

Women, HIV AND AIDS: Perceptions of the female condom among students on UKZN Howard college campus.

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ETHICAL CLEARANCE NO: HSS/0353/012M

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Thesis presented in fulfillment of the Degree of Master of Social Science, in
The Centre for Communication, Media & Society, School of Applied Human
Sciences, University of KwaZulu-Natal, Howard College, Durban, South
Africa.

COLLEGE OF HUMANITIES

DECLARATION - PLAGIARISM

I,, declare that

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Signed

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ACKNOWLEDGEMENTS

I would like to thank my supervisor, Eliza Govender for her support and assistance throughout the period of studying and working towards this degree. She has been of immense support in my academic success and confidence. I also would like to thank Professor Keyan Tomaselli, Dr Lauren Dyll-Myklebust, Dr Nyasha Mboti, Mary Lange and Mike Maxwell. You all contributed to the success of my academic undertaking in different ways and taught me how to think out of the box; this is the result of all you have taught me.

My deepest gratitude goes to my parents Professor and Dr (Mrs) Ogunlela. You have given me so much, prayed for me and had faith in my ability to pursue a Masters degree. God will grant you longer days to reap that which you have sown. I also thank my siblings, Mrs Olufunke Adekayode, Mr Ayodele Ogunlela and Mr Olugbenga Ogunlela; you were my pillars of strength. I extend my gratitude to Mr Ademola Adekayode, who has been so supportive and made me feel more of a brother than an in-law; God will enlarge your coasts and your family.

Mr and Mrs Akin Lot; thank you for everything you have done for me in South Africa. With you, I found a home away from home and you showed me love that I truly can't explain. To Mr & Mrs Popoola, I will forever be thankful to God that I found friends who later became family to me. I appreciate you all, especially Simisola.

To my colleagues with whom I fought this 'War', I say kudos for remaining strong soldiers in this academic accomplishment. I specially want to thank Prestage Murima, Duduzile Zwane, Precious Gumede, Nzokhule, Siyasanga Tyali, Luthando Ngema, Sandisa Nyokana, Musara Lubombo, Diana and Nyasha Muza, Paidamoyo Gomo, Phoebe Mboti and Enhle Malinga. You all have supported me in numerous ways and I look forward to sharing the good news of the greatness that is yet to come.

Last, but not least, I would like to thank someone special who brought so much positive energy and was my pillar of strength. Gwendolene Cimuka Hankwebe, I truly lack the words to express how wonderfully supportive you have been. God will reward you a hundred fold for everything.

Finally, my greatest gratitude goes to God who granted me success and strength. To Him I return all the glory and thanks for His endless love.

ABSTRACT

Unprotected heterosexual intercourse is the major cause of the transmission of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS); however people still engage in unsafe sexual practices. Much research has therefore focused on preventive approaches and barrier methods to combat HIV and AIDS. Global HIV and AIDS statistics show that women are worst affected, leading researchers and non-governmental organizations to design interventions and programs to prevent HIV infection among women. Female condoms, also known as femidom, are effective and safe in preventing HIV if used consistently. The cost of the first generation female condom, FC1 led to slow uptake, resulting in the production of the more cost-effective second generation female condom, FC2. However, studies show that the FC2 is underutilized for a number of reasons beyond cost, including availability, reduced sexual pleasure, gender inequality and culture.

There is a paucity of literature on perceptions of the female condom (Callender, 2012). This study sought to address this gap by accessing perceptions of the female condom among students on the University of KwaZulu-Natal (UKZN)'s Howard College campus. This research study adopted an interpretive paradigm and employed mixed methods of research, both quantitative and qualitative. The population/participants were drawn from male and female students at UKZN who reside in two residences on the Howard College campus, namely, John Bews and Pius Langa.

A non-probability snow ball sampling method was used to select a sample frame of 124 students comprising both female and male students. Questionnaires and focus group were used to gather data; a total of 100 questionnaires were administered and a focus group was conducted with eight participants in three separate sessions. The qualitative data gathered were analyzed using the Statistical Package for the Social Sciences (SPSS), which generated simple frequencies and percentages. The quantitative data was transcribed and analyzed through thematic analysis with the help of the NVivo10 qualitative data analysis package. Thematic analysis developed by Braun & Clarke (2006) was employed to create categories and emerging themes that were derived from the coding process. Paulo Freire's participatory development paradigm and the empowerment theory provided the conceptual framework within which the research is located. This enabled an exploration of how participatory approaches like focus group discussions create opportunities for participation. Kieffer's (1984) four stages of empowerment guided the data analysis within the framework of empowerment theory.

The study found that male students are more supportive of female condoms than female students. It also revealed that female students do not feel empowered by female condoms; this is as due to inadequate information and insufficient promotion of female condoms.

Furthermore, the findings revealed that the most common source of information about female condoms among students was friends, followed by the clinic. Media and billboards had minimal effect in providing information and awareness on the female condom. Students feel that culture does not influence condom (male or female) use; this could suggest a positive future for femidom use in South Africa.

ACRONYMS

ABC	Abstain, Be Faithful & Condomise
AIDS	Acquired Immunodeficiency Syndrome
CCMS	Centre for Culture, Communication and Media Studies
CDC	Centers for Disease Control and Prevention
CFPD	Communication for Participatory Development
DramAidE	Drama AIDS Education
FDA	Food and Drug Administration
FHI	Family Health International
HIV	Human Immunodeficiency Virus
NDoH	National Department of Health
PEPFAR	President's Emergency Plan for AIDS Relief
TVEP	Thohoyandou Victim Empowerment Programme
UKZN	University of KwaZulu-Natal
UNAIDS	The Joint United National Programme on HIV/AIDS
UNFPA	United Nations Population Fund

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CHAPTER ONE: INTRODUCTION

South Africa has the highest Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) infection rate in the world and has implemented the largest AIDS prevention program in the world in recent years (Human Sciences Research Council, 2009). The South African government and other stakeholders have made a firm commitment to combating the epidemic.

It is estimated that 40 million people are living with HIV and AIDS in sub-Saharan Africa. While the epidemic affects both men and women, 60 percent of new infections occur among women and girls (Avert, 2009). Women are generally at greater risk and are twice more likely to be infected than men through unprotected sexual intercourse.¹

It is important to note that some sub-Saharan African countries that exhibited high prevalence have reported a reduction in HIV incidence rates since 2001. These countries are Malawi (73%), Botswana (71%), Namibia (68%), Zambia (58%), Zimbabwe (50%), and South Africa and Zimbabwe (41%) (UNAIDS, 2012)². To maintain this momentum, there is a need to step up HIV prevention programs in the region, particularly in South Africa.

South Africa had an estimated population of 49.9 million people in 2010 (Statistics South Africa, 2010). The country is currently home to approximately 51 million people (Statistics South Africa, 2011).

¹ Women, HIV and AIDS-The global picture. Available from: <http://www.avert.org/women-hiv-aids.htm#contentTable0>
Accessed [2 March, 2012]

² UNAIDS(2012), press release. Available from:
<http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2012/november/20121120prresults/>
Accessed [3 December,2012].

Approximately 5.6 million people are living with HIV and AIDS in South Africa and it is estimated that 310,000 people have died from AIDS. The prevalence rate is 17.8% among people aged 15-49, with the 25- 34 age group, being most affected. The statistics also show that almost one in three women in the age group 25-29 is infected with HIV, as is a quarter of men aged 30-34 (Avert, 2009). Prevalence refers to pre-existing and new cases of a disease over a certain period of time (National Cancer Institute,)³.

The number of people living with HIV in South Africa increased from 4.21 million people in 2001 to 5.38 million in 2010. There are approximately 26.07 million women in South Africa and HIV prevalence is highest among women of reproductive age (15-49 years) (Statistics South Africa, 2011). A more recent data shows that the HIV incidence rates in South Africa have reduced by a third. The data reveals that the new infection rates dropped from 540000 in 2004 to 370000 in 2012 (UNAIDS 2014)⁴.

BACKGROUND TO STUDY

Women, HIV and AIDS in South Africa

The fact that most sexual relationships in Africa are controlled by men is one reason for the increase in HIV and AIDS prevalence among women regardless of their knowledge about the epidemic (Ngubane, 2010).

³ Cancer prevalence overview statistics. Available from: <http://surveillance.cancer.gov/prevalence/> Accessed [29 october,2013].

⁴ UNAIDS (2014). New HIV report finds big drop in new HIV infections in South Africa. Available from: <http://www.unaids.org/en/resources/presscentre/featurestories/2014/january/20140117southafrica/> Accessed 6 Februrary,2014].

The apartheid system entrenched patriarchy and repression that supported men's dominance in heterosexual relationships and reinforced traditional gender roles where women are seen to be passive and vulnerable and masculinity is associated with power, control and violence; all of which increase women's vulnerability to HIV and AIDS (Shefer, 2005, Patton, 2004; SANSP 2010).

Traditional laws also have suppressed women and made them dependent on men for economic survival. Women's vulnerability is heightened by limited access to education and social norms that deny them healthy sexual practices and control over their sexuality (Aphane, 2005, Orege 2005).

HIV and AIDS is a major public health issue, especially for women and interventions are required to reduce prevalence among women (Jemmott & Brown, 2003). There are various barrier methods for preventing HIV, including the male condom and female condom. Female-initiated preventative measures have great potential to help women combat the spread of HIV and AIDS. The most widely available and familiar prevention method for women is currently the male condom. However, studies have revealed that only a small fraction of people who engage in heterosexual intercourse actually use condoms and that women do not have the ability to negotiate their use as a result of gender inequalities (Catiana et al., 2001; Harvey et al., 2003).

It is clear that condoms alone do not empower women and that the high HIV prevalence rate among women calls for a method that can empower women and place them in charge (Stein, 1990). The earliest HIV prevention methods for women were mechanical and chemical

barriers, namely, the diaphragm and microbicides gel. A diaphragm is a silicone shaped cup with a flexible, shallow ring that a woman inserts into her vagina to cover the cervix (Planned Parenthood)⁵. Microbicides gel is a compound that is applied into the vagina to prevent Sexually Transmitted Infections (STIs) and HIV (World Health Organization)⁶.

A number of empirical studies have been conducted to ascertain whether these methods prevent HIV infection. A study by the Methods for Improving Reproductive Health in Africa (MIRA) found that the diaphragm and gel provide no protection against HIV. They are classified as dual methods of prevention when both are used at the same time (Bird et al., 2004). A study on the diaphragm, lubricant gels and condoms found that male condom use at last sexual intercourse was more prevalent than the use of the diaphragm and gel (Harvey et al., 2003).

Problem Statement

Studies in South Africa have revealed that women were more interested in the diaphragm and gel than the female condom solely because they can be used covertly without the knowledge of their male partners (Terris-Prestholt et al., 2006; Buck et al., 2005). However, Jemmott & Brown (2003) argue that, while some women prefer female condoms as this puts them in charge and takes almost the same time to use as the male condom, the cost of the female condom deters take up rates. Marseille & Kahn (2008) note that the female condom is not promoted via the mass media, but only through partnerships with the National Department of

⁵ The diaphragm at a glance. Available from: <http://www.plannedparenthood.org/health-topics/birth-control/diaphragm-4244.htm> Accessed [29 October, 2013].

⁶ World Health organization-Microbicides Available from: <http://www.who.int/hiv/topics/microbicides/microbicides/en/> Accessed [29 October,2013]

Health (NDoH) for distribution. A lack of exposure to female condoms can result in low demand and uptake among women.

The need for this study is based on Olive Shisana and Julia Louw's (2007) observation that, while global statistics indicate the severe impact of HIV and AIDS on women, they are not included in practical approaches and studies to combat the spread of HIV. They note that, "Experiences in HIV/AIDS research, programming and policy indicate that globally we are 'missing the women'" (Shisana & Louw, 2007:29). They add that the Human Sciences Research Council (HSRC) and Social Aspects of HIV and AIDS Research Alliance (SAHARA) have emphasized the need to explore why women are 'missing' in HIV and AIDS research and policy programs and to seek and implement ways to ensure that women are involved and actively participate in work on HIV and AIDS. Above all, there is a need to identify how women can protect themselves from HIV and AIDS.

This study examines perceptions of the female condom among students at the University of KwaZulu-Natal (UKZN), Howard College campus. It builds on earlier studies conducted with specific reference to Abstain, Be faithful and Condomise (ABC) message, voluntary counseling and testing (VCT) campaigns and student involvement in HIV message design at UKZN carried out by Eliza Moodley (2007), Abraham Mulwo (2008), Lengwe John-Eudes Kunda (2008) and Given Mutinta (2012).

These studies focused on various aspects including students' perceptions, meaning creation and communication of the ABC strategy in the reduction of HIV and AIDS. They serve as a baseline study that provided in-depth understanding of UKZN students' perceptions of HIV

and AIDS. However, these studies did not address the specific needs of women, and the use of female condom for safer sexual practices.

This study therefore builds on various studies conducted at UKZN by assessing awareness of female condoms among male and female students and comparatively assessing female and male students' perceptions of female condoms. The study also seeks to ascertain whether or not women feel empowered by the introduction of the female condom and to identify existing modes of communication around female condoms. The study is located within the overarching concept of participatory development and draws on empowerment theory. Participatory development emphasizes participatory approaches to stimulate dialogue that enables people to be actively involved in processes that affect their lives.

Research questions

The main research question for this study relates to students' (male and female) perceptions of the female condom. The study also seeks to establish whether or not women feel empowered by the introduction of the female condom and to examine existing forms of communication to promote the female condom. This will enable the identification of participants' sources of information on the female condom.

Structure of Dissertation

Chapter one outlined statistics relating to the HIV and AIDS epidemic in South Africa, particularly in relation to women. It summarized the purpose of the study and the research questions it addresses and provided an outline of the structure of the dissertation.

Chapter two presents a literature review on various issues, including health communication, ABC messages, women empowerment, women and HIV and AIDS, and the female condom.

Chapter three presents the theoretical framework of the study and the conceptual and theoretical approach that guides and informs this study.

Chapter four discusses the research methodology employed, including the methodological approach and the rationale/motivation for selecting this approach. It also presents the challenges/limitations of the study.

Chapter five presents and analyzes the quantitative data collected by means of the survey.

Chapter six presents; analyzes and interprets the qualitative data gathered through the focus group. Thematic analysis is used to understand women students' perceptions of female condoms.

Chapter seven presents the conclusion and recommendations emanating from the study.

The following chapter presents a review of the relevant literature.

CHAPTER TWO: LITERATURE REVIEW

Introduction

A substantial body of literature exists on HIV prevention. This chapter explores the relevant literature on health communication, HIV and AIDS communication Abstinence Be Faithful and Condomise (ABC) messages, perceptions of condom use among university students, new approaches to HIV prevention, women, HIV and AIDS, women empowerment, the female condom in South Africa and the future of female condoms. The discussion on the importance of health communication provides a framework for understanding perceptions of female condoms. It sets the scene for an examination of HIV and AIDS communication and the ABC approach to HIV prevention, as well as some of the critiques of the ABC approach and alternative approaches to HIV prevention such as the SAVE & GEM approaches which are briefly discussed later in the chapter.

Scholars have pointed to the need to formulate new approaches to HIV prevention to address gender inequality and to empower women to negotiate condom use or safer sex practices. A review of the literature on women empowerment and debates around female condoms highlights the challenges women experience in negotiating condom use. The latter sections of this chapter address issues relating to the introduction of the female condom as a method designed to empower women in negotiating safer sex, the barriers and challenges to its uptake and use and the future of female condoms. There is a paucity of literature on perceptions of female condoms; this study addresses this gap and critically analyzes the studies that have been conducted on this issue.

HEALTH COMMUNICATION

Health communication is an essential means of reaching out to patients, and people (students) in general about health-related issues like HIV and AIDS. However, successful communication requires a strategic and planned approach with appropriate media to convey messages that take people's culture, tradition and beliefs into account (Marks, 2002; Northouse & Northouse, 1992).

Chronic diseases and viruses like HIV require adequate communication between health practitioners and the public. Health communication involves the implementation of communication strategies to enlighten and influence people's decisions to improve or enhance their health. It has been defined as "the art and technique of informing, influencing and motivating individuals, institutional and public audiences about important health issues" (Parrot, 2004:751). Parrot (2004) adds that health communication includes the prevention of diseases and a general improvement in the health and lives of individuals. The National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC) define health communication as "the study and the use of communication strategies to inform and influence individual and community decisions to enhance health"⁷.

Taking the aforementioned definitions into consideration, health communication is the planned communication of health messages designed to motivate and improve the health standards and conditions of people or a target audience. It further involves the use of "discussion groups, posters, handouts, public service announcements, discussion groups, work place or clinic-based counseling" (Synder, 2007:32).

⁷ [Gateway to Health Communication & Social Marketing Practice](http://www.cdc.gov/healthcommunication/HealthBasics/WhatIsHC.html). Available from: <http://www.cdc.gov/healthcommunication/HealthBasics/WhatIsHC.html> [Accessed 14 June, 2012]

Health communication has the potential to give people the courage and strength they require to talk about HIV and AIDS. It enhances their ability to live normally and enjoy optimal health outcomes (Thorne et al., 2004). Rauf (2010), states that people who are not exposed to factual and accurate information on HIV and AIDS are at greater risk because they do not have the skills, support and encouragement to engage in healthy and safer sex practices. Addressing issues relating to female condoms falls under the broader scope of health communication as it provides factual and relevant information on what people think about the uptake and use of female condoms (Coleman & Ball, 2010).

HIV AND AIDS COMMUNICATION

Communication channels

Health communication can cover a range of health, diseases and prevention issues. For the purpose of this study, the discussion on health communication will focus on HIV and AIDS with regards to women. A number of health communication campaigns in South Africa have addressed various issues relating to HIV and AIDS, including prevention, treatment, care and support and voluntary counseling and testing (VCT). This review focuses on communication relating to HIV prevention. A health communication campaign that is carried out using at least one form of media is referred to as a mediated health communication campaign (Synder, 2007). Mass communication channels like radio, television and the internet have been very effective in reaching large mass audiences; a combination of mass media and interpersonal channels can yield effective health communication results (Mckee, Bertrand & Benton, 2004).

As noted earlier, there has been widespread implementation of health communication interventions to address HIV and AIDS-related issues in South Africa (Govender, 2011).

One of the most popular mediums is television, as more than half the population has access to television (Shisana et al., 2008). Popular media-based communication on HIV and AIDS in South Africa includes *Soul City*, *Tsha Tsha*, & *Khomonani* (Govender, 2011).

Soul City was the pioneer public health communication television series in the country, and offered the first series that addressed issues specifically relating to HIV and AIDS (Dagron & Tufte, 2006). A more recent drama-based television series, *InterSEXions* is a creative approach to using TV as a medium to bring about change in people's lives. Each episode tackles different issues, namely, HIV Counseling & Testing (HCT), open and honest discussion within relationships, reducing multiple and concurrent partnerships as a strategy to prevent HIV infection, an increase in uptake and consistent condom use (Ogunlela, 2012). *InterSEXions* addresses many of the key challenges facing young women identified by several HSRC studies (Shisana et al., 2005, 2007 & 2008). Television series are effective in addressing health communication issues because they use a combination of characters and plots and consistently emphasize the key problem (HIV&AIDS) from different perspectives (Brown,1994).

In countries like the United States, television has been used to promote the early detection of cancer using patients who have survived cancer as members of the cast in different episodes of a program. It has been reported that this resulted in more people voluntarily undergoing mammograms and breast examinations (Erwin et al., 1999). It is clear, therefore, that health communication interventions, particularly through mass media, influence the audience's behavior (Coertze 2011, Singhal and Rogers 1999).

HIV and AIDS communication is not limited to mass media applications but extends to more participatory-based approaches such as the use of theatre and drama to promote positive behavioral outcomes. An example of this the approach is the work of Drama in AIDS Education (DramAidE), an organization that works in communities, schools and tertiary institutions in South Africa. DramAidE communicates information about HIV and AIDS using a Freirean-based methodology that seeks to engage people in critical dialogue using theatre, role play and drama (Nduhura, 2004; Durden & Nduhura; 2011; Botha & Durden 2004).

The above discussion suggests that health communication yields optimal results when established across different communication channels that reach out to specific audiences with appropriate and relevant health information (Maibach & Parrott, 1995).

While communication channels for HIV and AIDS information have now advanced to offer an integrated or mixed method approach to messaging using mass media and interpersonal communication, the actual HIV message has also undergone transition and development. An earlier, successful HIV messaging initiative is the work on HIV prevention in Uganda. The country's success in reducing HIV and AIDS infections is attributed to the promotion of ABC (Singh et al., 2003). This led to this approach being extensively adopted in sub-Saharan Africa and other parts of the continent (AVERT, 2009).

Communication messages: Origins of the ABC approach

Sexual intercourse is one of the key modes of HIV transmission. Prior to the ABC approach various organizations like the World Health Organization (WHO), the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the United States President's Emergency Plan

for AIDS Relief (PEPFAR) were involved in HIV prevention programs. They provided health communication materials with information on abstinence, fidelity and the use of condoms to prevent the sexual transmission of HIV (Population Action International, 2008).

In 1994, a Tanzanian sought to effectively communicate the HIV prevention message by formulating a visual representation of the ABC approach which he called 'fleet of hope' (Population Action International, 2008). The representation showed the AIDS epidemic as a flood with people drowning. The survival options were three boats representing, abstinence, fidelity and condom use; the boats were linked to each other by a bridge which depicts that any of the lifesaving options are equally possible and helpful and can therefore be adopted to prevent HIV and AIDS. This strategy was adopted in many countries, especially in sub-Saharan Africa⁸. This is one of the many examples of attempts to communicate HIV prevention options in the region.

During the 1980s, the Ugandan government launched information campaigns on the sexual transmission of HIV that mainly focused on youth abstinence and fidelity. Due to the increased rate of HIV prevalence in the country, in the 1990s the promotion of condoms became more acceptable to the government and a multi-sector response around the ABC approach made a remarkable change in the acceptance and application of the approach⁹. An overall view of the ABC in Uganda was contained in the Guttamacher report. Surveys conducted in 1988, 1995 and 2000 on the ABC approach in Uganda were reviewed and the

⁸ Journey Of Hope Experiential Learning Activities for Making Positive Life Choices in the Time of AIDS Pandemic. Available from: <http://www.ponline.org/ics-wpd/mmc/media/PLMAL36.pdf> Accessed on [June 26, 2012].

⁹ ABC Guidance #1 (Abstinence, Be Faithful, and correct and consistent Condom use) Available from: <http://www.state.gov/s/gac/partners/guide/abc/> Accessed on [27 March, 2012].

findings revealed that all three components of the ABC messages were effective and contributed to reducing exposure to HIV (Singh, Darrock & Bankole, 2003; Moodley, 2007; Mulwo, 2008).

However, a number of critics claimed that the promotion of sexual abstinence was the reason for Uganda's success in reducing HIV prevalence and that the effect of the ABC approach was over emphasized (Mulwo, 2008). These contradictory perspectives on Uganda's ABC initiative suggest that both the ABC approach and the promotion of sexual abstinence could have played a key role in the decline in HIV prevalence. The Ugandan president at the time had a different perception and argued that the promotion of condoms had a role to play in HIV reduction, especially in HIV positive couples. However, it cannot be said that condom use is the major cause of the reduction in HIV prevalence in Uganda (Stammers, 2005).

It is clear that several factors contributed to the reduction in the HIV prevalence rate in Uganda. These factors range from awareness about HIV to a well-coordinated campaign that attracted support from all sectors, private and public, schools, religious bodies, employers and labor organizations (Mulwo, 2008).

In Malawi an article condemned the ABC approach and called it 'a disaster in Africa'.¹⁰ The article highlighted that despite the ABC approach having played a key role, the 'D' factor, which stands for death, accounted for most of the reduction that was recorded; none of these factors worked independently or in isolation (World Association of Christian Communication).

¹⁰ The ABC D isaster. Available from: <http://archive.waccglobal.org/wacc/content/pdf/3024> Accessed [21 May, 2012].

Despite reservations concerning the ABC approach, “in the light of the escalating epidemic this slogan has been reinterpreted and transposed into more complex strategies notably by PEPFAR which has its source of funding from United States Agency for International Development (USAID)” (Kunda, 2008:54). This could suggest that PEPFAR provided a new definition of the original ABC approach; this is discussed in the following section. In light of another argument, the basis for the decline in HIV in Uganda is said to be far from the adoption of ABC approach. HIV reduction is not as easy as merely adopting the ABC approach and there must have been other variables that contributed to the reduction in Uganda (Wawer. Grey, serwada, 2005).

PEPFAR definition of ABC

In 2003, the United States government pledged 15 billion dollars to combat HIV and AIDS through PEPFAR; the funding was approved on the basis that 30% was to be dedicated to interventions that advocated for only abstinence (Green, 2006). This resulted in debate among scholars and activists on the seemingly biased conditions imposed by PEPFAR which later sparked critiques of PEPFAR’s definition of ABC. PEPFAR’s definition suggested that programs that encouraged unmarried youths to abstain from sexual activities were the best way to ensure that they are not exposed to HIV and AIDS and other sexually transmitted diseases. This is important as most HIV cases occur among youth aged 15-24 (UNAIDS, 2004).

Abstinence means that young people are expected to abstain from sex as long as they are not married; this is also known as ‘delayed sexual debut’. It can have a relatively significant impact on the general wellbeing of young adults and reduce HIV and AIDS prevalence rates

(Pettifor et al., 2004). While abstinence is 100 percent effective if adhered to consistently, in the real world, it can and does fail (Dailard, 2003). This requires consideration of the experiences of young people who are most vulnerable to early sexual activities (Moodley, 2007, Mulwo, 2008, Kunda, 2008, Mutinta, 2012) and challenges the PEPFAR definition of abstinence.

‘Be faithful’ encouraged individuals to practice fidelity in marriage and other sexual relationships in order to reduce their risk of being infected with HIV. As soon as an individual begins to have sex, they face a higher risk of contracting HIV. “Be faithful” approaches have had a remarkable effect in Uganda’s fight against HIV. Programs relating to fidelity in marriage, monogamous relationships and a reduction in sexual partners among unmarried person who are sexually active (Shelton et al., 2004) were successful in promoting positive behavior change.

‘Correct and consistent condom use’ refers to the correct use of condoms which reduces the likelihood of HIV infection. However, studies have shown that while correct and consistent use of condoms drastically reduces the risk of infection, it does not eliminate it, as condoms are approximately 80-90 percent effective in the prevention of HIV (PEPFAR, 2007; Hearst & Chen, 2004; Weller & Davis, 2004, Pinkerton & Abramson, 2004).

UNAIDS definition of ABC

The Joint United Nations Programme on HIV and AIDS’s (UNAIDS) definition of ABC is, abstinence or delay of sexual debut, being faithful to one’s partner or reducing the number of sexual partners, and correct and consistent use of condoms which usually applies to sexually active young people, couples where one partner is HIV positive, sex workers, their clients

and any other person who engages in sexual activity with someone who may have been at the risk of being exposed to HIV¹¹.

This definition offers a broader approach as it considers both married and unmarried youth, unlike the PEPFAR definition that does not take young people into consideration. The UNAIDS definition encourages young people who are sexually active to use condoms. It proposes that each element of the ABC approach is relevant to different people at different points in their lives.

The strength of the UNAIDS definition for this study is that it considers young adults who comprise the population of this study and are most vulnerable to HIV infection. It also presents consistent condom (either male or female condoms) use as a preventive method. However some scholars have argued that the UNAIDS definition is still limited in terms of its benefits, particularly for women and girls, as many cannot negotiate safe sex with partners or choose to abstain from sex¹² (WHO, 2009; Wheelock et al., 2012).

According to Moodley (2007), while UNAIDS offers a broad approach for a broad audience which encourages condom use among young people who are sexually active, encouraging safer sexual practices,

The use of condoms is limited when it prescribes that anyone engaging in sexual activity with partners who may have been at the risk of HIV exposure should use condoms. Few people are aware of their status and ignore the need for precautionary measures. The definition should rather promote condom use in any high risk sexual behaviour and when there is lack of

¹¹ The ABC's of HIV prevention. Available from: <http://www.avert.org/abc-hiv.htm> Accessed [23 May, 2012].

¹² UNAIDS definition of ABC. Available from: <http://www.avert.org/abc-hiv.htm#contentTable1> Accessed [23 May, 2012].

knowledge of one's partner's previous sexual relationships (Moodley, 2007: 11).

PEPFAR's promotion of abstinence and fidelity without attaching importance to condom use which is known to be a key HIV prevention has resulted in much criticism of the ABC approach (Susser, 2009; Mulwo, 2008). This is discussed in the following section.

Criticisms of the ABC Approach

The ABC approach was designed to apply to everyone, including young people. Yet PEPFAR's definition does not consider youths. ABC is also presented as an infallible approach without considering that youths exist in different social contexts which affect the decisions they make and their sexual behavior (Angeline, 2010).

A general criticism of the ABC approach (PEPFAR & UNAIDS) is its 'one size fits all' nature that focuses more on preventative measures than on educating young people about alternate, risk free activities. Risk free activities are believed to provide safer sexual activities for young people; the inclusion of risk free alternates such as female to male oral sex (fellatio) and pleasure in sexual health in HIV messages can help to reduce HIV (Philpott, Knerr & Maher, 2006). This message is missing in the ABC strategy (Kerwin et al., 2011).

A further criticism is that the ABC approach assumes that fidelity within marriage guards against HIV infection. Many people unsure of their partners' HIV status and in many cultures extra-marital affairs are a common way for married men to prove their masculinity (Parikh, 2007). In sub-Saharan Africa, research has revealed that most women contracted the disease from their husbands. The PEPFAR approach does not take the high risk and exposure to HIV

in married relationships into account (Sindag 2005; Linney 2007; Gupta 2000; Ngubane, 2010).

From a broader perspective, it is argued that the ABC approach is too western and does not apply to an African context (Rombo & Njue, 2012). HIV and AIDS are often generalized across the entire population without recognizing the African context and the need to contextualize HIV messaging (Govender, 2010; 2011).

Arising from critiques of the PEPFAR definition of ABC, attention turned to funding and promoting context-specific HIV prevention interventions including the promotion of condom use among youths. Condom usage is a key HIV prevention method in Africa. Indeed, despite its initial lack of support for condom promotion, PEPFAR has now adopted a more holistic approach to HIV prevention which includes condom use. In light of the cultural diversity in South Africa and the need to consider social, economic and cultural influences on sexual decisions, condoms are now promoted as one of many HIV preventative strategies (for example the USAID/PEPFAR funded Scrutinize, *Intersexions*, and Sex Tips for Girls series among others (AIDSTAR-one2011)¹³. This forms part of the \$45 million PEPFAR funding to support research into combination approaches to HIV prevention in Tanzania, Zambia and South Africa (ibid).

In Africa, sub-Saharan Africa and particularly South Africa, different university-based interventions promote condom use to prevent HIV among students. Studies have shown that

¹³ AIDSTAR-one (2011). Combination Approaches: An overview of combination approaches. available from: http://www.aidstarone.com/focus_areas/prevention/pkb/combination_approaches/overview_combination_prevention Accessed [30 October,2013]

students' attitudes to condom use vary (Madu & Peltzer, 2003; Mulwo, 2008; Kunda, 2008; Bosompra, 2001; Lule & Gruer, 1991; Mutinta, 2012).

Perceptions of male condoms among university students

There is a direct connection between perceptions and condom use; students with positive perceptions will engage in more consistent condom use than those who have negative perceptions (Alarape, Olapegba & Chovwen, 2008). This applies to male and well as female condoms. The Planned Parenthood Federation of America (2006) notes that, many negative perceptions about condoms are untrue; these perceptions affect people's uptake of condoms.

The literature on condom use and perceptions among university students focuses on male condoms, with only a few studies including women in a comparative analysis of their perceptions, attitudes and beliefs relating to male condom use (Callender, 2012). There is a paucity of literature on the use of female condoms (ibid). A decade ago, very few studies had been conducted on condom use among university students, despite their vulnerability to HIV infection (Iwuagwu, Ajuwon & Olaseha, 2000). The situation has since changed, with more studies now focused on condom use among university students; this has established the basis for further studies on HIV prevention and safer sex practices among students (Heeren et al., 2009; Ma et al., 2009; Kang & Moneyham, 2010).

A study on condom use in Uganda and Nigeria found that a minority of students regarded condoms as an effective HIV prevention method, while the majority saw it as an unsafe method that promotes and encourages promiscuity (Lule & Gruer, 1991; Alarape, Olapegba & Chovwen 2008). A similar study in Madagascar revealed that students did not frequently use condoms if they were engaging in sexual intercourse with a steady partner; if their

partners were not ovulating; when there was a decrease in sexual pleasure, discomfort when using condoms, breakage, or lack of knowledge on how to use condoms; when condoms were costly; where people believed that condoms were contaminated with HIV; when partners refused to use condoms, or if condoms were unavailable prior to intercourse (Rahamefy et al., 2008). Kenyan and Ghanaian university students also had negative perceptions of condom use and perceived them as an unreliable HIV prevention method (Sindiga & Luhando, 1993; Bosomptra, 2001). As in Madagascar, students suggested that unavailability; partner trust and partner disagreement affected their uptake of condoms (Kidan & Azeze, 1995).

Studies of condom use in South Africa have found that students' perceptions were based on inconvenience, negative feelings during sex and partners' resentment of condom use (Madu & Peltzer, 2003). This suggests that South African students have different perceptions from their counterparts in other African countries. Nicholas (1998) found that South African students complained about the number of condoms required for several rounds of sex, distrust by partners and some cases of vaginal injury. Some also believed that condoms were not meant for those who truly love and trust each other but for casual partners (Abdool et al., 1994).

While studies at UKZN have shown that students are willing to use condoms as they are free, the dispensers are often empty. Some students feel that since there is no absolute guarantee of protection, there is no need for condom use (Mulwo, 2008; Kunda, 2008). This finding corresponds with the perceptions of students in Kenya and Ghana who felt that condoms are unreliable (Sindiga & Luhando 1993; Bosomptra, 2001). The mixed perceptions of university students in various contexts suggest that there are both positive and negative influences on

condom uptake and consistent use; these perceptions need to be explored further. Critiques of the ABC approach to HIV prevention underline the need for a new approach.

A NEW APPROACH TO HIV PREVENTION

HIV prevention approaches should move beyond adding more alphabets; advancing global HIV prevention should include holding national governments, donors and global agencies accountable for prevention efforts that are tailored to national epidemics and support interventions and address the factors related to vulnerability (Collins et al., 2008; Liney, 2007; Marseille & Kahn, 2008).

The ABC is not an effective behavior change approach because it predicts behavior change in a linear rigid process which people cannot always adhere to, given the contextual and cultural factors that influence their decisions (Govender, 2010; 2012). In essence, it is not tenable to adopt a HIV prevention approach that predicts people's attitudes since people are not always in full control of their decisions or actions in engaging in sexual activities (Jemmott & Brown, 2003; Angeline, 2010; McGrath et al., 1993; Dutta- Bergman, 2005; Airhenbuuwa, 2006).

Recognizing that there is no easy or precise solution to HIV prevention is crucial as this ensures that the complex nature of the epidemic is considered when designing approaches (Mulligan, 2012). A new approach is required that extends beyond the simplicity of ABC (Green, 2012; Sindag, 2005; Linney, 2007; Gupta, 2000; Kerwin et al., 2011). Examples of alternate approaches to ABC that attempt to take the complexity of HIV into account are the SAVE and GEM approaches; these are explored in further detail below.

SAVE Approach

The ABC approach causes problems for religious leaders because it does not always cater for religious beliefs and orientation. The SAVE approach accommodates religious perceptions¹⁴. It was created by religious leaders who did not support condom use. They decided to establish a holistic approach premised on the success of the ABC approach as a “built upon and expanded strategy to provide information on non- sexual modes of HIV and AIDS transmission, testing, care and support for those already infected” (Jones & Chalcraft, 2009:6).

The SAVE approach was developed by members of the African Network of Religious Leaders Living with HIV and AIDS (ANERELA) (Jones & Chalcraft, 2009). It promotes safe sexual practices, anti-retroviral treatment, voluntary counseling and testing, and empowerment (Dworkin & Ehrhardt, 2007). Safe sexual practices include abstinence, being faithful and condom use, safe blood, safe injecting equipment, and prevention of mother to child transmission (PMTCT). The approach embraces everything that can be done to prevent HIV transmission, including having one sexual partner and using sterilized needles, etc. It advocates universal access to anti-retroviral (ARV) treatment and treatment for opportunistic infections, good nutrition and clean water.

The SAVE approach also advocates that voluntary counseling and testing (VCT) should be available and confidential for all who require it. It highlights two advantages of VCT. First, making VCT available to all has the potential to increase the number of people who will test and second, making it confidential encourages those who avoid testing for fear of stigma to get tested. The last element in the SAVE approach promotes empowerment through

¹⁴ SAVE: A NEW APPROACH TO HIV/AIDS PREVENTION. Available from: <http://www.hivaidsguide.com/2012/04/save-a-new-approach-to-hivaids-prevention/> Accessed [18 July,2012].

providing support to individuals and communities to obtain and maintain control over their lives and help reduce their susceptibility to HIV infection. There is very little literature on the SAVE approach except the independent evaluation by Jones & Chalcraft (2009); they critiqued the SAVE approach as being a religious-oriented approach which leaves out people who are considered ‘non-spiritual’.

Despite this criticism, the approach is gaining grounds in the approaches to HIV prevention adopted by government and non-governmental organizations (Jones & Chalcraft, 2009). Another alternate approach is the Gender relations, Economic contexts and Migration (GEM) approach designed by Dworkin & Ehrhardt (2007).

GEM Approach

The GEM (Dworkin and Ehrhardt, 2007) promotes a gender-specific and gender empowering approach to HIV prevention. Dworkin and Ehrhardt (2007) argue that, while researchers have called for gender-specific interventions, only recently have HIV and AIDS interventions and programs began incorporating this aspect. The ‘G’ component of the GEM approach emphasizes that interventions that expand protective methods for women besides the male condom should include methods that are female-initiated, like female condoms and messages that promote non-penetrative intercourse. The first key component emphasizes the design of interventions that improve women’s ability and skills to negotiate safer sex.

Philpott, Knerr & Maher (2006) and Kerwin et al., (2011) also emphasize the importance of risk free alternates that should be included in HIV messages. The need for women-centered HIV prevention approaches, including female condoms is supported by studies conducted by Shisana et al. (2007); the authors argue that women have been excluded from HIV prevention

initiatives and that their participation is crucial in the development and design of future HIV interventions.

The 'E' component represents Economic and Educational contexts and structural interventions which include government and decision-makers' full commitment to and support of HIV prevention strategies. This can be achieved by educating women to empower them as many drop out of school while men continue their education, giving them an advantage (Cornwall & Jewkes, 1995).

Paulo Freire (1970) posited that education makes people critically aware of their social reality, which empowers them to change their lived experiences. He termed this 'critical consciousness' and stated that only when people become conscious of their social reality are they empowered to change.

The 'M' component represents migration and population movement. Many countries do not consider immigrants in their HIV and AIDS, yet people migrate for employment, basic needs, security and livelihoods. This impacts HIV and AIDS prevalence (Dworkin & Ehrhardt, 2007). It is important to give immigrants information on HIV and AIDS and teach them negotiating skills, while offering additional support like jobs and financial support. Such strategies should take account of immigrants' sexual and reproductive health needs and provide them with the means to prevent HIV infection (Dworkin & Ehrhardt, 2007).

Rural-urban migration plays a key role in HIV transmission by expanding social and sexual associations between the two locations (Hu et al., 2006). A study conducted in 2011 estimated that of approximately 1,294 new cases of HIV infection in Shanghai, China, 880

were the result of rural-urban migration (Ye et al., 2012). The key challenge confronting the implementation of structural approaches such as GEM is that they take a long time to plan and execute and execute (Blankenship et al., 2006).

The GEM approach therefore highlights the keys challenges facing HIV prevention programs that do not address gender inequality (Murphy et al., 2006). It is therefore important for HIV prevention programs that address inequalities between women and their partners (Dunkel et al., 2004, Onoya et al., 2011). “Women do not have relationships of equality with the men they have sex with, and they can experience difficulties persuading men to use condoms” (Cairns, 2010). This poses a challenge, as HIV transmission may not be the primary concern during sexual interaction. Even women who have more equal relationships with men may still not use condoms as many men find condoms difficult to use or dislike using them.¹⁵

The challenges women experience in sexual relationships and their experiences of inequality and inability to negotiate condom have led to high HIV prevalence rates among women. Therefore women need to participate in the design and implementation of HIV and AIDS initiatives or interventions (HSRC, 2008; Rodney et al., 2010; Ngubane, 2011; Statistics South Africa, 2011).

WOMEN, HIV AND AIDS

The urgency of the need for women to be considered and included in HIV prevention promoted the United Nations Secretary General’s task force on women, girls and HIV and AIDS in Southern Africa to create a blueprint for countries in the region to address issues

¹⁵ Female condoms. Available from: <http://www.aidsmap.com/Female-condoms/page/1065758/> Accessed [12, March, 2012].

relating to HIV and AIDS prevention, infection, access to treatment, care giving, education, property and inheritance, violence and education (UNAIDS, 2010). This served as guide to HIV interventions that address issues relating to women, girls and HIV.

The 3rd annual Social Aspects of HIV and AIDS Research Alliance (SAHARA) held in 2005 in Dakar, Senegal promoted the adoption of a gender-based approach to HIV prevention in South Africa. The conference provided a framework that facilitated an understanding of the importance of gender in addressing HIV and AIDS and how to develop skills to do so (Kleintjes, Pugh & Prince, 2007; HSRC, 2008).

At the end of 2010, half of the total number of adults infected with HIV and AIDS worldwide were women (Avert, 2009). Approximately 26.07 South Africans are female and HIV prevalence is highest among women of reproductive ages (15-49 years) (Statistics South Africa, 2011). These statistics not only show that HIV prevalence is highest among women but that it mostly affects women who fall within the targeted age group for this study. They highlight that women-centered approaches to HIV prevention are crucial. However, many sexual relationships in Africa are dominated by men; this increases HIV prevalence among women regardless of their knowledge about the epidemic (Ngubane, 2010; Shefer et al., 2005; Gollub, 2000).

Rodney et al. (2010:69) note that, “women are compromised in protecting themselves against HIV; this is partly because of the inequality within their families and violence against them”; this is often accompanied by discrimination from their partners (Kort, 2009). However, family violence against women is perceived to have less effect on exposing women to HIV than their experience with their partners.

Women are believed to be coerced into certain sexual practices; a study in South Africa revealed that women who experience violence or dominance from their partners are more likely to be infected with HIV than those that do not have such experiences (Decker et al., 2009; Pool et al., 2000). Women's vulnerability to HIV can also be attributed to the cultural history of many African countries, where patriarchy led to men's dominance in heterosexual relationships and traditional gender roles. Women are seen to be passive and vulnerable and masculinity is associated with power, control and violence (Shefer et al., 2005, Patton, 2004; SA-NSP, 2010; Chirwa, 2011).

Traditional law also suppresses women and makes them dependent on men for economic survival. Women's vulnerability is heightened by limited access to economic and educational opportunities and social norms that deny them control of their sexuality (Aphane, 2005; Orege, 2005; Hoffman et al., 2004). In Malawi, a woman who generates vaginal lubrication during sex may be considered promiscuous or immoral (Woodson & Alleman, 2008). How can a physiological occurrence indicate promiscuity or immorality when this natural body response is not totally subject to human control? (Onoya et al., 2011)

Men's absence from their families can result in women engaging in transactional sex in order for them, their children and members of their extended families to survive (Scott et al., 2005). This exposes women to the risk of contracting HIV. Transactional sex is the practice of exchanging sex for financial reward (Meekers & Calves, 1997; Tarr & Aggleton, 1999). This is a reality in sub-Saharan Africa (Robinson & Yeh, 2009) that has greatly impacted the risk of infection in South Africa (Dunkle et al., 2004). Apart from being an alternative livelihood

source, women also engage in transactional sex in order to compensate for their partners' shortcomings (Hunter, 2002; Luke & Kurz, 2002).

While transactional sex is often perceived very negatively, a study in Durban revealed that for some women, it is a way of life and a means to achieve 'high-class' lifestyles (Leclerc-Malala, 2003). Studies have also indicated that UKZN students also engage in transactional sex in order to supplement their bursaries. Other students engaged in transactional sex not for money, but for luxuries such as cell phones, jewelry and expensive clothing (Mulwo, 2008; Kunda, 2008; Mutinta, 2012).

Gender roles have greatly affected women's chances of engaging in safer sex and obviously impact HIV prevalence rates among women (Banzhaf & Bellamy, (2008). It is clear that there will be no end to HIV and AIDS unless women's needs are addressed (Havlir, 2012). Shisana & Louw (2007) observe that, while global statistics reveal the disproportionate burden of HIV and AIDS suffered by women, practical approaches and studies to combat this situation have not been forthcoming. "Experiences in HIV/AIDS research, programming and policy indicate that globally we are 'missing the women'" (Shisana & Louw, 2007:29).

Decades into the epidemic, women are still bearing the greatest burden of HIV. This requires that women be given priority in research, care, and treatment at all levels (AIDS, 2012)¹⁶. The Human Sciences Research Council (HSRC) and the Social Aspects of HIV and AIDS Research Alliance (SAHARA) emphasize the need to explore why women are 'missing' in

¹⁶ Turning the tide for women, children and youth. Available from: http://www.aids2012.org/WebContent/File/AIDS2012_Plenary_Media_Release_25_July_2012_EN.pdf Accessed [31 July, 2012].

HIV and AIDS research and policy programs and to seek and implement ways to ensure that women are heard and considered in work relating to HIV and AIDS (Shisana & Louw, 2007).

The aforementioned UN task force noted that gender inequality remains a key problem in South Africa that has increased HIV infection because women cannot negotiate safer sex or even refuse sex. UNAIDS has identified six focus issues which could bring about immediate change.

The relevance of the focus issues presented by UNAIDS lies in their guidelines on the different issues or challenges women and girls face, thereby enabling interventions to locate their approaches within these issues (Onoya et al., 2011; Collins, Von Unger & Armbriste, 2008). Consideration of and adherence to the guidelines and directives produced by national and international organizations similar to the UNAIDS focus issues is vital to the implementation and sustainability of women-centered HIV interventions (Nelson, 2007). This study falls within the first focus issue as it addresses an area that deals with a prevention method that aims to reduce HIV infection rates among women.

The six focus issues presented by UNAIDS (2010) are:

1. Prevention among Girls and Young Women

The bridge of infection between older men and younger women and girls must collapse.

Many girls have sexual partners who are five to ten years older than them, and these men are more likely to be infected than boys and younger men. Relationships with older men are also more likely to be premised on unequal power relations, leaving girls vulnerable to abuse and exploitation.

2. Girls' Education

Female enrolment figures must be protected – AIDS may be taking girls out of school. Although gender equality has been achieved to a great extent in educational enrolment in Southern Africa, we need more information on the impact of the epidemic on the education of girls, particularly orphans.

3. Violence against Women and Girls

Girls and women must be protected from the direct and long-term risks of HIV infection as a result of violence. Girls and women who are sexually assaulted are at increased risk of HIV infection, through direct transmission and due to the long-term effects of sexual violence on risk-taking behavior.

4. Property and Inheritance Rights

The rights of women and girls to own and inherit land must be protected. In Task Force countries¹⁷ there are but a handful of small initiatives by determined organizations that provide women and girls with legal education and advice or assistance to prevent dispossession or restore their property.

5. Women and Girls as Care Givers

A Volunteer Charter should be adopted that articulates the rights and responsibilities of women and men who provide care and support to the sick and orphaned. Communities,

¹⁷ Any Country that signed up to partner with UNAIDS.

families, governments and development partners cannot continue to rely on ‘women’s resilience’ to provide safety nets for the sick and orphaned.

6. Access to Care and Treatment for Women and Girls

Gender norms, violence, stigma and discrimination must be addressed as they are potential barriers to women’s access to care and treatment¹⁸.

These guidelines have been adopted by many countries, especially with regard to HIV prevention among women. The right to health of all people is a key tenet of the World Health Organization. Member countries are encouraged to ensure that all women have the right to sexual and reproductive healthcare; this includes HIV prevention through the use of female-initiated methods (Mokete & Moodley, 2009; UNAIDS, 2010; Lanre, 2009).

The United Nations Populations Fund UNFPA (2010) advocates that HIV prevention strategies include expanding access to prevention methods that women can initiate. One option is promoting the female condom. The female condom was introduced to enable women to negotiate condom usage, have a means to protect themselves and engage in safer sexual practices (Zhongdan, et al., 2008; Gollub, 2000; WHO, 2002; Sippel, 2007). In light of women’s vulnerability to HIV and AIDS and their inability to negotiate safer sex, it is evident that they need a prevention method that can empower them.

To this end, the South African government set out to promote HIV prevention and to prevent unwanted pregnancies. The strategies put in place by the government have strengthened

¹⁸ Facing the future together. Available from: http://data.unaids.org/publications/External-Documents/sgreport_facingfuture_en.pdf Accessed [18 March, 2012].

sexual reproductive health and HIV prevention programs and services with a key focus on women empowerment through the promotion of the female condom (National Strategic Plan 2007-2011).

Women empowerment

Empowerment is a process that brings about change in communities and individuals; it enhances the equal distribution of needs, resources and power (Govender, 2011). In considering a women-centered approach to HIV prevention, empowerment refers to women at individual level where the equal distribution of power between women and their partners in decisions about safer sex is enabled. HIV programs and interventions need to regard empowerment as a key component of their strategies and ensure that women have knowledge of both HIV and AIDS and women-initiated or controlled prevention methods (Melkote & Steeves, 2001; Lee, 2001; Mckee et al., 2004).

Women empowerment is an approach to self-governance for women that changes social norms (Magar, 2003). Social norms are beliefs that could have cultural and economic origins and that ultimately increase women's vulnerability to HIV. Women empowerment challenges the norms that place women at subordinate levels to men and enables them to take control of their lives and embrace change (Batliwala, 1994).

Freedom is the key principle of empowerment for women; it is an expansion of their ability and freedom to make key choices in every area of their lives (Malhorta & Schuler, 2005). The individual capability of women to engage in or negotiate safer sex may be hindered if they lack support, are abused or are not empowered. These factors impede women's full involvement of women in HIV prevention programs or interventions (Bandura, 2005).

Empowerment has been criticized for being a vague concept that is not easily understood (Zimmerman, 1990; Laverack & Wallenstein, 2001; Kaler, 2001; Bandura, 1982; Rappaport, 1981). Some scholars have raised the difficulty of quantifying the goals of empowerment, arguing that such goals are changed at will, sometimes without a valid basis (Fetterman & Wandersman, 2005; Sonderling, 1997).

Empowering women liberates them from existing norms that place them in subordinate positions to their partners. These norms account for high HIV prevalence rates among women and underline the need for a female-initiated HIV prevention method like the female condom.

The Female condom

The female condom, also known as femidom, is a barrier method used during sexual intercourse to prevent the transmission of HIV and AIDS and sexually transmitted diseases; it was intended to offer better protection than the male condom (Gollub, 1993). It is worn by the female partner and blocks semen and body fluids from entering a woman's body.

The FC1 is the first generation female condom that was manufactured from polyurethane. It is impossible for tiny viruses like cytomegalovirus, hepatitis B and HIV to pass through polyurethane (Drew et al, 1990). However, the cost of this material inhibited uptake among women (Kahn, Billingham & Saba, 2001).

The second generation female condom, FC2 was produced in 2009 from less expensive material known as synthetic nitrile. The FC2 is a nitrile sheath or pouch 17cm (6.5 inches) in length. There is a flexible ring at each end; the one at the closed end is inserted into the

vagina to hold the female condom in place. The other end stays outside the vulva at the entrance of the vagina. This ring is a guide during penetration and stops the sheath from moving up inside the vagina. The Femidom has silicone lubrication and does not contain spermicides. It can be inserted ahead of sexual intercourse, and is oil-based to help retain sensation during sex.

Women who engage in consistent and correct female condom use can expect a lower rate of pregnancy and usage invariably lowers the chances of being infected with HIV and AIDS¹⁹ (Avert; Gollub, Dowdy, Sweat & Holtgrave, 2006). Macaluso et al. (2000) found that women at risk of STIs found the femidom acceptable and were willing to try it; some women were reported to engage in consistent femidom use. Furthermore, the use of both male and female condoms can enhance consistent condom use (Kloss, 2005). However the literature notes that many women still lack the power to negotiate male condom use; this is the rationale for the introduction of female condoms (WHO, 2004; Holmes et al., 2008; Dowdy, Sweat & Holtgrave, 2006). The different types of female condoms are examined in the next section.



FIG.1. The Female Condom

¹⁹ The female condom. Available from: <http://www.avert.org/female-condom.htm> Accessed[18 March, 2012].

Types of female condoms

There are several types of female condoms. The VA W.o.w condom is manufactured by MedTech in India; VA stands for V'Amour and W.o.w stands for 'worn of women'. It is similar to the FC1 in that it is produced from polyurethane, but it does not have a sponge at its end. The panty female condom is a pair of panties worn during intercourse and lubricated by a non-spermicidal lubricant. The sheath is fitted into the panties. After intercourse, it is discarded and the panties are washable and reusable (Chirwa, 2011). Also available is the Cupid female condom which is produced and distributed in India; it is produced from latex which is cheaper than polyurethane from which the FC1 and the Phonenurse female condoms are made and is distributed in China. These female condoms are similar in nature but are produced using different materials by different manufacturers.

The Program for Appropriate Technology in Health (PATH) women's condom is one of the newest female condoms that are designed to provide women with more comfort. Like the regular FC1 female condom, it is made with a polyurethane material, but in place of the inner ring, the PATH female condom includes pieces of foam to make the product and its insertion easier and more comfortable; the condom is in a capsule, which dissolves after use (PATH, 2009).

A study on the FC1 and PATH woman's condom by Schwartz et al. (2008) established that both were safe and generally acceptable. However, the PATH women's condom's different design was more acceptable than the FC1. As a result of women's complaints about the size of female condoms, PATH condoms are softer and thinner than other female condoms. The ring on other condoms was reported to cause pain in some women; this was replaced with small soft dots of absorbent foam which sit perfectly and make insertion easier (PATH, 2009).

A comparative study of two types of female condoms (FC2 & Phoenurse FC) by Hou et al. (2010) revealed that the regular FC2 is not available to most women in China due to its high cost, while the Phoenurse female condom which is manufactured by Condom Bao Medical Polyurethane Corp, Tianjin, China is available all over the country and is relatively cheaper. To ensure the availability and accessibility of the female condom an agreement was reached with the producers to make it available at a subsidized price to governments and donors in developing countries (UNAIDS, 2009).

A similar comparative study on FC1 and FC2 by Smit et al. (2006), conducted in Durban, South Africa revealed that despite complaints about size and lubrication, women found both condoms acceptable as there is no much difference between the two (Hou et al., 2010).

Despite the successful introduction of female condoms, there has been disappointment in the level of uptake; this can be attributed to the lack of knowledge about the female condom and the failure to market it vigorously (Hoffman, Mantell, Exner & Stein, 2004; Sippel, 2007; Gollub, 2000; Kort, 2007).

BARRIERS TO FEMALE CONDOM USE

Although studies have shown that female condoms are as effective as other barrier methods, and can protect women from HIV and STIs (UNAIDS & WHO, 2008; Gollub, 2000), many researchers have identified barriers to the uptake of condoms (Sakar, 2008; Raiford, Wingood & DiClemente, 2007). These include lack of education, cultural barriers, financial constraints, inability to negotiate safer sex and the belief that condoms inhibit sexual pleasure (Megafu, 2011; Chirwa, 2011). Some researchers suggest that distribution methods could be also a possible barrier (Macleod et al., 2010).

Sippel (2007:2) notes that, “despite being a highly effective protective method, only 20 million female condoms were distributed in 2006, this is 1 for every 100 women in developing countries”. This has serious implications for the effective adoption of female-initiated HIV prevention methods. Interestingly, some barriers to female condoms stem from stakeholders’ attitudes; these range from insufficient support from donors, to lack of promotion, lack of interest on the part of health providers and opposition to women empowerment (Dowdy, Sweat & Holtgrave 2006; Sippel, 2007; Macleod, 2010; Kahn, Billingham & Saba, 2001).

Barriers to the use of the female condom among women could include social and cultural, legal and policy, economic and financial and structural barriers (Kort, 2009). The particular barriers are determined by the context in which women live or the degree to which the society values cultural practices, beliefs or norms. In South Africa, culture is revered and given priority in decision-making on a number of issues, including safer sex practices. One cultural belief in South Africa that has greatly hindered female condom use is the belief that male sperms must enter women as child bearing is perceived to be their primary responsibility (Gould, 1993; Olley & Rotimi, 2003).

In Zambia, some men did not want to use condoms due to the belief that unprotected sex was a show of masculinity and superiority (Simpson, 2007). Pool et al. (2000), argue that male dominance in sexual matters can be traced back centuries and has cut across many generations, making it a very complicated issue to address. Studies on women and reproductive health in Uganda showed that women did not feel empowered or in control over their sexual and reproductive health even when they preferred to use other prevention

methods (Pool et al., 2000; Lule & Gruer, 1991). Gender inequality disallows women from making decisions on issues that affect their sexual and reproductive health.

A study on female condom use in Ghana found that lack of promotion and commercial sustainability affected usage (Naik & Brady, 2008). While various barriers exist to female condoms use there have been global efforts to address the major challenge to uptake, which is the unit cost of female condoms. Both the cost and size of female condoms remain key challenges (Mahoney, Thombs & Ford 1995; Ray et al., 1995).

In 2005, the nitrile female condom (FC2), a second generation female condom was introduced to address the issue of the cost of the first female condom (FC1) (Dowdy, Sweat & Holtgrave, 2006). However, the price of a female condom is still relatively high (Kahn, Billingham & Saba, 2001; Naik & Brady, 2008). In the United States, cost and availability still account for the low uptake and use of female condoms (FC2); they are more expensive and less available than male condoms (Weeks et al., 2010, Fernandez, Garrido & Alvarez, 2006).

One result of the high cost of female condoms has been their reuse that has been reported in many countries, especially in poor communities (Barbosa, Berquo & Kalckmann, 2000). The WHO does not support or encourage the reuse of female or male condoms (Kerrigan et al., 2000; WHO, 2002). The practice of reusing female condoms led to the establishment of a WHO protocol for cleaning female condoms so that reuse is safe. This includes soaking the device in diluted bleach and water as a means to disinfect it. It is then washed and dried, stored and manually lubricated when needed; this only applies to female condoms made from polyurethane (Macaluso et al., 2000; WHO, 2002).

Critics argue that this decision was uncalled for as promoted the continuous reuse of female condoms. However, a study in South Africa revealed that some women felt that female condoms could be reused at least once while others suggested that they could be reused seven to eight times. It is therefore clear that South African women regard female condom reuse as acceptable (Pettifor et al., 2001; Smith, Nkhama and Trottier, 2001).

It has also been reported that women find the female condom difficult to insert and remove. They also do not believe that female condoms are as reliable as non-barrier methods like the contraceptive pill (Weeks et al., 2010; Fernandez, Garrido & Alvarez, 2006). The US Food and Drug Administration (FDA)'s study conducted to ascertain the reliability of female condoms in preventing pregnancy found that the high pregnancy rates recorded by female condom users were most likely the result of the incorrect use of the device.

All of the abovementioned challenges need to be addressed if women are to be empowered.

Global and national trends to support Femidom

In 2005 a global consultation was held to encourage a global support and programs for female condom use; thereafter, the UNPF launched the global female condom initiative. The goals of the female condom initiative were to increase access to female condoms and integrate female condoms as an essential component of national HIV and AIDS policy guidelines and reproductive health programs. The initiative aimed to increase the uptake of female condoms, empower women to negotiate safer sex, promote the correct and consistent use of female condoms for HIV prevention and advocate for the inclusion of female condoms on the WHO essential drug list (Matthews & Harrison, 2006; UNFPA, 2006; Philpott, 2003).

A globally significant activity that complemented the UNPF global female initiative was the first ever global female condom day coordinated by US-based National Female Condom Coalition and supported by various organizations that support the promotion of female condoms, including the United States Agency for International Development (USAID, 2012). The global female condom day was an opportunity to increase awareness of the female condom as an HIV prevention method; it also motivated women to commit themselves to the promotion and increased access of female condoms.²⁰

The South African government's 1995 HIV and AIDS program included access to female condoms at public health facilities and service providers were trained to introduce the female condom (Mantell et al., 2001). This set the stage for changes in reproductive health and facilitated increased participation in all provinces and at all levels (Fonn et al., 1998).

The female condom in South Africa

The first generation of female condoms (FC1) was introduced in South Africa in 1997. Since then, the National Department of Health (NDoH) has included female condom distribution in HIV prevention and family planning in all nine provinces. According to the FHI 360, an international organization in South Africa that addresses human development; South Africa's national family planning program has played a major role in the introduction of female condoms. Female condoms were first introduced via family planning clinics and community-based programs in order to expand their acceptance.

²⁰ Why we are celebrating global female condom day. Available from: <http://www.blog.usaid.gov/2012/09/why-were-celebrating-global-female-condom-day/>

However in 2004, the NDoH decided to halt the distribution of Femidom due to lack of demand; an international organization, SUPPORT SA that promotes female condoms globally joined hands with the NDoH to determine the reasons for the low demand for female condoms. The investigation found that cultural, economic and social factors affect women's ability to negotiate for safer sexual choices.²¹

While other organizations such as gender justice organization, the Sonke Men's project, distributed more than 27,500 male condoms in various townships in 2010, such attention has never been given to the distribution of female condoms.

A survey to ascertain the perceptions and concerns of women relating to female condoms revealed that women in South Africa felt that the female condom was not attractive, was too big and that it was painful to insert (Marshall & Backos, 2002). Despite these challenges, women still support female condom use as it provides them with another option to protect themselves against HIV and AIDS (Mantell, 2004).

A few organizations have partnered with the NDoH in South Africa in the communication and advocacy of female condom; key organizations are Marie Stopes, the Society for Family Health (SFH), SUPPORT South Africa, Avert, Family Health International (FHI), and the UNPF, to name but a few. However, despite their involvement, there have been no significant mass media campaigns to promote the female condom; the partnerships with the NDoH only relate to distribution (Marseille & Kahn, 2008).

²¹ Support South Africa. Available from: <http://www.supportworldwide.org/country-programs/africa/south-africa/>

In 2008, the Thohoyandou Victim Empowerment Programme (TVEP), a rural women's organization in Limpopo, launched a training program to educate rural women on the importance and correct use of the female condom.²² This grassroots program has the potential to upscale communication about female condoms in South Africa.

The global campaign for microbicides noted that very few people have sufficient information on the female condom; this is due to inadequate promotion and communication. This suggests that this gap is a global issue that is not specific to South Africa (UNAIDS, 2010; Bogart, Cecil & Pinkerton, 2000). Given these barriers to female condoms, it is important that these factors are addressed in order to ensure an increase in future uptake and the use of female condoms in HIV prevention.

Future of the female condom

A holistic approach is required to increase the use of female condoms in HIV prevention. In countries like South Africa that have severe HIV and AIDS epidemics, the government and donor agencies must be committed and work together (Onyenechere, 2010). An advocacy approach is required that tasks every sector to contribute to the promotion of female condoms (Macaluso et al., 2000).

Ye et al. (2012) postulate that female condom use is determined not only at individual, social, and psychological levels (self-efficacy), including perceptions of susceptibility to HIV and the benefits of using a condom, but also at structural level with support from the community,

²² South Africa and the 2010 world cup: Pushing women's right to the fringe: Available from: <http://www.ngopulse.org>

doctors, health education and health promotions. National governments are tasked to engage in advocacy at multi-sectorial levels with support from medical and health personnel. Implementing such an approach to promote the use of female condoms to prevent HIV can significantly increase the uptake and use of female condoms (Francis-Chizaroro & Natshalaga, 2003; Sippel, 2007; Kelvin et al., 2009). A comprehensive communication approach is required to provide extensive information about female condoms and a communication strategy should be in place to market female condoms as an empowerment tool for women similar to the strategy used to promote other microbicides or barrier methods (Sippel, 2007).

As noted earlier, some scholars feel that the term 'empowerment' has no clear-cut definition (Zimmerman, 1990; Laverack and Wallenstein, 2001; Mohajer & Earnest, 2009); regardless of this, female condoms are still marketed as empowerment tools for women (Kaler, 2001). Kaler (2001) highlighted that some men understood the word empowerment to mean that they would become subservient to women if they relinquish some of their power or responsibilities to women in sexual matters. This emphasizes the need for a definition of empowerment that will enable a common understanding of the concept, especially in the context of women (Lord & Hutchison, 1993). This exemplifies the gap in the understanding, communication and promotion of female condoms.

Zimbabwe has shown globally recognized success in female condom distribution, sales and communication. The Zimbabwean government established a social marketing campaign for female condoms through Population Services International (PSI) which trained hairdressers how to communicate effectively with their clients on the benefits and use of female condoms

(Rogow, 2007). Their involvement in the introduction and negotiation of the female condom explains why men in Zimbabwe supported female condoms (Rogow, 2007).

The majority of men supported the use of the female condom because women can insert it before intercourse. This relieved them of responsibility and women could protect themselves when their partners were drunk and wanted to have sex (Kerrigan et al., 2000; Ray et al., 1995). Other reasons for men's support related to inserting and removing female condoms. Men said using a male condom made it very obvious when full erection was not attained and this affected their ego; this did not apply when a female condom was used (Kerrigan et al., 2000). The men added that with a female condom they did not have to withdraw from their partner immediately after intercourse and could even sleep while still inside their partners.

Involving men in the introduction of female condoms could therefore increase the acceptability and use of female condoms considering that men are often wholly in charge of safer sex practices (Matthews et al., 2006; Welsh, 2001).

In the United States, involving men in the promotion of female condoms was a huge success. Female condoms were included in prevention toolkits for men (Weeks, et al., 2010); this led to an increase in the use of female condoms. The reports also indicated that some men who have sex with men (MSM) were reported to have used female condoms for anal sex. (Mantell et al. 2009:1188) noted that hat, "Although not Food and Drug Administration (FDA) approved for anal use, several studies conducted found that the female condom was being used for anal intercourse among men who have sex with men (MSM)". However, the FDA observed that few studies had been conducted to ascertain whether or not heterosexual couples also used the female condom (Kalichman, Rompa & Cage, 2000).

Scholars have noted that an increase in the uptake and use of female condoms will require a multidimensional approach that includes the promotion, communication and support of female condoms. Attention should also be given to issues of redesign, cost, reuse, development and testing of interventions and evaluation of programs (Gollub, 2000; Hoffman et al., 2004; Raiford, Wingood and DiClemente, 2007; Callender, 2012).

Conclusion

There is need for health communication, especially around issues relating to HIV prevention. The ABC approach to HIV prevention has existed for many years. While it has attracted much criticism and various alternative approaches have been put forward, it remains the basis upon which these alternative approaches are built and considered.

The main criticism of the ABC approach is that it failed to consider gender inequalities and the circumstances surrounding women and their relationships with men. Many women occupy subordinate positions that have denied them the ability to negotiate safer sex practices and increased their vulnerability to HIV at the global level. A gender perspective of HIV is required that also considers female-initiated prevention methods besides the male condom. The female condom was produced with this in mind. However, the female condom has not been sufficiently promoted in South Africa. In South Africa the uptake and use has been very low. Considering that statistics show that youths in South Africa are most affected by HIV, it was imperative to ascertain the perceptions of university students about female condoms who likely fall within the age group of youths mostly affected by HIV in South Africa.

The next chapter presents the conceptual and theoretical framework that informs and guides this study.

CHAPTER THREE: CONCEPTUAL AND THEORETICAL FRAMEWORK

This chapter presents the theoretical framework that guides and informs this study. The study is located within the empowerment theory. The first section examines participatory development to explain its importance in the overall outcome of development. This is followed by a discussion on participation, the link to critical consciousness and how it stimulates dialogue and leads to empowerment.

Participatory Development

Communication is a fundamental part of development; it is the basis for most campaigns aimed at development (Wilkins, 2000). However, development always followed a linear process of communication, where information was transmitted from sender to receiver (Melkote & Steeves, 2001). Development communication comprises of two components, diffusion and participation (Morris, 2003).

Morris (2003) notes, that, the diffusion model of communication was conceived by Everett Rogers (1962) and is also known as the diffusion of innovation theory. This model regards behavior change as the aim of any communication campaign in the sense that providing individuals with new ideas and information leads to change.

The concept of diffusion refers to the process by means of which innovation/new ideas are communicated through a social system (Ascroft & Agunga, 1994). The diffusion of innovation stemmed from an approach that guides planning for modernization. It highlights the need for communication at local level in the process of modernization (Melkote, 2006). However, this was perceived as a top-down approach where information was passed down from those at the top, allowing no opportunity for members of communities to express their

point of view. Rogers (1962) presented a new approach to development. He argued that development communication should be a participatory process that brings about change in people's social and material lives through greater control of their environment and political lives (Inayatullah, 1967). There are other possible approaches to development, namely, equal distribution of information and socio-economic benefits, participation in self-development at grassroots level, self-reliance and the independence of local communities (Rogers, 1962).

Critiques of the modernization paradigm led to the emergence of alternative paradigms to development, one of which is participatory development (Singhal & Sthapitanoda, 2006; Servaes, 2002; Melkote & Steeves, 2001). A popular critic of the modernization paradigm is Gunder Frank (1969), cited in Servaes (1995); who argued that it was not tenable and could not be practically implemented, especially in developing nations like most African countries. These discussions later catalyzed the need for participatory development, where communication is pivotal to development processes.

The notion of participation in development evolved from the demand for greater access to information and freedom of expression. The participatory approach to development involves a horizontal process of exchanging information which initiates interaction that leads to the involvement of grassroots communities in development (Cornish & Dunn, 2009).

Participatory approaches to development have resulted in the inclusion of stakeholders and local communities in development; indeed they become key participants in the creation and use of knowledge to influence change (Wheeler, 2007). The concept of participation has

different meanings to different people and this has affected its practical application (Huesca, 2003). Participatory development is a post-modernist paradigm of development that emphasizes the plurality of opinions. This is in stark contrast to the modernization development paradigm that encouraged economic growth through industrialization.

Participation is a concept and practice that involves relevant people in the entire development process through an autonomous communication process (Manyozo, 2008). Manyozo notes that the definition of participation is contested terrain. Participation requires an understanding of the reality of the world in terms of the present or existing situation. This allows for a proper interpretation of events that leads to an appropriate course of action. Freedom of expression promotes democracy (Chasi, 2011).

The participatory paradigm is important for this study, as women need to be active agents of their own sexual choices and decision-making; they need to realise that they are the most vulnerable to HIV and should be involved in processes that aim to empower them to effect change. Furthermore, women should be enlightened about the only female-controlled method (female condom) which was designed to empower them to negotiate safer sex (Peters, Van Driel & Jansen, 2013). Engaging women around issues relating to female condom use will promote an understanding of vulnerability to HIV and provide information that empowers them to negotiate the use of female condoms as an alternative HIV prevention method.

However, the Institute of Development Studies notes that addressing women via dialogue could be a problem. In many societies, women have no say and their opinions are subject to the approval of men. In these situations, change agents are important to facilitate discussion with formal and informal group leaders who will encourage women to actively participate

(Moser, 2007). Participation is therefore central to development, particularly in addressing HIV prevention with women. The next section explores the key attributes of participation in order to understand perceptions of female condoms and the key determinants to ensure women empowerment.

Approaches to Participation

The concept of participatory development is based on the principles of renowned Brazilian educator, Paulo Freire; who emphasised that “education is not transmission of information from those who have it, the powerful, to those who lack it, the powerless, but rather the creative discovery of the world” (Freire, 1970:44-48). This Freirean approach advocates educating the disadvantaged and creating a space for active participation towards social change. This occurs when people have been made aware of their social reality and are empowered to take collective action. In this study, Freire’s reference to the powerless (Freire 1970:44-48) will be applied to women who need to negotiate the use of female condoms for safer sex.

There are two main approaches to participation. The first is based on Freire’s perspective and the second on UNESCO’s 1970s debate on access, participation and self-management. The Freirian approach champions active participation and involvement of the marginalized in order to change to their conditions (Mohan, 2001). The process start with conscientizing, which enables people to cast their minds back to establish how they were marginalized and take action to change this state of affairs. Conscientization is the process of developing an awareness of people’s social reality through reflection and action; it is necessary because it creates awareness of the current state (Freire, 1970). This approach postulates that

empowerment leads to unified action among the marginalized; its strength lies in dialogue and unified action.²³

The Freirean approach focuses on empowering the marginalized who have no voice; as noted earlier, this is a central concept in this study. While the UNESCO approach focuses on the use of the media as a means for participation, it does not provide practical applications to engage people in participation. Although different in context, these two approaches (Freirean & UNESCO) both suggest that people should be actively involved in decision-making processes and should be able to express their opinions through dialogue, which is the basis for genuine participation.

The UNESCO approach emphasizes that access refers to the use of the media for public service to give people the opportunity to choose different programs and provide opportunities for feedback. It locates power in the hands of the public; members of the public are involved in the formulation of communication policies and plans and the selection of various media for the purpose of communication (Servaes, 1995). Participatory approaches employ different channels of communication including workshops, group meetings and interactive sessions like focus group discussions (Boeren, 1992). This study draws on Freire's work to provide the theoretical setting for this research.

Understanding the concept of Participation

The concept of participation was formulated in response to the perceived failure and criticisms of the one-way flow of development (Melkote, 2001). In contrast, participation promotes a two-way flow of communication that encourages dialogue. It is therefore a

²³ <http://www.aontas.com/commmed/theorists.html>

continuous process of dialogue, listening and action between people in order to determine their needs and implement ways to bring about change (Cornish & Dunn, 2000; Cornwall & Jewkes, 1995). Participatory communication is a development approach that emphasizes the importance of local communities' cultural identity, democratisation and participation at all levels; international, local, individual and collective (Servaes, 2002). All people should be included in development decision-making processes in order to enable them to express their needs or perceptions of areas where they would like to see development or change (Moriarty et al., 2007). This approach leads to the correct meaning of participation, where opportunity becomes right, beneficiaries become citizens, consultation becomes decision-making and micro becomes macro (Gaventa & Valderamma, 1999). Participation in development is not restricted to increasing the number of voices in the decision-making process but also focuses on the values of those involved, such as inclusion and democracy (Guijt, 2008:171).

For the purpose of this study, the term 'participation' indicates the importance of working with men and women to understand their perceptions of the female condom and how these perceptions influence female condom uptake. The study is also premised on the notion that women can sometimes be powerless in condom negotiation and that understanding their perceptions of the female condom provides a new social reality that can contribute to some level of change in their behavioral choices and sexual practices.

The word participation is derived from the Latin word, *participationem* which means to take part (Chasi, 2011). It can be further broken down into two parts: *pars*, meaning part, piece, side, share, assigned or granted and *capere* meaning to take, grasp, lay hold of, catch, undertake, be large enough for and comprehend (ibid: 138).

Elections can be used as an analogy to explain participation; participation in elections is conditional as individuals have to be eligible to vote (Chasi 2011). This could infer that, even though it is believed to benefit everyone, participation is not meant for everyone as all times; certain criteria or conditions might have to be met before one is considered eligible to participate.

Chasi (2011) posits that, in the African context, the notion of participation has been high-jacked by those (leaders and agencies) who do not believe that Africa can be developed. This means that those who decide the criteria for eligibility to participate do not believe in development. The development goals that should be achieved through participation are truncated because those who are entrusted with development already hold a stereotype of Africa even before the commencement of the project. This belief is passed on to Africans who are made to believe that it is the true state of their reality; this prevents the marginalized from understanding how to access available alternatives that could bring about change (Chasi, 2011).

In terms of the current study, this could mean that the stereotypes that place women in subordinate positions in negotiating safer sex and make women believe that they are subject to the dictates of their male partners, affect their ability to understand how female condoms can empower them to negotiate safe sex and change HIV prevalence among women. Chasi's work demonstrates participation in an African context; it explains how cultural and social constructs in a society dictate who qualifies to participate. This suggests that women's participation in discussions on the use of female condoms for HIV prevention is subject to or could be affected by challenges arising from factors like culture, religion, laws and traditions which sometimes dictate that women's voices should not be heard. Given the understanding

and application of participation in an African context, it is evident that the concept of participation, although designed to benefit people, can be manipulated in ways that hinder empowerment.

Criticisms of participation

The criticisms of the participatory approach to development have highlighted doubt relating to claims of participation. Critics argue that instead of empowering people at grassroots level, it merely creates alternatives to involving the poor in big agencies projects in order to serve the interest of these agencies (Kappor, 2000; Parafitt, 2004; Hickey & Mohan, 2005). This suggests that, instead of participation empowering people, it is taken over and used for the interests and benefit of the organizations that establish development projects.

While participatory methodology has being incorporated into several research projects, Cooke & Kotari (2001) argue that participation has being misconstrued by many and can be termed a new form of tyranny. This point of view is supported by Mefalopolus (2003), who postulates that ever since the 1990s, participation as a substitute for development has become an overused word in the field of development. Yoon (1996) sees participation as the foundation upon which many organizations build their methodology; however it has been inadequately understood and implemented. This explains the position that, “participation changes its colour and shape at the will of the hands in which it is held” (White, 1994: 8) and suggests that participation is at the ‘mercy’ of those who implement it. The definition of participation has been defined and adopted in many ways, from pseudo participation (the vertical approach) to genuine (the horizontal approach) efforts aimed at generating participatory decision-making (Melkote, 2001).

In summarizing this section on participation, it is clear that participation is not an end in itself but a means to an end, which is empowerment (Nikkah & Redzuan, 2009; Cornwall & Jewkes, 1995). However, Freire argues that for participation to exist, people need to be made aware of their social realities and provided with an opportunity to engage in what he calls critical consciousness.

Critical consciousness

Critical consciousness is a concept coined by Freire that is premised on the need for people to be made aware of their social reality in order to fully participate in a process to overcome elements of oppression (Freire, 1993). The concept stemmed from his criticism of the 'banking' system of education where the teacher assumed the position of a depositor of knowledge to passive students. Freire argued this education system reduces students' ability to question authority by limiting their ability to be actively involved in the learning process; this is an act of suppression.

Sanders (1968:12), defines conscientization as:

An 'awakening of consciousness', a change of mentality involving an accurate, realistic awareness of one's locus in nature and society; the capacity to analyze critically its causes and consequences, comparing it with other situations and possibilities; and action of a logical sort aimed at transformation. Psychologically it entails an awareness of one's dignity.

Sanders (1968) acknowledges, the need for people to be aware of their social reality (nature and society) which allows them to critically (analyse) make informed decision (action) towards change (transformation).

Freire proposed that teachers should lead with a democratic approach with critical ideas. This creates a democratic process that stimulates a mutual learning environment where the transfer of knowledge is dyadic between teachers and students. A democratic process helps to create a connection between people's social, political and economic life where they have a common understanding of their ideologies and interests (Shor, 1993). Shor further posits that the Freirian concept of critical consciousness follows three steps that lead to critical thoughts; these steps are examined below.

The intransitive thought - In this stage, people are dominated to the point that they are disempowered and made to believe that they cannot take action to change their situation. With reference to this study, this stage is one where women are dominated by men and denied the ability to negotiate safer sex, which makes them vulnerable to HIV.

The semi-transitive thought - At this stage, people are partly empowered; they take action or steps towards changing to their situation but they fail to adopt a collective approach to address it.

This exemplifies a situation where women are informed about the female condom which was introduced to empower women by using a female-controlled HIV prevention tool, but they fail to adopt a unified or collective approach to its uptake and use.

Critical transitivity - This stage occurs when people think about their situation critically and collectively; they reflect deeply and this creates what is known as critical consciousness.

In the context of this study, this would be the stage when women take collective and united action to accept and use the female condom as an empowerment tool for women to prevent HIV. In this stage, people can achieve the changes that are necessary and at the same time

feel empowered to think and take action regarding their situation and relate it to the power and control in the broader society (Shor, 1993).

Only when people take charge of their lives and development can they be said to have reached critical consciousness; this is known as praxis (Shor & Freire, 1987). This is related to the concept of empowerment which is a process in which people endeavor to identify their problems, engage in critical assessment of the cause and develop ways to overcome such problems (Melkotte & Steeves, 2001).

The opposite of critical consciousness is magic consciousness (Dagron & Tufte, 2006). In this situation, superior powers are the custodians of people's rights; they take control of these rights and utilize them for their own benefit. Magic consciousness deprives people of the right to be involved in decisions that affect them as their fate is decided by superior powers that they cannot question. This limits their ability to take action because only when human beings perceive a challenge, understand it, and realize the possibilities of action will they take steps to change the situation (Dagron & Tufte, 2006).

In a situation of magic consciousness, people are not critically conscious of their reality. In terms of this study, magic consciousness refers to misconceptions about female condoms that prevent people from taking steps to use these condoms. By limiting access to information about female condoms, magic consciousness does not allow women the opportunity to be critically conscious of their reality; this affects their ability to be empowered through the use of female condoms for HIV prevention.

Critical consciousness therefore requires ongoing dialogue to address the flaws of magic consciousness. Freire suggested that dialogue can act as a catalyst to participation as it creates an environment for people to express themselves and become actively involved in processes towards change.

Dialogue

Dialogue is “a conversation between two or more people in which participants seek to clarify what each one thinks and believes” (Kincaid & Figueroa, 2009:1313). Through this dialogical process people can move from the obscurity of the situations surrounding them towards making a more participatory contribution to change.

Freire asserted that dialogue stimulates reflection (thinking) and action; “without dialogue there is no communication, and without communication there cannot be true education” (Freire, 1970:45). Dialogue is the only way to question opposing powers and enable people to express themselves (Dagron and Tufte, 2006). However, over time, as dialogue continues, most groups will agree towards a state of greater unity (Kincaid, 1993). As suggested by Serveas (1999), a participatory communication approach should be used in dialogue which should include:

- Viewing people as the main agents of change and emphasizing their aspirations and strengths which encourage them to meet their needs.
- Seeing people as the center of development, and educating and encouraging them to be active in improving themselves and their community.
- Emphasizing local/grass root initiatives rather than national ones.

The Freirean approach is applicable in any society including an African society (Nyiranda, 1996) as it enables an understanding of how education, communication and participation can be used to create awareness and change (Okigbo, 1996). This approach has produced remarkable results when applied to issues related to HIV and AIDS (Durden and Nduhura, 2003). However, the approach overlooks the fact that not everybody will know how to raise the key questions that relate to their social reality (Okigbo, 1996; Taylor, 1993) and it may also not be applicable in every circumstance as it was initially designed for adult literacy; therefore the Freirean approach should be adopted with caution at the local level (Thomas, 1996).

Dialogue itself is a form of empowerment as it creates a common frame of reference for discussions between two people or groups. It allows people to take control of their lives through discussions which enable them to engage in a learning process (Fetterman, 2002). Therefore dialogue will contribute to an understanding of students' perceptions of the female condom, its use and barriers to uptake.

EMPOWERMENT THEORY

Melkote & Steeves (2001) define empowerment as a process in which people and organizations take charge of flexible participation patterns in their communities and issues that relate to their existence and wellbeing. Another perspective on empowerment states that empowerment is conceptualized as enabling, which essentially refers to the acquisition of knowledge and status to take control of one's life; it is the capacity to benefit from involvement in a development initiative (Lee, 2001).

Freire posited that development aims to empower people to have more control over the issues that directly affect them. Since participation cannot be directly measured and is dependent on people's responses, it is measured based on the outcome of how many people are empowered (Laverack, 2006).

The empowerment theory connects people's welfare with their immediate environment. Mental wellbeing is related to collected effort and labor to establish a productive and responsive community (Zimmerman & Perkins, 1995). The empowerment theory focuses on increasing people's wellbeing in order to address problems, provide an equal chance for participants to increase their knowledge and skills, and engage professionals as team mates rather than authoritative, skilled persons (Zimmerman & Perkins, 1995). Empowerment "can therefore be seen as "a process by which individuals and groups gain power, access to resources and control over their own lives. In doing so they gain ability to achieve their highest personal and collective aspirations and goals" (Chatterjee & Canda, 1998:91).

Empowerment is about people gaining control over their collective lives and democratic participation in the life of their community (Rappaport 1987). This implies that empowerment will give women the power to take control of their own lives and enhance their ability to liberate themselves from oppression by their partners. Empowerment is an intentional process based in local communities, involving mutual respect and is a fundamental basis for a people-oriented approach to development and change (Kotze, 1997). Empowerment is a global concept that can be applied in local contexts to meet local needs (development); Rantanen (2005) describes this as 'glocalization', where a global concept or idea is incorporated into a local setting to benefit the latter. This is a planned process which promotes critical reflection, caring and group participation, through which people who lack

an equal share of valued resources gain greater access to and control over these resources (Cornell Empowerment Group, 1989). This suggests that empowerment should be a planned process that requires mutual and group participation that will lead to change.

The theories of empowerment are inclusive of both processes and outcomes (Swift & Levin, 1987, Perkins & Zimmerman, 1995). The empowerment of individuals may constitute either or both of two attributes, namely, participation in community organizations and at organizational level; the process of empowerment may constitute unified decision-making and structured leadership.

At the community level, the process of empowerment may involve unified decision to access government and community resources. Empowerment outcomes refer to the functioning of empowerment that enables the study of the effects of the process of empowerment. For individuals, the outcomes might include specific sensed control and the skills to mobilize resources, while organizational outcomes might include organizational growth, policy leverage and the development of relevant organizational networks.

Furthermore, at community level, empowerment outcomes might include organizational unity, accessible resources in the community and evidence of diversity. This study will be viewed through the prism of empowerment at individual level where students, especially females, are individually empowered through engaging in discussions about female condoms, unpacking key perceptions of female condoms and their use by women for HIV prevention. This can be viewed as an approach to self-governance in order to move towards changing social norms (Magar, 2003).

Empowerment also serves as a key element which challenges the norms that place women in subordinate positions to men, enabling them to take control of their lives and embrace change (Batliwala, 1994). Women's individual capabilities may be reduced if they lack support, are abused or not empowered. This has a negative effect on their full involvement in processes that will empower them (Bandura, 2005).

For women, empowerment is an expansion in their ability and freedom to make key choices in their lives, with less involvement of a superior power (Malhorta & Schuler, 2005). This is only possible when conditions such as gender inequality, gender violence and cultural norms that create powerlessness among women are removed (Hammuda & Dulaimi, 1997). It is argued that people understand their own needs better than anyone else; therefore, they should have the right and power to define and establish their desires (Cochran, 1986). In other words, women should be given the right to negotiate safer sex practices with the use of a female-controlled HIV prevention method like the female condom, which in itself is empowering.

Empowerment consists of four key developmental stages: entry, advancement, incorporation and commitment (Kieffer, 1984).

At the entry level, a person's experience of events that could be termed life threatening, constitute the motivation; Kieffer (1984) refers to this as an act of provocation. This mirrors women's inability to negotiate safer sex which leads to an increase in HIV prevalence among women. This necessitated the introduction of the female condom to empower women to negotiate safer sex in order to prevent HIV infection. At this level, students' experiences and perceptions of female condoms will determine if they are empowered or see female condoms

as an empowerment tool for women in HIV prevention. This is relevant to this study because, as noted in the literature review, women are the most affected by HIV; this is linked to many reasons, including inequality, gender violence and cultural beliefs. At this level, students' (especially females) experiences and perceptions of the female condom will determine if this level is applicable to the entire process of empowerment.

The advancement stage is made up of three key aspects: a mentoring relationship, collective peer support relationships within an organized structure and the development of a deeper understanding of social and political relations. This stage identifies organized structures as interventions or agencies that have established support structures that create a platform for the establishment of communication and programs that empower women and promote female condoms. This was tested by establishing how students found out about female condoms and what support structures they can identify that are in place for the communication of information on and the promotion of female condoms.

The incorporation stage relates to growing political consciousness where people are informed about the challenges that women experience that increase their susceptibility to HIV and the availability of female-controlled HIV prevention methods that empower women to negotiate safer sex. This implies that at this stage, women are supported by the government through the promotion and awareness of female condoms in HIV prevention. This stage is similar to the advancement stage but it specifically relates to collective action on the part of the government; this will be tested by the students' perceptions of the promotion of female condoms in South Africa.

The final stage is the commitment stage; this is about individual or collective involvement in the uptake of female condoms in HIV prevention and sustained support for women's ability to negotiate safer sex. This stage is vital because this is when women are expected to be able to negotiate safer sex by initiating female condom use and to a greater extent liberate themselves from the factors that have made them highly vulnerable to HIV. This level will be tested by students' responses to the question of whether or not they feel empowered by female condoms.

Critiques of empowerment

The empowerment theory is not free from criticism. The biggest obstacle to an analytical presentation of the practice of empowerment has been the lack of consensus on the aims of empowerment. Furthermore, the empowerment theory is not clearly explained or understood (Zimmerman, 1990:169).

Laverack and Wallenstein (2001) describe empowerment as a thorny and elusive concept and note that its definition is very vague. There are many definitions of empowerment. Some men perceive women empowerment as a strategy to place women above men (Kaler, 2001). Furthermore, there are different types of empowerment, including psychological (Bandura, 1982), individual (Rappaport, 1981; Swift & Levin, 1987), process and outcome-oriented empowerment (Fetterman & Wandersman, 2005) or a combination of any of the above.

The difficulty of measuring some goals of empowerment also makes it a problematic approach (Mohajer & Earnest (2009). Empowerment might be used a means to an end for

development, where the end is an outcome already defined by the objectives of those expected to help bring about change (Sonderling, 1997).

If there is no unified concept and meaning of empowerment, it will be practiced without proper understanding (Lord & Hutchison, 1993). To this end, empowerment should encompass an approach that ensures that participation and empowerment involves everyone from the grassroots levels up, which would be an appropriate approach in promoting female condoms.

Conclusion

Participatory approaches stimulate dialogue which brings about collective action for change. This is a reliable approach that enables communities to address common problems or challenges affecting them which in the case of this study, is women's inability to negotiate condom use or safer sex which has contributed to the high HIV prevalence rate amongst women (Figuerola et al., 2002; Servaes and Milikhao 2005). Hence the participatory approach of dialogue and critical consciousness were adopted to establish communication to address the issues facing women and the negotiation of safer sex practices, ascertain their perceptions of the female condom and assess if they feel that the introduction of female condoms has empowered them. This is based on Kincaid and Figuerola's (2009) assertion that communication in development means dialogue and participation, which is a means to empowerment. This assertion (Kincaid & Figuerola, 2009) guided the design of the focus group discussion questions which drew on the CFPD community dialogue stage to gather qualitative data. The next chapter presents the research methodology used in this study and further explains the community dialogue stage.

CHAPTER FOUR: RESEARCH METHODOLOGY

This study analyzes perceptions of the female condom among students on UKZN's Howard College campus in order to explore the discourse on female condoms amongst students. The population of this study is identified as students at UKZN's Howard College campus who reside in the Pius Langa and John Bews residences. Questionnaires were used to gather quantitative data and focus group discussions were held to solicit qualitative data, which provided the opportunity to gather more data on students' perceptions of female condoms. This chapter discusses the research design, research methods, research population, sample frame, and methods of data collection and analysis.

Research Design

The research design for this study took the form of a survey. According to Nworgu (1991), a survey is a research method in which a group of people or items, considered to be representative of an entire larger group, are studied by collecting and analyzing data related to them. A survey is the collection of information from a sample of a relevant population by means of personal interviews or forms such as questionnaires (Bowling 1997). Information is gathered through oral and written questionnaires (Sarantakos, 2005). A survey allows a researcher to study a small portion of a larger population and draw conclusions about them (Rea & Parker, 2005).

The advantage of a survey is that it is a fast and inexpensive way to solicit responses about the beliefs, attitudes and perceptions of a sample; furthermore it helps to produce real world empirical data (Kelly et al., 2003). The drawbacks of a survey are that the data produced is likely to lack detail on the specific topic researched and the feedback rate could be difficult to

control (Kelly et al., 2003). However, a survey is the best way to produce quantitative or numeric descriptions of some parts or portions of an entire population (Fowler, 2009). With regards to this study the numeric descriptions are related to the entire population and not portions of the population.

This research study is set within an interpretive paradigm; this approach assumes that people make and relate their personal subjective and inter-subjective meanings as they interact with the wider world. Interpretative researchers are expected to establish the meaning participants assign to a phenomenon (Orlikowosoki & Baroudi 1991). This sets a strong basis for the adoption of the interpretive paradigm. It enables the process of establishing and understanding students' perceptions of the female condom.

Research Methods

The study employed mixed methods research which included the collection and analysis of quantitative and qualitative data. Mixed methods research is a combination of more than one method in a particular study; this increases the reliability of the findings since different understanding is embedded in different methods (Denzin, 1978). Campbell & Fiske (1959) argue that the use of more than one method (multi-operationalism) is beneficial to any study as it gives credence and validity to the findings of the study. Drawing on this, the concept of the mixed methods research informed the use of questionnaires and focus groups in the gathering of data to support the validity of the findings. Although the research is positioned within the interpretative paradigm, the questionnaire which is a positivist approach was flexibly used to assist with gathering data that can be quantified and show relevant findings in tables and percentages. The focus group drew on the initial data presented through the questionnaires and was used as a basis to gather data that assisted in interpreting and

analyzing students' perceptions of female condoms. The data sets work together to understand the perceptions of females but are presented and analysed independently before collectively. .

Quantitative data was solicited by closed-ended questions to establish attitudes, behavior or performance (Harris & Brown, 2010). Quantitative research can be used to identify where similar responses exist, where there are differences and if there are any relationships. It allows a researcher to engage with a large number of people and enhances the results (William, 2007). Quantitative approaches further enable a researcher to summarize numerous sources of information and since it allows the researcher to keep a distance, it may reduce bias (Kruger, 2003). However, quantitative research may sometimes produce exaggerated results and these results are limited to descriptions that are numerical and cannot explain people's perceptions in detail.

Qualitative research uncovers more information and details about people than quantitative research and costs less, as quantitative research requires larger groups. It involves the collection of data through different empirical approaches like case studies, introspection, personal experience, interviews, artifacts, observation and historical interactions (Dezin & Lincoln, 2005). However, since qualitative research collects data from specific groups of people, the data can only be used for that group and no other.²⁴ Qualitative research provides in-depth and detailed analysis as it stimulates respondents to discuss issues further.

²⁴ Learning to analyze data. Available from: http://hive.library.uwa.edu.au/hive/hive.cgi/zip/218293/html/pop_advdis.html [Accessed 13, June 2012].

Qualitative research enables the researcher to find answers on how social experiences exist and how the meanings assigned to them are derived; this suggests that social experiences are central to understanding how students' perceptions of female condoms are formed (Denzin & Lincoln, 2005). Denzin & Lincoln (2005) note that qualitative methods enable researchers to study phenomena in their real form and to interpret the findings based on the different meanings people have of an idea, concept or phenomenon.

Research population

The population/participants for this study were drawn from male and female UKZN students from different race groups who reside in two on-campus residences at the Howard College campus, namely, John Bews and Pius Langa. Prior to the commencement of the study, the researcher made contact with the resident assistants and floor representatives in the two residences and solicited their assistance with the study. They put the researcher in contact with the residents who formed the population of this study.

John Bews is a female residence, while Pius Langa is for both male and female students. These residences house students from all faculties (schools), departments and levels of study. Another rationale for the choice of these two residences was that both residences have undergraduate and postgraduate students. This allowed for variance and diversity in the levels of study of the sample population.

The rationale for the mixed population is based on the consideration that women's inability to negotiate condom use and safer sex practices led to a high HIV prevalence rate among women. It is therefore imperative that alongside women, men's perceptions of the only

female-controlled barrier method (female condom) are explored. This enabled a comparative analysis of the male and female students' perceptions of female condoms.

Sample frame

The non-probability snow ball sampling method was used to select a total sample frame of 124 students comprising both male and female students who formed the respondents and participants for both the survey (questionnaires) and focus group discussions. Pius langa residence has 252 rooms and John Bews has 114 rooms. Taking into consideration the sampling method used, the research sample was made up of students who were referred to the researcher by the resident assistants. However, not all students agreed to participate and this led to working with 124 students who voluntarily accepted to participate in the study.

For the survey, the respondents comprised 20 male and 80 female students (40 from Pius Langa and 40 from John Bews residence); the rationale for this is based on the fact that the literature reveals that negotiating safer sex practices has always being men's responsibility, which has made women vulnerable to HIV (Decker et al., 2009; Shefer et al., 2005; Patton, 2004). Female condoms were produced to give women the opportunity to negotiate safer sex (Pool, 2000; Jemmott & Brown, 2003; Sippel, 2007; Megafu, 2011). Taking this into account, it was deemed necessary to ascertain the perceptions of more female than male students. A female only residence was therefore selected to provide a larger sample of female students, and a mixed residence was selected to provide more insight into the perceptions of male and females. Also, considering that HIV and AIDS statistics show highest prevalence amongst blacks, this informed the decision to draw samples from the two residences were most residents are black students and easy accessible (HSRC,2008; Jones & Chalcraft, 2009; Fourie, Van Rooyen; Wouters, Rensburg & Meulemans,2010; Schutte, 2011). The ages of the

participants and respondents were not considered, a major criterion was to be a student resident at either of the two selected halls of residence. However the findings revealed that most of the respondents who filled out the questionnaires were between the ages of 21-29.

According to Heckathorn (2002), snowball sampling is used when the researcher does not have full access to his/her intended population. Inasmuch as I had access to the residences, I did not have access to the number of female residents that was adequate for the study; this sampling method enabled me obtain more respondents via reference from those who the resident assistants had spoken to. In this sampling method, the researcher selects a few respondents and asks them to refer or recommend other people who meet the research criteria and are willing to participate (Sarantakos, 2005). The researcher starts by identifying an individual (resident assistant) who is regarded as an appropriate respondent; this respondent is then asked to identify another and this continues until the population is complete; it is also known as 'chain letter sampling' (Oliver, 2006).

The resident assistants for Pius Langa and John Bews residences were identified as appropriate respondents and they suggested other participants on different floors who were approached with the assistance of floor representatives. Snow ball sampling presented several challenges, one of which was that some female students declining to fill in the questionnaires. The reasons varied from not being interested to not being supporters of female condoms. Others commented that they were busy preparing for examinations. The male students were more co-operative and willing to be part of the study sample.

Another challenge presented by snow ball sampling is that participants may be suggested who may have little understanding of the topic; this affects the quality of the data collected (Oliver, 2006). This was addressed by briefing potential respondents on what the study sought to achieve and stressing that their participation was voluntary before administering the questionnaire.

Data collection

The data gathering methods used was questionnaires and focus groups. The rationale for the use of questionnaires is that they are cost effective, easy to analyze and reduce bias (Potter, 2012). A major drawback of questionnaires that was experienced is that there is a high possibility of respondents being slow to return them; this extends the duration of the research and does not allow the researcher adequate time to probe further into responses (Peil, 1995).

A focus group is a group of 6-12 participants with a moderator who asks questions on a topic or issue (Smithson, 2000). Focus groups can be used to further explore people's perceptions and attitudes (Duggleby, 2005). In this study focus groups were used to solicit responses that complemented the data gathered from the questionnaires. This qualitative research method can be described as a type of research that entails giving data meaning, translating it, and make the data easily understandable to the reader.

Questionnaires

A total of 100 questionnaires were administered in the ratio of 80 females from both Pius Langa and John Bews residences and 20 males from Pius Langa residence. This proportion is considered appropriate as women are most affected by the HIV epidemic; KwaZulu-Natal has

the highest prevalence rate in South Africa.²⁵ Studies have shown that HIV prevalence is four times higher in women than in men (Shisana et al., 2005).

Furthermore, it was considered important to understand female students' perceptions of female condoms, given that this preventative method was designed for women. Hence the study predominantly explores female perceptions, with some engagement of men to provide a holistic picture of perceptions of female condoms.

The questionnaire was designed by adapting the format of the female condom attitude scale instrument developed by Torsten Neilands & Kyung-Hee Choi (2002). The scale is an instrument comprised of five relevant factors derived from 15 likert scale survey items. These items measure women's attitudes to the female condom. The scale predicts female condom use, behavior, self-efficacy in the use of male condoms, sexual comfort and attitudes towards male condoms. The questionnaire included a section specific to female condoms, which is relevant to this study. This section included questions related to sexual pleasure, inconvenience, improved protection, sexual inhibition and challenges relating to the insertion of the female condom (Neilands & Choi, 2002).

The questionnaire was self-administered; such questionnaires are designed to be filled out by respondents without the intervention of the researcher (Lavrakas, 2012). Jenkins and Dillman (1995) argue that when respondents are asked to fill out a questionnaire it means that they fill it out from their own perspective; this could be detrimental because the respondents may not share a common frame of reference with the researcher. Given this, a pilot/pre-test of the questionnaire was conducted with 20 respondents to test its reliability and validity.

²⁵ <http://www.avert.org/south-africa-hiv-aids-statistics.htm>

Pre-test

A pilot test is essential in designing a questionnaire. It tests whether a questionnaire solicits the kind of responses desired. It helps to improve the questions and the validity of the questionnaire and also to establish if the questionnaire meets the purpose of the research (Creswell, 2003; Bowling, 1997). A pilot test of 20 questionnaires was conducted. It was distributed to 10 male and 10 female students who were randomly selected using the purposive sampling method. Purposive sampling is a method where the researcher decides which individuals to select (Oliver, 2006). This is a valid method because the researcher can identify respondents who can provide data for the study. However, it could introduce some bias which could have a negative effect on the validity of the conclusions (Robson, 2002). It should be noted that the data collected from the pilot test was not used in the final analysis for this study. It merely assisted in testing the questionnaire to ascertain if respondents understood each question and if the questions were well formulated to solicit the kind of responses required. A few changes were made to two questions that respondents experienced difficulty in understanding.

Focus groups

A focus group is a dialogue between members of a selected sample population; it is conducted to provide data on the key questions of a research study. Focus groups are group interviews that use relatively similar groups as respondents to gather information about certain topics (Hughes & DuMont, 1993). Another definition that is applicable to this study presents focus groups as an informal discussion that is planned in order to obtain people's perceptions on specific issues (Kreuger, 1998). This method considers unforeseen events as it allows the researcher to make changes when and where necessary (Morgan, 1988). This was evident when the focus group

discussions were held; some questions had to be rephrased to enable better comprehension by the participants.

A focus group was conducted with eight participants in three separate sessions; this size was chosen so that the researcher would be able to closely interact and monitor and not lose any vital details provided by the participants. The first focus group session was made up of only males; the second was made up of only females and the third was a mixed session of both males and females. The rationale for the different sessions was that this would enable the researcher to compare the different ways in which participants behaved or responded in each group.

The drawback of focus groups is that the sample is often small and an inadequate representation of the general population (Duggleby, 2005). However, Ulin et al, (2002) argue that a small focus group of relevant and well-informed people is very reliable and valuable. This study employed the mixed methods approach to address the limitations of each data collection tool and provide quantitative and qualitative data on perceptions of female condoms.

The focus group sessions were held at a comfortable venue with seats arranged in a circle, though some participants opted to sit on the floor after a while. This was welcomed as it allowed participants to adopt positions they considered comfortable. Each session started with the introduction of the researcher, assistants and the purpose of the focus group discussion. Participants were also given the opportunity to introduce themselves, and state the degree they were registered for and the year of study. Each session ended with participants being offered light refreshments and given pamphlets with information about female

condoms supplied by the HIV&AIDS Support Unit at UKZN's Howard College campus.

Informed consent

This study commenced only after ethical clearance was obtained from the university's Research Ethics Committee. Informed consent forms were distributed prior to the commencement of each questionnaire and focus group session. A consent form contains key details about the research; it informs participants how and what their participation entails (Howard & Demets, 1981). It is important that participants' consent is sought as participation must be voluntary (Faden & Beauchamp, 1986). Participants must be made aware of who the sponsor of the project is, if any, the area the study is to explore, how much of their time will be required, the confidentiality of the results and their identities and how the results will be used (Peil, 1995). All of these issues were carefully explained to the participants prior to the administration of the questionnaires and the focus group sessions in order to ensure that the participants had a clear understanding of the research and their participation.

The CFPD model prioritizes dialogue for facilitating discussion and was used as a basis for designing and drawing up the semi-structured focus group guide. A digital tape recorder was used to record the dialogue of the focus group discussion sessions and the recording was transcribed for analysis.

Communication for participatory development (CFPD)

For the purpose of this study, the community dialogue stage of the CFPD model which has often being used as a theoretical concept or framework was adapted for the focus group

discussions. It informed the order in which the questions for the focus group sessions were asked.

The importance of the application of CFPD in focus groups is based on the influence of dialogue, which is described as “a conversation between two or more people in which participants seek to clarify what each one thinks and believes” (Kincaid & Figueroa, 2009:1313). Freire asserted that dialogue stimulates reflection (thinking) and action; “without dialogue there is no communication, and without communication there cannot be true education” (Freire, 1970:45). Dialogue can therefore be seen as a means to engage participants in discussions that can solicit responses on their perceptions of female condoms.

The CFPD model is guided by work of Paulo Freire (1970) who described communication as dialogue and participation aimed at creating cultural identity, commitment and participation (Kincaid & Figueroa, 2009). CFPD is a planned activity that involves the use of local media and dialogue among various stakeholders about a shared problem in order to develop and institute activities that contribute to its resolution (Bessette, 2004). The model assumes that through participatory development, the necessary conditions for social change are made available by dialogue and collective action. Freire (1970) stated that dialogue and participation enhance commitment and empowerment. CFPD focuses on stakeholder’s involvement in the processes (dialogue and collective action) that lead to human development (Figueroa et al., 2002).

An appropriate model of CFPD must be based on dialogue, information sharing, collective action and understanding (Kincaid & Figueroa, 2009). The CFPD model presents dialogue as fundamental to the journey that humans travel, individually or collectively, towards

developing themselves (Lubombo, 2011). This model is entrenched in the concept that equal opportunities for participation and expression from the community level upwards are the basis for the success of any project. Hence it can be said that the CFPD model is appropriate in communication issues relating to the female condom because it allows people from the grassroots to the top to participate equally and express their opinions.

The CFPD model provided a horizontal platform for participatory dialogue which enhanced dialogue about students' perceptions of the female condom. However, the model's designers noted that it does not provide answers to questions that relate to managing conflict (Kincaid & Figueroa, 2009). Conflict is inevitable when dealing with people with various needs and this leads to divergent opinions. To this end, Lubombo (2011) argues that it is likely that not everyone will actively participate when it is time for dialogue. This was the experience during the focus group sessions; initially some participants were not actively involved in the discussion but this changed after a while and everyone became involved even though some were more vocal than others.

Below is the CFPD model as presented by Figueroa & Kincaid (2009):

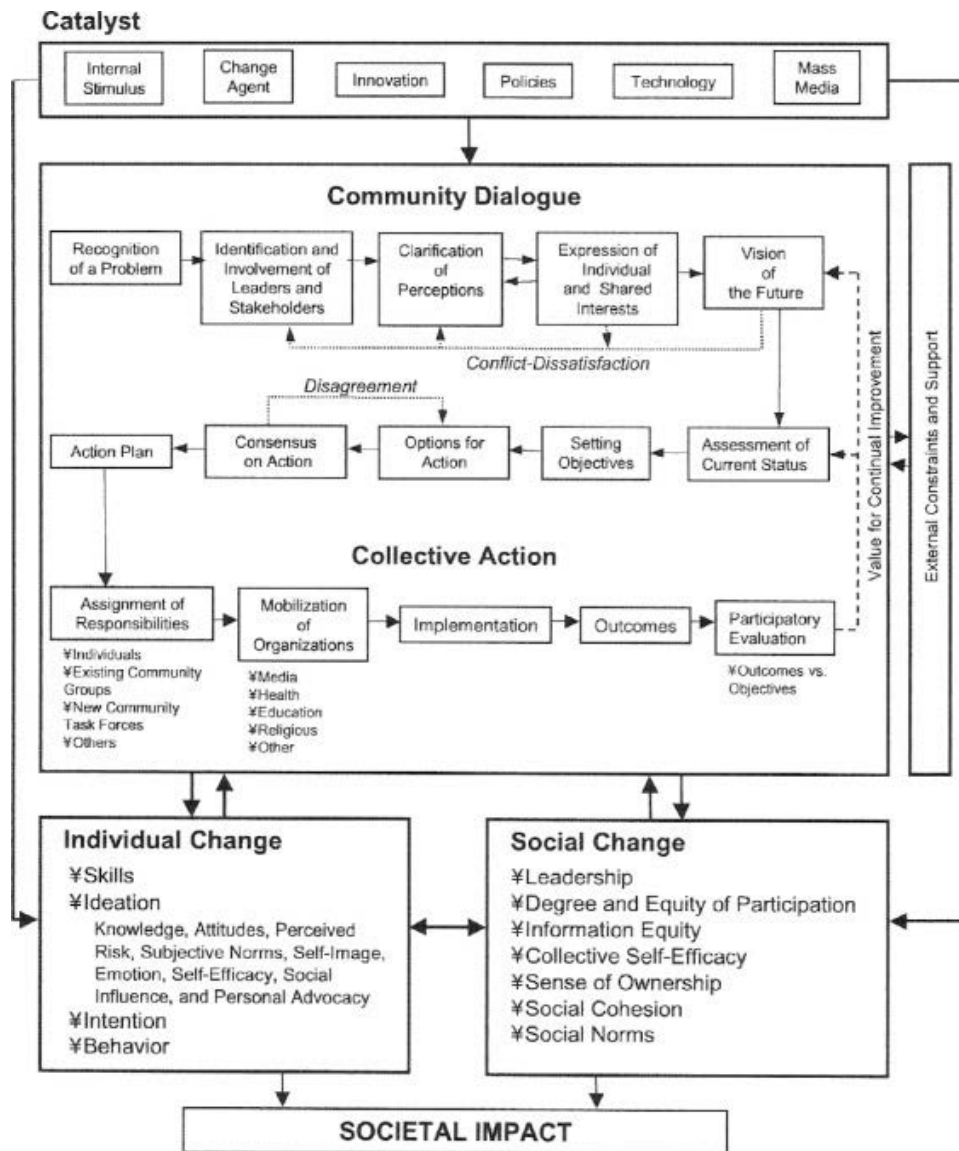


FIG.2. CFPD model Figueroa & Kincaid (2009).

Application of the Community dialogue stage

This stage presents the steps that were considered when conducting community dialogue or group discussions similar to the focus group discussions for this study. This section describes how these steps were used in the focus group discussion sessions.

The community dialogue stage begins with the identification of the catalyst which in the context of this study is the innovation of the female condom as an empowerment tool for women in the negotiation of safer sex practices and the prevention of HIV. A catalyst is meant to create an environment where people engage in mutual conversation; it could be an external force which connects people; an experience, the media or any discovery that links people together. It is an integral part of any process aimed at initiating a conversation between people who are strangers or not, and it ensures that interest in dialogue is sustained (Karahalios, 2004). During the focus group discussions, participants were first asked if they knew what a female condom is and what it is used for. This helped to create a basis for the discussion as it got participants talking about the female condom and further created a common frame of reference.

The first process is recognition of the problem; participants were asked if they knew and could explain the challenges that women experience that has resulted in their inability to negotiate safer sex and increased their vulnerability to HIV. This assisted the assessment of whether the participants recognized the existing problem and could identify the causes.

The second process is the identification and involvement of leaders and stakeholders; here participants were asked questions that revealed whether or not they could identify any stakeholders or government agencies that they think should be involved in the promotion, use and uptake of female condoms, as well as the nature of these stakeholders' responsibility.

The third process is clarification of perceptions; this stage was vital to this study as it sought to ascertain students' perceptions of the female condom. During this stage, key questions relating to participants' perceptions of the female condom were asked. This revealed relevant

information that illustrated the varied views, opinions, understanding, misconceptions and perceptions that the participants have of the female condom as well as the general discourse around female condoms.

The fourth process is the expression of individual and shared needs; this process enabled each participant to express their individual opinions on female condoms and contribute to the discussion. This highlighted the individual and collective thoughts of the participants. This step also helped to create arguments that allowed each participant to contribute their personal and collective thoughts or perceptions of the female condom.

The fifth process is vision for the future; participants were asked what changes or long-term benefits they think the uptake of the female condom will bring to women in the prevention of HIV and in negotiating safer sex.

The sixth process is the assessment of current status; participants were asked to state their opinion on the present state of the promotion, uptake and use of female condoms among women, specifically in South Africa.

The seventh process is setting objectives; this process is linked with the previous stage. After participants had stated their opinions on the current status of female condoms in South Africa they were asked to make suggestions regarding steps, activities or processes that could bring about change, bearing in mind the current status of the use of female condoms by women to prevent HIV. They were further asked what they thought the outcome of these steps, activities or processes would be.

The eighth process is options for action; here the participants were asked to give their opinions on various options to achieve the set objectives in the eight processes. This revealed participants' opinions on the varied and numerous possible options for action to achieve the set objectives of changing to the current status of the female condom in South Africa.

The ninth process is consensus on an action plan, which entailed asking questions that solicited participants' opinions and arriving at a united course of action on the use of female condoms. This stage gave the participants a sense of empowerment as they became aware that the success of female condoms in preventing HIV and promoting women's empowerment in negotiating safer sex is dependent on their collective support and action.

The tenth stage is the action plan; here participants were asked how they individually planned to implement all that was discussed and ensure that they support and embrace the use of female condoms to enable women to negotiate safer sex and reduce their vulnerability to HIV.

The table below provides a summary of the application and outcomes of adopting the steps of the CFPD model in the focus group discussions which facilitated dialogue in the discussion of issues relating to female condoms.

Facilitating the focus group discussions in light of the Communication for Participatory Development Model		
PURPOSE	ACTIVITY	OUTCOME
To adopt the participatory approach to dialogue through focus group discussions and solicit participants' perceptions of female condoms.	Participants in the different sessions were asked the same questions from the focus group discussion guide and were allowed to express and share their individual and collective views as well as opinions and ideas.	Participants in every session willingly contributed to the overall success of the focus group discussion sessions. The participatory approach to dialogue contributed to the success of the sessions; it provided an opportunity for the exchange of ideas and opinions as well as the clarification of some myths about female condoms and issues relating to their uptake and use.

FIG.3. Facilitating the focus group discussions in light of the Communication for Participatory Development Model

Challenges in data gathering

The challenges included the sample size, distribution of questionnaires and the focus group discussion sessions. The sample size for the study may not be an accurate representation of students at UKZN's Howard College campus; however the sample size was relatively adequate in gathering reliable data on students' perceptions of female condoms. The rationale for this assumption is premised on the fact that a balanced proportion of both male and female students comprised of the sample for the study to assess students perceptions of female condoms.

The administration of the questionnaires did not present any major challenges apart from the respondents' failure to return the completed questionnaires on time. A number of respondents took a significant amount of time to complete the questionnaires and required constant reminders by the researcher and floor representatives. A total of 91 of the 100 administered questionnaires were completed and returned.

Whilst the above challenges were not anticipated, the researcher did make provision for the challenge of the researcher being male and engaging in a study related to women. A female floor representative from the residences was selected to assist with the administration of questionnaires and a woman assisted with the female only focus group discussion.

Data analysis

The quantitative data was analyzed using the Statistical Package for the Social Science (SPSS); this generated simple frequencies and percentages. The quantitative data on each questionnaire was captured on *SPSS 21 data entry mask*²⁶; this was followed by a check to ensure that the variables were given the right attributes which were either nominal or ordinal. Nominal variables are used for classifications that are qualitative. This means that these classifications can be measured in terms of the distinct categories that they belong to and cannot be ranked or quantified in an order. Examples are gender (male and female), marital status (unmarried, married, divorcee and widower). Ordinal variables have an order; an example is socio-economic status. They are useful for assessments that are subjective and can be ranked in an order that explains a scale or a ranking that is done in a sequence that is meaningful.

²⁶ Data entry mask is the interface on SPSS where data from questionnaires are entered.

An example is the students' level of study, residences, social classification (upper, middle and lower class) and 1 = strongly agree, 2 = agree, 3 = I don't know, 4 = disagree and 5= strongly disagree.²⁷ This was followed by cross tabulations where necessary and then the generation of the tables and graphs which were used for further analysis.

The qualitative data was transcribed and analyzed by themes through the use of the NVivo (10) qualitative data analysis package. Thematic analysis is a qualitative research practice which includes looking through data to identify any recurrent patterns. "A theme is a cluster of linked categories conveying similar meanings and usually emerges through the inductive analytic process which characterizes the qualitative paradigm"²⁸.

Braun and Clarke (2006) note that thematic analysis entails forming codes from data sets and organizing these into themes. The table below reflects Braun and Clarke's (2006) six-step process of thematic analysis.

Phase	Description of process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion

²⁷ Types of variables. Available from: http://www.unesco.org/webworld/idams/advguide/Chapt1_3.htm Accessed [25 June,2012].

²⁸ <http://subvista.wordpress.com/2010/03/25/new/>

	across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and literature, producing a scholarly report of the analysis.

FIG.4. Steps of thematic analysis. Adapted from Braun and Clarke (2006: 87)

Before the commencement of this process, the researcher attended three online webinars to gain further knowledge of NVivo10, the new version of NVivo qualitative data analysis software. NVivo10 has a relatively different interface from NVivo9 and it was important to receive further training. The online webinars were organized by QSR International the software developers for NVivo10²⁹.

Drawing on Braun & Clarke (2006), the steps in the thematic analysis were applied in this study in the following manner:

²⁹ Link to online webinar. <https://www2.gotomeeting.com/join/171770802/106006913>

- 1- Firstly, the transcript was closely studied to enable an understanding of the content in the data. Next, the data was cleaned, which entailed formatting the raw data, highlighting the responses and adjusting the line spacing between the responses.
- 2- This was followed by the sorting of the data; the data set from the focus group guide sections entitled clarification of perceptions, expression of individual and shared needs, vision for the future and assessment of the current status was extracted for further analysis as the questions solicited responses that are related to perceptions.
- 3- The next step was to import the raw data to the NVivo 10 working environment; this was followed by the creation of codes. A code is often short words or phrases that sum up or present the attributes of a portion of a statement based on visual data (Saldana, 2009). Inductive coding was used at this stage; this kind of coding is developed by the researcher by directly studying the data and creating codes, where phrases or words are used to assign meaning to different sentences or paragraphs (Strauss & Corbin 1990).
- 4- An inductive approach to coding was adopted in this research project. The themes identified have a strong link to the data set and are not derived from a pre-defined set of codes (Patton 1990; Braun & Clarke 2006). The inductive approach to coding helps the researcher to ensure that the data is coded with participants' exact words, enabling the exact context of use to be presented; it also increases reliability and replication (Krippendorff 2004).
- 5- The next step was to search for themes, which entailed a search for recurrent patterns of responses from the participants.
- 6- The final step combined the review, defining and naming of themes. This entailed carefully going through the themes to narrow them down and establish if any could be merged. Based on the themes, the qualitative data was analyzed within the framework of empowerment through Kieffer's (1984) four stages of empowerment.

Conclusion and summary of methodology

The methodology guided the data collection process of this study. The survey was used to gather quantitative data about perceptions of female condoms. This was used to produce simple tables and percentages relating to students' perceptions of female condoms. The focus group discussions produced qualitative data.

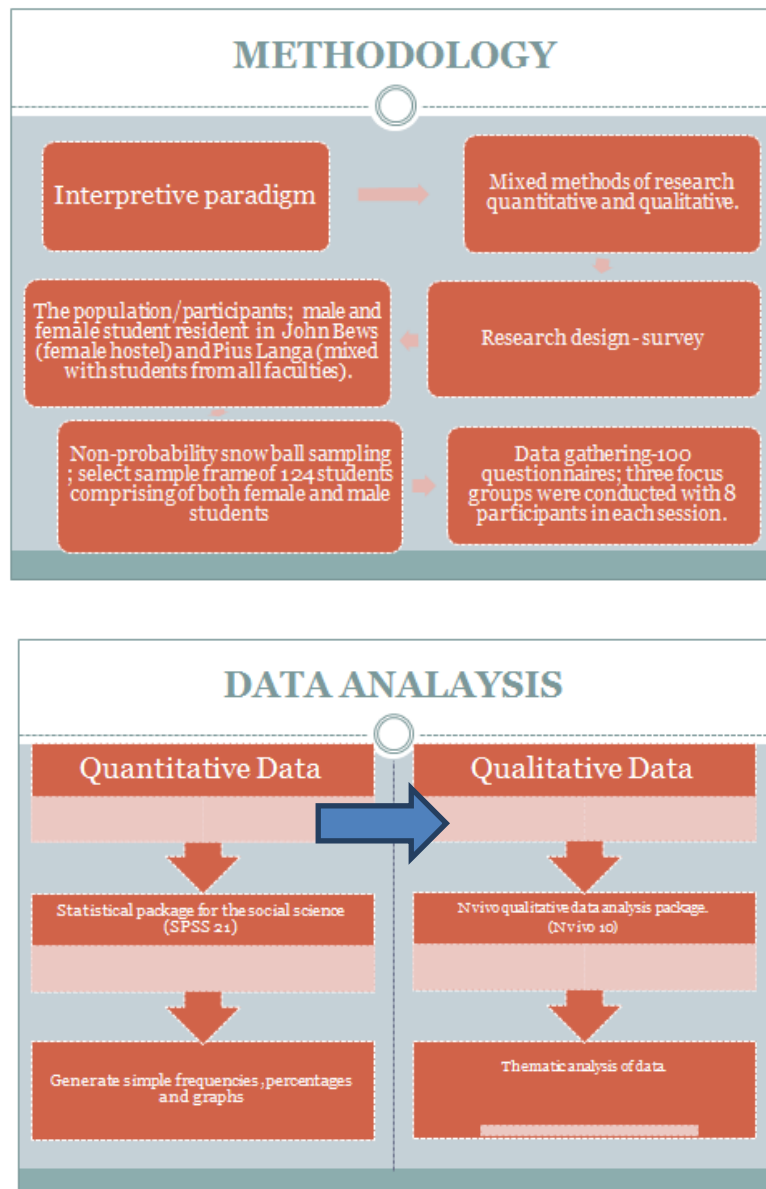


FIG.5. Summary of methodology

The next chapter presents and analyzes the qualitative data.

CHAPTER FIVE: QUANTITATIVE DATA PRESENTATION AND ANALYSIS

This study employed a mixed methods approach that included the collection and analysis of quantitative and qualitative data. This chapter presents and analyzes the quantitative. The data are analyzed based on the findings presented in the tables. The first section presents the demographic data of the respondents, the next section presents data about the HIV prevention methods used by the respondents and the last section presents data on their perceptions of female condoms.

A total of 100 questionnaires were administered to residents at John Bews and Pius Langa residences on UKZN's Howard College campus; 91 were returned and used for this study. The questionnaire for this study was designed by adapting the female condom attitude scale instrument designed by Neilands & Choi (2002). Overall, this chapter presents the data that explores students' (male and female) perceptions of the female condom, the empowerment of female students by the introduction of female condom and the forms of communication that exist about female condom.

DEMOGRAPHIC DATA

A total of 91 respondents filled the questionnaires of which 20.2% were male and 76.6% were female.

GENDER		
	Frequency	Percent
Male	19	20.2
Female	72	76.6

TABLE 1

The bigger sample of females for this study was to gain insight into females' perceptions, usage and challenges with female condoms; given that it is the only available female-controlled barrier or HIV prevention method in South Africa (Terris-Prestholt et al., 2006; Buck et al., 2005). This was further motivated by the need to understand whether the female condom is an empowerment tool for women, and to gain more insight into their perceptions of the usage and challenges of female condoms which need to be considered when promoting them in the future.

Table 2 below indicates that 17% of the respondents were in the age range 17-20, 64.9% were between the ages of 21 and 29, 13.8% were in the age range 30-39 and 11.1% were between the ages of 40 and 49. This diversity of the sample in terms of the age categories shows that male and females across all ages were given an opportunity to share their perceptions of female condoms. The majority of the respondents were aged 21 to 29; an HSRC survey (2008) revealed that the highest HIV prevalence rate in KwaZulu-Natal is among young people aged 21-29. This suggests that a majority of the respondents fall within the age category of young people mostly affected by HIV in the province.

AGE		
	Frequency	Percent
17-20	16	17.0
21-29	61	64.9
30-39	13	13.8
40-49	1	1.1

TABLE 2

Ninety-two percent of the respondents in the survey are Black and 4.3% are White; there were no Indians or Coloureds amongst the population. Although UKZN's student population comprises of Blacks, Whites, Indians and Coloureds, the population of residents at Pius Langa residence is mainly Black students as many come from rural areas or live outside the Ethekwini region. The John Bews residence also accommodates mostly Black students and a few international study exchange program students from Canada and the United States of America; some of these students accounted for the 4.3% of the students that are White.

Research has shown that HIV prevalence is highest among the Black population (Mulwo, 2008; HSRC, 2008; Avert, 2009; Statistics South Africa, 2011). It is therefore important to ascertain Black students' perceptions of an HIV preventative method such as female condoms. The limitation is that the perception of students of other races will not be ascertained. However, taking into account that HIV statistics in South Africa show that prevalence rates are highest among Black people the findings of this study will provide relevant information on Black students' perceptions of female condoms.

RACE		
	Frequency	Percent
Black	87	92.6 %
White	4	4.3 %
Coloured	0	0.0 %
Indian	0	0.0 %

TABLE 3

Eighty-seven percent of the respondents were single, 3.2% were married, 4.3% were co-habiting and only 1.1% was separated/divorced. The category of single can, however, be misinterpreted; for some students, 'single' may be considered to mean being in a relationship and not married, while others could identify themselves as single because they are unmarried

but engaged in sexual practices. The term could also be used to suggest that they are not dating at the moment (Moodley, 2007).

Some students could be separated/ divorced, but understand ‘single’ to mean that they are not in a relationship or married, while in reality they are separated/ divorced. Furthermore, some respondents could be co-habiting with their partners but, owing to the long period of co-habitation; they see themselves as married. Different understandings of these concepts could affect the data.

MARITAL STATUS		
	Frequency	Percent
Single	82	87.2
Married	3	3.2
Co-habiting	4	4.3
Separated/divorce	1	1.1

TABLE 4

Table five below indicates that 24.5% of the respondents were in their first year of study, 17.0% were in their second year, 26.6% were in their third year and 28.7% were at postgraduate level. This indicates there was a fair representation of all levels of study.

YEAR OF STUDY		
	Frequency	Percent
First	23	24.5
Second	16	17.0
Third	25	26.6
Postgraduate	27	28.7

TABLE 5

Most of the respondents in the survey were from the College of Humanities, followed by the College of Law and Management Studies and the College of Agriculture, Engineering and

Sciences. This data further indicates that the study sample was representative of the wider student community.

The survey was designed to have a sample size of a 100 respondents made up of 60 students from Pius Langa residence (20 male and 40 female) and 40 female students from John Bews, a female-only residence. Given that femidoms were designed for women to empower them to negotiate safer sex, the sample contained more women in order to ascertain their perceptions of female condoms. The 20 male students were selected to provide their perceptions of female condoms. This provided a basis to compare and contrast male and female students' perceptions of female condoms. As noted earlier, 91 questionnaires were returned; 62.8% of the respondents were from Pius Langa residence, and 34.0% were from John Bews residence.

Knowledge and information about female condoms

The respondents were asked questions to determine if they knew about female condoms and the source(s) of their information. The table below shows that 91.5% of the respondents know about female condoms while 4.3% had no knowledge of the female condom. The overwhelming majority of the respondents therefore knew about the female condom.

KNOWLEDGE OF FEMALE CONDOM		
	Frequency	Percent
Yes	86	91.5%
No	4	4.3%

TABLE 6

Asked how they heard about female condoms, 43.6% of the respondents cited friends; 36.2% the clinic, 1.1% billboards and 7.4% the media. This could suggest that young people engage in discussions and dialogue about condom usage and the option of female condoms. It further

indicates that the public sector service is a secondary source of information about female condoms as most respondents obtained their information through friends.

SOURCE OF INFORMATION ABOUT FEMALE CONDOM		
	Frequency	Percent
Friends	41	43.6%
Clinic	34	36.2%
Billboard	1	1.1%
Media	7	7.4%

TABLE 7

Use of HIV prevention methods

The respondents were asked about the various HIV prevention methods they have used; this question was a build up to the questions that solicited their perceptions of female condoms. It was imperative to ascertain which of the prevention methods they had used as this would determine if their perceptions were derived from experience through use or from knowledge or attitudes.

Seventy-six percent of the respondents had used male condoms as a HIV prevention method and 23.4% had never done so. This means that most students have used male condoms before and suggests that the respondents are familiar with male condoms as a HIV prevention method. More than two-thirds of the respondents indicated that they use male condoms, suggesting that the practice and usage of these condoms are a common HIV prevention method among students.

MALE CONDOM USE		
	Frequency	Percent
Yes	72	76.6%
No	19	23.4%

TABLE 8

When respondents were asked if they had used a female condom before, 92.6% stated that they had not; only 4.3% had used one. The fact that most respondents had never used a female condom shows that their perceptions of female condoms were not derived from experience of its use. This could suggest, as noted earlier, that the preference for male condoms as a HIV prevention method is based on experience and prior usage; this could affect the uptake of female condoms in the prevention of HIV. This also raises the question of why women are not using female condoms. What are their perceptions of the female condom and how can these be addressed?

FEMALE CONDOM USE		
	Frequency	Percent
No	87	92.6%
Yes	4	4.3%

TABLE 9

Perceptions of female condoms

Asked about their perceptions of female condoms; 52.6% of male respondents strongly agreed that female condoms offer better protection than male condoms, and none strongly disagreed. Furthermore, 36.6% of female respondents strongly agreed and 5.6% strongly disagreed that female condoms offer better protection than male condoms.

An important finding is that more male than female respondents perceived that female condoms provide better protection than male condoms. This suggests that men could be included in the promotion of the uptake and use of female condoms.

This finding also challenges notions of power, where the man appears to be the one who controls sexual activity by his choice of condom usage rather than the woman (UNAIDS,

2010; Pool et al., 2000). The finding that most male students in the sample support female condoms gives women an opportunity to negotiate its use and suggests that men are willing to negotiate female condom use.

FEMALE CONDOMS OFFER BETTER PROTECTION THAN MALE CONDOMS						
		Female condoms offer better protection than male condoms				
		Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
	% within Male	52.6%	21.1%	15.8%	10.5%	0.0%
	% within Female	36.6%	14.1%	36.6%	7.0%	5.6%

TABLE 10

Sixty-eight percent of the male respondents strongly agreed and 10.5% strongly disagreed that female condoms put women in charge of negotiating safer sex, while 50.7% of female respondents strongly agreed and 14.1% strongly disagreed that female condoms put women in charge of negotiating safer sex. This finding maintains the trend already noted that more men than women have positive perceptions of female condoms. This could have a positive or negative effect on female condom use. It either suggests that men are willing to support female condom use and agree that it empowers women or that men agree that it empowers women, but would not support it as it may affect threaten their masculine power (Shefer, et al., 2005; Patton, 2004).

FEMALE CONDOMS PUT WOMEN IN CHARGE OF NEGOTIATING SAFER SEX						
		female condoms put women in charge of negotiating safer sex				
		Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
	% within Male	68.4%	15.8%	0.0%	5.3%	10.5%
	% within Female	50.7%	15.5%	8.5%	11.3%	14.1%

TABLE 11

Turning to perceptions of the convenience of the female condom; 66.7% of the male students strongly agreed, and 1.1% strongly disagreed that female condoms are inconvenient to use. Forty-five percent of female respondents strongly agreed, and 18.3% strongly disagreed that female condoms are inconvenient to use. This implies that, inasmuch as young people are of the opinion that female condoms provide women with the opportunity to negotiate safer sex, almost 20% of females identify it as inconvenient to use.

A point of significant interest is the difference in the percentage of males who believe the female condom is easier to use than females, with the male count being almost 22% higher. The issue of inconvenience was one of the challenges identified by the students.

FEMALE CONDOMS ARE INCONVENIENT TO USE							
			female condoms are inconvenient to use				
			Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
		% within Male	66.7%	5.6%	16.7%	0.0%	11.1%
		% within Female	45.1%	7.0%	22.5%	7.0%	18.3%

TABLE 12

Thirty-six percent of male respondents strongly agreed, 31.6% agreed, and 21.1% strongly disagreed that female condoms makes a woman's partner think that she does not trust him, while 56.3% of female respondents strongly agreed, and 5.6% strongly disagreed that female condoms makes a woman's partner think that she does not trust him. This suggests that regardless of the fact that female condoms are supported by men and are believed to provide better protection than male condoms, if its use is negotiated by a woman her partner will think she does not trust him.

This questions the validity of men's support for female condoms. Female condoms were produced to be used by women and if men actually support their use, this should not be linked to distrust.

FEMALE CONDOM MAKES A WOMAN'S PARTNER THINK THAT SHE DOES NOT TRUST HIM						
		female condom makes a woman's partner think that she does not trust him				
		Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
	% within Male	36.8%	31.6%	0.0%	10.5%	21.1%
	% within Female	56.3%	18.3%	8.5%	11.3%	5.6%

TABLE 13

Table 14 shows that 47% of male respondents strongly agreed, and 36.8% strongly disagreed that female condoms are not easily accessible, while 43.7% of female respondents strongly agreed, and 25.4% strongly disagreed that female condoms are not easily accessible. This

could imply that even if people decide to use female condoms as an HIV prevention method, as they are not easily accessible, they have to use other HIV prevention methods.

FEMALE CONDOMS ARE NOT EASILY ACCESSIBLE						
		female condoms are not easily accessible				
		Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
	% within Male	47.4%	10.5%	5.3%	0.0%	36.8%
	% within Male	43.7%	1.4%	8.5%	21.1%	25.4%

TABLE 14

The survey revealed that 73% percent of the total male respondents strongly agreed, and 10.5% strongly disagreed that female condoms are well promoted in South Africa, while 60.9% of female respondents strongly agreed, and 2.9% strongly disagreed that female condoms are well promoted in South Africa. This suggests that men have more exposure to the promotion of female condoms than women.

FEMALE CONDOMS ARE WELL PROMOTED IN SOUTH AFRICA						
		female condoms are well promoted in SA				
		Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
	% within Male	73.7%	15.8%	0.0%	5.3%	5.3%
	% within Female	60.9%	23.2%	10.1%	2.9%	2.9%

TABLE 15

Asked about female condoms as an empowerment tool, 73% of the male respondents strongly agreed, and 10.5% strongly disagreed that female condoms empower women. A key finding is that 55.1% of female respondents strongly disagreed and 11.6% strongly disagreed that female condoms empower women. This suggests that most female respondents do not feel empowered by female condoms; this could account for most female respondents expressing negative perceptions of female condoms.

FEMALE CONDOMS EMPOWER WOMEN							
			Female condoms empower women				
			Strongly Agree	Agree	I don't know	Disagree	Strongly Disagree
Gender	Male	Count	14	2	1	0	2
		% within Male	73.7%	10.5%	5.3%	0.0%	10.5%
	Female	Count	38	9	6	8	8
		% within Female	55.1%	13.0%	8.7%	11.6%	11.6%

TABLE 16

DISCUSSION

Female condoms offer better protection than male condoms

More male than female respondents felt that female condoms offer better protection than male condoms. This finding contradicts the perception that men do not support the use of female condoms, but it also questions why men believe the female condom offers better protection. Kerrigan et al. (2000) and Ray et al. 1995) found that most Zimbabwean men were of the opinion that the female condoms offer better protection because their partners could easily wear it before sexual intercourse and it removed the responsibility for protection from men when they were drunk.

The findings also confirm Gollub's (1993) assertion that female condoms were produced to offer better protection than male condoms. However, Wheelock et al. (2012) argue that effectiveness in condom use could be the result of the type of (male/female) condom most frequently used. Cultural practices and beliefs about the role of men in sexual practices put men in charge of negotiating safer sex practices and relegate women to subordinate positions (Gould, 1993; Pool et al., 2000; Olley & Rotimi, 2003; Simpson, 2007). This suggests that women lack the ability to negotiate condom use and will be more exposed to male condoms. This could be the reason why female respondents felt that male condoms provide better protection than female condoms.

Men's perceptions that female condoms provide better protection than male condoms could be the reason why researchers have argued that men should be involved in every phase of the promotion of female condoms (Matthews et al., 2006; Welsh, 2001). Nonetheless, it is believed that cultural barriers that subordinate women and entrench patriarchy do not encourage men to participate in any approach that empowers women (Megafu, 2011; Kort, 2009).

Inconvenience in the use of female condoms

Studies have shown that women find the female condom difficult to insert and remove (Weeks et al., 2010). The findings of this study contradict this conclusion, as more male than female students felt that female condoms are inconvenient to use. Madu & Peltzer's (2003) study in South Africa found that inconvenience is a key determinant of the uptake and use of female condoms among university students.

Rahamefy et al. (2008) found that inconvenience greatly affected uptake of condoms among university students in Madagascar. It is possible that male students felt that the female condom was inconvenient to use because they had had this experience with male condoms. These findings concur with those of previous studies that showed that inconvenience is a barrier to the uptake of female condoms (Weeks et al., 2010; Carter et al., 2009; Sakondhavat, 1990; Madu & Peltzer, 2003). In contrast, Jemmot & Brown (2003) argue that apart from the desire for free distribution of female condoms, some people believe that female condoms are convenient as almost the same time and technique is required as with male condoms.

However, it is important to emphasize that, besides the issue of inconvenience there is an issue of trust. Men support female condoms, yet they believe that if their partners use one, they do not trust them.

Issues of trust

Students were asked to give their perceptions of issues of trust when women use female condoms. Most felt that using a female condom would make a woman's partner think that she does not trust him. This is similar to the findings of studies conducted by Kidan & Azeze (1995) and Abdool et al. (1994) that noted that trust affected condom use among South African university students. Male students believed that if their partners trusted them, there was no need for them to initiate condom use and that condoms were not meant for partners who trust each other. This contradicts the finding of this study that most male participants are supportive of female condoms. If men are supportive of female condoms, why is their use by women construed as mistrust of her partner?

Accessibility of female condoms

The availability and accessibility of female condoms has been identified as one of the key challenges to their uptake and use. The study revealed that most students feel that female condoms are not easily accessible. In partnership with the NDoH, Support South Africa has played a key role in the promotion of female condoms. It found that the uptake of female condoms in South Africa declined over the years as a result of low demand.

Promotion of female condoms in South Africa

More male than female students felt that female condoms are well promoted in South Africa. This suggests that more men are exposed to the promotion of female condoms. This could be linked to Agha & Van Roseem's (2002) observation that some interventions in Tanzania adopted interpersonal approaches which target more men in the promotion of female condoms; hence men received more exposure to female condoms than women. Another argument is that, since men negotiate condom use, it is reasonable to expose men to the promotion of female condoms so that they can support their uptake and use by their partners (Kulczycki et al., 2004).

If most students agree that female condoms are well promoted in South Africa, why have only a few used a female condom? This suggests that the promotion of female condoms does not lead to uptake. It corresponds with the findings of Chirwa's (2011) study that examined the acceptability of the female condom among female health workers in Botswana; the study found that the promotion of the female condom in Botswana did not lead to its uptake and use; neither did it have a positive effect on its acceptability among health workers. This clearly suggests that the promotion of female condoms is not enough to be sufficient to increase its uptake and use.

Female condom as an empowerment tool

The inability of women to negotiate condom use to prevent HIV is a key reason for the introduction of a female-initiated barrier method like the female condom (Megafu, 2011; Pool, 2000). It is believed that the female condom will empower women to negotiate safer sex and reduce their vulnerability to HIV. The study revealed that more male than female students felt that female condoms put women in charge of negotiating safer sex. This validates Barbosa, Berquo & Kalckmann's (2000) argument that women in many communities have never had the opportunity to ensure safer sex; their partners constantly assume this role and the most common method is the male condom; this could have an effect on their perception of female condoms.

Furthermore, studies have revealed that women have expressed concern about having to touch their genitals, which is required when female condoms are used; this affects their perception of its use (Miller, Exner, Williams, Ehrhardt, 2000; Latka et al., 2008). To address this issue, in New York, female condoms were introduced as an erotic toy for foreplay before they were introduced as a method for safer sex and HIV prevention (Miller et al., 2000). This correlates with the notion proposed by Kerwin et al. (2011) that the messages about both pleasure and safer sex in the promotion of female condoms increase support for female condoms.

The findings of the abovementioned studies provide the basis for questioning men's behavior and also pose new questions on why men in this study were supportive of female condoms. They also provide a basis for further studies of UKZN students to explore whether the

promotion of female condoms as an erotic toy could have had an effect on the way men have perceived the purpose of female condom.

Pool et al. (2000) argue that men's dominance in sexual matters is linked to women's feelings of disempowerment. Women do not feel that they have control over their sexual and reproductive health even when they would prefer to use other prevention methods like female condoms.

This study revealed that more male than female students felt that female condoms empower women. However, some people are not supportive of any efforts to empower women; this greatly affects the possibility of women being empowered through female condom use (Sippel, 2007). Even if women feel that using a female condom would empower them, resistance to women's empowerment in the broader society could discourage them from making this choice.

Sources of information about female condoms

The findings revealed that most of the respondents heard about the female condom from friends, followed by information from the clinic. The media and billboards played an insignificant role in on providing information and awareness of the female condom. Marseille & Kahn (2008) concluded that besides the role of different organizations in promoting female condoms; there is inadequate communication about female condoms, especially via the mass media. Hoffman, Mantell & Exner (2004) describe this as an information gap, as clinics and the media should be primarily involved in the dissemination of vital information about female condoms.

As noted in the literature review, Mckee, Bertrand & Benton (2004), argue that mass communication channels are very effective in reaching large mass audiences; however they have being underutilized in communicating and disseminating information about female condoms. This indicates that more needs to be done with regards to communication and the exchange of information about female condoms through the mass media.

Conclusion

The chapter presented and analyzed the quantitative data on perceptions of the female condom among male and female students. It should be noted that most of these perceptions are not based on students' experiences of the use of female condoms, but rather on perceptions about female condom usage. However, this creates a basis for further enquiry about how these perceptions can influence the uptake of female condoms. While most male respondents support the use of female condoms and feel that they provide better protection than male condoms, they also feel that they are inconvenient to use. The following chapter presents and analyzes the qualitative data.

CHAPTER 6: QUALITATIVE DATA PRESENTATION AND ANALYSIS

This chapter presents the qualitative data gathered through the focus group discussions that were held to complement the findings of the survey and solicit further perceptions of female condoms among students at the UKZN Howard College campus. The focus group allowed the participants to share their perceptions about female condoms, discuss other issues around the use of female condoms and engage in discussions on deterrents to female condoms use. Three focus group sessions were held: one with eight male students, one with eight females and a mixed session of eight male and female students.

The CFPD model proposes two stages. The first is steps to promote collective dialogue and the second is to promote collection action. For the purpose of this study, only the steps towards collective dialogue were used from a methodological perspective during the facilitation of the focus group discussions. The collective dialogue stage is made up of a 10-step process, namely, recognition of the problem; identification and involvement of leaders and stakeholders; clarification of perceptions; expression of individual and shared needs; vision for the future; assessment of current status; setting objectives; options for action; consensus for action; and action plan (Figueroa & Kincaid 2009).

This process for engaging respondents in collective dialogue provided the basis for the design of the focus group guide and the active participation of the respondents in the focus group. The collective dialogue process therefore adopted some steps which enabled questions and discussions on issues relating to female condoms and an exploration of how the challenges to the use of female condoms could be addressed.

As presented in the methodology chapter, responses have only been categorized for *clarification of perceptions* around the female condom, *expression of individual and shared*

needs, which was achieved by having separate male and female focus groups, and a combined focus group, *assessment of current status* of female condoms, and *vision for the future* in terms of what respondents understand to be the plans or considerations for the future of female condoms. It is also important to note that in adapting the CFPD model community dialogue stage, a flexible rather than a rigid approach was used; hence the selection of stages that best suit the study rather than the adoption of the entire process. It is important to use and transcribe data that is relevant to one's research; this makes analysis a lot easier and ensures that the researcher is working with only what is needed (McLellan, McQueen & Neidig, 2003; Markle, West & Rich, 2011).

Decades into research on the prevention of HIV and AIDS, new challenges have arisen in relation to changing behavior and new communication strategies are required (McKee, Bertrand & Benton 2004). A general limitation of health communication theories and approaches is that they focus on the individual; however, the spread of HIV and AIDS is not solely dependent on individual behavior. Socio-cultural issues that influence and may limit individuals' behavioral choices should also be considered (McGrath et al., 1993, Dutta-Bergman 2005, Airhenbuwa 2006).

This required an approach that would promote dialogue and participation, and since dialogue allows participants to share their feelings and experiences (Kincaid & Figueroa, 2009), the study drew on Kincaid & Figueroa's (2009) CFPD model that is based upon dialogue, information sharing, collective action and understanding (Kincaid & Figueroa, 2009). This model is central to this study because it enabled the design of questions which enabled participants to reflect on their perceptions of female condoms and engage in dialogue which initiated further discussions about deterrents to female condom use.

The qualitative data gathered during the focus group discussions using the steps of the CFPD model to understand students' perceptions of the female condom are presented below. FGD1 represents the first session (males only), FGD2 (females only) represents the second session and FGD3 (males and females) represents the third session. The participants are identified as R1 (Participant1), R2 (Participant2), R3 (Participant3), R4 (Participant 4) and so on. The data is first explored by presenting the focus group data within the relevant processes of the CFPD model and secondly, the data set from the focus groups is analyzed within the broader themes using thematic analysis. The first part of the data analysis was undertaken to demonstrate the relevance of dialogue as a participatory approach and further present the key findings using thematic analysis to analyze empowerment guided by the four developmental stages of empowerment (Kieffer, 1984).

SELECTED STEPS OF THE CFPD PROCESS

Clarification of perceptions

This stage provided the opportunity to solicit further responses on the participants' perceptions of female condoms. This category is one of the key sections as the study sought to ascertain students' perceptions of female condoms. As shown in the findings from the survey, students have different perceptions regarding female condoms. Students used the focus group to share more information on their perceptions and discuss issues relating to the use of female condoms. The focus group also enabled participants to clarify issues that that can be termed misconceptions about female condoms.

The perceptions discussed in this section relate to issues of poor promotion, high cost, inaccessibility, misconceptions about the use of female condoms and the link with culture,

and how these affect the use of female condoms. These were selected as perceptions on the basis that the literature has identified them as challenges to female condom use.

Male participants mentioned that they had never seen a female condom before and attributed this to poor promotion of female condoms.

“Health care providers do not promote female condoms at all; they do that for only male condoms; in fact I have not seen any before”
(FGD1-R2, 2013).

This suggests that health care providers pay more attention to promoting male condoms.

Female participants noted that there are more men who use male condoms than women who use female condoms.

“The number of women who use female condom is far less than men who use male condoms; it is expensive and not as easily accessible as male condoms” (FG2-R4, 2013).

Participants attributed the decline in female condom use to the cost and lack of accessibility of female condoms. They further explained that the cost of female condoms would have an effect on the campus clinic supplying these condoms.

“One female condom costs between R80-R100 and I have never even seen one at a pharmacy and I doubt this will make it available for free at the campus clinic” (FGD2- R5, 2013).

Unlike male condoms, which were readily available and free at clinics and public toilets, female condoms were expensive and had to be purchased.

The discussion further provided the students with the opportunity to clarify issues relating to misconceptions, one of which was that female condoms have to be inserted eight hours before intercourse. Students were under the impression that female condoms cannot be inserted shortly before intercourse and some questioned if the FC2 could actually be inserted minutes prior to intercourse.

“It’s quite inconveniencing using it considering that a female condom must be worn eight hours before intercourse” (FGD1-R7, 2012).

“Why must I insert a condom eight hours before we meet”? (FGD2-R2, 2013).

“I have a problem with it considering that I will have to insert it eight good hours before sex” (FGD2-R7, 2013).

This led to a discussion on knowledge, views and perceptions of FC1 and FC2.

“I am not sure but I learnt that the new female condoms can be inserted shortly before intercourse” (FGD3-R7, 2012).

“Someone informed me that the new female condoms can be worn soon before intercourse and that it’s the old one that had to be worn eight hours before. Not really sure though” (FGD3-R4, 2013).

An interesting discussion arose when participants debated culture and female condom use. They used various definitions of culture. Members of the female group agreed that culture has no effect on female condom use, while members of the male group debated for some time before consensus was reached that the belief that culture had an effect on female condom use was not true. In the mixed session, most participants agreed that culture does not affect male or female condom use.

“We need this false belief to stop, culture has nothing to do with playing safe” (FGD3-R7,2013).

“I strongly disagree that any cultural norms of beliefs affect safer sex be it through the use of female or male condoms” (FGD3-R5,2013).

In contrast with studies that have found that cultural norms affect sexually-related issues such as condom use, students were of the opinion that this is not the case.

Participants further argued that people need to protect themselves against HIV and culture has nothing to do with this.

“Culture in no way can affect female condom use, we need to be safe and protect ourselves from HIV .This has nothing to do with culture, I think if this issues can be clarified, it will make a great difference in how people understand culture and sexual practices” (FGD3-R4,2013).

“HIV is real and I’m in certain that directly or indirectly no cultural belief hinders using condoms or affects female condom use” (FGD3-R6, 2013).

This finding contradicts previous studies that found that culture has an effect or determines the uptake and use of male and female condoms (Gould, 1993; Olley & Rotimi, 2003; Megafu, 2011). The participants in all sessions agreed on issues of cost, accessibility and promotion of female condoms. Although all the participants were initially reserved about discussing culture and female condom use, after some debate, they agreed that culture has no effect on female condom use.

One of the challenges in gathering data through focus groups is that participants may be influenced by the opinions of others; hence their agreement with a point that they initially disagreed on. Another issue that seemed to pose a challenge was the participants' knowledge of the types of female condoms (FC1 & FC2).

When participants were asked about the types of female condoms, it appeared that most thought that there was only one type. The facilitator had to engage in further dialogue to explain the FC1 and FC2 types of female condoms. The participants shared similar perceptions and the discussion took longer than expected because all the participants had very valuable contributions to make with regards to women and female condoms as well as the negotiation of safer sex.

In all the focus group sessions, it was observed that whenever a participant tried to make a contribution that made female condoms seem an easier method than male condoms there were always counter-arguments. This contradicts the findings of the survey that male students were in favour of female condoms.

Expression of individual and shared needs

The focus group allowed students to freely express their individual interests, debate differences and establish similarities in their needs and perceptions of female condoms. The question in this section has to be repeated and explained as participants, especially in the mixed session, found it challenging to understand the meaning of 'expression of individual and shared needs' with regards to female condoms. As noted in the survey, the participants also had varied individual and shared needs with regards to issues around female condoms.

Students argued that, to increase the uptake of female condoms there is a need to promote female condoms, and make them cheaper and smaller.

“I feel that the factors that can influence female condom use will be to have it well promoted, cheaper and smaller” (FGD1-R5, 2013).

“I expect that more promotion should be engaged in to promote female condoms. So much promotion has been done for male condoms and that’s why it’s popular” (FGD2-R3, 2013).

Participants also said that they prefer something that adds to the fun of sexual intercourse and that the size of female condoms prevents this.

“We like fun, we want something that is fun and can add flavour to intercourse, and female condoms don’t look like they can. Tjo! (An exclamation) it’s ugly. The producers need to reduce its size; it doesn’t encourage its use” (FGD3-R1, 2012).

Participants in both the male and female sessions felt that male condoms are good enough and that there is no need for female condoms; this accounts for the low uptake.

“The truth is that male are good enough and there is no obvious need for female condoms” (FGD2-2, 2013).

“The acceptance and use of female condom is low because people are content with male condoms and don’t really see why female condoms were produced” (FGD1, R4-2013).

This finding does not concur with the finding from the survey that revealed that most male students agreed that female condoms are better than male condoms.

Assessment of current status

There are varied perceptions and beliefs about the current status of female condoms with regards to their uptake and use. Participants were asked to share their opinions on the current status of female condoms in South Africa. Most made assertive comments. The participants in all three sessions agreed that not much has been done in South Africa with regards to female condoms. Hence, most discussions did not portray a positive perception of the current status of female condoms.

Members of the male focus group were very expressive and passionate in discussing the use of female condoms; they felt that the current status of female condoms in South Africa is not impressive and added that the government is doing more with regard to male condoms and not paying sufficient attention to female condoms.

“In South Africa, all we know is male condoms. Nobody, not even the government or should I say ministers or even health officials promote female condoms. The use is very low and none of my friends have used it” (FGD1-R4, 2013).

“The current status in South Africa is bad, the government does not support in the uptake, use or even promotion of female condoms, so much is done with regards to only male condoms and absolutely nothing is done with female condoms” (FGD1-R3, 2013).

However, these findings contradict the finding from the survey that reveals that most students felt that female condoms are well-promoted in South Africa. Another contradiction is found in the statement made during the males only focus group session that male condoms are better and more reliable than female condoms. Yet, the survey found that most male students

agree that female condoms provide better protection than male condoms. These contradictions suggest that people's perceptions and opinions of people vary; the challenge is to align preventive methods with specific behavior. Further discussions highlighted that the lack of support from government has negatively affected programs and activities to promote female condoms.

“Currently the attitude of the government and medical staff does not do any good for the use of female condoms and this affects organization that set up programs to promote female condoms use”(FGD2-R8,2013).

“The use of female condoms in SA is very low; organizations are not encouraged and supported enough by the Department of Health which represents the government in promoting the use of female condoms”(FGD3-R1,2013).

Some participants felt that little is done to promote female condoms.

“I can't really say much but I know that male condoms are mostly promoted, advertised and used. I am not sure anything much is done with regards to female condoms as compared to male condoms”(FGD2, 2013).

“The use of female condoms is very low, it not promoted and scarce as compared to male condoms that we see and always hear about”(FGD3-5,2013).

Participants also had the opportunity to engage in dialogue and express their concerns about the current status of female condoms on campus. This was an important discussion that

provided very relevant data on students' perceptions of the current status of female condoms at the UKZN Howard College campus. Students felt that university management and clinic staff members have also not engaged in any form of promotion of female condoms on campus.

“The government or school authorities has not supported female condoms, even organizations that have tried to do this are not supported by the South African government” (FGD1-R7, 2012).

“UKZN management does nothing about female condoms, absolutely nothing. They only distribute free male condoms” (FGD3-R5, 2013).

Students also stated that they had not seen or heard any form of advertising or promotion of female condoms via any form of media.

“I have never seen a poster, hand bill or promotional material about female condoms on campus” (FGD2-R7 2013).

“There is no distribution of free female condoms on campus. I have not seen even a poster on female condoms on campus or any show to promote” (FGD3-R1, 2013).

“Most of us have been to the campus clinic. Not once has anyone said or can say they saw a female condom not even a wall poster” (FGD3 ,2013).

The above findings show that there is no media coverage or communication about female condoms on the UKZN Howard College campus and that government and university management has given more support to male condoms by making them available at no cost.

Vision for the future

After the students engaged in discussions and presented their perceptions of the current status of female condoms in South Africa, further discussions and questions solicited their contributions and perceptions about the future of female condoms with regard to uptake and use. Overall, participants presented similar opinions on the future of female condoms. They said that they do not see a positive future for female condoms in South Africa.

Members of the male group stated that they do not see a future for female condoms and doubt that men will support female condoms.

“In my opinion there is no future for the female condom, it has been in existence for a while and the use is still very low. I doubt men will really support it” (FGD1-R4, 2013).

“What future? Female condoms have been here for long and its use is super low. There is no future for it and that why we support male condoms” (FGD1-R8, 2013).

Once again, these findings do not correlate with the findings of the survey that indicated that most men support female condoms. This raises the need to further question whether men genuinely support female condoms and if they do, whether such support would extend to using them.

The contradictions in some of the findings from the survey and focus group could be the result of the level of independence respondents have when filling out questionnaires which is not the case in focus group discussions. Participants could be influenced by the opinions or positions of other participants.

Students also stated the cost of female condoms impacts their future. They said that if female condoms were cheaper, more people might use them. However, as noted earlier, most students feel that increased promotion and a reduction in the size of female condoms are required to increase usage.

“The future of female condoms depends on how well it is promoted and supported by producers in terms of reducing its size and cost”
(FGD1-R7, 2013).

“If it can be affordable and made to look better than male condoms, I am sure that in future we will embrace it and use and hopefully men will support its use”(FGD2-R4, 2013).

These statements support Stammers’s (2005) argument that promotion efforts play a very vital role in the uptake and usage of condoms. Kerwin et al. (2011) argue that promoting condoms can help increase their consistent use.

It was also clear that both male and female students do not know how female condoms empower women. This came through strongly as participants argued that students are not educated about how female condoms empower women and unless women are educated about how this occurs, men will not be supportive of their use in future.

“If women and men can understand how it empowers women, then men will be supportive. As it is now, women do not even know enough about female condoms so how does a man support”? (FGD3-R1, 2013).

“We lack the basic information about female condoms, ask anybody here, they all know about male condoms and can easily use it”
(FGD3-R5, 2013).

This suggests that students lack adequate knowledge about the empowerment of women through female condoms and emphasizes the need for more education. These findings suggest that students feel that an increase in the use of female condoms depends on promotion, a reduction in the size and cost of female condoms and educating both male and female students about how female condoms empower women. It is important to note that female students feel that besides cost, if female condoms can be produced that look better than male condoms, they will be encouraged to use them in future.

The next part of this chapter is the thematic analysis. This presents the analysis of relevant themes and topics that emerged from the focus group discussions.

Application of Thematic analysis for this study

The thematic analysis designed by Braun & Clarke (2006) was adapted for the analysis of the entire data. This allowed for the derivation of themes which were drawn from recurring patterns of comments, ideas and opinions from the qualitative data. The rationale for adopting thematic analysis was based on the fact that thematic analysis allows for contributions from both the researcher and participants and also allows for the easy identification of variance and similarities in the data set (Braun & Clarke, 2006).

This entire qualitative data was firstly explored to identify codes which are short words or phrases that are linked to a portion of a statement based on visual data (quantitative)

(Saldana, 2009). Inductive coding was used at this stage; this kind of coding is developed by the researcher by directly studying the data and creating codes where phrases or words are used to assign meaning to different sentences or paragraphs (Strauss & Corbin, 1990).

The inductive approach to coding helps the researcher to ensure that the data is coded with participants' exact words in the exact context of use; it also promotes reliability and replication (Krippendorff, 2004).

Inductive coding required the researcher to go through the data and create codes from responses gathered through the focus group discussions. The initial codes derived were cost; reduces pleasure; size; friends; no support from government; health workers do not care; not readily available; creates discomfort; poor publicity; and culture. Codes with similar meaning or similar attributes were then merged into one result. This led to the final codes, namely, cost; size; poor publicity; and mixed perceptions which were developed into overall themes to discuss the key findings which are presented later in this chapter.

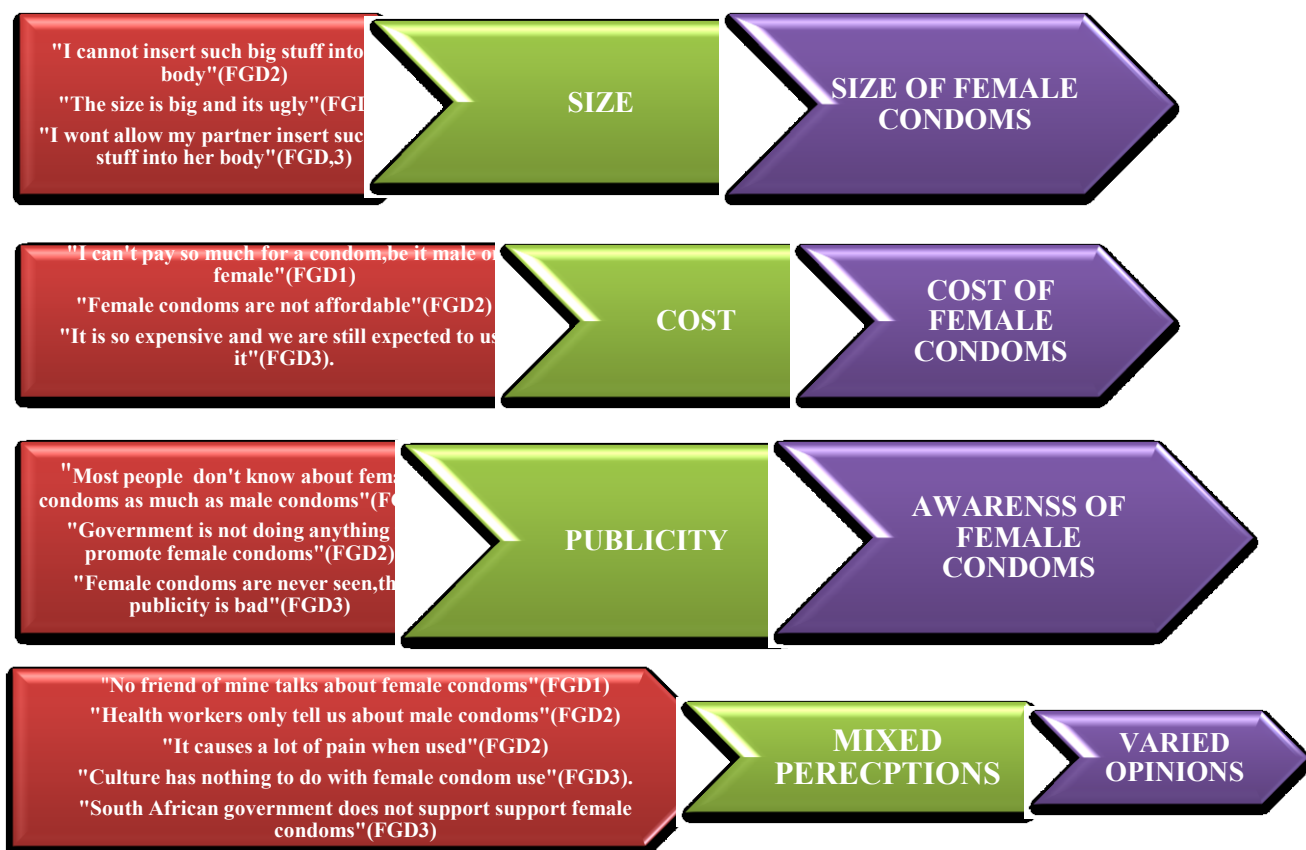


FIG.6. Process of inductive coding

DATA ANALYSIS

The thematic analysis was used to analyze the qualitative data guided by the four developmental stages of empowerment (Kieffer, 1984). The empowerment theory is the theoretical framework that guided and informed this study. According to Melkote and Steeves (2001), empowerment is a process in which people and organizations take charge of flexible participation patterns in their communities and of issues that relate to their existence and wellbeing. In this study, empowerment theory contributed to an understanding of whether female students feel empowered by female condoms. This forms a relevant section of the study as female condoms were produced to provide women with an alternative HIV prevention method which is also an empowerment tool for the negotiation of safer sex.

The key themes derived are, *comparison of the size of male and female condoms; cost of female condoms; inadequate knowledge about female condoms, influence of peers on female condom use; attitude of stakeholders towards female condoms; discomfort experienced from use of female condoms; culture not a barrier to female condom use and students' preference for male condoms*. These themes were derived from recurrent and similar patterns of discussions contained in the data gathered through the focus group discussion sessions. The four stages of empowerment consist of entry, advancement, incorporation and commitment (Kieffer 1984). The themes identified were then aligned with the stages of empowerment to better understand students' perceptions of the female condom and the opportunities that may arise for this HIV prevention method to serve as a form of empowerment to women.

The themes are analyzed within the four stages of empowerment below.

ENTRY LEVEL STAGE

The first stage of the empowerment theory is the entry level stage. At this stage, a person's experience of events that could be termed life threatening provides the motivation. This mirrors women's inability to negotiate safer sex which leads to an increase in HIV prevalence among women. The female condom was introduced to empower women to negotiate safer sex and prevent HIV infection. At this level, students' experiences and perceptions of female condoms will determine if they are empowered or see female condoms as empowerment tools.

Comparison of the size of male and female condoms

Students argued that, the size of female condoms was one of several challenges to their uptake and use. Across the three sessions this issue was central to all comments made by

students. Participants were very passionate in explaining and arguing that the large size of female condoms discourages them from using them; some even stated that the size scares them. Male participants said that this is the reason why they don't want their partners to use female condoms.

"The size is scary; I won't want to have such inserted into my lady"

(FGD1-R8, 2013).

"Just looking at its size, I won't want such to go into my girlfriend, way too big and ugly" (FGD1-R6).

Female participants adopted a similar position.

"That thing is big, how can I be afraid of what is expected of me to insert into my body"? (FGD2-R2, 2013).

"Female condoms are big, the size is a turn off and I'm not willing to put such into my body" (FGD2-R4, 2013).

Participants also stated that the producers of female condoms seem to be unaware of this issue.

"I doubt the manufacturers have an idea of how discouraging the size of female condoms is...." (FGD1-R5 2013).

"Sincerely the producers didn't think about the size, it big and ugly. One will pass and go for a male condom" (FGD3,-R8 2013).

Female participants expressed their preference for smaller male condoms.

"A male condom is better and smaller in size" (FGD2 R-3, 2013).

“The size of male condoms is attractive and it is portable compared to the big size of female condoms. I prefer the size of male condoms to that of female condoms” (FGD2-R1, 2013).

Male participants agreed and stated that their partners prefer the size of male condoms.

“My girlfriend prefers the size of make condoms and she also does not like the size of female condoms” (FGD1- R2, 2013).

“My girlfriend once told me that she perfectly loves the way male condoms looks especially the size and design” (FGD1-R5, 2013).

These findings concur with a study on female condoms in Durban by Smit et al. (2006) that revealed that people complained most about the size of FC2 and stated that there was no difference between the size of FC1 and FC2. Another study found that women felt that both the appearance and size of female condoms were challenges to its uptake and use (Marshall & Backos, 2002).

Cost of female condoms

The second theme is related to the effects of the cost of the female condom on its uptake and use. Participants emphasized that the high cost of female condoms has an effect on the distribution of free female condoms on campus and its availability in pharmacies. They felt that this was why the university authorities did not distribute female condoms.

“This University cannot place female condoms for free; they are very expensive” (FGD1-R8, 2013).

“The unit cost of female condoms is high and this would affect the ability of the school management to provide them for free. Male

condoms are cheap and that's why we have them for free on campus"

(FGD3-R6, 2013).

Female participants also expressed their opinions about the high cost of female condoms and stated that if female condoms were free, they would consider using them.

"I just can't afford it, how many will I buy if I need to play safe? If it were available for free on campus, maybe female students will try it"

(FGD2-R1, 2013).

"I heard it costs about R100, I would never buy it, and I could try it when I get it for free (FGD2-R3, 2013).

This corresponds with Jemmott & Brown's (2003) observation that, while some women would like to use female condoms, they would prefer not to have to pay for them.

An important point made by the participants was that the availability of free male condoms has an effect on the uptake and use of female condoms. Participants argued that they would not spend money on female condoms when male condoms are available at no cost and/or are cheap. The participants went on to say that the high cost of female condoms accounts for their low demand; hence, pharmacies do not stock female condoms.

"One cannot spend so much on female condoms when we have free male condoms available and they are a lot cheaper" (FGD3-R6, 2013).

"If female condoms cost that much, then I guess we can understand why people don't use it and if people don't use it why should it be stocked in a pharmacy? Pharmacies are there to make money; they won't stock what does not sell" (FGD3-R2, 2013).

This could explain why, as revealed in this study, female students prefer male condoms to female condoms. The finding concurs with evidence from previous studies that showed that, apart from the various other challenges to female condoms, cost has been advanced as a major reason for their low uptake and use at the global level (Kahn, Billinghamurst & Saba, 2001; Drew et al., 1990).

According to Hou et al., (2010) female condoms are not available because they are expensive. The cost of female condoms has been a major barrier in the United States, where they are more expensive and less available than male condoms (Weeks et al., (2010). Female condoms cost about \$3.00 and male condoms cost less than a dollar but are provided free through Medical Aid and other family planning interventions (Witte et al. 2010). Rahamefy et al. (2008) posit that cost has greatly affected the uptake and use of female condoms in Madagascar. A more extreme consequence is noted by Barbosa, Berquo & Kalckmann (2000) who note that despite successful attempts to persuade some people to use female condoms, the high cost has resulted in its reuse, especially in poor communities.

Culture not a barrier to female condom use

Most participants argued that culture has nothing to do with a women's decision to use a female condom. This finding contrasts with the literature that suggests that culture and beliefs play a role in the negotiation of safe sex. Participants were very passionate in their responses to this issue across all the sessions, with the male only session being the most vocal. While these participants started the discussion with much uncertainty, after further debate, most agreed that culture has no effect on the use of female condoms.

"I support having safe sex but I strongly disagree that culture has an effect on who negotiates it" (FGD1-R2, 2013).

“We don’t know of any culture that states or dictates that a woman cannot use a female condom” (FGD3, 2013).

Participants also explained while some cultures encourage respect for men, this does not mean that women cannot negotiate male or female condom use.

“There are cultures that actually encourage men to be respected but definitely no culture states that a woman cannot use female condoms or even ask to use a male condoms if she pleases” (FGD1-R3,2013).

Participants in the female session agreed and expanded on this issue.

“I don’t think culture has an effect on female condom use but I think people have just decided to base their assumptions on the notion of patriarchy that women cannot be in charge of such issues (FGD2-R4, 2013).

“My father is Zulu and my mother is Xhosa. My brother’s wife is Zimbabwean. I have learnt extensively about these cultures and I have never being told that any of these cultures have an effect on who decided the use of either a male or female condom. Female condoms are for the safety of the health of both parties so why will anyone believe that culture has an effect on the use of female condoms use by women?(FGD2-R6).

These responses provide evidence that participants do not feel that culture influences the negotiation of safer sex or use of the female condom. This finding is crucial, considering that

female condoms were developed to empower women and allow them to negotiate its use in light of cultural barriers.

This finding does not concur with scholars who posit that cultural factors form part of the challenges women experience in the use and uptake of female condoms (Hammuda & Dulaimi, 1997; Gould, 1993; Olley & Rotimi, 2003; Kort, 2009; Megafu, 2011).

The results suggest that at the entry stage, students are partially empowered; the cost and size of female condoms does not offer any motivation for empowerment but the students feel that culture is not a barrier to female condom use. A level of empowerment is available at this stage because students challenge existing beliefs that culture influences condom use. This is premised on the idea that empowerment can also serve as a key element in challenging the norms that place women in subordinate positions to men and enabling them to take control of their lives and embrace change (Batliwala, 1994).

ADVANCEMENT STAGE

The advancement stage is made up of three key aspects: a mentoring relationship, collective peer support relationships within an organized structure and the development of a deeper understanding of social and political relations. This stage identifies organized structures in the form of interventions or agencies that have established support structures that create a platform for the establishment of communication and programs that empower women and promote female condoms.

This question was explored by establishing how students came to know about female condoms and what available support structures they could identify for the communication and promotion of female condoms.

Inadequate knowledge about female condoms

Participants shared similar opinions on the awareness of female condoms. Most felt that awareness is very low; hence their lack of knowledge on female condoms even to the extent of being unable to identify the various types.

“The promotion of female condoms is very low, yet a lot is not done to increase its awareness it and we are expected to know how to use it and tell others; how does one tell other of what they have no idea about”? (FGD1-R8, 2013).

Other participants felt that low awareness has affected the availability of vital knowledge about female condoms.

“How can I know the types of female condoms when it is not even well promoted, I have never seen an advert or even a bill board promoting female condoms and then you ask which I know? Not a realistic question I must say” (FGD3-R5, 2013).

Still others stated that if female condoms were to be promoted and available, their uptake and use would increase.

“We are made to believe that female condoms are produced to empower us but yet we are lost. We do not have enough information about it not even on how to use it” (FGD2-R4, 2013).

“The basic information we need about female condoms is lacking” (FGD2-R7, 2013).

“We do not have the needed information we need about female condoms. When people are well informed, then an increase in use will be recorded” (FGD3-R2, 2013).

The lack of information and education about female condoms affected students’ ability to tell people about them or, worse still, to use them themselves. These findings are similar to those of a study on female condoms by Hoffman, Mantell & Exner (2004); they argue that, while female condoms have been produced, awareness of the product is low and people only have a vague idea of what they are. Naik & Brady (2008) found that the lack of awareness of female condoms has played a major role in low uptake and use.

Further supporting evidence is contained in responses from members of the ZAZI Facebook page. The ZAZI campaign is a USAID/PEPFAR funded program in partnership with the NDoH and other relevant agencies which encourages women and girls to stand up for their health and reproductive rights like using female condoms in sexual intercourse as a HIV prevention method. Below are some responses from members of ZAZI Facebook page. These comments were posted on the page when questions related to female condoms were asked on the 2nd Global Female Condom Day on September 16, 2013.

ZAZI1: I cannot explain exactly how condoms are used but I have some in my purse and I have never used them but I wish to.

ZAZI2: Where does one get female condoms? Can i buy them at the pharmacy or garage like the male condom?

ZAZI3: More education is needed to be done about female condoms; most women haven’t seen it and I don’t like the fact that I have to put it in hours before sex.

ZAZI4: I know nothing about female condoms, I only hear about it but nobody educates us about using it and all³⁰

These comments support the findings of this study that suggest that there is inadequate information about female condoms which has resulted in low uptake and use.

Influence of peers on female condom use

The analysis of the quantitative data in the previous chapter revealed that most students received information about female condoms from their friends. The discussions also centered on the determinants or influences of female condom use among students.

Participants across the different sessions explained that their peers influenced their decision to use a female condom.

“I can’t encourage my partner to use a female condom, what my friends have told me about it makes it unappealing” (FGD1-R7, 2013).

“When we discuss with our friends, we only talk about male condoms and not female condoms” (FGD2-R1, 2013).

“We discuss a lot and agree on many decisions, female condoms has never been a topic but male condoms and this has made us agree that it’s best to use” (FGD3-R5, 2013).

³⁰ These comments were rewritten for clarity as the authors wrote their comments in short hand but the meanings were not changed.

This suggests that friends or peers' perceptions affect the way in which students view female condoms. Alarape, Olapegba & Chovwen (2008) argue that there is a direct link between students' perceptions of condoms and their use.

As noted earlier, the friends students rely on for information about female condoms may lack adequate information and knowledge. At this stage, empowerment is low as students are not empowered through any organized structure that promotes or engages in communication about or promotion of female condoms. As revealed in the survey, media and billboards showed minimal effect in providing information and promoting awareness about female condoms.

The core of this stage is the available sources of information and communication about female condoms that students could identify; the above data presents their collective responses and shows that students are not adequately informed about female condoms and that their peers influence their decisions to use female condoms. It is important to reiterate that the findings of the survey showed that more students received information about female condoms from their friends than from any other source of information (clinics, billboards, etc.). Given this, it is evident that students lack information on female condoms and how they can be used to prevent HIV prevention and empower women.

Empowerment is conceptualized as enabling, which essentially refers to acquiring knowledge and status to take control of one's life; it is the capacity to benefit from involvement in support initiatives (Lee, 2001). Drawing on this, at the advancement stage, students are not empowered because they lack knowledge and cannot identify any support structure or initiative that provides information and communication about female condoms. This could

explain why their peers are the most common source of information and why they influence their peers regarding the use of female condoms.

In another light, considering that peer support is one of the key elements of this stage, it can be assumed that the influence students have on each other (peer support) in decisions to use female condoms presents some level of empowerment. However, the data shows that empowerment is not present, as the influence students have on each other is not directed to the uptake of female condoms; as most discussions centre on male condoms. This has affected female condom use amongst students. This does not concur with the views of scholars who argue that empowerment occurs when people gain power to take individual or collective action to achieve control over their lives (Laverack, 2006; Zimmerman & Perkins 1995; Chatterjee & Canda, 1998).

INCORPORATION STAGE

The incorporation stage is about growing political consciousness where people are informed about the challenges that women experience. This includes women's susceptibility to HIV and the availability of a female-controlled HIV prevention method that empowers women to negotiate safer sex. This implies that at this stage, women are supported by the government through the promotion and awareness of female condoms in HIV prevention. This stage is similar to the advancement stage but it specifically relates to collective action on the part of the government; this is tested by the responses on the students' perceptions of the promotion of female condoms in South Africa.

Attitude of stakeholders towards female condoms

Participant's comments highlighted that the government and health workers have not encouraged female condom use. This was highlighted in the discussions on their opinions on female condom use in South Africa. In all the focus group sessions, participants were very clear that stakeholders' attitudes have negatively affected the uptake of female condoms.

"In South Africa, the government does not promote female condoms; they are only concerned about male condoms and that is why you cannot see female condoms anywhere and people don't use it" (FGD2-R1,2013).

"The government and doctors only support male condoms, they don't care about female condoms trust me. (FGD2-R8, 2013).

The effect of the lack of support for female condoms from the government was explained by participants.

"Some local and international NGOs have tried to promote female condoms in South Africa but the South African government is really not supporting them" (FGD3-R6, 2013).

"I learnt that some organizations promote female condoms but the lack of government support has not helped them in this regard. (FGD2-R8, 2013).

These statements reveal that the government's lack of support for the promotion of female condoms has also affected the activities of NGOs with programs to promote female condoms in South Africa.

This could be the reason for Onyenechere's (2010) assertion that the South African government needs to be more supportive of female condoms through establishing and

implementing policies and supporting organizations that support such promotion. This finding does not agree with the finding from the survey presented in the previous chapter. The survey revealed that students agreed that female condoms are well-promoted in South Africa. However, the finding from the discussions through dialogue reveals that students are of the opinion that female condoms are not well-promoted, especially by the South African government. In contrast, Beksinska, Smit, & Mantell (2011) maintain that the South African government has supported the promotion of female condoms in South Africa.

These contradictions further validate the advantage of dialogue through focus group discussions. Focus groups enable further responses to be solicited as well as perceptions on an issue through dialogue (Morgan, 1988; Duggleby, 2005). The focus group discussions enabled clarity to be obtained on the students' perceptions of the promotion of female condoms in South Africa. While the survey respondents agreed that female condoms are well-promoted, focus group participants stated that they are not, especially by the South African government.

Health care providers have been identified as stakeholders in the promotion of female condoms in South Africa. This led the South African government to formulate a policy in 1995 that included access to female condoms in the public sector and service providers were trained to introduce the female condom (Mantell et al., 2000). However participants identified the South African government and health workers as key stakeholders who have not supported the uptake and use of female condoms. Participants felt that health workers' attitudes have negatively affected the uptake and use of female condoms.

“Most health care providers in my opinion don’t care about female condoms; I have paid several visits to the clinic and hospital and never has one shown me a female condom” (FGD1-R8, 2013).

“Many ladies cannot recall anytime a health worker ever promoted female condoms to any of us. I do not even know how to use it” (FGD2-R5, 2013).

“Nurses do not seem interested in informing patients about female condoms; they always will tell us about male condoms” (FGD3-R7, 2013).

These comments suggests that the government and health workers are not supportive of female condoms; as the participants noted, more attention is given to male condoms. This could also account for the increase in the uptake and use of male condoms among the participants.

While some organizations have designed interventions like the ZAZI campaign to promote and increase the uptake and use of female condoms in South Africa, these interventions have not received the required support from the government. Yet an agreement was reached with the producers of the female condom to make it available at a subsidized price to governments and donors in all developing countries (UNAIDS, 2009).

At the incorporation stage, stakeholders like the government and health workers are expected to support the promotion of the uptake and use of female condoms which leads to empowerment. However, the responses of the participants reveal that the government and health workers do not support female condoms as much as male condoms. In the analysis of the CFPD stage (assessment of the current status) students argued that the university

management has also not supported female condoms as much as male condoms which are distributed free of charge. This indicates that at the incorporation stage stakeholders have not empowered students because they have not supported the uptake and use of female condoms.

COMMITMENT STAGE

The final stage is the commitment stage; this stage is about individual or collective involvement in the uptake of female condoms in HIV prevention and sustained support for women's ability to negotiate safer sex. This stage is vital because it is at this stage that women are expected to be able to negotiate safer sex by initiating female condom use and to a greater extent liberate themselves from the factors that have made them highly vulnerable to HIV. This level will be explored from the responses of students to the question on whether they feel empowered by female condoms.

Discomfort experienced from use of female condoms

Participants shared their opinions and perceptions of discomfort experienced from the use of female condoms.

“The pains experienced while inserting and after it use is not worth the use” (FGD1-R2, 2013).

Furthermore, there is the challenge of keeping the female condom in place during use,

“I have a friend who told me it was a task to have it stay in place and so much pain was experienced, I definitely would not want to go through this pain” (FGD2-R6, 2013).

“Just imaging the stories about the pain people go through, I won't use it” (FGD2-R1, 2013)

Participants in the mixed session affirmed that they had prior information that the female condom affects sexual pleasure and this impacts their willingness to use it.

“We are well informed that users of female condoms experience a decrease in sexual pleasure and experience pains; how can we then be expected to use it or encouraged to tell others to use them?”

(FGD3-R4, 2013).

These responses highlight that students feel that the pain experienced when using female condoms affects their use and the likelihood of students encouraging their peers to use them. These findings align with Marshall & Backos’s (2002) argument that women have often complained about the appearance and size of female condoms as well as the pain experienced during their use which have presented a challenge to uptake and use. Megafu’s (2011) study on female condoms in South Africa revealed that although there are other challenges to female condoms, the belief that female condoms inhibit sexual pleasure has affected their uptake and use.

Students’ preference for male condoms

Participants noted that the cost and size of female condoms made students prefer male condoms.

“We prefer and are used to male condoms than female condoms”

(FGD1-R3, 2013).

“I totally prefer male condoms, female condoms is a no no for me”

(FGD2, 2013).

A similar response cites the ease of use of male condoms as the reason why students prefer them.

“Male condoms are definitely easier to use and that’s all we like most” (FGD2-R2, 2013).

“We mostly use and like male condoms; it’s very easy to use. No one complains about it. (FGD3-R8, 2013).

These comments suggest that students are familiar with and prefer male condoms. This finding concurs with a study on female condoms in United States that revealed that people preferred male condoms to female condoms and that this greatly affected the uptake and use of female condoms (Witte, Stefano & Hawkins, 2010; Rahamefy et al., 2008); Barbosa, Berquo & Kalckmann, 2000). Furthermore, many women do not believe that female condoms are a reliable barrier method (Weeks et al., 2010). These studies echo the findings of this study that reveal that women do not feel empowered by female condoms.

The commitment stage is a crucial stage because it emphasizes that individual and collective action towards change is the key focus for empowerment. However, this contradicts the concept of empowerment in relation to how it applies to the commitment stage. Empowerment “is a process by which individuals and groups gain power, access to resources and control over their own lives. In doing so they gain ability to achieve their highest personal and collective aspirations and goals” (Chatterjee & Canda, 1998:91). In the commitment stage, students are not empowered individually or collectively as a result of discomfort from female condom use and preference for male condoms which does not encourage them to use female condoms for HIV prevention.

A summary of the entry, advancement, incorporation and commitment stages of empowerment establishes that students are not empowered to use female condoms as they have negative perceptions of female condoms, are inadequately informed about female condoms and key stakeholders have not given their attention to the promotion of female condoms as much as male condoms. These factors have greatly impacted the ability of students, especially women to use female condoms as a HIV prevention method. It is important to note, however, that scholars postulate that the challenge in analyzing empowerment is the lack of consensus on the aims of empowerment; it not a clearly defined concept (Zimmerman, 1990; (Sonderling, 1997; Laverack & Wallenstein, 2001; Kaler, 2001; Mohajer & Earnest, 2009). Since participation cannot be measured and is dependent on responses from people, it is measured based on the outcome of how many people are empowered (Laverack, 2006).

The quantitative and qualitative data is collectively important to answer this study's research questions.

Addressing the research questions

The key research questions in this study are addressed based on the findings presented in the analysis of both the qualitative and quantitative data. The responses to the research questions gathered through the survey and focus group discussions are presented below.

What are students' (male or female) perceptions of the female condom?

The first research question explored students' perceptions of the female condom. Information was gathered to assess the respondents' perceptions of the female condom and if women feel empowered by its introduction.

The study revealed while some students feel that female condoms are well-promoted, others disagree, especially when it comes to the South African government. Most male students said that female condoms offer better protection than male condoms. However students believe that female condoms are not easily accessible.

More male than female students felt that female condoms put women in charge of negotiating safer sex. The findings also reveal that more male than female students are of the opinion that female condoms are inconvenient to use. Most students perceive that using a female condom makes a woman's partner think that she assumes that he is promiscuous and not engaging in safer sex practices. Another finding is that more male than female students feel that the female condom is an empowerment tool for women.

What communication exists about the female condom?

This question led to the gathering of information to establish how the participants came to know about female condoms and current communication about female condoms.

The findings revealed that the most common source of information about female condoms among students was friends, followed by the clinic. The media and billboards showed minimal effect in providing information and awareness on the female condom.

Students still believe that female condoms must be inserted eight hours before sexual intercourse. However, this is not the case with the FC2; this misconception was clarified during the focus group sessions and students were informed that the FC2 can be inserted

shortly before sex. Students were also informed about the types of female condoms, as they were not aware of the FC1 and FC2.

Conclusion

In addition to the quantitative data, qualitative data was gathered to solicit further responses on students' perceptions of the use of female condoms. The qualitative data was gathered through a participatory approach which encouraged dialogue with students on female condoms. Kincaid & Figueroa, (2009) note that dialogue is a conversation that clarifies what people think or believe and allows them to express their individual opinions and obtain clarity on important issues.

The data was firstly analyzed through the CFPD community dialogue stage with the consideration of the steps related to *expression of individual and shared needs, assessment of current status of female condoms and vision for the future*.

The study was located within the empowerment theory and the qualitative data was further analyzed through thematic analysis drawing on Kieffer's (1984) four stages of empowerment, namely, entry stage, incorporation stage, advancement stage and commitment stage.

The themes that emerged are *comparison of the sizes of male and female condoms; cost of female condoms; inadequate knowledge about female condoms; influence of peers on female condom use; attitude of stakeholders towards female condoms; discomfort experienced from use of female condoms; culture not a barrier to female condom use; and students' preference for male condoms*.

The findings reveal that students are not empowered to use female condoms for HIV prevention.

- More male than female students felt that female condoms offer better protection than male condoms. This was evident in the findings from both the survey and focus group discussions.
- More male than female students agreed that female condoms put women in charge of negotiating safer sex.
- The findings revealed that more male than female students felt that female condoms are inconvenient to use.
- Students perceive that using a female condom will make a woman's partner think she does not trust him.
- Most students felt that female condoms are not easily accessible. This finding was evident in the data from both the survey and focus group discussions.
- The survey revealed that most students perceived that female condoms are well promoted in South Africa. However the focus group revealed a discordant finding.
- The findings from the focus group revealed that students feel that there is insufficient promotion of female condoms in South Africa and that their use is not promoted by the government. Students believe that this is one of the factors that accounts for the low uptake and use of female condoms in the country.
- A key finding from the survey was that more male than female students feel that, female condoms empower women.
- Another key finding is students do not believe that culture influences female condom use. This does not correspond with studies and scholars that argue that cultural practices account for the challenges women experience in the negotiation of safer sex. To this end, Basu & Mohan (2009) advocate for culture-centered approaches to HIV

and AIDS prevention. This foregrounds the need to promote dialogue that is rooted in the participants' culture which enables increased participation and a better understanding of different cultures.

The following chapter presents the conclusion and recommendations.

CHAPTER SEVEN: CONCLUSION

This study sought to ascertain students' (male and female) perceptions of the female condom, the existing mode of communication about the female condom and other relevant information about female condoms. The literature review explored the relevant literature on health communication, HIV and AIDS communication, ABC messages, perceptions of condom use among university students, new approaches to HIV prevention, women, HIV and AIDS, women empowerment, the female condom in South Africa and the future of female condoms. The research methods included survey as a research design, using mixed methods for collecting and analyzing quantitative and qualitative data. As earlier established, the mixed methods approach was not rigidly adopted; the data from both the survey and focus groups were independently presented and further analyzed.

The research population was male and female students residing at two on-campus residences at the UKZN Howard College campus, namely Pius Langa and John Bews. The sample frame was made up of 124 students who formed the study participants; they were selected using a non-probability snow ball sampling method.

The study was located within the overarching concept of participatory development and empowerment theory. The CFPD community dialogue stage was adapted as a methodology to engage the students in dialogue on issues relating to female condoms which led to the solicitation of their knowledge and perceptions about female condoms.

The key findings of this research study revealed that male students are more supportive of female condoms than female students. Female students do not feel empowered by female condoms; this is a result of inadequate information and insufficient promotion of female

condoms. The most common source of information about female condoms among students was friends, followed by the clinic. Media and billboards had a minimal effect in providing information and awareness on the female condom. Students feel that culture does not influence condom (male or female) use.

The findings from the focus group provided further information on students' perceptions of students regarding female condom use. The focus groups consisted of three sessions; one each with male and female students and a mixed session of male and female students. The sessions provided a basis for discussions that promoted dialogue amongst the students about deterrents to female condom use and other issues. This enabled students to engage in extensive discussions that led to the clarification of perceptions, expression of individual and shared needs, assessment of current status and a vision for the future of female condoms.

The data was further analyzed through thematic analysis. The themes that emerged were comparison of the size of male and female condoms; cost of female condoms; inadequate knowledge about female condoms; influence of peers on female condom use; attitude of stakeholders towards female condoms; discomfort experienced from use of female condoms; and students' preference for male condoms. The analysis was guided by Kieffer's (1984) four stages of empowerment that revealed that students are not empowered to take up female condoms as a HIV prevention tool that was produced to empower women in the negotiation of safer sex. This research study has added to the growing body of literature on HIV prevention and to the scarce literature on the perceptions of female condoms noted by Callender, (2012).

The data from the survey and the focus groups provide evidence of the importance of understanding perceptions. The survey found that more male than female students are

supportive of female condoms. The findings revealed that the most common source of information about female condoms among students was friends, followed by the clinic. The media and billboards had minimal effect in providing information and awareness on the female condom.

The high cost and large size of female condoms and the lack of support from government, health workers and university management were presented as barriers to the uptake of female condoms among students. Most female students are of the opinion that male condoms provide better protection than female condoms. This could be because male condoms are better promoted and cheaper than female condoms.

With regard to trust, male students believe when women use female condoms, this means that they do not trust their partners; more female than male students agreed with this point of view. The study also found that students do not agree that culture has a role to play in the uptake of female condoms. They stated that there is no culture that abhors safer sex practices, but agreed that people have drawn their conclusions based on patriarchy which is not a sufficient basis to assert that culture in its entirety affects female condom use. This challenges earlier studies that strongly suggest that culture is among the challenges women experience in the use of female condoms. The study also revealed that most female students do not feel empowered by the introduction of female condoms.

Recommendations

The first recommendation that emerges from the findings is that female condoms should be reduced to a smaller, more attractive size, like male condoms. The cost of female condoms should also be addressed. The FC2 was produced in response to the lack of uptake of the FC1

due to its high cost. However, as established by this study, the cost of female condoms is still relatively high compared with male condoms. This has greatly affected the uptake and use of female condoms as students prefer to use male condoms which are cheaper and/or free.

The second recommendation relates to communication, promotion and dissemination of information about female condoms. The South African government and other stakeholders should support an increase in communication and promotion of female condoms through the media and other sources to complement the information students receive about female condoms from their peers. Stakeholders should also actively support interventions to increase the uptake and use of female condoms.

The third recommendation is for a reliable communication strategy to educate people and promote the female condom in the form of Entertainment Education (EE). EE is a strategic communication medium that has been used in health communication. It has been used in South Africa to address issues relating to HIV and AIDS and has produced remarkable results (Myers, 2011).

EE “is a strategic process to design and implement a communication form with both entertainment and education elements to enhance and facilitate social change” (Coleman, 1999:76). It refers to “the intentional placement of educational content in entertainment messages” (Singhal & Rogers, 2002: 117).

The entertainment media is a persuasive tool in educating the public about social problems; including HIV & AIDS (Singhal & Rogers, 1999). EE is “the process of designing and implementing entertainment programmes to increase audience members’ knowledge about a

social issue, create favorable attitudes and change their overt behaviour regarding the social issue” (Vaughan et al., 2000:181). This establishes that EE is a planned communication strategy that can be used in the communication and promotion of female condoms.

The fourth recommendation that emerges from this study is that further research should include the collective action stage of the CFPD model to gather people’s perceptions and empower them to engage in collective action for change.

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APPENDICES

Appendix A: ETHICAL APPROVAL



18 June 2012

Mr Temitope Ogunlela (211523912)
School of Applied Human Sciences

Dear Mr Ogunlela

Protocol reference number: HSS/0353/012M

Project title: Women and HIV & AIDS: Perceptions of female condoms among students at UKZN, Howard College Campus

In response to your application dated 21 May 2012, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

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

Yours faithfully

Professor Steven Collings (Chair)
Humanities & Social Science Research Ethics Committee
/ms

cc Supervisor: Professor Keyan Tomaselli and Eliza Govender
cc Academic Leader: Professor JH Buitendach
cc Ms Alice Palan

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Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville



APPENDIX B: INFORMED CONSENT FORM

To be read out by researcher before the beginning of the interview/Focus Group Discussion. A copy of the form will be signed by the respondent.

Dear Participant

Thank you for taking part in this research study. Your input will add significant value in to the research project titled ***Women, HIV AND AIDS: Perceptions of female condom among students on UKZN Howard College campus.*** This study aims to explore the various perceptions students at University of KwaZulu-Natal, Howard College have of the female condom. This research is conducted by Temitope Ogunlela (Student No: 211523912) towards my M.sc degree.

Please be advised that that you may choose not to participate in this research study and would you wish to withdraw at any stage, you have the full right to do so and your action will not be of any disadvantage to you in any way.

Your participation in this research will be through filling out a questionnaire or taking part in a focus group discussion; these will be arranged to ensure minimal disruption to your schedule. The information obtained will be treated as confidential; pseudonyms will be used in identifying respondents or participants when necessary. This will be safely stored at the University of KwaZulu-Natal, Howard College Campus.

Should you have any questions my contact details are:

Temitope Ogunlela

Centre Communication, Media and Society

University of KwaZulu-Natal,

Howard College Campus

Cell: 0782122107

e-mail: temilela@yahoo.com

Should you need further clarity, please contact me or my supervisors:

Prof. Keyan Tomaselli

tomasell@ukzn.ac.za

Eliza Govender

govendere!1@ukzn.ac.za

Thank you for agreeing to take part in the project. Before I start I would like to emphasize that:

- your participation is entirely voluntary;
- you are free to refuse to answer any question;
- you are free to withdraw at any time.

DECLARATION:

I,hereby declare that I am fully aware of the contents of this document and the nature of the research project, and I fully agree to participate in this research project.

However, I am taking part in this project as a volunteer, and therefore I have full rights to refuse to answer questions that I may not wish to answer. I also have full rights to withdraw at any point in this research project should I wish to do so, and my action will not be of any disadvantage to me in any way.

Signature of Participant

Date

APPENDIXC: QUESTIONNAIRE

Dear respondent,

This questionnaire is designed to gather authentic information on student's perceptions of the female condom. Please only tick one relevant answer.

Thanks for your participation.

PART A

Demographic data

- 1- Age
 - 1- 17- 20
 - 2- 21-29
 - 3- 30-39
 - 4- 40-49

- 2- Which Race do you belong to?
 - 1- Black
 - 2- Coloured
 - 3- Indian
 - 4- White
 - 5- Other (specify)

- 3- Marital Status
 - 1- Single
 - 2- Married
 - 3- Co-habiting
 - 4- Separated/Divorce

- 4- In what year of study are you?
 - 1- First
 - 2- Second
 - 3- Third
 - 4- Post- graduate

- 5- Which college and school do you belong to?

- 6- In which residence do you reside?

- 1- Pius Langa
- 2- John Bews

PERCEPTIONS OF FEMALE CONDOM

7- What type of family planning/ HIV prevention method have you used?

- 1- None
- 2- Male condom
- 3- Female condom
- 4- Injection or Pill

8- Do you know about female condoms?

- 1- Yes
- 2- No

9-If yes, specify how did you get to know about it?

- 1- Friends
- 2- Clinic
- 3- Billboard
- 4- Hand bill
- 5- Media

10- Do you agree that female condoms offer better protection than male condoms?

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

11- Female condoms put women in charge of negotiating safer sex.

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

12-Female condoms are inconvenient to use.

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

13- Using a female condom makes a woman's partner think that she does not trust him.

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

14- Female condoms are not easily accessible

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

15- Female condoms must be inserted hours before intercourse.

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

16- Female condoms are well promoted in South Africa.

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

17- Female condoms empower women.

- 1- Strongly agree
- 2- Agree
- 3- Strongly disagree
- 4- Disagree
- 5- I don't know

APPENDIX D: FOCUS GROUP DISCUSSION GUIDE

RECOGNITION OF THE PROBLEM

Statistics shows that HIV prevalence is highest among women;

In your opinion, what factors have led to the high HIV prevalence among women?

IDENTIFICATION AND INVOLVEMENT OF LEADERS AND STAKEHOLDERS

In your opinion which stakeholders or government agencies has played a key role in the promotion and uptake of female condoms?

CLARIFICATION OF PERCEPTIONS

What is your perception about the female condom?

Have you ever seen a female condom?

Are female condoms available in the campus clinic?

What types of female condoms do you know?

Do you think the number of women who use female condom is the same as number of men who use male condoms? If no why?

Do you think health care providers promote female condom alongside other family planning or HIV prevention methods, if yes, how; if no why?

Female condoms are as available as male condoms in pharmacies, if yes, which pharmacy; if no what do you think is the reason for this?

How affordable are female condoms?

EXPRESSION OF INDIVIDUAL AND SHARED NEEDS.

What can each of you say about female condoms in the negotiation of safer sex for women? Explain the factors that you think can influence female condom use.

It is believed that culture has an influence on the use of female condoms; give your opinion on this.

Would you recommend female condom to a friend; if not why?

Would you allow or encourage your partner to use female condoms?

VISION FOR THE FUTURE

What future benefits will the uptake and use of female condoms bring for women?
In future, would men support their partners in the use female condoms?

ASSESSMENT OF CURRENT STATUS

What do u think is the current status of female condoms in South Africa?

What forms of communication about female condom exists on campus?
Do you discuss about female condoms with your friends, if yes, what; if no why?

Which poster, hand bill or program on female condoms have you seen on campus?

Is there distribution of free female condoms on campus; if yes, where?

How sufficient is the communication to encourage the uptake of female condom on campus?

Can you identify any advert spot on TV, radio or any media about female condoms?

How affordable are female condoms at the moment?

How supportive is the South African government in the uptake and use of female condoms?

SETTING OBJECTIVES

What steps, activities or processes will you suggest to be followed to bring about change in the current state of female condoms?

What will be the outcome of the aforementioned suggestions?

OPTIONS FOR ACTION

How can the suggestions made above be achieved?

Consensus for action

What is the collective agreement to how you intend to support the uptake of female condoms?

Action plan

How do you as an individual intend to support the uptake of female condoms?