO CONDUCT RESEARCH AT KDC : Probing the socio-cultural factors restricting the female condom use in Clermont, Durban

I have pleasure in informing you that permission has been granted to you by Kwadabeka CHC to conduct the above research" at Clearmont clinic.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once YOU PROVIDE THE FINAL ETHICAL CLEARANCE FROM THE KZN Provincial and EThekweni District Offices.
3. Please ensure this office is informed before you commence your research.
4. The Kwadabeka CHC (Facility) will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Facility.

Thanking you

Sincerely


.....
CLINICAL MANAGER



19 November 2015

Ms Nelisiwe Mnguni 203513775
School of Social Sciences
Howard College Campus

Dear MsN Mnguni,

Protocol reference number : HSS/0810/015M

Project title: Probing the socio cultural factors restricting the Female Condom Use in Clermont, Durban

Full Approval – Full Committee Reviewed Protocol

With regards to your response received on 12 and 16 November 2015 to our letter of 29 July 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

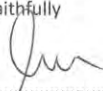
Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Dr Maheshvari Naidu
cc Academic Leader Research: Professor Sabine Marschall
cc School Administrator: Ms Nancy Mudau

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snvmanm@ukzn.ac.za / mohunp@ukzn.ac.za

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