MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES IN THE CONTEXT OF A GENERALIZED HIV/AIDS EPIDEMIC: A CASE STUDY OF AN URBAN AND RURAL AREA IN MOZAMBIQUE

MANUEL JOSÉ MACIA

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SUPERVISOR: PROFESSOR PRANITHA MAHARAJ

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Declaration

Submitted in fulfilment / partial fulfilment of the requirements for the degree of **Doctor of Philosophy in Development Studies**, in the Graduate Programme in **School of Development Studies**, University of KwaZulu-Natal,
Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of **Doctor of Philosophy in Development Studies** in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Student signature

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Date

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Editor name and surname (*if applicable*)

Dedication

In Memory of Julieta Muantepa,
My Mother-in-law;

To José Machenganhane Macia,
My Father;
and Celeste Sitoe;
My Mother

To Neuza Jualina Manuel Macia,
My Daughter;

and

To Maria Manuela Muantepa Rico,
My Wife

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Abstract

This study investigates male sexual behaviour and protective practices in the context of a generalized HIV/AIDS epidemic in Mozambique. It focus on how gender norms, particularly notions of masculinity influence sexual behaviour and the ability of men (and women) to protect themselves against HIV infection. A combination of qualitative and quantitative methods is used in this study. The qualitative data comes from 16 focus group discussions and 20 in-depth interviews and the quantitative data comes from a survey conducted with 209 men and 217 women. This methodological approach has proven useful in exploring complex and sensitive matters such as sexual behaviour. In this study, where it was possible, the findings from the survey were supported by quotes from focus groups discussions and in-depth interviews.

The findings of this study reveal that traditional gender norms, particularly rigid notions of masculinity are still prevalent in the study settings. The existing notions of manhood are mostly associated with traditional views of men as providers and main breadwinners. In contrast, women are seen as the family caregivers. Practices which bring social prestige both in the community and in the society at large are highly valued for men. Meanwhile, traditional notions of masculinity face enormous challenges in the existing socio-economic context which is characterized by a lack of employment and widespread poverty. This has negative consequences for male self-esteem including their sense of manhood. The study shows that some men believe that having multiple sexual partners is part of male identity and is supported by culture. Similarly, some women also believe that a man cannot be satisfied with one partner or stay long without having sex. These beliefs have important implications in a country with a high prevalence of HIV/AIDS.

The study found that traditional notions of manhood prevent men from accessing correct health information thereby perpetuating the cycle of harmful practices for themselves and their females partners. The findings of this study suggest that despite a universal awareness of HIV infection and protective strategies, multiple sexual partnerships and unprotected sex among heterosexual men and women are the driving force sustaining the HIV/AIDS pandemic in the study settings.

This is worsened by the widespread negative meanings attached to condoms. The study shows that the level of condom use (31 percent among men and 20 percent among women) is encouraging but not sufficient to curb the level of HIV infections. Consistent condom use remains a major challenge as much fewer men and women report using condoms in all their sexual encounters.

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List of Figures and Tables

List of Acronyms

ABC	Abstinence, Be faithful and use Condoms
ACASI	Audio computer-assisted self-interviewing
AIDS	Acquired Immune Deficiency Syndrome
API	Amenities Possession Index
ART	Antiretroviral Therapy
CEP	Centro de Estudos da Populacao (Centre of Population Studies)
CNCS	National AIDS Council
CSPRO	Census and Survey Processing System
DANIDA	Danish International Development Agency
DHS	Demographic and Health Surveys
DNEAP	Direcção Nacional de Estudos e Análise de Políticas (National Studies and Policy Analisys Board)
FGD	Focus Group Discussions
FRELIMO	Frente de Libertação de Moçambique (Mozambique Liberation Front)
GDP	Gross Domestic Product
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
IAF	Inquérito aos Agregados Familiares (Households Survey)
ICPD	International Conference on Population and Development
IDI	in-depth interview
INE	National Institute of Statistics
INJAD	National Survey on the Reproductive Health and Sexual Behaviour of young people and Adolescents
INSIDA	National Survey on Prevalence, Behabioural risks and Information about HIV and AIDS
IOF	Inquérito de Orçamento Familiar (Family Budject Survey)
IPV	Intimate Partner Violence

ISS	the Netherlands Institute of Social Sciences
MCT	Ministerio da Ciência e Tecnologia (Ministry of Science and Technology)
MISAU	Ministério da Saúde (Ministry of Health)
MPD	Ministério da Planificação e Desenvolvimento (Ministry of Planning and Development)
MF	Ministry of Finance
OMM	Organização da Mulher Moçambicana (Mozambican Women Organization)
RENAMO	Resistência Nacional Moçambicana (Mozambique National Resistence)
SCLT	Social Cognitive Learning Theory
SCRP	Soul City Regional Programme
SIDA-SAREC	Swedish International Development Co-operation Agency
SPSS	Statistical Package for Social Sciences
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWAA	Society for Women and AIDS in Southern Africa
TPA	Theory of Planned Action
TRA	Theory of Reasoned Action
UEM	Universidade Eduardo Mondlane (Eduardo Mondlane University)
UKZN	University of KwaZulu-Natal
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Populations Fund
WHO	The World Health Organization
WLSA	Women and Law in Southern Africa (WLSA Mozambique)

CHAPTER 1: INTRODUCTION

1.1 Background to the Study

The AIDS pandemic confronting the sub-Saharan Africa region has begun to raise salient but increasingly public concerns among scholars and policy makers about the role that sexuality and sexual behaviour plays in public health. There is growing evidence to suggest that gender roles and relations, and more specifically the process by which masculinity and femininity are socially constructed and enacted, are important factors determining an individual's vulnerability to HIV infection (Gupta, 2000; Blanc, 2001; Varga, 2003; UNAIDS, 2008). Yet, the predominant focus of most research has been on young people and women. Attention to men only began to emerge as a topic of serious enquiry in recent years, with a particular focus on how men (especially boys and young men) are socialized (Foreman, 1999; Ampofo, 2001; Varga, 2001). Despite this, there continues to be a paucity of research on the factors influencing the risk of HIV infection among men (Barker and Ricardo, 2005; Dover, 2005). Consequently, our understanding of male sexuality and sexual behaviour in the context of HIV/AIDS continues to be generally inadequate. The implications of this knowledge gap for the efficacy of programmatic interventions designed to address the HIV/AIDS challenge in sub-Saharan Africa is appreciable, since the successful design and implementation of these programmes has been shown to be dependent on exploring and factoring in notions of femininity and masculinity (Bell, 2000; Harrison, 2008).

Men have also been generally neglected in reproductive health programmes (Greene and Biddlecom, 2000; Sonfield, 2004). The disproportionate focus of interventions on women is due to the combination of a number of biological, socio-economic and cultural factors that render them more vulnerable to HIV infection than men. From a biological perspective, women have a larger surface area of mucosa which is exposed to their partner's sexual secretions during intercourse. A man's semen infected with HIV typically contains a higher concentration of the virus compared with a woman's sexual secretions. Thus, male-to-female transmission is much more efficient than the opposite. Because of this biological difference, women are more likely to

contract other sexually transmitted infections (STIs) than men (UNAIDS, 1997). Furthermore, since it is women who are at risk of unwanted pregnancy, most modern contraceptives have been designed for them. They are also perceived to be more motivated in protecting their own reproductive health (Dreggan, 1998 cited in Maharaj, 2000). A range of social, cultural and economic factors also "combine to prevent women from either knowing what to do to protect themselves or, if they know, from taking action to do so" (Foreman, 1999: x). In some societies, women are not in full control over their bodies and their sexuality, and their dependency on men increases their risk of HIV infection. In many societies women have been accorded less access to training, education and resources as families and communities consign them to domestic chores and apply the limited available resources on boys (Burgoyne and Drummond, 2008). Studies show that women who are economically dependent are more likely to engage in sex for money or favours, less likely to succeed in adopting risk reducing strategies, and less likely to leave a relationship that they perceive to be risky (Gupta, 2000; Maharaj, 2000; Ghosh and Kapileni, 2005). These dynamics have contributed to a general neglect of men and a reliance on stereotypes about male sexual behaviour (Varga, 2001). While recognizing the importance of these arguments and respecting the necessity of interventions to address the reproductive health needs of women, over the last decade the emphasis has progressively shifted from an exclusive focus on women to include men.

1.2 Why focus on Men?

The need to focus on men in sexual and reproductive health issues is a subject matter which took centre stage and prominence especially after the 1994 International Conference on Population and Development (ICPD) in Cairo (UNFPA, 2000). A number of compelling reasons exist for focusing on men. Firstly, men's health is important but receives relatively less attention. Men may have their own reproductive problems including family planning, prevention and treatment of STIs, infertility, sexual dysfunction, prostrate cancer and urological conditions (Maharaj, 2000; Sonfield, 2004; Greene and Biddlecom, 2000). However, in most settings, prevalent norms of masculinity prevent men from seeking information or admitting their limited knowledge,

which puts them at risk of HIV infection. They are socialized to be independent, not to display emotions and not to seek assistance in time of need or stress. This expectation of invulnerability associated with being a 'man' runs counter to the expectation that men should protect themselves from potential infection and leads to denial of risk (Gupta, 2000; UNFPA, 2000; Dworkin, 2005).

A second reason for involving men is that their behaviour puts them at risk of HIV infection. In many societies, cultural beliefs and expectations place men under pressure to conform, which heightens their vulnerability to HIV infection. According to Foreman (1999), men engage in risky sexual behaviour because they are conditioned to do so rather than because they want to. Men are socialized into believing, implicitly or explicitly, that their identity as men, and therefore as individuals, is defined by their sexual behaviour, which often entails an active and varied sexual life with many sexual partners (Varga, 2001; Shefer and Ruiters, 1998). Studies have shown that men who adhere and are supportive of rigid notions of manhood, who associate masculinity with risk taking, dominance, and sexual conquest, and who associate health-seeking attitudes and behaviours as a sign of weakness, are more likely to have very poor health outcomes (Peacock et al., 2009). Data from a number of sources suggest that life expectancy for men is lower than that of women in almost every region of the world (WHO, 2007). Estimates indicate that males of all ages represent 80 percent of homicide victims worldwide (Peacock et al., 2009). Male deaths due to violence are approximately two times higher than of women (Peacock et al., 2009). In addition it is also estimated that almost three times as many males die from road traffic injuries than females (Peacock et al., 2009). Furthermore, males who hold traditional views about masculinity are more likely to have contracted sexually transmitted infections (STIs) and they are more likely to view sexual relationships as adversarial, to have more negative attitudes towards women and less likely to use condoms (Kaufman et al., 2009; Peacock et al., 2009).

Thirdly, unprotected sex between men endangers both men and women. In many societies, sex between men is frowned upon and as a result, some men keep their sexual behaviour hidden. Some men who have sex with men also have sex with women which increase**s** not only their own risk but their sexual partners as well (UNAIDS, 1999; Gupta, 2000). A fourth consideration is that men's behaviour also places women in position of vulnerability. On average, studies show

that men are more likely than women to have two or more concurrent or consecutive sexual partners (Foreman, 1999; Todd et al., 2009; Soul City, 2008; Shelton, 2009; UNAIDS, 2009). In many societies worldwide it is believed that variety in sexual partners is essential to men's existence and it is natural for men it seek multiple partners for sexual release (Gupta, 2000; Mankayi, 2008)

Finally, since masculinities are historically dynamic and are influenced by time and contexts, socio-economic change in Africa may produce notable ramifications for male identity and sexual behaviour (Ouzgane and Morrel, 2005; Connell, 2007). For instance, a study conducted in East Africa suggests that high levels of unemployment and low incomes may prevent men from fulfilling socially mandated roles (breadwinner, provider), which in turn undermines male identity and self-esteem, and fosters risky sexual behaviour as a means of reclaiming the sense of manhood (Silberschmidt, 2005). In contrast, it has also been speculated that the HIV/AIDS pandemic and its impact on the familial situation and communities may induce men to challenge the long-entrenched gender norms and attitudes (Barker and Ricardo, 2005; Peacock et al., 2009).

In Mozambique, as other Southern Africa countries, the HIV/AIDS epidemic affects a significant proportion of the population, with 16 percent or about 1.6 million inhabitants infected. Women are disproportionately the most affected with 887300 women infected in 2009 compared with 615300 of men. It is estimated that about 96300 individuals may have already died of AIDS since the beginning of the epidemic (Ministry of Health, 2008; UNAIDS, 2008). Local studies have generally focused on young people (boys and girls aged 15-24) as well as on the so called high-risk groups, namely commercial sex workers, truck drivers, migrant mine workers, populations in prison and traditional healers (Ministry of Science and Technology, 2007; National Institute of Statistics, 2002; Santos and Artur, 1993; CNCS, 2004). Much of the focus however, is limited to the general assessment of awareness among the targeted groups. Young women have deserved special attention due to their subordinate position in society and because women in general seem to be the main victims of gender inequalities (Osorio et al., 2002; Cruz e Silva et al., 2007). A study by a non-governmental organization highlights the burden of gender inequalities in society, including the feminization of the AIDS epidemic in Mozambique (Cruz e Silva et al., 2007). The

research seems to suggest that men and older men in particular are mostly to blame for the current HIV/AIDS burden because they are the main beneficiaries of the patriarchal social structures wherein the pervasive gender inequalities in the Mozambique's society impose a vicious cycle of women vulnerability including vulnerability to HIV infection (Cruz e Silva et al., 2007).

In his study in Mozambique, Matsinhe (2006) also notes that more recently some intervention programs have focused on women as their main target group due to structural factors including extreme poverty and cultural practices which make women more vulnerable to HIV infection and other sexual and reproductive negative outcomes. Matsinhe (2006) observes that available data indicates that females aged 15-24 years present higher HIV infections rates than males of the same age cohorts, which is in line with the international trends (Hallman, 2004). In addition, Matsinhe (2006) provides empirical evidence which suggests that men have collectively enjoyed the privileges of the current gender hierarchies within the Mozambique's society including being the main decision-makers in sexual and reproductive health matters. For example, in some rural settings in central Mozambique, Matsinhe (2006) found that intergenerational sex between older men and younger women (including teenagers) is generally accepted, with little consideration of the negative impact on the sexual and reproductive health of young women.

Moreover, the evidence suggests that in general, there is a perception that not only men are to blame for the perpetuation of intergenerational multiple concurrent sexual partnerships, but also, young women because they engage in sexual relations with older men in order to gain an acceptable standard of living which they have become accustomed to (Matsinhe, 2006). This rationale leads to a conclusion, shared by both men and women interviewed, that the spread of HIV infection in the country is promoted by women who are motivated by greed, while men are viewed as victims and not transmitters of the virus. Besides, some respondents portrayed women as "having a lot of diseases" which reinforce the gender stereotypes portraying women as disease carriers. It seems to be part of the widely subscribed idea that because men have an uncontrollable biological drive for sexual intercourse it is legitimate for them to engage in multiple sexual partnerships, while women are expected to remain chaste and not submit to the

demands of men for sex (Matsinhe, 2006: 171). Another finding is that although married or cohabiting older women perceive themselves at risk of HIV infection due to their partners' infidelity they feel unable to change the situation because they fear the breakdown of their relationship. For these women marriage has become an important resource which should be secured at all costs including putting themselves at risk of HIV infection. As part of this strategy married or cohabiting older women try to avoid all kinds of confrontation with their partners which threaten their social and economic situation (Matsinhe, 2006: 171-172).

Although the existing HIV/AIDS studies and intervention programs in Mozambique may reflect a growing public concern and strong political commitment to change the course of the epidemic including alleviating its devastating impact within the society, they also show some important gaps and, in some cases, even practices which seem to result from adopting international paradigms and approaches in addressing the epidemic (Dworkin and Ehrhardt, 2007). One of the gaps in understanding the AIDS epidemic in Mozambique is the scarcity of the use of integrated analyses which employs both quantitative and qualitative methods to understand sexual behaviour of men and women (Osorio and Andrade, 2002). Another existing gap is the disproportionate focus on the so called high risk groups in a country with a generalized HIV/AIDS epidemic (Ghys et al., 2004; Zwi and Cabral, 1990). There is no doubt that some sub-population groups are likely to be more vulnerable to HIV infection than others (Ghys et al., 2004). However, concentrating on the so called high risk groups has the potential of diverting attention from the need for safer sex practices by all sexually active individuals and it may give a false sense of security to the rest of population which do not fall into these categories. Moreover, overly focusing on "high risk groups" may have detrimental consequences, including stigma and discrimination or denialism through the process of "othering" (Petros et al., 2006; Mbonu, den Borne and De Vries, 2009). Therefore, this study breaks new ground by investigating the sexual behaviour of men and women and their protective practices.

1.3 Statement of the Research Problem

This study recognizes the importance of male sexual and reproductive health both in and of itself, as well as a means of protecting the health of women (Varga, 2001; Sonfield, 2004; Peacock et al., 2009; Mahalik, Burns and Syzdek, 2007). Moreover, in this study, the concept of masculinity is investigated as the basis for understanding how gender influences sexual behaviour and the ability of men and women to protect themselves against HIV infection. The starting point of the concept of masculinity (or about what constitute ideal or actual characteristics of 'being a man') in use in this study is that which defines masculinities as configurations of practice that are accomplished in social action and, therefore, can differ according to the gender relations in a particular social setting (Connell and Messerschmidt, 2005: 836). In addition, the study also uses the Raewyn Connell's notion which emphasizes that there is no single version of masculinity that can be found everywhere (Connell, 2007). Therefore, constructions of masculinity may differ from one culture to another and from one historical moment to another, and multiple masculinities may be found even within the same culture or organization (Connell, 2007). The study focuses more specifically on how both men and women are made vulnerable to rigid notions of manhood and gender hierarchies.

It is generally accepted that collectively men are the main beneficiaries of the current gender hierarchies, and evidence shows that men benefit most from existing gender inequalities. In contrast, women are collectively disadvantaged and carry most of the burden of patriarchal society. However, there is a need to look at the traditional norms of masculinity which are harmful not only to women but also to men themselves (Peacock et al., 2009). This approach has the advantage of shifting the focus from the simplistic approach which always tends to portray men as the endless winners and women as the endless losers to an integrated approach which recognizes that men are both agents of change as well as 'holders of rights to the ultimate benefit of men and women' (Ehrhardt et al., 2009: 119). In this study, it is argued that men are diverse and that there are many men who find themselves trapped by the same gender norms which subjugate women, and yet they are pressured to meet the standards to be a "real men". In addition, frustrations which may result from the failure to fulfill this imagery could be part of the

problem: a significant number of men do not have access to education, employment and health care including services which respond to their physical, emotional and mental needs (Dixon-Mueller et al., 2009; Higgins et al., 2010; Collumbien and Hawkes, 2000). Therefore, important for this study is traditional notions of manhood that prevent men from accessing correct health information and knowledge including those on sexual and reproductive health, thereby perpetuating the cycle of harmful practices for themselves and their female partners (Sonfield, 2004; Ehrhardt et al., 2009).

The study recognizes the importance of focusing on women since they are the main victims of the current gender inequalities which has a negative impact on their sexual and reproductive health. It also appreciates the important contributions and all efforts which intend to minimize or even to eradicate the negative impact of gender inequalities (Gupta, 2000; Dixon-Mueller et al., 2009). However, the study argues that it is urgent to tackle the rigid notions of masculinity and gender ideologies which not only harm women but also trap men**.** By focusing on the sexual behaviour of heterosexual men and women the study highlights the determinants of sexual behaviour, and the factors that inhibit or facilitate behaviour change. In this regard, the study argues that there is a need to see men, including adult men, not just as a problem, but rather as part of the solution to the negative consequences of gender inequalities (Kaufman et al., 2009; Peacock et al., 2009). Furthermore, the current prevention initiatives are likely to have limited success if they focus exclusively on women. Therefore, there is a need for research on the sexual behavior of both men and women in order to develop context-dependent or context-friendly programmes. The focus on the sexual behaviour of both men and women intends to identify some of barriers to behaviour change as well as the opportunities that exist for transforming gender relations (Dixon-Mueller et al., 2009; Ehrhardt et al., 2009; Higgins et al., 2010).

This study uses the concept of sexual behaviour defined by Dixon-Mueller (1993) in a paper entitled “the sexuality connection in reproductive health” (Dixon-Mueller, 1993). According to Dixon-Mueller (1993), sexual behaviour consists of actions and acts that are empirically observable, at least. In other words, sexual behaviour consists of what people do sexually with others or with themselves (Dixon-Mueller, 1993: 273). The relevant literature describes sexual

behaviours as a set of sexual practices (behaviours) which include age at first sex, premarital sex, number of partners, condom use, commercial and transactional sex, age mixing in sexual relationships, multiple sexual partnerships (Cleland et al., 2004, Harrison et al., 2005; Cohen and Trussell, 1996; Wellings et al., 2006). In addition, protective practices are defined in the contexts of sexual risk as a set of behaviours, decisions or practices that individuals adopt to protect themselves and their sexual partners against STIs including HIV/AIDS (Slaymaker, 2004; Eaton et al., 2003; Green et al., 2006).

1.4 Aim of the Study

The overall aim of this study is to improve our understanding of the sexual behaviour and protective practises of men and women in the context of high levels of HIV infection in Mozambique.

Specific objectives of the study

1. To describe the patterns of sexual behaviour of men and women in Mozambique and the socio-economic and cultural context in which it occurs.

This objective provides detailed information about the sexual behaviour of both men and women based on selected demographic characteristics. The analysis takes into consideration the socio-economic and cultural context in which the behaviour occurs. Describing sexual behaviour patterns within the context in which they occur is deemed important in improving our understanding of the determinants of sexual behaviour of men and women (Tawfik and Watkins, 2007; Beyrer, 2007; Shelton, 2009).

2. To investigate the strategies considered as appropriate, practical and effective to cope with the risk of HIV infection as well as the opportunities for and constraints on changing behaviour with specific emphasis on partner communication.

This objective assesses specifically the extent to which both men and women in the study settings are dealing with the HIV/AIDS epidemic. It particularly looks at the relationships dynamics with specific emphasis on partner communication as one of the key elements in negotiating sexual needs and protection from harmful practices (Dixon-Mueller, 1993).

3. To investigate and analyse how the process of decision-making defines and influences sexual behaviour among men and women.

This objective investigates the extent to which gender and power relations influence sexual behaviour choices among men and women, and more importantly how these dynamics enhance or minimize the perception of sexual risk in the context of a generalized HIV/AIDS epidemic (Ghys et al., 2004).

1.5 Conceptual Framework

The conceptual framework for the study draws heavily on the model proposed by Eaton, Flisher and Aarø (2003). Eaton et al., (2003) proposes a model for understanding sexual risk behaviour in Southern Africa, and more precisely for understanding of the factors that promote or perpetuate unsafe sexual behaviour (Eaton et al., 2003). The model consists of three interrelated levels of risk factors: within the person; within his or her proximal environment (including interpersonal factors and the immediate living environment); and within the distal broader context (including structural and cultural factors). The factors operating at both the personal and interpersonal levels emphasizes physiological and behavioural aspects of sexual risk behaviour including subjective and objective features, that is, the immediate living environment. The third level emphasizes cultural and structural factors which determine sexual behaviour. Thus, the model highlights the crucial role played by personal and proximal factors as well as by cultural and structural factors including the organizational elements of society at large. The authors of the model note, however, that all the factors which are grouped into these three levels are potentially reciprocally determining. Therefore, these three levels overlap to a certain extent and reciprocally

influence each other (Eaton et al., 2003: 150, 162).

Personal factors: The first level of factors operating at the personal level highlights factors which influence individual's behaviour. These personal factors include knowledge and beliefs; perception of personal risk; self-efficacy; perceived costs and benefits; intentions; and self-esteem. Knowledge and beliefs refer to one's level of knowledge and awareness regarding sexual health threats including knowing, for instance, that HIV is a fatal infection which can be transmitted either through non-sexual modes, notably sharing of needles and syringes by injecting drug users, through mother-to-child during birth, but mainly through unprotected sex with an infected individual (Eaton et al., 2003: 151; Cleland et al., 2004). Perception of personal risk is of particular importance since it is believed that perceptions about the seriousness of a health threat may lead to protective behaviour (Eaton et al., 2003: 152). In the model, self-efficacy is defined as the "expectations that one can successfully complete a given behaviour, such as using a condom" (Eaton et al., 2003: 158; Boer and Mashamba, 2007). Intentions are postulated to be the major determinants of health-related behaviour. Attitudes may also play an important role in influencing actual behaviour (Eaton et al., 2003: 158). Self-esteem is the last element operating at the personal level. It is believed that a person with a poor sexual self-concept may rely on others for affirmation. For example, a person with low self-esteem is more likely to think that condoms are offensive to their partner, or to think that using condoms may embarrass their partner. In addition, they may also think that the introduction of condoms in the sexual relationship may raise suspicious about their sexual health status (Eaton et al., 2003: 159).

The proximal context: The second level of factors in the model is the proximal context. It encompasses interpersonal factors and physical and organizational environment. Interpersonal factors refer to communication or negotiating skills including assertiveness. Interpersonal factors include negotiating condom use; coercive, male-dominated sexual relationships; peer pressure; and interactions with adults. Coercive, male-dominated sexual relationships describe the situations deemed widespread in sub-Saharan Africa in which the terms and conditions of sexual intercourse between men and women are mostly determined by men. It is believed that the imbalance of power between men and women, particularly young women, hinders women from

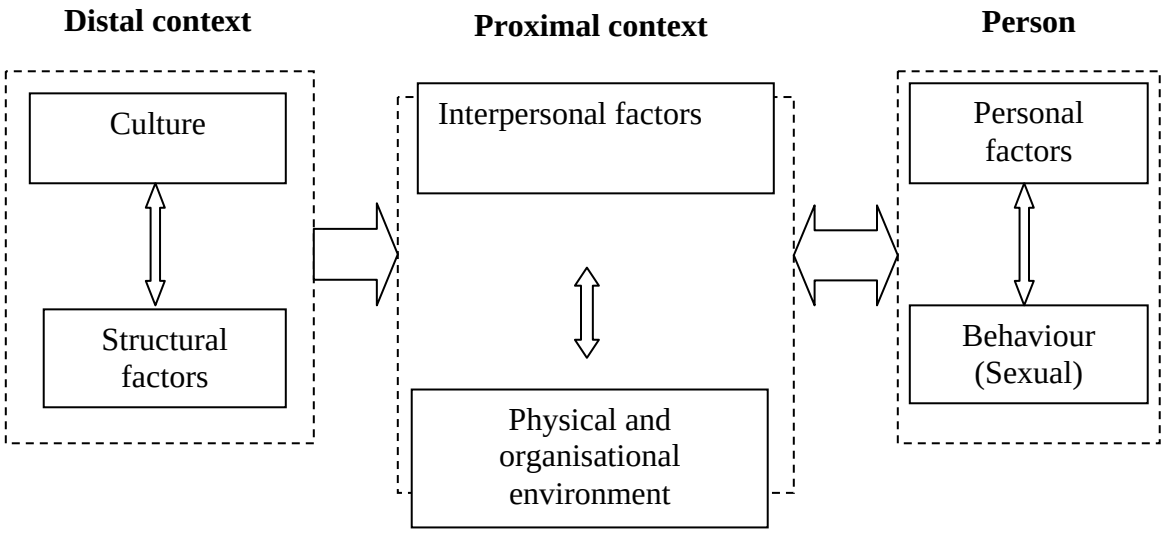
adopting safer sex practices (Gupta, 2000, Higgins et al., 2010). Furthermore, coercive, male-dominated sexual relationships describes the sexual double standards existing in sexual relations between men and women including situations in which young women are physically forced or bullied into having sex (Gupta, 2000, Eaton et al., 2003: 159). Peer pressure refers to situations in which an individual takes a specific action or behaviour under the influence of others (Eaton et al., 2003: 159-60). Here, the authors of the model observe that peer pressure is not necessarily a negative influence since positive examples set by friends and role models can promote safer sexual behaviour (Eaton et al., 2003: 160). Physical and organizational environment refers to the individual's access to or availability of particular resources, services and structures that also influence one's behaviour. With regard to this, gender and power relations, structures and the dynamics of the local economies may play a significant role in determining access to existing resources. Physical and organizational environment include factors such as lack of access to condoms; limited access to the media; lack of recreational facilities; living on the streets; and being in prison (Eaton et al.; 2003: 160).

The distal broader context: The distal context is the third level of factors in the model. It consists of two sub-levels, namely culture and structural factors. As defined in the model, culture "comprises aspects such as traditions, the norms of the larger society, the social discourse within a society, shared beliefs and values, and variations in such factors across subgroups and segments of populations" (Eaton et al., 2003: 150). For example, the low status of women in sexual relationships in sub-Saharan Africa is attributed to culture. With regard to this, the model highlights scientific evidence which shows that pervasive, culturally entrenched gender discrimination increases the vulnerability of African women (Eaton et al., 2003: 161). Eaton et al. (2003) argue that some of these cultural beliefs tend to portray male sexuality as a biologically determined 'need' and, at the same time, make claims about male sexual 'right'. One claim which seems to be part of the same continuum is "the notion that masculinity implies having unprotected sex with numerous partners and that sexual desire is a natural force that one should not attempt to control" (Eaton et al., 2003: 161). However, the authors of the model also note that not all these norms are accepted incontestably. In the model, structural factors includes legal, political, economic or organizational elements of society. They include factors such as urban

versus rural conditions, and poverty. Poverty is one of the most important determinants of sexual risk behaviour. The model posits that poverty, unemployment, overcrowding and low levels of education are linked to high levels of risky sexual activities and less knowledge about HIV and AIDS. On the other hand, poverty is often the reason for transactional sex, in which women agree to sexual relationships with men in exchange for financial support (Eaton et al., 2003: 162).

In contrast to previous social psychological theories (including Health Belief Model, Theory of Reasoned Action, Theory of Planned Action, and Social Cognitive Learning Theory) which tend to overestimate individual agency to explain HIV risk related behaviours. The model proposed by Eaton et al. (2003) emphasizes the interactive effects of personal, proximal and distal factors in determining one's sexual behaviour (Eaton et al., 2003). Therefore, this model offers an extended field for understanding the interplay of the different factors operating in those three levels of analysis. Figure 2 presents the model for organizing the relationship between sexual behaviour, personal factors and the proximal and distal contexts. Furthermore, the model seems to fill the gap that social-cognitive theories did not sufficiently address, particularly to structural factors which seem to play a significant role in influencing vulnerability and risk of HIV infection (Eaton et al., 2003, Parker et al., 2000). This is particularly true for countries like Mozambique where extreme poverty, high levels of unemployment, gender inequalities, and socio-economic hardships seem to enhance individuals' vulnerability to HIV infection.

Figure 1.1: Conceptual framework for organizing the relationship between sexual behaviour, personal factors and the proximal and distal contexts



Source: Eaton et al., (2003)

1.6 Organization of the Thesis

This study consists of ten chapters. Chapter one outlines both the background and motivation in carrying out this study. It also outlines the aims and objectives of the study, (including the research questions and the rationale of the study). Chapter two outlines the relevant literature which supports the study. The methodology applied in the study is described in the next chapter. The main findings of the study are discussed from chapter four to chapter nine. The final chapter discusses the main findings of the study and draws some recommendations for further research and policy design.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The high burden of HIV/AIDS worldwide has trigged huge interest in human sexual behaviour particularly the socio-economic, demographic, and cultural determinants (UNAIDS, 2008; Foreman, 1999; Rao-Gupta, 2000). In this chapter, the relevant literature on male and female sexual behaviour including aspects of sexual and reproductive health is reviewed. It focuses more specifically on the process of gender socialization and its impact on sexual behaviour, factors contributing to an increased risk of HIV infection including early age at first sexual debut, multiple partnerships and condom use.

2.2 Socialization

A review of studies of men in Africa identified the role of socialization as a key determinant of male risk-taking behaviour (Barker and Ricardo, 2005; Shefer and Ruiters, 1998; Mankayi, 2008; Pearson and Makadzange, 2008; Ampofo, 2001). At an early age, children learn to distinguish male and female roles and expectations. In many cultures, boys are generally taught to be tough, decisive, and powerful and decision-makers while girls are socialized to be passive, innocent, submissive and refrain from decision-making (Elisabeth et al., 2003; Ampofo, 2001). A qualitative study in Zambia among young boys found that men were perceived as physically strong, bold, hardworking, powerful, courageous and the head of the household (Elisabeth et al., 2003). This is illustrated by the following comment by one participant in a focus group discussion who stated that a man ‘ought to be married and have children. He should be knowledgeable, hardworking and take responsibility for the family by providing money for food for his wife and his children and, in general, be a good leader of his family, set a good example’ (Elisabeth et al., 2003).

In a qualitative study in Ghana, Ampofo (2001) describes how girls and boys since their early teenager years are socialized to learn particular behaviours that are widely perceived as appropriate for boys and girls. Children make the conceptual distinctions between female and male at an early age and they begin to express sex role preferences at this time (Ampofo, 2001). The findings of the study indicate that young adolescents had been socialized to define appropriate female and male roles as opposite and polarised. Girls are thought to assume domestic roles and a position of deference in relation to males, and boys tended to express a sense of entitlement and assume a position of dominance in male-female relationships. According to the author, this was not uncommon in all areas of decision-making, including those that impinge on sexual and reproductive health (Ampofo, 2001).

Sometimes the socialization process may lead to double standards in sexual relations and consequently in different attitudes and behaviours with regard to sexual matters (Isugo-Abanihe, 2003). This is most clearly captured by Silberschmidt (2005: 243) who notes that while "sexual potency gives social potency, value and self-esteem to men, sexual modesty gives social value to women – but certainly not to men", and "in particular in relation to sexuality, what gives social value to a man does not give social value to a woman". For example, in their qualitative study among Xhosa youth in a South African township, Wood and Jewkes (2001) found that a 'successful' man was defined in terms of their number of sexual partners, the choice of a main partner, and how desirable his partner was to other man, and above all, his capability to 'control' his girlfriends (Wood and Jewkes, 2001).

In South Africa, Varga (2003) describes how gender ideals are grounded in traits that reinforce poor sexual negotiation dynamics and behavioural double standards that place adolescents at risk of early pregnancy and other sexual and reproductive health complications (Varga, 2003: 168). Yet, Varga (2003) notes that although both men and women face complex and conflicting pressures concerning fidelity, not only were men extolled and women condemned for having multiples partners, but for girls such behaviour carried with it the potentially added liability of paternity rejection, with serious social and financial repercussions for the pregnant adolescent.

Such sexual dynamics reinforce unequal gender relations and can lead to early pregnancy and poor sexual and reproductive health outcomes (Varga, 2003; Blanc, 2001).

In a qualitative study in South Africa, Shefer and Ruiters (1998) note how participants strongly subscribed to the notion that men needed sex; were focused on sex; were 'ever ready' to have it and that it was ultimately a biological urge outside their control. In addition, the authors also observed that while men clearly constructed their sexuality as emerging out of physical need, they also spoke of the significance it played in their self-perceived image as men. In contrast, women were viewed as less sexual, or they should not appear as sexual as men, which consequently led to the imperative for women to be passive and receptive in sexual relationships with men. In situations where women were perceived as taking the lead, this behaviour was perceived as undermining masculinity (Shefer and Ruiters, 1998).

In a qualitative study in KwaZulu-Natal, South Africa, Scorgie et al. (2009) found that both men and women revealed intricate expectations about the nature and quality of sexual intercourse and concluded that it was those expectations that largely motivated women's vaginal practices. Women's vaginal practices refer to "a wide variety of products to alter the appearance, shape and appeal of their genitals" (Scorgie et al., 2009: 268). Thus, vaginal practices cover also what is known as traditional love potions including those aimed at tightening the vagina and or at diminishing wetness, a practice known in the literature as 'dry sex' (Scorgie et al., 2009; Bagnol and Mariano, 2008). According to the authors, some men in focus groups discussions repeated that they have a more-or-less constant need for sex and that women were expected to respond to this need, no matter how frequently it arose. The authors quote one urban male focus group participant who said: 'whenever the penis stands up then she must lie down'. In the same line, one rural male focus group participant "maintained that he wanted a different woman for every night of the week". The authors concluded that all this seemed to give expression to the social norms of multiple sexual partnerships as a defining feature of masculinity (Scorgie et al., 2009: 274).

In a qualitative study in Zimbabwe, Pearson and Makadzange (2008) found that a complex and dynamic socio-cultural context around sexualities, masculinities and reproductive health affect men's health-seeking behaviour. The authors observe that traditional Shona culture promotes the role of men as confidants and advisors. In this regard, ideologies of masculinity are cited as restricting honest discussions of sexual health. For example, men were under pressure to maintain an image of virility (e.g. without any type of sexual dysfunction) and ensure that their female partner remained faithful to them. Therefore, any discussion indicating weakness or failure was avoided because this is not seen as a masculine characteristic. Another worry among respondents was that some unscrupulous men would exploit a man's 'weaknesses' by luring or seducing his heterosexual partner. On the other hand, some respondents expressed discomfort regarding receiving treatment from female health providers. The authors observe that Zimbabwean men are used to having more power in social interactions and expect respect and deference from women. For example, for some health services such as a STI diagnosis, a woman may examine a man's genitals, ask him sensitive and intrusive questions and chastise him about his behaviour. Some respondents perceived this as an 'affront' to the masculinity. They equated genital examination by a female nurse to castration (Pearson and Makadzange, 2008)

Sexual double standards that exist in heterosexual relationships were highlighted in a qualitative study by Mankayi (2008) among a group of South African soldiers. The study found that all young adult male officers expected women to express their sexuality in monogamous relationships while men are encouraged to have multiple sexual partners. Importantly, married men were also expected to be morally upright and, while it was not uncommon for them 'because they are men' to experience sexual desires for other women, they were not encouraged to act on those instincts (Mankayi, 2008: 629). In this regard, the author concludes that the stigma associated with 'having known-about sexual relationships' was acute for women, but did not equally apply to man. From participants' point of view, multiple partners were seen as a demonstration by men of their 'manhood'. According to Mankayi (2008), the best thing for men was to have sex, a great deal of it and with as many women**,** if possible.

In some parts of Africa, young men participate in initiation practices, or rites of passage, as part of the process of socialization (Mgqolozana, 2009). A review of studies of young men notes that in parts of Eastern Uganda as part of the rite of passage young men undergo circumcision and are required to spend a certain period of time in seclusion, healing from the process (Barker and Ricardo, 2005). After the month-long healing process is completed, the young man is encouraged to engage in sexual relations with any village woman of his choice (provided it is not the woman he intends to marry). Through this ritualised sex, the young man is said to rid himself of "evil and boyish spirits." He is also urged to have "live sex," which refers to unprotected sex. Barker and Ricardo (2005) report stories and experiences of young men who had undergone circumcision without anaesthesia and sometimes even pour salt and/or pepper to their wounds. The rites of passage involving 'circumcision without anaesthesia', or the act of 'pouring salt and/or pepper on the wound' and/or having "live sex" are meant to socialize the boys to feel courageous and fearless. Morrell and Swart (2004: 106) observe in Uganda that "through circumcision, all men become heroes. They are heroes because they have suffered the ordeal with dignity." In addition, Morrell and Swart (2004) observe that in Uganda after circumcision men are expected to marry and establish their household and take responsibility for dependents.

2.3 Sexual Experience

A number of studies suggest that both girls and boys are becoming sexually active at an early age (Varga, 2001; Meekers and Ahmed, 2000; Pettifor et al., 2009; 2004; Mpofu et al., 2006; Harrison et al., 2005; Izugbara, 2008). However, boys are more likely to be sexually active at an earlier age than girls. In their study in Botswana, four out of every ten males were sexually experienced, compared with one out of every seven females (Meekers and Ahmed, 2000). In addition, men are more likely to be sexually active than women, judging by their premarital sexual experiences. Zaba et al. (2004) found that men are more likely than women to spend much longer in the sexually active, unmarried state. Smaller proportions of men than women claim not to be sexually active before marriage. The authors observe that Uganda and Zambia have the

highest proportions of women who reported that they were not sexually active prior to marriage; Kenya has the lowest.

In their review, Barker and Ricardo (2005) note that in many cultures, young men experience pressure to be sexually active and to have multiple sexual partners. In South Africa, MacPhail and Campbell (2001) found that if a young man does not have sex with a girl, his reputation may become tainted. Barker and Ricardo (2005) argue that these sexual experiences are viewed by peers as a sign of sexual competence or achievement, rather than acts of intimacy and this pattern of sexual behaviour often persists into adulthood and has direct implications for the spread of HIV/AIDS.

While lack of sexual awareness and experience remains highly valued for young women, men may be stigmatized if they cannot demonstrate sexual experience (Varga, 2001; Wood and Jewkes, 2001; Barker and Ricardo, 2005; Izugbara, 2008). In her study of young Zulu men in KwaZulu-Natal, Varga (2001) found that a significant minority of young men would prefer to abstain from sex before marriage but they feel obliged to engage in sexual relations because of fear of social rejection. Young men face pressure not only from other men but also from young women, which reinforces traditional views about manhood and sexuality.

In a qualitative study in Nigeria, Izugbara (2008) analyses the “abstinence-until-marriage” policy and highlights the contradictory sentiment of rural Nigerian male youth with regard to masculinity scripts, which emphasizes sexual experimentation and multiple partnerships as a feature of manhood and the policy of “abstinence-only until marriage” is intended to enhance youth sexual health (Izugbara, 2008) The study found that rural Nigerian young males understand abstinence as two-folded: on one hand, abstinence helps young males to “grown into healthy, strong and confident male; to conserve their strength, virility, and fertility until marriage”. At the same time, however, participants noted that abstinence could also be detrimental to their sexual and reproductive health, impacting their virility, and causing them frustration (Izugbara, 2008: 18). The author reports that in their daily lives rural young males were persuaded that having girlfriends and having sex were critical in socializing young males on their future roles of fathers,

husbands, and breadwinners. In this regard, abstinence was therefore viewed as likely to rob male youth of the requisite early experiences and learning they needed to undertake these tasks later in life. In addition, since having sex was viewed as a marker of full manhood, abstention was associated with the capacity to cause young males disrespect, ridicule, and disdain among their peers (Izugbara, 2008). The author concludes that the social context in which they live, particularly the norms and scripts which organize and shape their behaviours, including sexual behaviours, ultimately may persuade young males to engage in risky behaviours in order to maintain their reputation among their peers and society at large.

In Maputo Karlyn (2005) observes how gender roles regulate the behaviour of men and women. Traditional gender roles emphasizes male sexual prowess with a focus on performance and being in charge. Thus, boys learn that men should always want sex and that all physical contact leads to penetrative sex and ejaculation. Young men interviewed in Maputo consistently expressed such rigid gender roles and this is mostly illustrated by the belief that men always want to have sex and they would be able to have sex everyday without a problem. In contrast, traditional gender roles emphasize passivity, compliance, physical appeal and being a wife and mother. Thus, girls learn that they should place more emphasis on pleasing men sexually than on their own sexual pleasure (Karlyn, 2005). Many girls accept that sex is for men and as a result, women should not talk about or want sex. However, the study found that some women maintain that it is important not to give in too quickly to male demands for sex.

Pettifor et al. (2009) in South Africa found that although the majority of young people did not report having had sex at an early age, eighteen percent of young men and eight percent of young women reported early sexual debut (15 years-old or before). Early sexual debut was associated with having an older first sexual partner among males and females and forced sex among females. The authors concluded that because of the high prevalence of HIV infection in the general population, sexual behaviours which might be deemed low risk in low-prevalence settings represent a much greater risk in high-prevalence risk settings such as South Africa (Pettifor et al., 2009). A study in Zimbabwe found that early coital debut was a significant predictor of HIV infection independent of other identified factors in the population under

investigation (Pettifor et al., 2004). In this regard, women with early coital debut had a significantly higher risk profile including multiple lifetime partners (Pettifor et al., 2004).

2.4 Multiple Sexual Partners

Unprotected sex with a large number of sexual partners significantly increases the risk of HIV infection. In many societies, men and women have more than one sexual partner, either simultaneously or concurrently (Lagarde et al., 2001; Wellings et al., 2006; Halperin and Epstein, 2006; Nshindano and Maharaj, 2008; Gregson et al., 2002; Joffe et al., 1992; Harrison et al., 2006; Todd et al., 2009; Soul City, 2008)**.** A survey of sexual behaviour in developing countries found that there is a wide variation in the prevalence of multiple current partnerships among men aged 15 to 49 years ranging from 0.2 percent to 55 percent (Carael, 1995). Men in Lesotho, for example, were most likely to report multiple sexual partners, although formal polygamy is low by African standards. The very high labour migration, affecting more than half of the adult male population, appears to have resulted in the weakening of marriage and a rise in extramarital sexual relations (Carael, 1995).

In general, studies show that multiple sexual partnerships are more common among men than women (Carael, 1995; Shisana et al., 2005; Meekers and Ahmed, 2000; Akwara et al., 2003). A national population survey in South Africa found that 27 percent of men and 6 percent of women aged 15 to 24 years have reported having more than one sexual partner and among 25 to 49 years old, 14.4 percent of men and 1.8 percent of women reported having more than one sexual partner (Shisana et al., 2005). The likelihood that men have two or more concurrent partners also puts them at greater risk of becoming infected and also, transmitting the virus to their partner. This is an indication that women are put at risk by their partner's behaviour (Lawoyin and Larsen, 2000; Smith, 2007; Parikh, 2007; Hirsch et al., 2007, Wardlow, 2007; Jacubowski, 2008; Sheppard et al., 2001, Dunkle et al., 2008; Hugonnet et al., 2002; Glynn et al., 2003).

In their study in Botswana, Meekers and Ahmed (2000) found that male focus group participants argue that men are expected to have multiple partners, but that women are not. However, using data from a survey, Meekers and Ahmed (2000) show that both men and women have multiple sexual partners and the difference between men and women is small, with 57 percent of sexually experienced women reporting they had two or more partners in the past year, compared with 63 percent for men.

Men who are not married are more likely to have more sexual partners than married men. Using data from Demographic and Health Surveys (1994-1999) among men of reproductive age in 18 sub-Saharan African countries, Bankole and Singh (2001) found that among men who are in a union, the proportion that had two or more sexual partners ranges from about eight percent in Burkina Faso and Mali to about 51 percent in Mozambique. However, among men who are not in a union, the proportion with two or more partners ranges from 34 percent in Ghana to 69 percent in Cameroon (Bankole and Singh, 2001).

In their study in Zambia, Kimuna and Djamba (2005) found that almost 19 percent of married men had extramarital sex. The study found that young age is associated with extramarital sex among married men. In their study in Nigeria, Lawoyin and Larsen (2002) found that the majority of extramarital partners were steady girlfriends. Having these steady partners appear to protect men from going to non-regular, high risk partners. However, in situations where the man is not living with the steady girlfriend or the wife, he may have other sexual partners.

A qualitative study in Uganda concluded that “HIV prevention messages may be inadvertently contributing to increased difficulty in acknowledging HIV risk and to newer forms of sexual secrecy and that structural determinants, including persistent poverty, intercept with gender inequalities to shape marital risk” (Parikh, 2007: 1198). The author observes that despite local narratives of love, trust, monogamy and sexual partners’ reduction, the reality was that most of the husbands who participated in the study reported having had an extramarital relationship during their current marriage. In addition, most of the spouses of men admitted during separate interviews that they were suspicious of their husband extramarital relationships and expressed

disapproval of this sexual behaviour. For example, one female respondent said “whenever your husband comes to sleep with you, you feel worried that he is going to infect you with AIDS”. Indeed, the author notes that the association of men’s extramarital sex with women’s vulnerability to HIV infection was a common sentiment among women, which was an indicator that there was a widespread awareness of the HIV risk from their partners (Parikh, 2007: 1200 - 1201)

In their study about the reasons for multiple sexual partnerships among young people in Zambia, Nshindano and Maharaj (2008) found that multiple partnerships were relatively widespread among young people and that concurrent relationships were most common. In addition, and contrary to expectations, the majority of respondents held positive attitudes to multiple sexual partnerships. The majority of young people felt that there was nothing wrong with having multiple partners as long as people were getting what they wanted out of the relationships: young women were able to satisfy their material needs while young men gained social status and sense of belonging (Nshindano and Maharaj, 2008: 39)

In many countries, extramarital sexual activity by women is not acceptable. However, for men such activity is regarded as legitimate and justified especially if their wives are pregnant or breast-feeding (Lawoyin and Larsen, 2000). Both men and women observe that men have sexual relations with other women when their wives are pregnant or abstinent postpartum. In their study in Nigeria, Lawoyin and Larsen (2000) found out that almost half of men had other partners during their wife’s pregnancy period and also, during the postpartum period. Also, sexual relations with non-regular and multiple partnerships were more common in the postpartum period than in pregnancy. Meanwhile, studies have shown that while postpartum sexual abstinence may yield good health outcomes for both the mother and the child, on the other hand, though, postpartum sexual abstinence has become a risk factor for HIV infection and other sexually transmitted infectios given the fact that the men tended to get involved in extra-marital sexual activities (Cleland et al., 1999; Glynn et al., 2001). In addition, and as a result of modernization, other studies have reported that there is a shift among young mothers in some communities who shorten the postpartum sexual abstinenece either to enjoy sex or to attract their partners to stay at

home, which also may result in unwanted pregnancies if contraceptive methods are not used (Sule-Odu et al., 2008).

Karlyn (2005) observes that women tacitly accept men's biological drive to have multiple sexual partners. As a result, male sexual pleasure and satisfaction is paramount in these relationships. This is consistent with the findings of a study in West African countries that in a patriarchal society, women accept these beliefs (Orubuloye, Caldwell and Caldwell, 1993). In the study of sexual behaviour of Nigerian men, Isiugo-Abanile (2003) found that 53 percent of surveyed men reported that they ever had extramarital sexual relationships and more than 18 percent reported having an extramarital sexual relationship in the previous week.

Research in some countries suggests that there are some changes in sexual behaviour. A recent national HIV prevalence survey in South Africa found that most sexually active respondents reported that they had only one partner during the year with a higher proportion of females (97.4 percent) reporting this than males (83.7 percent) (Shisana et al., 2005). In addition, a comparative analysis of six countries found that in two countries in sub-Saharan Africa that have experienced declines in HIV prevalence during the 1990s, increases in all of the ABC behaviours (abstinence/delay of sexual debut, being faithful/ partner reduction, and condom use with non-regular partners) have been reported (Bessinger, Akwara and Halperin, 2003). The review found that in Uganda, the proportion of single men reporting two or more sexual partners in the previous year declined from 54 percent in the late 1980s to 33 percent in the mid-1990s. In Zambia, the proportion of single men reporting multiple partners declined from 54 percent to 30 percent. In addition, Uganda, Zambia and Zimbabwe witnessed considerable increases in reported condom use with non-regular partners in the late 1990s. At the end of the decade, almost 70 percent of men in Zimbabwe reported condom use at last sex with non-regular partners, followed by 59 percent of men in Uganda (Bessinger, Akwara and Halperin, 2003).

A comparative study of four longitudinal population-based surveys (1998-2007) on sexual partnership in Zimbabwe, Uganda and South Africa found that men reported a higher number of lifetime number of sexual partners than women (Todd et al., 2009). In all sites and in all birth

cohorts, men aged more than 35 years reported an average of more than 6 lifetime sexual partners. Among women, born in the 1960s or earlier, the mean reported number of lifetime partners was lower in Southern Africa compared with the East African sites. However, in all sites, men in the later birth cohorts had fewer lifetime sexual partners than earlier births cohorts within each age group, although this reduction in reported lifetime sexual partners was not seen in later birth cohorts of women. The magnitude of this effect was large in the younger men in all four cities. The study showed that men continued reporting more sexual partners than women in the past 12 months. The male-to-female ratio for mean number of partnerships in the last 12 months was reasonably consistent around 1.60 (range 1.41-1.86) for all sites, with an overall average of 1.50 indicating that, on average, men reported 50 percent more partners than women (Todd et al., 2009).

Other studies also have reported some evidence of sexual behaviour change in sub-Saharan Africa (Gregson, Todd and Zaba, 2009; Cremin, Mushati, Hallett et al., 2009; Biraro, Shafer, Kleinschmidt et al., 2009; Boileau, Clark, Bignami-Van Assche et al., 2009; Slaymaker, Bwanika, Kasamba, et al., 2009; Hallett et al., 2007; Mmbaga et al., 2007; Green et al., 2006; 2009). Slaymaker et al. (2009) found that cohorts of women (born after the 1980s) are delaying sexual debut compared with earlier cohorts (born before 1980) although the trends are less clear in men. For example, the authors found that there was strong evidence from the DHS and the Masaka study that women in the 1980s and 1990s cohorts were starting sex later. Similarly, for men, both the DHS and the Masaka study showed a trend towards delayed age at first sex (AFS) in the late birth cohorts, but the only significant effects were seen in Masaka with a higher relative hazards in those born in the 1970s and a lower hazard in those born in the 1990s (Slaymaker et al., 2009: i14).

Biraro et al. (2009) also suggest that there is a clear delay in age at first sex in Ugandan women although the same is not clear among men (Biraro et al., 2009). In this regard, the authors found that, between 1993 and 2006, median age at first sex increased from 16.7 years to 18.2 years among 17-20 year-old girls and from 18.5 years to 19.9 years among boys. Both sexes reported a dip in age at sexual debut between 1998 and 2001. One or more casual partners in the last 12

months among men rose from 11.6 percent 1997 to 12.7 percent in 2004 and then declined to 10.2 percent in 2006. Among women, it increased from 1.4 percent in 1997 to 3.7 percent in 2004 and then declined to 1.4 percent in 2006. The rise in casual partners between 1997 and 2004 was driven mainly by older age groups. Trends in condom use with casual partners varied by age, increasing among those aged 35 years or more, declining in the middle age groups and presenting a dip and then a rise in the youngest age group (13-19 years) (Biraro et al., 2009)

In Tanzania, Mmbaga et al. (2007) found that from 1991 to 2005 decreased trends in the proportions of young men reporting being sexually active was observed. Nevertheless, no equivalent decrease was observed among young women or the older age groups. A significant proportion of young men aged 15-24 years reported a reduction in the number of sexual partners. Similar trends were also observed among young women. In contrast, however, there were no corresponding trends of reported reduction in the number of sexual partners among participants aged 25-44 during the past 5 years. On the other hand, a significantly increased trend in reported condom use was observed in the study population. The increased trends were significant among young women and older men (Mmbaga et al.; 2007)

Assessing behaviour change in generalized HIV epidemics in Manicaland, Zimbabwe, Hallett et al. (2007) found that the impact of behaviour change on the spread of HIV was sensitive to the structure and reaction of the sexual network. Thus, reducing cross-generational sex could have limited impact on the risk of HIV infection unless it was accompanied by a reduction in the number of risky sexual encounters. In addition, the authors came to the conclusion that the benefits of delaying sexual debut was comparatively minor and tended to diminish if males continued to prefer young partners or if young women spent more time outside of marriage. Of interest is that the authors also found that, in Manicaland, Zimbabwe, if older men were to use condoms as frequently as young men, there would be a reduction in the risk of HIV infection (Hallett et al., 2007)

In Ghana, Awusabo-Asare et al. (1993) found that due to traditional norms and poor economic status women tended to accept the promiscuous behaviour of their partners as part of the nature

of men. Women who are economically dependent are under pressure to stay with their partners in order to ensure their children's well-being as well as to have access to the resources of men. Similar findings were observed in Nigeria. According to Isiugo-Abanile (2003), the social and economic dependency of women on their spouses gives men enormous influence in the household, a position that is strengthened and maintained by a patrilineal family system (Isiugo-Abanile, 2003). As a result, women have little or no control over their sexuality and also, limited decision-making authority (MacFadden, 1992)

A review of literature found that a substantial proportion of young women have sexual relations with partners who are considerably older, in most cases six to ten years older (Luke and Kurz, 2002). Often young women lack the ability to negotiate safer sexual practices with partners who are older and also more experienced than themselves (Luke and Kurz, 2002). A study in sub-Saharan Africa noted that poverty and low socio-economic status often compel young girls to have sexual relations with men who are much older than them (Luke and Kurz, 2002). Studies have found that often young girls, but also older women and even young men provide sexual favours in return for gifts (Gregson et al., 2002; Chatterji et al., 2004; Dunkle et al., 2007; 2004; Hawkins, Mussá and Abuxahama, 2005; Robinson and Yeh, 2009). In most cases, the worth of the gift often determines the type of sexual activity which may vary from kissing and petting to full penetrative sex (Luke and Kurz, 2002; Longfield et al., 2004; Luke, 2006).

Assessing the factors influencing transactional sex among sexually active men and women aged 15-49 years old in 12 sub-Saharan Africa, Chatterji et al. (2004) found that the proportion of sexually active women engaging in transactional sex varied from less than 2 percent in Niger to 11 percent in Zambia. Likewise, the proportion of sexually active men engaging in transactional sex ranged from about 5 percent in Guinea to 24.7 percent in Zambia. Of note is that transactional sex was highest among young women aged 15-19 years. As with women, the percentage of men engaging in transactional sex was higher in the younger age groups than among men aged 25 years and older. In eight of the 12 countries, young women living in rural areas were less likely to engage in transactional sex as compared with urban women. In addition, the study found that married women were significantly less likely to engage in transactional sex than single women

(Chatterji et al., 2004).

In their study in Soweto, South Africa, Dunkle et al (2004) found that of all 1395 women aged 16-41 years who participated in the study, 49.8 percent reported ever having a non-primary partner, and 21.1 percent of the overall sample reported ever engaging in transactional sex with such a partner. Transactional sex with roll-ons (ongoing relationship at the time of the survey and overlapping with primary partner) was more common than transactional sex with once-offs (partners with whom they had sex only once). Thus, 19.8 percent of respondents reported transactional sex with roll-ons compared with 6.1 percent of respondents who reported transactional sex with once-offs. Most women who reported transactional sex with once-offs also reported transactional sex with roll-ons indicating substantial overlap between these behaviours. Among women reporting any transactional sex, 43.2 percent reported receiving food, 36.7 percent clothing, 30.1 percent transport, 33 percent cosmetics, 13.9 percent items for their children or families, 11.9 percent somewhere to sleep, 8.2 percent school fees, 94.6 percent cash (Dunkle et al., 2004).

In their study in Kenya, Robinson and Yeh (2009) found that women engaging in transactional sex were more likely to expose themselves to higher risk sex (unprotected anal and vaginal intercourse) when they faced 'health shocks' at home – for example, a sudden illness affecting a household member, more especially a child. The study found that in such circumstances women engaged in both formal and informal transactional sex in order to generate income which could help them cope with such ordeals (Robinson and Yeh, 2009).

Investigating transactional sex or "informal exchange relationships" and condom use among Luo males aged 21-45 years in Kisumu, Kenya, Luke (2006) found that a market of risky sexual activity existed, where even a small transfer was associated with a substantial decrease in the probability of condom use. The author found that there were no significant difference between partnerships involving adolescents and those involving adult females. In addition, the author also found that male partners gave some form of material assistance to their adolescent female partners in the great majority of cases in the last month prior of the study. The figure, however,

was significantly lower, than the proportion of adult partnerships involved in transfers. In this regard, there were slight differences in the type of transfers given in adolescent and adult partnerships. Adults received significantly less in gifts and slightly more in rent and monetary transfers (Luke, 2006).

In Mozambique, a study by Hawkins, Mussá and Abuxahama (2005) found that young women were involved in multiple sexual partnerships with a number of sexual partners, including transactional sex with older married men (Hawkins, Mussá and Abuxahama, 2005). All the narratives of respondents explicitly pointed out that the primary motive for transactional sex was economic and young women did not have any emotional attachment or expectations beyond exchange of sex for money and other economic benefits (Hawkins, Mussá and Abuxahama, 2005). In addition, the study found that these young women demonstrated high levels of knowledge regarding HIV/AIDS and were very aware of the risks associated with multiple sexual partners and unprotected sex. Nevertheless, it seemed that both knowledge and awareness did not translate into a perception of personal risk and vulnerability (Hawkins, Mussá and Abuxahama, 2005)

A project in Mozambique found that in settings where the HIV prevalence is very acute, higher rates of HIV infection were found among young pregnant women aged 15-24 years than in other settings (Ministry of Health, 2008; CNCS, 2008; WHO, 2009). In addition, the analysis came to the conclusion that in those settings there were high proportions of married men with sexual partners outside the regular partnership compared to the national average. Furthermore, in those settings there were high levels of young men and women involved in high risk sex including multiple concurrent partners and low use of condoms in the past year (Ministry of Health, 2008).

A constellation of factors including gender and economic inequalities may exacerbate the risk of HV/AIDS among men. A study in Southern Nigeria by Smith (2007) found that for the vast majority of male respondents, the intersection of economic and gender inequalities featured in accounts of their extramarital relationships. The study found that men frequently viewed extramarital relationships as arenas for the expression of economic and masculine status. On the

one hand, the author reports that nearly all men wanted to hide their extramarital relationships from their wives, although, in some cases, men in a troubled marital relationship with little prospects of reconciliation would openly talk about their infidelity. On the other hand, for a significant number of men it would be far less beneficial having extramarital affairs without the opportunity to display masculine sexual and economic prowess to their peers (Smith, 2007)

A study of the Soul City Regional Programme (SCRP) in ten Southern Africa countries found that there were consistent evidence regarding perceptions, attitudes and practices around sexual relationships across gender and age. The study found that there were at least four forms of multiple concurrent partnerships prevalent in the region, namely steady partner and other 'side' partners, intergenerational sexual partnerships, transactional sexual partnerships and polygamy. The study found that "both men and women talked about men having a 'steady' partner who is a wife or girlfriend they love or have a commitment to, and at the same time having 'girlfriends', 'secret affairs' or extramarital affairs". A range of reasons for involvement in multiple concurrent partnerships had been given, including dissatisfaction in relationships, cultural and social norms, desire for money and material possession and alcohol abuse (Soul City, 2008: 15).

Studies suggest that religion and religiosity may discourage risky behaviour and therefore serve as a barrier to HIV infection (Agadjanian, 2005a). In the south west of Nigeria, Orubuloye, Caldwell and Caldwell (1997) found that the traditional religion did not condemn the sexual relations of men outside of marriage. However, neither did it commend it, but simply ignored it. The society was not *macho,* although it did respect virility. Traditional religion, in fact, largely ignored sexuality, either male or female, and emphasized fertility, in a society where successful agriculture and defense depended on human labour, and the survival of the lineage was dependent on reproduction (Orubuloye, Caldwell and Caldwell, 1997).

According to Orubuloye, Caldwell and Caldwell (1993), even economically independent women do not have total control of their sexuality, except on certain culturally defined occasions, such as before marriage, especially if they were betrothed; while menstruating; during pregnancy; a year after childbirth, especially while breastfeeding; after becoming a grandmother; and after

menopause. However, neither traditional controls of mandated abstinence periods, nor a great degree of economic and physical independence, seem to ensure that they have as much control over their sexuality as one might anticipate (Orubuloye et al., 1993).

According to Tallis (2000) when gender differences and power differentials in sexual relationships are not explicitly and decisively addressed, people may not use the knowledge they acquired or the methods available to protect themselves against the risk of HIV. For men, the pressure to perform sexually and with many partners places them at risk of HIV infection. This in turn impacts on women who have little or no power and control in sexual relationships. It is also important to point out that not all men have the "same amount or type of power, the same opportunities, and the same life trajectories" (Ouzgane and Morrel, 2005: 4).

Limited economic opportunities sometimes force men to seek employment away from their homes and communities. This results in the separation of partners and families for prolonged periods of time and encourages the establishment of sexual relationships at the place of employment, thus facilitating the spread of STIs (Abdool Karim, 2001; Hirsch et al., 2002; Agadjanian, Arnaldo and Cau, 2009; Anarfi, 1993). A multi-country study found that the number of women reporting more than one regular partner is approximately 10 percent in Tanzania and Lusaka while in Lesotho the proportion is as high as 39 percent. According to Carael (1995), this disproportion may reflect the temporary migration of more than half of the adult male population which leaves couples separated for the majority of the time.

A study in Mozambique found that women who were married to migrant workers were more likely than those who were married to non-migrants to think that their husbands have had sex with other women (Agadjanian, Arnaldo and Cau, 2009). In addition, the study found that migrants' wives were more likely than non-migrants' wives to be very worried about getting infected by their husbands (Agadjanian, Arnaldo and Cau, 2009). An exploratory socio-behavioural study about sexuality, migration and AIDS in Ghana predicted that because migration removes people from one place to another and "free" them from the harsh cultural restrictions and control against sexuality, this would create a fertile environment for the spread of

the HIV/AIDS epidemic (Anarfi, 1993: 21). Indeed, in her study in Kenya, White (1990) observed that the sex work practiced by women in some large cities in Kenya was, in part, an attempt to escape from oppressive rural patriarchal societies (White, 1990; see also Nauright, 1994).

In his analysis of the HIV epidemic in Southern Africa, Hargrove (2008: 15) observes that "the seriousness of the HIV epidemic in southern and eastern Africa has its roots in the 19th century – in the employment practices instituted on mines, farms and cities, where millions of men have, ever since, lived apart from their families for the greater part of each year. This destruction of family unit was a sociological disaster waiting for the arrival of HIV and is the source of many other social ills – not least the increasingly violent nature of South African society". The author concludes that none of previous efforts to encourage abstinence, fidelity or condom use nor current interventions such as the roll-out of antiretroviral therapy (ART) combined with education and counseling addresses the fundamental social problem which have ensured that the HIV epidemic is so severe in Southern Africa – the breakdown of family structure associated with oscillatory migration (Hargrove, 2008: 61)

In a qualitative study in northern Tanzania, Thaxton (2005) observes that traditionally women had the main responsibility for rearing children and ensuring sufficient resources to meet family demands. However, new economic and social factors- including declining fish catches, reduced agricultural productivity and husbands spending more money on alcohol and sex- have forced women in these communities to seek employment to support their households. However, due to limited opportunities women are increasingly turning to sex work as a means of supporting themselves but this increases their exposure to the risk of HIV infection. The study also notes that men often travel in search of economic opportunities and they often have to live under dangerous and unpleasant working conditions, inadequate accommodation and also, isolation (Thaxton, 2005). According to Thaxton (2005), these male migrants often form new social networks in the area and often respond to their new conditions with exaggerated masculinity and sexual bravado.

In their qualitative study in Zambia Merten and Haller (2007) showed how the deterioration of

economic conditions impacted negatively on the livelihoods of local small traders, particularly the small fishing traders such as that of Kafue Flats (Merten and Haller, 2007). The study found that sexual transactions between local women and commercial fishermen were perceived as necessary to meet livelihood needs, despite the threat of HIV infection. Thus, fish-for-sex deals could be requested by fishermen or even based on mutual consent, but the main motivation for women to become involved in such transactions was economic. In addition, people involved in 'fish-for-sex' relationships were aware of their risk of contracting HIV infection, but they continued with their behaviours (Merten and Haller, 2007).

In his study in KwaZulu-Natal, Hunter (2004) examines how the changing socio-economic context, particularly the high unemployment, has impacted on the institution of marriage. In Zulu culture, marriage usually involves the payment of *ilobolo* (bride wealth). Hunter (2004) observes that the institution of marriage predicated on *ilobolo* (bridewealth) is naturally vulnerable to economic change. Throughout the last century, men were increasingly forced to turn to wage labour in order to buy cattle for *ilobolo* or simply to save money in order to pay *ilobolo* in cash, in lieu of cattle. However, the steady increase in unemployment since the 1970s has dramatically challenged the institution of marriage and became an important factor in reshaping male sexualities.

According to Morrell (2001), economic change has led to the emergence of a new masculinity. He points to the new roles that black men in South Africa had to embrace in response to economic changes. The increase in the number of black professional women has made it difficult for the traditional division of labour in the home to be maintained. As a result, young black professional men have been much more participatory in the home and supportive of the main partner's professional career. However, not all men react in the same way. Morrell (2001) argues that some men become defensive. He points to the increase in the incidents of rape in South Africa which are seen by feminists as one way of men asserting their dominance of women. In this situation, women often bear the brunt of feelings of emasculation that confront men.

In Mozambique, Agadjanian (2005b) notes that the deterioration of the labour market has forced men to seek employment in types of type of work that traditionally 'belonged' to women. For example, street commerce has traditionally attracted less educated, poor urban women seeking cash employment, who are least likely to find better paid jobs elsewhere. However, men, forced out of the formal labour market, have been increasingly joining the ranks of the street vendors. As the cost of living continues to climb and wages stagnate, these jobs further erode the economic dominance of men. In addition, the last two decades have also seen a rapid reduction in employment opportunities for Mozambique's mine workers in South Africa. As a result, migration to South Africa has increasingly become illegal and therefore often a financially unrewarding and even a humiliating experience. A study in Kenya and Tanzania by Silberschmidt, (2005) shows how socio-economic changes have disempowered men and as a result, they are finding it difficult to fulfill their role of breadwinner and provider. Because of this failure, some refer to them as "figure" heads of household (Silberschmidt, 2005: 193) or as "just a pair of trousers" (Elisabeth et al., 2003: 8).

Meanwhile, some studies have suggested that not only the condition of being poor is one of underling factors for risky sexual behaviour, but also wealth status may lead some segments of the population to engage in risky sexual activities such as multiple sexual partnerships (Awusabo-Asare and Annim, 2008; Madise, Zulu and Ciera, 2007). In a comparative study in Ghana and Kenya, Awusabo-Asare and Annim (2008) found that there is some empirical evidence that wealthier people engage in risky sexual behaviours. In this study, the authors found that in general, for both Ghana and Kenya, men in the highest wealth quintile were found to be more likely to have multiple sexual partners than other groups which seems to challenge the view that poverty is the driving force of sexual risk behaviour, therefore, leading to the rapid spread of HIV infection in sub-Saharan Africa (Awusabo-Asare and Annim, 2008: 28). Likewise, Hargreaves et al., (2002) found that the association between SES – a composite variable of education status, occupation and household ulitilies and the risk of HIV infection was not linear and it was depedent upon sex and age of the individuals. Thus, the authors concluded that HIV was associated with a lower SES among females aged 15-24 whereas in males aged 15-24 and

females aged 25-49 there was some indication that it was associated with higher SES (Hargreaves et al., 2002; see also Mishra et al., 2007).

2.5 Condoms

The use of condoms as a protective tool against both sexually transmitted infections, including HIV and unwanted pregnancy in sub-Saharan Africa still heavily depend upon a vast array of context-dependent and structural factors including socio-demographic factors (Parker, Eaton and Klein, 2000; Maharaj, 2006; Leclerc-Madlala, 2002; Boer and Mashamba, 2007; Lagarde et al., 2001; Slaymaker and Zaba, 2003). Although there is an emerging consensus among a number of experts that condom use can be an effective prophylactic method in preventing the further spread of HIV infection, particularly in countries most affected by the pandemic – a consensus underpinned by the relative success in curbing the pandemic in some countries such as Thailand and Uganda (Hearst and Chen, 2004), it has ignited a great deal of controversy in various quarters. This has engaged the attention of several researchers who have been discussing their dynamics and gathered evidence suggesting that both rigid norms of masculinity and the nature of relationships seem to be the major obstacles to condom use (Gomez and Marin, 1996; Adetunji, 2000; Adetunji and Meekers, 2001; Flood, 2003; Maharaj; 2006; Grady et al., 1999; Agha, 1998; Weir et al., 1999; Davis and Weller, 1999; Meekers and Klein, 2002; Holland et al., 1991; Rivers and Aggleton, 1999; Kaler, 2004; Clark, 2004; Evans and Lambert, 2008; de Walque and Kline, 2009).

Most studies show that awareness of condoms is nearly universal, with the majority identifying condoms as an effective method of preventing HIV infection (Maharaj and Cleland, 2004; Mozambique Demographic and Health Survey, 2003). For example, the Mozambique's Demographic and Health Survey (National Institute of Statistic, 2005) found the majority of men and women were able to identify the condom as an effective means to protect against HIV infection. However, condom use remains relatively low, with the majority reporting that they did not use condoms at last sexual intercourse. However, studies show that condom use is

considerably higher among the younger than older populations (Rutenberg et al., 2001; Bankole and Singh, 2001).

A multi-country study on men's family planning attitudes and behaviour also found that the levels of condom use are higher among unmarried sexually active men than married men (Salem, 2004). In 27 of the 36 countries surveyed, unmarried sexually active men are at least five times more likely to report condom use than married men. The study found that unmarried men are more likely than married men to use condoms because they want to protect themselves and partners against the risk of pregnancy and STIs (including HIV/AIDS). However, other studies suggest that married men are more likely to use condoms in non-regular sexual relationships. In Zimbabwe, it is reported that the majority of men who use condoms are doing so for pregnancy prevention outside the stable marital relationships (Adetunji, 2000). However, studies show that condoms use is also low even with occasional partners (Adetunji 2000; National Institute of Statistic, 2005). According to the National Institute of Statistic (2005), only 32 percent of men and 23 percent of women used condoms in their last sexual encounter with an occasional partner. Moreover, while only four percent of married women had outside partners, 23 percent of married men had extramarital partners.

Studies show that in long-term, regular relationships condoms are least likely to be used (Adetunji, 2000; Meekers and Richter, 2005). In a quantitative study on female condom use also in Zimbabwe, Meekers and Richter (2005) note that consistent use with marital partners was negatively associated with the reporting of multiple partners in the past year, and positively associated with using the device for pregnancy prevention. Consistent use with regular non-marital partners was associated with numerous variables including perceived ease of use, and effectiveness for STI prevention, low perception of risk of HIV infection, and the desire to prevent pregnancy and infections. This is consistent with other studies in other parts of Africa (Maharaj and Cleland, 2004; Karlyn, 2005; Chen, 2004; Chimbiri, 2007).

Assessing the use of condoms within marriage in Malawi, Chimbiri (2007) arrived at four striking findings. Firstly, the study found that condoms were negligible within marriage.

Secondly, that there was a great deal of discussion about condoms especially among males in their social networks. Thirdly, virtually all the discussion of condoms, by both men and women, was in the context of preventing STIs and HIV/AIDS in extramarital relationships. Lastly, and most importantly, initiating discussion of condom use in marriage was likely to bring an 'intruder' into the domestic space (Chimbiri, 2007). The author notes, for example, that both married men and women were quite aware that they were at risk from their partner. However, their concern about infection did not lead to discussion of condom use in marriage. The author also notes that although many women suspected their husbands were unfaithful, they differed in their views about condom use within their marriage (Chimbiri, 2007: 1110)

In their study in KwaZulu-Natal, South Africa, among marred or cohabiting men and women, Maharaj and Cleland (2005) found that although couple's knowledge of condoms and where to obtain them was high, relatively few men and women reported consistent use. Rural men and women were less likely to report consistent condom use than urban men and women. In general, women were more likely than men to have positive attitudes toward condom use in marital or cohabiting relationships (47 percent compared with 29 percent), but only about 45 percent of either sex had ever discussed the method with their partner. In addition, a higher proportion of women than men felt at risk of HIV infection from their partners (Maharaj and Cleland, 2005)

In their study in Mozambique, Prata et al. (2006) reported that although both young men and women (aged 15-24 years) had accurate knowledge of HIV transmission modes, overall the use of condoms was low. Almost 22 percent of young men and 10 percent of young women reported condom use at last sex. In addition, this study shows that the use of condoms varied according to sex, and marital status. Young unmarried men were more likely to report having used a condom at last sex compared with ever-married young men. On the other hand, the findings showed that the use of condoms remained lower among females than males (Prata et al.; 2006).

A study in Zimbabwe by Adetunji and Meekers (2001) found that condom were less likely to be used in marital relations than in non-marital relations. For example, their findings indicate that on average one in ten men and women had used a condom within their marital relations three

months before the survey. However, over 60 percent of males and females had reported having used a condom at last sex with a casual partner, and 90 percent of males had reported having used a condom at last sex with a commercial sex worker. In addition, condom use with steady non-marital partners varied considerably by sex. In this regard, over 60 percent of males and less than 40 percent of females reported the use of a condom at the last sex with a steady non-marital partner (Adetunji and Meekers; 2001).

Analyzing the determinants of condom use among young people (15-24 years) in urban Cameroon, Meekers and Klein (2002) found that both males and females who perceived themselves at moderate-to-high risk of HIV infection were more likely than other males and females to report ever having used condoms. In addition, the study found that those males who believed that condoms reduced sexual pleasure were 36 percent less likely than those who thought otherwise to have used a condom at last sex. Moreover, men and women who believed that they were able to convince their regular partner to use a condom were more likely than other men and women to report having used a condom at last sex. The findings also showed that there was a positive association between self-efficacy and use of condom at last sex for both men and women (Meekers and Klein, 2002: 342).

Based on nationally representative samples of both men and women aged 14-54 years from 13 sub-Saharan African countries**,** de Walque and Kline (2009) found that in general, the use of condom in that region was still low. They also found that men reported using condoms more frequently than women, and that the unmarried report condom use more frequently than the married with their spouse. In addition, the findings show that married men from most of the countries reported using condoms with extramarital partners nearly as frequently as unmarried men. However, married women from most of the countries reported less condom use with extramarital partners than unmarried women. This, according to the authors, was especially troubling because HIV in Africa is mostly spreading through heterosexual intercourse and multiple sexual partnerships was a risk factor for HIV infection. Since marriage usually implies regular sexual intercourse, the probability to pass the virus from extramarital partner to spouse

was higher than an unmarried person who may have multiple partners but not regular sexual intercourse (de Walque and Kline, 2009).

In their study in Nigeria, Sunmola, Olley and Oso (2007) found that 68 percent and 41 percent of sexually active men and women (aged 18-34 years) who were involved in compulsory national service in Ibadan reported condom use at last intercourse before the survey. For both men and women, condom use was common if they had one or more regular sex partner and if they were purchasing condoms. In addition being single and having the intention to use a condom in the next sexual encounter were strong predictors of condom use among women. However, the study also found that there was a high risk of HIV transmission in the sample population since consistent condom use was lower, 15 percent among men and 4 percent among women (Sunmola, Olley and Oso, 2007).

Some studies have found that level of education is associated with high levels of condom use within non-spousal partnerships. In their study of four cities in sub-Saharan Africa, Lagarde et al. (2001) found that based on the reports from men, condom use was associated with higher levels of education of the male partner in Yaoundé, Cameroon, and with higher education level of the female partner in Cotonou, Benin, and Kisumu, Kenya. Based on the reports from women, the study found that condom use was associated with higher education levels of the female partner in Kisumu, Kenya, and Ndola, Zambia, and with higher education level of the female partner in Yaoundé. However, associations with other determinants varied across cities and for men and women (Lagarde et al., 2001).

2.6 Barriers to Condom Use

A number of studies suggest that condom use for the prevention of HIV/AIDS and STIs poses a big challenge and their use is invariably contingent upon, for example, such factors as the nature of the relationship, and/or marital status (Maharaj, 2001; Maharaj and Cleland, 2004; Karlyn, 2005; Chen, 2004; Chimbiri, 2007; Preston-Whyte, 1999; Bond and Dover, 1997; Varga, 2000; Thomsen et al., 2004; Hounton et al., 2005; Agha et al., 2002; Longfield et al., 2002)

In their study in South Africa**,** Maharaj and Cleland (2004) observed that both men and women expressed strong negative attitudes towards the use of condoms within such relationships as they associated condom use with lack of trust, as being offensive and suggestive of infidelity. Thus, although the knowledge of condoms was relatively widespread, their use was fairly limited due to the fear of the partner's reactions, lack of confidence in the product, reduction in sexual pleasure and interruption of spontaneity. In another study in KwaZulu-Natal in South Africa, Abdool Karim (2001) also reports similar sentiments among rural women. The study found that condom use was rare and inconsistent, and the majority of women lacked the skills to negotiate condom use. An important tension identified in relation to condom use was that between the need to protect themselves against infections and the need for intimacy and trust. For some women, condoms represented a barrier to intimacy and trust. In his study of men in Australia, Flood (2003) also observed that the need for intimacy and pleasure led to a general reluctance to use condoms.

In Zimbabwe, Ray and Maposhere (1997) found out that there were two kinds of obstacles regarding the use of male and female condoms. The first was related to the nature of relationship between sexual partners and the second obstacle was related to the difficulties associated with using the method correctly and consistently. The nature of partnerships, regular or non-regular, is reported as being an important predictor of condom use in a given relationships.

In their study about the reasons for non-use of condoms in 8 countries in sub-Saharan Africa**,** Agha et al. (2002) found that the most frequently reported reason for not using a condom at last sex with a marital or a regular (non-marital) partner was that they were concerned about accusations of lack of trust. Among marital partners, both males and females reported low levels of condom use in the last sex act. For example, females reported condom use levels as low as 3 percent in Eritrea and as high as 21 percent in Luanda (Angola). Males reported similarly low levels of condom use. Eritrean males reported the lowest levels of condom use (1 percent) and Cameroonian males reported the highest levels of condom use in marital partnerships (22 percent). Both males and females reported higher condom use with a regular (non-marital)

partner than a marital partner. For females, condom use with a regular partner varied between 26 percent and 59 percent. For males, condom use with a regular partner varied between 35 percent and 74 percent. In addition, the results show that condom use with a casual partner varied between 28 percent and 49 percent among females, and between 41 percent and 60 percent among males. Other reasons for not using condoms included dislike of condoms, partner objection and not having a condom at hand (Agha et al., 2002)

In Southwest Nigeria, Messersmith et al. (2000) found that men were more likely to report having contracted an STD from a casual sex partner than from a sex worker. In this study it was found that men were most uncertain about their vulnerability to STDs with casual partners. As in other studies, general reasons for condom use varied according to the type of sexual partner. Among currently married clients, only 4 percent reported using condoms with their spouses for STD prevention, compared with 84 percent who reported using condoms with commercial sex workers. The most common reason for use of condoms with their casual, non-commercial sex worker partners was to prevent pregnancy. However, the reasons for nonuse of condoms with casual partners were related in some cases to the nature of relationship. But what left no doubt is that most men did not use condom with their wives. The belief that it was inappropriate to use a condom with a spouse was the most commonly mentioned reason by respondents (Messersmith et al., 2000)

In Zambia, Bond and Dover (1997) reported that one of the major barriers was the negative connotations associated with condom use. For example, people's accounts about condoms breakage, loss of sexual pleasure, suspicions of infidelity and most importantly condoms being associated with prostitutes or diseases were among the reasons given for not using them (Bond and Dover, 1997: 384-386). In KwaZulu-Natal, South Africa, Preston-Whyte (1999) describes and discusses in depth what she called "the condom dilemma". The author also identified the issue of trust, the negative associations of condoms with casual and multiple sexual partners as something which easily comes to people's mind whenever the issue of condom is raised. In addition, the author argues that the association of condoms with the treatment of sexually transmitted diseases has further contributed to their negative image (Preston-Whyte, 1999).

The symbolism of condoms have long before identified as one of the core determinants of sexual and reproductive health. In her study in KwaZulu-Natal, South Africa, Varga (1997) found that the condom's ugly connotation were an overwhelming component in the decision of women to avoid them. The negative symbolism of condoms was a significant deterrent to their use, and stood in direct opposition to what these women sought from intimate personal sexual relationships. According to the study, condoms were associated with disease, infidelity, and illicit sexual acts. In stark opposition to such imaginary, women looked to their primary partner for purification, trust, intimacy, and affirmation of love. In addition, the study concluded that by definition, condoms were excluded from intimate, personal sexual relations. Furthermore, it was found that condom use was also conditioned by the conceptual categories into which sex workers placed their partners. Thus, sex with clients was regarded as dirty, illicit, and impersonal. For all these reasons, protection with a condom was seen as legitimate. In contrast, though, personal partners were viewed by those women as clean, intimate, trustworthy, and invited physical acts of love and affection (Varga, 1997: 82). Likewise, Machel (2001) in Mozambique also came to the similar conclusions regarding the symbolism of condoms. In this regard, the study found that while some young women perceived the use of condoms as preventing intimacy, they also observed that insisting on condom use led their male partners to view such attitudes as challenging their masculinity – a finding also observed in other settings of sub-Saharan Africa (Machel, 2001).

Condoms are a highly effective barrier method because they protect against both STI/HIV and pregnancy. In a case study in Zimbabwe and Mozambique, Prata et al. (2008) concluded that condom dual-use policies have the potential to significantly reduce HIV infection and unintended pregnancy. Using available DHS data from both countries, the study found that overall in Zimbabwe, ever use of modern methods has increased but condom use, although growing has remained low. In this regard, only 13 percent of females reported having ever used a male condom. Furthermore, the vast majority of women using condoms were currently unmarried, whereas most married women used use oral contraceptive pills. According to the authors, these findings were significant taking into consideration that individuals who are at greatest risk for

HIV in a generalised epidemic such as Zimbabwe are married people. Similarly, in Mozambique, the 1997 and 2003 DHS data show a sharp increase in actual use of all modern methods as well as ever use of modern contraceptive methods. However, the authors point out that a large percentage of family planning goals are being met by HIV prevention programmes which have focused largely on unmarried individuals than married individuals. As expected, modern contraceptive use by unmarried, sexually active women contributed greatly to contraceptive prevalence nationwide. Furthermore, the available data shows that more sexually active unmarried women than married women reported condom use (Prata et al., 2008).

In their study yet again in Mozambique, Speizer and White (2008) found that female youth who wanted to get pregnant soon were significantly less likely to use condoms with non-marital partners than youth who wanted to delay childbearing. Of interest in this study is that the authors found a kind of intentionality in their agency. They explain that it is a common reality in sub-Saharan Africa that pregnancy (or childbearing) is often a precursor to union formation and marriage. The authors conclude that under such circumstances, youth may choose not to use condoms with a non-marital partner with whom they intend to conceive. In addition, their study also found that more educated urban youth were the most likely to use condoms with all non-marital partners than less educated rural female youth (Speizer and White, 2008: 543)

In their study in Botswana Kraft et al. (2009) found that almost half of sexually active men and women aged 15-49 years who participated in the study reported consistent condom use in the past year, with only few reporting dual–method use. According to the study the majority of respondents reported having used one of the two dual-protection strategies that would prevent pregnancy and infection transmission the last time they had sex. Approximately 60 percent of those who had multiple concurrent partnerships reported consistent use of condoms in the past year (Kraft et al.., 2009). In their community-based survey of women aged 15-49 years in Nigeria, Sedgh et al. (2006) found that overall, 28 percent of the women reported having experienced an unwanted pregnancy at some point in their lives. The proportion of respondents who had ever had an unplanned pregnancy was greater among never-married than currently or previously married women (Sedgh et al., 2006: 178-179).

Assessing the use of condom among young women (aged 15-24 years) in Manchester, United Kingdom, Holland et al. (1991) describe a variety of situations determining the use of condom among their respondents. Such conditions included the issue of power control and pleasure; women's demand for safe sex as well as women's opposition to condoms. For example, the authors found that despite the general perception that men disliked condoms; their respondents did not see men dominating all sexual encounters, meaning that women had a lot to say in this regard. Moreover, one of the issues the researchers found was that women themselves were opposed to condoms identifying a range of reasons for not using them. Some of the reasons included fear of the breakdown of their relationship, or that condoms "killed" the romantic moment, and in many instances**,** sex was unplanned (Holland et at.; 1991).

In Mozambique, Karlyn (2005) arrived at the conclusion that although condom use among young people is frequent, it is largely dependent on partner type. In addition, he notes that the use of the condom with the principal partner was acceptable only for the prevention of pregnancy, but with secondary partners, condom use, although common, is inconsistent. With the primary girlfriend, men cannot introduce unconventional sexual practices because they would be considered disrespectful; it violates the norms of acceptable behaviour within a primarily procreative relationship. Condoms prevent pregnancy and as a result, undermine male authority in the relationship. The unnaturalness of condoms contradicts the act of sex (and love) which involves a natural exchange of intimacy, fluids and, in the view of young people in Maputo; blood (Karlyn, 2005).

The dominant role men play in determining condoms is aptly captured by Karlyn (2005) who observes that the power dynamics dictating responsibility for prevention sat predominately with men…either as the agent of prevention or acceding to the wishes of his partner (Karlyn, 2005). Given such a scenario, women had the responsibility to introduce a condom to prevent unwanted pregnancy during their fertile period. However, outside this period, the man controlled the use of the condom. In a bid to maximize the use of condoms, Karlyn (2005) notes that some women would lie about their fertile period and menstruation as a way of encouraging the use of condoms

and men would accept the use of condoms with the primary partner during her fertile period. Karlyn (2005) attributes the erratic and non use of condoms among young people in Maputo to the following reasons: reduction in sexual pleasure, difficulties in manipulating the condom in the 'heat of the moment', discomfort for one or both partners, loss of erection, breakage/slippage, loss of intimacy, and stigmatization of one or both partners as being unclean.

Meursing and Sibindi (1995) observes that although the distribution of condoms has greatly increased, the community still harbours a number of doubts about their efficacy as rumours abound that condoms leak, or are even infected with HIV. At the same time the men blame condoms for interfering with the quality of their sexual lives; whereas women blame condoms for promoting promiscuity. These sentiments provide satisfactory evidence for not using condoms.

Some researchers argue that there are no clear signs that these negative attitudes are changing even in steady relationships (Hearst and Chen, 2004; UNFPA, 2000). Hearst and Chen (2004) observe that in many sub-Saharan African countries the level of HIV infection remains high despite reports of high rates of condom use. For example, in Botswana condom sales have risen from one million 1993 to three million in 2001, yet the HIV prevalence rate rose from 27 percent to 45 percent among urban pregnant women and in Cameroon condom sales increased from six million to 15 million while HIV prevalence rose from three percent to nine percent during the same period. Moreover, they argue that there is no clear example of a country that has been successful in reversing a generalized epidemic primarily by means of condom promotion. Consistent use of condoms, one of the most effective strategies available to prevent HIV transmission, seems to be problematic for men and in consequence for women (Hulton and Falkingham, 1996). It can be surmised that increased condom sales does not mean increased and consistent condom use.

Grady et al. (1999) investigating perceptions of condoms among men and women in the United States of America, found out that compared with single women, married women rate the condom more positively in terms of health risks and less positively for interference with pleasure, while marital status was unrelated to men's rating of the condom on these dimensions. In contrast,

married men rate the condom lower than single men on effectiveness at preventing STIs, but marital status is unrelated to women's rating of the condom on these dimensions. The results also show that married women rate the condom more poorly on effectiveness at preventing pregnancy than single women and that both married men and women rate the condom less favourably than their single counterparts on the need to plan ahead.

A study in Australia identified a number of barriers to condom use. In Australia, Flood (2003) found that men gave five reasons for the non-use of condoms by heterosexual men. First, because men perceive a greater risk of pregnancy than disease they rely on their partners to use other methods. Second, some men experience a decline in penile sensation and difficulties in using condoms. Third, men complain that condoms 'kill the moment' and interrupt sexual activity. Fourthly, men feel that in monogamous, regular relationship there is no need for condoms. Finally, young men believe that they are not at risk of HIV infection because they perceive their social circles, institutions, the heterosexual community and heterosexual sex as safe.

In a study in the United Kingdom on the determinants of unsafe sex, Green et al. (2000) noted that almost all women who participated in the study reported inconsistent use of condoms in different episodes. The study came to the conclusion that one cannot assume that women will necessarily determine whether condoms are used in the long-term in a relationship because the women themselves did not think that their partner was a risk to them. In other words they were using individual assessments of risk rather than generalized assessments of risk. Hoffman and Cohen (1999) also arrived at the same conclusion that generally "people use more oblique approaches to determine the safety of a new sexual partner. Relying on their skills and perceptions, people may cognitively size-up a new person or make a partner assessment. Unfortunately, partner assessments are not a reliable means of protection from contracting STD" (Hoffman and Cohen, 1999: 555)

In Mozambique, Groes-Green (2009) observed a similar phenomenon. The author notes that young people may not use condoms because they usually make personal judgments based on physical appearances. If they judge that a partner does not look like "dirty" then there was a

higher likelihood that condoms would not be used. In addition, interacting with respondents in their day-to-day life the author came to the conclusion that young people did not use condoms consistently as advocated. One of the reasons the respondents gave despite being knowledgeable about the risk of getting infected with HIV/AIDS was that condom sometimes "ruined the moment" or there were not time "to ask for such a thing" (Groes-Green, 2009: 659).

Studies have shown that married individuals, particularly women, are at greater risk of HIV infection duo to their partners' sexual behaviour. In their study among married and cohabiting couples in urban Zambia and Rwanda, Dunkle et al. (2008) estimated that 55.1 percent to 92.7 percent of new heterosexually acquired HIV infections among adults in Zambia and Rwanda occurred within sero-discordant marital or cohabiting relationships, depending on the sex of the index partner and on location. In this study, the authors note that the cultural context provides support for men's extramarital sexual activities and prevent women from practising HIV prevention within their relationships, which accelerates their risk of HIV infection in marriage. In addition, their analysis suggests that marriage also poses a risk of HIV infection for men. The study also suggests that the heightened risk of HIV infection within marriage is the result of premarital and extramarital sexual activity (Dunkle et al., 2008). In her study in KwaZulu-Natal, South Africa, Maharaj (2004) also found that a large proportion of women were concerned about the risk of HIV infection due to their marital or cohabiting partners' sexual behaviour. The author concluded that in general women in marital or cohabiting unions knew or suspected that their partner had other sexual partners (Maharaj, 2004).

Many studies suggest that some women face violence in their sexual relations which limits their ability to negotiate protective practices including condom use. In many cases, the types of violence range from psychological pressure to physical assault (Uthman et al., 2009; Ntaganita et al., 2008; Beyrer, 2007; Wood and Jewkes, 2001; Hallman, 2004; MacPhail and Campbell, 2001; Bauni and Jarabi, 2000). In their study in sub-Saharan Africa, Uthman et al. (2009) found that "intimate partner violence against women was seen as acceptable under certain circumstances. The study found that "neglecting the children" was the most frequent reason given by both men and women for justifying intimate partner violence against women, followed by "going out

without informing husband and arguing back with husband". "Refusing sexual relations" and "burning food" were less likely to be mentioned by respondents (Uthman et al., 2009:7-8).

In their study of pregnant women in Rwanda Ntaganita et al. (2008) found that HIV-positive pregnant women were more likely to experience intimate partner violence (IPV) than HIV-negative pregnant women. This violence took the form of pulling hair, slapping, kicking with fists, throwing to the ground and kicking with feet as well as burning with hot water. In addition, the study also found that HIV positive participants were twice more likely to report physical intimate partner violence than those who were not HIV positive (Ntaganita et al., 2008)

In her study of African mine workers in South Africa, Campbell (2001) shows how living conditions impact on masculine identities and sexual desires. In the extremely dangerous environment of underground mining, sex is regarded as one of the most easily available recreational activities at the end of a difficult and tiring day – with a range of factors undermining the likelihood of protected sex. In this context, the social and sexual identities of men are forged in response to the threatening life challenges they face that make them particularly vulnerable to HIV infection. While masculinity 'hardens' men in the mines, it also exposes them to risks and this contributes to their vulnerability in sexual relations and Campbell (2001) argues that the very concept of masculinity that enables men to cope with their dangerous working conditions, simultaneously serves to endanger their sexual health. The study found that the notion of masculinity was closely associated with the concept of courage, fearlessness, and persistence in the face of the challenges of underground work. Closely related to this is a macho sexuality, which was described in the comment: there are two things to being a 'man': "going underground, and going after woman". Linked to this masculine identity were the insatiable sex desires, the need for multiple sexual partners, and a desire for flesh-to-flesh sexual intercourse.

In a study among South African male soldiers, for which the military professional ethos tends to excuse or even promote risky behaviour, Mankayi (2009) found that high risk sexual practices appear to persist regardless of people's knowledge of HIV/AIDS. The sexual practices of respondents seemed to be influenced by the social meanings attached to intimate relationships

and the various categories of sexual partners with whom they get involved with. Condom use, for example, was constructed as unnecessary and inappropriate with long-term partners, who were perceived as trustworthy. Therefore, the association of condoms with lack of trust and faithfulness were sufficient reason for unsafe sex. However, the study also found that "for some men condoms symbolized masculinity and that the number of condoms you had and used signaled masculine sexual tendencies" (Mankayi, 2009: 40).

Addressing structural approaches to HIV prevention, Rao-Gupta et al. (2008) observe that for many people, the simple fact that the majority of the world's HIV infections occur in developing countries is evidence that social, economic, and political structures motivate risk behaviours and shape vulnerability. However, they also highlight the importance of structural factors in HIV epidemics. Some studies show an association between structural factors and HIV risk without clearly indicating direct causality. Other studies have more explicitly described the mechanisms by which structural factors can affect HIV risk. For example, sexual violence, a manifestation of gender inequality, has been linked to an increased risk of HIV transmission. Other examples include the role of migration in influencing HIV risk, such as studies on mine workers in South Africa (Beyrer, 2007). Research suggests that hazardous working conditions, lack of social support, and separation from family has led to some mine workers engaging in unprotected sexual intercourse with commercial sexual workers which increases the risk of HIV infection (Rao-Gupta et al., 2008)

In South Africa, Hallman (2004) found that being from a poor household significantly increases the risk of engaging in unsafe behaviour. She found that low socio-economic status influences sexual experiences in a number of ways: it not only increases the odds of women exchanging sex, it also increases the chances of women experiencing coerced sex and the odds of having multiple partners in the year before the survey, and it decreases the age of first sexual activity, condom use at last sex, and communication with most recent sexual partners. More importantly, low socio-economic status impacts more negatively on women than men by increasing the risk of early pregnancy (see also Hallman, 2005).

Studies have highlighted the importance of partner communication in enhancing sexual and reproductive health outcomes including the use of modern contraceptive methods as well as for sexual satisfaction (Holmberg and Blair, 2009; MacNeil and Byers, 2009; Beres, 2009; Williamson et al., 2006; Sivaram et al., 2005; Desgrées du Lou, 2005; Pliskin, 1997; Kesby, 2000; Huong, 2009; Wolff et al., 2000; Harrison et al., 1997). In their comparative study of India and South Africa, Lambert and Wood (2005) found that verbal communication about sexual matters is mostly indirect, and language or phraseology that carries implications of personal experience is often actively avoided. In both the Indian and South African contexts, processes of 'othering' served to explain the inappropriate initiation of those who, according to 'traditional' norms, lacked sexual experience. In addition, the study concludes that indirect forms and avoidance are strongly gendered in both countries settings, and this was a particular characteristic of women in their interactions with either potential or actual sexual partner. In both settings, distancing devices are characteristic of verbal communication about sex while sexual communication itself includes 'languages' of visual and bodily interactions beyond the boundaries of speech (Lambert and Wood, 2005: 537).

A qualitative study of condom use among married couples in Kampala, Uganda, Williamson et al. (2006) found that most respondents reported they were satisfied with the sexual relationships with their steady or marriage partners. The majority of respondents reported high levels of openness with their spouse about their sexual needs. Meanwhile, fewer women than men said that they trusted their spouse. In addition, more women than men were happy with the decision to use condoms. On the other hand, most partners in this study said that they resolved differences by discussing and trying to reach a compromise, rather than deferring to the man's wishes. Furthermore, participants believed that high levels of communication helped them achieve consistent condom use. Thus, aspects of communication were viewed by respondents as important for consistent condom use which generally included discussion, agreement, trust and honesty (Williamson et al., 2006: 92)

2.7 Summary

In this chapter, the relevant literature on male and female sexual behaviour including aspects of sexual and reproductive health was reviewed. Studies have shown that gender ideologies are generally inculcated from a very early age and boys learn to dominate heterosexual relationships including sexual and reproductive matters while girls are actively encouraged to be submissive and obey their male partners. This has had a significant negative impact on sexual and reproductive health in sub-Saharan Africa. Sexual experience varies according to gender in this region. Men are more likely to report higher levels of lifetime number of sexual partner than women. Multiple concurrent sexual partners have been identified as one of the main factors driving the HIV epidemic in Africa and this has been exacerbated by unprotected sex in casual or non-regular relationships. Studies have shown that even in contexts of generalized epidemic which characterize many sub-Saharan Africa countries, particularly in Eastern and Southern Africa, condoms still remain an issue of great controversy. However, there are some signs of positive changes in the HIV epidemic in sub-Saharan Africa. The increase in condom use in relationships alongside other protective measures is hypothesized as one of the contributing factors to this positive signs, but structural factors are a huge challenge in the fight against HIV/AIDS epidemic.

CHAPTER 3: CONTEXT AND METHODOLOGY

3.1 Introduction

The purpose of this chapter is to describe the methodology used in the study. The chapter starts by providing a brief description of Mozambique, including a socio-economic and demographic profile of the country, and then describes the study settings. It then considers the combination of techniques used to gain an understanding of male and female sexual behaviour and protective practices in the context of a generalized HIV/AIDS epidemic. The chapter also examines the methods used in data analysis in more detail. Finally, ethical considerations and the limitations of the study are considered.

3.2 The Context: Mozambique

Mozambique is one of two Portuguese-speaking countries in Southern Africa. It is situated to the South of Tanzania; East of Malawi, Zambia, and Zimbabwe; and North-East of South Africa and Swaziland. Mozambique is administratively divided into 10 provinces namely Cabo Delgado, Niassa and Nampula provinces in the North; Zambezia, Tete, Manica and Sofala provinces in the Centre and, finally Inhambane, Gaza and Maputo provinces in the South. Maputo City is the capital city of Mozambique and is regarded as the 11th province. Mozambique is a relatively large country constituting almost 799 380 square kilometers of land area.

Mozambique is the third most populous country in Southern Africa. Since the 1950s the population of Mozambique increased from 5.7 million in 1950 to 20.2 million in 2007 (National Institute of Statistics, 2000; 2009). The population of Mozambique is relatively youthful. Almost half of the population (47 percent) is aged 0-14 (National Institute of Statistics, 2009). According to the 2007 census 10.4 million of the population are females (52 percent) and 9.7 million are males (48 percent). In addition, according to the 2007 census, the majority of the population, 70 percent, lives in rural areas compared with 30 percent which lives in urban areas. Furthermore,

the 2007 national census data indicate that the Central region is the most populated with about 43 percent of the nationwide population, followed by the Nothern region with 34 percent and, at the bottom, the South region with about 23 percent (National Institute of Statistics, 2009).

Mozambique has been enjoying a peaceful and stable political environment since the end of 16 years of "civil war" in 1992, which pitted the Government of the Republic of Mozambique and the armed rebel movement, RENAMO**,** heavily backed by the apartheid government of South Africa. Thereafter, a democratic electoral process was established. In 1994, the country held its first general election, which was won by FRELIMO, the ruling party from the time Mozambique gained its independence from Portugal. The country has so far held four successful general elections in 1994, 1999, 2004 and 2009. All the elections held were deemed free and fair by the international community and the country has been hailed for its commitment to democracy and peace.

Mozambique has been experiencing steady economic growth after the end of the "civil war" in 1992. The Gross Domestic Product (GDP) per capita increased on average by 10 percent between 1996 and 2000. However, Mozambique is still considered one of the poorest countries in the world. Available data suggest that 54.1 percent of Mozambique's population live below the poverty line (Ministry of Finance, 2001). Poverty is more prevalent in rural areas (70 percent) than the urban areas, although urban poverty has also become a matter of concern. For instance, the incidence of poverty in rural areas is 55.3 percent compared to 51.5 percent in urban areas. Maputo city is the least poor province with only 47.8 percent of its population living below the poverty line while Sofala province is the poorest province in the country with about 88 percent falling below the poverty line (Ministry of Finance, 2001). In aggregated terms, recent data on the levels of poverty in Mozambique do not indicate significant improvement. In fact, the third round of the family budject national survey (IOF08) indicates that the national average of poverty in Mozambique has not change since the last survey (IAF02). Thus, 54.7 percent of Mozambique's population was found below the poverty line (Ministry of Planning and Development, 2010). The incidence of poverty is still higher in rural areas with 56.9 percent compared with urban areas with 49.7 percent (Ministry of Planning and Development, 2010).

The 2007 census indicates that almost half of the Mozambique's population (50.4 percent) is illiterate (National Institute of Statistics; 2009). The level of illiteracy is much higher among women than in men. According to the National Institute of Statistics (2009) the rate of illiteracy is higher among women (64.25 percent) than men (34.6 percent). On the other hand, the rate of literacy is much higher in urban areas than rural areas. Only 21.6 percent of women living in rural areas are literate compared with 64.9 percent in urban areas. This imbalance in education obviously has serious implications for gender relations.

In common with other Southern African countries, Mozambique also faces a severe HIV/AIDS pandemic (Whiteside, 1998; UNAIDS, 2008; Ministry of Health, 2004; 2008). The past two decades has experienced a steady and growing increase in the levels of HIV infections. Some researchers argue that the presence of foreign troops (principally Zimbabweans) in the central region, and the return of refugees from neighbouring hard hit countries (particularly South Africa and Zimbabwe) after the end of war was a major factor contributing to the increase in HIV prevalence in Mozambique (Karlyn, 2005). The most recent prevalence data estimates that 16 percent of sexually active adults aged 15 to 49 years in Mozambique, that is, 1.6 million people are HIV positive (Ministry of Health, 2008). This prevalence rate is the same as that was reported in the 2004 Epidemiological Surveillance which may suggest some signs of stabilization of the epidemic (Ministry of Health, 2008). Nevertheless, the 2007 Epidemiological Surveillance data shows important changes in the rates of HIV prevalence, both at regional and provincial levels.

At regional level, the most significant change in Mozambique's HIV/AIDS epidemic pattern is that the South region, namely Maputo city, Maputo province, Gaza and Inhambane provinces, is the most hard hit region with a HIV/AIDS prevalence rate of 21 percent followed by the Central region with 18 percent and lastly the Northern region with 9 percent (National Institute of Statistics, 2009). At provincial level, what is noteworthy is that all the southern provinces have shown increasing trends in HIV/AIDS prevalence rates compared with other provinces of the country, except the Zambezi province which also showed some increase. Thus, in Maputo province the HIV prevalence rate increased from 22 percent in 2004 to 26 percent in 2007. In

Gaza province the prevalence rate increased from 25 percent in 2004 to 27 percent in 2007. Similarly in Inhambane province the prevalence rate increased from 10 percent in 2004 to 12 percent in 2007 (Ministry of Health, 2008)

According to some estimates, the size of Mozambique's population, without HIV/AIDS would have been about 18.9 million in 2004, but because of AIDS, it is estimated that the population size might have fallen to 18.6 million. It is predicted that, in the absence of HIV, Mozambique would have a population of 21.8 million by 2010, but due to HIV/AIDS the population size is projected to increase to only 20.6 million (National Institute of Statistics, 2004). The high level of mortality among the 15-49 years is likely to alter the structure of the population and is also likely to slow population growth (Whiteside, 1998; Whiteside and Sunter, 2000). The estimated annual population growth rate was projected to slow or even to decline due to high levels of mortality (UNAIDS, 2002). The most recent census suggests that the population of Mozambique increased at a rate of 2.3 percent (National Institute of Statistics, 2009).

The most immediate consequence of the AIDS epidemic is the rapid increase in morbidity and mortality. It is estimated that in the past 20 years, Mozambique has lost almost 855 000 people to HIV/AIDS (National Institute of Statistics, 2008). The number of HIV/AIDS related deaths increased from 63 571 in 2002 to 81 247 in 2004 and is expected to reach 97 975 by 2010 (National Institute of Statistics, 2008). The highest mortality rates are concentrated in the Central region of the country**,** with 67 percent of total deaths followed by the Southern region with about 21 percent of total deaths (National Institute of Statistics, 2008). In 2007, the population census found that Malaria and HIV/AIDS were the leading causes of death (National Institute of Statistics, 2009).

Orphanhood is one of the most dramatic outcomes of HIV/AIDS. The most recent data indicates that the number of AIDS orphans rose from 172 311 in 2002 to 557 531 in 2010 (National Institute of Statistics, 2008). On the other hand, one of the most visible effects of HIV/AIDS is the increase in the number of sick people. The number of new AIDS patients in health facilities has increased from 83 000 in 2003 to 109 000 in 2004, and is projected to soar to 178 000 cases

in 2010, unless measures are taken to reduce this impact (National Institute of Statistics, 2004). The health sector is under huge strain as it is not equipped to cope with the epidemic.

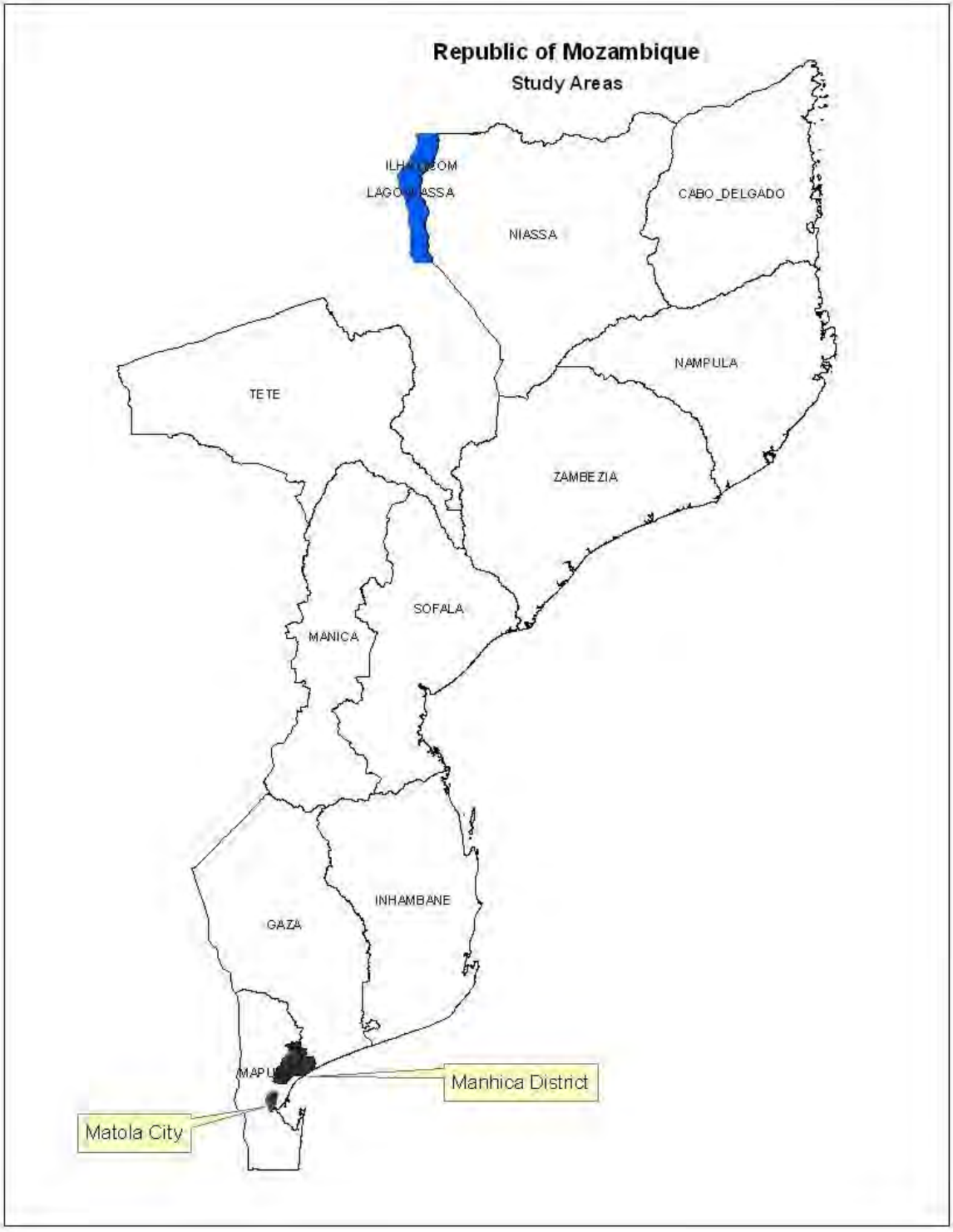
3.3 Study Sites

The study was conducted in one urban and one rural area in Mozambique. The districts in which the study was based have been chosen on the basis of their existing levels of HIV prevalence. The chosen study areas were Manhiça district and Matola city, South of Mozambique.

Matola city is the most industrialized city in Mozambique with a population of 672 508 inhabitants (National Institute of Statistics, 2009). It is situated 10 kilometres South-West of the capital city of the country and is part of Maputo's city metropolitan area. According to the 2007 epidemiological surveillance survey, 23 percent of Matola city antenatal clinic attendees aged 15 to 49 years were HIV positive (Ministry of Health, 2008). In the major health facilities which serve the inhabitants of Matola city, it was found that 25 percent of antenatal clinic attendees aged 15 to 49 years were HIV positive (Ministry of Health, 2008).

Located 80 km north of Maputo city, Manhiça is typical of rural areas in Mozambique. The majority of its inhabitants speak Shangana/Ronga, a variant of Tsonga, which is the second largest mother tongue spoken in Mozambique. Like other rural areas, the primary economic activity in the area is small scale subsistence farming. The district also has a long standing tradition of sending mine workers to South Africa. According to the 2007 epidemiological surveillance, 29 percent of local antenatal clinic attendees aged 15 to 49 years are HIV positive, representing the second highest in the Southern Region of the country (Ministry of Health, 2008).

Figure 3.1: Map of Mozambique and Study Areas



3.4 Methodology

The study uses a combination of qualitative and quantitative methods. A combination of methods in social science research, particularly on complex themes such as gender, sexuality and sexual and reproductive health are now very common and recommended (Silberschmidt, 2005; Maharaj and Cleland, 2004; Varga, 2003; Ulin et al., 2002). The fieldwork for the study was carried out in three phases, namely: focus group discussions, a household survey and in-depth interviews. This approach allowed an exploration of some of the main areas of interest from a variety of angles and benefits from the unique insights offered by each methodological approach (Simmons and Elias 1994). First, from the perspective of attaching meaning to beliefs, values, norms and experiences within a specific context, and second from the perspective of magnitude i.e. how widespread and pervasive were sexual behaviours and protective practices and what were the key determinants of these practices. The use of combined methods in this study intends to make a contribution to the existing literature on sexual and reproductive health in Mozambique (and elsewhere) wherein either quantitative or qualitative methods are generally applied (National Institute of Statistics, 2002; 2005; Ministry of Health, 2010; Clark, 2004; Gregson, et al., 2002; Boerma et al., 2003; Smith, 2007; Shimbiri, 2007). The use of a single method has clear limitations for complex psyco-social phenomenon such as gender, masculinity and sexual behaviour. By applying combined methods, this study is well positioned to help answer a range of questions.

3.4.1 Process of Data Collection

With the assistance of *Centro de Estudos da Populacao* (Centre of Population Studies), Eduardo Mondlane University, a call for applications to form the research team was announced. Four research assistants were selected, two males and two females. The females and one male were in their 20s and 30s while one male was in his 40s. Prior to the pretesting of the questionnaire, an extensive training period which lasted 5 days was held to ensure that the researchers were

completely familiar with the aims and objectives of the study. The pretesting of the questionnaire took place in Nhongonhane, Marracuene district, about 30 kilometers North of Maputo city during the last week of July 2006. The questionnaires pretesting were carried out in conjunction with SWAA project - Society for Women and AIDS in Southern Africa already working in the study area. This allowed the research team to interact with potential participants in this study. On the other hand, it provided an important opportunity to assess and gauge the reaction of respondents to sensitive issues, particularly the questions related to sexual behaviour. In this regard the questionnaire pre-testing also helped the research team to check the understandability of some questions by the respondents within the socio-cultural context. Particular attention was paid to questions about "sexual acts", including vaginal, oral and anal sex for which there is no formal terms in both the Changana and Ronga languages and are cultural taboo in public discourse. After the pretesting of the survey instruments**,** the questionnaires were revised.

Data collection for the study took place between August and October 2006. In order to make sure that the fieldwork would run without planning constraints, the main investigator held prior meetings with the local authorities in the study setting to familiarize them with the study. Involving local authorities and communities leadership was particularly important in planning both the focus group discussions and the survey administration. Community leaders assisted the research team in listing households for subsequent random selection and questionnaire administration. This is because household structures change overtime in each enumerator area and house-to-house listing allowed updating the households. Before the questionnaire was applied, written or verbal informed consent was obtained from all participants.

3.4.2 Focus Group Discussions

Focus group discussions are an exploratory research method used for the purpose of exploring people's thoughts and feelings as well as obtaining detailed information about a particular topic or issue and providing insights into needs, expectations, attitudes and perceptions of participants (Neuman, 1994). The aim of the focus group discussions was to generate and debate common

perceptions of both men and women about what was being a man in the local context and how those images reinforced particular sexual behaviours and influenced protective practices among men and women**.** The discussions allowed the research team to explore current knowledge and awareness about sexual risks and how these impacted on the sexual behaviour of men and women as well as some of the challenges they faced in changing their sexual behaviour. In addition, focus group discussions allowed the research team to get more insights into norms, beliefs and values determining sexual behaviour and protective practices. Furthermore, in the early stage of the study, focus group discussions were useful in helping to refine the research instruments for the later phases of the study, particularly for the household survey.

Sampling Design: A total of 16 focus groups discussions were held: 8 in the urban area and 8 in the rural area. Focus group participants were recruited from different sources including direct contact with individuals through health services, informal trading markets, sport fields and/or other public venues. The focus group discussions took place from August to October 2006. During the recruitment process, the potential focus group discussions participants were individually briefed on the nature of discussions and they were asked whether or not they were willing to participate in the study. In order to be eligible for the study respondents had to be aged 20 to 40 years and they had to be sexually active. Focus group discussions were conducted with

- Married men (4 groups – 2 in urban and 2 in rural)
- Sexually active, unmarried men (4 groups- 2 in urban and 2 in rural)
- Married women (4 groups- 2 in urban and 2 in rural)
- Sexually active, unmarried women (4 groups – 2 in urban and 2 in rural)

Field Procedures: At each session, one moderator and one note taker of the same sex as the participants led the discussions. The primary responsibility of the moderator was to facilitate and guide group discussions while the primary responsibility of the note taker was to observe and record group activities and discussions. Each focus group constituted six to ten participants. All the interviews were held in the local language by the moderator and note taker. All the focus group discussions were tape recorded with the permission of participations. The tapes were transcribed and then translated into English. Before the interview started, the moderators

introduced themselves and briefed the participants on the nature of the study. It was stressed that participation in the study was voluntary and that it was important that they gave honest contributions. In addition, the interview team assured participants of confidentiality.

The median age of participants was 27 years for men and 23.5 years for women. The majority of both rural and urban participants reported belonging to a wide range of Christian churches including Catholic, Assembly of God, Methodist, Anglican as well as Presbyterian. A significant number of Zion Church members were also among the participants. The majority had some formal education, ranging from Grade 4 to Grade 12, and teachers training for basic education. Few of the rural women had completed their primary school education.

3.4.3 Household Survey

During the second phase of the study a household survey was conducted. The aim was to conduct interviews in 200 households in each site. A total of 200 men and 200 women were to be selected for the study. It was decided that 400 households would be able to provide sufficient information for this stage of the study. While the number of households was rigorously reached as planned, the number of subjects was exceeded for nine subjects in the male sample and seventeen subjects in the female sample. In total, 209 men and 217 women were interviewed. The primary purpose of the survey was to collect detailed information on the sexual behaviour of men and women including number of sexual partners, type of sexual partners (such as regular, non-regular, commercial), frequency of specific behaviours (such as vaginal, oral and anal sex), as well as the conditions under which sexual activity takes place (such as having intercourse under duress or due to economic need). The survey also collected information on awareness and perception of risk of HIV infection and strategies to protect themselves against the risk of HIV infection. In addition, the survey obtained detailed socio-economic and demographic information that may impact on risky sexual behaviour and ability to adopt strategies to protect themselves.

Sampling Design: A multistage probability sampling method was applied. For the study only residents in each household were randomly selected for the interviews. A previously recorded enumerator area list in each study site was used (National Institute of Statistics, 1997). Within each urban and rural site a number of sub-districts (geographic enumerator areas) were chosen and then eight smaller areas selected within these sub-districts. In total, 16 enumerator areas (8 in the urban and 8 in the rural areas) were chosen for survey data collection. In each enumerator area 25 households were randomly selected from a list of 80 to 100 households which had been previously made with the assistance of local community leaders (National Institute of Statistics, 1997). The household questionnaire was used to identify all eligible men and women in the household. In order to be eligible for the interview, the household member had to be a resident of the household and had to be aged 20 to 49 years. Those men and women selected for the interview were asked a series of introductory questions to determine if they were sexually active. The study only included men and women aged 20 and above as it was felt that they were more likely to have ever had sexual intercourse. In addition, in Mozambique a person is eligible to marry without parents consent by the age of 18. Unmarried men and women were only asked to complete the interview if they ever had sexual intercourse. Those men and women who fell in the acceptable age range and reported themselves to be married were considered eligible for the interview. In each household, one index adult respondent was randomly selected for the interview using the Kish grid (Németh, 2003). The Kish grid gives a procedure of selecting the respondent which will answer the questionnaire among eligible members in the selected household. The Kish grid ensures that all eligible members in a given household have an equal chance of being selected to complete the questionnaire (Németh, 2003). When using the Kish grid, the interviewer uses a simple procedure for ordering members of the household on a cover sheet assigned to each sample household. The interviewer lists each adult on one of the lines on the form. Each member of the household is identified in the first column by their relationship to the head of the household. In the next two columns, the interviewer records the sex, age, education and marital status of each adult. Then the interviewer assigns a serial number to each adult. Males are first numbered in order of decreasing age, followed by females in the same order. Then the interviewer consults the selection table. This table provides the identification number of the adult to be interviewed (Németh, 2003).

Field Procedures: The questionnaire for men and women were relatively similar, with some minor differences. The questionnaires were pre-tested to identify any unanticipated problems with specific items. The pre-testing aimed to assist in refining of the questionnaire. The pre-testing phase took place in Marracuene district, 15 kilometres North of Maputo city. After this was done, the research team had to improve the questionnaire in the following week. During the survey, respondents in the household were briefed about the purpose of the study and then were asked if they were willing to participate in the study. At that stage, respondents were presented with an informed consent form which indicated their willingness to participate in the study. Some of the respondents were not comfortable in signing the consent form, but they gave their verbal consent to participate in the study. The team was the same for both rural and urban sites. Respondents were interviewed by an interviewer of the same sex. The principal investigator of the study assumed overall responsibility for the supervision of field work by ensuring that households were correctly identified and only eligible members of the household were interviewed. At the end of the second phase of the study, both men and women were asked if they would be willing to be interviewed at a later stage.

Table 3.1 presents the general sample characteristics of study participants. A total of 426 respondents participated in this study, 209 men and 217 women. Among men, 49 percent were interviewed in the rural area and 51 percent in the urban area. Among women, 49 percent were interviewed in the rural area while 51 percent were interviewed in the urban area.

Table 3.1: Percentage distribution of respondents by selected socio-demographic characteristics

Sample characteristics	Men %	Women %
Place of residence		
Urban	50.7	51.2
Rural	49.3	48.8
Age		
20-29	51.7	56.3
30-39	26.3	27.9
40-49	22.0	15.8
Level of Education		
None	13.4	23.5
Primary	47.4	48.8
Secondary or higher	39.2	27.6
Marital Status		
Married/cohabiting	66.0	55.3
No	34.0	44.7
API		
Low	21.1	30.9
Lower medium	28.2	23.0
Upper medium/high	50.7	46.1
Religion		
None	16.7	4.6
Roman Catholic	19.1	27.2
Protestant/Evangelical	41.1	45.6
Muslim	1.0	1.4
Siao/Zion	18.2	20.3
Other	3.9	0.9
Ethnic group/Mother tongue		
Chope	16.3	13.4
Ndau	1.9	1.4
Ronga	28.7	27.6
Changana	39.2	46.1
Bitonga	5.3	3.3
Macua	2.4	1.4
Xitsua	2.9	2.8
Other	3.3	4.0
Employment status		
Employed	38.8	12.9
Not employed	61.2	87.1
Total	**209**	**217**

The majority of respondents of both sexes were aged between 20 and 29 years, comprising 52 percent of the male sample and the 56 percent of female sample, respectively. Among men, 13 percent of men never attended a school. Forty-seven percent had primary education and 39 percent had secondary education or more. Level of education was higher among men than women. Among women, about 24 percent never attended a school, 49 percent reported having primary education and only about 28 percent had secondary education or more. The majority of men and women reported that they were married or cohabiting. Sixty-six percent of men and 55 percent of women were married. The majority of respondents were Christians. Among those, 41 percent of men and 46 percent of women were Protestants/Evangelical. Nineteen percent of men and 27 percent of women were Catholic. Thirty-nine percent of men were currently employed at the time of the survey compared with only 13 percent of women. The socio-economic characteristics of participants were measured by the Amenities Possession Index (API). Table 3.1 shows that the 56 percent of men and 46 percent of women had a medium-high socio-economic status. The majority of respondents were originally Changana or Ronga speakers.

3.4.5 In-depth Interviews

In the third phase of the study**,** in-depth interviews were conducted. In-depth interviews are a qualitative data collection technique which involves an intensive one–to–one "conversation with a purpose" between the interviewer and the respondent (Ulin et al., 2002: 46). The interview itself takes the form of a one sided conversation in which the interviewer encourages the respondent to talk freely and guides the discussions to new topics from time to time (Campbell et al., 1999). The main advantage of in-depth interviews is its ability to provide insight into and understanding of the context in which the behaviour occurs and broader structural determinants (e.g. power relations) of behaviour (Campbell et al., 1999).

The aim of the in-depth interviews was to obtain detailed information on individual knowledge and awareness of AIDS, their attitudes to protective practices and their sexual behaviour. The in-depth interviews focused on how gender differences influence the sexual behavioural choices of

men and women as well as their ability to protect themselves against the risk of HIV infection. Of particular interest was the nature of sexual relations, quality of sexual relationships, and personal motivations for engaging in sexual relationships, and the successes and failures in coping with the risk of HIV infection. The in-depth interviews focused on some of the same issues as the focus group discussions and survey interviews but they tried to obtain more detailed information.

Sampling Design: A total of 20 in-depth interviews were conducted in the rural and urban areas, 10 in the urban area and 10 in the rural area. The sampling frame for this phase of the study was limited to respondents who agreed at the end of the survey to be interviewed in a follow-up phase. A purposeful non-probability quota sampling method was used to select respondents for the interviews. An attempt was made to obtain an equal distribution of married and unmarried and men and women. In the rural area the majority of respondents were neither married nor cohabiting. The median age of respondents of the in-depth interviews was 30.5 years for males and 31.5 years for females.

Field Procedures: All the interviews were conducted in the local language by the same interview team used in the survey. All the in-depth interviews were tape recorded with the permission of respondents. The tapes were transcribed and then translated from Changana/Ronga or Portuguese into English. Broadly, the in-depth interviews were used to assess the validity of data collected in the focus group discussions and the survey.

3.5 Ethical Considerations

This study observed all the required procedures to ensure confidentiality and anonymity of respondents. First, respondents were fully briefed about the goals of the study and expected outcomes and they were asked if they would be willing to participate in the study. Participants also were informed that they were at liberty to withdraw from the study at anytime. In order to ensure confidentiality and anonymity during data collection and management, all notes and completed questionnaires were kept in a locked filing cabinet. Only identification numbers, no

names, were recorded on the questionnaires and data files. In addition, the survey data were presented in the aggregate in order to ensure that there were no negative comebacks to respondents. Apart from that, permission to conduct the study has been sought from the relevant administrative authorities. Approval for the study was obtained from the University of KwaZulu-Natal ethics committee and Mozambique's Bioethics National Committee at Ministry of Health.

3.6 Data processing and analysis

To ensure the quality of the manual editing and coding work, verification of completed questionnaires was carried out on a 100 percent basis by the main investigator. Data entry was done by a team of three trained encoders using the CSPRO system. CSPRO (Census and Survey Processing System) is a computer softwere for data processing and management specially designed to speed up data entry, editing and frequencies outputs (National Institute of Statistics, 2005). The quantitative data from the survey were analysed separately for men and women using Statistical Package for Social Sciences (SPSS). SPSS is one of the most widely used computer software for statistical analysis in Social Sciences. In the first instance in this study, the analysis focused on describing and summarising the distribution of specific variables of interest. Thereafter, bivariate analysis was used to investigate the relationship between the dependent and independent variables. In addition, the chi-square test was applied to determine the statistical association between particular variables. The analysis also made use of both simple and multiple logistic regression analysis. Simple logistic regression is used to explore associations between one (dichotomous) dependent variable and one (continuous, ordinal, or categorical) independent or outcome variable. Multiple logistic regression analysis is used to explore associations between one (dichotomous) dependent variable and two or more independent variables (which may be continuous, ordinal or categorical). The purpose of multiple logistic regression is to isolate the relationship between the dependent variable and the independent variable from the effects of one or more other variables (called covariates or confounders) (Wuensch, 2008). Both simple and multiple logistic regression analysis were used to assess the association between independent variable(s) of interest and a dichotomous dependent variable.

The qualitative data were coded and organized by themes and categories. Using a general inductive approach for qualitative data analysis (Thomas, 2003) a wide range of categories were thoroughly explored in each interview and then compared to other interviews. The general inductive approach is frequently reported in health and social science research (Thomas, 2003). The general inductive approach for qualitative data analysis offers a straightforward set of procedures which can be used for the analysis of qualitative data. It generally consists of five important steps: first, preparation of raw data files (data cleaning); second, close reading of text and identification of segments of information; third, creation of categories (coding); fourth, overlapping coding and uncoded text (reduce overlap and redundancy among categories); and fifth, continuing revision and refinement of the category system (Thomas, 2003: 5-6). In this study, the process began with reading of the transcriptions in order to identify particular themes, categories, and inter-relationships (Campbell et al., 1999). An important step was the process of coding of segments of the texts. After this had been completed the segments on the same topic was sorted and compared across all interviews. The data were sorted into particular themes according to differences and similarities (Ulin et al., 2002; Thomas 2003). A variety of themes under investigation included: (i) socio-economic challenges and difficulties facing men and women in the study settings; (ii) valued characteristics of men and women in the study settings; (iii) perceptions of changes among different generations of men and women regarding gender relations, social and familial duties and sexual behaviour; (iv) parent expectations of boys and girls in relation to education, employment, family responsibility as well as socially acceptable sexual behaviour for both men and women; (v) HIV/AIDS awareness and protective practices; (vi) perceptions about gender relations, the role of culture and sexuality; (vii) sexual dynamics and partner communication; (viii) multiple sexual partnerships; (ix) condom use; and (x) family planning.

3.7 Limitations of the Study

One of the key limitations of this study relates directly to the culture of silence that surrounds sexual matters (Gupta, 2000). In many parts of the world, sexual behaviour is rarely openly discussed. Moreover, or because of that, there are also methodological barriers and complexities. One of the main challenges facing sexual behaviour studies and sexual and reproductive matters is that self-reported sexual behaviour data are subject to self-representation bias (Gregson et al., 2004; Plummer et al., 2004; Wittrock, 2004; Fenton, et al., 2001; Schroder et al., 2003). For example, studies have shown that although people in some settings may be reluctant to report number of sexual partners, people in other settings, particularly men, may over-report number of sexual partners (Weir et al., 2004). Catania et al., (1990) point out that there are a number of reasons that motivate same people to conceal their true sexual behaviour. This includes concern about privacy, embarrassment and fear of reprisals. Moreover, it is possible that some respondents have trouble recalling how often and with how many people they have had sexual relationships (Catania et al., 1990). Since diverse factors might impact on the reliability of findings on sensitive issues as sexual behaviour, a combination of methods was deemed useful to compare methods as well as confirm or validate results (Dare and Cleland, 1994). Plummer et al. (2004) observes that assessing sexual behaviour is challenging not only because it is a sensitive and private matter but also because of methodological complexities. The author notes, however, that there is no “gold standard” in sexual behaviour research. Nevertheless, multiple, complementary research methods are ideally recommended (Plummer et al., 2004). According to Fenton et al., (2001) participation bias (including refusal to answer a particular question) as well as reporting and recalling bias (including sex related and social desirability bias) are the most common challenges in measuring sexual behaviour (Fenton et al., 2001). A new research technique on sexual behaviour confirms the challenges facing face-to-face interviews. In their study in Brazil, Hewett et al., (2008) found that reporting of sexual behaviours was generally higher in audio computer-assisted self-interviewing (ACASI) than in face-to-face interviews. In addition, the study found that, when responding to questions posed by research staff or health

care providers, women over-reported protective behaviours than they did in audio computer-assisted self-interviewing (Hewett et al., 2008). These findings reinforce the results from other studies which suggest that socially desirable and norm-driven responses are very common in face-to-face interviews (Hewett et al., 2008)

In this study, although confidentiality was ensured and respondents were urged to be honest in their answers self-response bias may not be completely overcome (Catania et al., 1990; Wittrock, 2004; Fenton et al., 2001; Schroder et al., 2003). As in similar studies, male respondents may have exaggerated or over-report their sexual behaviour while women may have tended to minimize or under-report their sexual activities (Wittrock, 2004). Another limitation of this study is related to cross-sectional surveys design. Cross-sectional surveys are used to collect data on a given population to describe the relationship between one particular phenomenon under investigation and other factors of interest. Cross-sectional surveys provide a 'snapshot' of the outcomes and the characteristics associated with it, at a specific point in time (Levin, 2006). Cross-sectional surveys are purposefully descriptive and aim to measure the prevalence of certain conditions of interest and have been a method of choice in sexual and reproductive health related research (Cleland et al., 2004; Pettifor et al., 2005; Jewkes, Levin and Penn-Kekana, 2003; Glynn et al., 2003; Macphail, Williams and Campbell, 2002). However, one of the most important limitations of cross-sectional studies is that they give no indication on the sequence of events; therefore, relationships of causality between one or more phenomenon cannot be established (Pettifor et al., 2004; Maharaj and Cleland, 2008). Nevertheless, cross-sectional studies indicate the associations that may exist and are useful in generating hypothesis for further research (Levin, 2006). In line with this, causality inferences among different factors described in this study are simply hypothesis which are open to further investigation or confirmation.

3.8 Summary

In this chapter both the context of Mozambique and the methodology used in this study were described. A combination of both qualitative and quantitative methods was deemed critical for

investigating the sensitive topic of sexual behaviour. For example, qualitative methods are regarded as more appropriate to identify and conceptualize salient issues (Fitzpatrick and Boulton, 1994). In this study, two qualitative methods were used, namely focus group discussions and in-depth interviews. Focus group discussions as an exploratory method were particularly useful in attaching meaning to beliefs, values, norms and experiences within a specific context as well as to refine the survey instruments. The in-depth interviews obtained more detailed information from the perspective of respondents regarding particular issues including personal and intimate issues and the reasons behind certain decisions or behaviours. The household questionnaire allowed the researcher to investigate how widespread and pervasive were sexual behaviours and protective practices in the study settings and what were the key determinants of those practices.

CHAPTER 4: NOTIONS OF MASCULINITY IN THE ERA OF HIV/AIDS

4.1 Introduction

Studies suggest that it is critical to address socio-cultural factors, which enhances both individual and societal vulnerability to HIV/AIDS (Varga, 2001, 2003; Blanc, 2001; UNAIDS, 2008; Rao-Gupta, 2000; Campbell, 1995; Izugbara, 2008). Gender, defined as the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles, which ascribe to men and women differential access to power is understood as one of the most powerful social factors influencing the risk of HIV infection among men and women (Varga, 2001, 2003; Blanc, 2001). Numerous studies suggest that unequal gender relations play a major role in the current HIV/AIDS crisis in sub-Saharan Africa (Rao-Gupta, 2000; Foreman, 1999). It is also believed that identifying valued characteristics of manhood (and womanhood) as well as concomitant gender roles and stereotypes may help to understand the different attitudes and behaviours of both males and females in relation to sexual health matters including protective practices (Karlyn, 2005, O'Sullivan *et al* 2007). Therefore, investigating gender roles within intimate relationships in the study sites was deemed important to shed light on some of the challenges facing men and women in adopting protective strategies and also it may point out opportunities for more appropriate policy design.

This chapter examines the dominant notions of masculinity, or more precisely, what it means to be a man. The chapter looks at perception of manhood and more specifically, the defining characteristics of 'a man'. The starting point is that gender socialization plays a determining role in influencing the sexual behaviour and protective practices of men and women. In addition, it investigates whether or not men conform to the traditional notions of masculinity. Furthermore, the chapter investigates the extent to which men feel pressured by such notions of masculinity to engage in particular sexual behaviours which may increase their risk of HIV infection.

4.2 The notion of 'Manhood'

In order to obtain the dominant notions of manhood and womanhood in the study sites, the following questions were asked of both men and women: "*In your opinion, what characteristics are most valuable in a 'man' or 'woman'?" "To be a 'real man or real woman' what are you supposed to be? Do you conform to these expectations? Are men today, different from men in the past? Are woman today different from women in the past?"*

The perspective of men

The findings from the focus group discussions and in-depth interviews show that most men and women subscribe to traditional notions of masculinity. According to stereotypical notions of 'manhood', men are required to assume economic responsibility for their family. It is of a particular interest that having children not only gives men a certain sense of pride in being able to reproduce children, which is a symbol of virility, but also it gives him social status which, in turn, leads to community recognition.

During focus group discussions and in-depth interviews, almost all men reported that having a wife and being able to father children as well as having a house are the most important defining elements of manhood. In addition, the pressing need to have or reach such characteristics seems to be more for social and community reasons rather than for individual ones, since it is necessary for a man to be recognised by the community as "a real man".

"You are a real man when you have a wife and children. You must have children so that people will see that you are a man. I see myself as a real man. Because I have my own house, a wife and I have got a son."

(Rural married male, IDI # 12)

The ability to reproduce children *per se* might not be enough to conform to the traditional notion of manhood. It is essential also for a 'real' man to have visible signs of his economic status,

including owning his own home in which he will exert his power and authority. This notion of manhood is illustrated in the quotes below.

"A real man is the one who has a good financial situation. He must have either money or a house. If he does not have this, he becomes almost invisible, worthless".

(Rural married male, IDI # 17)

"To be regarded as a real man a person must have a place to live, a family. I think that the person must work to have a good financial situation. He must have some resources and to have resources he must have a good business".

(Urban non married male, IDI # 15)

This quotation highlights the awareness of the respondent of the criteria needed to be perceived as a 'real' man. The criteria include, among others, having a place to live – for example, a home or homestead. However, respondents point out that is difficult to fulfill such expectations particularly because of the high levels of unemployment in the study sites. The respondent further explained that few people are employed, therefore, only few people are in a position to conform to traditional notions of manhood. These quotations seem to suggest that a significant number of men do not feel entirely comfortable in conforming to the traditional notions of masculinity, leading to frustrations and anxieties which in turn may have a negative impact on their relationships with their female partners.

Although most respondents agreed that a 'real' man must have material possessions to earn the respect of his community, one male respondent, however, took a slightly different position when outlining the defining feature of a "real man". According to this respondent, having a family (i.e. a wife and children) is the most important feature of being a "real man" rather than having material possessions. He argues that although material possessions are important in defining manhood, it is not enough because sometimes a woman can have more money than a man. This suggests that manhood is defined by characteristics which should somehow be exclusive to men.

"Look, I regard myself as a 'real' man. To be a man it is not about having money, because even women can have more money than men. So, what is needed is to have children. What is taught to a boy is that you have to marry a woman, have a boy child to perpetuate the family name"

(Rural married male, IDI # 14)

This quote is insightful not only because it highlights the sexual aspect of manhood, but also it points out a very important issue in the definition of manhood, that is, the idea of perpetuating a lineage, a task generally assumed to be handed to men in patrilineal societies. Women bear the "passive role" of conceiving men's children, and male children in particular. It expresses the idea that the man is seen as the most important member of the family. Some respondents feel that having a girl child is not the same as having a boy child. A girl child girl is "less important" because she does not determine the perpetuation of the family lineage because a girl child is supposed to procreate and perpetuate another family lineage but not that of her fathers. Such perceptions may have a serious impact on gender relations and inequalities. Of interest in the quote is that although money means power in the sense that it gives access to resources, particularly economic goods and social prestige, the respondent observes that money alone does not define a 'real' man. Therefore, from the respondent's point of view what is peculiarly crucial for a man is to be able to father children in order to be regarded as a real man. The idea that money is not central to defining manhood can be an indirect recognition of the changes in society which has led to more women entering the labour force and achieving financial successful.

Meanwhile, although traditional gender role norms and stereotypes still determine the interactions of men and women - men as providers and women as caregivers, other qualities emerged during the interviews. For many men, for instance, it is also understood that is important for them to have a formal education or some kind of economic and financial status that will make them, as one respondent observed, '*visible'* in society.

"Most of my friends say the higher education you have the better for you. One other thing is that people see you differently if you have a good job. School and employment are two important factors, if you do not have them, you may even have friends but they will try to put you aside because you did not study. If you have these two things, then people will regard you as a man".

(Urban non-married males, FGD # 18)

This is of particular interest because it shows that the notions which define manhood (also womanhood) are dynamic and may incorporate new values and norms within a society. For example, while employment provides a source of income, it is intricately linked to 'traditional' notions of masculinity. In addition, higher education seems to be part of the new values defining a man. Education is seen as assigning men greater social status in the community. This is significant because education is viewed as key to greater economic mobility.

Furthermore, some respondents highlighted some of the moral values which are also understood as important defining elements of manhood. These include honesty, social responsibility, and politeness to all members of the community but above all, being a role model for children.

"A 'true' man is a respected man. Here, in this area, a man is the one who respects the elders, has friendships with everybody, and it does not matter if they are young or old. I have relationships with almost everybody here and I am proud of that".

(Urban non-married male, IDI # 16)

Studies have shown that the notion of public respect is central in many sub-Saharan African societies and elsewhere (Parikh, 2007; Hirsch et al., 2007). In contrast, in this quote the respondent highlights the notion of respect as an essential element which defines real manhood. Meanwhile, it should also be noted that the respondent emphasizes that respect should be cross generational. Thus, a real man shows respect to everyone regardless of age. In this regard, one respondent stated that he is proud of being regarded as a respectful man in the community.

Some men explained that it is acceptable for men to engage in multiple sexual partnerships because it is a part of their culture. However, they were very critical of women with multiple sexual partners. Women with multiple sexual partners are labelled prostitutes. This finding is supported by research in other parts of Africa. For instance, Orubuloye et al. (1995) argue that African culture has always recognized the male need for, and right to, multiple sexual partners and they point to polygynous marriage as one aspect of societal acceptance of this point.

"A man can have more than one sexual partner because we should not confuse polygamy with prostitution. In our culture, even here in Manhiça, there are men with two women, and we cannot say that it is not a cultural practice. We cannot run away from culture"

(Rural married male, IDI # 12)

Moreover, it seems that men are somewhat aware of the double standard which pervades gender relations in society. They even describe the advantages that men enjoy in sexual relationships in their society as well as the extent to which the very same society is harsh towards women.

"According to culture, a man is allowed to have more than one partner, but this does not exist for women. A woman with many sexual partners gets a bad reputation in the society. They call her a lot of names, and if she is somebody's wife it gets worse".

(Rural married males, FGD # 12)

Strikingly, for some men, multiple sexual partners are as important as having a balanced diet. The men explained that just as it was important to taste a variety of dishes men need to have many sexual partners in order to remain healthy.

"I will not deny that I have had some adventures. Not because my partner does not satisfy me, but there are such things. When I have conversation with friends we use to say 'eating rice everyday is harmful to the health: eating rice today, tomorrow, and the day after tomorrow is not good. We must have a balanced diet".

(Urban married males, FGD # 14)

Some men believe that sexual intercourse with multiple partners is a prerequisite for good health. Sex with many partners is seen as a key component of good health, this is consistent with other studies conducted among young men in South Africa which found that many young men feel that sexual activity is important for them to maintain good health and 'prevent insanity' (Leclerc-Madlala, 2002). Male peer groups have an important role to play in perpetuating these beliefs. Some men achieve masculine status through their sexual prowess.

The perspective of women

Women in both the urban and rural area also subscribe to traditional notions of masculinity. For most women, the man is the primary breadwinner and head of the family and this is the most important and defining characteristics of true manhood. This sentiment was expressed during both focus group discussions and in-depth interviews as illustrated in the quote below.

"He has to take care of the children, he must build a house, getting us food, getting us clothes and helping with school material"

(Rural non-married females, FGD # 05)

This quote highlights the gender roles that exist in society which assigns men the role of breadwinners and providers. As the respondents highlighted, a man should provide shelter as well as food for his family. It is noteworthy that the respondents included the formal education of the children as part of male responsibility. This may suggest that respondents in the study sites understand the role which formal education plays in modern society. For example, one of the strongest expectations parents manifested during focus group discussions and in-depth interviews was to see their children, regardless of their gender, educated and employed which is an important indicator of positive change in society and may have a positive impact on the sexual and reproductive health of future generations of both young men and women.

On the other hand, it is also of particular interest to note that the notion of manhood is not only defined from the perspective of social duties and obligations within the family and society but also through the economic role that men play in the household. Thus, as some men previously indicated, some women also share the idea that men gain their identity by their involvement in activities which generates income for their family. During focus group discussions and in-depth interviews some women reiterated the view that a real man must go to work or have an occupation and feed his family.

> *"For me, to be a real man, a man must work. He must have respect for his household. He must have a real life, where the basic needs of the family are met and the man and the woman play their social roles: me as wife and mother, and him as my husband and the father of our children."*
>
> (Rural married females, FGD # 06)

Again, the issue of respect is highlighted in the above quote. Important to note in the quote is the meaning of respect for these women. For the respondents, respect encompasses two important features. The first is related to fidelity to sexual partner. Thus a man who is faithful to his wife is regarded as respectful of his relationship. The second feature is related to the fulfillment of traditional gender roles, particularly the role of husband and wife in the relationship. In this regard, a woman is a wife and sometimes a mother and she should act accordingly. Similarly, a man is a husband and sometimes a father, and therefore it is expected that he too should behave accordingly.

Meanwhile, is noteworthy that both infidelity and domestic violence do not form part of notions of manhood. This is of particular importance because it reveals that women value healthy and non-violent relationships. Some studies have shown that generally the relationships between men and women are marked by violence and abuse such that some women tend to view this as integral part of relationship (Wood and Jewkes, 2001).

"A real man, when the sun rises, goes to work. He comes back from work and meets his wife, chats with her; that is a real man, a good family leader. A real man does not go to bars or beats his wife. A good man gives money to his wife, not to lovers".

(Urban married females, FGD # 03)

As can be seen from the above quote, while a 'real man' is defined in terms of qualities already mentioned by other respondents, the women in this focus group also argue that a 'real man' does not engage in practices that are harmful to women. For these women, practices such as violence against women and infidelity do not define a real man. This seems to contradict some perceptions of the practices of a real man, which although not publicly defended, are still socially tolerated. Such practices include violence against women and unsafe sexual networking which are perceived as important features of masculinity (Wood and Jewkes, 2001; Varga, 1997; 2003; Blanc, 2001) This is an interesting departure from traditional notions of manhood which is usually characterized by violence, including sexual violence and risk taking attitudes towards the adoption of a more responsible and caring manhood (UNFPA, 2000).

Furthermore, for some young women, apart from a man having to sustain his wife and his children, a "real man" also has to be approachable. For some young women, an approachable, friendly man is much more preferable than a rude and violent man who is only interested in controlling the woman. Thus, for some young women possessing good inter-personal and communication skills is seen as very critical for men. In addition, being sensitive to women's needs is also viewed as an important defining feature of the *modern* man. The quotes below seem to illustrate these perceptions.

"A real man is the one who is a partner, a friend, a person who is able to handle problems with his wife, who knows how to help her, understand her".

(Urban married female, IDI # 05)

"For me, a real man is one who carries his duties as a man, because there are some people who are men because God made them men, but they do nothing to show that they are men. As a woman, I think a man should be a companion, must be someone who understands me. He chats with me as his partner. He should respect me. He should have a consideration of me; that is how I think we can define a real man"

(Urban non-married females, FGD # 10)

4.3 Do men conform to Traditional notions of Masculinity?

Important and rapid changes in society have been challenging traditional notions of masculinity. High levels of unemployment and poverty facing men are at the core of such challenges. For example, unemployment seems to have undermined the dominant notions of manhood because the gender stereotyped role of men as breadwinners require them to have some source of income in order to fulfill their duties. However, the existing socio-economic conditions, characterized by extreme poverty and unemployment, have undermined the traditional notions of men as providers and breadwinners.

The perspective of men

Both the focus group discussions and in-depth interviews suggest that high levels of unemployment, widespread poverty and harsh living conditions were among the most frequently mentioned socio-economic challenges facing both men and women in the study sites. The quantitative data from the study indicates that 39 percent of male respondents reported that they were currently employed compared with only 13 percent of women (Table not shown). In addition, an analysis of occupation shows that, the majority of men were security guards (17 percent) - one of the lowest paid occupations in Mozambique, followed by bricklayers (seven percent), taxi drivers (six percent), farm workers (five percent), and mine workers (four percent). Indeed, men interviewed in both study sites either in focus group discussions or in-depth interviews lamented the fact that it was very hard for them to be a man as is socially and culturally prescribed.

"To be a real man, it means to have a job, because if you do not have one, that shows that you do not know even how to take your children to school. People will despise you".

(Urban married males, FGD # 13)

As this quote suggests, to be considered a 'real man' it is crucial to be employed and have a source of income. Not having a job or a source of income may be seen as a sign of inability to carry out one's social duties including obligations to one's own children. A man in such situation might not only be seen as incapable by the society at large but he himself may regard himself as a failure.

This view of manhood is widespread in the study sites. In fact, the requirement for being a real man goes beyond just having employment. It involves holding certain types of employment which are considered as high status positions. Men who hold certain types of jobs (such as in a big, private or stated owned company) are seen as not endangering their position in society and able to maintain their status as a 'real' man. But in the absence of certainty and security in the employment market, they feel anxious and unable to fulfill their duties as a man. These frustrations have made some men to lose their self-esteem as they feel that they are not man enough. On the other hand, those who are fortunate enough to secure permanent and rewarding jobs may still enjoy the status of successful men.

"We are sculptors and what we say does not have the same value as what people working in a corporation say".

(Urban married males, FGD # 13)

"I think that in the past, men had jobs. But today we do not have. In the past there was a diversity of jobs. The only job that there is now is commerce [informal market]. Life is more difficult for men. I think that a man faces more problems because he is the head of the family".

(Urban married males, FGD, # 13)

Poverty and unemployment also seems to have some negative effects on the self-esteem of men. Studies have shown that male self-esteem is being eroding under the current circumstances of both high levels of unemployment and poverty (Silberschmidt, 2005; Kaufman et al., 2008). Some men emphasized that although moral values such as being a respectful man play an important role in defining a "real man" in the community; however for a poor and unemployed man this does not add any value. The perceptions that manhood is defined by socio-economic status rather than by moral values are so strong among men in the study sites. The following quotes illustrate these sentiments.

"I think that a person is only considered when he has got something. It does not help to be poor. For example, I am unemployed and if I speak with someone, he will not listen to me, it does not matter what I say".

(Urban married males, FGD # 13)

"Men are considered real men when they have they own piece of land and have families which they can provide for. When you do not have these things, people will not see you as a man. You have to have money and a house".

(Urban non-married males, FGD, # 17)

Furthermore, some men were of the view that although many men have been trying in their everyday life to achieve the expectations of 'true manhood', very few have been successful because of high levels of unemployment. Several men interviewed in both settings expressed the same views about how and to what extent men have been fulfilling their manly duties according to social expectations.

"*We try to meet those expectations but it is difficult. There is no employment, there is nothing for us to do, every single day we wake up and we wonder what we are going to eat. So, there is nothing you can do when you do not work."*

(Urban non-married males, FGD, # 17)

"Not all men can fulfill those expectations. There are those who try but they cannot. For instance, it is said that to be regarded as a man you have to study and work, but not all of us can. We know how hard it is to get a job and schools have no vacancies, so people might be willing to work and study but it is not always possible for them"

(Urban non-married males, FGD # 18)

The quotes above suggest that the notion of "real manhood" is context-dependent, and for some people, elusive. Therefore, to be seen or to feel oneself as a "real man" is something which could be held and enjoyed for sometime but which is also possible to lose. This is because "being a real man" is intimately related to socio-economic conditions which are generally subject to rapid, unpredictable change. The emphasis on men having employment or a source of income as a defining prerequisite for manhood just shows how the idea of men as providers is still very strong among respondents

But socio-economic conditions not only are important to sustain one's family, but also to show the community and society that this particular man is hardworking, which in turn, brings social recognition and prestige. In this regard, some respondents, particularly men perceive women as only interested in obtaining money.

"When you have money you are regarded; you are recognized as someone. When you have everything you are regarded as a real man. If you do not have anything, people will despise you, you will be nothing. So, you must work. For a woman to see that you are a man, you must work. Women here want money. It is very hard!"

(Rural non-married males, FGD # 15)

It seems not surprising that in the context of extreme poverty and where women are economically dependent on men, women seek men who can support them financially as is suggested in the quote above.

The perspective of women

The women's views about the extent to which men have been fulfilling their gender roles and expectations can be seen through the perceptions of women of changes in men's character over time. Those perceptions may allow comparison of what is socially expected and shared by men and women, their definitions of "real manhood" and what, in practice, men have become in everyday life. An overwhelming majority of women both in focus group discussions and in-depth interviews reported that men's sexual behaviour and their failure to fulfill traditional gender roles are the most significant differences between men of their time and men in the past. It should be noted here that the notion of 'men in the past' is relative and should be understood in the context of research. What was important, though, was to rely on respondents' memories and lived experiences.

In this regard, some women complained about the lack of responsibility of younger generations of men particularly with regard to parenthood. They said that "today's men" usually impregnate women but they do not take responsibility for the pregnancy or their newborn child. This, according to the women, is one of the most important differences between the "new generation" of men and the "older generation" of men

"*Nowadays a man can make you pregnant after loving each other, but then things will change, he does not want to take responsibility and then he leaves you alone with the baby. Those of the past they did not do such things. They cared for their children. Today, if he has another woman outside, he forgets the one he is living with and only worries about the other one*".

(Rural non-married females, FGD, # 5)

This quote not only illustrates the frustrations of some women who may have entered into relationships believing that they would have the necessary attention and care from their partners, but this did not happen. They may have fallen in love, gotten pregnant and then faced abandonment. This seems to lead to the perceptions that nowadays men are not trustworthy and faithful. Indeed, being impregnated and then abandoned may cause women a great deal of social

and economic insecurity including carrying the stigma of being a single mother and assuming responsibility for childrearing without any financial support. Male infidelity (or perceptions of it) was deemed the most important characteristic differentiating today's men from men in the past. This was highlighted many times during the interviews with women. Men are regarded as sexually irresponsible, particularly for pursuing multiple and concurrent sexual partners, including having a number of separate households.

"In the past, if a man wanted to have a second wife he would talk with his first wife, until all the families come to an understanding. But today that has changed, a man can have many families outside and you will never know how many he has. So I would say that they have changed and this is because what counts nowadays is to have money".

(Urban married female, IDI, # 5)

Again, money is seen to play a corrupting role in society, particularly among men. According to this respondent, men are the main beneficiaries of the current socio-economic system, since they are more likely to be employed. Employment provides them with an income which makes them have more power but, at same time, they are less responsible. This seems somehow contradictory. As described earlier, many men in the study sites complained about the lack of job opportunities. However, some men use their income to extend their sexual networking including 'having other families', of which their current wives are not aware.

Some women argued that it was justifiable for men to have more than one partner because there are so many more women than men in society. According to these women, multiple sexual partnerships is a way of giving women who do not have their own men to have a sexual relationship. However, they felt that they would rather not know about their partner's other sexual relations. Indeed, because women are in subordinate position in relationships they perceived that they cannot change the course of events; therefore they have to secure their relationships at all costs. In other words, women may have internalized the idea that they must adopt whatever strategy they can in order to hold their partners including accepting their multiple sexual partnerships so that they will not abandon them.

"You will feel unable to do something. What you have to do is to fight for your partner, there, at home. According to the statistics, a man has a reason to have other women. The statistics say that there is one man for every seven women. If a man stays with only one, what about the others? Who will they stay with? What I fight for is for my husband to care about me. He must 'respect' me even if he has other girls. For me, as long as I do not know, that is all right".

(Rural married females, FGD # 01)

However, the perception that men have changed is not an exclusive feature of men. Both men and women agree that not only have men changed but women have also changed. Women are seen as more sexually relaxed and less committed to their relationships than in the past. A group of married women in a focus group discussions and in-depth interviews observed that relationships are less committed. They argue that relationships between men and women often do not last for a long period of time. The following quotes are testimony of such views.

"By the way, this happens with both women and men. Men want to test everything. They want to have sex with as many women as possible. That is why they get involved with all the women they meet. So the men nowadays are not serious. They are totally different from the men of the past. I think both men and women are not serious".

(Urban married females, FGD # 10)

"Women have changed too. Women today want their husbands to give them money, and when their husbands do not have money they no longer see them as being men, so they go out and look for those men who have money. That is why we have so many diseases"

(Rural married female, IDI # 01)

4.4 Harsh Living Conditions impacting notions of Masculinity

The socio-economic context also seems to put pressure on men and women which lead to them adopting a number of survival strategies including sexual networking. For instance, both focus group discussions and in-depth interviews revealed that multiple sexual partnerships which appears to be more socially tolerated for men but strongly condemned for women is viewed by some men as an expression of manhood. However, the risky sexual behaviours of men are directly attributed to their harsh living conditions.

The perspective of men

During focus group discussions and in-depth interviews some men highlighted that the lack of jobs and recreational activities in the study areas lead men, particularly young men to engage in risky and dangerous activities. The following quotes illustrate these views.

"*There is a lot of crime here. As most men here do not work, sometimes some steal, and this happens because they do not work. There is nothing for us to do"*

(Urban non-married males, FGD # 17)

"*There are a lot of criminals here. There are many who are addicted to drugs. I have always tried to keep away from this myself. There are no jobs. I have some friends who sometimes call me to do some jobs. This is what makes me to survive"*

(Urban non-married male, IDI # 17)

Of interest is that the scarcities of jobs, which are associated with strong competition among employment seekers for the few vacancies that sometimes are offered in the labour market, lead some men to think that they are discriminated against in favor of women. This was expressed by the same respondents during the interviews.

"Men do not have access to jobs here, and there is a lot of discrimination. It is even difficult for us, with a university degree and good curricula, to get a job. But women can easily get one"

(Urban non-married male, IDI # 17)

This quote may lead to two different interpretations regarding the competition for employment between men and women. The first is that when some gender oriented policies are implemented in order to challenge the structural gender inequalities, they may be perceived negatively by men. The second is that the respondent seems to suggest that for a woman it does not matter whether or not she has the qualifications to secure a job, as long as she is a woman she will get it. The underlying idea is that women may use their gender to secure employment. This stereotyped view may gain support in a labour market dominated by males.

In addition, the lack of employment also may lead to corrupt practices (or to what people perceive as unfair treatment) where the unemployed are forced to pay officials bribes in order to secure employment. This is illustrated in the in-depth interviews.

"*We have problems of jobs. There are no jobs here. To get a job you have to pay first. When you go to local authorities to ask for a 'declaration' (reference letter) they charge you a lot of money. For example, they know that I do not have that money, but as I need that declaration I have to get money anywhere and anyhow"*

(Urban non-married male, IDI # 16)

Indeed, some men reported that they had to engage in sometime illicit activities to pay the bribes which will allow them to secure employment and this puts them under enormous financial stress. The harsh living conditions may also impact negatively on their families. Some respondents highlighted that there are some families which manage to survive, but it is usually a minority. The following comment summarizes such a view.

"There are many pressures here. Families face many challenges; there is a lack of financial resources for their survival. The unemployment rate is very high. Of course that is not general, there are some families that manage to survive, but they are the minority because if we look at the district, not only in its headquarters, we see a lot of pressure, hunger and misery"

(Rural married male, IDI # 11)

Some respondents view the harsh living conditions (including the high levels of unemployment and poverty) as increasing vulnerability to risky behaviours including sexual risk taking. This association was drawn in one rural focus group discussions as the quote below illustrates.

"The main problem we face here is poverty. People are poor which makes them vulnerable to many problems including AIDS. Other problem is early marriage. Children get married at an early age because of their living conditions. In addition, poverty leads 'our' women to look for other means of gaining a living like sex"

(Rural married males, FGD # 12)

From the quotes above it can noted that the harsh living conditions make some men to engage in risky behaviours, particularly crime and drug abuse while the harsh living conditions sometimes push women to engage in transactional sex. These practices, in turn, may enhance risky sexual behaviours, which increases the risk of HIV infection. Indeed, when the respondents say "poverty leads 'our' women to look for other means of gaining a living like sex" this suggests that women are forced into transactional sex in order to survive.

The perspective of women

In both focus group discussions and in-depth interviews the women highlighted similar reasons raised by men regarding the factors which lead men to engage in risky behaviour. According to these women, male risky behaviours such as multiple sexual partnerships in particular and infidelity results from gender socialization (including what it means to be a man) which legitimates the risky sexual practices of men. Indeed, it seems that there exists two competing

views about what it means to be a man, although these views are not necessarily mutually exclusive. One associates manhood with loyalty, respect, hard work, family care and social responsibility. The other associates manhood with socio-economic and financial success. However, multiple sexual partners can also be associated with both economic success and 'loose' moral values, defined here as a set of practices or social conduct which can be regarded as socially unacceptable by some segments of society, particularly women. For this particular case, loose moral values could be characterized by lack of sexual responsibility. For example the following quote highlights irresponsibility as one of the defining features of "today's men"

"Men of today are different from the men of the past because, for instance, men actually are not loyal, they do not believe in what they say either. Sometimes they say that they do not want to do something wrong, but they get influenced by others".

(Urban non-married females, FGD # 10)

Meanwhile, the prevailing socio-economic and living conditions in the study areas are perceived as impacting differently on men and women. For example, some women felt that if a man does not work or earn an income this happens because of his own fault, unlike women who generally are not educated, therefore they cannot find employment.

"The problem of unemployment and poverty in this area does not have the same burden for men and women. A man is supposed to work. If he does not work, he may not be fine mentally. But for women it is very difficult to find a job. Many women are not educated like myself. God did not bless women. A woman was born to suffer. But if a man does not work, he does not want to work. He just suffers from his own inability"

(Rural non-married female, IDI # 04)

This quote provides two important insights regarding the social consequences of gender inequalities in the study areas and maybe within the Mozambique's society at large. One of the consequences is unequal access to opportunities. The lack of opportunities and their low socio-economic status makes some women feel powerless to change their situation. However, for this

respondent, it is inconceivable that a man could just remain without a job or a source of income. This interpretation is not surprising since men are seen as the provider and the main breadwinner. According to these female respondents, a man should at all costs, continue to fulfill his role as provider. Such views may exacerbate the social pressure on men to engage in risky activities.

The second view is that women are the most disadvantaged social group, particularly because they do not have access to education. This perception of woman as lacking an education is of particular interest. For example, the respondent perceives that women have relatively few economic opportunities. In addition, one of the obvious consequences of gender inequalities is that a woman may exchange sex for economic support. This seems to be happening in the study areas with severe negative sexual and reproductive health outcomes.

Furthermore, socio-economic difficulties were mentioned by the female respondents as contributing to an increase in crime and substance abuse by men. In this regard, they complained that women were often soft targets for criminals. They also talked about sexual assault. This was blamed on the rise of unemployment in the study areas.

"In this neighbourhood we are victims of robberies at gun point. For instance, yesterday, there was a house which was broken into. It was terrible. Sometimes people are assaulted at bus stops, and those who suffer the most are those coming back from school or work at night".

(Urban non-married females, FGD # 17)

"There is a lot of crime. For example, people who attend evening classes are constantly robbed, raped. There is a lot of violence. Girls and young women are those who suffer the most. When they meet a girl they steal their bags; their clothes are taken as well including their mobile phones"

(Urban non-married females, FGD # 10)

4.5 Summary

Gender norms and concomitant expectations are still playing an important role in defining both collective and individual agency in the study sites. Men and women are expected to behave (and they try to do so) in such a way that they conform to stereotyped notions of masculinity and femininity. Traditional notions of masculinity (and femininity) seem to continue to exert a strong influence on male attitudes and behaviour in gender relations, particularly the notion of masculinity which defines a man as the main provider and the figure of authority in the family. For example, respondents, both men and women, emphasized that in order to be viewed as a "real man" a man has to fulfill conditions that make him *visible* in the society. He must be in employment and also must take responsibility for the welfare of his wife and children.

These findings seem to be in line with what was reported in South Africa (Sideris, 2005). Sideris (2005) reports, for example, that among both men and women the status of manhood is conferred by having a wife and child, and establishing a home separate from one's parents. Therefore, the boys' aspirations to manhood always incorporated the imagery of becoming the head of family at some point in their life. For men and women it was clear that paternal authority included duties and obligations such as the responsibility of being a provider and protector of the family unit against external threats (Sideris, 2005: 122).

A man with a formal education and source of income has greater social visibility and respectability in the community. Of note is that these views are not confined to men. Women also stressed that a "real man" is the main provider and head of the family. Indeed, the image of 'true manhood' encompasses two important features among women. Firstly a man is defined by his economic role within a household which he performs by carrying out any activities which results in any kind of income, particularly financial income. Secondly by performing his traditional social duties and obligations such as taking care of family members and ensuring his authority in the household. Furthermore, for women it is also important to have a man who is approachable and sensitive to a woman's needs.

Meanwhile, men feel it is becoming very difficult to entirely fulfill their role of breadwinners as expected. The main reason pointed out as an obstacle for such lack of performance is that they do not find jobs and as a result securing their livelihood is very hard. This may have a direct impact on men's self-esteem. While the current, harsh socio-economic context reflected in high levels of poverty, unemployment and lack of opportunities seems to have a direct impact on men's sense of manhood, women however, perceived significant changes in men's character itself. For female respondents, the main aspect that would characterize men is that related to sexual behaviour. Men are perceived by women as less responsible in relationships and that they are much prone to multiple sexual partnerships. This has led to situations of risk taking, including risky sexual behaviour through multiple sexual partnerships which has increased recently.

These findings are somehow consistent with the findings reported in other sub-Saharan African countries (Silberschmidt, 2001; Agadjanian, 2005b). For example, the erosion of men's self-esteem resulting from socio-economic difficulties has been the object of extensive inquiry in sub-Saharan Africa in the recent years. Silberschmidt (2005) found in rural and urban East Africa that although the main axis of patriarchal power is still the overall subordination of women and dominance of men, the deteriorating conditions have seriously undermined the normative order of patriarchy in both Kisii and Dar-es-Salaam. While men have more relative freedom, compared to women, particularly in sexual and reproductive matters, lack of access to income earning opportunities has made men's role as heads of households and breadwinners precarious. With the majority of men reduced to 'figureheads' in households, men's authority has come under threat and so has their identity and self-esteem (Silberschmidt, 2005: 195). Similar trends have been reported in Mozambique (Agadjanian, 2005b). A study by Agadjanian (2005b) found that the deterioration of the labour market has forced men to seek employment in specific types of work that traditionally 'belonged' to women. For example, street vending has traditionally attracted less educated, poor urban women seeking cash employment, who are least likely to find better paid jobs elsewhere. However, men, forced out of the formal labour market, have been increasingly joining the ranks of the street vendors. As the cost of living continues to climb and wages stagnate, these jobs further erode the economic dominance of men (Agadjanian 2005b)

Moreover, both the socio-economic and macro-economic environment impacts differently on men and women. Sexual networking may serve two different goals for men and women. For men, for example, while sexual networking may express an alternative male identity construction through a collection of serial or concurrent sexual partners perceived nowadays as a integral part of men's character (see Hunter, 2005); for women it may serve as a pragmatic strategy to respond to the social and economic daily realities of their situation (Abdool Karim, 2001; Adimora and Schoenbach, 2005; Stratford et al., 2007).

Both the focus group discussions and in-depth interviews show clearly that socio-economic factors have played a major role in sexual behaviour risk taking. This finding seems to be in line with other study findings where the dominant notion of manhood in sub-Saharan Africa is generally associated with multiple sexual partners for men (Barker and Ricardo, 2005; O'Sullivan et al., 2007, Varga, 1997, 2001, 2003). The danger associated with multiple sexual partners has also been stressed. Studies have shown that multiple sexual partnerships increase the risk of HIV/AIDS, since the probability of being infected and infecting others is statistically high (Carael, 1995; Abdool Karim, 2005).

Gender norms and beliefs also influence male sexual risk behaviour. Some men tried to justify their behaviour by arguing that it is part of 'African culture' for men to have more than one sexual partner simultaneously. In addition, some men and women argued that the number of women exceeds the number of men; therefore it was acceptable for men to have more sexual partners. Some men argued that it was acceptable for them to have many sexual partners as it is good to have a balanced diet. Indeed, metaphors which tend to compare having different female partners with different types of food are part of such accounts to justify multiple sexual partnerships (Maharaj, 2004). In her study in Kwazulu-Natal, South Africa, Maharaj (2004) noted the tendency of men to change or alternate sexual partners as a way of balancing their "sexual diet". Maharaj (2004: 133) quotes one respondents as saying "a week or three … then I am through with her… it proves my manhood, as it is no use eating the same kind of food every

day." There is no doubt that this kind of attitudes may lead to sexual behaviour which put men and their partners at risk of HIV infection or other sexually transmitted infections.

Some women in the study sites were worried about the notions of masculinity that associate manhood with multiple sexual partnerships and were particularly critical of male sexual behaviour. They are aware of peer pressure and men's fears of being perceived by their peers as dominated by women among the leading factors for the risky sexual behavior of men. Some female respondents reiterated that the fear of being seen as under a woman's control or the fear of been seen as a 'bottled man' has contributed to male resistance to change since showing emotional affection, particularly love for a woman, may symbolize male weakness. Meanwhile it would be simplistic to say that some of those beliefs and gender stereotypes are only held by men. Empirical evidence from interviews with women show that the idea that there are more women than men in society as a moral justification for male multiple or extra-marital relations is also defended by women. On the other hand, the same gender norms put women in a subordinate position because they lack the power to negotiate safer sexual practices; women blamed themselves for their partners' behaviour since they are expected always to please their partners.

CHAPTER 5: PERCEPTION OF RISK OF HIV INFECTION

5.1 Introduction

Several studies have shown that a fundamental requirement for sexual behaviour change is a feeling of personal risk and vulnerability to HIV infection (MacPhail and Campbell, 2001; Asiimwe-Okiror et al., 1997; Sheppard et al., 2001; UNAIDS, 2008). In order for sexual behaviour change to occur, individuals must first realize and convince themselves that the benefits of changing behaviour clearly outweighs the costs (UNAIDS, 1999). In line with this, studies and intervention programs have shown and advocated that personal perception of risk of HIV infection is an important first step for the adoption of safer sexual behavior (UNAIDS, 1999; Eaton et al., 2003; MacPhail and Campbell, 2001). Studies suggest that greater awareness of AIDS does not necessarily translate into behaviour change, [which] suggests the need for greater consideration of socio-economic and cultural factors that influence sexual and reproductive behaviour (Varga, 2001; MacPhail and Campbell, 2001). In this regard, Mozambique has not been an exception (Karlyn, 2005).

The overall aim of this chapter is to investigate both awareness and knowledge of HIV/AIDS as well as self-perception of risk of HIV infection among both men and women in the study sites. The chapter starts by examining awareness of HIV/AIDS awareness and then it looks at perceptions of the severity of HIV/AIDS in the family and the community. Finally it concludes by assessing both self-perceived individual risk of HIV infection among men and women in the study sites and the factors influencing risk perceptions.

5.2 Awareness of HIV/AIDS

To assess both awareness and knowledge about HIV/AIDS, four questions were asked of the study participants during the survey: "*Have you ever heard of an illness called AIDS?"; "Is AIDS an incurable and fatal disease?"; "Is there anything a person can do to avoid getting*

HIV/AIDS?"; "What can a person do to avoid getting HIV/AIDS?" The first question is to assess general awareness about HIV/AIDS infection. The second question intends to ascertain whether or not respondents were fully aware of the danger of HIV/AIDS. The third question aims to assess awareness of the measures available to protect against the risk of HIV infection. The fourth question was to allow respondents to name the methods available which can be used to avoid the risk of HIV infection. Table 5.1 shows the percentage of respondents who reported that they have ever heard of HIV/AIDS.

Table 5.1: Percentage of respondents who have ever heard of HIV/AIDS and knew that it was a fatal disease

	Men		Women	
	n	**%**	**n**	**%**
Heard of HIV/AIDS				
Yes	208	99.5	216	99.5
No	1	0.5	1	0.5
N	**209**		**217**	
Know that it is an incurable and fatal disease				
Yes	207	99.5	184	85.2
No	1	0.5	27	12.5
Don't know	0	0.0	5	2.3
N	**208**		**216**	

As shown in Table 5.1, awareness of HIV/AIDS among respondents, in the sense that they have heard of a disease called AIDS, is almost universal. In fact, nearly all respondents (99.5%) of both sexes reported that they have ever heard of HIV/AIDS. However, men were more likely than women to know that AIDS is an incurable and fatal disease, with 99.5 percent of men reporting so compared with 85 percent of women.

Table 5.2 shows the percentage of respondents who believe that there are measures that can be taken to avoid getting HIV/AIDS. Those respondents who reported that there are measures that can be taken to avoid getting HIV/AIDS were then asked about specific measures to reduce the risk of HIV infection. Each measure was read out to the respondents and they had to say whether

or not they believed that specific measure could be used to reduce the risk of HIV infection. Table 5.2 indicates that the majority of respondents of both sexes believed that there is something a person can do to avoid getting HIV infection. Men were more likely than women to report that there is something a person can do to avoid getting HIV infection, with 96 percent of men saying so compared with 88 percent of women. On the other hand, women were more likely than men to be skeptical, believing that there is nothing a person can do to avoid getting HIV infection. Thirteen percent of women reported that there was nothing a person could do to avoid getting HIV infection compared with 4 percent of men.

Table 5.2: Percentage of respondents who believe that is there something a person can do to avoid getting HIV/AIDS and the measures that can be taken to avoid the risk of HIV infection

Is HIV infection avoidable?	**Men**		**Women**	
	n	**%**	**n**	**%**
Yes	200	96.2	189	87.5
No	8	3.8	27	12.5
N	**208**		**216**	
Measures to prevent the risk of HIV infection				
Abstain from sex	10	5.0	25	13.2
Use condoms	172	86.0	176	93.1
Avoid multiple sexual partners	110	55.0	50	26.5
Avoid sharing razors and blades	29	14.5	18	9.5
All	**208**		**216**	

Regarding the specific methods a person can adopt to protect himself or herself against HIV infection, the use of condoms, avoiding multiple sexual partners, abstaining from sex and avoiding sharing razors blades were the most frequently mentioned measures. However, differences can be seen between men and women. In this regard, women (93 percent) were more likely than men (86 percent) to mention the use of condoms as one of the strategies a person can adopt to avoid the risk of HIV infection. In addition, women (13 percent) were slightly more likely than men (5 percent) to mention abstaining from sex. Meanwhile, men (55 percent) were

more likely than women (27 percent) to mention that avoiding multiple sexual partners is one of the strategies to avoid getting HIV infection. Likewise, men (15 percent) were more likely than women (10 percent) to mention that by not sharing contaminated instruments like razors and blades the risk of HIV/AIDS could be avoided.

In order to assess accurate knowledge about HIV/AIDS, respondents were urged to give their opinion by approving or disapproving of a set of statements regarding HIV/AIDS. Table 5.2.1 presents the percentage of respondents who agreed with specific statements regarding HIV/AIDS.

Table 5.2.1: Percentage of respondents who agreed with specific statements about HIV/AIDS

Statement	Men %	Woman %
A person can get HIV/AIDS by having sexual intercourse with a condom	31.6	16.1*
A person can get infected with HIV/AIDS by using a sterilized needle	20.1	14.7
A person can get infected with HIV/AIDS through mosquito bites	38.3	21.7**
A person who looks healthy can be infected with HIV/AIDS	89.5	87.1**
People can protect themselves from HIV/AIDS by using condoms correctly every time they have sex	89.0	64.5**
People can protect themselves from HIV/AIDS by having one uninfected sex partner who also has no other sexual partners	90.4	67.3**
N	**208**	**217**

Note: * significant P < 0.05 percent; ** significant P < 0.01

It is noteworthy that women seemed to be more knowledgeable than men about the conditions under which one can get infected with HIV/AIDS. In this regard, women were less likely than men to agree that a person can get HIV/AIDS by having sexual intercourse with a condom, with about 16 percent of women agreeing with the statement compared with about 32 percent of men. Similarly, women were less likely than men to agree that a person can get infected with HIV/AIDS by using sterilized needles, with about 15 percent of women agreeing with this

statement compared with 20 percent of men. Again, women were less likely than men to agree that a person can get infected with HIV/AIDS through mosquito bites, with 22 percent of women agreeing with this statement compared with 38 percent of men.

Table 5.2.1 shows that men were more likely than women to report that a person who looks healthy can be infected with HIV/AIDS. Likewise, men were slightly more likely than women to report that people can protect themselves from HIV/AIDS by using condoms correctly every time they have sex. Eight-nine percent of men agreed with that statement compared with 87 percent of women. Moreover, the findings shown in Table 5.2.1 also suggest that men were more likely than women to report that people can protect themselves from HIV/AIDS by having sex with one uninfected partner who also has no other sexual partners. Ninety percent of men agreed with this statement compared with 67 percent of women.

To assess awareness and knowledge about HIV/AIDS the following question was asked during both focus-group discussions and in-depth interviews: *"Have you ever heard about AIDS? What do you think about it?"* The focus-group discussions and in-depth interviews findings confirmed that participants were aware of HIV/AIDS. The interviews confirm that both men and women have heard of HIV/AIDS.

Public awareness campaigns of HIV/AIDS have been indicated by respondents as one of the main source of information about HIV/AIDS. This can be illustrated in the following interview extract:

"Yes, we have heard of AIDS. AIDS is a sexually transmitted infection that we must fight against. It is said that it does not have a cure. We had a talk where some condoms were distributed. We have been advised not to use blades or other cutting instruments before sterilizing them".

(Rural non-married males, FGD # 15)

"I think AIDS affects everybody and everyone knows about it. We, young people in particular, are aware of AIDS because there are programs. Everything is about AIDS. All newspapers, radios and television programmes talk about AIDS."

(Urban non-married females, FGD # 10)

As it can be seen from the above interviews extracts, respondents are aware that AIDS is a fatal disease and that sharing unsterilized instruments (such as needles, blades, scissors, etc) may increase the risk of HIV infection. In addition, the media, particularly newspapers, radio and television play a significant role in creating awareness about HIV/AIDS. However, in some situations the general information about HIV/AIDS which is provided by the media is still not enough. They would prefer a direct and more personal approach that provides information on the modes of HIV transmission and the strategies to protect against this devastating disease. The quote below illustrates this sentiment.

"I believe that there is not enough information. Not to say that we do not know that AIDS exists, we know but we just need someone to direct us. So there is a problem of lack of information, although it is not a general problem".

(Urban non-married male, FGD # 18)

The interviews also suggest that in some situations, for example, a sudden change in one's physical appearance may trigger gossiping and suspicions of a possible illness, particularly HIV/AIDS. In this regard, it is likely to lead to judgments and speculation about the causes of death of loved ones and acquaintances, or about the illness they may have been suffering from. Such attitudes exacerbate stigma and fears of revealing the cause of death. The account below seems to support this interpretation.

"People have in mind that HIV/AIDS is real. I am sure about that because they are facing the harsh reality of losing their relatives. They may even know that although their relative did not do a blood test, external characteristics make them to conclude that he or she may have been infected by the 'disease of the century'.

(Urban married male, IDI # 17)

In addition, the transmission of HIV from mother to child has become a harsh reality in the community. This also has created greater awareness of HIV/AIDS

"There are many diseases. When we see a person getting thin we suspect that it might be AIDS. This is a very serious disease and what is worst is that we can even be infected by the disease not only through sex but also in hospitals. There are babies that are born with it".

(Rural married female, IDI # 01)

This quote indicates two important issues related to people's awareness of HIV/AIDS. The first is that because of the secrecy surrounding HIV/AIDS suspicions that certain individuals are living with HIV/AIDS (especially if they lose weight) may arise. Attitudes such as these may exacerbate stigma and discrimination. The second issue is that respondents are aware that sexual intercourse is not the only route of HIV transmission. What is striking is that health facilities are viewed with some suspicion. The fact that babies are usually born in hospitals or clinics including those who are born HIV positive, make some people think that the institution itself might be a place of transmission. Sometimes such negative attitudes are formed because some health facilities do not take the necessary precautions to maintain high hygiene standards.

In general, people are worried about HIV/AIDS and they are fearful of getting infected with it. But, at the same time, the adoption of protected sexual intercourse is an emotive topic. While unprotected sex may be a way of expressing intimacy, love and loyalty between partners, protective sex (e.g. condoms use) may raise suspicions of infidelity or promiscuity and mistrust, particularly in settings where there is no tradition of partner communication, a finding consistent

with other studies (Varga, 1997). The following comment seems to illustrate the doubts some respondents have with regard to personal perception of risk.

"In meetings everyone agrees that people should be careful. Condoms might even be distributed and the people accept them, but the point is whether people use them when the 'true time' arrives, I mean there, at the right moment [of having sex]"

(Rural married male, IDI # 18)

As can be noted, the quote above suggests that the biggest challenge facing both men and women is to translate knowledge into practice. That is, sticking to one partner, or reducing the number of partners or using condoms. In this regard, it is clear for the respondents that the challenge is not awareness of the modes of HIV transmission, but rather how people behave in their interpersonal relationships. Again, it would be misleading to think that people in interpersonal relationships decide everything according to their own volition. Studies have shown that the individual decision-making process is not a completely rational process. According to MacPhail and Campbell (2001: 1614), "the complex nature of sexuality means that individuals will conduct their sexual lives through experiences and beliefs that have been generated through their membership of a particular society and community."

Sometimes men and women may face a dilemma of complying with protective messages spread by awareness campaigns and the daily barriers they face in protecting themselves. For example, they may be aware of the risk posed by HIV/AIDS, but context-specific and other conditions including the location, the opportunity for sex or being under the influence of alcohol may prevent them from protecting themselves. In this regard, some respondents said that sometimes, when men and women are enjoying themselves, the youth in particular, they are less likely to be careful and take precautions against the risk of HIV infection.

"I think people are aware of HIV/AIDS, although I am doubtful. However, we, the youth, sometimes when we are enjoying ourselves, we do not care about condoms, but people are aware of HIV/AIDS".

(Rural non-married female, IDI # 09)

"I usually go out on Fridays to have a drink with my friends, in the "barracas" [shebeens], and I always get surprised with what I see there. I see people having sex in the public. It is possible that people do not know that their behaviour may lead to them getting infected with a disease".

(Urban non-married males, FGD # 18)

The quotes above suggest that although respondents are aware of HIV/AIDS, perception of personal risk of HIV infection may still be elusive for a large number of men and women. This may be a cause of concern in the context of a generalized HIV/AIDS epidemic.

5.3 Perceived Severity of HIV/AIDS in the Community

Studies suggest that perception of the seriousness of the HIV/AIDS pandemic in the community is important for sexual behaviour change (UNAIDS, 1999; 2008). In this study, perceived severity of HIV/AIDS in the community was investigated. To that end, two questions were asked to measure to what extent study participants perceived the severity of HIV/AIDS in their areas. The first question was "*Do you personally know anyone who is infected with HIV/AIDS"* The second question asked was "*Do you personally know anyone who died or you think has died of AIDS"* Table 5.3 present the percentages of respondents who reported that they knew someone infected with HIV/AIDS or died of AIDS.

Table 5.3: Percentage of respondents who reported that they knew someone infected with HIV/AIDS or died of AIDS

	Men		Women	
	n	**%**	**n**	**%**
Know someone infected with HIV				
Yes	46	22.1	75	34.7
No	162	77.9	135	62.5
Not sure	0	0.0	6	2.8
Knew someone who died or suspect has died of AIDS				
Yes	110	52.9	109	50.5
No	98	47.1	87	40.3
Not sure	0	0.0	20	9.3
Total	**208**		**216**	

Table 5.3 shows that few men and women reported knowing someone who is infected with HIV/AIDS. This is not surprising, since secrecy is still one of the major obstacles to behaviour change. Studies have shown that fear of stigma, discrimination and social marginalization increase HIV risk and vulnerability (UNAIDS 2008). Research suggests that stigmatizing attitudes to HIV and those most at risk of HIV infection derive from two main sources. The first is fear of contagion, which is an important source of disease-related stigma through the ages. The second is negative, valued-based assumptions about people living with HIV, which intensifies prejudice and discrimination (UNAIDS, 2008). In addition about half of both men and women reported that they knew someone who died or they suspect had died of AIDS which is of particular note. In this regard, women were more likely than men to report that they knew somebody who was currently infected with HIV/AIDS. This may be due to the fact that, in general women are caregivers and may be more exposed to those who suffer from health problems including HIV/AIDS. In addition, women may share information about people's health problems both with families and other community members.

About 35 percent of women reported knowing somebody who was infected with HIV/AIDS compared with about 22 percent of men. Similarly, half of respondents of both sexes reported that

they knew someone who died of HIV/AIDS or they suspected the death was caused by HIV/AIDS. In this regard, about 53 percent of men reported that they knew someone who died or they suspect had died of AIDS compared with 51 percent of women. These findings confirm that the impact of HIV/AIDS within communities has become a sad reality which, in principle, would encourage or compel men and women to adopt protective behaviour. However, it seems that conflicting values and gender norms including the tradition notions of masculinity which encourage men to seek multiple sexual partnerships and the association of condoms with illicit sex and disease may constitute the big challenges hampering men and women from adopting safer sex practices

To assess their perceptions about the severity of HIV/AIDS in the community, respondents were asked during focus groups discussions and in-depth interviews about the seriousness of HIV/AIDS in the study areas. They were also asked whether they felt confident that both men and women were taking all the necessary precautions to curbing the HIV/AIDS pandemic in their communities. In both the study sites, HIV/AIDS was seen as a very serious problem. In some situations the high levels of morbidity and mortality had become an undisguised reality in the community. They argued that this was because many people, particularly women, were falling sick and even dying. This is well illustrated in the following quote:

"In this area, people know of this disease, because of people who come from South Africa are already sick [mine workers]. We have seen great numbers of people coming back from there without life. People start believing that this is real. Even in meetings, the first thing we talk about is about this disease. We have received information from brigades that talk to us about this. Therefore the people are aware about it. The disease is killing a lot of people".

(Rural married females, FGD # 04)

The perception that the HIV/AIDS epidemic is very serious is also clear among respondents who witnessed the death of acquaintances and loved relatives. In addition, some men and women were caring for children orphaned by HIV/AIDS.

"We have a problem in Trevo neighbourhood. We have plenty of orphaned children because of AIDS. In fact, we are losing our children to this disease. In my block there are six people who are infected with HIV/AIDS and it seems that only one is taking treatment."

(Urban married female, FGD # 04)

"I had a brother- in- law who was a truck driver. We used to tell him to be careful when you are on the road", but unfortunately he died. He was a victim of AIDS."

(Rural married male, IDI # 11)

This quote may serve as a clear example of the impact of HIV/AIDS on families and community. On the other hand, however, it may reinforce the association of HIV/AIDS with particular groups of people such as truck drivers, sex workers, mine workers, etc. While these categories of people are vulnerable to HIV infection as the quotes show, the attitude that HIV/AIDS affects others may have some unintended consequences encouraging some people who are neither truck drivers nor mine workers, for example, to think that they are at low or no risk of HIV infection.

Furthermore, the widespread perception that the level of HIV/AIDS in the community is severe is also demonstrated by the comments of one HIV positive respondent who observed that there are many people in the community with similar physical symptoms as him.

"There are many cases here, but if a person does not tell you something, or does not do the test you will never know that he or she has this disease. But yes, there are many cases here. We suspect HIV/AIDS when a person falls sick and does not get better, or when we see infections that cause death".

(Rural married male, IDI # 13)

5.4 Perceived Personal Risk of HIV Infection

Perception of risk of HIV infection is understood as an important predictor of safe sexual behaviour, therefore, a precursor to sexual behaviour change (Sheppard, 2001; Kibombo et al.,

2007). To assess self-perceived risk of HIV infection respondents were asked: "*Do you think your chances of getting HIV/AIDS are great, moderate, small, or no risk at all?"* Table 5.4 shows the percentage of respondents by self-perceived risk of HIV infection.

Table 5.4 suggests that most respondents reported a low self-perceived risk of HIV infection. But men were more likely than women to report themselves at great or moderate risk of HIV infection. Almost equal proportions of men and women reported feeling little or no risk at all. On the other hand, women were more likely than men to report that they did not know if they were at risk of HIV infection. Thus, as can be noted in Table 5.4, 32 percent of interviewed men reported feeling that they were at great risk of HIV infection compared with 16 percent of women. Seventeen of men reported feeling at moderate risk of HIV infection compared with 8 percent of women.

Table 5.4: Percentage of respondents by self-perceived risk of HIV infection

	Men		**Women**	
	n	**%**	**n**	**%**
Level of perception of risk of HIV				
Great	66	31.6	35	16.1
Moderate	36	17.2	18	8.3
Small	76	36.4	70	32.3
No risk at all	8	3.8	24	11.1
Living with HIV	2	1.0	0	0.0
Don't know	21	10.0	70	32.3
Total	**209**		**217**	

Of interest is the fact that quite a significant proportion of women were unable to report or specify the extent to which they perceived themselves at risk of HIV infection. Indeed, almost 32 percent of women in both study sites said that they did not know whether or not their chances of getting HIV infection were high, medium or even low compared with 10 percent of men. On the other hand, about 36 percent of men were more likely to report little risk of HIV infection compared with 32 percent of women. Furthermore, about 4 percent of men reported that they did not feel at risk of HIV infection at all compared with 11 percent of women. These findings seem

to be consistent with another study in Mozambique (Arnaldo, 2004). Two explanations can be made for these findings. First, differences in self-perceived risk of HIV infection suggests that, on one hand, the majority of women do not perceive themselves at risk of HIV infection, which may just reveal low risk perception of HIV infection among women. If this is true, these findings are very worrying in the current context of a generalized epidemic and low levels of voluntary counseling and testing. Second, self-perception of risk of HIV infection among men may reflect their own risky sexual behaviour (Maharaj, 2004; Kibombo et al., 2007). In other words, men who usually report risky sexual behavior are more likely to be aware that they are at risk of HIV infection.

To assess the association between perception of risk of HIV infection and each of the selected socio-economic and demographic characteristics, a bivariate analysis was applied. The selected background characteristics include place of residence, age, level of education, marital status, household socio-economic status, and number of sexual partners in the last 12 months. Household socio-economic status was assessed using the Amenities Possession Index. The Amenities Possession Index comprises three values, namely low API, lower medium API and upper medium or high API. Respondents who reported that they were HIV positive (two males) were excluded from the analysis since it was felt that the question was not relevant for them. Table 5.5 shows the percentage of respondents who reported great or moderate risk of HIV infection, by selected background characteristics.

The bivariate analysis indicates that place of residence and education has a strong association with self-perceived risk of HIV infection among women. Among men, however, no association is found. Looking at each one of the variables for men, the results indicate that rural men are slightly more likely to report being at great or moderate risk of HIV infection than urban men, with 51 percent of rural men reporting so compared with 47 percent of urban men. Men aged less than 35 years were also more likely than men aged more than 35 years to report being at great or moderate risk of HIV infection. Almost 51 percent of men aged less than 35 years reported being at great or moderate risk of HIV compared with 47 percent of men aged 35 or more years. Education seems to have some influence on perception of risk among men, but the relationship is

not significant. Thus, 52 percent of men with secondary or higher education report being at great or moderate risk of HIV infection compared with 47 percent of men with less than secondary education. Men who were neither married nor cohabiting were more likely to report a higher risk of HIV infection than married and cohabiting men. On the other hand, men with a higher socio-economic status were more likely to report a higher risk of HIV infection than men with a lower socio-economic status. Men who reported two or more partners were more likely than men with one partner to report a higher risk of HIV infection. This may suggest that respondents are aware of the risk associated with multiple sexual partnerships, but this association was not significant.

Table 5.5: Percentage of respondents who reported a moderate or high risk of HIV infection, by selected background characteristics

	Men		Women	
	n	%	n	%
Background characteristics				
Place of Residence				
Urban	106	47.2	111	32.4*
Rural	101	50.5	106	16.0
Age				
Less than 35	134	50.7	159	24.5
35 or more	73	46.6	56	25.0
Level of Education				
Less than secondary	125	47.2	157	19.7*
Secondary or higher	82	52.4	60	36.7
Marital Status				
Currently married/ Living together	136	48.5	120	20.0
Neither	71	50.7	97	29.9
API				
Low	43	41.9	67	19.4
Lower medium	58	50.0	50	22.0
Upper medium/high	106	51.9	100	29.0
Number of sexual Partners				
1	115	45.2	201	22.9
2 +	91	53.8	16	43.8
All	**207**		**217**	

Note: * significant P < 0.05 percent

The bivariate results for women suggest that urban women (32 percent) were more likely to report being at great or moderate risk of HIV infection than their rural counterparts (16 percent). Table 5.5 shows no clear difference in reporting great or moderate risk of HIV infection among women by age. Indeed, women aged 35 years or more were as likely as the women aged less than 35 years to report being at great or moderate risk of HIV infection. Level of education has a strong effect on perception of risk of HIV infection among women. Women with secondary or higher education were more likely than women with primary education and those with no education to report a great or moderate risk of HIV infection. Thirty-seven percent of women with secondary or higher education reported a great or moderate risk of HIV infection compared with 20 percent of women with less than secondary education. Thus, as with place of residence, education is statistically significant for women. Marital status, although not statistically significant, also seems to influence self-perceived risk. Women who were neither married nor cohabiting (30 percent) were more likely to report a higher risk of HIV infection than married and cohabiting women (20 percent). Of interest is that women who reported two or more partners in the past 12 months were more likely than those with one partner to report a higher risk of HIV infection. This suggests that these women are aware of the implications of engaging in multiple sexual partnerships. However, other underlying factors may impel them to engage in multiple sexual partnerships. These results conform to what other studies have found with regard to some of the factors influencing perception of risk of HIV infection among women such as place of residence and level of education (Sheppard et al., 2001).

To investigate more thoroughly the factors influencing perception of risk of HIV infection among men and women, a logistic regression analysis was applied to assess the determinants of great or moderate risk of HIV infection. Thus, risk perception of HIV infection is the dependent variable with two values. If a respondent reported a great or moderate risk of HIV infection that value was coded “1” and it was coded “0” otherwise. The independent variables are place of residence, age, level of education, marital status, household socio-economic status and number of partners in the past 12 months. Two separate models were fitted for men and women. In Model I, the logistic regression analysis assesses the effects of each independent variable without controlling for other

variables. In Model II, the odds ratios of each variable are presented after controlling for other factors. Results are presented in Table 5.6 for men and Table 5.7 for women, respectively.

The logistic regression analysis results for men show that none of the characteristics have a statistically significant unadjusted effect on perception of risk of HIV infection. Nonetheless, more educated men are more likely to report a higher perceived risk of HIV infection than less educated men. Men with secondary or higher education were more likely to report a higher risk of HIV infection (odds ratios = 1.23).

Table 5.6: Odds ratios for men who reported a moderate or high risk of HIV infection by selected characteristics: logistic regression results

	Odds ratios and 95% confidence intervals	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	1.19 (0.69 – 2.05)	1.65 (0.79 – 3.45)
Age		
Less than 35	1.00	1.00
35 or more	0.85 (0.48 – 1.50)	0.87 (0.46 – 1.64)
Level of Education		
Less than Secondary	1.00	1.00
Secondary or higher	1.23 (0.71 – 2.16)	1.25 (0.63 – 2.45)
Marital Status		
Married/ living together	1.00	1.00
Neither	1.09 (0.61 – 1.94)	0.97 (0.48 – 1.97)
API		
Low	1.00	1.00
Lower medium	1.39 (0.63 – 3.08)	1.45 (0.64 – 3.29)
Upper medium/high	1.50 (0.73- 3.06)	1.93 (0.79 – 4.69)
Number of sexual Partners		
1	1.00	1.00
2 +	1.41 (0.81 – 2.46)	1.39 (0.79 – 2.45)

Note: * significant P < 0.05 percent

Similar trends are observed with regard to marital status, household socio-economic status and number of partners in the past 12 months. For example, men who were neither married nor cohabiting were more likely than married and cohabiting men to report a higher risk of HIV infection. Men with a higher socio-economic status were also more likely to report a higher risk of HIV infection than men from a lower socio-economic status. Similarly, men who reported two or more partners were more likely than men with one partner in the last 12 months to report a higher risk of HIV infection (odds ratios = 1.41). After controlling for other variables, none of the independent variables have a statistically significant adjusted effect on perception of risk of HIV among men.

Table 5.7 shows the odds ratios of women who reported a great or moderate risk of HIV infection. The results of Model I show that place of residence and education have statistically significant unadjusted effects on self-perceived risk of HIV infection. Thus, women living in rural area were less likely than those living in urban area to report a higher risk of HIV infection (odds ratios = 0.40). Similarly, women with secondary or higher education were two times more likely than those with less than secondary education to report a higher risk of HIV infection (odds ratios = 2.35).

Table 5.7: Odds ratios for women who reported a great or medium risk of HIV infection by selected characteristics: logistic regression results

	Odds ratios and 95% confidence intervals	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	0.40* (0.20 – 0.78)	0.52 (0.22 – 1.24)
Age		
Less than 35	1.00	1.00
35 or more	1.03 (0.51 – 2.08)	1.52 (0. 69 – 3.35)
Level of Education		
Less than Secondary	1.00	1.00
Secondary or higher	2.35* (1.22 – 4.54)	1.67 (0.76 – 3.68)
Marital Status		
Married/ living together	1.00	1.00
Neither	1.71 (0.91 – 3.18)	1.51 (0.77 – 6.20)
API		
Low	1.00	1.00
Lowe medium	1.17 (0.46 – 2.89)	1.26 (0.49 – 3.23)
Upper medium/high	1.70 (0.81- 3.57)	0.10 (0.41 – 2.42)
Number of sexual Partners		
1	1.00	1.00
2 +	2.62 (0.93 – 7.42)	2.06 (0.69 – 6.20)

Note: * significant P < 0.05 percent

Other variables do not have a statistically significant unadjusted effect on perception of risk of HIV infection. Meanwhile, after controlling for all variables, place of residence and education are no longer statistically significant. This is of interest because it suggests that people's attitudes and behaviour are influenced by a multitude of factors where a given direction caused by one factor may change or lose its strength as a result of an interaction of different factors.

During the focus group discussions and in-depth interviews the questions related to the perception of risk of HIV infection among men and women who participated in the study were asked as follows: *"Do you think that both men and women in this area are aware of the risk of HIV infection?"* The empirical evidence from both focus group discussions and in-depth

interviews indicate that in general men and women perceived themselves at risk of HIV infection. Interestingly, however, neither men nor women associated their risk of HIV infection to their own sexual behaviour. They felt that they were at risk of because of their surrounding circumstances such as the harsh living conditions as well as their partner's sexual behaviour. Several accounts from the interviews suggest that male control of economic resources, particularly money, seems to play a critical role in exposing them and their partners to the risk of HIV infection. It was highlighted during the interviews that a man even with just a 'little' money may feel that he is in a position to easily meet or satisfy his sexual needs. For example, some men during focus group discussions argued that when a man has even a 'little money' and meets a woman in the street he feels empowered to just 'take' her to have sex. This can be illustrated in the quote below.

"When a man has got his 'little of money' and meets a woman in the street he just takes her to have sex. Sometimes, he does not carry a condom to protect himself. The same thing might happen tomorrow and after tomorrow. This may increase their risk of HIV infection".

(Urban non-married males, FGD # 17)

Denialism seems to be another obstacle to personal perception of risk of HIV infection. It seems that the majority of respondents had heard of AIDS and was aware of the dangers of unprotected sexual intercourse and some also knew people living with HIV/AIDS but they did not feel personally at risk of HIV infection.

"Nowadays the slogan is 'be faithful to one another'. But it seems that both men and women are competing in having sexual partners. But if they do this, they must use condoms. They must like their bodies, and avoid diseases. I think there is a kind of 'ignorance' among people. My brother-in-low usually says: 'AIDS does not exist'. So it is not because people do not have information. It is not because he does not hear or he does not see. I have relatives who have already died of AIDS. When he is told that this might be HIV/AIDS, he just refuses. He says: 'no, it is not'. When he goes to the hospital, I ask him what the doctor said, he answer: 'the doctor

said nothing'. The big challenge is that people blame witchcraft or they feel that they will never get infected. They tend to think that it happens to others".

(Urban non-married females, FGD #02)

There is a tendency for some people to pretend that HIV/AIDS is not their problem, but 'a problem of others'. In other words, they will 'deny' the problem and rather evoke supernatural forces such as witchcraft as the cause of their illness. However, denialism is directly related to fear of stigma and discrimination. In a society in which beliefs about witchcraft are still strong, if one can manage to sell the idea that they are the victim of witchcraft, the society will take pity on them, but if they are perceived to be suffering from HIV/AIDS, the society will blame them and they will experience feelings of embarrassment and shame.

Furthermore, fatalistic ideas may exacerbate low perceived risk of HIV/AIDS. In addition, personally knowing someone who was either living or had died of AIDS may lead some people to think that death is inevitable, it is better to die having had sex instead of dying without having had sex. In this regard, sex is viewed as the ultimate reward before death arrives.

"We know that AIDS exists. But when you have a chance to have sex, you just forget it. I had gonorrhoea twice. The first time I had it, I started feeling the symptoms two days after having had sexual intercourse. I went to the health care centre and they told me that I had gonorrhoea and they gave me a prescription. I followed the prescription and I told my girlfriend to go there and she also followed the prescription. After some time, I had sex with her again and I was again infected. I do not know whether I was careless or the medicine they gave me was not helping but the truth is that I had another treatment, it was then that I learned that I had to use condoms".

(Urban non-married men, FGD # 18)

"Sometimes we have unprotected sex because we have in mind that we will die anyway whether we will use condoms or not. So why should we use them? When I talk with my friends

and we discuss AIDS, some ask why we should use condoms. If we are going to die, we rather die with a full stomach"

(Urban non-married men, FGD # 18)

These two quotes encapsulate graphically the many contexts of sexual risk that men, particularly young men experience in the study sites. For example, the respondent told his personal sexual stories in a focus group discussion with a little bit of pride. He talked about the two times he got a sexually transmitted infection which shows that he is a man and he has had sexual intercourse regularly, even if in a dangerous way. He shows no remorse for his risky sexual behaviour. In addition, he speaks about some of the conversations he has had with peers about the real need for using condoms. In order to minimize the importance of condoms, he and his peers evoke the inevitability of death. If condoms are available they can be used, but if not, they will prefer to have sex without a condom instead of postponing having sex.

Sometimes women do not think about their personal risk of HIV infection. They are more concerned about surviving in the face of difficult socio-economic conditions. This is particularly true for some women for whom securing a relationship is more vital than trying to impose some conditions in their relationships. The quotes below may illustrate this.

"Look, I have a sexual relationship with a married man. I cannot prohibit him to have other partners, because when we started this relationship, he already had others. We do not use condoms"

(Rural non-married female, IDI # 04)

"I think sometimes, a married woman is afraid to demand her husband to use a condom because she may end up being beaten. For the husband, her request may be understood as lack of trust. In addition, if they had children, they have to explain to one another why condoms are now necessary in the relationship"

(Urban married female, IDI # 08)

In some situations the severity of the HIV/AIDS pandemic and the risk that it poses for all residents may be attributed to the fact that the area is characterized by high mobility of people in search of employment.

"This area is very famous because people say that there are many jobs around. What happens is that a person may come to work while he is alone and he may become infected and infects all of us. There is no place where we can do HIV tests here, so we do not know how many of us are infected or not"

(Rural non-married males, FGD # 15)

As it was highlighted previously, in the rural site of this study, the main economic activities are predominantly agricultural, namely small farming and industrial farming. Manhiça district is the site of two important sugar cane plantations, where people from different locations of the country come to find employment. Therefore, these respondents may be describing daily situations where migrant employees of both Maragra and Xinavane sugar cane plantations have sexual relationships with locals, particularly local women. Of interest in this quote is that the respondents identify the possible source of sexual risk (unknown migrants with unknown sexual histories) and their sexual relations with the locals, but no reference is made to protective practices.

Some men, however, understood that the risk of HIV infection depended on their own sexual behaviour rather than on surrounding circumstances. Thus they feel that it is important for men to be careful and behavior responsibly.

"I am aware that there is the risk of catching the disease in any occasional relationships. But not all of us are aware of that. I am conscious that if I play with fire I will get burnt and that is why I do not take risks. I love my wife and I like the life I live, if I take the risk the ones to be harmed would be my children."

(Urban married males, FGD # 13)

Furthermore multiple sexual partnerships are understood by some men as an easy way to get infected with HIV/AIDS, Even though, men may not perceive themselves at risk of HIV infection because of their own sexual behaviour, they are worried about the risk posed by their female partners.

"A man who has, for instance, five wives or sexual partners he does not have total control over them. So, because they are many it is easy to be contaminated"

(Urban married males, FGD # 14)

In the above quote, two different perceptions with regard to multiple sexual partnerships can be explored. The first is that in the past, having more than one partner or being in a polygamous relationship was seen as a symbol of status, and a man who had more than one partner (or spouse) was seen as having the ability to control these women, which in turn gave him social prestige. That is why the respondent suggests that a man should be able to control his wives. The second perception is that although having multiple partners may elevate the status of the man among his peers, sometimes he may fail to control his partners. Sometimes men have so many sexual partners it is difficult to control the behavior of all their partners. Some of their partners may not be faithful, and therefore, they are putting themselves at risk of HIV infection. As it can be seen, the respondent is aware of the risk of HIV infection due to multiple sexual partnerships, but he highlights the possible deviant sexual behaviour of women as a source of risk.

Meanwhile, other participants observed that both men and women run the risk of getting infected with HIV because of infidelity. Nevertheless, they observed that it is the man who should take responsibility for protecting himself and his partner because he can – unlike a woman.

"Both [men and women] can spread the disease, but as a man you know how to prevent and she does not. HIV/AIDS affects when there is no trust, I must trust my wife and so she has to trust me. Nowadays what spreads the disease is lack of faithfulness, if we are not faithful to each

other we can easily have lovers and we can have unsafe sex. If I catch the disease I will pass it to her."

(Urban married males, FGD # 13)

These respondents recognize that one of main causes of HIV infection in stable relationships is the infidelity of one or both partners. Again, they recognize that sexual relationships outside the stable relationships are not always protected. Therefore, it is clear that if protective measures are not adopted in casual or irregular relationships, they are less likely to be adopted in stable relationships.

During the interviews many women, unlike men, reiterated that they run the risk of getting HIV infection mainly because of their partners' sexual behaviour. But they also noted that it could happen if a woman falls in love with a partner that has other partners. According to these women, falling in love with a man who has many sexual partners creates a dilemma: trust the man and do not insist on condoms or do not trust the man and insist on condoms.

"*From what I see, I think that is the man who infects us because they have many partners. Truly speaking, a girl can fall in love with a man who used to have sex without condoms. If she accepts to have unsafe sex with him, probably she will be infected, but if she trusts in condoms she will not be infected".*

(Rural married female, IDI # 04)

The quote above raises three important issues related to relationships. The first is that the respondent highlights the fact the men are generally perceived as having many sexual partners. The second is the notion that if a woman falls in love with such a man, she runs the risk of HIV infection because being in love means showing trust through unprotected sex – unprotected sex is seen as an expression of love. The third issue is related to the conflict facing women (but also men) regarding the role of condoms in relationships. Studies have shown that the introduction of condoms may create conflict in a relationship. The negative image of condom which is associated

with promiscuity and infidelity prevent both men and women from using them as a prophylactic measure (Varga, 2000; Bond and Dover, 1997).

Some women did not hesitate to say that their partners' extra marital sexual relationships were a matter of concern, since they might get involved with girls who might have also been involved with migrant workers. This was particularly highlighted in the Manhiça district where there are high levels of mobility because of the sugar cane industries. Once again, the extramarital sexual relations of men are seen as the main source of risk of HIV infection for women.

"We are all running the risk of being contaminated especially because there is a company nearby and lots of foreigners come and they might get involved sexually with the girls, contaminate them and, our husband in turn, might also have sex with them"

(Rural married female, IDI # 02)

Another stereotype which could be dangerous in terms of exacerbating stigma and discrimination is that of seeing migrants workers or 'foreigners' – not necessarily from other countries, as HIV/AIDS carriers. The quote above draws a clear image of sexual networking. It suggests that there is a pool of local young women who might have sex with sugar cane migrant workers and local married men. In a context of low condom use, it is not surprising that some women feel themselves at risk of HIV infection from their partners.

Sexual freedom that men generally enjoy in society has become a matter of strong concern for women. They expressed their anxiety over whether or not their partners engage in protected sexual intercourse in their extramarital relations. Women fear that they are at risk of HIV infection because of their partners' sexual behaviour.

"*We do not know the kind of woman he goes out with, maybe those women have health problems, and they are ill [with a STI] and have sex with him. For example, my boyfriend who I am dating for a long time, I cannot use condom with him, and he comes from where he comes*

from and he may give me diseases. If he starts being unfaithful to me, I do not care about him anymore, because perhaps he has a certain disease that he will bring to me.

(Rural married female, FGD # 01)

The quote above highlights the respondent's awareness of risk of HIV infection, as well as the male partner as a source of risk. However, it is important to note that until she decides to end the relationship which she perceives as risky it could be simply too late, because unfaithful partners tend to hide their extramarital or casual relationships.

Similar views about risk perceptions were highlighted in the in-depth interviews. One respondent observed that her sexual partner spends a great deal of time away from home.

"For me the major problem is AIDS. I am afraid to die even if I know I will die and everyone else will die but I will not look for death for myself now that I know that there is this disease called AIDS. I would rather die because of another disease or by a car accident not because of AIDS. That is why I insist on the use of condoms. To avoid arguing with my husband because he insists that he does not have outside lovers, when he is having a bath I put a condom in his blazer pocket."

(Urban married female, IDI # 06)

But not all women see the risk of HIV infection as resulting only from their partners' sexual behaviour. Some women acknowledged that the migration of people into the area in search of jobs is also a risk factor, because they get involved with people they 'may not know very well', and the fact that many people do not know their own HIV status becomes a source of risk.

"There are a lot of people coming from different places, including South Africa, who come to our village. We meet these people and we have sex with them without knowing whether they are infected or not. It has been difficult for people to go Manhiça just for a blood test. So people do not know if they are HIV positive or not."

(Rural non-married females, FGD # 08)

As it can be seen in the quote above, despite the concerns about relationships with unknown people and the awareness of the risk of HIV infection, protective measures are not mentioned. However, it is important to note that respondents also highlighted the difficulties in accessing facilities for HIV testing. In this particular case, the respondents suggest that it is very costly to travel to Manhiça district headquarters in order to conduct a blood test because it is far and, of course, they require money for transportation.

5.6 Summary

Nearly all respondent have heard of HIV/AIDS which suggests that public health awareness campaigns having been relatively successful in raising awareness of the epidemic. Irrespective of age and gender, respondents said that people in the community were becoming ill and were dying because of HIV/AIDS. Nevertheless, participants recognized that neither men nor women seemed to have changed their sexual behaviour. A number of studies have also found high levels of awareness of the risk of HIV/AIDS but limited behaviour change in sub-Saharan Africa (MacPhail and Campbell, 2001; Maharaj and Cleland, 2004; Karlyn, 2005; National Institute of Statistic, 2005).

Indeed, if behaviour change depended only on levels of awareness, the current scenario of HIV infection in sub-Saharan Africa would be different. In this study, for example, almost all men and women have heard of HIV/AIDS. However, although not surprising, men were more likely than women to be aware of the incurability and lethality of HIV/AIDS. Overall, both men and women believe that there is something a person can do to avoid getting infected with HIV. Protective behaviour such as use of condoms, avoiding multiple sexual partners and abstaining from sex were the most commonly mentioned strategies. Women were more likely than men to mention that abstaining from sex can protect one from getting infected. Awareness of the severity of HIV/AIDS in the community was also assessed. Interestingly, women were more likely than men to admit knowing someone who is infected by HIV/AIDS. In addition, nearly half of all the

interviewed men and women said that they already knew someone who had died or they suspect that he or she might have died of AIDS.

Overall, these findings are in line with what other studies have observed about the levels of awareness of HIV/AIDS among sexually active men and women in sub-Saharan Africa including Mozambique (Mozambique Demographic and Health Survey, 2003, Arnaldo, 2004; Kibombo, Neema and Ahmed, 2007, Maharaj, 2004; Sheppard et al., 2001; Smith and Watkins, 2005). In their study in rural Malawi, Smith and Watkins (2005) found that rural Malawians were aware of the risk of HIV infection and seemed to assess with some degree of accuracy their own personal risk, either because of their own sexual behavior or their partner's sexual behavior. During public conversations Malawians were able to identify the main routes of infection, and prevention strategies. They found that women are worried about the risk of HIV infection from their husbands, while men are more worried about the risk of HIV infection from their extramarital partners. In their study, Smith and Watkins (2005) observe that the primary prevention strategies of women centre around marriage: encouraging their husbands to be careful while men emphasized the importance of reducing their number of sexual partners, and focused on informed partner selection.

The perception of personal risk of HIV infection is deemed an important precursor for sexual behaviour change including the adoption of protective practices (Cleland, 1995; Maharaj, 2004; Sheppard et al., 2001; Kibombo, Neema and Ahmed, 2007). The results of this study concerning perception of risk of HIV infection seem to be mixed and somehow contradictory. For example, contrary to other study findings in sub-Saharan Africa where women are more likely to report great or moderate risk of HIV infection (Maharaj, 2004; Sheppard et al., 2001; Smith and Waltkins, 2005) the survey findings suggest that women have a lower risk perception of HIV infection than men. While nearly half of men admitted that they felt themselves at moderate or high risk of HIV infection, only a quarter of women reported that they felt themselves at moderate or high risk of HIV infection. It is of particular interest that a number of women were unable to say whether or not they were at moderate or high risk of HIV infection. Indeed, in a context where perception of risk is deemed important as a prerequisite for one to adopt protective

practices (Sheppard et al., 2001, Maharaj, 2004), this figure is somehow astonishing and, it may reveal that there are other underlying causes of the spread of HIV infection in the study sites. It can be recalled here that the rates of HIV infection in both sites are 25 percent in Manhiça district and 19 percent in Matola municipality, respectively (Ministry of Health, 2005). On the other hand, qualitative findings suggest that women during both the focus group discussions and in-depth interviews showed great concern about contracting HIV infection from their marital, cohabiting or regular partners. The findings of this study regarding low perception of risk of HIV infection among women are quite consistent with the findings of a research also conducted in Mozambique (Arnaldo, 2004). In this study in Mozambique, Arnaldo (2004) found that individual perception of risk of HIV infection was higher among men than among women.

In this study, perception of risk was assessed taking into account its association with demographic and socio-economic characteristics. The demographic and socio-economic characteristics included place of residence, education, age, marital status and household socio-economic status. For men, the demographic and socio-economic characteristics did not have any association with perception of risk of HIV infection. For women, two different pictures emerged. First, a significant proportion of women did not perceive themselves at risk of HIV infection – an unexpected result. Second, for women, the findings indicate that place of residence; age and education are important predictors of perception of risk of HIV infection. For example, women with higher level of education were more likely than less educated woman to perceive a great or moderate risk of HIV infection. In addition, the qualitative results suggest that women may feel at risk of HIV infection not because of their own sexual behaviour, but their partners' sexual behaviour. These findings are in line with what other studies have found regarding perception of personal risk of HIV infection of women (Maharaj, 2004; Sheppard et al., 2001). For example, Sheppard et al., (2001) found that women in both Ghana and Uganda reported feeling at greater HIV risk than men. However, they felt at risk not because of their own behaviour but their partners' sexual behaviour. In addition, although women perceived themselves at greater risk than men, they felt unable to change their behaviour due to their more subordinate position in society and particularly in sexual relationships (Sheppard et al., 2001). This seems to the case in Matola city and Manhiça district.

CHAPTER 6: CONDOM KNOWLEDGE, ATTITUDE AND USE

6.1 Introduction

In the absence of a vaccine, consistent and correct use of the male condom has long been recognized as the most reliable and effective method to curb the further spread of HIV infections worldwide (Davis and Weller, 1999; Agha, Karlyn and Meekers, 2001; Kate et al., 2001; Abdool Karim, 2001). It is believed that if condoms were used correctly and consistently outside regular sexual relationships, the current rates of HIV/AIDS infections would not have been so high, particularly in sub-Saharan Africa (MacPhail and Campbell, 2001, Buchacz et al., 2001; Mehryar, 1995; Eaton et al., 2003). Studies have shown that condom use is considerably higher among the younger than older populations as well as higher in non-marital relationships than in marital or steady relationships (Rutenberg et al., 2001; Bankole and Singh, 2001). Furthermore, increasing evidence suggests that both rigid norms of masculinity and the nature of relationships are the major obstacles to condom use (Maharaj and Cleland, 2004; Shefer and Ruiters, 1998). This chapter examines both qualitative and quantitative data on condom awareness, knowledge, attitude and use in the study areas. The chapter starts by examining awareness and knowledge of condoms as well as prevailing attitudes towards condom use. Then it examines partner communication about condoms. Finally the chapter ends with an analysis of current and consistent condom use.

6.2 Awareness of Condoms

To assess the level of awareness of condoms, respondents of both sexes were asked the following two questions: *"Have you ever heard of condoms?"* and *"Do you know of a place where you could get a condom, if you needed one?"* Table 6.1 shows that the knowledge of condoms is almost universal. Nearly all male and female respondents reported that they had ever heard of condoms, with 99.5 percent of men and women having knowledge of condoms.

Table 6.1: Percentage of respondents who have ever heard of condoms and knew of a source of supply

	Men		Women	
	n	**%**	**n**	**%**
Heard of condoms				
Yes	208	99.5	216	99.5
No	1	0.5	1	0.5
Know where to obtain them				
Yes	196	94.2	187	86.6
No	12	5.8	29	13.4
Total	**209**		**217**	

Meanwhile, studies have shown that knowing about condoms does not necessarily lead to knowledge about where to obtain them in case of need or, to have the proper skills about how to use them correctly (Varga, 1997). In this regard, the findings in Table 6.1 indicate that the majority of respondents of both sexes reported that they knew a place where they could get a condom if they needed one. Nevertheless, men were more likely than women to report that they knew a place where they could get a condom if they needed it. Almost 94 percent of men compared with nearly 87 percent of women knew a source of supply of condoms.

These findings suggest that the respondents of this study have basic information on which they can rely for protective sexual behaviour, in this case the use of condoms. However knowing about condoms including purchasing locations are only part of the preconditions required for one to perform an effective protective sexual behaviour. Other preconditions needed for a successful protective behaviour include attitudes towards and beliefs about condoms as well as self-efficacy (the ability to use a condom correctly and effectively) (Prata et al., 2006; Boer and Mashamba, 2007).

In order to assess the ability of respondents to successfully perform a protective behaviour particularly by using condoms, two indicators were measured: response-efficacy and self-efficacy (Boer and Mashamba, 2007). Response-efficacy measured how confident the respondent was about whether or not he or she could get a condom if needed. Self-efficacy assessed the

respondent's ability and skills to perform a particular protective behaviour, in this particular case to use a condom correctly and effectively. In this regard, respondents were asked the questions "*How confident are you that you could get a condom if you needed one?"* and *"How confident you feel that you know how to use a condom effectively?"* A four-category ordinal scale was used to record their choices, namely "very confident"; "somewhat confident"; "not confident"; and "never used". Results are presented in Tables 6.2.

Table 6.2: Percentage of respondents who feel confident that they could obtain a condom in the case of need and who also feel that they know how to use a condom effectively

	Men		Women	
	n	**%**	**n**	**%**
Confident they could get a condom in the case of need				
Very confident	176	84.6	112	51.9
Somewhat confident	24	11.5	45	20.8
Not confident	8	3.8	18	8.3
Never used	0	0.0	41	19.0
Confident they knew how to use a condom effectively				
Very confident	159	76.4	82	38.0
Somewhat confident	47	22.6	30	13.9
Not confident	2	1.0	29	13.4
Never used	0	0.0	75	34.7
Total	**208**		**216**	

As can be seen in Table 6.2, the majority of respondents reported that they were very confident or somewhat confident that they could get a condom if they needed one. Not surprising, men were more likely than women to report a higher degree of confidence with 85 percent of men reporting greater confidence compared with 52 percent of women.

In addition, Table 6.2 also presents the results regarding respondents' self-efficacy about condoms. It was no surprise that the differences between men and women are quite pronounced, with men reporting higher levels of confidence than women. On the one hand this may reflect the

fact that the use of condoms is controlled by men. But, on the other hand, it may reflect the lack of power of women in determining condom use. As expected, men were more likely than women to show higher levels of confidence on how to use a condom correctly and effectively. Thus, the results indicate that about 76 percent of men reported that they were very confident that they knew how to use a condom correctely and effectively compared with 38 percent of women who also reported having proper skills to use a condom correctly and effectively. In addition, 23 percent of men reported that they were somewhat confident on how to use a condom correctly and effectively compared with 14 percent of women. Notewhorthy is that a significant number of women, 35 percent, reported that they were not confident on how to use a condom correctly and effectively. Particularly worrying, 19 percent reported that they have never used a condom at all.

6.3 Beliefs about Condoms Efficacy

One of the most used indicators to assess beliefs about the efficacy of condoms has been to ask the question to what extent they believe that condoms can prevent against unwanted pregnancies and/or sexually transmitted infections including HIV/AIDS (Boer and Mashamba, 2007). Thus, in this study, respondents were also urged to express their beliefs about the efficacy of condoms. To that end, two indicators were used to measure whether or not condoms are perceived as an effective tool to prevent both HIV/AIDS and unwanted pregnancies. Results are presented in Table 6.3.

Table 6.3: Percentage of respondents who agree with specific statements about the effectiveness of condoms in preventing either unwanted pregnancy or HIV/AIDS

Statements	Men %	Women %
Using condoms is an effective way of preventing HIV/AIDS		
Agree	83.7	79.2
Mixed/no opinion	8.2	11.6
Disagree	8.2	9.3
Using Condoms is an effective way to prevent pregnancy		
Agree	87.0	71.8**
Mixed/no opinion	7.7	8.8
Disagree	5.3	19.4
Total	**208**	**216**

Note: ** Significant P < 0.01 percent

Overall, respondents of both sexes hold positive beliefs about the effectiveness of condoms in preventing both HIV/AIDS and unwanted pregnancies. However men were more likely than women to report high levels of positive beliefs on the effectiveness of condoms. In this regard, 84 percent of men reported that using condoms is an effective way of preventing HIV/AIDS compared with 79 percent of women.

Accordingly, 87 percent of men believe that using condoms is an effective way to prevent pregnancy compared with 72 percent of women. However, the same cannot be said for women. Women were less confident about obtaining condoms. In addition, women were less likely to report that they knew how to use condoms effectively. This may suggest that women lack consistent experience in using condoms, a finding consistent with another study (de Walque and Kline, 2009)

Both the focus group discussions and in-depth interviews show high levels of awareness about condoms and their role in preventing STIs (including the risk of HIV infection) and unwanted pregnancies. The issue of condoms was recurrent in nearly all the interviews even when the topics of debate were related to other aspects of sexual behaviour such as multiple partnerships

and infidelity. In this regard, during the interviews almost all respondents have shown that they knew about condoms. They also acknowledged that condoms are an effective protective tool against sexually transmitted infections (including HIV) as well as unwanted pregnancies. However, there is greater awareness of condoms as a strategy for disease rather than pregnancy prevention as the quote below illustrates.

"I think that everybody is aware of HIV/AIDS here. AIDS is a reality and we are all aware of that. That is why there is a total demand for the use of condoms.

(Urban non-married male, IDI # 17)

In the interviews it became clear that some respondents associate condoms with disease prevention rather than pregnancy prevention. This may result from the fact that condom use is generally perceived as indicating promiscuity and an absence of cleanness. In addition, as a result of the negative meaning attached to condoms, men and women who carry them are also perceived as diseased and unclean. Studies have recognized that it is unfortunate that current HIV prevention campaigns have also reinforced these stereotypes (Bond and Dover, 1997). In an in-depth interview, a male respondent explained why the use of condoms is so difficult in relationships. The respondent stated that broaching the topic of condoms is likely to lead to suspicions that the person has AIDS.

"When we use condoms people think that we have AIDS. I think that people are afraid of being seen as already infected with HIV/AIDS. Besides, a woman is afraid of losing her partner if she asks him to use a condom because he will think she has got AIDS."

(Urban married male, IDI # 18)

In this quote, some of the dilemmas surrounding the use of condoms in relationships are clear. First, it seems that both men and women are afraid of being perceived as living with HIV/AIDS since condoms are associated with diseases. Secondly, women are in a more fragile position because if she proposes the use of a condom she may lose the support of her partner as a direct consequence of broaching the topic.

A number of studies have found that condoms are more likely to be used for the prevention of disease (Varga, 2000; Preston-Whyte, 1999). This is largely because condoms are associated with illicit sex and promiscuity. This is aptly captured by the statement of a woman in another study who proclaimed: 'I have never seen a condom. Why should I use a condom? Condoms are only used by prostitutes' (Bond and Dover, 1997:384-5)

The awareness of condoms was also highlighted when respondents raised their concerns and fears of being infected by HIV/AIDS. According to some respondents, the fear of acquiring the virus was behind the growing demand for condoms in the study areas. It would seem that the HIV/AIDS epidemic is impacting on condom use among both men and women.

"For me the major problem is AIDS. I am afraid to die even if I know I will die anyway and everyone else will die. But I will not look for death by myself. Now that I know that there is this disease called AIDS, I would rather die because of another disease or by a car accident not because of AIDS. That is why I insist on the use of condoms".

(Urban non-married female, IDI # 06)

Other reasons why the demand for condoms has increased included, for instance, the lack of trust among partners. It seems that the perception that a partner posed a risk was one of the motivating reasons for the increasing demand for condom use. According to some respondents, condoms are the most effective strategy against the risk of HIV infection. They felt that trust does not provide protection against sexually transmitted infections, including HIV infection.

"You cannot trust anybody nowadays. People just do not trust one another anymore and even if you are a faithful to your partner, you can still be infected by the disease. So before they stop using condoms, they should do a test".

(Rural married female, IDI # 05)

The above quote confirms the high levels of awareness of HIV/AIDS and the risks associated with unprotected sexual intercourse as well as the strategies to adopt in order to protect against the risk of HIV infection. On the other hand, the quote seems to contradict the discourses on trust, which is used by both men and women as the main reason for not using condoms (see Longfield et al., 2002; and Agha et al., 2002). In this regard, it seems that people use "trust" more for moral reasons rather than because they are fully convinced of the faithfulness of their partners, because it may appear somehow contradictory to stay with a partner they do not trust, which may cause them embarrassment. This interpretation seems to be in line with the model developed by Eaton et al. (2003) which states that people with a poor sexual self-concept may rely on others for self-affirmation. But more importantly, precisely because of their poor sexual self-concept such people are more likely to think that proposing the use of condoms is immoral or offensive to their partners. For example, Longfield and his colleagues (2002) conclude that the use of trust which was the focus of youth sexual relationships hampered them to explore partners's sexual history or to adopt protective practices including the use of condoms. In addition, they noted that "youth appear to repeat a cycle of trust and broken trust, without adopting sustainable risk reduction methods" (Longfield et al., 2002: 17). In this study, respondents stressed that is not sufficient for one partner to be faithful, because even in such circumstances, one can become infected by an unfaithful partner. This seems particularly true for women who still have expectations that their partners are faithful, but at the same time they suspect that they are not. Furthermore, studies have shown that negative connotations associated with condoms prevent both men and women from protecting themselves against sexually transmitted infections including HIV (Parikh, 2007; Smith, 2007; Hirsch, 2002; de Zoysa, Sweat and Denison, 1996).

6.4 Attitudes towards Condoms

To measure attitudes towards condoms respondents were invited to give their opinions about a set of statements regarding condoms. Respondents were asked if they agree or disagree with a set of statements. To avoid forcing respondents to choose between two categories, a third alternative was also given to allow respondents to express their uncertainty or doubt about a specific statement. Table 6.4 gives the percentage of respondents who agreed with particular statements

about condoms. The findings presented in Table 6.4 suggest that in general respondents hold relatively negative attitudes towards condoms despite their awareness of the efficacy of condoms in protecting against HIV infection. One striking finding to note is that there is huge disagreement between men and women in most of the statements. In this regard, men were more likely than women to hold negative attitudes towards condoms use.

Table 6.4: Percentage of respondents who agree with specific statements about condoms use

	Men	**Woman**
Statements	**%**	**%**
Using condoms reduces sexual pleasure	47.3	13.9**
A women loses a man's respect if she asks him to use a condom	29.5	26. 9
The man has greater influence than the woman over whether or not to use a condom	73.1	53.2**
Condoms encourage promiscuous behaviour	43.3	31.9**
The only reason to use condoms is because you don't trust your partner	58.2	33.3**
It is acceptable for married couple to use a condom	36.1	51.9**
It is acceptable for a married woman to ask her husband to use a condom	38.9	47.7**
It is acceptable for a woman who is not married to ask her partner to use a condom	94.2	84.3*
It is acceptable to use a condom with someone at the beginning of a relationship	92.3	82.9*
Total	**208**	**216**

Note: * Significant $P \leq 0.05$ percent;** Significant $P \leq 0.01$ percent

For instance, while about a half of interviewed men, 47 percent, agreed with the statement that using condoms reduces sexual pleasure, only 14 percent of women held the same view. On the other hand it is of interest to note that 73 percent of men and 53 percent of women agreed with

the statement that the man has greater influence than the woman over whether or not to use a condom. Similarly, while 44 percent of men thought that condoms encouraged promiscuous behaviour, only 32 percent of women shared the same view. Furthermore, about 59 percent of men and 33 percent of women agreed that the only reason for use of condom is lack of trust.

As observed earlier, the belief that using condoms is an effective method to prevent HIV/AIDS and unwanted pregnancy hardly translates into condom use particularly in long-term relationships. In this regard, men were less likely than women to accept condom use within marriage or in long-term relationships. The findings show that only about 36 percent men thought that it was acceptable for a married couple to use a condom compared with almost 52 percent of women who perceived no problem in a married couple using a condom. Women (48 percent) were more likely than men (39 percent) to agree that it is acceptable for a married woman to ask her husband to use a condom.

The fact that women in general presented more positive attitudes to condoms than men also deserves particular attention. As expected, both men and women thought that it was acceptable for a woman who is not married to ask her partner to use a condom, with about 94 percent of men agreeing with the statement compared with 84 percent of women. Accordingly, while almost 92 percent of men felt that it is acceptable to use a condom at the beginning of a relationship, fewer women (83 percent) felt that this was acceptable.

Very often condoms became a controversial and disputed topic during the qualitative interviews. Although condoms are well known as a method of preventing sexually transmitted diseases including HIV infection, as well as unwanted pregnancies, use of condoms seem to be very selective and dependent upon the nature of relationships, a finding consistent with other studies (Maharaj and Cleland, 2004; Adetunji, 2000; Preston-Whyte, 1999). During the interviews, respondents outlined a number of barriers to condom use including fear of partner's reaction; the nature of relationships; lack of confidence in the product; lack of trust between partners; reduction in sexual pleasure and discomfort during sexual intercourse.

In the interviews, a number of negative attitudes to condoms emerged. Some associate condoms with a lack of trust within relationships. Because condoms are largely perceived as sending lack of trust messages and superficiality within relationships, many respondents showed reluctance to use them. Some men in focus group discussions, for example, did not hesitate to establish a direct link between condoms use and lack of trust. They even argued that a woman would be entitled to demand condoms from her partner when she found out that her partner had other sexual partners. They argued that only in relationships were there was a lack of trust was it justifiable to use condoms.

"Well, if she finds out that he has a lover over there, then it is her right to force him to use condoms, because she has lost all the trust she had for him".

(Rural non-married males, FGD # 18)

"*I think that for married people it is not acceptable to use condoms unless they do not trust each other. But if they trust each other and they feel no danger they should not".*

(Rural married male, FGD # 12)

Resistance to condoms in marital and cohabiting unions or even in long-lasting relationships was not only a male phenomenon. Some women also were opposed to condoms within these unions. During both rural and urban focus group discussions and in-depth interviews some women argued that marriage was a place of trust; mutual belonging and intimacy. This therefore meant that there was no need to use condoms. For some women, it was absurd that married and cohabiting couples, who are supposedly committed to each other, use condoms.

"Wait! If he is my husband, I am with him because I trust him. We are married; I think he should trust me too. I think we should not use condoms".

(Urban non-married females, FGD # 09)

"If they are married and trust each other there is no point in using condoms. Your husband!? If I find a condom in my husband's pocket he has to explain to me why he has got that condom because, to me, that is a sign that he betrays me because we do not use condoms here at home"

(Urban non-married females, FGD # 03)

Once more, the above quote clearly confirms that the topic of condoms is a very emotive topic within marriage. Studies have reported that condoms are almost always associated with either illicit sex or diseased people (Varga, 2000; Bond and Dover, 1997). For example, some respondents are more concerned about accusations of lack of trust than protecting themselves against the risk of HIV infection. In the above quote, it is clear that the female respondent prefers to obtain an explanation from her husband regarding his infidelity rather than protect her health by demanding condom use. The consequence of such attitudes is that, in reality, both men and women may have extramarital relationships and some do not use condoms to avoid moral judgements. This, of course, may have serious negative health consequences for their sexual reproductive health.

Meanwhile a large number of women in both focus group discussions and in-depth interviews showed positive attitudes to condoms even in long-lasting relationships. Health concerns were the reasons behind such attitudes. They argued that this was because men are unfaithful and they did not know whether or not their extramarital partners have sexually transmitted infections including HIV/AIDS. This clearly shows that women not only are upset about their partners' infidelity but also about the negative impact on their sexual and reproductive health.

"*Men do not know if their lovers are sick or not, and they will never tell them that they are sick. When my husband goes out, he always takes condoms with him, but even then it might happen that his lovers will not accept to use them and he may infect me with her diseases."*

(Rural married female, IDI # 04)

"If you have lovers at least use condoms. In doing so there is a lower risk of infecting your husband and your husband infecting you"

(Rural married female, IDI # 02)

Lack of trust in the effectiveness of condoms seems to play a significant role in discouraging people from using them more frequently. Stories of condoms tearing during sexual intercourse have been used as justification for the distrust of the effectiveness of condoms, therefore, rendering them dispensable in some circumstances. During the interviews some respondents highlighted that condoms were not a reliable product and they were somewhat doubtful about their efficacy, as is illustrated in the following comments:

"I do not rely that much on condoms. For me it is 50 percent condoms and 50 percent of faithfulness. Condoms can get torn. They are not 100 percent safe. I have a cousin who told me that once he was having sex with his girlfriend and the condom broke and he did not feel this happening. Then he did not tell his girlfriend to avoid an argument."

(Rural non-married males, FGD # 18)

As this quote shows, defective condoms which sometimes result from incorrect use may occur from negative messages spread about condoms, particularly from the Catholic Church, which has spread the message that "condom are not a hundred percent safe", thus exacerbating the lack of trust in the product (Bosmans et al., 2006). Of interest here is that there is scientific evidence which suggest that condoms are not 100 percent effective (Holmes et al. 2004), which is also used by some to argue that condoms are not completely reliable, therefore, there is no need for condoms. Such beliefs are used as an excuse for not using condoms is well illustrated in the quote below.

"Others say that girls have pimples during puberty because they have not had sex yet. I think that condoms get damaged when you have sex with a virgin".

(Rural non-married males, FGD # 18)

It could be seen in the quote that this respondent is trying to argue that sexual intercourse with a virgin does not need any protection with a condom because it is useless, since the condom is going to be damaged during the sexual act. If a man is already sexually active he is likely to put the young girl with whom he engages in sexual intercourse at risk of acquiring a sexually transmitted infection including HIV/AIDS.

A common complaint during the interviews was that related to the interference of condoms with sexual pleasure. Men and women during focus group discussions and in-depth interviews both in rural and urban areas said that condoms reduce sexual pleasure, disrupt sexual excitement and cause discomfort. The perceptions that condoms prevent pleasure and cause discomfort are viewed as the reasons behind the low use of condoms in some communities. This can be seen in the quotes below:

"Well, I think that condoms here in our neighbourhood are not respected. Many see condoms as causing discomfort and few young people use them. That is why the rate of positive people here is high. "

(Urban married males, FGD # 17)

"You avoid AIDS by using condoms, but as I said earlier, there are some people who do not like to use them. They say that they do not feel anything with it."

(Urban non-married male, IDI # 16)

Some women in focus group discussions were surprised when the interviewer raised the question of condoms use within marriages. On the one hand this is because there is a widespread understanding that in marriage there should be complete intimacy between a man and a woman without any restrictions. In other words, it is understood that sex within marriage is not only legitimate and expresses intimacy but also a duty that husband and wife owe to each other. On the other hand it is because condoms are perceived as a barrier preventing the pleasure of flesh-to-flesh sex.

"It is not acceptable for married people to use condoms. No! Things do not go well with Jeito [brand name for Mozambique male condom]! It is not acceptable. You do not feel anything with those small plastics!"

(Rural non-married females, FGD # 06)

The views that condoms constitute an obstacle to sexual pleasure were also highlighted by some men in rural focus group discussions. Unanimously, they voiced the concern that the reduction of sexual pleasure was the main reason for the resistance to condoms.

"Many people say that condoms inhibit sexual pleasure. For me, the first thing she or he is looking to achieve is pleasure.

(Rural non-married males, FGD # 18)

The perception that condoms prevent sexual pleasure and intimacy raised a hot debate in one urban female focus group discussions. Respondents argued that the use of condoms in the context of marriage was a violation of their sexual rights. For these women, the use of condoms in marital unions deprived them of their right to sexual pleasure and intimacy and, apart from that; they viewed flesh-to-flesh sex as a way to compensate for their hard work in the household.

"Look, I work so hard as a housewife. I usually do farming and I cannot suffer from work and then not get anything there [in the bed]. I need to feel him. I cannot sweat while he is inside the condom, what about me?"

(Urban married females, FGD # 03)

6.5 Communication about Condoms

Partner communication, either about the need to use condoms or about other sexual health matters is understood as very critical for the success of any protective strategy (Best, 2002; Sivaram et al., 2005). In order to assess partner communication about condoms respondents were asked: *"have you ever discussed with your sexual partner about whether or not to use a*

condom?" This question was asked of all respondents who reported having had sex in the last 12 months, regardless of whether or not it was marital and cohabiting, or non-marital and non-cohabiting. It is believed that partner communication about condoms is an important predictor of use (Sivaram et al., 2005). Studies have shown that lack of partner communication about condoms is a major barrier to use (Bauni and Jarabi, 2003; Muhwava, 2004; Chimbiri, 2007). Table 6.5 shows partner communication about condoms.

Table 6.5: Percentage of respondents who reported partner communication about condoms with their most recent partner

	Men		Women	
	n	**%**	**n**	**%**
Have ever discussed the use of condoms with a partner				
Yes	117	56.3	102	47.0
No	91	43.8	115	53.0
Total	**208**		**217**	

Table 6.5 shows that men are more likely than women to report that they have ever discussed with their partners about whether or not to use a condom. Almost 56 percent of men and 47 percent of women reported that they had ever discussed condoms with their partners, irrespective of whether or not they actually used them. On the other hand, it is of interest to note that almost half of respondents of both sexes reported that they have never discussed whether or not to use a condom.

Table 6.6 presents the bivariate analysis of partner communication about condoms. The bivariate analysis for both men and women show that there is a significant association between partner communication about condoms and selected demographic and socio-economic variables. Thus, place of residence, age, level of education and marital status seem to play a very important role in influencing discussions about whether or not to use a condom. Living in urban areas, being younger, or having secondary education or more, as well as not being in marital or cohabiting unions enhances partner communication about condoms.

Table 6.6: Percentage of respondents who reported partner communication about condoms, by selected background characteristics

	Men		Women	
	n	%	n	%
Place of residence				
Urban	106	66.0*	111	64.9**
Rural	102	46.1	106	28.3
Age				
20-29	108	70.4**	121	57.9**
30-39	54	50.0	60	40.0
40-49	46	30.4	34	23.5
Education				
None	28	32.1**	51	17.6**
Primary	98	44.9	106	46.2
Secondary +	82	78.0	60	73.3
Marital status				
Married/cohabiting	138	43.5**	120	38.3*
Neither	70	81.4	97	57.7
Total	**208**		**216**	

Note: * Significant P ≤ 0.05 percent; ** significant P ≤ 0.01 percent

Thus, men living in urban areas were more likely than those living in rural areas to report that they have ever discussed with their partner whether or not to use a condom, with 66 percent of urban men saying so compared with 46 percent of rural men. Similarly, women living in urban areas were more likely than women in rural areas to report that they have ever discussed with their partners on whether or not to use a condom. Age, like place of residence, seems to influence partner communication. In this regard, young men and women aged 20-29 year-old were more likely than men and women of other age groups to report that they have ever discussed with their partners about whether or not to use a condom. The same is found with regard to education. Thus, both men and women with secondary or higher education were more likely than less educated respondents to report that they have ever discussed with their partners about whether or not to use a condom. Interestingly, it seems that partner communication increases as the level of education increases. Finally, the findings indicate that married and cohabiting men and women were less

likely than men and women who were neither married nor cohabiting to report that they have ever discussed condom use with their partners.

6.6 Condoms Use

Studies have employed various measures to assess condom use among sexually active individuals. These measures of condom use include, for example, categorization by type of use (e.g. ever use, current use, never use); frequency of use (e.g. always, occasionally, never), reference period for use (e.g. weeks, months or years) as well as use by type of partnership (e.g., casual, regular or commercial) (Meekers and Klein, 2002; Weir et al., 1999; Rotermann and Mckay, 2009, Maharaj and Cleland, 2004; 2007; Adetunji, 2000; Agha, 1998; Bankole and Singh, 2001). Thus, to assess level of condom use in the study areas three questions were asked. First, respondents were asked whether or not they have ever used a condom. Second, they were asked whether or not they used a condom during the last sex 12 months before the survey. Finally, to assess the consistency of condom use, respondents were asked how often they used condoms. A three-point scale was used to assess the frequency of condom use: always, occasionally and never.

6.6.1 Ever Use

To ascertain whether condoms were ever used in the study sites, respondents were asked the question "*Have you ever used a condom?"* Table 6.7 shows the percentage of respondents who reported ever using a condom.

Table 6.7: Percentage of respondents who have ever used a condom

Ever used a condom	**Men**		**Women**	
	n	**%**	**n**	**%**
Yes	107	51.4	94	43.3
No	101	48.6	123	56.7
Total	**208**		**217**	

Table 6.7 indicates that men were more likely than women to report that they have ever used a condom with their partner, with 51 percent of men reporting ever having used a condom compared with 43 percent of women.

Bivariate analysis was conducted to examine the relationship between ever use of condoms and selected socio-economic and demographic characteristics, namely place of residence, age, education and marital status as well household socio-economic status. Table 6.8 shows the relationship between ever use of condoms and selected socio-demographic characteristics.

Table 6.8: Percentage of respondents who reported that they have ever used a condom by background characteristics

Background characteristics	**Men**		**Women**	
	n	**%**	**n**	**%**
Place of residence				
Urban	106	69.8*	111	71.2*
Rural	102	32.4	106	14.2
Age				
20-29	108	62.0*	121	53.7*
30-39	54	42.6	60	38.3
40-49	46	37.7	34	17.6
Level of Education				
None	28	32.1*	51	11.8*
Primary	98	34.7	106	34.9
Secondary or higher	82	78.0	60	85.0
Marital Status				
Married/cohabiting	138	37.7*	120	34.2*
Neither	70	78.6	97	54.6
API				
Low	43	37.2**	67	23.9**
Lower medium	59	30.5	50	24.0
Upper medium/high	106	68.9	100	66.0
Total	**208**		**217**	

Note: * Significant $P \leq 0.05$ percent; ** significant $P \leq 0.01$ percent

As can be seen in Table 6.8, living in urban areas, being younger, having secondary education or more and being neither married nor cohabiting seem to be strong factors influencing ever use of condoms. In this regard, men and women living in urban areas were more likely than men and women living in rural areas to report having ever used a condom with their partners, with about 70 percent of urban men and 71 percent of urban women reporting ever use compared with 32 percent of rural men and 14 percent of rural women, respectively. Age is an important predictor of ever-use of condom. Ever use of condoms decreases with the increase in age. In other words, younger respondents were more likely to report ever using a condom than older respondents. Likewise, formal education appears to be one of the strongest predictors of ever use of condoms. The data shows that more educated respondents were more likely than less educated respondents to report having ever used a condom. In addition, men and women who were neither married nor cohabiting were more likely than married and cohabiting respondents to report having ever used a condom.

The analysis of the API index indicates that men with a higher socio-economic status were almost two times more likely than men with a lower socio-economic status to report having ever used a condom with their partners. About 70 percent of men with a high API reported having ever used a condom compared with 31 percent of men with a lower medium API and 37 percent with a low API. Similarly, women with a high socio-economic status were almost three times more likely than women with a lower socio-economic status to have ever used a condom with their partners. The findings for women indicate that 66 percent of women with an upper medium or high API reported that they have ever used a condom with their partners, while 24 percent of women with lower medium and low API reported having ever used a condom. All the variables for both men and women are statistically significant.

6.6.2 Current Use

To assess current use of condoms respondents were asked the following question: “the last time you had sex, did you or your partner use a condom?” First, univariate analysis was conducted to

determine current condom use among respondents who were sexually active in the last 12 months. In addition, bivariate analysis was conducted to determine the relationship between current users and selected socio-economic and demographic characteristics. Finally, a logistic regression analysis was fitted to determine the strength of the associations. As can be seen in Table 6.9, the majority of respondents have never used a condom. However, it is worth noting that almost one quarter of men and women reported using a condom at last sex. Nevertheless, among current condom users, men were more likely than women to report that they used a condom at last sex, with almost 31 percent of men reporting condom use at last sex compared with about 20 percent of women.

Table 6.9: Percentage of respondents who used a condom at last sex

	Men		Women	
Used a condom at last sex	**n**	**%**	**n**	**%**
Yes	65	31.3	44	20.3
No	42	20.2	50	23.0
Never used	101	48.6	123	56.7
Total	**208**		**217**	

Bivariate analysis consisted of examining the association between current condom use and selected socio-economic and demographic characteristics, namely place of residence, age, education, marital status, perception of risk of HIV infection, number of sexual partners in the last 12 months and household socio-economic characteristics using the Amenities Possessions Index (API). Condom use at last sex is conventionally used to assess current condom use. It is usually associated with a reference period (Bankole and Singh, 2001). In this study, the reference period is 12 months prior to the survey. Table 6.10 shows the percentage of respondents who reported condom use at last sex by selected background characteristics.

The bivariate analysis shows that place of residence, age, level of education, marital status and household socio-economic status is strongly associated with condom use at last sex. In this regard, urban men and women were more likely to report having used a condom at last sex compared with rural men and women. Whereas 43 percent of urban men reported that they used a

condom at last sex only 20 percent of rural men reported use at last sex. Likewise, whereas about 34 percent of urban women reported condom use at last sex, a lower percentage of rural women (6 percent) reported use at last sex.

Table 6.10: Percentage of respondents who used a condom at last sex by selected background characteristics

Background characteristics	Men		Women	
	n	%	n	%
Place of residence				
Urban	106	42.5*	111	34.2*
Rural	102	19.6	106	5.7
Age				
20-29	108	42.6*	121	27.3*
30-39	54	27.8	60	15.0
40-49	46	8.7	34	5.9
Level of Education				
None	28	10.7*	51	7.8*
Primary	98	20.4	106	14.2
Secondary or higher	82	51.2	60	41.7
Marital Status				
Married/cohabiting	138	15.2*	120	12.5*
Neither	70	62.9	97	29.9
API				
Low	43	23.3**	67	11.9*
Lower medium	59	13.6	50	10.0
Upper medium/high	106	44.3	100	31.0
Perception of Risk of HIV infection				
Low	107	31.8	163	19.6
High	100	31.0	53	22.6
Number of sexual Partners				
1	116	29.3	201	20.4
2+	92	33.7	16	18.8
All	**208**		**217**	

Note: * Significant $P \leq 0.05$ percent; ** significant $P \leq 0.01$ percent

Of note is the decrease in condom use at last sex as the age of the respondent increases. In other words, men and women aged 20-29 year-old were more likely than men and women of older age

groups to report having used a condom at last sex. Likewise, level of education, in particular, seems to influence condom use at last sex regardless of the sex of respondent. The data indicates that the use of condoms increases with the level of education. Thus, men and women with secondary or higher education were more likely than men and women with less than secondary education to report the use of condom at last sex. In addition, respondents who were neither married nor cohabiting were more likely to report the use of condoms at last sex than married and cohabiting respondents.

Both men and women with a higher socio-economic status were more likely than men and women with a lower socio-economic status to report having used a condom at last sex. About 44 percent of men with an upper medium or high API reported having used a condom at last sex compared with 14 percent of men with a lower medium API and 23 percent of men with a low API. In addition, 31 percent of women with upper medium or high API reported that they used a condom during the last sex event compared with 10 percent of women with a lower medium API and 12 percent of women with a low API. The bivariate analysis shows that the association between current condom use and perception of risk of HIV infection and number of sexual partners is not statistically significant. However, men who reported more than one partner in the past 12 months were slightly more likely to report condom use at last sex than men with only one partner. Similarly, women who reported feeling a higher risk of HIV infection were more likely to report condom use at last sex than women who reported a lower risk of HIV infection.

Multivariate analysis

In order to assess which factors are the strongest determinants of condom use at last sex in the last 12 months, a logistical regression analysis was applied. The dependent or outcome variable is whether or not they had used a condom at last sex. The dependent variable consisted of two values: ‘Yes’ which was coded “1” and ‘No’ which was coded “0”. The value coded “1” has been taken as a reference group. The independent or predictor variables are place of residence, age, level of education marital status, household socio-economic status, perception of risk of HIV infection and number of partners in the last 12 months. Separate models for male and females

have been fitted to account for gender differences in condom use at last sex. The results are given in Table 6.11

The results of logistic regression analysis for men show that a number of the selected socio-economic and demographic characteristics have a statistically significance unadjusted effect on condom use at last sex. The unadjusted logistic regression results show that men living in rural areas were less likely than those living in urban areas to report having used a condom at last sex (odds ratios = 0.33). Similarly, men aged 40 years and above were less likely to report that they used a condom at last sex (odds ratios = 0.13). On the other hand, the findings show that men with secondary or higher education were almost 9 times more likely than less educated men to report that they used a condom at last sex (odds ratios = 8.75). Men who were neither married nor cohabiting were also about 9 times more likely to report having used a condom at last sex than married and cohabiting men (odds ratios = 9.43). Furthermore, men who reported more than one sexual partner in the last 12 months were more likely than those who with only one partner to report condom use at last sex, but this was not significant (odds ratios = 1.23). Perception of risk of HIV infection was not related to condom use. Men who perceived themselves at higher risk of HIV infection were less likely to report using a condom use at last sex.

Table 6.11: Odds ratios for men who used a condom at last sex, 12 months before the survey: logistic regression results

	Odds ratios and 95% confidence intervals	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	0.33*(0.18 – 0.62)	1.19 (0.46 – 3.12)
Age		
20-29	1.00	1.00
30-39	0.52 (0.26—1.05)	1.96 (0.74-- 5. 15)
40-49	0.13* (0.04 – 0.39)	0.30 (0.09 – 1.03)
Level of Education		
None	1.00	1.00
Primary	2.14 (0.59-7.80)	1.69 (0.41 – 7.04)
Secondary or higher	8.75* (2.45 – 31.27)	3.97 (0.85 – 18.55)
Marital Status		
Married/Cohabiting	1.00	1.00
Neither	9.43* (4.82 – 18.45)	6.99** (2.84 – 17.23)
API		
Low	1.00	1.00
Lower medium	0.52 (0.19 – 1.45)	0.53 (0.17 – 1.64)
Upper medium/high	2.63* (1.18 – 5.88)	1.06 (0.34 – 3.26)
Perception of risk of HIV infection		
Low	1.00	1.00
High	0.97 (0.54 – 1.74)	0.84 (0.41- 1.75)
Number of Sexual Partners		
1	1.00	1.00
2 +	1.23 (0.68 – 2.21)	1.16 (0.56 – 2.40)

Note: * Significant $P \leq 0.05$ percent; ** significant $P \leq 0.01$ percent

Meanwhile, after controlling for other variables, only marital status continues to have a statistically significant effect on condom use at last sex (odds ratios = 6.99). The other variables no longer have a statistically significant effect on the use of condoms at last sex. These findings may have important implications for policy design and interventions since they suggest that people make decisions based on wrong judgements regarding both the circumstances and

appropriateness of condom use. Indeed, the fact that only marital status continued having a strong association with condom use at last sex seems to suggest that the use of condom is highly dependent on marital status rather than other socio-demographic variables assessed in this study which, in turn, suggests a low personal risk perception. In this regard, the results suggest that men may have more worries regarding pregnancy or disease prevention depending on whether one is single, married or cohabiting which is not enough to curb the HIV epidemic (see also Agha et al., 2002).

The results of logistic regression analysis for women are shown in the Table 6.12. Table 6.12 shows that women living in rural areas were less likely than those living in urban areas to report having used a condom at last sex (odds ratios = 0.16). Similarly, women aged 30 and above were less likely than women aged less than 30 years to report having used a condom at last sex. As is the case with men, women who are relatively more educated, that is, with secondary education or higher were 8 times more likely than other age groups to report having used a condom at last sex (odds ratios = 8.39). Likewise, women who were neither married nor living together were almost three times more likely to report having used a condom at last sex than their married and cohabiting counterparts (odds ratios = 2.99).

Table 6.12: Odds ratios for women who used a condom at last sex, 12 months before the survey: logistic regression results

	Odds ratios and 95% confidence intervals	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	0.16*(0.05 – 0.29)	0.13* (0.04 – 0.43)
Age		
20-29	1.00	1.00
30-39	0.47 (0.21 - 1.06)	0.49 (0.18-- 1. 30)
40-49	0.17* (0.04 – 0.74)	0.22 (0.04 – 1.14)
Level of Education		
None	1.00	1.00
Primary	1.94 (0.61 - 6.16)	0.83 (0.22 – 3.15)
Secondary or higher	8.39* (2.68 – 26.31)	1.41 (0.32 – 6.17)
Marital Status		
Married/ Cohabiting	1.00	1.00
Neither	2.99* (1.49 – 5.98)	1.98 (0.89 – 4.39)
API		
Low	1.00	1.00
Lower medium	0.82 (0.25 – 2.67)	0.96 (0.26 – 3.60)
Upper medium/high	3.31* (1.41 – 7.76)	0.97 (0.34 – 2.75)
Perception of Risk of HIV Infection		
Low	1.00	1.00
High	1.20 (0.57 – 2.54)	0.90 (0.38- 2.14)
Number of Sexual Partners		
1	1.00	1.00
2 +	0.90 (0.25 – 3.31)	0.36 (0.09 – 1.50)

Note: * Significant $P \leq 0.05$ percent

On the other hand, the logistic regression results shows that women with a higher socio-economic status were more likely than women with a lower socio-economic status to report having used a condom at last sex. Women with a upper medium or high API were three times more likely than women with low API to report having used a condom at last sex (odds ratios = 3.31). Women who perceived a high risk of HIV infection were also more likely to use a condom than women

who perceived a lower risk of HIV infection but this was not significant. The association between condom use at last sex and number of sexual partners was not statistically significant. After adjusting for other factors, only one variable had a statistically significant effect on condom use at last sex. Place of residence remains the strongest predictor of condom use at last sex for women. Urban women were significantly more likely than rural women to report condom use at last sex. These results suggest that if a woman lives in a rural area, independent of other socio-demographic factors, including her level of education she will rarely use a condom. This is not surprising at all given the fact that rural areas tend to be less open about sexual matters than urban areas.

The nature of relationships

In general, studies have shown that the use of condoms is generally dependent upon the nature of relationships. Thus the nature of relationships could have some influence on condom use in the present study. Some studies suggest that condom use is much lower in long-term, stable relationships than less stable relationships (Varga, 2000; de Walque and Kline, 2009; Maharaj and Cleland, 2004; Adetunji, 2000; Agha, 1998). Understanding the nature of a relationship and the use of condoms was explored in more detail in the focus group discussions and in-depth interviews.

There is greater resistance to condom use in marital or cohabiting relationship or long-lasting relationships than in occasional or casual encounters. Many respondents in both focus group discussions and in-depth interviews reiterated that if people were married or were living as married, then it was not acceptable to use condoms. They argued that married couples should not use condoms because marriage implied loyalty to one another. According to some women in the focus group discussions, condoms were only acceptable for couples who were not in a long-term relationship.

"It is acceptable to use condom. However, married people should be loyal. But for people who are not yet married, they should use condoms".

(Rural non-married females, FGD # 06)

Similarly, some men in the in-depth interviews were also adamant that for married people the use of condoms was out of the question, unless there was no trust between partners. Such beliefs not only show the extent to which sexual moralities are so entrenched within marital relationships (Smith, 2007) but also many men and women still associate condoms with infidelity, a finding consistent with earlier studies (Preston-Whyte, 1999, Varga, 1999).

"Well, I do not use condoms. I do not even want to hear about them. Only when I am on a trip, maybe I can use them, I do not know".

(Urban married males, IDI # 18)

"As long as we are married we cannot use condoms. We must take control of ourselves and avoid betrayals"

*(*Rural non-married male, IDI # 14)

Nevertheless, some women in the focus group discussions acknowledged the importance of using condoms even in cohabiting relationships. The infidelity usually practiced by their partners was given as the main reason. Some females reported that because men are generally unfaithful, it was up to the women to force the use of condoms in relationships that carried some risks. Some women who perceive themselves at risk of HIV infection because of their partner's sexual behavior are likely to take measures to protect themselves. For example, a woman with an unfaithful husband may get the support of the society for her actions, thus giving legitimacy to her actions. On the other hand, it is of interest to note that women did not talk about abandoning their sexual relationships which they perceived as risky. Rather, they talk about persuading their partners to practice protective practices including using condoms with their sexual partners outside the marital relationships.

"My daughter's father does not want to use condoms, but he has other women. He used to say: 'I do not need to use condom'. I have told him: 'you want to have children and you do not want to take care of your life'. There are men that do not understand. It only depends on women to use condoms".

(Urban married females, FGD # 02)

Likewise, some men in focus group discussions also had positive views about condoms within marriage. While they argued that marriage symbolized trust and fidelity between the partners they recognized that men in particular are sometimes tempted to have sex outside marriage. These views not only confirm that extramarital sex is a common phenomenon in the study sites but they also show that men tend to feel that they cannot resist sexual temptations outside of their marriage. This may be due to fact that extramarital sex for men is tolerated whereas for women it is strictly taboo. From this point there is no doubt that if protective practices are not fully observed, particularly correct and consistent use of condoms, these men can acquire and pass the virus to their marital or cohabiting partners.

"As soon as a couple gets married the couple should not have sex outside, because the marriage requires them to be faithful. Therefore, they should not have sex outside their marriage. Nevertheless, people end up "stealing" because they cannot fight against temptation". If a man cannot resist temptation, the man should use a condom with his partner. Within marriage it is not acceptable to use condoms unless one of the married partners is HIV positive".

(Rural married males, FGD # 12)

Sometimes the reluctance to use condom may be related to age. Some women in focus group discussions expressed that they would not use condoms because condoms are for young people. In addition, some admitted that they do not know how to use a condom. In fact, studies have shown that the use of condom is positively associated with age and level of education. Condom use is greater among the younger population as well as those with higher levels of education, a finding consistent with other studies (Agha, 1998; Lagarde et al., 2001). The quote below may well illustrate that sentiment

"We do not use condom, my dear. But you young people do. In our youth there were no condoms. We used to have sex with no condom. Our husbands died without using one. Condoms are for you young people. We do not know how to use them."

(Urban married females, FGD # 03)

Timing of Condom Use

One of the most frequently mentioned aspects during the interviews was the timing of condoms use. Although few participants reported the use of condoms, in both focus group discussions and in-depth interviews respondents said that men and women who decided to use the condoms generally started using condoms at the beginning of their relationships. They argued that they use condoms at the onset of a relationship because it is a time when they are starting to establish trust and intimacy - they do not fully trust each other at this stage. After they have stayed together long enough and the necessary trust has been established, they decide to give up using condoms.

"I think we stop using a condom when we have sex with the same person many times and we gain trust, because in the first days of sex you are still getting to know each other, after sometime has passed, maybe two, four or more months we stop using condoms because we think we know each other well, therefore we stop"

(Rural married males, FGD # 12)

Some women said that the beginning of a relationship is the right moment to start using condoms because partners were in the process of getting to know each other. Trust is an important factor which affects sexual decision-making about condoms (Longfield, Klein and Berman, 2002). Both men and women seek to establish trust at the beginning of the relationship. However, men and women may perceive certain advantages of using condoms while they are in the process of 'studying' each other. For example, for women it is not only important to create greater familiarity during the period the partners try to 'know' each other, but it has the advantage of preventing unwanted pregnancies and diseases. This is illustrated in the following quote:

"We always have to use condom at the beginning of a relationship because we do not know each other yet, and we should avoid pregnancies and prevent diseases".

(Urban non-married female, IDI # 09)

"It is acceptable to use condoms when the partners are in the courtship phase. Because in that moment you do not trust him"

(Rural non-married females, FGD # 06)

A group of women in their forties also reiterated in the focus group discussions that young people use condoms at the beginning of their relationships because they are not sure if the relationship will lead to marriage and they therefore felt it was necessary to protect themselves against the risk of HIV infection.

"Young people use condoms when they are beginning a relationship because they do not know yet whether or not they will get married".

(Urban married females, FGD # 03)

Some men also shared similar views. In one rural focus group discussions men also said that condoms are used at beginning of a relationship because trust has not yet been established. It is important for condoms to be used because partners are not sufficiently familiar with each.

"As I am married and I do not have lovers I do not use condoms. But I did use condoms before I got married because I did not know who my wife would be".

(Rural married males, FGD # 11)

Similarly, some female respondents explained that condoms allow partners who do not know each other very well to develop greater familiarity with each other without the fear of an unplanned pregnancy.

"Yes, it is acceptable. It is not a matter of trust. It is also to avoid unwanted pregnancies because you may not want to have children at the wrong time. And partners may be in the process of knowing each other, so they use condoms"

(Rural non-married female, IDI # 09)

Meanwhile, in one urban focus group some men observed that they had sex without a condom for the experience of knowing how sex feels without a condom. However, once they engage in sex without a condom they hardly ever return to using them again. Sex with condoms is viewed as incomplete sex. For many sex is defined as vaginal penetration that requires flesh-to-flesh contact. For some, using condoms hinders sexual satisfaction as the quote below illustrates. Sex with a condom is seen as creating inhibitions.

"I might use condoms. But, for instance, if I have a friend and I may tell her that we will use condoms. However, a time will come that she will say that she does not want to use condoms anymore, or a time might come that I will not want to use condoms because I will want to feel everything"

(Urban married males, FGD # 14)

Again, ejaculating into a woman is regarded as paramount by some men (and women). Studies have shown that in some sub-Saharan Africa settings, sex with condoms is understood as not the 'real thing' or is connected to masturbation (Bond and Dover, 1997, Varga, 1997; 2000; Campbell, 2001; Scorgie et al., 2009)

6.7 Consistency of Condoms Use

Studies have shown that for condoms to be effective as a preventive tool against HIV infection and other sexually transmitted infections it requires consistent and correct use (UNAIDS, 2000; Agha, 1998; Adetunji and Meekers, 2001; Davis and Weller, 1999). It is believed that the effectiveness of condoms at preventing HIV transmission is estimated to be as low as 60 percent

if not used correctly and consistently or as high as 96 percent if used correctly and consistently (Davis and Weller, 1999; UNAIDS, 2000). Thus, in this study the frequency of condom use was assessed to ascertain the extent to which condoms are used in the study areas.

Consistency of condom use was the last indicator to measure the use of condoms in the study areas. Thus, those respondents who answered the question whether or not they used a condom at last sex were then asked to indicate how often they used a condom. A three-category ordinal scale was applied to measure the frequency of condom use, namely *always, occasionally and never.* The last category was included to ascertain the real percentage of consistent condom use in the study settings. Table 6.13 presents the results.

Table 6.13: Percentage of respondents who reported consistent condom use

	Men		Women	
	n	**%**	**n**	**%**
Frequency of condom use				
Always	32	15.4	22	10.1*
Occasionally	75	36.0	72	33.2
Never	101	48.6	123	56.7
Total	**208**		**217**	

Not surprisingly the number of consistent condom users is quite low. A small percentage of men and women reported consistent condom use. Table 6.14 shows that for both men and women there is strong association between the frequency of condom use and all selected explanatory variables. In addition, the results of the bivariate analysis also suggest that consistent condom use in both sexes is very low. Nevertheless, men are more likely than women to report that they always used a condom, with about 15 percent of men reporting consistent condom use compared with 10 percent of women. Of note but also not surprising is that large proportions of both men and women reported that they have never used a condom though women outnumber men in this regard. These findings seem to be in line with what have been found with regard to the low levels of condom use in Mozambique (National Institue of Statistics, 2002; Prata et al., 2006).

Nevertheless, these findings may represent a significant improvement compared with previous data, but not yet enough to curb the progression of HIV/AIDS.

The bivariate analysis was applied to assess the levels of consistent condom use. The independent variables includes place of residence, age, education, marital statues, perception of risk, number of sexual partners in the last 12 months and household socio-economic status. Table 6.14 shows the percentage of respondents who reported that they always used a condom, by selected background characteristics. The results indicate that, for men, age, education, marital status and socio-economic status are strong predictors of consistent condom use. Thus, younger men aged 20-29 years were more likely than men of older age groups to report that they always used a condom with 21 percent reporting consistent use compared with 9 percent of men in the older age groups, respectively.

Table 6.14: Percentage of respondents who reported consistent condom use, by selected background characteristics

Background characteristics	Men		Women	
	n	%	n	%
Place of residence				
Urban	106	19.8	111	16.2*
Rural	102	10.8	106	3.8
Age				
20-29	108	21.3*	121	12.4
30-39	54	9.3	60	10.0
40-49	46	8.7	34	2.9
Level of Education				
None	28	3.6**	51	3.9*
Primary	98	8.2	106	8.5
Secondary or higher	82	28.0	60	18.3
Marital Status				
Married/cohabiting	138	5.1**	120	4.2**
No	70	35.7	97	17.5
API				
Low	43	9.3*	67	7.5
Lower medium	59	6.8	50	4.0
Upper medium/high	106	22.6	100	15.0
Perception of Risk of HIV Infection				
Low	105	14.3	164	9.8
High	101	15.8	53	11.3
Number of Sexual Partners				
1	116	12.1	201	9.5
2 +	92	19.6	16	18.8
Total	**208**		**217**	

Note: * Significant $P \leq 0.05$ percent; ** significant $P \leq 0.01$ percent

Men with secondary or higher education were more likely than less educated men to report that they always used a condom. Furthermore, the findings indicate that men who were neither married nor cohabiting were more likely than married and cohabiting men to report consistent condom use, with 36 percent of them saying so compared with only 5 percent of married and cohabiting men. Finally, the findings indicate that men with a higher socio-economic status were

more likely than men with a lower socio-economic status to report that they always use a condom. About 23 percent of men with an upper medium or high socio-economic status reported consistent condom use compared with 9 percent of men with a low socio-economic status and 7 percent of men with a lower medium socio-economic status.

For women, the bivariate analysis indicates that place of residence; education and marital status are associated with consistent condom use. Thus, women living in urban areas were more likely than those living in rural areas to report that they always used a condom, with about 16 percent of them reporting that they always used a condom compared with just 4 percent of rural women. In addition, women aged between 20-29 years were more likely than women aged 30 and above to report that they always used a condom. Similarly, women with secondary or higher education were more likely than less educated women to report that they always used a condom. Furthermore, the findings indicate that women who were neither married nor cohabiting were more likely than married and cohabiting women to report that they always used a condom, with 18 percent reporting so compared with just 4 percent of married and cohabiting women. Although not statistically significant ($P \leq 0.075$), women with an upper medium or high API were more likely than women with a lower medium and a low APIs to report that they always used a condom. In this regard, 15 percent of women with an upper medium or high API reported consistent condom use compared with 8 percent of women with a low API and 4 percent with a lower medium API. All the variables described are statistically significant for both men and women.

In order to assess the determinants of consistent condom use, a logistical regression analysis was done. Respondents who reported ‘always’ using condoms were classified as consistent users while those who reported occasional or never using condoms were classified as non users or not consistent users. Thus, the variable has two values: consistent use coded as “1” and inconsistent use coded as “0”. The value coded “1” has been taken as a reference group. The independent or predictor variables include place of residence, age, level of education, marital status, household socio-economic status, perception of risk and number of sexual partners in the last 12 months.

Separate models for males and females have been used to account for gender differences in consistency of condom use. The results are given in Table 6.15 and Table 6.16, respectively.

The results of logistic regression analysis for men show that education and marital status variables have statistically significant unadjusted effects on consistent condom use. Thus, men with secondary or higher education were more than ten times more likely to report consistent condom use than men with less education (odds ratios = 10.53). Similarly, neither married nor cohabiting men were ten times more likely to report consistent condom use than men in marital and cohabiting unions (odds ratios = 10.40). Place of residence, age and socio-economic status do not have statistically significant unadjusted effects on consistent condom use. Nevertheless, it is important to note that men living in rural areas were less likely than men living in urban areas to report consistent condom use (odds ratios = 0.49). Likewise, men aged 30-39 years and those age 40-49 years were also less likely than younger men to report consistent condom use (odds ratios = 0.38 and 0.35, respectively).

Table 6.15: Odds ratios for men who reported consistent condom use: logistic regression results

	Odds ratios and 95% confidence intervals	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	0.49(0.22 – 1.08)	2.35 (0.68 – 8.24)
Age		
20-29	1.00	1.00
30-39	0.38 (0.14—1.06)	1.58 (0.72 - 6. 75)
40-49	0.35 (0.11 – 0.08)	1.66 (0.41 – 6.78)
Level of Education		
None	1.00	1.00
Primary	2.40 (0.29-20.05)	1.49 (0.15 – 15.19)
Secondary and more	10.53* (1.35 – 82.03)	4.42 (0.41 – 47.36)
Marital Status		
Currently married/ living together	1.00	1.00
No	10.40** (4.21 – 25.67)	12.54** (3.44 – 45.71)
API		
Low	1.00	1.00
Lower medium	0.71 (0.17 – 3.01)	1.69 (0.29 – 9.97)
Upper medium/high	2.85 (0.93 – 8.79)	2.46 (0.44 – 13.71)
Perception of Risk of HIV infection		
Low	1.00	1.00
High	1.13 (0.53 – 2.43)	1.02 (0.42- 2.48)
Number of Sexual Partners		
1	1.00	1.00
2 +	1.77 (0.83 – 3.79)	2.0 (0.81 – 4.97)

Note: * Significant $P \leq 0.05$ percent

In addition, men with an upper medium or high API were almost three times more likely to report consistent condom use than men having a low medium API (odds ratios = 2.85 and 0.71, respectively). Conversely, men with a lower medium API were less likely than men with a low API to report consistent condom use (odds ratios = 0.71). Condom use is higher among men with

two or more partners than men with fewer partners but this is not statistically significant. In addition, men with a higher perception of risk of HIV infection were more likely to report condom use than men with a lower perception of risk of HIV infection but this is also not significant. After controlling for other variables, only marital status continues to have a strong statistically significance adjusted effect on consistent condom use. Thus, men who were neither married nor cohabiting were more than twelve times more likely to report consistent condom use than men in marital and cohabiting unions (odds ratios = 12.54).

Table 6.16 shows the results of logistic regression analysis of consistent condom use for women. The results indicate that place of residence; education and marital status variables have statistically significant unadjusted effects on consistent condom use. In this regard, it could be seen that women living in rural areas were less likely than those living in urban areas to report consistent condom use (odds ratios = 0.20). Again, women with secondary or higher education were five times more likely to report consistent condom use than women with less education (odds ratios = 5.50). Furthermore, women who were neither married nor cohabiting were almost five times more likely to report consistent condom use than women in marital and cohabiting unions (odds ratios = 4.89). Age, perception of risk of HIV infection, number of sexual partners in the last 12 months and household socio-economic status do not have statistically significant unadjusted effects on consistent condom use for women.

Table 6.16: Odds ratios for women who reported consistent condom use: logistic regression results

	Odds ratios and 95% confidence intervals	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	0.20*(0.07 – 0.62)	0.30 (0.07 – 1.31)
Age		
20-29	1.00	1.00
30-39	0.79 (0.29 - 2.14)	0.13 (0.34-- 3. 75)
40-49	0.21 (0.03 – 1.68)	0.48 (0.05 – 4.53)
Level of Education		
None	1.00	1.00
Primary	2.27 (0.47 - 10.93)	1.05 (0.18 – 6.08)
Secondary and more	5.50* (1.16 – 26.12)	1.33 (0.119 –98.53)
Marital Status		
Married/ Cohabiting	1.00	1.00
No	4.89* (1.73 – 13.79)	3.71 *(1.24 – 11.17)
API		
Low	1.00	1.00
Lower medium	0.52 (0.10 – 2.78)	0.76 (0.13 – 4.19)
Upper medium/high	2.19 (0.76 – 6.34)	0.95 (0.27 – 3.38)
Perception of Risk of HIV infection		
Low	1.00	1.00
High	1.18 (0.44 – 3.19)	0.81 (0.28- 2.37)
Number of Sexual Partners		
1	1.00	1.00
2 +	2.21 (0.58 – 8.45)	0.24 (0.29 – 5.35)

Note: * Significant $P \leq 0.05$ percent

After controlling for other variables, only marital status remains a strong predictor of consistent condom use. Thus, women who were neither married nor cohabiting were almost four times more likely to report consistent condom use than women in marital and cohabiting unions (odds ratios = 3.71).

The focus group discussions and in-depth interviews show both men and women are aware of condoms and their importance in protecting against the risk of sexually transmitted infections and unwanted pregnancies. Consistent condom use is deemed critical to curb the HIV infection (Davis and Weller, 1999; Slaymaker, 2004; Prata et al., 2006). But consistent use of condoms seems to be a big challenge even in secondary relationships. Secondary relationships can be defined as an extramarital relationship or relationship which happens simultaneously with the regular and committed relationship. Three reasons may be behind such a challenge: The first is a moral reason, that is, to avoid negative meanings attached to condoms, (which symbolize uncleanness, disease and lack of trust). Individuals may avoid condoms even in secondary relationships in order to preserve the status of the relationship. The second is that men may continue using their power to influence sexual decision-making as appears to be the case in stable or 'committed' relationships (Varga, 2000). Thirdly, women who are secondary partners, but are not necessary sex workers also may not be keen to be seen or perceived as secondary (and 'unclean') partners. This poses similar dilemmas to those in marital and cohabiting unions. Although women in secondary relationships may perceive themselves as secondary partners, they may not cease to have some expectations to become primary partners or improve their relationship status. Furthermore, because of their socio-economic vulnerability, women may avoid confrontation which could jeopardize their relationships. Recent studies have shown that while married men report significant condom use in extramarital sex, married women report alarmingly low levels of condom use in extramarital encounters (de Walque and Kline, 2009).

Indeed, some male respondents in rural focus group discussions acknowledged that inconsistent condoms use is a big problem. They argued that men and women forget about using condoms for a variety of reasons including alcohol consumption.

"In the first days a couples are usually aware of condoms. They may practice safe sex, but after a month or two they end up forgetting about them. Many of those who have AIDS acquired it because they forgot that they should use a condom. Some have sex while they are drunk and they forget or they are in a hurry and they end up having sex without a condom".

(Rural married males, FGD # 12)

On the other hand, inconsistent condom use can also be illustrated in the following comments by one male respondent in the in-depth interviews. He recognizes that condoms are available in stores. Even though he says that he does not use condoms frequently, he buys and uses them when he is suspicious of a new partner. The quote also suggests that sometimes men use condom with suspicious partners in order to protect their spouses.

"There are condoms for sale here, in stores. But I do not buy them because I do not use condoms with my wife. When I have an outside girlfriend and I am suspicious of her, I buy condoms before having sexual intercourse, because I cannot infect my wife. But only occasionally I do use them."

(Rural married male, IDI # 13)

One female respondent admitted during the in-depth interviews that at beginning she insists on using condoms with her partner but after a short while they stop using them. The respondent reported that in general men usually try to convince their partners that there is no need to use condoms, because as they argue, the relationship has developed and trust is already established, therefore they can have sex without condoms.

"I insist that he should use a condom. I do not say that we will use it forever. But because we are at the beginning of the relationship we use it, but thereafter we will stop.

(Urban non-married female, IDI # 09)

One urban male respondent confirmed in the in-depth interviews what other respondents said about consistency in using the condoms. He said that the rationale for the termination of condom use is the life span of the relationship. They use condoms at the beginning, but the longer the relationship lasts the more likely they are to stop using condoms.

"What happens is that you can tell people that AIDS exists. They will use condoms for some time but after some time they will say 'we have been dating each other for some time, there is no risk of an infection'. People think like that."

(Urban married male, IDI # 15)

In addition, some respondents blamed the failure to use condoms on the "heat of the moment", which is generally associated with the fear that their partner may change their mind about having sexual intercourse and as a result there is a tendency to engage in unprotected sexual activities. Indeed, in a rural focus group discussion one man admitted that he has had unprotected sex in similar situation.

"I cannot deny that I have had sex without condoms even knowing that I have to use them. What happened is that we were together for some time and one day I was careless about using condoms just because I did not have them in my hands. And because we were kissing each other and condoms were a little bit far from where we were, so I started wondering: 'if I stop, in order to fetch condoms will she still be in mood for sex?', I was afraid that she would change her mind and say that she does not want sex anymore"

(Rural non-married males, FGD # 18)

6.8 Summary

The findings presented in this chapter clearly indicate that awareness of condoms is quite universal among men and women who participated in the study. This is consistent with the findings of similar studies about awareness of condoms and knowledge both in sub-Saharan Africa and elsewhere (Davis and Weller, 1999; Lagarde et al., 2001; Boer and Mashamba, 2007; Bankole and Singh, 2001). For example, a study by Agha (2001) and her colleagues found that the average total number of respondents of both sexes who knew of *JeitO* (Mozambique's condom brand) was 55 percent in Maputo province (where Matola city and Manhiça districts are located) and 56 percent nationwide (Agha et al., 2002). Other reports about low levels of condom

knowledge among sexually active populations in Mozambique are documented (Bankole and Singh, 2001; Prata et al., 2006). In this study, however, almost all the respondents of the study sample reported that they knew of condoms. In addition, the findings also suggest that a high number of participants knew where they could get a condom if they needed one. Nevertheless, although not surprising, the data also shows that men were more likely than women to be aware of a source of supply of condoms. Worryingly but not surprising is the fact that the findings also indicate that women were far less likely than men to report that they were confident about how to use a condom effectively. Indeed, it may be somewhat worrisome that about a half of women reported that they did not know how to use a condom effectively in a context where HIV/AIDS is rampant.

The findings show that the respondents have a relatively high level of positive beliefs about the efficacy of condoms. In this regard, both quantitative and qualitative findings show high levels of awareness about condoms and the role they might play in preventing STIs including HIV/AIDS and unwanted pregnancies. However, many men and women still express negatives attitudes towards condoms. Consistent with what has been reported in other studies men were more likely than women to hold negative attitudes towards condoms. This is in line with another study conducted in Côte d'Ivoire which found that more men than women hold negative attitudes about condoms (Guiella and Madise, 2007). For example, about a half of men and only 12 percent of women reported that condoms reduced sexual pleasure. Likewise, while almost a half of males reported that condoms encouraged promiscuous behaviour, only about one-third of females held similar views. In addition, whereas about half of males (59 percent) associate the use of condoms with lack of trust, only one-third of females agreed.

Qualitative findings point out that the issue of trust among partners; concerns about the efficacy of the product (defects on certain brands of condoms), sexual pleasure and intimacy are among the top reasons given for not using condoms. This is consistent with similar findings reported elsewhere (Bankole and Singh, 2001; Agha et al., 2002; Thomsen, et al., 2004). A study by Thomsen et al (2004) in Mombasa, Kenya, reported that there were at least 50 reasons for not using condom by men in that location. Those reasons included, among others, beliefs that

condoms prevent sexual pleasure; that condoms were defective, that they were harmful, that they were unnecessary, that it was too hard to use in the moment of 'heat' as well as other external forces (Thomsen et al., 2004). Similarly, in Mozambique, Agha et al. (2002) also found that while the first reason for not using condoms was the association of lack of trust in partner. The dislike of condoms was the second most frequently cited reason among both urban females and males (Agha et al., 2002).

The findings of this study suggest that partner communication about condoms is sporadic and still a challenge. For example, more than a half of males reported that they had ever discussed condoms with their partners, while the percentage is considerably lower for females. On the other hand, the findings suggest that condoms are no longer an unknown subject in relationships. Living in urban areas, being young, having secondary or higher education and being neither married nor cohabiting is positively associated with partner communication about condoms. These findings are consistent with other studies in sub-Saharan Africa (Guiella and Madise, 2007; Abdool Karim, 2001; Abdool Karim et al., 1994; Muhwava, 2004). For example, a study by Abdool Karim (2001) in KwaZulu-Natal, South Africa found that almost 94 percent of respondents believed that asking their partners to use condoms indicated a lack of trust (Abdool Karim, 2001: 194). Another study by Amuyunzu-Nyamongo and his associates (2005) in four sub-Saharan Africa countries concluded that negotiating the use of condoms became difficult once the issue of trust in relationships was introduced. According to the authors, that situation was even worse for those young women who might have received money or gifts from their partners (Amuyunzu-Nyamongo et al., 2005).

Furthermore, communication about condom is also very low among those men and women who said that they had never used a condom at all. This may be due to the fact that the subject of condoms; particularly in long-term relationships is an uncomfortable topic for both men and women (Chimbiri, 2007). But, on the other hand this may suggest a low personal risk perception among study participants. In this regard, many men and women who never used a condom reported that condoms had never become a topic of discussion within their relationships. One of the reasons given for this is that they had never needed to use them. This reality may reveal the

extent to which risk assessment is low among respondents. These findings are consistent, for example, with what Agha et al. (2002) have found in eight sub-Saharan Africa settings. They concluded that the fact that in most countries both married male and female respondents frequently reported trusting their partners, disliked condoms and that they did not use a condom because of not having them in the hands was a clear indication how important personal risk perceptions were in determining condom use in stable relationships (Agha et al., 2002).

As expected, men were more likely than women to report that they have ever used a condom. However, socio-demographic variables play a significant role in this. In fact, the bivariate analysis results indicate that place of residence, age, education and marital status are positively associated with ever using a condom among men and women of the study sites. Thus, the findings suggest that living in urban areas, being young, having secondary or higher education as well as being neither married nor cohabiting enhances ever use of condoms. It is noteworthy that among both men and women ever use of condoms is strongly associated with education and marital status.

Similarly, according to the results, men are more likely than women to report that they used a condom at their last sexual encounter. Indeed, men are more likely to report current condom use than women. For example, the unadjusted logistic regression analysis results indicate that men with secondary education and more were almost nine times more likely to report having used a condom at last sex than less educated men. Among women, the unadjusted logistic regression analysis results indicate that women with secondary or higher education were eight times more likely to report having used a condom at last sex than less educated women. Even having primary education alone does have a positive association with current condom use. These findings are quite consistent with other studies (Lagarde et al., 2001; Green, Fulop and Kocsis, 2000; Bankole and Singh, 2001). For example, a study by Lagarde et al., (2001) in four sub-Saharan African cities found that out of a large number of factors examined, education was found to be the most consistent determinant of condom use in non-spousal partnerships (Lagarde et al., 2001). Likewise, in an eighteen sub-Saharan African country study including Mozambique, Bankole and Singh (2001) found that more educated men were more likely to report having used a condom.

They also added that even having only a primary school education compared to no schooling showed a positive relationship with ever use of condom in most of the countries (Bankole and Singh, 2001: 18).

In addition, the logistic regression analysis results suggest that men who were neither married nor cohabiting were more likely to have used a condom at last sex than married and cohabiting men. The logistic regression analysis results for women also point to the similar trends. Indeed, women who were neither married nor cohabiting were more likely to have used a condom at last sex than married and cohabiting women. Focus group discussions and in-depth interviews gave a number of different reasons for non use of condoms, particularly among married and cohabiting partners. Those reasons include the nature of relationship, trust, sexual pleasure and intimacy, among others. Similar results have been reported elsewhere (Muhwava, 2004; Bauni and Jarabi, 2003). For example, Muhwava (2004) in Zimbabwe found that while condom use was higher in Zimbabwe than other African countries, negative conceptions about condoms still existed and that affected their use in regular or marital relationships. According to the author, both men and women were strongly against the use of condoms in marital relationships (Muhwava, 2004: 13).

Similarly, a study in Zambia (Agha, 1998) found that women in regular relationships may view them as precursor to marriage, and may become careful with something which can jeopardize their marital prospects, including engaging in casual sex. Thus, single women may establish casual relationships with men in order to form emotional ties leading to marital partnership and greater financial and emotional security, as well. Furthermore, given that Zambian women have low socio-economic status, they have limited ability to negotiate condom use in sexual relationships. For women like those, relational factors were very important in determining whether or not their partners used condoms. The author conclude that women's reports of higher condom use in casual or non regular sex than in marital sex was consistent with the finding that men are more likely to use condoms outside of marriage than within marriage (Agha, 1998).

The same pattern is also observed with regard to the frequency of condom use among men and women of the study areas. Qualitative findings suggest that sustained condom use was dependent

not only on the nature of relationship but also upon its duration. The findings indicate that when the relationship tended to last longer, the possibility of sidelining condoms becomes high. These findings are in line with other study findings (Longfield, Klein and Berman, 2002). Indeed, in their study Longfield, Klein and Berman (2002) found that most participants listed factors that are linked to discontinuation of use and establishment of trust among youth. One of the most recurrent factors was that related to the timing in relationships. Respondents described that youth usually abandon condom use after feeling that they 'know' their partner well, spending time in relationships, feeling reassured that partners are sexually faithful, and confirming trust through further 'investigations'. Furthermore, the discontinuing of condom use indicated advancement in relationships to more serious levels, especially consideration of marriage. In addition, participants indicated that some youth believed that trust was the only form of protection they need against STIs and HIV. Consequently, many explained that youth presumed that they did not need to use condoms with trusted partners or partners that they love (Longfield, Klein and Berman, 2002)

Meanwhile, the quantitative results suggest a slight improvement in the reports of condom use compared with other previous findings in Mozambique but it is still not enough to curb the progression of HIV infection. Furthermore, the results of bivariate analysis also suggest that consistent condom use among men and women is very low. Nevertheless, men were more likely than women to report that they always used a condom. For men the bivariate analysis results indicate that living in urban areas, being younger, having secondary education or more, being single or never married, and having an upper medium or high API is associated with consistent condom use. For women, the patterns are not so different. In fact, bivariate analysis results for women indicate that living in urban areas, being younger, having secondary or higher education, being neither married nor cohabiting, and having an upper medium or high API is associated with consistent condom use. The results of logistic regression analysis for men show that education and marital status have statistically significant unadjusted effects on consistent condom use. Thus, men with higher levels of education are ten times more likely to report consistent condom use than less educated men. Similarly, married or cohabiting are more likely to report consistent condom use than men in marital and cohabiting unions.

The results of logistic regression analysis for women indicate that place of residence; education and marital status variables have statistically significant unadjusted effects on consistent condom use. Thus, women living in rural areas were less likely that those living in urban areas to report consistent condom use. However, women with higher levels of education were five times more likely to report consistent condom use than women with less education. These findings are in line with other studies about condom use in sub-Saharan Africa (de Walque and Kline, 2009; Hounton et al., 2005). Based on nationally representative samples from 13 sub-Saharan Africa countries, de Walque and Kline (2009) came to the conclusion that levels of condom use were generally low, that men reported using condoms more frequently than women, and that unmarried individuals reported using condoms more frequently than married individuals with their spouses. However, it was disturbing to note that while married men reported condom use in extramarital relationship as unmarried men did, married women reported very low levels of condom use in extramarital relationships (de Walque and Kline, 2009).

CHAPTER 7: SEXUAL BEHAVIOUR

7.1 Introduction

In most parts of the world, the main route of HIV transmission is high-risk activities, namely the use of injectable drugs, male-to-male anal sex, and sex work (UNAIDS, 2008). In sub-Saharan Africa, it is widely documented that the most predominant force fuelling the HIV/AIDS epidemic is heterosexual unprotected intercourse (Orubuloye, Caldwell and Caldwell, 1997; Caldwell, 1999; Halperin and Epstein, 2007; Guiella and Madise, 2007). Apart from that, it is also recognized that risky sexual behaviours, including multiple sexual partnerships and extramarital unprotected sex have played a significant role in the spread of HIV infection in sub-Saharan Africa (Orubuloye, Caldwell and Caldwell, 1995; Smith, 2007; Shanti, 2007). There are a number of indicators to measure risky sexual (UNAIDS, 2000, 2008). The core indicators to measure sexual risk behaviour include age at first sex, premarital sex, extramarital sex, multiple sexual partnerships, commercial sex and use of condoms (Cleland et al., 2004; Carael, 1995; Cohen and Trussell, 1996). The use of all or some of the specific indicators to measure sexual behaviour risks of a given adult population may vary, depending upon the nature and objectives of each study.

This chapter describes the sexual behaviour of men and women. It looks specifically at lifetime number of sexual partners; the number of sexual partners in the 12 months as well as the type and characteristics of the most recent sexual partner. Furthermore, the chapter focuses more specifically on the sexual behaviour of marital and cohabiting partners. Indeed, empirical evidence elsewhere suggests that HIV/AIDS is rampant within marital and cohabiting unions (Glynn et al., 2003, Smith, 2007). Thus highlighting the patterns of sexual behaviour and protective practices among men and women in Manhiça district and Matola Municipality may shed light on the determinants of the current high level of HIV infections in both areas.

7.2 Sexual Behaviour

In order to assess the sexual behaviour of men and women in both study settings a selected number of questions, based on the UNAIDS *core indicators* guidelines, were asked (UNAIDS, 2000; 2008). Respondents were asked to give information about lifetime number of past sexual partners since they became sexually active, the number of partners in the last 12 months prior to the survey, partner type and characteristics. Indicators of sexual behaviour are probably the most valuable of all indicators in monitoring the level of HIV infections (UNAIDS, 2000).

7. 2.1 Lifetime Number of Sexual Partners

Lifetime number of sexual partners refers to the total number of sexual partners since he or she became sexually active (Slaymaker, 2004; Oral, 2004; Wittrock, 2004; Brown and Sinclair, 1999). While one's sexual history may consist of a range of sexually related events (Murkowski, Croake and Keller, 1978; Holmberg and Blair, 2009; Dixon-Mueller, 1993; Varga, 2001; Higgins and Hirsch, 2007), lifetime number of past sexual partners is related to sexual risk behaviour (Slaymaker, 2004; Clark, 2004; Gregson et al., 2002; Todd et al., 2008). The risk of HIV infection is greater for people who have sex with many sexual partners. According to Slaymaker (2004), this risk depends on the rate at which new partners are acquired and on whether those partners have other sexual partners.

It is generally used by some scholars and researchers as an indicator of sexual risk exposure to sexually transmitted infections including HIV/AIDS, particularly when safe sex practices such as the use of condoms are not observed (Shepard, et al., 2001; Carpenter, et al., 1999; Gregson et al., 2002; UNAIDS, 2008). Thus, in order to obtain information about their lifetime number of sexual partners, respondents were asked: "*In total, how many partners have you had sexual intercourse with in your entire life?"* The results are shown in Table 7.1

Table 7.1: Percentage of respondents by total lifetime number of past sexual partners

Lifetime number of sexual partners	Men		Women	
	n	%	n	%
1	14	6.7	70	32.3
2-4	58	27.7	123	56.6
5 +	137	65.6	24	11.1
Total	**209**		**217**	

The data indicates that few men and women restrict themselves to one sexual partner. Indeed, while only 6.7 percent of men reported that they had only one sexual partner in their entire lifetime, the corresponding proportion for women was 32 percent. Of interest but not surprising is the fact that men are more likely than women to report a higher number of past sexual partners. Women were more likely than men to report that they had two to four partners in their lifetime. Almost 57 percent of all interviewed women admitted that they had between 2 to 4 sexual partners in their lifetime compared with only 28 percent of men. Almost two-thirds of men (66 percent), compared with 11 percent of women, reported having five or more lifetime number of sexual partners.

In order to assess the characteristics of men and women who reported more than five lifetime number of sexual partners a bivariate analysis was performed with some selected socio-economic and demographic characteristics. The socio-economic and demographic characteristics include place of residence, age, level of education and marital status and household socio-economic status.

Table 7.2: Percentage of respondents who reported five or more partners in their lifetime, by selected socio-demographics background

	Men		Women	
	n	**%**	**n**	**%**
Place of residence				
Urban	106	64.2	111	17.1*
Rural	103	67.0	106	4.7
Age				
Less than 30	108	60.2	121	13.2
30 and more	101	71.3	94	8.5
Level of Education				
Less than secondary	127	70.1	157	8.3
Secondary or higher	82	58.5	60	18.3
Marital Status				
Married/cohabiting	138	69.6	120	6.7*
Neither	71	57.7	97	16.5
API				
Low	44	68.2	67	11.9
Lower medium	59	71.2	50	4.0
Upper medium/high	106	61.3	96	14.0
Total	**209**		**217**	

Note: * significant $P \leq 0.05$ percent.

Table 7.2 shows the percentage of men and women who reported five or more partners in their lifetime by selected socio-economic and demographic characteristics. Table 7.2 shows that place of residence and marital status seems to emerge as the most powerful determinant of lifetime number of sexual partners for women. However, for men, none of the variables were statistically significant.

For men, the findings suggest that young adult men in their twenties were less likely than men in their thirties and forties to report five or more lifetime partners. Indeed, Table 7.2 shows that 60 percent of men below 30 years reported five or more lifetime sexual partners at the time of the survey compared with 71 percent of men aged 30 years and over. Therefore, these findings

suggest that accumulation of sexual partner's overtime for men. In this regard, taking into consideration that young men may continue acquiring sexual partners if they do not change their behaviour then, lifetime numbers of sexual partners will increase as their age increases. This is of serious concern in the context of the HIV/AIDS pandemic. The bivariate analysis shows that there is a significant association between place of residence and lifetime number of sexual partners for women. The picture for men is slightly less clear. Indeed, no significant differences among urban and rural men are observed although rural men were more likely than urban men to report five or more lifetime partners. Similarly, level of education seems to play a marginal role in influencing lifetime number of sexual partners for men. Nevertheless, it is worth noting that men with less than secondary education were more likely than men with secondary or higher education to report five or more lifetime sexual partners.

Meanwhile the fact that men with less than secondary education reported having had more than five lifetime sexual partners does not indicate that they are more prone to multiple sexual partnerships than men with secondary or higher education. In other words, for men lifetime number of sexual partners cannot be explained by education attainment only. The number of lifetime sexual partners for men seems to be related to other factors which underlie the propensity of men to collect sexual partners during the course of their life.

Finally, marital status of men (as education) seems to play a marginal role in determining lifetime number of sexual partners. Married and cohabiting men were more likely than men who were neither married nor cohabiting to report five or more partners in their lifetime. This could be due to the fact that single and never married men are still young. Indeed, 56 percent of men aged 20-29 years reported themselves single or never married (Table not shown). Here, and contrary to what one would expect, the marital or cohabiting status of men does not prevent the men from accumulating sexual partners. This, though not surprising, is a cause of concern since the findings reflect risky sexual behaviour, which is in line with the general worldwide trend (Wellings et al., 2006; Cohen and Trussell, 1996; Cleland et al., 2004). Lifetime number of sexual partners is not significantly associated with the socio-economic household status of men. Nevertheless, it should

be noted that men with an upper medium or high API were more likely than men with a low and lower medium API to report five or more lifetime number of sexual partners.

With regard to women, the findings shown in Table 7.2 indicate that place of residence and marital status seems to have a strong influence on women's lifetime number of sexual partners. Thus, Table 7.2 shows that urban women were more likely than rural women to report five or more lifetime sexual partners. The findings regarding place of residence are statistically significant. Of interest regarding age is that women's lifetime sexual partner tends to peak during their twenties but, generally, declines sharply as they age increase, above thirties. These findings may represent a significant shift in the sexual behaviour of younger women compared with the older generation of women. In addition, the findings seem to be consistent with other studies findings where it has been suggested that although women usually underreport their lifetime sexual partners, young women are more likely than older women to report a higher numbers of sexual partners (Gregson et al., 2002; Todd et al., 2008).

Level of education seems to impact on lifetime number of sexual partners for women. Thus, women who had secondary or higher education were more likely than women with less education to report more lifetime number of sexual partners. This seems to be consistent with what other studies have suggested that while education plays a pivotal role in enhancing women's sexual health, including delaying marriage it also allows an open window to more premarital sex (Bankole and Singh, 1998). In contrast, marital status seems to play a significant role in women's lifetime number of sexual partners. In this regard, the findings suggest that married and cohabiting women were less likely than neither married nor cohabiting women to report five or more partners in their lifetime. These results are also statistically significant. For women, lifetime number of sexual partners seems to be associated with the socio-economic status of the household. Thus, women with an upper medium or high API were more likely than women with a low and lower medium API to report five or more lifetime number of sexual partners. However, these findings are not statistically significant.

7.3 Concurrent and Serial Multiple Partnerships

Studies have shown that there is a strong link between HIV infection and multiple sexual partnerships (Wellings et al., 2006; Smith, 2007; Kazaura and Masatu, 2009). Although some of the preventive measures such as abstinence and mutual monogamy are very useful in curbing the spread of HIV infection, the reality though shows that for different reasons, men and women engage in sexual relations with other people rather than their marital, cohabiting or non-cohabiting but *regular* partners (e.g. boyfriends or girlfriends) (Agha et at., 2002). Thus, investigating the concurrent and sequential partnerships of men and women would draw a reliable picture and also provide some explanations with regard to the current high HIV infections rates in the study areas. Concurrent partnerships are defined as risky sexual behaviour where sexually active men and women have more than one sexual partner overlapping in time (for months or years). By contrast, sequential partnerships (also known as serial monogamy) is defined as the tendency to have one relatively long-term partner after another (lasting a few months or longer), or the more 'one-off' casual and commercial sexual encounters (Halperin and Epstein, 2007; Wellings et al., 2006; Lagarde et al., 2001). Two indicators are used in this study to track sexual networking as well as sexual risk behaviour. The first indicator refers to the number of sexual partners in the last 12 months prior to the study. The second indicator refers to the three most recent sexual partners, including partner type and characteristics at last sex.

7.3.1 Number of Sexual Partners in the last 12 months

In order to measure the proportion of respondents who may have exposed themselves to the risk of HIV infection by engaging themselves with more than one sexual partner, they were asked "*How many partners have you had sex with in the last 12 months?"* The results are shown in Table 7.3. As shown in Table 7.3 the majority of both men and women reported that they just had one sexual partner in the last 12 months before the survey. However, proportional differences among sexes are also observed.

Table 7.3: Percentage of respondents by number of sexual partners in the last 12 months

Number of sexual partners in the last 12 months	Men		Women	
	n	%	n	%
0	1	0.5	0	0.0
1	116	55.5	201	92.6
2+	92	44.0	16	7.4
Total	**209**		**217**	

Thus, about 93 percent out of all interviewed women said that they had only one sexual partner in the last 12 months before the survey compared with 56 percent of men. Meanwhile men were more likely than women to report more than one sexual partner in the last 12 months. An astonishing 44 percent of men, almost half of the male sample, said that they had two or more sexual partners in the last 12 months compared with only 7 percent of women who admitted having had two or more sexual partners in the same period. In order words, 44 percent of all men who participated in the study had engaged in multiple sexual partnerships in the last 12 months before the survey. This trend could be described as high risk sex. This seems to be consistent with some of the suspicions raised in the qualitative findings by some women in marital or cohabiting unions about their partners' sexual behaviour. Furthermore, married and cohabiting women were asked if their partner had other sexual partners. The results are shown in Table 7.3.1.

Table 7.3.1: Percent distribution of female respondents who reported that their married or cohabiting partner had other sexual partners

Does your partner have other partners?	Women	
	n	%
Yes	26	21.7
No	83	69.2
Don't Know	11	9.2
Total	**120**	

The majority of married and cohabiting women reported that their partner did not have other sexual partners. However, significantly, Table 7.3.1 shows that about 22 percent of women in marital and cohabiting unions reported that their partners had other sexual partners. In addition, 9 percent reported that they did not know if their partner had other sexual partners. Likewise, married and cohabiting men were asked if they had other sexual partners. The majority reported not having other sexual partners. Table 7.3.2 shows that almost 6 percent of married and cohabiting men reported having other sexual partners. Although this evidence does not necessarily indicate a higher-risk sex *per se*, it does indicate, however, that sexual networking among respondents it is not an uncommon phenomenon in the study sites**.**

Table 7.3.2: Percent distribution of married or cohabiting male respondents who reported that they had other partners

Do you have other partners?	**Men**	
	n	**%**
Yes	8	5.8
No	130	94.2
Don't Know	0	0.0
Total	**138**	

In order to assess the characteristics of men and women who reported more than one sexual partner in the past 12 months, bivariate analysis was performed with some selected socio-economic and demographic characteristics. Table 7.4 shows the percentage of respondents who reported more than one sexual partner in the last 12 months.

Table 7.4: Percentage of respondents who reported more than one sexual partner in the last 12 months, by selected demographics indicators

	Men		Women	
	n	**%**	**n**	**%**
Place of residence				
Urban	106	42.5	111	11.7*
Rural	102	46.1	106	2.8
Age				
Less than 30	108	50.0	121	11.6*
30 and more	100	38.0	94	2.1
Level of Education				
Less than secondary	126	46.8	157	5.1*
Secondary or higher	82	40.2	60	13.3
Marital Status				
Married/cohabiting	138	42.8	120	5.0
Neither	70	47.1	97	10.3
API				
Low	43	46.5	67	6.0
Lower medium	59	40.7	50	6.0
Upper medium/high	106	45.3	100	9.0
Total	**208**		**217**	

Note: * significant $P \leq 0.05$ percent.

The findings suggest that place of residence is strongly associated with the propensity to report more than one sexual partner in the past 12 months for women but not for men. For example, urban women (12 percent) were more likely than rural women (3 percent) to report having had more than one sexual partner in the last 12 months prior to the survey. The relationship is statistically significant. However, although Table 7.4 suggests that rural men (46 percent) were more likely than urban men (43 percent) to report having had more than one sexual partner in the last 12 months, the relationship is not statistically significant.

Likewise, age seems to play a significant role in influencing multiple partnerships for women but not for men. Indeed, younger women (12 percent) were more likely than older women to report that they had more than one sexual partner in the last 12 months. Although not statistically significant the Table 7.4 results indicate that younger men (50 percent) were more likely than

older men (28 percent) to report having had more than one sexual partner in the last 12 months prior to the survey. These findings may suggest that, although multiple sexual partnerships is largely a male phenomenon, sexual networking among females is also occurring, particularly among younger women.

The results also indicate that, among men, the level of education seems not to have had a significant influence on sexual networking in the past last 12 months. In this regard, the findings suggest that male multiple sexual partnerships is a phenomenon which seems to go beyond education attainment. For example, among men, regardless of the level of education almost half of men had more than one sexual partner in the last 12 months before the survey. Meanwhile, Table 7.4 suggests that men with less than secondary education were more likely than men with secondary or higher education to report having had more than one sexual partner in the last 12 months.

Meanwhile, the picture is slightly different for women. Level of education seems to be related to sexual networking. As it can be seen in Table 7.4, more educated women were more likely than less educated women to report having had more than one sexual partner in the last 12 months. Thus, while women with less than secondary education were less likely to report having had more than one sexual partner in the last 12 months (5 percent), about 13 percent of women with secondary or higher education were more likely to report having had more than one sexual partner in the last 12 months. Three interconnected reasons may explain this pattern of female's sexual networking. First, a number of studies suggest that education attainment delays early marriage (Singh and Samara, 1996). Second, women may express their sexuality more freely nowadays than before. Third, because of their lower socio-economic status, young women may involve themselves with different sexual partners in order to support themselves financially (Varga, 2003). The data are statistically significant for women but not for men.

Meanwhile, very worrying is that marital status seems not to influence multiple sexual partnerships among males. Indeed, the findings suggest that married or cohabiting men in particular, did not refrain from engaging in multiple partnerships in the last 12 months before the

study. Indeed, although men who were neither married nor cohabiting (47 percent) were more likely than married and cohabiting men to report multiple sexual partners, almost 43 percent of men in marital and cohabiting unions reported having had more than one sexual partner in the last 12 months before the survey. Among women, married or cohabiting women (five percent) were less likely than women who were neither married nor cohabiting to report more than one sexual partner in the last 12 months.

In addition, the socio-economic status of the household does not have any influence in reporting more than one sexual partner in the last 12 months for both men and women. Nevertheless, the findings suggest that men with a low and upper medium or high API were more likely than men with a lower medium API to report having had more than one sexual partner in the last 12 months. Of interest though is that, among women, sexual networking seems to increase with the increase in socio-economic status. Thus, women with a higher socio-economic status (9 percent) were more likely than women with a lower socio-economic status (6 percent) to report having had more than one sexual partner in the last 12 months.

In order to assess the strength of the association, logistical regression analysis was also conducted. The dependent variable was the number of partners in the last 12 months before the survey. The variable consists of two values: “1 partner” reporting was coded “0” and “2 partners and more partners” was coded “1”. The value coded “1” has been taken as a reference group. The independent variables were place of residence, age, education, marital status and household socio-economic status. The models were fitted separately for male and females to accounts for gender differences in number of sexual partner in the last 12 months. The results of the models for males are given in Table 7.4.1

Table 7.4.1: Odds ratios for men who had more than one sexual partner in the last 12 months prior to the survey: logistic regression results

	Odds ratios and 95% confidence intervals Men	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	1.16(0.67 – 2.00)	1.41 (0.67 – 2.96)
Age		
Less than 30	1.00	1.00
30 and more	0.61 (0.35 - 1.07)	0.55 (0.29 - 1.05)
Level of Education		
Less than secondary	1.00	1.00
Secondary or higher	0.77 (0.44 – 1.34)	0.60 (0.30 – 1.19)
Marital Status		
Currently married/ living together	1.00	1.00
Neither	1.19 (0.67 – 2.13)	1.08 (0.51 – 2.28)
API		
Low	1.00	1.00
Lower medium	0.79 (0.36 – 1.74)	0.84 (0.37 – 1.90)
Upper medium/high	0.95 (0.47 - 1.94)	1.38 (0.57 – 3.33)

Note: * significant $P \leq 0.05$ percent

The logistic regression analysis results for men confirm the results of the bivariate analysis. Indeed, Table 7.4.1 shows that none of the variables fitted had any effect in both models for men. Nevertheless, the results shown in Model I indicate that rural men were slightly more likely than urban men to report more than one partner in the last 12 months (odds ratios = 1.16). Likewise, men who were neither married nor cohabiting were more likely than married and cohabiting men to report more than one sexual partner in the last 12 months (odds ratios = 1.19). In addition, older men were less likely than younger men to report more than one sexual partner in the last 12 months (odds ratios = 0.61). After controlling for other variables, none of the variables have any

statistically significant effect on men reporting more than one sexual partner in the last 12 months. The logistic regression analysis results for women are shown in Table 7.4.2.

Table 7.4.2: Odds ratios for women who reported more than one sexual partner in the last 12 months: logistic regression results

	Odds ratios and 95% confidence intervals	
	Women	
	Model I Unadjusted	**Model II Adjusted**
Place of Residence		
Urban	1.00	1.00
Rural	0.22* (0.06 – 0.794)	0.16* (0.03 – 0.77)
Age		
Less than 30	1.00	1.00
30 and more	0.17* (0.04 - 0. 75)	0.17* (0.03 - 0.82)
Level of Education		
Less than secondary	1.00	1.00
Secondary or higher	2.87*(1.02 – 8.02)	0.93 (0.27 – 3.24)
Marital Status		
Currently married/ living together	1.00	1.00
Neither	2.18 (0.76 – 6.24)	1.42 (0.45 – 4.49)
API		
Low	1.00	1.00
Lower medium	1.05 (0.22 – 4.71)	1.17 (0.23 – 6.03)
Upper medium/high	1.56 (0.46 - 5.28)	0.56 (0.14 – 2.24)

Note: * significant $P \leq 0.05$ percent

The results of logistic regression analysis show that rural women were less likely than urban women to report more than one sexual partner in the last 12 months (odds ratios = 0.22). Likewise, older women aged 30 years and above were less likely than younger women aged below 30 years to report more than one sexual partner in the last 12 months (odds ratios = 0.17). Women with secondary or higher education were almost three times more likely to report more than one sexual partner in the last 12 months (odds ratios = 2.87). Meanwhile, although not statistically significant, the logistic regression results indicate that women who were neither married nor cohabiting were twice more likely than married and cohabiting women to report

more than one sexual partner in the last 12 months (odds ratios = 2.18). In addition, the results also suggest that women with a higher socio-economic status were more likely than women with a lower socio-economic status to report having had more than one sexual partner in the last 12 months before the survey (odds ratios = 1.56).

After controlling for other variables, place of residence and age still have a strong negative effect on women reporting more than one sexual partner in the last 12 months. However, level of education loses its strength, after adjusting for other variables.

7.3.2 Partner Type and Characteristics

Studies have shown that partner type and characteristics may interfere with the adoption of safer sex practices (Maharaj and Cleland, 2004). Thus, in order to assess more thoroughly the partner with whom both men and women had sex with in the last 12 months, two questions were asked. First, "*How would you describe this partner?"* Second "*How old was this partner?"* The first question intended to assess some of the prevailing conditions within which relationships occur, by identifying the type as well as other personal characteristics of the partner which may have played a determining role in protective practices. The second question aimed to assess how much older or younger these partners were since it is recognized that power differences in relationships and sexual risk depend, although not exclusively, upon age. Indeed, studies have found that HIV infection was much more severe among young women in their late teens and early twenties, while among men was more severe from late twenties and above (Williams and Campbell, 2002; Boerma et al., 2003). Explanations given suggest that this was due to the fact that, for economic reasons, young women usually get involved with older men who are more likely to have had multiple sexual partners, including commercial sex workers and, therefore, more likely to be infected with HIV than younger men (Glynn et al., 2001; Macphail, Williams and Campbell, 2002; Boerma et al., 2003; Longfield et at., 2004).

The majority of respondents of both sexes reported that they had last sex with their marital or cohabiting partner, or regular partners in the last 12 months before the survey (Table not shown). However, women were more likely than men to report that they had last sex with their marital, cohabiting or regular partners. All the women in marital and cohabiting unions reported having had sex with a marital or cohabiting partner compared with 95 percent of men. Table 7.5 shows a detailed breakdown of characteristics of partners at last sex. Among married and cohabiting respondents, the findings show that although the majority of both men and women reported that their last sexual encounter before the survey had been with their marital or cohabiting partner, some men get involved in extra-marital relationships. Indeed, Table 7.5 shows that about four percent of men reported having had their last sexual encounter with a casual acquaintance.

Among respondents who were neither married nor cohabiting, men were more likely than women to report that their last sexual encounter was with a non-regular sexual partner. Women were more likely to report that their last sexual encounter was with a regular partner. Thus twenty percent of men reported that their partner at the last sexual encounter was a regular partner (girlfriend) compared with 38 percent of women who reported having had the last sexual encounter with a non-cohabiting but regular partner (boyfriend). As can be seen, the breakdown of characteristics of partners at last sex conforms to expectations that men are more likely than women to engage in sexual relations with short-term partners. Almost four percent of men reported that the partner at last sex before the survey had been a casual partner. None of the women reported sexual relations with a casual partner. Moreover, about 12 percent of men reported that the partner at last sex was a “friend” compared with five percent of women who also reported that they had last sex with a “friend”. A friend may be a lover but can also be a personal friend with whom men and women sometimes engage in occasional sex.

Table 7.5: Percentage of respondents who reported partner type and characteristics at last sex in the last 12 months

Breakdown of characteristics of partner at last sex

	Men		Women	
	n	**%**	**n**	**%**
Marital/cohabiting	131	62.7	120	55.3
Casual acquaintance	9	4.3	0	0.0
Non-cohabiting *regular*	42	20.1	82	37.8
Friend	24	11.5	11	5.1
Ex-partner	2	1.0	4	1.2
Total	**208**		**217**	

Finally, one percent of men reported that the partner with whom they had last sex with before the survey was former partner compared with the same percentage (one percent) of women who reported having had last sex with a former partner. Of interest but not surprising is that an overwhelming majority of men reported that most of their three more recent partners in the last 12 months were younger than themselves. In contrast, the partners of women were overwhelming older (Tables not shown). This is in line with what has been reported in similar studies about age differences among sexual partners (Glynn et al., 2001; Carael, 1995; MacPhail, Williams and Campbell, 2002; Boerma et al., 2003; Longfield et al., 2004; White et al., 2000; Gregson et al., 2002; Mpofu et al., 2006; Todd et al., 2009)

The study also recorded the characteristics of the second and third most recent sexual partners for both men and women in the last 12 months before the survey. The results for men are given in Table 7.6. Fewer women (7 percent) than men (44 percent) reported having two or more partners in the past 12 months (Table 7.3). Table 7.6 suggests the respondent's sexual networking and the potential risk this may represent if protective practices are not observed.

In this regard, Table 7.6 shows two features which may deserve some attention. The first one is that about 12 percent of men reported their second most recent partner was a marital or

cohabiting partner, which supports the earlier claim made by women that men engage in extra-marital sexual relationships. The second feature is that the majority of men reported that their second and third most recent sexual partners was a friend. Thus, the findings show that about 7 percent of men who reported having had more than one sexual partner in the last 12 months said their second most recent sexual partner was a casual acquaintance while about 1 percent of men reported that the second most recent partner was a client. Few men in the study report commercial sexual relationships. Ten percent said that their second most recent sexual partner was an ex-partner. In addition, and again the findings show that about 70 percent of men reported that their second most recent sexual partner was a friend. This is of particular interest because it may suggest that some relationships incorporate particular meanings which have a direct influence on sexual behaviour and protective practices choices. In the survey, about 23 percent of men reported three or more sexual partners in the past year at the time of the survey. Almost 21 percent reported that their third partner was a casual acquaintance while almost one percent said it was an ex-partner. Again, about 72 percent of men reporting three or more partners identified their third most recent sexual partner as a "friend". In the present study, what is called a friend seems to be similar to that of *pito* or *pita* (a term generally used by teenagers and young people to mean sexual partner) described in other studies (Hawkins et al. 2005, Karlyn, 2005; Meekers and Calves, 1997). Nevertheless, the very nature of such a relationship is that it is irregular and the primary goal is for sexual pleasure. Although, economic exchange may occur it is not a precondition for it (e.g. affection gifts, etc.).

Table 7.6: Percentage of respondents by breakdown of partner type and characteristics of second and third most recent sexual partners in the last 12 months

	Men		Women	
	n	**%**	**n**	**%**
2nd most recent partner				
Marital/cohabiting partner	11	12.0	0	0.0
Casual acquaintance	6	6.5	1	6.3
Friend	65	70.1	13	81.3
Ex-partner	9	9.8	2	12.5
Client	1	1.1	0	0.0
Total	**92**		**16**	
3rd most recent partner				
Casual acquaintance	10	21.3	0	0.0
Friend	34	72.3	3	75.0
Ex-partner	3	6.4	0	0.0
Other	0	0.0	1	25.0
Total	**47**		**4**	

7.4 Relationships Duration and Change

Concurrent partners or overlapping sexual partners as well as sequential sexual relationships, also known as serial monogamy, are deemed important determinants of sexual risk (Orubuloye and Caldwell and Caldwell, 1995; Parikh, 2007). Thus, to assess in which the ways in which both men and women who participated in the study acquired and changed their relationships, two questions were asked for all respondents with a sexual partner in the last 12 months prior to the survey: The first question was "*Is he/she still your sexual partner?"* The second was "*For how long have you had sex with this partner?"* While the first question intends to ascertain partner change, the second question aims to assess the duration of sexual relationships. Results are given in Table 7.6.1.

According to Table 7.6.1, two important patterns emerge. Firstly, the data show that men were most likely to report multiple concurrent sexual partnerships. Secondly the few women who

engaged in multiple sexual partnerships in the last 12 months before the survey were no longer in these relationships. In order words, men were more likely than women to report having relationships with more than one sexual partner simultaneously. In this regard, the findings show that the majority of respondents were still in their relationship with the partner at last sex, which is not surprising since the majority of respondents reported that the partner at last sex was a marital, cohabiting or non-cohabiting but *regular* partner. Nevertheless, men were more likely than women to report having more than one relationship at same time, with about 62 percent of men reporting up to two partners simultaneously compared with 31 percent of women. In addition, men were more likely than women to report having relationships with three partners simultaneously.

Table 7.6.1: Percentage of respondents who maintain up to three partners simultaneously

Is he or she still your partner?	Men		Women	
	n	**%**	**n**	**%**
1st partner (partner at last sex**)**				
Yes	188	90.4	197	90.8
No	20	9.6	20	9.2
Total	**209**		**217**	
2nd partner (2nd most recent)				
Yes	57	62.0	5	31.2
No	35	38.0	11	68.8
Total	**92**		**16**	
3rd partner (3rd most recent)				
Yes	34	72.3	1	25.0
No	13	27.7	3	75.0
Total	**47**		**4**	

In addition, Table 7.6.1 also shows an interesting pattern: the pattern of partners change. In this regard, the findings suggest that men were more likely than women to change their partners. Indeed, 10 percent of men reported that they had terminated their relationships with their most recent partner compared to 9 percent of women, which means that they are like to form new

relationships, probably with partners who also had previous sexual partnerships. On the other hand, about 38 percent of men reported that they had ended their relationship with their second partner compared with 69 percent of women. Finally, about 28 percent of men who reported having had 3 partners in the last 12 months also reported having ended their relationship with their third most recent partner. Among women, 75 percent reported having ended their relationship with their third most recent partner in the last 12 months.

Table 7.7 shows the duration of the relationship among men and women in the survey. Table 7.7 shows that the majority of respondents maintained their relationship with their most recent partner for more than a year. Nevertheless, women were slightly more likely than men to maintain their relationship for more than a year. In this regard, about 90 percent of women reported that they were in relationship with their most recent partner for more than a year compared with 88 percent of men. This is not surprising at all, since the majority of respondents also said that their most recent sexual partner was a marital, cohabiting or non-cohabiting but *regular* partner.

Table 7.7: Percentage of respondents by relationship duration with partners in the last 12 months

How long have you had sex with this partner?	**Men**		**Women**	
	n	**%**	**n**	**%**
1st partner (partner at last sex**)**				
Less than a year	26	12.5	22	10.1
More than a year	182	87.5	195	89.9
Total	**209**		**217**	
2nd partner (2nd most recent)				
Less than a year	41	44.1	11	68.8
More than a year	52	55.9	5	31.2
Total	**92**		**16**	
3rd partner (3rd most recent)				
Less than a year	25	53.2	4	100.0
More than a year	22	46.8		
Total	**47**		**4**	

Regarding those respondents who reported having had two sexual partners in the last 12 months, men were more likely than women to report that they were in the relationship less than a year before the survey, with 44 percent of men reporting so compared with 69 percent of women. Among men who reported three sexual partners in the last 12 months, the majority said that they were in their third relationship less than a year, with 53 percent of them reporting so compared with about 47 percent who also said that they were in the third relationship for more than a year. These findings clearly suggest the extent to which men were more likely to expose themselves to high risk behaviour by engaging in sexual relationships with different partners, and, therefore increase their vulnerability to HIV/AIDS.

7.5 Summary

There is a strong consensus among scholars, researchers and policy makers that the spread of HIV infection is largely dependent upon unprotected sex among people with a higher number of partners (UNAIDS, 2008). In this chapter, sexual behaviour of both men and women in Manhiça district and Matola city was investigated. Lifetime number of sexual partners was investigated in order to draw some profiles of sexual networking of men and women who participated in the study. Tracking lifetime number of past sexual partners is deemed important, since according to previous studies the odds of being HIV positive increased with the number of sexual partners (Cohen and Trussell, 1996; Macphail, Williams and Campbell, 2002; Boerma et al., 2003). Consistent with what other studies have reported in sub-Saharan Africa (Wellings, et al., 2006; Smith, 2007; Parikh, 2007), the findings of this study suggest that unprotected sex among heterosexual men and women is not uncommon in the study settings. In this regard, the findings regarding number of past sexual partners show that although men are more likely than women to report more lifetime number of past sexual partners it is an undeniable fact that both men and women accumulate sexual partners over their lifetime. However, while those women who had more than one sexual partner since they became sexually active hardly go beyond four sexual partners in total, men tend to have, by far, more than five sexual partners. This pattern among

men is confirmed when respondents were urged to reveal the number of sexual partners 12 months before the survey. In this regard, the majority of respondents reported only one sexual partner during the past 12 months before the survey. Nevertheless, the data also show that men were more likely than women to get involved in multiple partnerships with the majority of them having between two to four sexual partners. This may not be surprising since multiple partnerships and partner accumulation is not an unusual phenomenon worldwide, particularly among men (Cohen and Trussell, 1996; Wellings, et al., 2006). Indeed, a comparative study by Wellings and her colleagues (2006) on sexual behaviour in 59 developed and developing countries, including Mozambique, found that although monogamy is still the dominant pattern among the sexually active adult population worldwide, reporting of multiple partnerships is common, although more frequent among men than women (Wellings, et al., 2006).

Looking more closely at sexual partnerships, the data shows that in both Manhiça district and Matola city younger men were more likely to report more sexual partners than older men. These findings clearly seem to be in line with what other studies have found with regard to young people's sexual behaviour and the potential negative outcomes for sexual health including the risk of HIV infection (Wellings et al., 2006). In addition, the findings also seem to confirm the characterization of sexual risk; particularly high-risk sex practiced by young people and young adult men in particular (UNAIDS 2008). Similarly, younger women aged less than 30 years were more likely than older women to report that they had more than one sexual partner in the last 12 months. The findings seem to be in line with other studies with regard to self reporting of number of sexual partners in the last 12 months. According to those studies, from 20 years of age women tend to be more monogamous compared with their male counterparts (Wellings et al., 2006).

As one would expect, married and cohabiting men and women should have restrained themselves from having multiple sexual relationships. The findings tend to confirm such expectations. In this regard, the data show that the majority of married and cohabiting men and nearly all married and cohabiting women confirmed that they had last sex within their marital or cohabiting union in the last 12 months before the survey. However, the practice of multiple partnerships is not an uncommon practice even among married and cohabiting men. In fact, married and cohabiting

men were more likely than married and cohabiting women to report more than one sexual partner in the last 12 months. If condoms were not used in those sexual encounters it will not be a surprise if HIV infection is rampant in marital and cohabiting unions in the study sites. This seems to be consistent with what has been found in other sub-Saharan African settings (Cohen and Trussell, 1996; Carpenter et al., 1999; Sheppard et al., 2001; Glynn et al., 2003). These findings are comparable with the 2003 Mozambique Demographic Health Survey (National Institute of Statistic, 2005). According to this survey the national average of married men who had more than 2 partners was about 8 percent. In addition, 15 percent of married men in the Maputo province, where both Manhiça district and Matola city are located, reported having more than 2 partners a year before the study (National Institute of Statistic, 2005).

Studies suggest that "multiple sexual partnerships – particularly overlapping or concurrent partnerships – by both men and women lie at the root of the generalized epidemic of HIV in Southern and Eastern Africa" (Shelton, 2009: 367). The present study found that men are more likely to engage in multiple concurrent (overlapping) sexual partnerships than women. For instance, men were more likely than women to report having more than one relationship simultaneously. An interesting pattern refers to the duration of the relationship. With regard to this, the findings suggest that women are more likely to change their partners at a faster pace, particularly in non-marital or non-cohabiting secondary relationships, while men are more likely to have more than one relationship simultaneously.

These findings are not surprising at all. For example, analyzing studies on the AIDS pandemic in sub-Saharan Africa Cohen and Trussell (1996) noted that in general, women are aware that their partner has other partners. In addition, the authors also noted that the number of women reporting that their partners had other partners correlated with the number of sexual partners that men usually reported (Cohen and Trussell, 1996). Therefore, the findings presented in this study are quite consistent with reports of male multiple sexual behaviour, which is deemed one of the main cause for the spread of HIV infection among sexually active individuals. In addition, this sexual behaviour seems to be sustained by factors which go beyond demographic characteristics, particularly for men. Both bivariate and logistic regression analysis show that, for men, most of

the selected socio-economic and demographic variables play a marginal role in influencing male multiple sexual partnerships. By contrast, for women, place of residence; age and level of education seem to be influential in reporting of number of sexual partners in the last 12 months. These findings seem to be consistent with other studies done in sub-Saharan Africa. For example it is suggested that for economic reasons, young women usually get involved with older men who are more likely to have had multiple sexual partners, including commercial sex workers and, therefore, more likely to be infected with HIV than younger men (Glynn et al., 2001; Macphail et al., 2002; Boerma et al., 2003; Longfield et al., 2004). On the other hand, the need for sexual gratification and traditional notions of manhood appear to be the driving forces behind male multiple partnerships regardless of their background characteristics (Longfield et al., 2004, Kippax et al., 1994; Setel, 1996; Mahalik, et al., 2007). In this regard, Longfield et al., (2004) for example, found that most men believed that sex and happiness were synonymous and that men felt that younger women were able to satisfy a man's sexual needs better than older partners (Longfield et al., (2004: 129). Furthermore, Kippax et al., (1994) were even more radical when arguing that the notion of heterosexual masculinity functioned as a barrier to safer sex. In their study, the authors concluded that there were strong evidence from both developed and developing countries, from rural and urban populations, of a power differential between men and women. They characterized men as sexually insatiable and male sexual behavior as an uncontrollable drive. Other feature that framed sexual encounters was the tendency of men to claim 'ownership' of their sexual partners (Kippax et al., 1994). This may explain why demographic variables are not as relevant in explaining male sexual behaviour in the present study.

Meanwhile, the desirability bias may have influenced the results of the present study. In this particular case, men may have given a higher number of sexual partners so that they appear to conform to tradition notions of 'real men'. In contrast, females may have underreported their actual numbers of sexual partners to appear innocent or 'well behaved' and fulfilling societal expectations of the ideal woman (Slaymaker, 2004; Wittrock, 2004; Fenton, et al., 2001). Therefore, as a worldwide phenomenon, it should not be underestimated that also in this study men may have exaggerated the number of sexual partners as females may have underreported it.

Nevertheless, studies have shown that men are more likely to report a higher number of sexual partners than women (Slaymaker, 2004).

CHAPTER 8: STRATEGIES OF BEHAVIOURAL CHANGE

8.1 Introduction

Studies have shown that awareness about HIV/AIDS (including modes of transmission as well as protective strategies) is high in sub-Saharan Africa (Cleland and Maharaj, 2004; Abdool Karim, 2001; Mozambique Demographic and Health Survey, 2003). Despite all this, the level of HIV infections continues to rise. Studies in Mozambique and elsewhere have also shown that although there is high levels of awareness about HIV/AIDS, the HIV infection rates are still climbing (Ministry of Health, 2005; Abdool Karim, 2001, UNAIDS, 2008). In addition, studies have shown that in the absence of biomedical interventions such as vaccines, behaviour change is critical and it is the most effective strategy to curb the further spread of the HIV/AIDS epidemic (Orubuloye et al., 1995; Asiimwe-Okiror et al., 1997; Abdool Karim, 2001). The overall aim of this chapter is to describe the behavioural strategies adopted by both men and women to protect against the risk of HIV/AIDS in the study areas as well as some of the factors facilitating and inhibiting behaviour change. Moreover, it explores attitudes to behaviour change. By describing attitudes to behaviour changes this may help to identify the factors facilitating and inhibiting behaviour change in the study areas. This chapter relies basically on qualitative evidence drawn from focus groups discussions and in-depth interviews. It starts with a description of behavioural strategies adopted to protect against the risk of HIV/AIDS. Then it explores some of the socio-economic and cultural barriers to behaviour change.

8.2 Awareness of the Risk of HIV/AIDS

Respondents were asked the following two questions: *"How serious is the problem of HIV/AIDS for both men and women in this community?" and "What can people do to avoid getting infected with HIV/AIDS?"* In both focus group discussions and in-depth interviews respondents mentioned that HIV/AIDS is indeed a serious threat to their lives and the stability of their families. Some of the respondents felt that HIV/AIDS is a serious problem in their

neighbourhoods and they pointed out that there has been an increase in the number of people dying of AID related illness. The following quotes illustrate the general sentiment:

"Here in the Machava neighbourhood, women are dying the most. In the past, it was TB which killed people. Today it is AIDS. So the problem of AIDS is grave"

(Urban married females, FGD # 04)

"The problem is real here. Many people are dying of AIDS. Since last year, I know at least two people who died of AIDS in this neighbourhood"

(Rural married males, FGD # 11)

"In my block [a total of 15 households] there are six people infected. It seems that only one is on treatment. We, women, are the ones who suffer the most, because when our sons get this disease, all the burden falls on the mother"

(Urban married females, FGD # 04)

In addition, some respondents stated that the AIDS epidemic is impacting negatively on both individuals and families**.** There are a number of members of the community who are either sick and/or dying of AIDS. Often women assume primary responsibility for the burden of caring for the sick and/or dying. Sometimes the family refuses to take responsibility for people living with HIV/AIDS. They are forced to suffer stigma and discrimination and in extreme cases, face complete rejection and abandonment.

"Here, in Trevo neighbourhood, AIDS is a big problem. The rate of infection is very high. There was the case of a girl who was sick [of AIDS]. Up to now she is still in the hospital. Although she was sick, her family did not take care of her, they sent her away. But she does not have money to pay the rent and not even to eat. We are worried because this disease weakens people. We are particularly worried because we do not know when there will have a cure for this illness"

(Urban married females, FGD # 09)

"I have seen someone who has AIDS. I know a lot of people who came from countries like South Africa, who died from AIDS"

(Urban non-married male, IDI # 16)

Respondents identified a number of HIV protective strategies, including abstinence, faithfulness and the use of condoms. Some respondents noted that mutual monogamy was very critical in order to deal with HIV/AIDS pandemic. This shows the success of awareness campaigns, particularly the ABC strategies, in reaching the population.

"From the time a couple gets married they should be faithful. Marriage requires them to be faithful to each other. Therefore none of the spouses should have sex outside their marriage.

(Rural married males, FGD # 12)

"This disease really exists. And both men and women must be careful and trust each other. They must have only one partner"

(Urban non-married females, FGD # 02)

Condoms were also identified as a HIV protective strategy. However, most respondents highlighted that it was important to use condoms in cases of occasional sex or in extra- marital relationships. Condoms are less acceptable in stable, long-term relationships.

"Well, because we cannot forbid the men to go outside marriage but we have to encourage them to use condoms. If you have lovers at least use condoms. In doing so, there is a minimum risk to infect your husband, or your husband will not infect you"

(Rural married female, IDI # 02)

"As I am working in South Africa, I use condoms there. But when I am here I do not use them with my wife, although I am afraid of catching this disease"

(Rural married males, FGD # 11)

Although it seems somewhat uncomfortable for some respondents, abstinence has been identified as one of the strategies adopted to lower their risk of HIV infection. Such behaviour may happen when all the efforts to convince their partner to practice safer sex have not been successful. This is the case of one female respondent who decided to abstain from sex because her partner represented a risk for her.

"Look, it may sound absurd but sometimes I stay several months without having sex with my husband. We may stay 3 or 4 months without sex. Sometimes we are like brothers and sisters. We just greet each other"

(Urban married female, IDI # 07)

"You have to control yourself [temporary abstinence], because no one is going to die from not having sex"

(Rural non-married male, IDI # 14)

In some cases, however, it seemed that people were failing to protect themselves against the risk of HIV infection for a variety of reasons. In this regard, female respondents in particular were quite doubtful about whether or not people effectively used condoms to protect against the risk of HIV infection. They observed that it was difficult to maintain mutual faithfulness in a sexual relationship. Often the woman was faithful to her husband but her husband was not faithful to her. Some of the women hinted that it was difficult to achieve faithful because they suspected men of having extramarital relationships. The following quotes support these sentiments.

"People use condoms. But if you are faithful [to each other] then you are safe unless your husband is infected"

(Rural married female, IDI # 01)

"I think that people are using condoms more often and, they are being more careful with cutting objects. However, it is not for every man, but they are using condoms more often"

(Rural married female, IDI # 02)

In some circumstances people might not be successful in dealing with the risk of HIV infection due to a number of factors including a range of context-specific factors (Evans and Lambert, 2008). For example, some participants in focus group discussions expressed their doubts about whether or not people were adopting appropriate and effective strategies to protect themselves against the disease.

"*I do not think people are using condoms as they should. Some people think that condoms contain the virus and, apart from that, they say that they feel no pleasure when they have sex with condoms. But abstinence is impossible nowadays"*

(Rural non-married females, FGD # 08)

As it can be seen in the quotes above, some women doubt their ability to practice safer sex with their partners. On one hand, the respondents express positive attitudes towards condoms and they are aware of the importance of using condoms to prevent HIV/AIDS. On the other hand, however, they stated that it is not always possible to use condoms. In addition, some men and women hold strong negative attitudes towards condom. This was also highlighted in the interviews.

Some respondents highlighted the role of HIV/AIDS campaigns in creating awareness in their communities. They felt that these strategies were useful in raising awareness of the risk of HIV infection from not only sexual intercourse but also blood transmission. They emphasized the need to avoid contaminated instruments during traditional ceremonies like circumcision.

"There are people who are doing public awareness throughout neighbourhoods. We also see women from "Organização da Mulher Moçambicana" (Mozambique Women Organization)[1] walking around the households teaching the population how to protect from AIDS; how to use condoms and to use new blades when they go to traditional healers in order to avoid getting infected by the disease"

(Urban married females, FGD # 04)

Furthermore, the risk of HIV transmission from mother-to-child was also highlighted during the interviews.

"There is a man in the Maxaquene neighborhood whose wife was pregnant and gave birth, but she got ill afterwards. She had a blood transfusion and then, the doctor said that she could go home. After a few times, she got ill again and she went to the hospital. They discovered that she had AIDS. Some time later she died. The man and the child are still alive"

(Urban married females, FGD # 04)

What it is highlighted in the above quote is the possible transmission of HIV infection in the clinics, due to poor blood screening, which it is not uncommon. However, it is highly unlikely that the route of HIV transmission was blood transfusions. It is possible that there is some denial about their status among both men and women.

8.3. Obstacles to Behaviour Change

Obstacles to behaviour change in the context of HIV/AIDS epidemic, particularly in sub-Saharan Africa are well documented (Caldwell, 1999; Varga, 999; Preston-White, 1999). Thus, obstacles to behaviour change were also investigated in this study. A constellation of factors seems to be behind the difficulties facing both men and women from taking practical and effective measures to protect themselves against HIV/AIDS in the study areas. Such obstacles may range from

[1] Mozambique's Women Organization (OMM) is a women league connected to the FRELIMO party

behavioural (both personal and interpersonal) to context-dependent or structural factors, including socio-cultural as well as economic reasons (Eaton et al., 2003, Lecrerc-Madlala, 2002; Orubuloye and Caldwell and Caldwell, 1995; Caldwell, 1999; UNAIDS, 2008).

8.3.1 Personal and Interpersonal Obstacles for Behaviour Change

Low risk assessment of HIV infection

Studies have shown that the awareness of HIV risk and vulnerability is very important to adopting preventive measures (UNAIDS, 2008; Abdool Karim, 2001; Eaton et al., 2003). Both the focus group discussions and in-depth interviews indicate that although people show high levels of HIV/AIDS awareness (see Chapter 5 and Chapter 6) they also show an astonishing low assessment of personal risk of HIV infection. Indeed, during the interviews it was very common for respondents to make personal judgements about their partners. These personal judgements are generally based on the physical appearances of their partner. For example, some men and women pointed out that if a person looked healthy or physically attractive then they were less likely to perceive themselves as at risk of HIV infection. In addition, they were more likely to trust someone who did not have a history of many sexual partners. This can be illustrated in the following quotes.

"Men have that obsession of saying: 'I trust you because you are fat, you have nothing'. I personally refuse such judgements. You may trust me, but I do not trust you. It was not you who took my virginity and it was not me who took your virginity. We can date for one or two years, but we should use condoms"

(Urban non-married female, IDI # 06)

Sometimes such judgements are based on the financial or economic situation of the person. For example, some women become attracted to men because of their money. This is seen as one of the major motivating factors why young women become involved with 'wealthy' older men.

"It is said that nowadays what counts is money. You get impressed with a person and you just get involved with him. Young women, for example, as long as they see that this man has a flashy car, they hardly try to find out more about him, or whether or not that car belongs to him. As long as they see that this guy is good-looking, they get involved"

(Urban married female, IDI # 07)

Some men and women do not perceive a risk of HIV infection because it is not seen as a problem in their community. In some situations, if the information about HIV prevalence rates is not widely published, people may think that their community is free of the pandemic or that it is not a matter of concern to them. This can be seen from the quote below where respondents do not think that Manhiça district is one of the more affected areas.

"Here in Manhiça the problem of AIDS is not terrible, because when a man gets a woman, she is the only one. It is very rare to see a womaniser here. So I think that people are not fully aware of AIDS here in Manhiça"

(Rural married females, FGD # 01)

Sometimes the perception of trust may prevent people from adopting protective practices even in non-marital relationships. Condoms may only be used at the beginning of the relationship - a time when both partners are starting to learn more about each other and also, develop greater familiarity. In this case, the association of condoms with the lack of trust may lead to the discontinuation of condom use in the relationship.

"Well, this is so funny. In the first days a couple is usually aware of condoms. They may practice safe sex, but after a month or two, they end up forgetting about them. This is what brings about problems. Those who have AIDS, many acquired it because they forgotten that they should always use condom"

*(*Rural married male, FGD # 12)

Some adult women in particular may think that their marriage protects them from the risk of HIV infection. Some married women assume that they are safe because they do not have sexual relations with other men. As a consequence, those women are reluctant to admit that their husbands - who usually stay away from home for long periods of time for economic reasons - may involve themselves in risky sexual relationships. In other words, it seems that the women assume that just as they are faithful to their partners their partners are also faithful to them, or because of the socio-cultural norms of gender inequality they cannot have a say on sexual matters. In addition, some women still believe that only young people are at risk of HIV infection because of their sexual behaviour as the quote below suggests.

"I cannot accept to do the test because I know that I do not have this virus. I am an adult woman and I do no play around with other men. I just wait for my husband. I can maybe get infected by food or clothes"

*(*Rural married female, IDI # 10)

As illustrated in the above quote, the assumption that young people are at risk of HIV infection because of their sexual behaviour may find some support from existing research which suggests that young people, especially women, are the most infected with HIV/AIDS (UNAIDS, 2008; Abdool Karim, 2001, Ministry of Health, 2010). However, this does not mean that adult or married women are completely protected from the risk of HIV infection because of their age or marital status. For example, studies suggest that women are increasing at risk of HIV infection in marital relations (Smith, 2007; Parikh, 2007; Jacubowski, 2008).

Furthermore, there is the commonly held belief among women that men will not miss the opportunity to have sex and this increases their risk of HIV infection. Many women subscribe to traditional notions of masculinity which emphasizes the uncontrollable sexual drive of men. Some women argue that condoms are more likely to be used in long-term relationships than short-term relationships. They argue that in occasional sexual encounters it may not be possible to use condoms because sex is more likely to be spontaneous and unplanned.

"I think people are more likely to use condoms in regular relationships. In occasional encounters everything is done so quickly. They do not have time for it [to use condoms]. In occasional sexual intercourse there is no time to use condoms. There are some men that use it when the woman tells them to do so, but often things are done in rush and, things done in rush are never well done".

(Urban married female, IDI # 05)

These findings from the interviews contradict the findings from earlier research which suggest that condoms are more likely to be used in non-marital or occasional relationships than in marital or steady relationships (Adetunji, 2000). However, as some studies have also suggested, occasional sex is generally unplanned, which means that it may often happen that men and women who involve themselves in occasional and non-marital sex do not have "enough time" to look for condoms or to decide to delay sexual intercourse (WHO, 2005).

Multiple sexual partnerships

One of the most frequently perceived obstacles to behaviour change is the phenomenon of multiple partnerships (WHO, 2005; Kippax, Crawford and Waldby, 1994; Anarfi and Awusabo-Asare, 1993; Awusabo-Asare, Anarfi and Agyeman, 1993; Meekers and Ahmed, 2000). In the study settings, respondents, particularly women, said that multiple sexual partnerships were so widespread and tolerated for men in such a way that it appeared as if it was a normal or 'natural' part of sexual relations. By contrast, however, multiple sexual partnerships were strongly condemned for women. In addition, they also highlighted the prevailing double standards regarding male and female sexual behaviour.

"In our society, unfortunately, when this practice is done by the man it is tolerated. But when it is a woman who gets involved with different men she is labeled as a 'gunwoman' [promiscuous]"

*(*Rural married females, FGD # 01)

"When a woman is caught betraying her husband she is asked to take her belongings and forced to runaway. But men on the other hand, have lots of lovers, from the first day of the month till the last but he is not expelled".

(Urban married females, FGD # 03)

In addition, it seems that the issue of trust is not exclusively used for monogamous relationships as advocated by the ABC strategies (Parikh, 2007) but ironically, for some men, trust is equally applicable in multiple relationships. These beliefs and attitudes may enhance the risk of HIV infection. The following conversation between the interviewer and the respondent might shed more light on this.

"Q: You said earlier on that you have got other sexual partners.
S: *Yes, I do. I have got two whom I trust.*
Q: And do you use condoms with these two sexual partners?
S: *No, I do not.*
Q: Are they your wives?
S: *No, they are just my friends [lovers], but I trust them. Probably one day I will live with one of them*.
Q: So, you have two friends or girlfriends with whom you do not use condoms because you trust them. Are they from Matola city?
S: *Yes, there were.*
Q: And what about the one from South Africa that you told me about?
S: She is my wife. She is now in South Africa and she will be back on Sunday.
Q: So does that mean that you have got three? You have three women with whom you do not use condoms?
S: I trust my two friends because one of them is a teacher and she is always advising me not to bring her diseases. I have to trust her although I have no proof that she went for a HIV test."

(Urban non-married male, IDI # 16)

Indeed, the above quote illustrates in some detail the motivation of some men who get involved in multiple sexual relationships. In this regard, it is noteworthy that the respondent does not hide the fact that he has a number of sexual partners although he only trusts one of his partners. He trusts her not only because she keeps reminding him not to bring her diseases, but also because of her profession as a teacher. A teacher is perceived as more trustworthy and of a higher moral standard and therefore she is associated with a lower risk of HIV infection. It is clear that there are a number of factors influencing personal perception of risk of HIV infection.

Meanwhile, some men have very negative attitudes towards multiple sexual partnerships but this does not mean that their behaviour is consistent with their attitudes. In the focus group discussions one participant was adamant that multiple sexual partnerships is unacceptable although he admitted that he had also had other sexual partners, which contradicts his strongly held beliefs.

"A man should have only his wife. If he is a father, he should only have his wife. The man who has extramarital relationships has no education. I am not saying that I did not do that, but if I do that it is a lack of education on my side".

(Urban married males, FGD # 14)

The quote illustrates that some men still believe in the sanctity of marriage which is widely supported by religious movements. He advocates for monogamy in marriage but he also acknowledges that even he may have engaged in extramarital relationships in the past. Indeed, many of the men in this study reported engaging in extramarital relationships during their marriage.

Of particular note is the fact that many women stressed that men should practice safe sex because it is quite impossible to prevent them from having many sexual partners. For these women, partner communication is important so that women can convince men to use condoms.

"*Because it is almost impossible to prevent men from having other sexual partners elsewhere, the most important thing to do is to adopt protective measures by using condoms. It is acceptable for a man to have sexual affairs outside the marriage, but he should hide his relationships and he should not neglect his wife"*

(Rural non-married females, FGD # 07)

It emerged during the interviews that it is important for men to show their female partners respect. The notion of 'respect' seems to dominate sexual relationships in some African societies (Thornton, 2003). In the interviews, women explained that they cannot prevent men from engaging in extramarital liaisons but men should not disrespect their wives by openly flaunting their relationships. Thus, according to the respondents, this would show that the men are 'respectful' to their wives.

In addition, some men also noted that it is not only men who are unfaithful. Sometimes women were also likely to have other sexual partners. Some men and women are not faithful to their partners which increase their risk of HIV infection.

"*I do not think that men and women are aware of the risk of HIV/AIDS, because not all women are faithful to their husbands, and also we men, we are not faithful to our wives."*

(Urban non-married male, IDI # 16)

Fear to know their HIV status

There are some situations which may resemble what Pinker (2007) termed 'rational ignorance.' 'Rational ignorance' refers to the situations where one 'intentionally' chooses not to know something because of its negative or harmful effects. Sometimes men and women may choose not to know about their HIV status to avoid potential damage to their social reputation. These denialist attitudes may reveal to what extent stigma (both personal and social) and discrimination have been so strong within society and how it makes people, particularly men, to anticipate the

consequences of social condemnation or the fear of being viewed as a failure (UNAIDS, 2008, Cameron, 2005).

Some respondents highlighted a number of factors that represent barriers to the normalization of HIV/AIDS in society including denialism, disbelief, and fear to know their HIV status.

"Some people did not perceive the risk posed by HIV/AIDS to them. Some simply do not believe in the existence of HIV/AIDS. Some say they will only believe in it if they were facing death. Some say that they will only believe in it after doing the test. Others say that if they do the test and if the results are positive, then they will give up all their plans or they will kill themselves"

(Rural married male, IDI # 13)

Some women said that it would be better not to know their HIV status because there is no cure for AIDS. They argued that if they found out that they were HIV positive then they would commit suicide. For some, AIDS is a death sentence. This can be illustrated by a quote below of a woman who had an affair with a married man.

"I am having an affair with a married man and I cannot do the test because if I am HIV positive I will commit suicide because I know that there is no cure for this disease."

(Rural non-married female, IDI # 04)

For some women, the AIDS epidemic has created a great deal of uncertainty about the future. They are worried about the impact their death will have on their children. For example, some women said that they could not bear looking at their children and how they would live as orphans, particularly after their death.

"Look. If my husband suggested to me that I take the test I would do it. But if I found out that I am HIV positive, I would feel very bad because I would think that I am a dead person and what about my children, they would stay to suffer in this world"

(Rural married female, IDI # 02)

Lower self-esteem

Some men are aware of the risk of HIV infection but choose to ignore the potential negative outcomes of risky sexual behaviour. They feel that the benefits far outweigh the costs. Many of the men live and work under harsh conditions and for some sex is seen as the only outlet for releasing the stress in their lives. They therefore feel that their need for sex must be satisfied. Sex makes them feel powerful and also, a means of taking control over their lives. This attitude may sometimes get them into trouble because they may engage in risky sexual behaviours.

"Once, somebody told me: 'I will die for what I have eaten' [I will die from sex or after having had sex]. What happens is that people prefer to run the risks even knowing that sooner or late they will die"

(Urban non-married males, FGD # 18)

Indeed, the *isiZulu* expression "sifa sidlile" (which seems to be incorporated into Tsonga/Ronga, the spoken mother languages of the study sites) which means 'I will die from sex' or 'I will die after sex with a woman' reveals how entrenched risky behaviours are in the local male sexual culture. Consistent with other studies, this study found that the fear of death did not dominate sexual decision-making (Campbell 2001). Many of the men expressed the willingness to take risks that could endanger their health. Death was embraced with acceptance and courage.

"People may bear in mind that AIDS really exists, but at the end of the day they say that is all the same"

(Urban non-married male, IDI # 16)

Lack of communication about sex and sexual health matters

In the interviews, some women observed that, although they feel that they have the same rights as men influence sexual decision-making in their relationships, in practice this does not always happen because of lack of communication about sexual matters between partners. In addition, the conditions under which the sexual act occurs is not conducive to open communication. Some women argue that if there is greater equality in the relationship there is likely to be greater open discussion about sex and sexually related matters without fear of accusation of unfaithfulness or lack of trust. Furthermore, as the relationship progresses it is likely that greater familiarity develops and there is greater openness between partners.

"If there is no frequent dialogue between partners, the shyness will remain. That is why I said earlier that first, you and your partner should be friends. Because if you are friends, I mean if you have certain intimacy the coyness disappears. Thus, from that point it is easier to talk about everything".

(Urban non-married females, FGD # 10)

Some respondents reported that discussions about sexually related matters are much more difficult in occasional sexual encounters than in steady, long-term relationships. This is because there is limited trust and confidence in the relationship. In short-term relationship the desire to have sex is the main motivation. There is little or no effort to try and further the relationship.

"*No, there is no talk in occasional sex. They just go straight to the point of having sex. For example, there is someone who proposed to me a long time ago. We just met each other in a nightclub and after dancing we left together. In fact, if I find somebody in a nightclub that proposes to me, while I am alone, then I can have sex with him. So I do not think that we will keep talking. This is what is happening"*.

(Urban non-married females, FGD # 02)

In other situations, sexual partners do not talk about sex and about sexual health issues at all. Sometimes women engage in sexual relations with men in exchange for money. In these relationships, they do not have sufficient power to negotiate safer sexual practices. But, on the other hand, a man may think that because he is paying for sex he should determine the terms and conditions under which the sexual act occurs. This may include unprotected sex.

"It is difficult to speak about sex, but at the same time it is easy. It is easy if we have in mind that nowadays what counts is money"

(Rural non-married male, IDI # 14)

The above quote highlights the difficulties of talking about sex. There are a number of taboos surrounding sex and sexual matters in African societies which are well documented (Lambert and Wood, 2005; Kesby, 2000). Sometimes money is used as mediating tool which fills the gap left by poor communication. In this regard, the quote clearly shows that, on one hand, men have access to sex through money while women, in turn, have their material needs satisfied in exchange for sex. This operation seems to correspond to what is known as transactional sex. Transactional sex is deemed widespread in sub-Saharan Africa (Caldwell, 1999; Lecrerc-Madlala, 2002; Bagnol and Chamo, 2003)

In transactional sex there is no need for communication about sexual matters. To some extent, money preserves men from the embarrassment of having to talk with 'necessary competence' to convince their partners about their sexual desires and needs. On the other hand, money may also prevent women from developing expectations about the future of relationship. Indeed, money not only establishes the limits of the relationship but also it lays out the rights and the obligations of each partner within the sexual transaction.

Sometimes the lack of communication about sex is a result of inadequate skills to negotiate safer sexual practices as is the case of the above example, but also broaching the topic of condoms may create some awkwardness in the relationship. Condoms are sometimes associated with diseases, including a HIV positive status. Indeed, studies have shown that condoms are one of the most

contested topics in sub-Saharan Africa. A number of studies have reported a range of negative attitudes towards condoms, including the belief that condoms prevent pleasure and intimacy (Caldwell, 1999; Preston-White, 1999; Varga, 1997; Abdool Karim et al., 1994; Holland, 1991; Bond and Dover, 1997)

"Sometimes, at the beginning, when a woman suggests to her partner to use condom, usually the man says: 'Do you not trust me? Do you think I am sick?' From that point, the woman replies: 'no, it is not you. I am afraid of getting pregnant'. So then, the man suggests using pill. I think we are more fearful of pregnancy rather than being infected by HIV"

(Urban non-married females, FGD # 10)

The above quote summarizes the dilemma that many women face in convincing their partners to use condoms. Although in general women may have some reservations about condoms they still insist on their use because of their dual protective benefits. This is observed in the focus group discussions. Some women prefer to use condoms instead of hormonal contraceptive methods because they protect against the risk of pregnancy and HIV infection. However, it is much easier to convince men to use condoms for pregnancy prevention than disease prevention. The introduction of condoms in a sexual relationship may lead to suspicions of lack of trust. Men are more likely to agree to use a condom to protect against pregnancy. However, some men may suggest using other family planning methods. In that case, women are not protected against the risk of HIV infection.

8.3.2 Context-dependent and Structural Obstacles

Context-dependent and structural factors may also indirectly influence individual sexual behaviour. According to Parker and his associates (2000), structural forces are divided into three categories, namely (i) economic (under)development and poverty; (ii) mobility, including migration, seasonal work, and social disruption due to war and political instability; and (iii) gender inequalities. Other approaches take into account structural factors including the role

played by culture and particular geographical areas (Eaton et al., 2003; Leclerc-Madlala, 2002, Varga, 2000).

Socio-economic conditions

The interviews suggest that there is a connection between socio-economic living conditions and the risk of HIV infection. Men who are migrants may engage in risky sexual behaviour. Migrant workers who work in the mining industry in South Africa often spend long periods away from home and during this time they may become involved in sexual relationships with other women. In addition, in order to meet their economic and financial needs, some women whose husbands have gone to work in the mining industry in South Africa, in despair may end up exchanging sex for economic support, because of irregular remittances from their husbands.

"What happens here is that most of the men work in the mines in South Africa. They only come back at the end of the year. During this period that they are absent from their homes, there is lack of food for some families; so women can date some men and end up infected. They just cannot wait for their husbands to come at the end of the year"

(Rural married male, IDI # 10).

Furthermore, broaching the topic of condoms in a relationship may jeopardize the sexual relationship. This is clear in the following response by one female respondent.

"In my case, I refuse to have sex without a condom but the other girls say: 'life is difficult Martha. If you are waiting for a man who will only sleep with you , then continue looking for that man who might have been born for you'. That is what my friends say. They also say 'you already have a child, and you better stay with him as long as he brings money every month and he helps you with the little things".

(Urban non-married females, FGD # 6)

Sometimes their low socio-economic status may force women to engage in risky sexual behaviours. When sex gives women access to basic economic necessities it is very difficult to follow prevention messages that advocate a reduction in the number of sexual partners. Women who are economically dependent on men have less power to negotiate the use of safer sexual practices. They are more likely to submit to their partners demand for fear of abandonment and destitution, a finding consistent with a number of other studies (WHO, 2003). Studies from across the developing world indicate that poverty is a major driving factor for women exchanging sex for economic gain or survival (Weiss, Whelan et al. 2000; Longfield et al., 2004).

In addition, male respondents observed in the focus group discussions that their favourable financial situation in society also increases their risk of HIV infection. They argued that because men generally have greater access to money, this has also made it easier for them to afford multiple partners. This attitude is illustrated in the following comment:

"*I think we still have high numbers of people who are infected. That is because people, mainly women, are dependent on men mostly. This is because a great number of them have money. For instance, a man can afford to have two, three, four, five lovers at the same time and some men do not want to use a condom. Therefore they are exposed to diseases*."

(Rural married males, FGD # 12)

This is of particular interest because it reveals the extent to which men are aware of the advantages that money brings in increasing access to many sexual partners but also increases their risk of HIV infection. Studies show that men who engage in transactional sex have a high risk of HIV infection (Robinson and Yeh, 2009; Awusabo-Asare and Annim, 2008; Chatterji et al., 2004; Merten and Haller, 2007).

Peer pressure

Peer pressure is another factor influencing the risky sexual behaviour of men and women. Studies among young people suggest that peer pressure is a key factor in most young people's decisions

not only to become sexually active but to engage in unsafe sex practices (Varga, 1999). Some women in focus group discussions also observed that stereotypical notions of manhood have also increased the likelihood of men engaging in multiple sexual partnerships. Indeed, studies have found that dominant ideologies of masculinity, which encourage men to be independent, dominant, invulnerable aggressors and providers, whose virtues are strength, virility and courage puts them at risk of HIV infection (WHO, 2003; Lecrerc-Madlala, 2002). They argued that those men who are faithful to their partners are generally labelled as being controlled by their female partners, meaning that they are dominated by the women. Thus, men are generally fearful of being viewed or perceived as being under a woman's control. According to these women, this has been a major factor contributing to their resistance to behaviour change.

"He can even like you as his wife but he wants other girlfriends out there. This is the problem! Because he, as a man, thinks he should have other women, you see? Friends also put pressure on him. They label him as "matreco"[2] if he only has one partner. It is said that, that the woman is dominating him. People say that his woman may have cast a spell over him.

(Urban married females, FGD # 03)

Interesting to note in the quote above is that it reproduces in strong terms what many men fear the most: being perceived as weak and dominated by women. But most importantly, it shows the fear men being perceived as being under the control of women. Indeed, because men are viewed as 'sexually insatiable animals' they are aware of the risks of being trapped by women if they are not clever. Some men are fearful of being bewitched by women because this is likely to lead to negative outcomes for their mental health as well as their social reputation. Thus men cannot openly show their love for their partner because of the fear of being viewed as controlled by women, which is seen as a serious threat to their male identity.

Furthermore, during focus group discussions some men admitted that they also face pressure to behave like a 'real man'**.** Men sometimes may have many sexual partners in order to demonstrate

[2] An expression used by young people to refer to a failed man. *Matreco* is a name for a young man who is unable to show that he is or has **t**he potential to be a "real man", particularly if he is unable to control a woman.

their manhood. Mankayi (2008: 629) also notes that the use of women's bodies for purposes of sexual pleasure is an important part of manhood and male sexuality. Men are not criticized (in the same way as women are) if they have multiple sexual partners.

"Look: I am a married man and I have to stay with my wife. But, then, six women come close to me and need me. This means that there is no way that I can ignore them. We get infected because those women are also human beings and they need a man, and that man is me. So, how can I have only one partner? Statistics say that there are more women than men".

(Urban married males, FGD # 14)

Moreover, peer pressure may also encourage men to engage in multiple sexual relationships. Some men have sexual relations with multiple partners in order to conform to the expectations of their peers, that men are always ready for sex and whenever they have sexual urges, they should find a woman to satisfy their desires.

"What usually happens is that a person says that it is the custom of this place. It is said that if you have only one wife you are nothing. You should have many [women] in order to find always at least one partner who is ready for you"

(Rural non-married males, FGD # 15)

In focus group discussions and in-depth interviews it was clear that men find themselves under pressure from their peers to engage in sexual relations. A commonly held belief is that a 'real man' will exploit all sexual opportunities that arise with women and men who do not conform to this expectation will have to suffer the consequences which takes the form of ridicule by peers.

On the other hand, some men accuse women of seducing them sexually. They argue that women use seduction to tempt men into having sexual intercourse with them. They dress in a sexually provocative way in order to attract the attention of men. Furthermore, some men argue that women are also not shy to indicate their willingness to engage in sexual activities and sometimes they do this by showing up at the man's house. This is illustrated in the following comment.

"I usually have sex with many girls but not because I love them. Women are the ones to blame. Indeed, they dress in such a way that you cannot afford not to notice them. On Sunday, for instance, I was coming back from the beach with a girl. I had never met her before, but she accepted to come to my house. Why did she come if she did not know me? She lives in Mafalala[3] suburb but she accepted to come to Matola with me. Why was not she worried that I might kill her? She came with me because she wanted to have fun. We came to my home, we drank beer and then we had sex".

(Urban non-married male, IDI # 16)

But above all, the quote seems to suggest two features which are of particular note. The first feature is that men, including young men, present themselves as victims of seduction by women. Furthermore, it reproduces some conservative views which tend to blame women for the sexual assault they suffer. Such perceptions suggest the extent to which gender stereotypes are deeply entrenched in the minds of men. The second feature is that sex, particularly for unmarried young people, is often spontaneous and not always planned. Therefore, if protective measures are not taken, the risk of getting infected by HIV is high.

Myths and misconceptions over condoms

Of particular note about the obstacles preventing men and women to protect themselves against HIV infection are the circulating myths and misconceptions about condoms. Some respondents expressed the fear that condoms are contaminated with the virus. These myths surely reinforce the bad reputation of condoms (Preston-Whyte, 1999). In addition, such misconceptions are generally supported by some men who clearly use them in order to persuade their partners that condoms are not only unnecessary because they hinder flesh-to-flesh sex but that they are also dangerous. It should be noted that as men are supposed to be more knowledgeable about sex than women, the likelihood of women disputing such claims are lower. This can be noted in the following quotes below.

[3] A legendary and over populated suburban area of Maputo's city

"What happens is that people, particularly men, say that condoms are already infected. I have had conversations with young men who say that condoms contain the virus. Apart from that, they say they feel no pleasure when they have sex with condoms or that condoms cause damage for both men and women"

(Rural non-married females, FGD # 08)

"Others say that they do not feel pleasure with condoms. Sometimes they say that the condom is AIDS itself. They say that you no longer have to use condoms because it is like infecting yourself with the virus"

(Rural non-married males, FGD # 15)

Apart from the fear that condoms are contaminated, there is also the association of condoms with a lack of trust. The quote below may serve as a candid example of such beliefs.

"Condoms are HIV carriers, so they do not prevent AIDS. When you use condoms it is because you do not love your partner. I do not use condoms because I am afraid of them. I do not like them. If it is my time to die, I will die"

(Rural married female, IDI # 11)

The above quotes show that there are a number of negative associations attached to condoms. Condoms are also a highly emotive topic. They are seen as ineffective and some men and women believe that they may be carrying the virus. Other studies have also found the belief that condoms are permeable and do not protect against HIV infection (Bond and Dover 1997).

Furthermore, some conservative religious beliefs may also prevent the use of condoms in sexual relationships. For example, some women in focus group discussions said that men refuse to use condoms because it was against their religion. This is of interest because similar claims have been reported elsewhere in sub-Saharan Africa (Bond and Dover, 1997). Some religious groups are resistant to condom use. Religious groups, such as Catholics and some evangelists, moralize

against condom use, arguing that they promote promiscuity and that people should learn to resist temptation (Bond and Dover, 1997: 385)

"There are some men who do not accept to use condom, because they say that the Bible says, we should not toss the sperm, because we are tossing children"

(Urban non-married females, FGD # 02)

Alcohol consumption and lifestyle

Alcohol consumption has been seen as one of the major factors that enhance the risk of HIV infection (Stoner et al., 2007; Theall et al., 2007; Hendershot and George, 2007; WHO, 2005; Samuelsen, 2006; Kongnyuy et al., 2007). Indeed, the widespread sale of alcohol, either the traditional home-made beer or western beer throughout the study sites was identified as one of the major factors contributing to the risk of HIV infection. In some situations, for example, the same places which sell alcoholic drinks are also reported to have rooms that they rent for temporary sexual encounters.

"Alcohol consumption in 'barracas'[4] makes the AIDS situation very risky. Whenever there is a 'barracas' selling beer you will also find some rooms on rent to customers. This means that a man will come from Chamanculo[5], for example, to drink in a 'barraca' because he heard of rooms being rent for sex. After drinking they rent a room and spend the night".

(Urban married males, FGD # 14)

Some specific risk factors, which are context-dependent to Manhiça district, are both understood as contributing to the spread of HIV/AIDS. Some respondents argue that industries, particularly the two sugar cane factories and the railway network, is fuelling the AIDS epidemic in the Manhiça district. Apart from this, there are many taverns that sell home-made beer to men and

[4] Stall for food and alcohol vending**.** It could be compared to shebeens, with the difference that there is no law prohibiting such activities in Mozambique.
[5] One of the Maputo city's suburbs

women without any age restrictions and this has also encouraged both young and old to engage in risky sexual behaviours.

"Alcohol is one of the key problems here. When people drink and get drunk they tend to have sex, and when they are drunk there is no time for anything. We see that kind of things happening here everyday. Manhiça is a corridor and after 6 pm we see a lot of trucks parked here. These truck drivers are not all from here, but all of them have a place to sleep here and have sex".

(Rural married male, IDI # 11)

Alcohol consumption often leads to a lower perceived personal risk of HIV infection. It is said that alcohol consumption has become part of the popular culture in the areas. In this regard, it is reported that both men and women of different ages engage in alcohol consumption. The following quote illustrates these perceptions:

"Yes, because alcohol is sold until late and, by then, you do not know what you do. People stay there drinking until midnight, almost everyday. For example, now that is getting dark everybody is going to the "barracas". Everybody is equal there. There are no children or adults"

(Rural non-married male, IDI # 14)

Some men reported not using condoms while under the influence of alcohol. Alcohol is dangerous because it usually weakens their resistance and makes them to want sex. Some men argued that alcohol provides a sense of bravado and the feeling that they are invincible. When people are under the influence of alcohol they are more likely to be driven by passion rather than common sense. Alcohol makes men more courageous and daring and they loose control over their rationality.

Sometimes men also engage in unprotected sexual relationships with younger women because they perceive them as 'safe' – free from HIV infection. Some studies in sub-Saharan Africa and elsewhere have made references of the tendency of men, particularly adult and young adult men,

of targeting young women because they are understood as HIV free, an attitude which hinders the possibility of safer sex practices (Hoffman and Cohen, 1999; Stoner et al., 2003; Maticka-Tyndale et al., 2005). Such beliefs can be well illustrated by the quote below.

"Nowadays there are more people going to barracas. Lately, barracas have been frequented by female youth and they are seduced by men and they end up having unsafe sex with them. These men also have the tendency to have unprotected sex with very young girls because they think that these girls are safe. In addition a man thinks that he can have unsafe sex when they know that this woman do not frequent night clubs or barracas. But there is a higher risk of him contaminating her".

(Rural married males, FGD # 12)

Some women, for instances, might get involved with a number of sexual partners in order to maintain their lifestyle. They place heavily emphasis on maintaining a modern lifestyle which is dependent on the acquisition of prestigious material goods such as cell phones, jewellery, branded clothing and luxury cars. In these sexual relationships, women are at increased risk of HIV infection because they are less likely to have much bargaining power in these sexual relationships.

"I do not think that people are protecting themselves well enough from HIV infection. One day a female friend of mine told me that she had sex the previous night. Then she admitted that she did not use any kind of protection. But the funniest thing is that she changes partners a lot. When I see her with someone and I ask her about it, she usually replies: 'I am with him for money while the other one is to take me out'. I believe that she has never had a HIV test because she has never spoken about it"

(Urban non-married males, FGD # 18)

8. 4 Summary

A constellation of factors both behavioural (personal and interpersonal) and context-dependent or structural factors seem to prevent men and women from adopting protective measures against

HIV infection. The findings suggest that although both men and women display high levels of awareness of HIV/AIDS they also have astonishing low personal assessment of risk. Some men and women do not perceive themselves at risk of HIV infection because they trust their partners. Consistent with other studies, the study found that men and women did not adopt protective strategies with partners they perceived as being safe (Hoffman and Cohen 1999). Instead of assessing their partners' sexual history they depended on a combination of visual and verbal cues to judge if their partner was clean or free from diseases (Hoffman and Cohen, 1999). However, studies suggest that these cues are not always reliable and may increase the risk of HIV infection. (Hoffman and Cohen, 1999)

Some men and women perceive their partners as trustworthy and therefore they do not feel there is a need for condoms in these relationships. In some situations, condoms are used with partners at the beginning of their relationships, but they stop using condoms as the relationship develops. Indeed, the issue of trust has emerged as an important issue in a number of studies. For example, in their study of sex workers in India, Evans and Lambert (2008) found that condom use became much more difficult for sex workers with their regular customers. The study found that the use of condoms with their regular partners was regarded as an expression of lack of intimacy in the relationship. In the late 1990s, Preston-Whyte (1999) also observed that the issue of trust was paramount. The negative association of condoms with casual and multiple partners served as a major barrier to their use in regular relationships. Other studies have also observed that local understanding of faithfulness and risk differs in significant ways from public health concepts. According to Parikh (2007: 1201), "a man can be 'faithful' as long as he continues providing economic support and maintains a respectful public reputation by keeping knowledge of extramarital relations away from people in the home and in the family's social networks." Thornton (2003) also noted that some men in Black South African communities acquire their male identity through their sexual relations. They also acquire a range of obligations to 'support' their woman by providing them with financial and other support.

The findings suggest that the widespread practice of multiple partnerships is a major barrier to behaviour change. The findings from both the focus group discussions and in-depth interviews

indicate that multiple sexual partners as well as extramarital relations are quite common in the study areas. Indeed, respondents, particularly women, stated that multiple partnerships were so widespread in the areas in such a way that it appeared to be a natural part of sexual relationships. They also observed that although both men and women engaged in multiple partnerships, but it was expected of men but not for women. Men with multiple partners were condoned by both men and women while women with multiple partners were heavily criticised. These findings are quite consistent with other studies which point out that multiple sexual partnerships in sub-Saharan Africa constitute one of the driving forces sustaining the HIV/AIDS epidemic. For example, a study by Meekers and Ahmed (2000) in Botswana found that among sexually experienced youths, 59 percent of females and 66 percent of males reported having at least one casual partner in the past year. In addition, male focus group participants argued that males were expected to have multiple partners, but females were not. Nevertheless, the study found that both males and females often had multiple sexual partners. Moreover, the study also found that difference between males and females was relatively minor, with 57 percent of sexually experienced females reporting that they had two or more partners in the past year, compared with 63 percent for males (Meekers and Ahmed, 2000). Other studies describe similar findings (Chama and Maharaj, 2008; Lau and Muula, 2004; Cohen and Trussell, 1996).

The phenomenon of transactional sex has been reported in other studies (Luke and Kurz, 2002; Hawkins et al., 2005; Bagnol and Chamo, 2003; Robinson and Yeh, 2009; Awusabo-Asare and Annim, 2008; Chatterji et al., 2004; Merten and Haller, 2007). In a study in cross-generational and transactional sexual relations in sub-Saharan Africa, Luke and Kurz (2002) noted that financial reasons were the main motivation for young girls engaging in sexual relations, with older men. In addition, in the same study, the authors reported, for example, that in urban Mozambique, transaction is related to the class of girls: 63 percent of working-class secondary schools girls, compared with only 6 percent of middle class secondary schools girls who received material support from their current partners (Luke and Kurz, 2002). Other studies have also found that transactional sex is not uncommon. For women, sex can be used to obtain material benefits of various kinds from men. Leclerc-Madlala (2002) notes that the sexual economy operates on a continuum or ‘scale of benefits’ which ranges from the trading by women of sexual favours in

order to secure basic needs (such as food, schools fees and rents), to use of sex for obtaining costly fashion accessories (e.g. clothes) prestigious outings (e.g. invitations to dine at restaurants and attend cinemas), and the opportunity to spend time in luxury cars or sleep in hotels. Other studies have also found that sex is a major factor motivating men to engage in relationships and money is one the dominant reasons for females to engage in sexual relationships (MacPhail and Campbell, 2001: 1623).

Yet in Mozambique, another study by Hawkins et al., (2005) found that a number of distinct relationship categories were identified in the narratives of respondents, each one of those relationships involving a distinct set of expectations (see also Meekers and Calvés, 1997). The study observed that not all types of relationships were necessarily entered into simultaneously, although the narratives suggested that multiple sexual partners were the norm (Hawkins et al., 2005). For example, the study noted that categories of relationships which involved *boyfriends* and *sex partners* were non-transactional, whereas those involving categories such as *lover, sugar-daddy*, and *sponsors* were transactional in nature (Hawkins et al., 2005). In Zambia, Merten and Haller (2007) reported that the general economic crisis and local livelihood changes were the primary reasons why women engaged in transactional sex, while the fishermen profited from women's economic dependency.

Furthermore, the findings indicate that people may deny the existence of HIV/AIDS. This denialist attitude seems to result from the fear of knowing one's own HIV status as well as the fear of stigma and discrimination. In the interviews some men and women stated that they would end their lives if they found out that they were HIV positive. In this regard, men and women would choose not to know their HIV status to avoid potential damage to their social reputation (UNAIDS, 2008, Cameron, 2005, Varga, 2001). Situations of 'rational ignorance' or the attitude of 'intentionally' choosing to ignore his or her HIV status were reported in other studies (Pinker, 2007; Varga, 2001). Thus, these findings are also quite consistent with what Varga (2001) found in Kwazulu-Natal. Varga (2001) found that a frequently expressed sentiment was what she called 'purposeful ignorance' of health status in order to prolong the positive psycho-emotional aspects of life in the face of inevitable HIV infection. In this regard, Varga (2001) noted that the

individual died twice after learning of his or her HIV (positive) status. The first death was psychological and emotional upon discovery of one's test result and the second death took place when the body itself succumbed to the physiological impact of the infection (Varga, 2001)

Consistent with other studies in sub-Saharan Africa, this study also shows that lack or poor communication among partners is a major barrier to behaviour change (Varga, 1999; Holland, et al., 1991). Some respondents said partner communication is minimal or non-existent. This is likely to lead to some misunderstanding in the sexual relationship and also, a lack of clarity concerning the partners' expectations of each other, a finding consistent with other studies (Varga 1999; Kesby, 2000; Lambert and Wood, 2005). Poor communication about sex and/or safer sex practices may result not only because people lack adequate skills to talk openly about sexual health matters but also suggesting condom use has the potential of creating awkwardness in the relationship (Varga, 1999).

Some respondents felt that communication is often limited in occasional sexual encounters. In those relationships the intention was to exploit the opportunity for sex. Some studies also have reported that in short-term relationships including casual sex, communication was poor or at least not straightforward (Beres, 2009; Varga 1999; Kesby, 2000). For example, discussing South African young people's sexual dynamics, Varga (1999) referred to the lack of direct communication on the issue of initiating sex. Rather, the author noted, youth seemed to rely primarily on implicit cues in alerting each other to expectations of appropriate sexual conduct. Thus, men were described as naturally unable to control themselves when faced with a potentially attractive sexual encounter. Yet still, according to the author, there was a strong suggestion that in responding positively to male sexual advances, women invited sexual coercion (Varga, 1999: 23-24). Beres (2009) in New Zealand also reported situations where both men and women in order to show their refusal to participate actively in casual sex, they would use what the author called 'tacit knowing' which consisted of a range of signals (subtle signals) including non-verbal indications.

Indeed, the ‘traditional’ notion of masculinity posits that men should take advantage of all sexual opportunities with women, whereas women are expected to be reluctant or indifferent to sex, submitting only in response to a partner’s request (O’Sullivan et al., 2007: 105). Other studies have also found that men are seen as having an uncontrollable desire for sex. Caldwell, Orubuloye and Caldwell (1995) found in Nigeria that when men were in the hotels and bars of Ado-Ekiti they often sought sexual relations with one of the young women. They spoke about their uncontrollable sexual desires that should neither be denied nor postponed. The fear of AIDS has not diminished such feelings. Risky sexual behaviour is also increased by drinking and drunkenness.

Some studies have reported that condoms are more likely to be used in occasional relationships than in marital or steady relationships (Adetunji, 2000; Maharaj and Cleland, 2004; Agha, 1998). However, the findings of this study indicate that even in occasional encounters the use of condoms is more complicated. Indeed the findings suggest that partners do not use condoms consistently in both types of relationships for a range of reasons including suspicions of lack of trust and intimacy and concern about reducing sexual pleasure. But in non-regular relationships, with the exception of commercial sex, it is said that sometimes sex just happens and broaching the topic of condoms may jeopardize the opportunity for sex in that moment (Agha et al., 2002). Some studies have also found that even in non-regular relationships condoms are not used consistently (Messersmith, et al., 2000).

Furthermore, the findings show that there is a strong peer pressure for men to engage in some high-risk sexual behaviour, particularly multiple sexual partnerships. Some respondents observed that some men who try to remain faithful to their partners are generally labelled as ‘weak’ and under the control of women, which contradicts the general and widely accepted expectation of men within a society. Therefore, the fear of being viewed as under the control of women has contributed to male risky taking behaviour.

Indeed, the findings show that in order to secure urgent economic needs, some women, whose husbands have gone to work in the mining industry in South Africa, sometimes end up

exchanging sex for economic support, because their husbands' remittances are irregular. On the other hand, studies have documented that the sexual life of mine workers in South Africa has proven to be dangerous for the mine workers and their families (Campbell, 1997; Campbell, 2001; Agadjanian et al., 2009). For example a study by Agadjanian et al., (2009) in Mozambique found that women who are married to migrants are much more likely than those married to non-migrants to think that their husbands have had sex with other women. This is hardly surprising given the widespread belief that men have an uncontrollable desire for sex and men engage in extramarital relations while away from home (Agadjanian et al., 2009). Similar findings are also reported in other studies (Anarfi, 1993; Bouare, 2007). For example, a study by Anarfi (1993) in Ghana concluded that migration in Ghana did not mean permanent removal from one's place of origin. Until they finally return, migrants maintain a close contact with their homes through visits. According to the author, the periods of visits are a fertile ground for the spread of any sexually transmitted diseases the migrants might have contracted (Anarfi, 1993).

There are also a numbers of myths and misconceptions surrounding condoms which serves as a major barrier to use. Respondents repeatedly expressed concern that condoms may carry the virus. This obviously creates a great deal of confusion about the effectiveness of condoms in preventing HIV infection and is also likely to limit use in sexual relationships. In addition, the study found that there are a number of derogatory labels that are used to describe condoms. Studies have reported a range of names to describe condoms: in some developed countries, for example, expressions such as "going to bed with your wellington on", or "washing your feet with your socks on" were found (Holland et al., 1991). In developing countries the scenario it is not very different. Expressions such as 'it's like eating sweets with their paper on' or 'bathing in a raincoat' are also reported (Preston-White, 1999). Studies have shown that many people do not like condoms because they believe that condoms reduce sexual pleasure, prevented men to control the dryness of women and result in loss of spontaneity (Scorgie et al., 2009; Agha et al., 2002).

Alcohol consumption seems to be one of the factors contributing to risky sex behaviour which increases the risk of HIV infection among men in particular. The widespread sale of alcoholic

drinks in the ‘barracas’, bars or backyards all over the study sites is understood by respondents as the major source of HIV risk infection. In some situations, the sale of alcohol is associated with the renting of rooms for the purposes of having sex. These findings are in line with what have been found in other studies. It is well documented that the so called ‘liquid of courage’ makes both men and women more vulnerable to HIV infection (Stoner et al., 2007; Theall et al., 2007; Christian et al., 2007). A study by WHO (2005) on alcohol use and sexual risk behaviour found a range of factors involved in alcohol use-related sexual risk behaviour. Those factors were psychological, socio-cultural, environmental or situational (WHO, 2005). Consistent with this study, other studies have also found that men and women are more likely to engage in risky sexual behaviour after consuming alcohol. For example, a literature review by Pithey and Morojele (2002) in South Africa concluded that for all age groups drinking was more common among males than females. In addition, the authors also conclude that there was a strong relationship between alcohol abuse and the risk of HIV/AIDS.

CHAPTER 9: SEXUAL DECISION-MAKING AND NEGOTIATION OF SEX

9.1 Introduction

"Sex is happening in both rural and urban settings, but partners hardly talk about it, particularly about its sexual and reproductive health implications".

(An adapted quotation from an article by Kesby, 2000)

Sexual negotiations and decision-making have been the focus of several studies in sub-Saharan Africa (Varga, 1997; Kimuna and Adamchak, 2001; Bankole and Singh, 1998). Most of these studies have highlighted the role of unequal power relations among partners and also have pointed out that this unequal power relations have contributed to the worsening of sexual and reproductive health outcomes (Wolff et al., 2000; Kesby, 2000; Grieser et al., 201). There are a number of factors that influence decision-making that impacts the sexual and reproductive health of men and women. In some cases, the need for emotional intimacy has had a very negative impact, particularly on women's reproductive health (Pliskin, 1997; Wolff et al., 2000; Kesby, 2000; Varga, 1997). On the other hand, studies have shown that limited partner communication about sex and sexual matters may also impact negatively on reproductive health outcomes such as unwanted pregnancy and sexually transmitted infections, including HIV/AIDS (Varga, 2003; Lambert and Wood, 2005; Pliskin, 1997). Thus, investigating sexual negotiations and the decision-making processes was deemed of particular importance for the understanding of power relations between men and women in the Manhiça district and Matola Municipality. Using data from the household survey as well as focus group discussions and in-depth interviews, this chapter assesses sexual negotiation and decision-making in the study areas. It begins with examining partners' communication about sex and then analyzes the power relations between sexual partners. It ends with an overview of sexual negotiations decision-making dynamics within marital and cohabiting relationships.

9.2 Communication about Sex

Partner communication has been identified as key for the enhancement of sexual and reproductive health among men and women (Blanc, 2001; Kesby, 2000). In addition, it is understood that partner communication about sexual matters (including sexual intentions and desires) have led to greater sexual satisfaction**,** that is, the general appraisal of the quality of one's sexual life (Beres, 2009; Holmberg and Blair, 2009). In this study, respondents were asked two questions about partner communication about sex. The first question asked about the difficulty of communicating with partners about sex. The second question explored shared decision-making with regard to sexual matters. Results are shown in Table 9.1

Table 9.1: Percentage of respondents who reported whether or not it was difficult to talk about sex with partner

	Men		Women	
	n	**%**	**n**	**%**
How difficult is to talk about sex				
Very difficult/somewhat difficult	42	20.1	45	21.0
Not difficult	167	79.9	172	79.0
Total	**209**		**217**	

As shown in Table 9.1, the majority of respondents, both men and women, report that it is not difficult to talk about sex with their partners, with 80 percent of men and 79 percent of women, respectively, reporting that it is not difficult for them to talk about sex. These findings are overwhelmingly corroborated by the results of both focus group discussions and in-depth interviews. Moreover, the findings are in line with studies in other countries (Blanc et al., 1996).

Table 9.2 looks at the demographic characteristics of respondents who reported that it is difficult to talk about sex with their partners.

Table 9.2: Percentage of respondents who reported that it is difficult to talk about sex with their partner, by background characteristics

	Men		Women	
	n	**%**	**n**	**%**
Place of residence				
Urban	106	12.3*	111	20.7
Rural	103	28.2	106	20.8
Age				
20-29	108	15.7	121	19.8
30-39	55	23.6	60	20.0
40-49	46	26.1	34	23.5
Level of Education				
None	28	42.9*	51	23.5
Primary	99	17.2	106	20.8
Secondary or higher	82	15.9	60	18.3
Marital Status				
Married/cohabiting	138	23.2	120	19.2
Neither	71	14.1	97	22.7
Total	**209**		**217**	

Note: * Significant P < 0.05 percent

The results of Table 9.2 indicate that both place of residence and education are strong predictors of partner communication for men. Despite the fact that both rural and urban men report that it is not difficult to talk about sex with partner, it is also evident that it is more difficult for rural men than urban men. Among men, as age increases, the level of difficulty in talking about sex also increases. Furthermore, the findings suggest that less educated men found it more difficult to discuss sex than more educated men. Meanwhile, it could be noted that as the level of education increases the level of difficulties to talk about sex and sexual matters decreases. In addition, it is of interest to note that married and cohabiting men are more likely than neither married nor cohabiting men to report difficulties in talking about sex with their partners.

By contrast, no clear association is found between partner communication about sex and demographic characteristics for women. Nevertheless, although not statistically significant, age seems to be a dominant factor in influencing partner communication about sex. The findings suggest that as the age increases, the level of difficulty to talk about sex also increases. However,

this may also indicate that the subject of sex may diminish in importance among couples who are living together for a long period of time. Also of note is that the percentage of women who admitted that it was difficult to talk about sex was about 20 percent.

Table 9.3: presents the results of how often partners jointly discuss about sex and sexually related matters.

	Men		Women	
	n	**%**	**n**	**%**
How often do you jointly discuss your sexual life?				
Always	83	39.7	16	7.4
Occasionally	84	40.2	111	51.2
Rarely/ Never	42	20.1	90	41.5
Total	**209**		**217**	

The results shown in Table 9.3 suggest that men are more likely than women to report that they always jointly discussed sexual matters with their partners with almost 40 percent of men reporting joint discussions compared with just 7 percent of women. These results seem to corroborate with previous evidence which suggest that, although many respondents of both sexes reported that it was not difficult to talk about sex, communication about sexually related matters is not a regular practice, particularly for women. On the other hand, the findings suggest that women were more likely than men to report that they discussed sexual matters with their partners occasionally. Slightly more than 50 percent of women reported occasional discussion about sexual matters compared with 40 percent of men. In addition, a sizable percentage of women, 42 percent, reported that they rarely or never discussed sexual matters with their partners, compared with 20 percent of men.

According to Agadjanian (2001), social interaction, both formal and informal, is important for promoting the spread of reproductive innovations. Thus, “informal interaction compensates and complements formal information channels by asserting the social legitimacy of novel reproductive ideas and practices” (Agadjanian, 2001:291-192). Men and women negotiate their fertility and contraceptive decisions using both the formal and informal channels. These

communication channels are of particular importance, especially for women because they give them some confidence to make decisions while lowering, at the same time, uncertainities (see Agadjanian, 2001). Given the gendered nature of childbearing in the study areas, it is not surprising that women are more likely than men to engage in conversations related to fertility and family planning. As explained elsewhere, sharing contraceptive experiences, especially with regard to side-effects, allows women to choose the contraceptive method that best suits them, both physically and physiologically (Agadjanian, 2001; Blanc et al., 1996). Table 9.4 shows the results of communication networks about sex and sexual matters including on fertility and family planning issues in the study sites.

Table 9.4: Percentage of respondents who reported that they talk about sex with someone else rather than their partner

	Men		Women	
	n	**%**	**n**	**%**
Talk to someone else about sexual and reproductive matters				
Yes	142	68.0	81	37.0
No	67	32.0	136	63.0
Total	**209**		**217**	
Who do you speak to?				
Mother	7	4.9	8	9.9
Father	11	7.7	2	2.5
Sister	9	6.3	21	25.6
Sister-in-law	7	4.9	6	7.4
Brother	43	30.3	3	3.7
Female relative	4	2.8	12	14.8
Male relative	19	13.9	4	4.9
Male friend/ Neighbor	134	94.4	10	12.3
Female friend/Neighbor	16	11.3	52	64.2
Religious leader	4	2.8	0	0.0
Health worker	16	11.3	2	2.5
Others	6	4.2	6	7.4
Total	**142**		**81**	

The findings suggest that men are more likely than women to talk to somebody else about their sexual matters with almost 68 percent of men reporting that they talk to somebody else about

sexual matters compared with 37 percent of women. In addition, the findings of this study suggest that these communication channels are mostly gender based, which it is not surprising at all given the strong gender divide that exists in Mozambique's society. This is supported by Agadjanian (2001: 300) who observes that "women and men's social networks in which social interaction occurs operate relatively independently, with little non-spousal communication occurring across gender lines." In other words, apart from their regular partner when men and women need to talk to somebody else about sexual matters, they usually go to somebody who is of the same sex, with the exception of situations where the partners are engaged in extramarital relationships. These findings are consistent with a study in Uganda (Blanc et al., 1996).

The findings show that men usually talk to male friends, neighbors or other male relatives, while women talk to female friends, neighbors and female relatives. Similar patterns have been reported elsewhere (Blanc et al., 1996; Shiravam, 2005; Agadjanian, 2001). Meanwhile, it is of interest that even though health workers are recognized as having accurate information about sexual and reproductive health matters, they score very low in respondents' preferences. This may occur as a result of the lack of feeling of emotional intimacy towards health professionals which prevents people from confiding their private sexual stories to them. Emotional intimacy as opposed to physical intimacy is an enduring building process (Pliskin, 1997). Examining difficulties people have with sexual health discourse in the United States, Pliskin (1997) noted that for some people it is much easier to have sex than to talk about it. In addition, the author observes that "knowing is subjective, derived from what is judged to be physical, verbal, and social compatibility, as well as judgment of the partner's character. Getting involved has nothing to do with having sexual relations, which can occur long before one gets involved. Sex and involvement are thus two distinct issues, where the physical act of sex is disconnected from the social act of involvement. And ironically, getting involved with a partner may actually increase risk of STDs when the couple stops using condoms" (Pliskin, 1997: 96). In line with this approach, the findings of this study suggest that the lack of 'social act of involvement' and 'social compatibility' make people less likely to open themselves to health workers despite the fact that health workers are the ones who hold accurate knowledge about sexual and reproductive health matters. In addition, the fact that health workers in the public sector are poorly paid, inadequately motivated and in some cases

undertrained are all associated with high levels of stress which results from overcrowded health facilities which make it very difficult for individual counselling.

9.3 Sexual norms and Beliefs

Respondents were asked about their perceptions and beliefs about women's ability to express their sexual desires and feelings. In addition, they were asked whether or not men had a preference for women who were less assertive in sexual matters. The results are given in Table 9.5.

Contrary to expectations, the results show a clear divide between men and women over the statements. Men were more likely than women to report that women find it difficult to tell their partners what they dislike sexually. For example, only one-third of women reported that they find it difficult to tell their partners what they dislike sexually compared with 79 percent of men. On the other hand, men were more likely than women to report that women find it difficult to tell their partners what they find sexually enjoyable. Less than one-fifth of women (19 percent) reported that women find it difficult to tell the partner over what they find sexually enjoyable compared with 38 percent of men.

Table 9.5: Percentage of respondents who agree with specific statements regarding the ability of women to communicate their feelings and sexual desires to partners, and perceptions about male preferences

Statements	Men %	Women %
Women find it difficult to tell their partners what they dislike sexually	79.4	33.6**
Women find it difficult to tell their partners what they find sexually enjoyable	37.8	18.9**
Men prefer women who are less assertive who like men to take the initiative	45.5	18.9**
Total	**209**	**217**

Note: ** Significant P < 0.01 percent

The findings suggest that men are more likely than women to agree with the statement which says that women find it difficult to tell their partners what they dislike sexually, with 79 percent of men agreeing with the statement compared with 34 percent of women. Similarly, men are more likely than women to agree with the statement which states that women find it difficult to tell their partners what they find sexually enjoyable, with 38 percent of men agreeing compared with 19 percent of men. In addition, men were also more likely to report that they prefer women who are less assertive and allow men to take the initiative, with about 46 percent agreeing with this statement compared with just 19 percent of women. These findings suggest that men may have been making judgments about women based on gender stereotypes which expect women to be disinterested or ignorant about sexual issues. On the other hand, the responses of women reveal that women do not assume these dominant gender stereotypes. The findings suggest that women are not completely passive in sexual decision-making, but they are active agents.

In general, the qualitative findings show a great deal of differences between men and women with regard to partner communication about sex and sexually related matters. Among men, for example, there is a strong sentiment and tendency to say that it is not difficult to talk about sex with their partner. However, it should be noted that such commnunication may be restricted to the intention of the male partner which is focused on ensuring that sexual intercourse occurs. This can be inferred from the statements below.

"For me it has been easy to talk about sex because before sleeping with a new partner, I ask her with whom she was before, or she stood alone. She can tell me what she did, but as I know that there is AIDS, I will not believe in her"

(Urban non-married male, IDI # 16)

"It is not difficult to talk about sex with my wife. When I am in my mood I tell her: 'let's go inside. I want to have sex' and she cannot refuse because she also needs it but also because she does not refuse if I tell her to do something"

(Rural married males, FGD # 11)

"My wife is straightforward. She tells me that we did not have sex for some days and she says that she wants sex"

(Urban married males, FGD # 13)

In the first quotation, for example, the respondent seems to be aware of the harmful sexual health outcomes if protective practices are not adopted but, at same time, shows the negative stereotypes which some men, if not many, have with regard to women. Some men feel that women are not trustworthy. In the second quotation, although the respondent recognizes the needs and rights of women for sex, it is ultimately men who are in control of sexual interactions and women must obey the decisions of men and also must satisfy their needs whenever they desire to have sex. Lastly, the respondent reports a situation where his partner invites him to have sex, which suggest that, in some cases, women take the initiative and may demand her rights to have sex with her partner.

While some women find it not difficult to talk about sex, for others there are circumstances which make it somewhat difficult. Thus, for those who see no difficulties in talking about sex with their partners continue to argue that these are modern times. According to these women, couples are now much open to each other when it comes to sex than they were in the past. In one focus group discussions all the participants unanimously agreed that the situation has changed and men and women now communicate more openly about sex.

"Nowadays there is 'no secrets' among couples about sex. Shyness is a thing of the past. Now, we talk about everything. Boyfriends and girlfriends talk to each other about everything."

(Rural married females, FGD # 01)

"I cannot lie to you. My husband and I we chat and when we have a desire for sex we just have sex"

(Urban married females, FGD # 03)

The women noted that open communication about sexual matters between partners is a relatively recent development and is a direct result of changes in society. They went on to point out that this was not the situation of their parents. Open communication in the past was not possible. Moreover, in some situations, cohabitation and the accompanying intimacy between partners also makes it less difficult to talk about sex as well as other sexual matters. This became clear when one rural married woman and one urban married woman stated that it was not difficult for them because they were very familiar with their partners. Nevertheless, other groups of women pointed out some of the difficulties in talking about sex with their partners.

"Difficulties come when the man 'goes outside' and gets 'different pleasures' and, then, accuses you of failing to give him such a pleasure. He starts complaining of 'incompatibilities'"

(Urban married females, FGD # 03)

For these women, for example, an extra-marital sexual liaison is a major source of tension among couples, which is not conducive to an open discussion about sexual and reproductive health matters. They argued that, in general, when their partners have other outside partners they usually blame the wives for not sexually satisfying them. Even if this is true, what it is clear from the discussions is the power that men yield in sexual relationship which allows them to assert their personal preferences while women find themselves with less power to influence the decision-making process. Furthermore, the lack of regular and open dialogue between partners makes it very challenging to broach the topic of sex because some women simply do not know how their partner will react. This aspect was highlighted during focus group discussions and in-depth interviews as shown in the quotes below.

"I think it is difficult because there is no regular dialogue on sexual matters among couples."

(Rural non-married females, FGD # 05)

"It is rather difficult to me. We rarely talk about sex. It is much more difficult from my side"

(Urban married female, IDI # 09)

"There is a problem of lack of communication between partners, particularly on sexual health matters including safe sex. It usually happens with me. I try to convince him to have safe sex. It is very difficult to me. He does not give me a chance"

(Urban married female, IDI # 07)

From the content of the above quotes it becomes clear that the long-term consequences of gendered socialization and norms which dictates that women must remain silent, if not ignorant, about sexual matters has had a clear impact on women's willingness to broach the subject of sex. Indeed, the interviews above seem to suggest that women find it very difficult to convince their partners to use condoms and negotiate safer sex because women are neither socially nor culturally supposed to broach the topic of sex and discuss them openly, unless their partners are open minded and approachable. Some women lack the necessary skills to communicate with their partners which serve as a major barrier to negotiating safer sexual practices. Moreover, the lack of communication seems to be directly linked to male power and dominance.

In some sectors of Mozambique's society it is not unusual for married people, both men and women, to have extra-marital relationships (Karlyn, 2005). When this happens either for men or for women it is generally known as taking a "*lover*" or having a 'love affair' (see also Maticka-Tyndale et al., 2005). In the interviews, both men and women used the term 'love affair' to describe the 'sexual relationship'. However, further investigations revealed that this rarely represented a close emotional or psychological attachment (Maticka-Tyndale et al., 2005). This type of sexual relationship when occurs outside the marriage is generally hidden from the general public or from close acquaintances, but is usually regarded as a regular sexual partnership. Many perceive these types of relationship as more romantic, less bound by strict social norms and more sexually satisfying. Therefore, it is not surprising that respondents pointed out that communication is much easier in non-marital than marital relationships.

According to some married women, the dialogue in marital relationships, that is, spousal communication tends to be hierarchical and authoritative, whereas dialogue in non-martial relationships is more equal. As indicated earlier, the relationships with non-marital partners are generally perceived as more sexually satisfying. For example, participants admitted that sex between lovers is generally free of strict social boundaries which includes unconventional sexual practices such as oral and anal sex, and is more sexually satisfying. On the contrary, women in marital relationships have to preserve their 'good name' so they are not allowed to express their sexual desires and fantasies. These can be illustrated in the quotes below:

"I think that talking is key. It is rather difficult when he is the husband rather than your lover, because in many cases, the dialogue of a husband is limited to general things of home such as 'did you do this', or 'why did not you buy that thing', etc, and when it is time for sex, you just open your legs. I think is better to be a lover."

(Urban married female, IDI # 07)

"It is said that a lover, a woman outside, does everything your husband wants, but when he arrives at home, his wife has some limitations but a lover will talk to him. She will listen to his problems. In addition, many men like things, certain things that lovers do that the wife does not allow"

(Urban married females, FGD # 04)

It is of interest to note that during the in-depth interviews at least eight women in both study sites admitted to have sexual relationships with married men. In all these cases, these women had relationships with 'friends' – another word usually coined to refer to a 'lover'. These findings are consistent with other studies where hierarchical relationships, mostly centered on power and control, and where men exert enormous power over their spouses (Varga, 1996, 2003; 1993; Blanc, 2001; Kesby, 2000; Desgrées du Lou, 2005).

9.4 Negotiation of Sex

In heterosexual sexual relations, the level of power may vary by age differences, race, class or socio-economic status of the individuals involved (Dixon-Mueller, 1993; Kaufman, 2008). In this study, gender and power relations among men and women and their partners was investigated. The aim was to establish a correlation between gender and age of respondent which have implications of power in gender relations (Singh and Samara, 1996; Luke and Kurz, 2002). According to some studies women are more likely than men to marry at a younger age in sub-Saharan Africa. For example, Singh and Samara (1996) found that in almost all countries in sub-Saharan Africa, between 60 to 92 percent of all women aged 20-24 had entered their first unions by age 20 (Singh and Samara, 1996). In addition, most studies suggest that men exert a great degree of bargaining power within these sexual relationships. Women have limited power to initiate or negotiate safer sexual practices, specifically condom use or refuse to have sex (Luke and Kurz, 2002).

Moreover, evidence from other studies suggests that gender norms dictate that girls should remain ignorant about sexual matters while boys should be very knowledgeable, often as a result of their sexual experience. However, many young men report limited information, counseling or guidance on issues of sexuality especially the responsibility of sexual activity, and, further, they are reluctant to admit that they lack this knowledge (Ampofo, 201) Furthermore, expectations about the role of men and women in society, which are a critical aspect of most children's socialization, leave many adults ill prepared to enjoy sex or protect their health (Shears, 2002). Men exercise their position of power by refusing to adopt safer sex practices, including their use of condoms. To assess the balance of power in sexual relations respondents were asked '*Who has more influence over whether or not to have sex: you, your partner or both?* In addition, respondents were asked *'How old is your sexual partner?'* The results are shown in Table 9.6

Table 9.6: Percentage of respondents by who has more influence over whether or not to have sex between them and their partners as well as age differences between partners

	Men %	Women %
Who has more influence over whether or not to have sex?		
Respondent	74.0	3.7
Partner	4.4	61.7
Both	21.6	34.6
Age differences among sexual partners		
Older	6.0	94.0
Younger	89.0	2.3
Same age	5.0	3.7
Total	**209**	**217**

As one would expect, the results indicate that men have, by far, more influence than women on whether or not to have sex. Almost 74 percent of men reported that they have more influence over whether or not to have sex. Few women (four percent) reported that they have more influence over whether or not to have sex. The dominant power that men exert in relationships was confirmed by women as well. Almost 62 percent of women admitted that the decision about whether or not to have sex depended mostly on their male partners. In addition, nearly 22 percent of men and 35 percent of women said that they jointly shared the decisions over whether or not to have sex with partners.

As indicated earlier, studies suggest that age is important in shaping sexual decision-making in relationships (Maticka-Tyndale et al., 2005; Luke and Kurz, 2002). The results shown in Table 9.6 indicate that while 89 percent of men reported that their partners were younger than themselves, 94 percent of women reported that their sexual partners were older than themselves, an expected result. Nonetheless, although not surprising, these findings are of interest for the understanding of power dynamics and its impact on the AIDS pandemic in the study areas.

During focus group discussions and in-depth interviews, respondents were asked two questions: "*Who do you think has more influence in decision-making about sexual behaviour?" "Do you, as*

man/woman, have equal power to share decisions about sexual behaviour?" The interviews findings indicate that the opinions of respondents are somewhat divided between those who say that both men and women equally share decision-making and those who are more categorical in saying that men have great influence than women in the sexual decision-making process. In this regard, some women observed that men have more influence than women. This is due to the fact that men are more assertive and dominant in sexual negotiations. In addition, they are more likely to assert their personal preferences while women are generally more reluctant to assert their personal preferences. The quote below illustrates those assessments.

"Men are faster. They are more decisive. When a man says today and now, a woman must accept. But a woman cannot do that even if a woman is not in the mood for sex".

(Rural married females, FGD # 03)

In many sexual relations double standards characterize and regulate the relationships between men and women. In this regard, participants made it clear that men are entitled to have sex with their partners whenever they desire while women have to submit to men's demands. This reveals the power and authority men exert in intimate relationships.

"*Men have more rights and influence on sexual behaviour and decision-making. Even a woman says 'I am not feeling well' he will say 'I have got a desire and I want it"*

(Rural non-married male, IDI # 14)

From the perspective of some women as is shown in the above comment, the power and desire of a man seems non-negotiable. On the other hand it is important to note that the quote also reveals that it is not unusual for women to have sex under duress. For example, when a woman says 'I am not feeling well', what will probably happen is that she will have sex anyway with her partner even if she is resistant to the idea (see also Machel, 2001 and Varga, 2001). The man will demand sex and he may even use threats or other mechanisms to ensure that his desires are not challenged. Furthermore, a mix of fear and shame may be behind women's silence. During the interviews, some women argued that generally women are afraid and ashamed of expressing their

sexual desires. In other words, even if they have the desire for sex they are not supposed to take the initiative. Indeed, one respondent found it difficult to respond to the question about who has more influence on sexual decision-making. She observes:

"It is the man who has the most influence. Often it is the man. But women, sometimes they are afraid of and ashamed, I don't know. It depends, sometimes the woman has influence, but I think it is mostly the man. He is more daring. It is the man who always takes the initiative. Even if a woman wants sex, she will never say it openly. She will wait for the man's decision…"

(Rural married females, FGD # 03)

Meanwhile, some women noted that even if a woman behaved as if she was not interested in sex this does not mean that she lacks the desire for sex. On the contrary, they argued, this it was because of sexual norms and beliefs which dictate how both men and women should behave in intimate relationships. For example, in focus group discussions some urban women highlighted how gendered sexual norms and expectations impacted on the attitudes of women towards sex, particularly by allowing men to be always in charge, although they also indicated that women have an important role because they also want sex. Thus women may use other communication strategies to show their sexual needs, particularly body language. On the other hand, even if a woman wanted to express her desire or feelings she is limited by the fear of being labeled 'impure' or accused of having learnt about sex from other men.

"I think both men and women have influence. But what usually happens is that we, the women, usually wait for a man to say something because often we wait for our boyfriends to decide on our behalf because women are made like that, they are shy. For example, I usually think that if I start he will think that I am a loose woman. So it is better to be in my corner, waiting for his decision, you see!"

(Urban non-married females, FGD # 10)

Some men feel that women have more influence because they can refuse to have sex. According to one man, the woman is the one who has more influence over whether or not to have sex,

because if she does not want sex, you cannot force her to have sex. The underlying assumption, which results from gender stereotypes, is that a woman does not broach the subject of sex. However, her gestures should be sufficient for a man to be able to read her non-verbal cues and understand that she wants sex.

"It is a woman who decides in one way or another, because if a woman does not want to have sex no man can even insist and open her legs. When I hear women saying "my husband raped me", I could never do that without her consent".

(Urban non-married male, IDI # 16)

Indeed, the widespread gender stereotypes which emphasize, among other things, that a woman cannot refuse a man's sexual demands has led to negative sexual and reproductive outcomes for many women. Gender stereotypes tend to place women, particularly young women, in a difficult situation. On the one hand, they are supposed to appear 'chaste', submissive and loving but on the other hand, they cannot refuse to have sexual intercourse. In fact, when a woman says "no", man tends to view this as part of the game which means "yes'. In addition, if a woman dresses in a manner which is viewed as sexy, it is understood that she was inviting men to have sex with her.

Although some women recognize that men have more influence than women over sexual matters, they also admitted that, in some cases, when a woman wants sex it is not difficult for her to persuade her partner through her seductive power to give into her demands.

"It is the woman who has more influence. Nowadays I think that no man can force a woman to do what she does not want. It is far easier to force a man rather than a woman. Indeed, the men are not even forced. I think a woman can very easily make a man to have sex, always!"

(Urban non-married female, IDI # 10)

Implicit in this account is the idea that men are always ready for sex. This is of particular note because it shows how gender stereotypes are reproduced by both men and women in everyday

life, but most importantly, it also shows the extent to which women are aware of the power they have and how they can use it when the need arises. In this regard, the extract from the interview may reflect the widely held assumption that a man should always be ready for sex and that he cannot resist it. On the other hand, these findings suggest that women also have power in sexual relationships and they may also exert enormous influence over the sexual decision-making process.

In addition, some men justified their influence over women by drawing on culture. For example; participants in one urban focus group discussions went on to argue that according to culture men have more power over women in the sense that women should submit themselves to the authority of men as it can be seen the following quote. In addition, men use 'culture' to discourage any challenge to their power.

"Men have more rights and influence than women. It is a cultural practice. My decision prevails!"

(Urban married male, IDI # 18)

A number of studies have observed that traditional African cultures are often patriarchal and tend to oppress women (Eaton et al., 2003). For example, it is not uncommon to find that men emphasize their need for variety in sexual relations. They often argue that it is part of man's nature to desire many partners and that "staying with one woman therefore goes against the essence of being a man" (Meyer-Weitz et al., 1998:44). In this case, 'culture' is used to legitimate particular sexual practices. In other words, as it has been done in the past, culturally, women should continue submitting themselves to male dominance and power. Therefore, the argument is used in an essentialist way as something that does not change and people should therefore conform to cultural norms.

Studies have shown that culture, alongside other context-dependent and structural factors play a significant role in increasing the risk of HIV infection (O'Sullivan et al., 2007, Varga, 2001, Blanc, 2001; Eaton et al., 2003). One of the direct consequences of culture, or more specifically

the way both men and women are socialized is that it inhibits negotiation of safer sex even in the context of a HIV/AIDS epidemic (WHO, 2003; UNAIDS, 2008; O'Sullivan et al., 2007). For example, the findings of this study suggest that while the norms of masculinity prevent men from adopting protective strategies; the norms of femininity prevent women from negotiating safer sex including the use of condoms or refusing sex if they perceive themselves at risk of HIV infection.

In this regard, social stereotypes which portrait women as the seductress and men as the 'victims' of women's seduction seem to undermine the image of men as the all powerful and dominant decision-makers in sexual relationships. On the other hand, the very same stereotypes, which portray men as 'victims' of seduction, seem to play another role with dire consequences for women. Indeed, when men are socially perceived as 'victims' of women's seduction, such perceptions may give them a green light to behave irresponsibly. In this regard, acts such as the (public) verbal harassment of women (e.g. whistling at women in the streets), sexual assaults or multiple partnerships are generally seen as a response by men to women's provocations, and therefore, it is seen as excusable.

Men exert an enormous influence over sexual decision-making as was demonstrated in the previous respondents' accounts, but this does not mean that women are completely powerless. In some relationships, women often exert an enormous influence over the decision about whether or not to have sex as one female respondent earlier suggested that it is easy for a woman to make a man want to have sex.

Nevertheless, there is no doubt that men have an important role in relationships including, for example, in deciding the timing of the sexual act. On the other hand, men are also aware of the limits of their power in sexual decision-making.

"I am the one who says when we can have sex. It can be today, tomorrow or the day after tomorrow, once or twice. But to tell you the truth, women are the ones who decide when they want, but men are the ones who initiates sex"

(Urban married males, FGD # 13)

Other studies have also found that women may refuse to have sex with their partners. Maticka-Tyndale and her colleagues in Kenya (2005) refers to situations where girls, aware of their lower socio-economic position in society would use the prerogative of refusing sex as a delaying tactic in order to gain more gifts from their potential boyfriends before sexual activity take place.

Some women in focus group discussions also stressed that gender norms dictate acceptable behaviour for men and women in intimate sexual relationship. These gender norms give men great control in sexual relationships but they also recognize that women also exert their personal preferences especially since they also want sex.

"What usually happens is that we women we wait for a man to say something because often we wait for our boyfriends to decide on our behalf. Women are made like that, they are shy. They usually think that if I start he will think that I am a loose woman. So it is better to be in my corner, waiting for his decision, you see?"

(Urban non-married females, FGD # 10)

Some women highlighted that generally women have blamed themselves for the failure of relationships. They tend to think that they were unable to keep their partners from straying from the relationship. At the same time, these women believe that a man does not get sexually satisfied with only one woman. Indeed, women may adopt a range of strategies to please their partners sexually so that they do not stray from the relationship. Recent studies suggest that women engage in particular sexual practices because they want to increase men's sexual pleasure while at the same time they are also seeking to exert their agency and control in their sexual relationships with men (Bagnol and Mariano, 2008; Scorgie et al., 2009; Ayikukwei et al., 2008). Some women are of the opinion that a man whose sexual desires are satisfied are more likely to be sexually faithful.

"What happens is that a man, sometimes look for other women because of his wife's behaviour, or when there is no understanding in the house because the wife cannot satisfy him. It is difficult to satisfy a man"

(Urban married females, FGD # 04)

In fact, some women argued that their lack of power in relationships makes it difficult for them to influence safer sexual relations or to convince their partners to be faithful. In this regard, one participant explained during the focus group discussion that the main reason why women do not try to convince their partners to remain faithful is the fear of ridicule from the larger community. They are accused of pursuing their partners which is not socially acceptable. Interestingly, it seems that there are also some women in the community who try to influence other women by dictating acceptable and unacceptable behaviour for women. They often criticise women who question their partner's sexual behaviour as trying to control their 'men'.

"It is very difficult. You can even die from anger. What will you do? Because he is a man! Men are stubborn. Even protesting, what will happen is that you become ashamed yourself. Will you have courage to say: 'my husband has other woman?' Everybody will laugh at you! It is better to stay at home and cry instead of protesting because you love your husband"

(Urban non-married females, FGD # 10)

9.5 Negotiating Sex: Level of Agreement and Disagreement between Partners

The study also investigated the extent to which partners agreed or disagreed about having sex, including the timing of sex as well as preferences. Two questions were asked to respondents: "*Was there a time when you wanted sex, but your partner did not?*", and "*Was there a time when your partner wanted sex, but you did not?*" The results are shown in Table 9.7 and Table 9.8

Both Table 9.7 and Table 9.8 indicate that there is widespread disagreement between men and women about whether or not to have sex at a specific time, which it is not surprising at all.

Interestingly, almost half of respondents of both sexes reported that there was some disagreement about whether or not to have sex, but men are significantly more likely than women to demand sex from their partners.

Table 9.7 indicates that almost 47 percent of men admitted that there was a time when they wanted to have sex but their partners did not want. In contrast, almost 43 percent of women admitted that there was a time when they wanted to have sex but their partner did not want. Respondents were also asked a question to determine whose preference prevailed at the time.

Table 9.7: Percentage of respondents by disagreement on timing of sex (whether or not there was a time when the respondent wanted sex, but his/her partner did not), and whether or not they had sex anyway

	Men		Women	
	n	**%**	**n**	**%**
Was there a time when you wanted sex, but your partner did not?				
Yes	98	47.1	93	42.9
No	110	52.9	124	57.1
Total	**208**		**217**	
Although the partner did not want, they had sex, anyway.				
Yes	57	58.2	48	52.2
No	34	34.7	30	32.6
Non-Response/Refusal	7	7.1	14	15.2
Total	**98**		**93**	

Table 9.7 indicates that more than a half of respondents admitted that they had sex anyway at the specific time. Once again, the findings indicate that men were more likely than women to report having had sex anyway despite their partners' disagreement. Almost 58 percent of men, compared with 52 percent of women, reported that they had sex anyway despite their partners' disagreement. However, it also worth noting that almost one third of both men and women reported that they did not have sex if their partner refused.

The results of Table 9.8 are even more interesting. In fact, the findings suggest that women are more likely than men to report that there was a time when their partners wanted sex but they did not want. Almost four fifths of women and 48 percent of men reported that that there was a time when their partners wanted sex but they did not want. However, the difference between men and women with regard to whose preference prevailed is small. Thus, the findings indicate that about 44 percent of women admitted having had sex anyway despite the fact that they did not want compared with 46 percent for men.

Table 9.8: Percentage of respondents by disagreement on timing of sex (whether or not there was a time when the partner wanted sex, but respondent did not), and whether or not they had sex anyway

	Men		Women	
	n	**%**	**n**	**%**
Was there a time your partner wanted sex, but you did not?				
Yes	99	48.1	176	81.1
No	107	51.9	41	18.9
Total	**208**		**217**	
Although she or he did not want, they had sex, anyway.				
Yes	46	46.5	68	43.9
No	47	47.5	64	41.3
Non-Response/Refusal	6	6.1	23	14.8
Total	**99**		**155**	

Of note, is the fact that about 15 percent of the women declined to respond to that particular question, which may suggest that those women may have had sex under duress. Furthermore, their silence may suggest that they were perhaps not proud of the kind of sex they had. Blanc and her colleagues reported similar findings in Uganda (Blanc et al., 1996).

The conditions under which sexual intercourse takes place involve both pleasurable and painful practices (Varga, 2003). Thus, in order to assess whether or not the respondents may have been subjected to uncomfortable and even painful sexual practices, including forced sex from their

partners, respondents were asked if they engaged in sexual practices which they did not like but felt they could not refuse. Those who had engaged in sexual practices that they did not like were then asked to name some of these sexual practices.

Table 9.9: Percentage of respondents who engage in sexual practices which they did not like but felt unable to refuse and type of sexual practice

	Men		Women	
	n	**%**	**n**	**%**
Does your partner have some sexual practices which you did not like, but you felt unable to refuse?				
Yes	9	4.3	74	34.1
No	194	93.3	139	64.1
Non-Response/Refusal	5	2.4	4	1.8
Total	**208**		**217**	

Type of Sexual Practice	**Men %**	**Women %**
Different positions	0.0	33.8
Oral sex	0.0	4.1
Anal sex	11.1	10.8
Other	44.4	23.0
Non-Response/Refusal	44.4	28.4
Total	**9**	**74**

According to Table 9.9, women were more likely than men to report that their partners had forced them to engage in sexual practices which they did not like. Almost 34 percent of women reported that they engaged in sexual practices which they did not like but felt unable to refuse their sexual partner compared with 4 percent of men. These findings may suggest that some women in the study sites have been subjected to forced sex or harmful sexual practices. Indeed, after being urged to name some of those sexual practices, about 34 percent of women said that their partners force them to have sex in different positions. Some women also reported that their partner force them to engage in oral and anal sex. It is worth noting that about 28 percent of women, who reported that their sexual partners had forced them to engage in sexual practices they did not like, declined to give more details.

Table 9.10 provides the percentage of respondents who admitted that they have ever had forced sexual intercourse and the frequency of forced sex. It is clear from Table 9.10 that women are more likely than men to report that they had sexual intercourse when somebody was physically forcing, hurting or threatening them. Almost 12 percent of women reported having ever had sex under duress compared with 8 percent of men. In addition, close to one percent of women reported that they often had to endure forced sex, 11 percent reported that they occasionally had to endure forced sex. Almost 8 percent of men reported that they occasionally had sex under duress.

Table 9.10: Percentage of respondent who reported ever experienced sex under duress and the frequency of forced sexual practices

	Men		Women	
	n	**%**	**n**	**%**
Have you ever had sexual intercourse when somebody was physically forcing you, hurting you, or threatening you?				
Yes	17	8.1	25	11.5
No	192	91.9	192	88.5
Total	**208**		**217**	
Would you say that you have had forced sex often, sometimes or never?				
	Men		**Women**	
	n	**%**	**n**	**%**
Often	0	0.0	2	0.9
Sometimes	17	8.1	23	10.6
Never	192	91.9	192	88.5
Total	**209**		**217**	

The issue of who has more influence in sexual decision-making between men and women prompted a heated debate among women. During the discussions, it became clear that some sexual acts (including oral and anal sex) were relatively common practices among couples in the study sites. In the focus group discussions it became clear that some women have been engaging in sexual practices which do not make them feel entirely comfortably. It was clear that some men were more interested in their own sexual pleasure than that of their partners. In addition, they did

not seem to take into account that their partners may not feel comfortable with specific sexual acts or positions. Many of the women did not feel comfortable to voice their concerns about their partner's sexual demands but it was clear that they often were subjected to sexual practices which caused them to suffer from pain or injuries.

"*Men like to be in a position* [sexual position] *that he feels himself okay. He takes you as he wishes. He is happy and you do not complain while you are suffering from pain. I think we should not accept everything. There is a woman that she cannot walk well anymore, because she had a man* [partner] *that forced her to do things that were very painful to her because he is very big!"*

(Urban non-married females, FGD # 09)

"*Yes!, they put you in a position* [sexual position] … *there are some positions that they* [the men] *impose, which you cannot endure. I do not accept that, but there are times when we all have to accept these acts".*

(Urban non-married females, FGD # 09)

Sometimes as it can be deduced from the quotes above, women are forced to engage in sexual practices that may have a detrimental impact on their sexual and reproductive health in order to ensure the sexual pleasure of their intimate partners. The account about a certain woman who was injured or had negative sexual impacts resulting from forced sex mentioned in one of the above interviews may reinforce this interpretation. For some women these sexual acts have become a daily routine of their lives. These findings seem to corroborate with the quantitative evidence described in Table 9.11. In the survey a sizeable minority of women admitted that they had been forced into having sex with their partners. These sexual practices may not be perceived as sexual abuse but they may have negative outcomes for women. Some women may perform particular sexual acts not because they are physically forced to, but because they feel they need to please or satisfy their partners sexually.

There is a double standard in sexual relations which places more emphasis on men's sexual pleasure rather than women or on both. This sexual double standard may emerge among sexual partners when, for instance, a woman tries to express herself sexually with her marital partner. This was clear during the interviews. In the focus group discussion, one female participant recalled a conversation she had with a female colleague who told her that she liked to suggest different positions during sex with her husband but the husband did not miss a chance to insinuate that she might have learned this behavior from another sexual partner.

"There are some women who like to engage in certain sexual positions. My colleague, for example, says that she suggests some positions to her husband but he wants to know where she learned this from"

(Urban non-married females, FGD # 09)

Moreover, the sexual double standard in intimate relationship may hinder women from exploring her sexuality even if it is with her own marital partner. For example, some women may prefer to have sex in ways that are perceived as socially acceptable. One of the traditional way of having sex is the so called "father and mother style" which is perceived as a more acceptable way of having sex with a husband. This suggests that gender socialization including how a woman should see sex and behave with regard to it have a profound impact on her sexual behaviour, and consequently on her sexual health and enjoyment.

"In my case, I do not accept when my boyfriend demands sex in different positions or to have anal sex. He usually says to me: 'mother: with you, there is just the father and mother style'. I can even say more: for me, just saying 'anal sex' sounds so disgusting!"

(Rural married females, FGD # 01)

On the other hand, it is believed that some women engage in particular sexual practices as a means of maintaining their relationship with their partner. For example, it was mentioned that some women perform oral sex in order to satisfy their partner's sexual demands. Refusing to perform oral sex is likely to jeopardize the relationship; so some women may find themselves

forced to engage in specific sexual acts in order to ensure their relationship. This is revealed in the comment by one female participant in the focus group discussion.

"I think that when he finds out the woman that does everything including oral sex, he will leave you and stay with her".

(Urban non-married females, FGD # 09)

Meanwhile, oral and anal sex is sometimes performed as a form of sexual reward among the partners depending on the type of sexual relationship. For example, if a woman feels comfortable and emotionally bound to her partner, she might be very willing to engage in particular sexual acts (including oral and anal sex).

"For example, if I am in a new relationship, there are things that I cannot do. But it may depend on whether or not the relationship is serious. If I do not know him well, then I cannot give all of myself. By "giving all of myself" I mean to do everything a man wants. But when I know that we will not stay together and he only wants to have fun I will not give him oral sex, for example. But, for my husband I can do everything with him and, of course, that there are things that we learn with time"

(Urban non-married female, IDI # 06)

This quote clearly shows the norms surrounding acceptable behavior within a sexual relationship. In addition, the quote seems to highlight two important aspects about sexual relations in marriage. The first is that some women may feel that is their right to express freely their sexual desires to their husbands. The second is that some women feel that because the man is their husband, they should please them sexually including engaging in particular sexual acts. However, some women are afraid of engaging in particular sexual acts because of concerns about their own health, as is illustrated in the comment by one woman in the focus group discussion.

"There are things that you cannot think or do even after getting married. One of the things is to have anal sex, not because a woman loses her value, as woman. That is not the point. She should not do that for the sake of her own health"

(Rural married females, FGD # 01)

Furthermore, some women highlighted the need for women to demand sexual satisfaction from their partners. They felt it is important that women do not remain silent about their own needs and they felt that women should have the same rights as men to experience sexual pleasure. Some women argued that they need to remind men that they have to make sure that the sexual experience is also pleasurable for women.

"It is not right to have sexual intercourse with a man and you keep quiet, looking at him while he is enjoying himself and you are not. I think that is not right, you have to say: excuse me, sir, what about me?"

(Urban non-married females, FGD # 05)

9.6 Summary

The findings outlined in this chapter show that the majority of men and women report that it is not difficult to talk to their partners about sex. In support of this, almost half of men and women admitted that they occasionally talk to their partners about sexual matters. Of interest, however, is the fact that women are less likely than men to report that they talk about sex with their partners. This probably result from the fact that, as some women highlighted during in-depth interviews and focus group discussions, it takes time to build trust in a relationship, but also the way relationships are structured is not conducive for open communication between the partners. These findings are somewhat consistent with other studies (Pliskin, 1997; Agadjanian, 2001). According to Pliskin (1997) partner communication about sexual health matters, particularly the need for protective practices was hampered by the absence of "emotional intimacy" between sexual partners. Agadjanian (2001) noted that interaction on reproduction-related matters was

first and foremost a gendered based phenomenon (Agadjanian, 2001). In addition, he noted that the intensity of interaction on reproductive matters varied depending on the stages of an individuals' reproductive life course. Thus, according to Agadjanian (2001), the interaction is particularly intensive immediately preceding important reproductive decision-making, such as the adoption of a contraceptive method. However, once the decision is made, the interest in communicating wanes and remains relatively low unless the selected contraceptive method has not met with expectations. However, the experience of negative side-effects may once again re-ignite discussion.

The findings of the present study suggest that both place of residence and level of education influence partner communication. Indeed, the findings suggest that although in general men tend to report that they do not experience any problems in talking about sex with their partners, it is also true that for rural men it is far more difficult to talk about sex than urban men. Still among men, it was found that as age increases the level of difficulties to talk about sex also increases. This could be explained by the fact that the biological drive for sex diminishes with the increase of age the interest in talking about sex may also diminish (Uddin, 2007). In rural Bangladesh Emaj Uddin (2007) observed that the frequency of sexual intercourse was lower at the beginning of the marriage, but it increased gradually and then declined due to old age. Consistent with this, it is possible that partners may lose interest in communicating with each other as the relationship develops. In addition, the results suggest that men with no formal education find it more difficult to talk about sexual issues than men with some education. Furthermore, it could be noted that as the level of education increases it becomes easier to talk about sexual matters. The results also suggest that it becomes more difficult for men who are married or living together to discuss sexual matters than men who are neither married nor living together. These results are somewhat surprising as one would expect that marital and cohabiting partners are more likely to be emotionally attached to one another and as a result it would be much easier to talk about sexual and reproductive health matters. However, another study conducted in Mozambique also found that communication between men and women in marital relationships is limited and often superficial but it is more common in an extra-marital relationship. In extra-marital relationship there is a need for greater caution in order to avoid harmful outcomes such as an unwanted

pregnancy which may jeopardize the stability of the relationship as well as the marriage of one or both of those who are involved (Agadjanian 2001).

For women, no strong association was found between partner communication about sexual matters and selected socio-demographic variables. Nevertheless, although not statistically significant, age seems to influence partner communication about sexual matters. As the age of the woman increases, the level of difficulty to talk about sex also increases. These findings are consistent with other studies with regard to partner communication about sex, which found that age as well as local moralities influence partner communication about sexual matters (Lambert and Woods, 2005; Huong, 2009). For instance, in their comparative study of modes of communication about sex in India and South Africa, Lambert and Wood (2005) observed that the reluctance to talk about sex, particularly in the South Africa context may mostly be related to the notion that talking about sex is somehow 'dirty' and it may indicate a certain lack of 'good morals.'

The findings suggest that communication is also structured along gender lines. In general, men are more likely than women to report that they had talked to somebody else about sexual matters. Men are more likely to report that they talked about sexual matters with other men, especially friends, neighbours or relatives. Similarly, females were more likely to talk about sexual matters to other females, especially friends, neighbours or relatives. These findings are in line with what Blanc and her colleagues (1996) found in Uganda (Blanc et al., 1996).

The findings suggest that when respondents report that it is not difficult to talk about sex, they may refer to 'sexual negotiations' rather than 'sexual decision-making' (Wolff et al**.,** 2000; Varga, 1997). In her study in Kwazulu-Natal, South Africa, Varga (1997) stated that the distinction between these two terms is critical in understanding the determinants of sexual behaviour. Thus, the author noted that "sexual decision-making is defined as decisions, preferences, and resolutions made by an individual regarding the conditions, such as the timing of intercourse or contraceptive use, under which sexual relations occurs. In contrast, sexual negotiation includes the verbal and non-verbal interactions and dynamics between partners in

deciding how and when intercourse will take place". Moreover, Varga (1997:52) observes that "both processes of sexual decision-making and sexual negotiation are heavily influenced by conceptual and ideological factors affecting what is perceived as appropriate gender-specific behavior."

The findings from the qualitative interviews of this study show that respondents tend to emphasize some aspects of sexual negotiation such as initiating sexual intercourse rather than the other aspects also mentioned by Varga (1997) such as contraceptive use or safe sex practices.

There have been a number of studies on the factors limiting partner communication about sexual matters (Bauni and Jarabi, 2000; Wolff et al., 2000; Desgréss du Loû, 2005; Siravam et al., 2005). For example, in their study Bauni and Jarabi (2000) conclude that cultural and religious beliefs, lack of knowledge, and what they called "men's obstinacy" were the major barriers hampering spousal communication about sexual and reproductive health matters. In India, Siravam and her colleagues (2005) have found that, although communication about sex and sexually-related matters happens it did not include significant discussions of health promotion. Partner communication involves both verbal and non-verbal techniques including body language (seduction by women, for example) with the aim of sexual intercourse (Parker, 2000; Karlyn, 2005; Pliskin, 1997; Lambert and Woods, 2005). The former would differ from partner communication about sexual matters and sexual and reproductive health which may demand verbal dialogue to build some consensus about how to avoid harmful practices or which protective practices should be adopted to prevent unintended sexual and reproductive health outcomes (Dixon-Mueller, 1993; Desgréss du Loû, 2005; Siravam et al., 2005).

In the present study, men are more likely than women to agree that women find it difficult to tell their partners what they dislike sexually. But, by contrast, the majority of women totally disagree with that very same statement. In addition, while about one-third of men agree with the statement which says women find it difficult to tell the partners what they feel sexually enjoyable, the statement is largely disapproved by women. It should be noted, however, that more than a half of men and three-quarter of women totally disagree with that particular statement. Furthermore, it is

important to note that almost half of men agree that they prefer less assertive women who allow them to take the initiative but, surprising only a few women agreed with the same statement. The findings regarding the male's preferred profile of women are consistent with what Maticka-Tyndale and her colleagues (2005) have found in Kenya where, among other aspects, boys highlighted that they preferred girls who were 'fresh' and 'innocent.' On the other hand, the findings of this study show that the majority of women are not completely powerless and submissive in sexual matters. In this sense, the findings are consistent with other studies which have reported that women have the ability to exert power in sexual decision-making (Varga, 1997; Maharaj and Cleland 2004).

An examination of power dynamics in sexual relationships shows that men tend to exert an enormous influence over the decision about when to have sex. More than a half of male respondents admitted that there was a time when they had sex because they wanted it, although their partners did not want to have sex. Women in their turn confirmed that it is not an unusual practice to have sex when they did not want to have sex. These findings are consistent with some studies which indicate that the sexual dynamics among men and women are mostly embedded within cultural and sexual norms which influence individual agency in the sexual relationship (Leclerc-Madlala, 2002). In the study sites it was found that both men and women view sex as the man's right and women are obliged to provide their partner with sex on demand. In many cases, men's preference tends to prevail at the expenses of women. Thus, many women give into men's demand for sex and this may reflect the impact of gender norms on sexual relations. In some societies, it is not uncommon for many people to believe that it is the man's right to demand sex and it is the woman's duty to submit to his demands. Importantly, women may feel obliged to have sex with their partners even when they do not want to have sex in order to avoid accusations of infidelity. This is consistent with findings from other studies (Scorgie et al., 2009). In their study, Scorgie et al. (2009) found that "some men claimed – or perhaps boasted – that they have a more-or-less constant desire for sex and that women were expected to respond to his desire, no matter how frequently it arose. As one young married man put it, 'whenever the penis stands up then she must lie down." Sometimes women engage in sexual practices because they want to ensure men's sexual pleasure and are seeking to exert their sense of control in their relationships.

On the other hand, even if a woman wanted to express her sexual desires she finds herself limited because of the risk of being labeled ‘impure’ or unfaithful. Some men accuse women of having learnt about sex from other men. On the other hand some men may also find themselves under pressure to proof their sexual prowess by having sex with their wives because of the risk of being given negative labels. Indeed, Bourdieu (1999) highlighted the phenomenon of what he called a “desired domination” where a woman ‘voluntarily’ accepts being ‘dominated’ by her partner during sexual intercourse. In that sense, for a man, dominating would mean being able to give sexual pleasure to a woman, at the risk of being seen as failed man, that is, just a “pair of trousers”, which seems to be very critical for the construction of male identity (Silberschmidt, 2005).

In addition, an interesting finding is that a sizeable number of women reported having experienced sexual practices which they do not like but, at same time, they felt unable to stop their partner. Some respondents complained that their partners forced them to engage in particular sexual acts which did not give them any sexual pleasure. These sexual acts caused them a great deal of discomfort and pain but they were unable to refuse their sexual partners. These women felt that they had to submit to their partner’s demand because of the fear of abandonment or desertion. They worried that their partner would leave them for other women who would be willing to engage in these sexual acts. This was seen as threat to the stability of their marriage. This may explain why some women find themselves unable to express their feelings with regard to what they dislike or what they found enjoyable sexually, a finding consistent with other studies (Varga, 1997; Maticka-Tyndale et al., 2005).

Nevertheless, the findings suggest that women are as likely as men to demand sex from their partners. Almost half of men and women reported that they had sex with their partners even though their partner did not want to have sex. In addition the findings reinforce earlier reports which suggest that women, in some cases, are active participants in sexual relations because they also influence the timing of sex. These findings show that women are not afraid to express their sexual desires and demand sex from their partners. Furthermore, the fact that more than a half of respondents had sex anyway despite the fact that their partners did not want sex at that time

indicates the existence of other factors influencing sexual relations between men and women. Nevertheless, men are more likely than women to have their demands satisfied. The findings of this study are consistent with other studies which suggest that women believe that men have an uncontrollable desire for sexual intercourse (Orubuloye and Oguntimehin, 1999). In their study Orubuloye and Oguntimehin (1999) state that almost two-thirds of women believe that the man should have more than one sexual partner in order to satisfy his sexual urges. In addition, many felt that variety is important for sexual enjoyment.

Although both men and women recognize that men have more influence than women over sexual matters, they also hinted that, in some cases, when a woman wants sex it is not difficult for her to persuade her partner through her seductive power to give into her demands. This is of interest, since it suggests that women also have certain power in sexual relationships which they exert in different ways from men. These findings are consistent with other studies which have reported the agency of men and women in sexual relationships (MacNeil and Byres, 2009). In this regard, in their study on the role of sexual self-disclosure in long-term heterosexual couples, MacNeil and Byres (2009) found that although men and women are similar in the way they share their sexual likes and dislikes, men were more likely than women to communicate their preferences verbally while women preferred nonverbal communication.

Studies have shown that culture, alongside other context-specific and structural factors, has played a significant role in HIV infection risk (O'Sullivan et al., 2007, Varga, 2003, Blanc, 2001). For example, empirical evidence from both focus group discussions and in-depth interviews suggest that men may engage in risky sexual behaviour including multiple and concurrent sexual partners to boost their status or to respond to social pressures and expectations. Likewise, the women, in order also to conform to social expectations of a 'decent woman' may fail to negotiate safer sex practices with their partners to avoid being accused of infidelity and promiscuity. These findings are consistent with other studies findings elsewhere (Foreman, 1999; WHO, 2003; Nshindano and Maharaj, 2008; Smith, 2007; Meekers and Ahmed, 2000). For example, a World Health Organization study (2003) indicates that despite the existence of multiple masculinities and femininities, however, it is the dominant ideology that most greatly

influences women's and men's attitudes and behaviour, making both women and men more vulnerable to the risk of HIV infection. In addition, the study also observes that in many societies, the dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal which distinguishes a 'good' woman from a 'woman of the street' and defines sexual practices associated with reproduction as morally good and those that are linked to pleasure as immoral, therefore bad. In sharp contrast, in many societies it is believed that variety in sexual partners is essential to men's nature as man and that men will inevitably seek multiple partners for sexual release (WHO, 2003)

CHAPTER 10: DISCUSSION AND CONCLUSIONS

10.1 Introduction

Similar to other sub-Saharan African countries, Mozambique faces a severe HIV/AIDS epidemic constituting one of the leading causes of morbidity and mortality among the Mozambique's population. In Mozambique HIV/AIDS is on course to be the leading cause of mortality among women (National Institute of Statistics, 2009). The main route of HIV transmission is via heterosexual intercourse. There are an estimated 1.6 million people living with HIV/AIDS in the country with the highest prevalence among women which highlights both the nature of the AIDS epidemic in Mozambique as well as the gender inequalities underlying sexual relations and unsafe sexual practices among men and women within the society at large (CNCS, 2007). This study aimed at improving our understanding of male sexual behaviour and protective practices in the context of a generalized HIV/AIDS epidemic (Ghys et al., 2004). There are compelling reasons to focus on men. One general reason is that despite the recognition that men's health is important, less attention has been paid to their specific needs, particularly their sexual and reproductive health (UNFPA, 2000). Perhaps more important and urgent than anything else is that male sexual behaviour in many settings of sub-Saharan Africa places them and their partners at risk of HIV infection. One of the factors that influences male risky sexual behaviour is traditional beliefs and expectations, particularly rigid notions of manhood which defines men as risk takers (Shefer and Ruiters, 1998; Peacock, 2009)

Gender norms were investigated in order to better understanding how dominant notions of manhood influence male sexual behaviour and the ability of men to protect themselves and their partners against the risk of HIV infection. The use of the concept of masculinity, or more precisely what constitutes ideal or actual characteristics of 'being a man' in the study settings in Mozambique intended to highlight how men in particular (but also women) are made vulnerable to rigid notions of manhood and gender hierarchies and how this impacts negatively on their sexual and reproductive health. The concept of generalised epidemics is used to define situations

where the HIV infection is widespread in the general population, and although sub-populations at great risk may continue to contribute disproportionately to the increasing spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic independent of sub-populations at high risk of infection (Ghys et al., 2004). The empirical evidence presented in this study seems to suggest that this is also the case in Mozambique.

In this study, mixed methods were used to provide different perspectives on the same topic of interest (Hanson et al., 2005). Using multiple, complementary research methods allowed the study to investigate male sexual behaviour and protective practices by highlighting numerical trends from quantitative methods while, at same time, offering specific details from qualitative methods (Hanson et al., 2005; Plummer et al., 2004). In this regard, qualitative methods assist in illuminating our understanding of male sexual behaviour by focusing on beliefs, norms and values. Likewise, quantitative methods provide an examination of the magnitude of the subject under investigation (Hanson et al., 2005; Plummer et al., 2004). Moreover, the use of mixed methods allows for the validation of findings provided by each method type (Campbell et al., 1999). The disadvantages of such a methodological approach, however, may be related to both the complexity and time required to undertake the research. Nevertheless, the trade-offs of combining research methods is numerous. This chapter discusses the main findings of male sexual behaviour and protective practices in the study areas. Firstly, it presents and discusses the findings in light of the model developed by Eaton's et al. (2003) on sexual risk behaviour which highlights the crucial role played by personal and proximal factors as well as cultural and structural factors including the organizational elements of society at large in enhancing both the vulnerability and the risk of HIV infection in developing countries. On the basis of the findings, the chapter presents some methodological reflections based on the current HIV/AIDS epidemic in Mozambique and in sub-Saharan Africa. In addition, the chapter ends with some suggestions for further research and recommendations for policy design and interventions.

10.2 Discussion

The findings of this study clearly show that gender norms, particularly traditional notions of masculinity and femininity are still prevalent in the study settings. The existing notions of manhood are mostly associated with traditional views of men as providers and breadwinners; and women as caregivers. Practices which bring social prestige both in the community and in the society at large are highly valued by men and women. Among the most valued characteristics of manhood in the study sites include the ability of a man to father children. Fathering a child is seen as sign of virility, but above all it is seen as a man fulfilling his role in perpetuating his family lineage. Furthermore, it was clear in this study that one of the most important elements defining manhood is the socio-economic status of men which assigns him the role of providers and main breadwinner. Therefore, a man who is employed or has a source of income is highly valued by both men and women. In addition, formal education is viewed as an important element defining manhood. Formal education, as one of the defining characteristics of manhood, suggests that masculinities are dynamic, therefore subject to change overtime. Studies have shown that education is a powerful catalyst for change (Connell, 2007).

The findings of this study show that gender norms and beliefs have a strong influence on male risky sexual behaviour. For example, some men view multiple partners as necessary for their good health. Attitudes like this may put men at risk of HIV infection but also their partners. Traditional notions of masculinity are also endorsed by women. This is of interest because it shows that existing gender ideologies are socially constructed and are largely sustained by both men and women. For example, the women in the study areas also highlighted that a “real man” is the provider and head of the family. From the women’s point of view, ‘being a man’ is twofold: first, a man is defined by his economic role within the household by undertaking activities which generate an income or result in economic gains. Secondly, a man defines himself by performing his traditional social duties and obligations such as taking care of family members and, in this way, ensuring that his authority and ‘respect’ is maintained. In addition, women also define a ‘real man’ as demonstrating sensitivity towards the needs of women including being approachable. These findings are consistent with findings reported in Nkomazi, South Africa,

where the status of manhood is conferred by having a wife and child, and establishing a home separate to that of one's parents as well as the responsibility of providing for the needs of the family, including protecting the family unit against external threats (Sideris, 2005).

Meanwhile, some women expressed great concern about particular notions of masculinity which associate manhood with multiple sexual partnerships and were particularly critical about this practice. One finding of this study (which also confirms previous studies) is that there is peer pressure from both men and women to engage in risky sexual behaviour, particularly multiple sexual partnerships. Some respondents observed that men who try to remain faithful to their partners are generally labelled as 'weak', meaning that they are dominated by their female partners. Being perceived as a 'weak' man contradicts the general and widely accepted expectation of men in society. Therefore, the fear of being viewed as under a woman's control may have contributed to male resistance to change, particularly among young men. According to Eaton et al. (2003) the proximal context, including peer pressure plays an important role in enhancing the HIV risk and vulnerability of both men and women. Studies have shown that culture, alongside other context-specific and structural factors, has played a significant role in the risk of HIV infection (O'Sullivan et al., 2007, Varga, 2003, Blanc, 2001). For example, empirical evidence from both focus group discussions and in-depth interviews suggest that men may engage in risky sexual behaviour including multiple and concurrent sexual partners to boost their male identity or to respond to social pressures and expectations. Likewise, women in order to conform to social expectations of being a 'decent woman' may fail to negotiate safer sex practices with their partners to avoid being accused of being unfaithful and promiscuous.

These gender expectations face a multitude of challenges within the existing socio-economic context. Eaton et al. (2003) posit that structural factors, particularly the living conditions characterized by poverty and high levels of unemployment create the conditions of vulnerability for both men and women. Many men reported difficulties in fulfilling these social expectations due to lack of employment and extreme poverty. Men not only felt pressure from their peers to meet the expectations of these dominant notions of manhood' but also from the women themselves. Furthermore, while the current socio-economic conditions including the high levels

of unemployment seems to have a direct impact on men's self-esteem and their sense of manhood, women on the other hand perceived significant changes in men's character itself. According to the women, the most important aspect of change is reflected in men's character, particularly with regard to their sexual behaviour. Men are perceived by women as lacking responsibility, particularly sexual responsibility and more likely to get involved in multiple sexual partnerships, therefore exposing themselves and their partners to sexually transmitted infections including HIV/AIDS.

The erosion of men's self-esteem resulting from the worsening socio-economic conditions has been the object of extensive inquiry in recent years in sub-Saharan Africa (Silberschmidt, 2005; Agadjanian, 2005b; Hunter, 2005; Kaufman et al., 2009). For example, Silberschmidt, (2005) found that in both rural and urban areas of East Africa the deteriorating socio-economic conditions had seriously undermined the normative order of patriarchy. Meanwhile, it was of interest to note that limited opportunities for men to earn an income have undermined their status as the head of the household and the main breadwinner and reduced them to 'figureheads' in households, therefore threatening their authority. However, men continue to have more relative freedom compared to women, a finding consistent with other study. Masculine identity is dependent upon traditional gender roles, particularly the roles which assign men the status of breadwinners, were under serious threats (Kaufman et al., 2009).

The findings of this study suggest that multiple sexual partnerships and unprotected sex among heterosexual men and women might be the driving force sustaining the HIV/AIDS pandemic in the study settings. Studies hypothesize that the overall number and rate of partner change may be associated with the increase in the risk of HIV infection since the probability of one being infected and infecting others is high (Todd et al., 2009; Carael, 1995). In this study, both men and women reported a high number of lifetime sexual partners. As expected, the findings indicate that men were more likely than women to report a higher number of sexual partners over their lifetime. Although a large number of respondents reported only one sexual partner in the last 12 months before the survey, the data also show that men were more likely than women to get involved in multiple sexual partnerships with the majority of them reporting between two to four

sexual partners. These findings are not surprising at all since multiple sexual partnerships and sexual partner accumulation overtime is a worldwide phenomenon, particularly among men (Cohen and Trussell, 1996; Wellings, et al., 2006). In addition, the present findings are quite consistent with other studies in sub-Saharan Africa (Wellings, et al., 2006; Smith, 2007; Parikh, 2007; Todd et al., 2008; Soul City, 2008). For example, a comparative study in 59 developed and developing countries, including Mozambique, found that although monogamy remained the dominant pattern among the sexually active adult population worldwide, reporting of multiple partnerships was more common among men than among women (Wellings, et al., 2006). It should be noted, however, that in the present study men may have overreported their number of sexual partners. In contrast, women may have underreported their number of sexual partners. The phenomenon of overreporting by men and underreporting by women is well documented (Slaymaker, 2004; Schroder et al., 2003). Other studies suggest that the differences in the reports of men and women with regard to the number of sexual partners are attributed to gender and motivation bias (Schroder et al., 2003). This could be the case for the present study as well.

In addition, the findings of this study show that the practice of multiple partnerships is not an uncommon phenomenon among married and cohabiting men. In fact, married and cohabiting men were more likely than married and cohabiting women to report more than one sexual partner in the last 12 months. For example, 43 percent of married and cohabiting men reported more than one sexual partner in the past 12 months compared with five percent of married and cohabiting women. If condoms are not used in those sexual encounters it is not surprising that HIV infection becomes rampant in marital and cohabiting unions in the study sites. This seems to be in line with what has been found in other sub-Saharan settings (Cohen and Trussell, 1996, Ministry of Health, 2008). For example, a study in Mozambique found that there were high levels of married men with sexual partners outside of spousal or regular partnerships (Ministry of Health, 2008). It is believed that this behaviour constitute one of the factors sustaining the current levels of HIV infection in the country. Furthermore, the findings of this study suggest that young women aged below 30 years are more likely to report that they had more than one sexual partner in the last 12 months. It has been suggested that for economic reasons, young women usually get involved with older men who are more likely to have had multiple sexual partners, including commercial sex

workers, therefore, they are more likely to be infected with HIV than younger men (Glynn et al., 2001; Macphail, et al., 2002; Boerma et al., 2003; Longfield et al., 2004). On the other hand, the pursuit of sexual gratification intertwined with traditional notions of manhood appears to be the driving force for multiple sexual partnerships among men regardless of their demographic background. These findings are consistent with other findings reported elsewhere (Foreman, 1999; WHO, 2003; Nshindano and Maharaj, 2008; Smith, 2007; Meekers and Ahmed, 2000). For example, a study by WHO (2003) indicates that despite the existence of multiple masculinities and femininities, it is the dominant ideology that greatly influences women's and men's attitudes and behaviour, making both women and men more vulnerable to HIV/AIDS epidemic. In addition, the study also observes that in many societies, the dominant ideal of femininity emphasizes uncompromising loyalty and fidelity in partnerships. It is this ideal that distinguishes a 'good' woman from a 'woman of the street' and defines sexual practices linked to reproduction as moral and those that are linked to pleasure as immoral. In sharp contrast, in many societies it is believed that variety in sexual partners is essential to men's nature and they will inevitably seek multiple partners for sexual release (WHO, 2003).

In line with this approach, the results of the present study suggest that dominant ideals of masculinity and femininity have a strong influence on the decision-making processes as well as on sexual and reproductive health. For example, the findings of the study show that the levels of disagreement among partners on whether or not to have sex at a specific time are relatively higher, with 47 percent of men and 43 percent of women reporting that there was a time they wanted sex but their partners did not want. It is worth noting that in most cases they had sex anyway, despite the disagreement. Nonetheless, the findings show that men were more likely than women to satisfy their demands, with 58 percent of men, compared with 52 percent of women, reporting that they had sex anyway. When the question was asked about the sexual demands of their partner, women were more likely than men to report that there was a time their partners wanted sex but they did not. In their study in Zimbabwe and Malawi Woodsong and Alleman (2008) found that both men and women agreed that it was not easy for a woman to refuse sex but that men are willing to have sex even when they do not initiate it. Some women

spoke of strategies to accommodate unwanted sex by either pretending they enjoyed it or simply making their bodies available (Woodsong and Alleman, 2008).

Kaufman et al. (2009) hypothesizes that where the masculine ideology is strongly endorsed, resulting in male partner dominance, this may result in sexual risk behaviours, including having unprotected sex when the partner wanted to be protected, or having sex when a partner did not fully agree. The findings of the present study seem to support this hypothesis in the sense that men from the study sites may behave according to the normative patterns of dominant notions of masculinity where their demands shall prevail. Of interest is that the findings suggest that sexual decision-making are usually limited to sexual negotiation such as initiating sex and/or deciding on the timing for sex rather than on reaching consensus on aspects such as safer sex practices (Varga, 1997). These findings are consistent with other findings in sub-Saharan Africa where sexual dynamics among men and women are described as mostly embedded within cultural and sexual norms (Leclerc-Madlala, 2002). Indeed, the findings of this study suggest that both men and women see sex as the right of men and a duty for women. In many cases, the preferences of men tend to prevail at the expenses of women. In some societies in sub-Saharan Africa, it is not uncommon for both men and women believe that it is a right of a man to demand sex while it is the woman's duty to submit to his demands (Scorgie et al., 2009. However, the findings of the present study also suggest that not only women submit to men's demands for sex but men also submit to women's demands for sex. Women are as assertive as men in sexual relations. In this study women were found not to be completely powerless and passive in sexual relationships. Indeed, the evidence from the present study suggests that despite the fact that both men and women recognize that men have more influence than women over sexual matters, they also admitted that when a woman wants sex it is not difficult for her to persuade her partner, particularly through her seductive power, a finding consistent with other studies (Wolff et al., 2000). Meanwhile, this does not mean that power and gender relations are a zero-sum game where one gains and the other loses (Gupta, 2000). The findings of the present study also show that gender inequalities most often benefit men rather than women in different forms.

The findings of this study indicate that there is almost universal awareness of HIV/AIDS. This suggests that existing public health campaigns have been successful in raising awareness of HIV/AIDS epidemic in the study areas. In addition, the negative impact of the epidemic on the ground is real. Respondents, irrespective of age or gender, acknowledge that people in the community were becoming sick and were dying because of AIDS. Nevertheless, the analysis of the data shows that neither men nor women seem to have changed their sexual behaviour. The disconnection between universal awareness of the risk of HIV/AIDS and limited sexual behaviour change in sub-Saharan Africa is well documented (MacPhail and Campbell, 2001; Maharaj and Cleland, 2004; Karlyn, 2005; National Institute of Statistic, 2005). The study also found gender differences in levels of awareness of HIV/AIDS. Indeed, men were more likely than women to be aware that there is no cure for AIDS. Overall, most men and women believe that there is something a person can do to avoid getting infected with HIV. Protective behaviour such as the use of condoms, avoiding multiple sexual partners and abstaining from sex were the most frequently mentioned strategies. Again, men were more likely than women to mention most of these strategies. These findings suggest that there is a great potential for positive changes. But, more advocacy work should be done addressing other aspects so far neglected in campaigns such as the focus on the traditional notions of masculinities which make men also vulnerable to HIV infection.

Low perception of risk of HIV infection is deemed a risk factor because it may reduce the motivation to take protective measures (Eaton et al., 2003). The findings of this study show that perception of risk of HIV infection seems to be mixed and somehow contradictory. For example, contrary to other studies in sub-Saharan Africa where women were more likely to report great or moderate risk of HIV infection (Maharaj, 2004; Sheppard et al., 2001) the quantitative findings of the study suggest that women have a lower perception of the risk of HIV infection than men. Indeed, while almost half of men admitted that they felt themselves at moderate or high risk of HIV infection, only a quarter of women reported that they felt themselves at moderate or high risk of HIV infection. It is of particular interest to note that almost 30 percent of women were unable to say whether or not they were at medium or high risk of HIV infection. These findings are also consistent with the findings of a study conducted in Mozambique (Arnaldo, 2004).

Investigating the factors influencing the perception of risk of HIV infection in Mozambique, Arnaldo (2004) found that individual perception of risk of HIV infection was higher among men than women (Arnaldo, 2004). On the other hand, the qualitative evidence from the present study shows that women express great concern about contracting HIV infection from their marital, cohabiting or non-cohabiting regular partners. The qualitative findings are in line with what other studies have found regarding perception of personal risk of HIV infection among women. For example, Sheppard et al., (2001) found that women in both Ghana and Uganda reported feeling at greater risk of HIV infection than men. Nevertheless, although women perceived themselves at greater risk than men in the interviews, they might not be able to change their behaviour due to their subordinate position in society and particularly in sexual relationships. And more importantly, it might not be due to their own behaviour, which is putting them at risk but that of their partners (Sheppard et al., 2001).

Condoms are regarded as one of the most feasible and efficient tools to curb the spread of HIV infection alongside sexual abstinence and mutual monogamy (Davis and Weller, 1999; UNAIDS, 2000; Bankole and Singh, 2001; Varga, 2000; Agha et al., 2002). Hence, it has been advocated that those who, for different reasons, are unable to stick to mutual monogamy or abstaining from sex, at least they should use condoms to protect themselves and their partners against sexually transmitted infections, including HIV (Holmes et al., 2004). The findings of this study show that the use of condoms at last sex is about 20 percent among women and 30 percent among men which is encouraging although insufficient to curb the current levels of HIV infection. These findings are consistent with other studies in sub-Saharan Africa (National Institute of Statistic, 2005; Prata et al., 2006; Agha et al., 2002; Adetunji and Meekers, 2001). For example, a study by Agha et al. (2002) found that the number of females who reported condom use was as lower as three percent in Eritrea and as higher as 21 percent in Luanda. Similarly, among males the reports of condom use was as lower as one percent in Eritrea and as higher as 22 percent in Cameroon (Agha et al., 2002). Other studies present much higher levels of condom use (Maharaj, 2006; Adetunji and Meekers, 2001). In South Africa, for example, Maharaj (2006) found that, overall, 53 percent of young respondents reported condom use at last sex, with 64 percent of males and 41 percent of females reporting condom use, respectively (Maharaj, 2006). Hearst and Chen

(2004) report that the use of condoms at last sex among young females (aged 15-24) varied from less than five percent in Niger and Chad, to over 40 percent in countries such as Zimbabwe, Uganda and Ghana. Among young males (aged 15-24) condom use at last sex varied from less than five percent in Niger, Eritrea and Chad to about 70 percent in Zimbabwe (Hearst and Chen, 2004). However, one of the challenges highlighted by the authors is what they called 'the condom paradox': a situation in which there are high reported numbers of sales and use of condoms while, at the same time, the rates of HIV infection also increases. One reason for this disparity is that people may not use condoms correctly and consistently, a required practise for condoms to be effective (Hearst and Chen, 2004).

The findings also show that, in general, the proportion of respondents who used a condom at last sex (including those who had more than one sexual partner) is still relatively low. This is a clear indication that safer sex practices are still a challenge in the study areas. What is shocking, although not surprising, is that those men who get involved in multiple sexual partnerships still do not adopt protective practices, particularly the use of condoms. This pattern seems to repeat itself among men in marital and cohabiting unions who also reported more than one sexual partner in the last 12 months. These findings are certainly worrying in a context of high rates of HIV infection, and may explain the soaring rates of HIV infection in the study sites (Ministry of Health, 2008). Furthermore, the findings also show that even among those who report that they never ever used a condom they also practice multiple sexual partnerships. The nature of the relationship has been found to be influential in the use of condoms. Studies have shown that the use of condoms tend to be more acceptable in non-marital, non-cohabiting relationships than in marital and cohabiting relationships (Maharaj and Cleland, 2004; Adetunji, 2000), this study confirms such a pattern. Meanwhile the study also found the existence of a partner type called 'friend' which is a non-marital and non-cohabiting partner. Indeed, most male and female respondents who reported more than one sexual partner in the last 12 months said that their second or third partners were friends. The fact that some men and women engage in sexual relations with partners whom they regard as "friends" may explain why they did not see the need for condoms, probably for the same moral and emotional reasons which hinder use in marital and cohabiting unions including the negative meanings normally attached to condoms (Wellings, et

al., 2006; Cohen and Trussell, 1996, UNAIDS 2008). Further research should investigate more thoroughly the protective practices used in sexual relations between friends as well as the meaning associated with condom use in these relationships. A study in Zambia found that single women may establish casual relationships with men in order to form emotional ties leading to marital partnership as well as greater financial and emotional security (Agha, 1998). Furthermore, given that Zambian women have low socio-economic status, they have limited ability to negotiate condom use in sexual relationships. For women, relational factors were very important in determining whether or not their partners used condoms (Agha, 1998). A similar scenario should not be excluded in sexual relations between friends in the study sites in Mozambique where married men are more likely to have a source of income or a good socio-economic status, which in turn allows them to support their extra-marital relationships, either with friends or other type of partners.

A constellation of factors both behavioural (personal and interpersonal) and context-dependent or structural factors seem to prevent men and women from adopting appropriate protective measures against HIV infection. The findings of this study suggest that although both men and women display high levels of awareness of HIV/AIDS they also display an astonishing low assessment of personal risk. Some men and women do not perceive themselves at risk of HIV infection because they *trust* their partners. This is consistent with other studies in which both men and women do not adopt protective strategies with partners they perceived as being safe (Hoffman and Cohen 1999). Instead of assessing their partners' sexual history they depended on a combination of visual and verbal cues to judge if their partner was clean or free from diseases (Hoffman and Cohen, 1999). One of the major barriers hampering people from adopting protective practices is the embarrassment of facing accusations of uncleanness, disease carriers or seen as being infected with HIV. Some men and women perceived their partners as trustworthy and therefore they did not feel the need to use condoms in these relationships. In some situations, condoms are used with partners at the beginning of their relationships, but they stop using condoms as the relationship develops. Indeed, the issue of trust has emerged as an important issue in a number of studies. For example, in the late 1990s, Preston-Whyte (1999) observed that the issue of trust was paramount. The negative association of condoms with casual and multiple partners served as a

major barrier to their use in regular relationships. Other studies have also observed that local understanding of faithfulness and risk may differ in significant ways from public health concepts. According to Parikh (2007), "a man can be 'faithful' as long as he continues providing economic support and maintains a respectful public reputation by keeping knowledge of extramarital relations away from people in the home and in the family's social networks" (Parikh, 2007: 1201). This phenomenon seems to be occurring in the present study. Indeed, few men reported having other spouses besides the ones they were living with. However, about 43 percent of married and cohabiting men reported more than one sexual partner in the last 12 months, which reflect extra-marital relationships which are kept secret. A Soul City study in Southern Africa (2008) found that in all countries including Mozambique, respondents talked about regular or steady partners and 'other' partners. In addition, the latter were often kept secret.

In the present study, some women revealed that although they were not in marital or cohabiting unions they had relationships with married or cohabiting men. This is consistent with the quantitative data where a sizeable number of respondents of both sexes reported having partners who were friends. This particular finding could be groundbreaking since sexual behaviour research have so far always hinted or even assumed that condoms are more recommended in non-marital or non-cohabiting relationships since such relationships are regarded as constituting high-risk sex (UNIDS, 2008). The findings of the present study suggest that the dynamics of relationships cannot be fixed in mutually exclusive categories such as marital or cohabiting relationships versus non-marital or non-cohabiting, or primary versus secondary relationships. Sexual relationships outside the marital relationship may have important implications for prevention strategies. Studies have shown that one of the dilemmas facing women in dire socio-economic conditions is that they are unable to convince their partners to use condoms because they need to maintain the relationship for economic support (Varga, 2003; Blanc, 2001; Gupta, 2000). However, emotional intimacy issues including love and pleasure may constitute another barrier for protective practices in extra-marital relationships as is the case in steady and long-term relationships. As in other studies, the findings of this study also suggest that condoms are still viewed as a barrier to intimacy and love regardless of the type of relationship.

The findings suggest that traditional notions of masculinities sustain the widespread practice of multiple partnerships, and are a major barrier to behaviour change. Culture, which sustains the traditional gender norms of masculinity (and femininity) are at the centre of a cycle of risk and vulnerability to HIV infection (Eaton et al., 2003). Several explanations have been put forward to justify multiple sexual partnerships in the study sites. Some men and women argued that it was justifiable for men to have more than one partner because there are more women than men in the society. Others argued that multiple sexual partnerships for men were inspired by the practice of polygamy, which is viewed as an important part of African culture. Others believed that men could not be confined to one sexual partner because male sexuality cannot be controlled. On the other hand, multiple sexual partnerships practiced by women seemed to be related to their socio-economic living conditions. In such situations some women, particularly young women get involved with many partners including older men in order to secure a higher socio-economic status. Indeed, the 'traditional' notion of masculinity posits that men should take advantage of all sexual opportunities with women, whereas women are expected to be ignorant or indifferent to sex, submitting only in response to a partner's request (O'Sullivan et al., 2007). Other studies have also found that men are seen as having an uncontrollable desire for sex. In Nigeria a study by Caldwell et al. (1999) found that men in the hotels and bars of Ado-Ekiti often sought sexual relations with one of the young women passing by, frequenting or working there. They spoke about their uncontrollable sexual desires that should neither be denied nor postponed (Caldwell et al., 1999).

Other findings of this study are that people may deny the existence of HIV/AIDS. This denialist attitude seems to result from the fear of knowing one's own HIV status as well as the fear of stigma and discrimination. In the interviews some men and women stated that they would end their lives if they found out that they were HIV positive. In this regard, men and women would choose not to know their HIV status to avoid potential damage to their social reputation (UNAIDS, 2008, Cameron, 2005, Varga, 2001). Situations of 'rational ignorance' or the attitude of 'intentionally' choosing to ignore his or her HIV status were reported in other studies (Pinker, 2007; Varga, 2001). In addition, the findings of the present study are also quite consistent with what Varga (2001) found in South Africa. Indeed, Varga (2001) found that a frequently

expressed sentiment was what the author called ‘purposeful ignorance’ of health status in order to prolong the positive psycho-emotional aspects of life in the face of inevitable HIV infection (Varga, 2001). Moreover, the findings of this study seems to be in line with research by Mahalik et al. (2007) about the relationship between masculinity, perceived normative health behaviours and men’s health behaviours (Mahalik et al., 2007). In their study, the authors confirmed their hypothesis that masculinity is a correlate of health behaviour. In addition, the authors hypothesizes that traditional masculine norms encourage men to engage in risky behaviours. In many cases these risky practices were instrumental for their acceptance by other men (Mahalik et al., 2007). Indeed, both ‘rational ignorance’ and ‘perceived normative health’ may be behind the resistance of men to visit health facilities, which increases their risk of HIV infection. One of the challenges health authorities currently face in Mozambique is that people, particularly men, go to clinics at a very late stage of HIV/AIDS, which makes it difficult to save their lives.

Consistent with other studies in sub-Saharan Africa, this study shows that poor communication among partners is a major barrier to behaviour change (Varga, 1999; Holland, et al., 1991). Some respondents said partner communication is minimal or non-existent. This is likely to lead to misunderstanding in sexual relationship and also, to a lack of clarity concerning partners’ expectations (Varga 1999; Kesby, 2000; Lambert and Wood). Poor communication about sex including safer sex practices may result not only because people lack adequate skills to talk openly about sexual health matters but also because broaching the topic of condom use has the potential of creating awkwardness in the relationships (Varga, 1999). Furthermore, some respondents felt that communication is often limited in occasional sexual encounters. In those relationships the intention was to exploit the opportunity for sex. If sexual encounters happen as are described, it means that there is no space to introduce the topic of condoms, for instance. Some studies also reported that in short-term relationships including casual sexual encounters, communication was poor or at least not straightforward (Beres, 2009; Varga 1999; Kesby, 2000). For example, discussing South African young people’s sexual dynamics, Varga (1999) referred to the lack of direct communication on the issue of initiating sex. Rather, the author noted that youth seemed to rely primarily on implicit cues in alerting each other to expectations of appropriate

sexual conduct. Thus, men were described as naturally unable to control themselves when faced with a potentially attractive sexual encounter (Varga, 1999).

The connections between mobility, household poverty and economic pressures and HIV risk infection seems to be overwhelming in this study. Indeed, the findings show that in order to secure urgent economic needs, the spouses of mine workers employed in the mining industry in South Africa, may end up exchanging sex for economic support, because their husbands' remittances are irregular. Studies have documented that the sexual life of mine workers in South Africa are dangerous for the mine workers and their families (Campbell, 2001; Agadjanian, Arnaldo and Cau, 2009; Anarfi, 1993; Bouare, 2007). A study by Agadjanian, Arnaldo and Cau (2009) in Mozambique found that women who are married to migrants are much more likely than those married to non-migrants to think that their husbands have had sex with other women. This is not surprising given the widespread belief that men have an uncontrollable desire for sex and men engage in extramarital relations while away from home (Agadjanian, Arnaldo and Cau, 2009).

Alcohol consumption seems to be one of the factors contributing to risky sexual behaviour among men in the study sites. The widespread sale of alcohol in 'barracas' (or shebeens), bars or backyards all over the study sites is viewed by respondents as the major source of HIV risk infection. These findings are in line with what have been found in other settings of sub-Saharan Africa (Stoner et al., 2007; Theall et al., 2007; Christian et al., 2007; Kongnyuy and Wiysonge, 2007). There is a need for programmes to focus on raising greater awareness of the dangers of alcohol consumption and its link with risky sex. This is necessary in order to limit its disruptive impact on sexual behaviour. A literature review by Pithey and Morojele (2002) in South Africa concluded that for all age groups alcohol use was more common among males than females. In addition, the authors found a strong relationship between alcohol abuse and risky sexual behaviour that increases exposure to HIV infection (Pithey and Morojele, 2002).

10.3 Conclusion

The overall aim of this study was to better understand male sexual behaviour and protective practices in the context of a generalized HIV/AIDS epidemic in one rural and one urban setting in Mozambique. One of the compelling reasons to focus on men is that male sexual behaviour in many settings of sub-Saharan Africa puts them and their partners at risk of HIV infection. The findings suggest that traditional beliefs and expectations expressed by rigid notions of manhood which, among other things, defines men as risk takers explained male risky sexual behaviour. The use of the model by Eaton et al. (2003) to understand sexual behaviour proved particularly useful in this study. The model highlighted the extent to which personal, proximal as well as distal factors in sexual relationships determine the level of personal risk and vulnerability. A combination of methods proved useful in investigating complex and sensitive matters such as sexual behaviour, particularly in settings of sub-Saharan Africa where sex and sexually related issues are surrounded by silence and taboos (Gupta, 2000; Woodsong and Alleman, 2008).

The results of this study rely heavily on self-reported information which has the potential of carrying both participation bias as well as response and recall bias. In this regard, some data may have somewhat been distorted or, respondents may have been selective in the information they provide (Schroder et al., 2003; Fenton et al., 2001). Cross-sectional study such as this one cannot give a sequence of events; consequently the direction of causality cannot be established (Pettifor et al., 2004; Maharaj and Cleland, 2008). Indeed, cross-sectional surveys provide a short description of what the reality of interest might be at a specific point in time. This has important implications for the generalizability of the findings of the study. Therefore, an attempt to generalise the results should be made with caution and it could be plausible only in the context of study sites.

The findings from this study have important implications for further research. The study found a partner type called ‘friend’ which is a non-marital and non-cohabiting partner. Further research should investigate more thoroughly the protective practices (including the meanings associated with it) used in sexual relations between friends. In addition, this study has shown that prevalent

notions of masculinity influence male risky sexual behaviour. To improve understanding of the extent to which traditional (and progressive) notions of masculinity determine male sexual behaviour in different settings, masculinity indicators related to male sexual behaviours should be developed taking into account the specific socio-cultural context.

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Appendices

MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES IN THE CONTEXT OF HIV/AIDS

FOCUS GROUP DISCUSSION GUIDE (**for both men and women**)

A

GENDER ROLES & NORMS

1. **What are the main problems, difficulties, pressures or challenges facing men here in Matola city/Manhiça district?**

2. **What are the main problems, difficulties, pressures or challenges facing women here in Matola city/Manhiça district?**

Probe: What risks do men and women face, here in Matola city/Manhiça district today? Do men and women face any different issues? How are they different? Does the situation in Matola city/Manhiça district put men at risk/in risky-taking activities differently from women? How do the difficulties/challenges occur in personal and family life for men and women? Who protects or supports men and women in the face of these problems?

B

VALUED CHARACTERISTICS OF MEN AND WOMEN

1. What characteristics are most valuable in men in Matola city/Manhiça district?

2. What characteristics are most valuable in women in Matola city/Manhiça district?

Probe: To be a "real man", what is a man supposed to be? To be a "real woman", what is a woman supposed to be? Do men and women conform to get these expectations? Why and how? Are the men today, different from the men in the past? Are the women today different from the women in the past?

C

SEX, GENDERED ACTIVITIES AND CHANGE

1. **Are there different expectations for men and women in the following areas of social life?**
    - Education and training
    - Employment
    - Family responsibility
    - Socially acceptable behaviour
    - Sexual behaviour

Probe: Do you think those expectations position men and women differently? How does this happen? What are the costs of fulfilling these norms and expectations of being a man and woman?

2. What do you think makes a man/woman a good husband/wife and/or a good lover?

Probe: Are these two things different? How are they different? How easy or difficult is it a good husband and lover simultaneously? How easy or difficult is it to be a good wife and lover simultaneously? What is the common feature here in Matola/Manhiça?

3. Does man's capacity to earn more than women/ being breadwinner affects his sexual relations with women?

Probe: Does it affect his sexual relations with his wife? Does it affect his sexual relations with other women? What happens if he cannot find work, and he cannot earn an income? In what ways does this may affect sexual relations between men and women here in Matola city/Manhiça district?

D

HIV/AIDS AWARENESS

1. How serious a problem is HIV/AIDS for both women and men in Matola/Manhiça?

Probe: Do you think that both men and women are aware of the risk of HIV infection?
What increases the risk of HIV infection among men and women? What strategies can men and women adopt to protect themselves against the risk of HIV infection?
Do you think that men and women are doing everything to avoid being infected by HIV/AIDS? How do people learn about sex and proper sexual behaviour for both men and women?

E

GENDER DIFFERENCES, CULTURE AND SEXUALITY

1. Who do you think has more influence in decision-making about sexual behaviour?

Probe: Do men and women have equal rights in determining sexual behaviour? Do men and woman have equal power to share decisions about sexual behaviour? Do men and woman collaborate equally in taking initiatives for sexual relations and acts? Can men and women equally take part in negotiations about safer sexual behaviour? How easy or hard is it for men and women to communicate about sexual issues?

F

MULTIPLE PARTNERSHIPS

1. Are there particular sexual acts and behaviours that are most acceptable for men than women?

Probe: Is there a double standard in sexual relations? Is it more acceptable for men to have other partners? What do you think when men have other partners? What can women do if their partner has other sexual partners? How do these women feel if their partner has other partners?

2. What do women fear in complying with men's unsafe behaviour, his demands (even risky) and/or not fulfilled expectations?

Probe 1: Do women fear that their male partner will go elsewhere to meet other women? How long could a woman wait before a man starts to look for other women because she just had a child, in this area? What may happen if a wife and/ a mother has other partner(s) outside marriage or buys sexual services from others? Are the consequences the same for both men and women? What has to happen to stop HIV spreading through this behaviour?

Probe 2: Can a woman, who knows that her husband/partner has other partners, suggest using a condom? Should a woman refuse sex with a husband/partner who has other partners? If a woman refuses to have sex with her husband/partner, what is the common reaction of men? What makes a man (and to a lesser extent some women) have two or more partners at same time?

G

CONDOMS AND CONTRACEPTIVE USE

1. When is it acceptable to use condoms here in Matola city/Manhiça district?

Probe: Is it at beginning of a relationship, when do you stop? What are the problems in using condoms? Is it acceptable for a married couple to use a condom? Can condoms be used as a method of family planning? Is a condom acceptable for men? Is a condom acceptable to woman? Is it easier to use condoms in regular or casual partnerships?

1. What are the common things a woman does when she wants sex but she does not want to get pregnant?

Probe: Can she suggest using a method of contraception? What are the consequences? Can she talk to her partner about contraception? What are the methods of contraception that she can use?

H

SEXUAL DYNAMICS AND EXPECTATIONS

1. Do you think men and women want different things from sex?

Probe: what do you think men want most from sex? What do you think women want most from sex? What do you think men and women both want from sex?

2. When a man/woman gets a new sexual partner what do you think he/she wants from the relationship?

Probe: 1 He thinks he will enjoy sex, he thinks it is another opportunity to prove his manhood; he thinks he will prove he is capable to please a woman sexually…

Probe 2: She thinks she will enjoy sex? She thinks she will be rewarded by her partner in one way or another, she thinks she will please her partner sexually…

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MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES IN THE CONTEXT OF HIV/AIDS

IN-DEPTH INTERVIEWS GUIDE (**for both men and women**)

A

GENDER ROLES AND NORMS

1. Do you think you are facing particular problems, difficulties, pressures or challenges as a man/woman, here in Matola city/Manhiça district?

Probe: What risks you as man/woman confront, here in Matola city/Manhiça district today? Do you feel as man/woman face any different issues because of your gender? How are they different? Does the situation in Matola city/Manhiça district put you as man/woman at risk/in risky-taking activities differently from women/man? How do the difficulties/challenges occur in your personal and family life? Who protects or supports you in the face of these problems?

B

VALUED CHARACTERISTICS OF MEN AND WOMEN

1. In your opinion, what characteristics are most valuable in man/woman in Matola city/Manhiça district?

Probe: To be "real man/woman" what are you supposed to be? Do you conform to these expectations? Are men today, different from men in the past? Are women today different from women in the past?

C

SEX, GENDERED ACTIVITIES AND CHANGE

1. **Do you feel that there are/were different expectations for you as a man/woman in the following areas of social life?**
    - Education and training
    - Employment
    - Family responsibility
    - Socially acceptable behaviour
    - Sexual behaviour

Probe: Do you think those expectations position you as a man/woman differently? How does this happen? What are the costs of fulfilling these norms and expectations of being a man and woman?

2. What do you think makes a man/woman a good husband/wife as well as a good lover?

Probe: Are the two things different from each other? If yes, in which way are they different? How easy or difficult is it to be a good husband and lover simultaneously? How easy or difficult is it to be a good wife and lover simultaneously? What is the common feature here in Matola/Manhiça for fulfilling these expectations?

(**Only for men**)↓

3. In your opinion, does your capacity to earn more than women/being breadwinner affects your sexual relations with women?

Probe: Does it affect your sexual relations with your wife? Does it affect your sexual relations with other women? What happens if you cannot find work, and you cannot earn an income? What ways might affect sexual relations between you and women?

D

HIV/AIDS AWARENESS

1. In your opinion, how serious a problem is HIV/AIDS for both women and men in Matola/Manhiça?

Probe: Do you think that both men and women are aware of the risk of HIV infection? Are you doing everything to avoid being infected by HIV/AIDS? Why? What are the prevention strategies you are currently adopting to cope with HIV/AIDS?

E

GENDER DIFFERENCES, CULTURE AND SEXUALITY

1. Who do you think has more influence in decision-making about sexual behaviour?

Probe: Do you, as man/woman, have equal rights in determining sexual behaviour? Do you, as man/woman, have equal power to share decisions about sexual behaviour? Do you, as man/woman, collaborate equally in taking initiatives for sexual relations and acts? Can you as man/woman equally take part in negotiations about safer sexual behaviour? How easy or hard is it for you to communicate about sexual issues?

F

MULTIPLE PARTNERSHIPS

1. Are there particular sexual acts and behaviours that are most acceptable for you as man/woman?

Probe: Is there a double standard in your sexual relations? Is it more acceptable for you as man/woman to have other partners? Do you think man have other partners? What can women do if their partner has other sexual partners? How do these women feel if their partner has other partners?

2. What do women fear in complying with men's unsafe behaviour, his demands (even risky) and expectations?

Probe 1: Do women fear that their male partner will go elsewhere to meet other women? How long could a woman wait before a man starts to look for other women because she just had a child, in this area? What may happen if a wife and/ a mother has other partner(s) outside marriage or buys sexual services from others? Are the consequences the same for both men and women? What has to happen to stop HIV spreading through this behaviour?

(Only for women)↓

Have you ever had a similar situation as described above in your sexual relationships? Can you tell us?

Probe 2: Can a woman, who knows that her husband/partner has other partners, suggest using a condom? Should a woman refuse sex with a husband/partner who has other partners? If a woman refuses to have sex with her husband/partner, what is the common reaction of the men? What makes a man (and to a lesser extent some women) have two or more partners at the same time?

G

CONDOM AND CONTRACEPTIVE USE

1. When is it acceptable to use condoms here in Matola city/Manhiça district?

Probe: If is it at the beginning of a relationship, when do you stop? What are the problems in using condoms? Is it acceptable for a married couple to use a condom? Can condoms be used as a method of family planning? Is condom use acceptable for men? Is a condom acceptable to woman? Is it easier to use condoms in regular or casual partnerships?

(Only for men)↓

What are the common things that a man does when he wants sex but he does not want to get his partner pregnant?

Probe: Can he suggest using a method of contraception? What are the consequences? Can he talk to his partner about contraception? What are the methods of contraception that he can suggest to use?

H

SEXUAL DYNAMICS AND EXPECTATIONS

1. Do you think men and women want different things from sex?

Probe: what do you think men want most from sex? What do you think women want most from sex? What do you think men and women both want from sex?

2. When a man/woman gets a new sexual partner, what do you think he/she wants from the relationship?

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Probe 2: She thinks she will enjoy sex? She thinks she will be rewarded by her partner in one way or another, she thinks she will please her partner sexually

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MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES SURVEY
IN THE CONTEXT OF HIV/AIDS

HOUSEHOLD QUESTIONNAIRE

IDENTIFICATION

NAME OF HOUSEHOLD HEAD .....

CLUSTER NAME

HOUSEHOLD NUMBER

SITE (Matola=1, Manhica=2) .....

ÁREA (urbano=1, rural=2) .....

RESPONDENT ROSTER NUMBER .....

HOUSEHOLD ELEGIBLE NUMBERS Mulheres Homens

INTERVIEWER VISITS

	1	2	3	Ultima vis	Final visit	
	Date ____/____ day month	____/____ day month	____/ day m	day month	day month	
Interviewer name	Hours:			year	year	**2006**
				Code	Code	

NEXT VISIT	DATE				
	TIME				

*Result Codes
1= Complete 3= Refused 5= Others _____ (especifique)
2= Postponed 4= Partly completed

Supervisor	Keyed by	Officer Editor
Name _____	Name _____	Name _____
Date____/____/____	Date____/____/___	Date____/____/___

MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES SURVEY
HOUSEHOLD ROSTER

To start this interview, I would like to know about the peolple who usually live in this household.
Any information you provide is strictly confidential. I need to know the age, sex, education, marital status and relationship of each member to you. Tell me the names of all males living in this household, from oldes to youngest. Then, all females names.
Also from oldest to the youngest. Do not forget to include youself in the appropriate order.

Line no	A household member first and last name	B* household member's relationship to informant	C Age	D** Education	E** Marital status	F*** Ocupation	G Elegible Person	H Person number	I Selected "R"
M									
A									
L									
E									
S									
F									
E									
M									
A									
L									
E									
S									

MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES SURVEY
HOUSEHOLD ROSTER CODES

Codes for B				
	01= himself/herself	04= son/daughter in low	07= parent in low	10= grandparent
	02= wife/husband	05= grand chil	08= brother/sister	11= other relative
	03= son/daughter	06= parent	09= co-wife	12= not related
				13= don not know
Codes for D				
	01= no formal schooling	04= secondary school completed		07= post-grad degree
	02= less than primary school	05= higher school (equivalent) completed		completed
	03= primary school completed	06= college/pre-university/university comp.		
Codes for E				
	01= never married	03= separeted	05= widowed	
	02= currently married	04= divorced	06= cohabiting	
Specification for F	This columm identifies the type of ocupation that may render to informant personal incomes which are used to personal as well as household consumptions. They may range from formal employment to the different income strategies.			

HOUSEHOLD SOCIOECONOMIC QUESTIONNAIRE

No	Questions and Filters	coding Categories			Skip
101	Does your household have:		Yes	No	
	Electricity?	Electricity	1	2	
	A radio	Radio	1	2	
	A television	Television	1	2	
	A telephone	Telephone	1	2	
	A refrigerator?	Refrigerator	1	2	
102	Does any member of your household own:		Yes	No	
	A house?	A house	1	2	
	A bicycle	A bicycle	1	2	
	A motocycle	A motocycle	1	2	
	A car	A car	1	2	
103	Does your household own any land?	Yes		1	
		No		2	
104	Does your household own any livestock	Yes		1	
		No		2	
105	What type of fuel does your household mainly use for cooking?	Electricity		1	
		LPG/natural gas		2	
		Biogas		3	
		Kerosene		4	
		Coal, Lignite		5	
		Charcoal		6	
		Firehood, straw		7	
		Dung		8	
		Other _____ (Specify)		9	
106	What is the main source of drinking water for members of your household?	**Piped water**			
		Piped into			
		Residence/yard/plot		11	
		Public tap		12	
		Well water			
		Residence/yard/plot		21	
		Public well		22	
		Bore hole		23	
		Surface water			**Q 120**
		Spring		31	
		River/stream		32	
		pond/lake		33	
		dam		34	
		rainwater		41	
		Tanker truck		51	
		Bottled water		61	
		Other _____ (specify)		96	

107	What kind of toilet facility does your household have?	**Flush toilet** Own flush toilet 11 shared flush toilet 12 **Pit toilet/latrine** traditional pit toilet 21 ventilated improved pit (VIP) latrine 22 No facility/bush/field 31 E _____ (specify) 96	
108	Do you share this facility with other households?	Yes 1 No 2	
109	Main material of the roof **Record observation**	Thatch 1 Iron/tin 2 Tiles 3 Multi-story dwelling 4 Other _____ (specify) 96	
110	Main material of the floor **Record observation**	Earth 1 Cement 2 Tile 3 Other _____ (specify) 96	

LISTA DOS MEMBROS DO AGREGADO FAMILIAR

Para começar esta entrevista, gostaria de saber a cerca de quem normalmente vive neste agregado familiar
Qualquer informação que você der é estritamente confidencial. Eu preciso saber o nome, o grau de parentesco
o sexo, a idade dos membros do seu Agregado Familiar, começando com o chefe do AF e depois os restantes.

Número de Ordem	A Nome do m	B Grau de pa em relação ao chefe do AF	C Sexo	D Idade	E Pessoa elegível	F Presença "S/N"

LISTA DE CÓDIGOS DO AGREGADO FAMILIAR

Códigos para B

01= próp	04= genr	07= sogros	10= Avos
02= espo	05= neto/	08= irmão/irmã	11= outro familiar
03= filho/	06= pais	09= outra esposa	12= s/vinculo familiar
			13= não sabe

MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES SURVEY
WOMEN'S QUESTIONNAIRE

IDENTIFICATION

NAME OF HOUSEHOLD HEAD.....

CLUSTER NAME & NUMBER .....

HOUSEHOLD NUMBER .....

SITE (Matola=1, Manhica=2) .....

AREA (urban=1, rural=2) .....

RESPONDENT ROSTER NUMBER .....

INTERVIEWER VISITS

	1st visit	2nd visit	3rd visit	Last visit	Final visita	
	Date _____/_____	_____/_____	_____/_	Day	Dia	
	day month	day month	day mo	Month	Mes	
Interviewer name				Year	Ano	**2006**
	Hours					
_____				Code	Código	
NEXT VIIT	DATE					
	TIME					

1= Completed 3= Refused 5= Others _____ (especify)
2= Postponed 4= Partly completed

Supervisor	Keyed by	Editor Officer
Name _____	Name _____	Name _____
Date____/____/____	Date____/____/___	Date____/____/___

SECTION 1. SOCIODEMOGRAPHIC BACKGROUND

NO	QUESTIONS AND FILTERS RECORD THE TIME	CODING CATEGORIES HOUR MINUTES		SKIP
101	How old were you at your last birthday?	Number of years Don't know	98	
102	For most of the time until you were 12 years old, did you live in a city, in a town in the countryside?	City Town Countryside	1 2 3	
103	How long have you been living continuously here in Matola/Manhica?	Years Always	97	
104	In the last 12 months, have you been away from your home for more than one month altogether, or even more ?	Yes No	1 2	
105	Have you ever attended school?	Yes No	1 2	 108
106	What is the highest level of school you attended?	Literacy program Primary EP1 Primary EP2 Secondary ESG1 Secondary ESG2 Technical Elementary Technical Basic Technical middle Teachers Training Higher Education	1 2 3 4 5 6 7 8 9 10	 108
	Check **106:** Literacy and Primary education ↓	Secondary education and more	→	108
107	Can you read and understand a letter or newspaper easily, with difficult, or not at all?	Easily With difficult Not at all	1 2 3	
108	What is your religion?	None Roman Catholic Protestant/Evangelical Muslim Siao/Zione Traditional/Animist Other _____ (specify)	1 2 3 4 5 6 7	
109	To which ethnic group do you belong to?	_____ (Specify)		
110	Are you currently married or living together with a man?	Yes, currently married Yes, living together with a man No	1 2 3	 115
111	Does your husband/partner has any other wives or regular partners besides you	Yes No Don't know	1 2 8	 113
112	How many other wives/partners does he have?	Number of wives Number of partners Don't know	Não sabe 98	
113	Did the union with your current husband/partner involve lobolo (brideprice) payr	Yes No	1 2	 115

	Check **133:** Lobolo (brideprice) ne↓	Not married/living together →		115
114	Has the lobolo (brideprice) been completely paid?	Yes No	1 2	117
	Confira: **110: Not married/living together** ↓			
115	What is your current marital status?	Never married Engaged Widowed Divorced Separated	1 2 3 4 5	
116	Do you currently have a *regular partner* *, that is, someone you have been havir for a year or more?	Yes No	1 2	

SECTION 2: SOCIOECONOMIC BACKGROUND

No	Questions and Filters	coding Categories		Skip
117	Aside from your housework, are you currently employed?	Yes No	1 2	
118	What is your main occupation, that is, what kind of work do you do most of the	(especify) _____ _____ does not do nothing	98	
	Work in Agricultur↓ Does not in agriculture	work →		120
119	Do you work mainly on your own farm, on family farm, on rent farm or on empl	Own farm Family farm rent/borrowed farm Employer form	1 2 3 4	
120	Do you usually work throughout the year, or do you work seasonally, or only once in a while?	Throughout the year Seasonally/part of the year Once in a while	1 2 3	
	Check: **119Work on Employer farm** ↓	Other activity, own farm, family farm or rent farm →		122
121	Do you receive any payment in cash or kind for this work?	Yes No	1 2	183
122	Do you share information with your partner about how much you earn from this	Always Sometimes Never	1 2 3	
183	**Cancelled question**			

SECTION 3: HUSBAND/PARTNER SOCIOECONOMIC CHARACTERISTICS

No	Questions and Filters	coding Categories		Skip
184	Has your husband/partner ever attended school?	Yes No Don't know	1 2 8	
185	What is the highest level of school your husband/partner attended?	Literacy program Primary EP1 Primary EP2 Secondary ESG1 Secondary ESG2 Technical Elementary Technical Basic Technical middle Teachers Training Higher Education Don't know	1 2 3 4 5 6 7 8 9 10 98	187

	Confira **185:** Literacy and Primary education ↓	Secondary education and more	→	187
186	Can he read and understand a letter or newspaper easily, with difficult, or not at all?	Easily 1 With difficult 2 Not at all 3		
187	Is your husband/partner currently employed?	Yes 1 No 2 Don't know 8		
188	What is his main occupation, that is, what kind of work does he do most of the	(especify) _____ _____ Don't know 98		
	Work in Agriculture ↓	**Does not work in agriculture**	→	190
189	Does he work mainly on his own farm, on family farm, or on rent farm?	Own farm 1 Family farm 2 rent/borrowed farm 3 Employer farm 4		
190	Does he usually work throughout the year, or do you work seasonally, or only once in a while?	Throughout the year 1 Seasonally/part of the year 2 Once in a while 3 Don't know 8		
	Confira: **18 Work on Employer farm** ↓	Other activity, own farm, family farm or rent farm	→	123
191	Does he receive any payment in cash or kind for this work?	Yes cash 1 Yes kind 2 No 3 Don't know 8		
192	Does your husband/partner share information with you about how much he earn his main source of income?	Yes/usually 1 No/rarely 2 Sometimes 3 NR/Refuse 8		

SECTION 4: HIV/AIDS RISK AWARENESS

No	Questions and Filters	coding Categories		Skip
123	Have you ever heard of an illness called AIDS?	Yes 1 No 2		132
124	Is HIV/AIDS an incurable and fatal disease?.	Yes 1 No 2 Don't know 8		
125	Is there anything a person can do to avoid getting HIV/AIDS?	Yes 1 No 2 Don't know 8		127
126	What can a person do? **(cycle all mentioned)**		Sim / Não	
		Abstain fro A	1	2
		Use condo B	1	2
		Avoid multi C	1	2
		Avoid wet l D	1	2
		Seek protection from traditional healer E	1	2
		Have sex w F	1	2
		Pray G	1	2
		Avoid shari H	1	2
		Avoid bloo I		
		Avoid sex v J	1	2
		Avoid bloo K	1	2
		Avoid injec L	1	2
		Other ____ 96 _____	1	2
		Don't know 96		96

127	Do you personally know anyone who is infected with HIV/AIDS?	Yes No Unsure NR/refuse	1 2 3 8	
128	Do you personally know anyone who has died or you think has died of AIDS?	Yes No Unsure NR/refuse	1 2 3 8	
129	Do you think your chances of getting HIV/AIDS are great, moderate, small, or no risk at all?	Great Moderate Small No risk at all Decline/Refuse Don't know	1 2 3 4 6 8	 131 131
130	Why do you think that you have no risk/a small chance of getting HIV/AIDS? **Record all mentioned**		Sim	Não
		Abstain from sex	1	2
		Infrequent sex	1	2
		Use condoms	1	2
		Have only one sex partner	1	2
		Limited No. of sex partners	1	2
		Partner has no other parts.	1	2
		No blood transfusion	1	2
		No injections	1	2
		Other_____ (specify)	1	2
		Don't know	1	2
	Confira: 129 Has great/moderate chances of getting HIV ↓	No/small Chances of getting HIV/AIDS	→	131a
131	Since you first heard of AIDS, what did you do to prevent being infected? **(Record all mentioned)**		Sim	Não
		Stopped all sexual activities	1	2
		Started using condoms	1	2
		Restricted sex to one partner	1	2
		Reduced number of partners	1	2
		Asked partner to be faithful	1	2
		Stopped injections	1	2
			1	2
		Other_____ (specify)	1	2
131a	Have you ever thought to be tested?	Yes,I have done already Yes, but I did not do yet No NR/refuse	1 2 3 8	132
131b	If your partner or your best friend invited you to be tested, would you accept to g	Yes, I would No, I am afraid to know my serostatus No, I am sure that I am not infected No, I do not need NR/refuse	1 2 3 4 8	

SECTION 5: KNOWLEDGE, ATTITUDES AND BELIEFS

	Now, I would like you to say if you agree, disagree or you have mixed feelings/ I opinion about the following statements:	Agree 1	Mixed/No opinion 2	Disagree 3	
132	a) A person can get HIV/AIDS by having sexual intercourse with a condom.				
	b) A person can get infected with HIV/AIDS by getting injections with a clean, sterilized needle				
	c) A person can get infected with the HIV/AIDS through mosquito bites				
	d) A person who looks healthy can be infected with the HIV/AIDS				
	e) People can protect themselves from the HIV/AIDS by using a condom correctly every time they have sex.				
	f) People can protect themselves from getting infected by HIV/ AIDS by having one uninfected sex partner who also has no other sexual partners.				

SECTION 6: CONDOMS

No	Questions and Filters	coding Categories				Skip
133	Have you ever heard of condoms?	Yes No			1 2	 139
134	Do you know of a place where one can get condoms?	Yes No			1 2	
135	How confident are you that you could get a condom if you needed one?	Very confident Somewhat confident Not confident Never used			1 2 3 4	
136	How confident you feel that you know how to use a condom effectively?	Very confident Somewhat confident Not confident Never used			1 2 3 4	
	Now, tell me if you agree or disagree with the statements below.	Agree 1	Mixed/No opinion 2		Disagree 3	
137	a) Using condoms reduces sexual pleasure					
	b) A woman loses a man's respect if she ask him to use a condom					
	c) The man has greater influence than the woman over whether or not to use condom.					
	d) Using condoms is an effective way of preventing HIV/AIDS					
	e) Condoms encourage promiscuous behaviour					
	f) Using condoms is an effective way to prevent pregnancy					
	g) The only reason to use a condom is because you don't trust your partner					
	Now, say whether is it acceptable or unacceptable for you the following stateme	Acceptable 1	Mixed/No opinion 2		Unaccepta 3	
138	a) Is it acceptable or unacceptable for a married couple to use a condom?					
	b) Is it acceptable or unacceptable for a married woman to ask her husband to use a condom?					
	c) Is it acceptable or unacceptable for a woman who is not married to ask her partner to use a condom?					
	d) Is it acceptable or unacceptable to use a condom with someone at the beginning of a relationship					

SECTION 7: PREGNANCY PREVENTION

No	Questions and Filters	coding Categories				Skip
	And, in relation to the following statements, do you agree or disagree with them or you have a mixed feelings, or even no opinion at all?	Agree 1	Mixed/No opinion 2	Disagree 3		
139	a) It is the woman's responsability to use a method to prevent and/or delay pregnancy					
	b) Family planning leads to promiscuous behaviour					
	Now, say whether is it acceptable or unacceptable for you the following stateme	Acceptable 1	Mixed/No opinion 2	Unaccepta 3		
	c) It is acceptable for a couple to use a method to space between births					
	d) It is acceptable for a couple to use a method to have no more children					
	e) It is acceptable for a man to propose using a method to his partner					
	f) It is acceptable for a woman to use a method without telling her partner about it					

SECTION 8: COMMUNICATION AND GENDER/POWER RELATIONS

No	Questions and Filters	coding Categories		Skip
140	Some couples find it difficult to talk about sex while others do not. Is it difficult to talk about sex, somewhat difficult, or not difficult to talk about sex with your female partner?	Very difficult Somewhat difficult Not difficult NR/Refuse	1 2 3 8	
141	Aside from your sexual partner, do you talk to anyone else about sex?	Yes No Other _____ (specify)	1 2 6	 143
142	Who do you talk to about sex? **Circle all mentioned**		Sim / Não	
		Mother	1 / 2	
		Father	1 / 2	
		Sister	1 / 2	
		Sister-in-law	1 / 2	
		Brother	1 / 2	
		Other female relative	1 / 2	
		Other male relative	1 / 2	
		Male friend/Neighbor	1 / 2	
		Female friend/Neighbor	1 / 2	
		Religious leader	1 / 2	
		Health worker	1 / 2	
		Other _____ (specify)	1 / 2	
143	In your sexual relationships, who has more influence over whether or not to hav sex: you, your partner or both?	Respondent Partner Both NR/Refuse	1 2 3 8	
144	In your sexual relationships, was there a time when your partner wanted to have sex and you did not?	Yes No NR/Refuse	1 2 8	 148
145	When that happened, did you let your partner know that you did not want to have sex?	Yes No	1 2	 148

146	How did you let him know this?	Told him I did not want sex Told him I was sick Told him I was tired Showed unwillingness Other _____ (specify)	1 2 3 4 6	
146a	Even though, have you had sex?	Yes No NR/Refuse	1 2 8	148
147	What was the main reason for having sex although you did not want to?	He persisted/persuaded her He threatened her She was afraid to refuse She wanted to please him It's wrong refusing sex for a partner He has more authority Other _____ (specify)	1 2 3 4 5 6 7 8	
148	In your relationship, was there a time when you wanted to have sex and your partner did not?	Yes No NR/Refuse	1 2 8	150
148a	Even though, have you had sex?	Yes No NR/Refuse	1 2 8	150
149	What made him decide to have sex though he did not want to?	She persisted/persuaded him She threatened him He was afraid to refuse He wanted to please her It's wrong refusing sex for a partner She has more authority Other _____ (specify) Don't know	1 2 3 4 5 6 7 8	
150	How often do you jointly discuss your sexual life?	Always/frequently many times Sometimes Rarely Never NR/Refuse	1 2 3 4 5 8	
151	Has your sexual partner had sexual practices that you don't like, but you think/feel you cannot refuse?	Yes No NR/Refuse	1 2 8	153
152	can you tell me, <u>at least three</u> of such sexual practices? **Recor all mentioned)**	Oral sex Anal sex Others _____ (especify) _____ NR/Refuse	1 2 8 88	
153	Can you point out at least <u>three qualities</u> (positives aspects)of your partner that like so much	1. _____ 2. _____ 3. _____ 4. nothing it pleases me NR/Refuse	 96 98	
154	Now, can you point out at least three imperfections (negatives aspects) that you don't like on him	1. _____ 2. _____ 3. _____ 4. Nothing it is unpleasant NR/Refuse	 96 98	

155	Have you ever had sexual intercourse when somebody was physically forcing y hurting you, or threatening you?	Yes No	1 2	 157
156	Would you say you have had forced sex often/frequently, sometimes/rarely or never?	Often/frequently Sometimes/rarely Never RN/Refuse	1 2 3 8	
157	Have you ever given/received anything from someone so they would have sex v	Yes No Don't know/don't remember NR/Refuse	1 2 6 8	
157a	Have you ever received anything from someone and you had to have sex with?	yes, many times/always Yes, sometimes/rarelly Never RN/Refuse	1 2 3 8	 159
158	What did you give/rece **(do not read out!)** **Cycle all mentioned** **If Respond "Yes", probe for type of gift.**	Money Food School fees Help with school work Drugs Shelter/rent Clothes Transport Jewelry Entertainment Other _____ (Specify)	1 2 3 4 5 6 7 8 9 10 96	

	Now, tell me if you agree or disagree with the statements below.	Agree **1**	Mixed/No opinion **2**	Disagree **3**	
159	a) Very few men in this area (Matola city/Manhica district) changed their behaviour because of HIV/AIDS				
	b) If a wife gets HIV or STI from outside the marriage, there is nothing the husband can do to avoid getting infected himself				
	c) A man needs to have more than one partner				
	d) A man can be satisfied with only one partner				
	e) It is acceptable for a husband to force his wife/partner to have sex with him				

	Now, tell me if you agree or disagree with the statements below.	Agree **1**	Mixed/No opinion **2**	Disagree **3**	
160	a) Women want to be guided in sex by a sexually experienced men.				
	b) Women are more concerned in pleasing their partners during sex, than themselves.				
	c) Sex between man woman tend to stop when he ejaculates (he had an orgasm)				
	d) Women find it difficult to tell their partners what dislike sexually				
	e) Women find it difficult to tell my partner what I find sexually enjoyble				
	f) men prefer women who are less assertive and who like men taking the initiative .				

SECTION 9: MULTIPLE PARTNERSHIPS

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Record the time	Hour Minutes	

It sometimes happens that men and women have sexual relations with partners other than their *regular partners*.
Now, I am going to ask about the three most recent sexual partners in the last 12 months.
This includes anyone you might have had sex with, for instance a friend, or casual partner, that is,
someone you might have met at a bar, wedding, special event, etc., even your spouse (regular partner).

161 In total, how many partners have you had sexual intercourse with, in your whole entire life?

Number of partners ____
RN/Refuse 98

162 How many partners have you had sex with, in the last 12 months?

Number of partners ____
No partners in the last 12 months 0
NR/Refuse 96

163 Think about your more recent sexual partner. How would you describe this partner?

PARTNER 1 (most recent)		PARTNER 1 (most recent)		PARTNER 1 (most recent)	
Spouse/regular partne	1	Spouse/regular partne	1	Spouse/regular partner	1
casual acquaintance	2	casual acquaintance	2	casual acquaintance	2
Sponsor	3	Sponsor	3	Sponsor	3
Friend	4	Friend	4	Friend	4
Ex/partner	5	Ex/partner	5	Ex/partner	5
Relative	6	Relative	6	Relative	6
Client	7	Client	7	Client	7
Other ____ _____ (specify)	96	Other ____ _____ (specify)	96	Other _____ _____ (specify)	96

164 What is/was their sex?

PARTNER 1 (most recent)		PARTNER 2 (second most recent)		PARTNER 3 (third most recent)	
Male	1	Male	1	Male	1
Female	2	Female	2	Female	2

165 How old is/was this partner

PARTNER 1		PARTNER 2		PARTNER 3 PARTNER 3	
Older	1	Older	1	Older	1
Younger	2	Younger	2	Younger	2
Same age	3	Same age	3	Same age	3
don't know	98	don't know	98	Don't know	98

166 Is he/she still your sexual partner?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2

Check **164: male partner** ↓ Female partner →

167 Have you had a child with this partner? **168**

PARTNER 1		PARTNER 2		PARTNER 3 PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2

168 Do you want to have a child with this partner?

PARTNER 1		PARTNER 2		PARTNER 3 PARTNER 3	
Yes	1	Yes	1	Yes	1 1
No	2	No	2	No	2 2
unsure	3	unsure	3	unsure	3 3

169 For how long have you had sexual relationship with this partner?

PARTNER 1 (most recent)		PARTNER 2 (second most recent		PARTNER 3 (third most recent)	
Less than a year	1	Less than a year	1	1 Less than a year	1
One year or more	2	One year or more	2	2 One year or more	2
NR/Refuse	8	NR/Refuse	8	88 NR/Refuse	8

170 Do you think this partner had other partners?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2
don't know	8	don't know	8	don't know	8

171 Have you ever asked your partner about the number of past sexual partners he/she had?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2
don't know	8	don't know	8	don't know	8

172 have you ever told your partner about the number of past sexual partners you had?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2
don't know	8	don't know	8	don't know	8

173 Have you ever used a condom with this partner?

PARTNER 1			PARTNER 1		PARTNER 1		
Yes	1	175	Yes	1	Yes	1	175
No	2		No	2	No	2	
don't know	8		don't know	8	don't know	8	

174 How confident are you that you could convince him that he should use a condom if you wanted to use one?

PARTNER 1		PARTNER 2		PARTNER 3	
Very	1	Very	1	Very	1
Fairly	2	Fairly	2	Fairly	2
Not	3	Not	3	Not	3

175 Have you ever discussed with your partner about whether or not to use a condom?

PARTNER 1			PARTNER 1			PARTNER 1		PARTNER 1		
Yes	1	**177**	Yes	1	**177**	Yes		Yes	1	**177**
No	2		No	2		No		No	2	
Don't know	8		Don't know	8		Don't know		Don't know	8	

176 What is the main reason that you have not discussed using a condom?

	PARTNER 1	PARTNER 2	PARTNER 3
1 Never used	1	1	1
2 Don't want to use a condom	2	2	2
3 Don't need to use a condom	3	3	3
4 Embarrassed/Shy	4	4	4
5 Afraid	5	5	5
6 He will think I'm promiscuous	6	6	6
7 He will think I don't trust her	7	7	7
8 He doesn't like condom	8	8	8
98 Don't know	98	98	98
96 Other_____ (specify)	96	96	96

177 The last time you had sex with, did you or your partner use a condom?

PARTNER 1			PARTNER 2			PARTNER 3			
Yes	1		Yes	1		Yes	1	1	
No	2	**181**	No	2	**181**	No	2	2	**181**

178 What was the main reason you used a condom? **(do *not* read options)**

	PARTNER 1	PARTNER 2	PARTNER 3	PARTNER 3
1.Own concern to prevent pregnancy	1	1	1	1
2. Own concern to prevent STI/HIV/AIDS	2	2	2	2
3. Own concern to prevent pregnancy and STI/HIV/AIDS	3	3	3	3
4. Did not trust partner/feels partner has other partners	4	4	4	4
5. Partner insisted/partner choice	5	5	5	5
6. Other (specify) _____	6	6	6	6
7. Don't know	98	98	98	98

179 The last time you had sex, who made the decision to use a condom?

PARTNER 1		PARTNER 2		PARTNER 3	
Self	1	Self	1	Self	1
Partner	2	Partner	2	Partner	2
Both	3	Both	3	Both	3
Other (Specify)_____		Other (Specify)_____		Other (Specify)_____	
_____	4	_____	4	_____	4
Don't know	98	Don't know	98	Don't know	98

180 How often do/did you use a condom with this partner?

PARTNER 1		PARTNER 2		PARTNER 3	
Always	1	Always	1	Always	1
Usually	2	Usually	2	Usually	2
Sometimes	3	Sometimes	3	Sometimes	3
Rarely	4	Rarely	4	Rarely	4
Never	5	Never	5	Never	5

181 The last time you had sex with, did you or your partner use or do something to prevent pregnancy?

PARTNER 1			PARTNER 2			PARTNER 3		
Yes	1		Yes	1		Yes	1	
No	2	→ **End**	No	2	→ **End**	No	2	→ **End**

182 Which method did you use?

	PARTNER 1	PARTNER 2	PARTNER 3	
1. Pill	1	1	1	1
2. IUD	2	2	2	2
3. Injections	3	3	3	3
4. Diaphragm/Foam/Jeley	4	4	4	4
5. Condom	5	5	5	5
6. Female condom	6	6	6	6
7. Traditional method/herbs	7	7	7	7
Specify_____				
8. Non penetrative sex	8	8	8	8
9. Safe days/Abstinence	9	9	9	9
96. Other _____ (Specify)	96	96	96	96

183 The last time you and your partner had sex, who made the decision to use anything to avoid pregnancy?

PARTNER 1		PARTNER 2		PARTNER 3	
Self	1	Self	1	Self	1
Partner	2	Partner	2	Partner	2
Both	3	Both	3	Both	3
Other (Specify)_____		Other (Specify)_____		Other (Specify)_____	
_____	4	_____	4	_____	4
Don't know	98	Don't know	98	Don't know	98

RECORD THE TIME	HOUR		
	MINUTES		

OBSERVATIONS: _____

THANK YOU VERY MUCH!

MALE SEXUAL BEHAVIOUR AND PROTECTIVE PRACTICES SURVEY
MEN'S QUESTIONNAIRE

IDENTIFICATION

NAME OF HOUSEHOLD HEAD.....

CLUSTER NAME & NUMBER .....

HOUSEHOLD NUMBER .....

SITE (Matola=1, Manhica=2) .....

AREA (urban=1, rural=2) .....

RESPONDENT ROSTER NUMBER .....

INTERVIEWER VISITS

	1st visit	2nd visit	3rd visit	Last visit	Final visita	
	Date ____/____	____/____	____/	Day	Dia	
	day month	day month	day mo	Month	Mes	
Interviewer name				Year	Ano	**2006**
	Hours					
				Code	Código	
NEXT VIIT	DATE					
	TIME					

1= Completed 3= Refused 5= Others _____ (especify)

2= Postponed 4= Partly completed

Supervisor	Keyed by	Editor Officer
Name _____	Name _____	Name _____
Date____/____/____	Date____/____/___	Date____/____/___

SECTION 1. SOCIODEMOGRAPHIC BACKGROUND

NO	QUESTIONS AND FILTERS RECORD THE TIME	CODING CATEGORIES HOUR MINUTES		SKIP
101	How old were you at your last birthday?	Number of years Don't know	98	
102	For most of the time until you were 12 years old, did you live in a city, in a town in the countryside?	City Town Countryside	1 2 3	
103	How long have you been living continuously here in Matola/Manhica?	Years Always	97	
104	In the last 12 months, have you been away from your home for more than one month altogether, or even more ?	Yes No	1 2	
105	Have you ever attended school?	Yes No	1 2	108
106	What is the highest level of school you attended?	Literacy program Primary EP1 Primary EP2 Secondary ESG1 Secondary ESG2 Technical Elementary Technical Basic Technical middle Teachers Training Higher Education	1 2 3 4 5 6 7 8 9 10	108
	Check **106:** Literacy and Primary education ↓	Secondary education and more	→	108
107	Can you read and understand a letter or newspaper easily, with difficult, or not at all?	Easily With difficult Not at all	1 2 3	
108	What is your religion?	None Roman Catholic Protestant/Evangelical Muslim Siao/Zione Traditional/Animist Other _____ (specify)	1 2 3 4 5 6 7	
109	To which ethnic group do you belong to?	_____ (Specify)		
110	Are you currently married or living together with a man?	Yes, currently married Yes, living together with a man No	1 2 3	115
111	How many wifes/partners do you live?	N° de mulheres/parceiras		
112	Do you have a wife/a regular sexual partner living elsewhere?	Number Yes, Wifes Yes, Parterns No	98	
113	Did the union with your current wife/partner involve lobolo (brideprice) payment	Yes No	1 2	115

	Check **133:** Lobolo (brideprice) ne↓	Not married/living together →	115
114	Has the lobolo (brideprice) been completely paid?	Yes 1 No 2	117
	Confira: **110: Not married/living together** ↓		
115	What is your current marital status?	Never married 1 Engaged 2 Widowed 3 Divorced 4 Separated 5	
116	Do you currently have a *regular partner**, that is, someone you have been havir for a year or more?	Yes 1 No 2	

SECTION 2: SOCIOECONOMIC BACKGROUND

No	Questions and Filters	coding Categories	Skip
117	Aside from your housework, are you currently employed?	Yes 1 No 2	
118	What is your main occupation, that is, what kind of work do you do most of the	(especify) _____ _____ does not do nothing 98	
	Work in Agricultur↓ Does not in agriculture	work →	120
119	Do you work mainly on your own farm, on family farm, on rent farm or on empl	Own farm 1 Family farm 2 rent/borrowed farm 3 Employer form 4	
120	Do you usually work throughout the year, or do you work seasonally, or only once in a while?	Throughout the year 1 Seasonally/part of the year 2 Once in a while 3	
	Check: 119 **Work on Employer farm** ↓	Other activity, own farm, family farm or rent farm →	122
121	Do you receive any payment in cash or kind for this work?	Yes 1 No 2	183
122	Do you share information with your partner about how much you earn from this	Always 1 Sometimes 2 Never 3	

SECTION 4: HIV/AIDS RISK AWARENESS

No	Questions and Filters	coding Categories	Skip
123	Have you ever heard of an illness called AIDS?	Yes 1 No 2	132
124	Is HIV/AIDS an incurable and fatal disease?.	Yes 1 No 2 Don't know 8	
125	Is there anything a person can do to avoid getting HIV/AIDS?	Yes 1 No 2 Don't know 8	127

126	What can a person do? **(cycle all mentioned)**	Abstain fro A Use condo B Avoid multi C Avoid wet l D Seek protection from traditional healer E Have sex w F Pray G Avoid shar H Avoid bloo I Avoid sex v J Avoid bloo K Avoid injec L Other ___ 96 _____ Don't know 96		Sim 1 1 1 1 1 1 1 1 1 1 1 1	Não 2 2 2 2 2 2 2 2 2 2 2 2 96
127	Do you personally know anyone who is infected with HIV/AIDS?	Yes No Unsure NR/refuse		1 2 3 8	
128	Do you personally know anyone who has died or you think has died of AIDS?	Yes No Unsure NR/refuse		1 2 3 8	
129	Do you think your chances of getting HIV/AIDS are great, moderate, small, or no risk at all?	Great Moderate Small No risk at all Decline/Refuse Don't know		1 2 3 4 6 8	 131 131
130	Why do you think that you have no risk/a small chance of getting HIV/AIDS? **Record all mentioned**	Abstain from sex Infrequent sex Use condoms Have only one sex partner Limited No. of sex partners Partner has no other parts. No blood transfusion No injections Other_____ (specify) Don't know		Sim 1 1 1 1 1 1 1 1 1 1	Não 2 2 2 2 2 2 2 2 2 2
	Confira: 129 Has great/moderate chances of getting HIV	↓	No/small Chances of getting HIV/AIDS	→	131a
131	Since you first heard of AIDS, what did you do to prevent being infected? **(Record all mentioned)**	Stopped all sexual activities Started using condoms Restricted sex to one partner Reduced number of partners Asked partner to be faithful Stopped injections Other_____ (specify)		Sim 1 1 1 1 1 1 1 1	Não 2 2 2 2 2 2 2 2
131a	Have you ever thought to be tested?	Yes,I have done already Yes, but I did not do yet No NR/refuse		1 2 3 8	 132
131b	If your partner or your best friend invited you to be tested, would you accept to	Yes, I would No, I am afraid to know my serostatus No, I am sure that I am not infected No, I do not need NR/refuse		1 2 3 4 8	

SECTION 5: KNOWLEDGE, ATTITUDES AND BELIEFS

	Now, I would like you to say if you agree, disagree or you have mixed feelings/ opinion about the following statements:	Agree 1	Mixed/No opinion 2	Disagree 3	
132	a) A person can get HIV/AIDS by having sexual intercourse with a condom.				
	b) A person can get infected with HIV/AIDS by getting injections with a clean, sterilized needle				
	c) A person can get infected with the HIV/AIDS through mosquito bites				
	d) A person who looks healthy can be infected with the HIV/AIDS				
	e) People can protect themselves from the HIV/AIDS by using a condom correctly every time they have sex.				
	f) People can protect themselves from getting infected by HIV/ AIDS by having one uninfected sex partner who also has no other sexual partners.				

SECTION 6: CONDOMS

No	Questions and Filters	coding Categories			Skip
133	Have you ever heard of condoms?	Yes No		1 2	 139
134	Do you know of a place where one can get condoms?	Yes No		1 2	
135	How confident are you that you could get a condom if you needed one?	Very confident Somewhat confident Not confident Never used		1 2 3 4	
136	How confident you feel that you know how to use a condom effectively?	Very confident Somewhat confident Not confident Never used		1 2 3 4	
	Now, tell me if you agree or disagree with the statements below.	Agree 1	Mixed/No opinion 2	Disagree 3	
137	a) Using condoms reduces sexual pleasure				
	b) A woman loses a man's respect if she ask him to use a condom				
	c) The man has greater influence than the woman over whether or not to use condom. d) Using condoms is an effective way of preventing HIV/AIDS				
	e) Condoms encourage promiscuous behaviour				
	f) Using condoms is an effective way to prevent pregnancy				
	g) The only reason to use a condom is because you don't trust your partner				

	Now, say whether is it acceptable or unacceptable for you the following statemen	Acceptable 1	Mixed/No opinion 2		Unaccepta 3	
138	a) Is it acceptable or unacceptable for a married couple to use a condom?					
	b) Is it acceptable or unacceptable for a married woman to ask her husband to use a condom?					
	c) Is it acceptable or unacceptable for a woman who is not married to ask her partner to use a condom?					
	d) Is it acceptable or unacceptable to use a condom with someone at the beginning of a relationship					

SECTION 7: PREGNANCY PREVENTION

No	Questions and Filters	coding Categories				Skip
	And, in relation to the following statements, do you agree or disagree with them or you have a mixed feelings, or even no opinion at all?	Agree 1	Mixed/No opinion 2		Disagree 3	
139	a) It is the woman's responsability to use a method to prevent and/or delay pregnancy					
	b) Family planning leads to promiscuous behaviour					
	Now, say whether is it acceptable or unacceptable for you the following statemen	Acceptable 1	Mixed/No opinion 2		Unaccepta 3	
	c) It is acceptable for a couple to use a method to space between births					
	d) It is acceptable for a couple to use a method to have no more children					
	e) It is acceptable for a man to propose using a method to his partner					
	f) It is acceptable for a woman to use a method without telling her partner about it					

SECTION 8: COMMUNICATION AND GENDER/POWER RELATIONS

No	Questions and Filters	coding Categories			Skip
140	Some couples find it difficult to talk about sex while others do not. Is it difficult to talk about sex, somewhat difficult, or not difficult to talk about sex with your female partner?	Very difficult Somewhat difficult Not difficult NR/Refuse	1 2 3 8		
141	Aside from your sexual partner, do you talk to anyone else about sex?	Yes No Other _____ (specify)	1 2 6		143
142	Who do you talk to about sex? **Circle all mentioned**		Sim	Não	
		Mother	1	2	
		Father	1	2	
		Sister	1	2	
		Sister-in-law	1	2	
		Brother	1	2	
		Other female relative	1	2	
		Other male relative	1	2	
		Male friend/Neighbor	1	2	
		Female friend/Neighbor	1	2	
		Religious leader	1	2	
		Health worker	1	2	
		Other _____ (specify)	1	2	
143	In your sexual relationships, who has more influence over whether or not to hav sex: you, your partner or both?	Respondent Partner Both NR/Refuse	1 2 3 8		
144	In your sexual relationships, was there a time when your partner wanted to have sex and you did not?	Yes No NR/Refuse	1 2 8		148
145	When that happened, did you let your partner know that you did not want to have sex?	Yes No	1 2		148

146	How did you let her know this?	Told her I did not want sex Told her I was sick Told her I was tired Showed unwillingness Other _____ (specify)	1 2 3 4 6	
146a	Even though, have you had sex?	Yes No NR/Refuse	1 2 8	148
147	What was the main reason for having sex although you did not want to?	He persisted/persuaded her He threatened her She was afraid to refuse She wanted to please him It's wrong refusing sex for a partner He has more authority Other _____ (specify)	1 2 3 4 5 6 7 8	
148	In your relationship, was there a time when you wanted to have sex and your partner did not?	Yes No NR/Refuse	1 2 8	150
148a	Even though, have you had sex?	Yes No NR/Refuse	1 2 8	150
149	What made her decide to have sex though she did not want to?	She persisted/persuaded him She threatened him He was afraid to refuse He wanted to please her It's wrong refusing sex for a partner She has more authority Other _____ (specify) Don't know	1 2 3 4 5 6 7 8	
150	How often do you jointly discuss your sexual life?	Always/frequently many times Sometimes Rarely Never NR/Refuse	1 2 3 4 5 8	
151	Has your sexual partner had sexual practices that you don't like, but you think/feel you cannot refuse?	Yes No NR/Refuse	1 2 8	153
152	can you tell me, <u>at least three</u> of such sexual practices? **Recor all mentioned)**	Oral sex Anal sex Others _____ (especify) _____ NR/Refuse	1 2 8 88	
153	Can you point out at least <u>three qualities</u> (positives aspects)of your partner that like so much	1. _____ 2. _____ 3. _____ 4. nothing it pleases me NR/Refuse	 96 98	
154	Now, can you point out at least three imperfections (negatives aspects) that you don't like on her	1. _____ 2. _____ 3. _____ 4. Nothing it is unpleasant NR/Refuse	 96 98	

155	Have you ever had sexual intercourse when somebody was physically forcing y hurting you, or threatening you?	Yes No	1 2	 157
156	Would you say you have had forced sex often/frequently, sometimes/rarely or never?	Often/frequently Sometimes/rarely Never	1 2 3	
		RN/Refuse	8	
157	Have you ever given/received anything from someone so they would have sex v	Yes No Don't know/don't remember NR/Refuse	1 2 6 8	
157a	Have you ever given/received anything to/from somebody in order to have sex v	yes, many times/always Yes, sometimes/rarelly Never RN/Refuse	1 2 3 8	 159
158	What did you give/rece **(do not read out!)** **Cycle all mentioned** **If Respond "Yes", probe for type of gift.**	Money Food School fees Help with school work Drugs Shelter/rent Clothes Transport Jewelry Entertainment Other _____ (Specify)	1 2 3 4 5 6 7 8 9 10 96	

	Now, tell me if you agree or disagree with the statements below.	Agree 1	Mixed/No opinion 2	Disagree 3	
159	a) Very few men in this area (Matola city/Manhica district) changed their behaviour because of HIV/AIDS				
	b) If a wife gets HIV or STI from outside the marriage, there is nothing the husband can do to avoid getting infected himself				
	c) A man needs to have more than one partner				
	d) A man can be satisfied with only one partner				
	e) It is acceptable for a husband to force his wife/partner to have sex with him				

	Now, tell me if you agree or disagree with the statements below.	Agree 1	Mixed/No opinion 2	Disagree 3	
160	a) Women want to be guided in sex by a sexually experienced men.				
	b) Women are more concerned in pleasing their partners during sex, than themselves.				
	c) Sex between man woman tend to stop when he ejaculates (he had an orgasm)				
	d) Women find it difficult to tell their partners what dislike sexually				
	e) Women find it difficult to tell my partner what I find sexually enjoyble				
	f) men prefer women who are less assertive and who like men taking the initiative .				

SECTION 9: MULTIPLE PARTNERSHIPS

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Record the time	Hour Minutes	
	It sometimes happens that men and women have sexual relations with partners other than their *regular partners*. Now, I am going to ask about the three most recent sexual partners in the last 12 months. This includes anyone you might have had sex with, for instance a friend, or casual partner, that is, someone you might have met at a bar, wedding, special event, etc., even your spouse (regular partner).		
161	In total, how many partners have you had sexual intercourse with, in your whole entire life?	Number of partners RN/Refuse 98	
162	How many partners have you had sex with, in the last 12 months?	Number of partners No partners in the last 12 months 0 NR/Refuse 96	
163	Think about your more recent sexual partner. How would you describe this partner?		
	PARTNER 1 (most recent)	PARTNER 1 (most recent)	PARTNER 1 (most recent)
	Spouse/regular partne 1 casual acquaintance 2 Sponsor 3 Friend 4 Ex/partner 5 Relative 6 Client 7 Other ___ _____ 96 (specify)	Spouse/regular partne 1 casual acquaintance 2 Sponsor 3 Friend 4 Ex/partner 5 Relative 6 Client 7 Other ___ _____ 96 (specify)	Spouse/regular partner 1 casual acquaintance 2 Sponsor 3 Friend 4 Ex/partner 5 Relative 6 Client 7 Other _____ _____ 96 (specify)
164	What is/was their sex?		
	PARTNER 1 (most recent)	PARTNER 2 (second most recent)	PARTNER 3 (third most recent)
	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
165	How old is/was this partner		
	PARTNER 1	PARTNER 2	PARTNER 3 PARTNER 3
	Older 1 Younger 2 Same age 3 don't know 98	Older 1 Younger 2 Same age 3 don't know 98	Older 1 Younger 2 Same age 3 Don't know 98
166	Is he/she still your sexual partner?		
	PARTNER 1	PARTNER 2	PARTNER 3
	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2
167	Have you had a child with this partner?	Check **164: Female partner** ↓	**Male partner** → **169**
	PARTNER 1	PARTNER 2	PARTNER 3 PARTNER 3
	Yes 1 No 2	Yes 1 No 2	Yes 1 No 2
168	Do you want to have a child with this partner?		
	PARTNER 1	PARTNER 2	PARTNER 3 PARTNER 3
	Yes 1 No 2 unsure 3	Yes 1 No 2 unsure 3	Yes 1 1 No 2 2 unsure 3 3

169 For how long have you had sexual relationship with this partner?

PARTNER 1 (most recent)		PARTNER 2 (second most recent		PARTNER 3 (third most recent)	
Less than a year	1	Less than a year	1	1 Less than a year	1
One year or more	2	One year or more	2	2 One year or more	2
NR/Refuse	8	NR/Refuse	8	88 NR/Refuse	8

170 Do you think this partner had other partners?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2
don't know	8	don't know	8	don't know	8

171 Have you ever asked your partner about the number of past sexual partners he/she had?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2
don't know	8	don't know	8	don't know	8

172 have you ever told your partner about the number of past sexual partners you had?

PARTNER 1		PARTNER 2		PARTNER 3	
Yes	1	Yes	1	Yes	1
No	2	No	2	No	2
don't know	8	don't know	8	don't know	8

173 Have you ever used a condom with this partner?

PARTNER 1			PARTNER 1			PARTNER 1			PARTNER 1		
Yes	1	175	Yes	1	175	Yes			Yes	1	175
No	2		No	2		No			No	2	
don't know	8		don't know	8		don't know			don't know	8	

174 How confident are you that you could convince her that he should use a condom if you wanted to use one?

PARTNER 1		PARTNER 2		PARTNER 3	
Very confid	1	Very confid	1	Very confident	1
Fairly confi	2	Fairly confi	2	Fairly confident	2
Not confide	3	Not confide	3	Not confident	3

175 Have you ever *a conversation* (discussed) with your partner about whether or n a condom?

PARTNER 1			PARTNER 1			PARTNER 1	PARTNER 1		
Yes	1	**177**	Yes	1	**177**	Yes	Yes	1	**177**
No	2		No	2		No	No	2	
Don't know	8		Don't know	8		Don't know	Don't know	8	

176 What is the main reason that you have not *a conversation* (discussed) using a condom?

	PARTNER 1		PARTNER 2	PARTNER 3	
1 Never used	1	Never used	1	Never used	1
2 Don't want to use a co	2	Don't want to use a co	2	Don't want to use a condom	2
3 Don't need to use a co	3	Don't need to use a co	3	Don't need to use a condom	3
4 Embarrassed/Shy	4	Embarrassed/Shy	4	Embarrassed/Shy	4
5 Afraid	5	Afraid	5	Afraid	5
6 He will think I'm promi	6	He will think I'm promi	6	He will think I'm promiscuous	6
7 He will think I don't tru	7	He will think I don't tru	7	He will think I don't trust her	7
8 He doesn't like condon	8	He doesn't like condon	8	He doesn't like condom	8
98 Don't know	98	Don't know	98	Don't know	98
96 Other_____ (specify)	96	Other_____ (specify)	96	Other_____ (specify)	96

The last time you had sex with, did you or your partner use a condom?

PARTNER 1			PARTNER 2			PARTNER 3		
Yes	1		Yes	1		Yes	1	
No	2	**181**	No	2	**181**	No	2	**181**

What was the main reason you used a condom? **(do *not* read options)**

	PARTNER 1	PARTNER 2	PARTNER 3	PARTNER 3
1.Own concern to prevent pregnancy	1	1	1	1
2. Own concern to prevent STI/HIV/AIDS	2	2	2	2
3. Own concern to prevent pregnancy and STI/HIV/AIDS	3	3	3	3
4. Did not trust partner/feels partner has other partners	4	4	4	4
5. Partner insisted/partner choice	5	5	5	5
6. Other (specify) _____	6	6	6	6
7. Don't know	98	98	98	98

The last time you had sex, who made the decision to use a condom?

PARTNER 1		PARTNER 2		PARTNER 3	
Self	1	Self	1	Self	1
Partner	2	Partner	2	Partner	2
Both	3	Both	3	Both	3
Other (Specify)_____		Other (Specify)_____		Other (Specify)_____	
_____	4	_____	4	_____	4
Don't know	98	Don't know	98	Don't know	98

How often do/did you use a condom with this partner?

PARTNER 1		PARTNER 2		PARTNER 3	
Always	1	Always	1	Always	1
Usually	2	Usually	2	Usually	2
Sometimes	3	Sometimes	3	Sometimes	3
Rarely	4	Rarely	4	Rarely	4
Never	5	Never	5	Never	5

The last time you had sex with, did you or your partner use or do something to prevent pregnancy?

PARTNER 1			PARTNER 2			PARTNER 3		
Yes	1		Yes	1		Yes	1	
No	2	→ **End**	No	2	→ **End**	No	2	→ **End**

Which method did you use?

	PARTNER 1	PARTNER 2	PARTNER 3	
1. Pill	1	1	1	1
2. IUD	2	2	2	2
3. Injections	3	3	3	3
4. Diaphragm/Foam/Jeley	4	4	4	4
5. Condom	5	5	5	5
6. Female condom	6	6	6	6
7. Traditional method/herbs	7	7	7	7
Specify_____				
8. Non penetrative sex	8	8	8	8
9. Safe days/Abstinence	9	9	9	9
96. Other _____ (Specify)	96	96	96	96

The last time you and your partner had sex, who made the decision to use anything to avoid pregnancy?

PARTNER 1		PARTNER 2		PARTNER 3	
Self	1	Self	1	Self	1
Partner	2	Partner	2	Partner	2
Both	3	Both	3	Both	3
Other (Specify)_____		Other (Specify)_____		Other (Specify)_____	
_____	4	_____	4	_____	4
Don't know	98	Don't know	98	Don't know	98

RECORD THE TIME

HOUR

MINUTES

OBSERVA OBSERVATIONS:

THANK YOU VERY MUCH!

INFORMED CONSENT FORM

My name is MANUEL MACIA from the Eduardo Mondlane University, here in Maputo, Mozambique, and University of KwaZulu Natal in Durban, South Africa. I, and a group of four assistants (2 males and 2 females) headed by myself, we are interviewing people of both sexes aged 20 to 49 years old, married or not, but who might have an experience of having a sexual partners in their life. The interviews are part of a research study which aims to gain a better understanding of the sexual behaviour and protective practices of men in the context of high levels of HIV infection in Mozambique. I would like to ask you to participate in this study.

I am going to ask you some personal questions. Some of the questions may be embarrassing or upsetting. Your answers are completely confidential. All information will be strictly confidential and no one will see it except the study team. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. You will not receive any money for your participation in the study. However, your honest answers to these questions will help us better understand what people like you think, say and do.

We would greatly appreciate your help in responding to this study. It will take about 45 minutes to 1 hour to answer the questions. Please note that everything you say will be kept private.

Do you have any questions about the purpose of the study or your participation?

Do you agree to be interviewed today?
(1) Yes
(2) No

If you have any questions about the study please feel free to contact the Eduardo Mondlane University Scientific board by telephone n◦ _____, and Dr. Pranitha Maharaj of the University of KwaZulu Natal (tel: (031- 260 2243).

Study Participant's Statement

I have been given an opportunity to ask any questions I may have, and all such questions or inquiries have been answered to my satisfaction. I further understand that my records will be kept confidential. I have been informed orally and in writing of whom to contact in case I have any questions.

I agree to participate in this study as a volunteer.

_____

Date
Signature of Study Participant