USING A CULTURAL MODEL TO ASSESS FEMALE CONDOM USE IN MPUMALANGA, SOUTH AFRICA

A Thesis in
Biobehavioral Health

by

Jonas DeWitt Webster

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The thesis of Jonas DeWitt Webster has been reviewed and approved* by the following:

Collins O. Airhihenbuwa  
Professor of Biobehavioral Health  
Thesis Advisor  
Chair of Committee

Patricia B. Koch  
Associate Professor of Biobehavioral Health

Edward A. Smith  
Senior Research Associate  
Human Development and Family Studies

Edgar P. Yoder  
Professor of Agricultural Extension and Education

Lynn T. Kozlowski  
Professor of Biobehavioral Health  
Head of Department of Biobehavioral Health

*Signatures are on file in the Graduate School
ABSTRACT

Culture is identified as a set of implicit and explicit guidelines inherited by members of a particular society that tell them how to view the world, experience it emotionally, and to how to “behave in relation to other people, to supernatural forces or gods, and to the natural environment” (Helman 1990, p 2). Culture plays a vital role in determining the level of health of the individual, family and community. Recently, public health researchers have begun to recognize culture’s position in health promotion by applying it to existing socio-behavioral variables to develop health-related interventions. The purpose of this study is to conduct a secondary data analysis of socio-cultural findings from the evaluation of an STI/HIV/AIDS prevention effort – the Mpumalanga Female Condom Project (MFCP). The study uses the PEN-3 model, a framework developed to centralize culture in health promotion interventions (Airhihenbuwa, 1995, 1999), to conduct a modified content analysis of phrases, words and issues from focus groups, open-ended questions, and key informant interviews to identify the relationship between culture and female condom acceptance and use in a peer education-focused community-wide STI/HIV/AIDS prevention effort. The PEN-3 Model helped describe the Mpumalanga peer educator, community member and MFCP staff knowledge, attitudes, and practices related to the female condom prevention effort. The analysis indicated that culture in the context of gender relations (the status of women in relation to men in society and community and the influence on sexual negotiation and decision-making) and communication are key factors in female condom acceptance and use in this community. Finally the Mpumalanga Female Condom Project helped to positively shape attitudes and norms that guide prevention behaviors related to STI/HIV/AIDS in the community. These
findings support theory that critical analysis through a cultural framework is a key factor in promoting behavior change at the individual, family and community level.
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CHAPTER 1

INTRODUCTION

Since AIDS was first identified more than 20 years ago the epidemic has increased exponentially and has been reported in all regions of the world. According to UNAIDS (2002), globally more than 20 million people have died as a result of the epidemic and an estimated 40 million people are infected with HIV, the virus that causes AIDS. Worldwide HIV/AIDS is the leading cause of death, and a social, political and economic detriment to many nations (WHO, 2001, US Census Bureau, 2000). However, the disease has not spread evenly throughout the world. For example, 96 % of HIV/AIDS related cases are in developing countries, with more than 24 million cases in Sub-Saharan Africa (Kaiser, 2002, Shishana & Simbayi, 2002). The 14 country members of the Southern African Development Community (SADC) account for half of the cases in the Southern Region of Africa (UNAIDS, 2000). SADC member countries with the highest HIV/AIDS prevalence among adults include Botswana, Lesotho, South Africa, Swaziland, Zambia and Zimbabwe (see graph) (HSRC, 2002).

SOUTH AFRICA DEMOGRAPHICS AND BRIEF HISTORY

The Republic of South Africa, situated at the southernmost tip of the African continent, is a landmass of 1,227,200 sq km, about twice the size of the US state of Texas. A Federal Republic and an independent member of the British Commonwealth, South Africa comprises 9 administrative provinces: Eastern Cape, Free State, Guateng, Kwazulu Natal, Limpopo (formerly Northern Province), Mpumalanga, Northern Cape, Northwest Province, and Western Cape (see map of South Africa on the next page). There are 3
capitals in the Republic that serve different official roles: Pretoria (administrative), Bloemfontein (judicial) and Cape Town (legislative).

Seventy-seven percent of South Africa’s 44 million people are Black and 10 percent are White, with 60 percent of Whites being of Afrikaner decent and the majority of the remaining 40 % being of British descent (the remaining minority of Europeans are of Jewish, Italian, Portuguese, German, Dutch and Greek descents). Eight percent of the population is “Coloured” (mixed heritage comprised of White and other ethnic/racial groups, e.g. Black, Malay, Indian, Asian, etc. or a combination of heritages from these groups. Asian Indians or members of other Asian groups make up a remaining 2.5 %. Sixty- eight percent of South Africans practice Christianity, 28.5 % practice traditional African religions, and the rest are Muslim or Hindu (2% or 1.5% respectively). Eleven
languages are officially recognized in South Africa: Afrikaans, English, Ndebele, Pedi, Sotho, Swazi, Tsonga, Tswana, Venda, Xhosa, and Zulu (Barbarin & Richter, 2001; Byrnes, 1996; Lonely Planet, 1998). However, English is the lingua franca, though in some regions and within certain business and administrative settings Afrikaans is spoken as often as English or predominately (Barbarin & Richter, 2001; Byrnes, 1996).

The history of South Africa dates back to around 100,000 B.C. to the San people (aka; “Bushmen”), a nomadic group that in more recent centuries intermarried and mingled with the Khoikhoi, a pastoral group. This resulting cultural group was eventually called Khoisan people. In recent centuries the nomadic Khoisan eventually settled at the southernmost tip of Africa, where the Atlantic and Indian Oceans converge and form a cape. Europeans began traveling to this region after Vasco de Gama opened the “Cape of Good Hope” spice route in 1498. In the mid-17th century Dutch traders, shipwrecked and ill, settled at Table Bay, the location of modern day Cape Town. Eventually these Dutch (modern day Afrikaners) settlers moved north, decimating the Khoisan people through aggressive acts and foreign illnesses until their numbers dwindled to insignificance. The Dutch then began to settle and farm the vast rural areas. Ongoing skirmishes between these “Boers” (Afrikaans word meaning farmer) and the Xhosa, another major African group living near the cape region, brought intervention from British immigrants who attempted to settle the conflicts and to acquire additional lands on the African continent. This was during the period the Dutch were losing their place as a world power. It was about this time the Afrikaner “Voortrekkers” (pioneers) made their now celebrated “Great Trek” away from British rule and met up with strong resistance from the Zulu, under the leadership of Shaka Zulu, the renowned chief. Shaka Zulu had been annihilating and enslaving tribe
people throughout Southern African for decades. The Zulu were eventually defeated by the Boers who used more advanced firepower against the Zulu’s rudimentary weapons. Meanwhile the Boers had begun establishing individual republics, when discovery of diamonds around Kimberly and gold around Johannesburg brought increased tension and led to eventual wars between the Afrikaners and the British settlers. The first of these “Anglo-Boer Wars” ended in an Afrikaner victory; the second ended in a bitter compromise (for the Boers) that established the Union of South Africa in 1910.

After World War II, unofficial racist policies against Blacks that had been in place for decades became official. These policies set the stage for Apartheid (Afrikaans word meaning apartness), which was officially established by the ultra-conservative, predominately Afrikaner National Party that won the 1948 elections. Apartheid policies established rigid race classifications that dictated where people could live, work, attend religious services and go to school. This meant that it was illegal for Blacks, “Coloureds”, Indians and Whites to interact professionally and socially on equal footing. Apartheid divided Blacks into 10 ethnic groups and forced them to relocate to individual rural “homelands” specific to that ethnic group regardless of where they were born. The purported intention was to put Blacks on lands that would allow them to become self-sufficient and self-governing. However, these areas had no potential for sustainability in the form of infrastructure, industry or agriculture. Abject social and economic conditions in the “homelands” forced many Blacks to eventually return to cities to find employment and to live in makeshift squalor (“informal settlements”), where they met a different set of social circumstances. Following several decades of internal resistance and international pressure, Apartheid officially ended in 1994 with the first free and fair elections that voted
in President Nelson Mandela, the African National Congress leader who had been
imprisoned by the Apartheid regime for 27 years (Barbarin & Richter, 2001; Byrnes, 1996;
Lonely Planet 1998).

HIV/AIDS IN SOUTH AFRICA

The Republic of South Africa has the greatest number of persons living with AIDS
worldwide (UNAIDS, 2000), with more than 20% of the adult population infected, the
largest number of children infected and with infection generalized to all age groups,
geographic regions and races (Shishana & Simbayi, 2002, UNAIDS, 2002). The most
recent UNAIDS global report conducted at the end of 2001 estimates that 5 million South
Africans are living with HIV disease. Of this figure, 4.7 million were adults (15-49 years)
with 2.7 million being women. This figure translates to 20.1% of the total adult population,
a more than 7% increase since 1998. Two hundred and fifty thousand of the 5 million
infected persons are children under age 15. (UNAIDS, 2002-). A total of 360,000 deaths
were attributed to AIDS at the end of 2001. Six hundred and sixty thousand children have
been directly affected by these deaths having either lost a mother, a father or both parents to
AIDS. These “children orphaned by AIDS” constitute a tremendous financial and
emotional burden on South Africa’s families, communities and the government
infrastructure. Projections indicate that by 2010 HIV disease will consume 17% of South
Africa’s economy, through sick employees, dying farmers and other related soaring costs
(USA Today, 2001, UNAIDS, 2001). With an estimated 1,200 South Africans becoming
infected daily, HIV/AIDS is reversing a trend of decades of health and economic progress
(UNAIDS, 1998).
Numerous socio-cultural and behavioral factors contribute to the current HIV/AIDS situation in South Africa and other SADC nations. According to the “Social Aspects of HIV/AIDS and Health” (2002), a review paper for the W.K. Kellogg Foundation, behavioral factors include unprotected sex with multiple partners; poor and inconsistent condom use; heterosexual anal sex; sex in the presence of sexually transmitted infections (STI) such as syphilis, gonorrhea, chlamydia and trichomonas; the practices to dry up the vagina and provide more friction for the penis (particularly prevalent in South Africa, Zambia, Zimbabwe), and male and female circumcision and initiation practices. Relevant socio-cultural factors contributing to the level of disease in this region include HIV/AIDS-related stigma and associated denial, exclusion and discrimination, issues related to gender such as the low status of women, women’s economic dependence on men, commercial sex work, “age mixing” (particularly older men having sex with younger women and girls), marriage and death rites, shifting norms which allow for high numbers of sexual partners, resistance to condom use, denial about teenage sexual behavior and lack of clear, non-judgmental information targeting teens, denial of homosexuality in black communities and a history of poor interventions for gay communities. Also implicated are extended political conflict and liberation struggles in the region, which have created refugee circumstances that put women and young girls at risk of being raped; high infection rates among soldiers (only HIV prevalence information from South Africa and Angola available); overcrowded prison facilities; substance abuse and indigenous healing practices. Finally South Africa’s AIDS epidemic is exacerbated by social and family disruption due to former Apartheid policies, an overburdened and transforming healthcare system, and inadequate welfare system. Poverty is a chief underlying factor associated with most of the behavioral and
socio-cultural factors implicated (HSRC, 2002-Kellogg, Gausset, 2001, Shisana & Simbayi, 2002, South Africa AIDS, 2003). Of the nine provinces in South Africa, Mpumalanga ranks among the heaviest hit by the HIV/AIDS. A recently administered national community-based prevalence survey shows an overall HIV/AIDS infection rate of 14.1% in Mpumalanga (Shisana & Simbayi, 2002). This figure differs significantly from the previous infection rate of 29.2% reported from the recent 2001 antenatal survey findings (UNAIDS, 2002). However, regardless of the large discrepancy in the figures, both studies rank Mpumalanga third among the 9 South African provinces in relation to HIV/AIDS infection rates, indicating that it is an immense problem.

MPUMALANGA PROVINCE

Mpumulanga is a Zulu word meaning “the place where the sun rises”. The Province is located in the northeastern corner of South Africa, bordered by the Limpopo (formerly Northern Province), Guateng, Northwest and KwaZulu Natal Provinces and the countries of Mozambique and Swaziland (See Mpumalanga map below). The 2.6 million residents occupy nearly 30,900 square miles (see map of South Africa for exact location) and speak mostly Swati (30%), Zulu (25.4%) and Ndebele (12.5%). Fifty one percent of the population of Mpumalanga are female. Blacks make up the large majority of the population (more than 89 %) compared to Whites (9 %), and “Coloured” and Indian (less than 1 % each). Mpumalanga’s varied terrain of lowland savannah, high plateau grasslands and picturesque mountain peaks and waterfalls, combine with diverse wildlife make it a popular tourist destination. In addition to tourism, farming, coal and gold mining, and sugar, dairy, wool and forest industries are the predominant revenue earning industries. A large migrant
labor force passes through Mpumalanga from other South African Provinces and neighboring Mozambique. In spite of the several industries it is an extremely poor region with the second lowest literacy rate in the country and a more than 30% unemployment rate. With a growth rate higher than the national average, a large proportion of the Mpumalanga’s population has limited participation in economic activity and low productive capacity, which prevents its disadvantaged communities from improving economically (Mpumalanga Provincial Legislature, 2003, SA Stats, 2002). This province and its female condom use is the focus of the present study. The Mpumalanga Female Condom Project (MFCP) office is located in the town of Bethal in the South Western area of the Province. The MFCP Evaluation was conducted in the High Veld, Low Veld and Eastern High Veld regions of Mpumalanga Province (Mpumalanga Provincial Legislature, 2003).
THE FEMALE CONDOM

Since 1992 the female condom has been available in Europe and more recently in several countries throughout the world, including those in Africa. It is made of polyurethane and provides protection against pregnancy and sexually transmitted infections (STIs) including HIV/AIDS by forming a barrier between the penis and the vagina, cervix and external genitalia (UNAIDS, 1997). In addition to being thinner, yet stronger, than the latex material used for the male condom, the female condom is odorless, “impermeable to sperm, HIV, and other organisms that transmit [STIs]” (p. 93, Porche, 1998). Advantages of using the female condom are the ability to insert it in advance of intercourse, allowance of spontaneity between partners, ability to engage in intercourse before a full erection is obtained (unlike with male condom), it covers the internal and external parts of the female genitalia, and the male partner does not have to remove the penis after ejaculation (unlike with the male condom) (Porche, 1998).

Until its advent, HIV/AIDS and STI prevention options were limited to abstinence, non-penetrative sex and male condom use. The female condom expanded this limited range of options by providing a female-initiated, alternative means of protection for women who are extremely vulnerable to infection (Chaya, Amen & Fox, 2002). An unpublished UNAIDS report addresses social and cultural factors surrounding female condom use in Mpumalanga (UNAIDS, 2002). Gender-related issues include women feeling more in control of their sexuality and experiencing more pleasure, women being protected from unwanted pregnancy or STI/HIV infection because of sexual coercion or rape, men appreciating the free feeling of the female condom (in contrast to the male condom), and
increased communication between men and women about sexual matters (UNAIDS, 2002). The Mpumalanga Female Condom Project (MFCP) incorporates these and other contextual issues through its mission to reduce sexually transmitted infections (STI) including HIV/AIDS by fostering safer sexual practices, large-scale condom promotion and distribution and improved STI care.

STATEMENT OF THE PROBLEM

Women are extremely vulnerable to HIV infection because of various social and cultural factors. The female condom is one method of prevention that can empower women.

STUDY RESEARCH QUESTIONS

1. What is the relationship between culture and acceptance and use of the female condom by women and men in Mpumalanga Province?
2. Using the PEN-3 Model how do peer educators and community members describe the relationship between culture and female condom acceptance by women and men in Mpumalanga Province?

STUDY PURPOSE

This study will reanalyze findings from the Mpumalanga Female Condom Project evaluation using the PEN 3 Model, a framework developed to “centralize culture in health promotion interventions” (Airihenbuwa, 1999). Specifically this secondary data analysis
uses PEN 3 as a modified content analysis tool to frame focus group, open-ended survey questions, and interview findings of the evaluation. The outcome of this activity will be the cultural analysis of female condom use for the prevention of HIV/AIDS in South Africa.

**SIGNIFICANCE OF THE FEMALE CONDOM STUDY**

With the exception of abstinence, HIV disease prevention efforts have focused on condom use as the most effective method of preventing the spread of the virus. Early condom use studies looked at gay men’s use of the male condom (Stokes, Vanable, & McKirnan, 1997). Since its introduction, female condom studies have addressed a variety of behavioral, social, cultural, and economic issues. Musaba, Morrison, Sunkutu, & Wong, (1998) looked at long-term use of the female condom among Zambia couples at high risk of contracting HIV. Other studies have addressed effectiveness (Marseille, Kahn, Billinghurst, & Saba, 2001), issues surrounding its marketing and distribution (Agha, 2001), utilization and acceptability in diverse populations (Harrison, Bachman, Freeman, Inciardi, 2001) and facilitators and barriers to use (Choi, Roberts, Gomez, Grinstead, 1999). Finally, a selected body of research has examined the role of the female condom in relation to empowerment and gender equity issues (Kaler, 2001; Gollub, 2000; Preston-Whyte, 1995).

An area that has received limited attention is how socio-cultural variables impact female condom use. The UNAIDS Mpumalanga Female Condom Project (MFCP) evaluation is one such study that attempted to do this. Initiated in Mpumalanga, an economically disadvantaged, predominately Black, rural South African province, the MFCP’s mission is to reduce STI including HIV/AIDS by fostering safer sexual practices, large-scale condom promotion and distribution and improved STI care. UNAIDS
conducted the MFCP evaluation in order to corroborate anecdotal findings supporting female condom use in several Mpumalanga communities and to determine socio-cultural and contextual issues responsible for its acceptance.

According to Kline (1999) “a theoretical framework provides researchers and program developers with a perspective from which to organize knowledge and to interpret factors and events” (p. 42). The MFCP evaluation was grounded in two theories: the AIDS Risk Reduction Model (ARRM) (Catania, Kegeles, & Coates 1990) and the Diffusion of Innovations Theory (Rogers, 1983, 1986, 1995). The ARRM extends from previously developed behavior change and human sexuality studies, but focuses specifically on an individual’s effort to change sexual behaviors related to HIV transmission. The individual 1) recognizes and labels his or her behaviors as at risk for contracting HIV, 2) commits to decreasing those high risk behaviors and adapts low risk activities, and 3) develops strategies and sets specific goals for making changes (Catania et al., 1990). The MFCP evaluation used the ARRM for a peer education approach that increased community member’s individual risk awareness.

Diffusion of Innovations Theory explains how an idea or innovation is disseminated throughout a community over time and how individuals respond to that idea. In addition the theory addresses how social norms influence the individual, family or community (Rogers, 1995). Diffusion of Innovations in the context of the MFCP study was used to market the female condom and to “diffuse” condom use norms using participatory learning methods (e.g., role plays, scenarios, etc.) throughout the Mpumalanga community (UNAIDS, 2002).
The MFCP researchers used the UNAIDS/Penn State HIV/AIDS Communication Framework to “organize knowledge and interpret factors” related to female condom use in Mpumalanga Province. The UNAIDS/Penn State Framework addresses HIV/AIDS prevention and control efforts from a social/environmental context as opposed to an individual focus (UNAIDS/Penn State, 1999, Airhihenbuwa, Makinwa & Obregon, 2000). The Framework was developed through a participatory process focusing on Africa, Asia, Latin America and the Caribbean. It addresses approaches to HIV/AIDS prevention, care, and support using strategies that evolved from within the meanings and values of the affected populations. The Framework identifies five contextual domains that should be the focus of new activities in HIV/AIDS prevention, care and support: **Government Policy** - the role of policy and law in supporting or hindering intervention efforts; **Socioeconomic Status** – collective or individual income/resources that may promote or hinder an adequate intervention; **Gender Relations** – status of women in relation to men in society and community and the influence on sexual negotiation and decision making; **Spirituality** – role of spiritual/religious values in promoting or hindering the transition of prevention messages into positive health actions; **Culture** – positive, unique, or negative characteristics that may promote or hinder prevention and care practices (UNAIDS, Penn State, 1999, Airhihenbuwa et al. 2000).

Although the MFCP evaluation was grounded in sound theories and models, two important factors need to be addressed. First, the AIDS Risk Reduction Model (ARRM) focuses on individual behavior change in an African community context. This is a potential problem when one understands the importance of family and community in the context of an individual’s health outcomes. For example Airhihenbuwa and Obregon (2000) posit that
theories upon which the ARRM (eg Health Belief Model, Theory of Reasoned Action) is based might be meaningful in a Western setting where individuality is supported, but has less relevance in an African context where the individual is more likely to measure his or her health based on family or community well-being (p.9). Additionally, Airhihenbuwa and Obregon (2000) point out the linearity of the Diffusion of Innovations Theory as a potential barrier to successful HIV/AIDS prevention efforts, particularly as it relates to level of education directly related to information attainment. However, the authors do support the Diffusion of Innovation Theory’s ability to change community norms by targeting key opinion leaders (p.8). Furthermore, the MFCP evaluation uses culturally appropriate strategies to “diffuse” prevention messages throughout the community, an aspect of this theory that Airhihenbuwa and Obregon support.

Second, the UNAIDS/Penn State Communications Framework for HIV/AIDS was used as an explanatory model in that it helped “organize knowledge and interpret factors” related to female condom use in the Mpumalanga context. Even though this process was effective in garnering relevant socio-cultural information about female condom use, there is still no instrument grounded in cultural theory that can be used to interpret the cultural contexts of use in South Africa.

Airhihenbuwa advances the centrality of culture in addressing health behavior (Airhihenbuwa, 1995). His PEN-3 Model addresses culture by applying the domains of community identity; relationships and expectations; and cultural empowerment to the development, implementation and evaluation of health promotion programs (Airhihenbuwa, 1995, 1999). PEN-3 will be used to reanalyze the findings from the MFCP evaluation. These findings will be checked through focus group and opened-ended results from
questionnaires completed by key informants, who participated in the original MFCP evaluation (i.e., peer educators, male and female community members, MFCP staff.).

ASSUMPTIONS

In conducting this study, the following assumptions were made:

1. Culture plays an important role in health decision-making, such as female condom use to prevent HIV infection.
2. The female condom is available to the Mpumalanga communities where the study was conducted and people can access the female condom.
3. The Mpumalanga Female Condom Project Evaluation is based on sound theory and methodology.

DELIMITATIONS

The study was delimited as follows:

1. Members of the Mpumalanga community participated in this study.

LIMITATIONS

The study was limited as follows:

1. The Mpumalanga Female Condom Project evaluation can be generalized to the Mpumalanga communities only.
2. The study is based on findings from a study conducted by UNAIDS that addressed female condom use in a particular population.
3. The Mpumalanga Female Condom Project evaluation was conducted in African languages and translated to English.

DEFINITION OF TERMS

**Acquired Immune Deficiency Syndrome (AIDS)** - Specific conditions represented by a suppressed immune system among individuals who have been infected with human immunodeficiency virus (HIV) (CDC, 1992).

**Apartheid** – Afrikaans word meaning apartness, which represents a system of racial segregation peculiar to the Republic of South Africa, the legal basis of which was largely repealed in 1991–92.

**Human Immunodeficiency Virus (HIV)** - Virus that attacks the T-Lymphocyte, white blood cells and damages the immune system, often leading to Kaposi’s Sarcoma, Pneumocystis Carinii Pneumonia, Pelvic Inflammatory Disease, and other illnesses manifested in an individual with a depressed immune system (CDC, 1992).

**PEN 3 Model** – health promotion model that addresses culture by applying the domains of community identity; relationships and expectations; and cultural empowerment to the development, implementation and evaluation of health promotion programs (Airhihenbuwa, 1999).
**Person Living With AIDS or PLWA** – a universal abbreviation for a person who is has been diagnosed with AIDS. Sometimes it is used for a person who is infected with HIV, the virus that causes AIDS (PLWHIV). But a more recently the acronyms have been combined to form PLWHIV/AIDS.

**South African Development Community** - SADC was formerly the Southern African Development Co-ordination Conference (SADCC), which was established in July 1979 to harmonize economic development among the countries in Southern Africa. There are 14 country members: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

**UNAIDS** - (Joint United Nations Programme for HIV/AIDS). As the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic (UNAIDS, 2003).

**SUMMARY**

The female condom has been promoted as a useful tool to prevent pregnancy and transmission of STI and HIV/AIDS, particularly in the developing world. In the context of increased HIV infection rates and vulnerability of South African women, it provides a female controlled method, which can promote sexual communication between heterosexual partners. However, continued research into social and cultural factors surrounding female
condom use is imperative. The purpose of this study was to critically reanalyze the findings from such a research effort, the Mpumalanga Female Condom Project evaluation using the PEN - 3, a model that centralizes culture in health promotion interventions. Chapter 1 of this thesis introduces the problem, study purpose, research questions, and the study’s significance, assumptions, limitations and definition of terms. Chapter 2 provides a systematic review of the literature surrounding female condom use and includes the foundation and rationale for conducting the study. Chapter 3 discusses the theoretical, methodological and analytical procedures used in the study. Study findings and discussion of the study implications are addressed in Chapter 4. Conclusions and recommendations for action are presented in Chapter 5.
CHAPTER 2
REVIEW OF THE RELATED LITERATURE
SOUTH AFRICA’S HIV/AIDS EPIDEMIC
PREVALENCE STUDIES

Apartheid left a myriad of social, economic and political challenges in place and “set the stage for contemporary social conditions that threaten the development of generations of South Africans to come” (Barbarin & Richter, 2001, p. 26). Because of Apartheid, tremendous inequities are apparent between Blacks and Whites in housing, education, employment, social services, and health. A poor public health infrastructure epitomizes the gravity of challenges. As preparation for a New South Africa was beginning in the early 1990’s, HIV/AIDS had already devastated economies in some African countries and had begun to ravage others. South Africa’s infancy as a nation free from the chains of Apartheid was simultaneously in an infant state in relation to the HIV/AIDS epidemic during this period. This situation was due in large part to its isolation from the outside world. However, the isolation unfortunately promoted limited access to information as well as lessons learned from the HIV/AIDS experience of other nations, including its African neighbors (Barbarin & Richter, 2001). The first death attributed to AIDS in South Africa occurred in 1982. By early 1990, 353 AIDS cases had been reported. This figure increased to 613 one year later and the incidence continued to increase exponentially with 1,123 cases reported in 1992, 10,351 cases in 1996 and 12,825 cumulative cases in 1997 (WHO, 1997). In 1993 a majority (90%) of cases were associated with marginalized Black South Africans with an estimated 75 % of cases attributed to heterosexual contact. However, these previous figures are assumed to be drastically underestimated, particularly in relation to the African homelands, where similar to other Southern African countries, around 80 % of cases were missing. This discrepancy was due
primarily to misdiagnosis, underreporting and poor access to health care facilities (Mitton, 2000). More realistic estimates suggest that 60,000 South Africans were infected by 1990 and this number was expected to double every 8.5 months, placing projected rates between 4 and 8 million by the year 2000 (Maputo, 1990, Mitton 2000).

WHO’s Global Program on AIDS (GPA) and eventually the Joint United Nations Programme for HIV/AIDS (UNAIDS) have conducted serological sentinel surveillance of specific groups to estimate HIV infection rates in a country. Serological surveillance of HIV infections “provides timely and cost-efficient data of sufficient accuracy for planning, implementing, and monitoring national AIDS programs” (Mann & Tarantola, 1996, p 7). An advantage of this method is that the data can be used to follow trends in HIV infection rates in different geographic locations in a country or across different populations over time. Sexually transmitted infection (STI) clinics and clinics used by injecting drug users (IDU) are typical sentinel surveillance sites. A disadvantage is it tends to overestimate the true HIV prevalence in a country. In areas with high HIV prevalence rates antenatal clinics are commonly used (Mann & Tarantola, 1996; Shisana & Simbayi, 2002). WHO/GPA conducted the first sentinel surveillance study of women at antenatal clinics in South Africa in 1990. The results of these surveys placed infection rates at 1.2 % (UNAIDS, 1999; Varga, 1999). However, there are several limitations of using data from antenatal surveys in estimating national HIV prevalence rates. For example, prevalence rates might be overestimated because only pregnant women of childbearing age participate in the study, which limits surveillance of women who don’t fall in that group; women who are not sexually active are not included in the study; and women who practices safe sex (i.e., condom use, etc.) are less likely to be present in the sample (Shisana & Simbayi, 2002).
Findings from the recently administered Nelson Mandela/HSRC Study, the first systematically national community-based prevalence survey conducted in South Africa corroborated overall HIV prevalence rates with UNAIDS findings. However, inconsistencies exist between the two studies for prevalence by provinces and among specific demographic groups (UNAIDS, 2002; Shisana & Simbayi, 2002).

The Nelson Mandela/HSRC Study prevalence rate was 11.4 % overall (CI 10.0% - 12.7%), with 15.6 % in the 15-49 year old range (Mandela/HSRC, 2002). The discrepancies in these figures between these figures and those of the GPA/UNAIDS figures are due to the method of data collection. The WHO/GPA/UNAIDS estimates are based on HIV prevalence rates of women attending antenatal clinics as described above. Significantly more South African women than men are infected (17.7 % vs. 12.8 %) in the 15 to 49 age group. In relation to race Black South Africans have the highest rate of infection (18.4 %), for adults age 15-49, followed by Coloureds (6.6 %), Whites (6.2 %), and Indians (1.8 %) (Mandela/HSRC, 2002).

The Mandela/HSRC survey also determined estimates based on age group, geographic locale and province. As expected, the most sexually active members of society have the highest percent of infection (25 – 29 year olds – 28 %, 30 – 34 year olds – 24 %, 35 – 39 year olds - 16 %, 40 to 40 year olds – 16 %). The largest percent of infected 15 – 49 year olds live in “informal urban settlement” areas (28.5 %), followed by formal urban areas (15.8 %), ethnic group areas (12.4 %) and farms (11.3 %). Of the 9 South Africa Provinces this survey indicates that Free State, Guateng, Mpumalanga, and KwaZulu-Natal have the highest infection rates at 14.9, 14.7, 14.1, and 11.7, and respectively. The lowest prevalence rate is attributed to the Eastern Cape (6.6 %). These estimates differ significantly from the 2001 UNAIDS antenatal survey findings, which indicate that
KwaZulu-Natal has the highest rates at 33.5%, followed by Guateng and Mpumalanga, (both 29.2%). The Western Cape had the lowest prevalence rate (8.6%).

A limited number of national, regional and local population-based studies have attempted to access HIV/AIDS knowledge, attitudes, practices and behaviors (KAPB) in South Africa. They have specifically looked at basic HIV knowledge (SAHIS, 1994; SADOH, 1998; HRSC, 1997, 1999, 2001). The South African Health Inequalities Survey, the first national survey of a randomly selected household sample of 3,786 participants, suggested high knowledge of modes of transmission of HIV, including transmission through unprotected sex and rapid spread of the disease in South Africa (SAHIS, 1994). The South African Demographic and Health Survey (SADHS) used data from South Africa’s 1996 census to access HIV/AIDS knowledge and awareness of 13,827 respondents 15 years of age and older. Although most of the respondents were knowledgeable about HIV (95%), there were several myths and/or misconception in place, including the mistaken belief that a healthy looking individual could not be infected with HIV or have AIDS (SADOH, 1998).

Several studies have addressed both male and female condom use in response to HIV/AIDS. Most studies highlight the inconsistency between sexual knowledge and HIV/AIDS knowledge and sexual behavior, including number of partners and condom use (Campbell, Mzaidume & Williams, 1998; Schoef, 1992; Varga, 1997; Wilson, Sibanda, Mboyi, & Msimanga, 1990). Condom use studies conducted in South Africa corroborate the literature from studies in other countries. For example, the SADHS study discussed in the previous section found low reported condom use among the sexually active respondents. Similarly, 40 to 50% of respondents in a 1999 public opinion survey state that they used condoms in response to the AIDS epidemic. However, only 22% of the mostly female respondents (85% were women ages 15-49) in the
SADHS study reported ever using condoms, with only 8% reporting condom use at last sexual encounter. Of those using condoms most were young, urban women using condoms during sexual encounters with non-marital partners (SADOH, 1998). A qualitative study that looked at youth (13 – 25 years old) in a township near Johannesburg found high levels of knowledge and low condom use in spite of increased HIV infection rates among South African youth (18.9% for 16-18 year olds and 43.1% for 21-25 year olds) (Williams, Campbell & MacPhail, 1999). Six mitigating factors limiting condom use among respondents include lack of perceived risk; peer norms that discourage condom use, limited condom availability, adult attitudes about condoms and sex in relation to youth, power imbalance in male/female relationships, and economic constraints (MacPhail, 2001).

**CONDOM STUDIES**

Since its introduction female condom studies have addressed acceptance and use as well as a variety of related social, cultural and economic issues. However, discourse on female condom dynamics cannot begin in isolation of the male condom, which preceded it by decades and which had been the focus of most HIV prevention initiatives until the female condom was introduced.

**MALE CONDOM STUDIES**

When properly used, the male condom is an “effective means (of) preventing the transmission of HIV, other STI and pregnancy” (UNAIDS, 2000). Early male condom use studies have looked at its use, acceptance, efficacy and effectiveness, and cost, along with numerous socio-cultural factors like fidelity, empowerment (e.g., sex workers), and sexual communication between partners.
Because of the initial high HIV prevalence rates among gay and bisexual men at the outset of the HIV crisis, related condom studies focused on this population. These early studies directed condom research targeting various populations. One such study of gay men and condoms applied the Theory of Reasoned Action to determine intentions to use condoms. The researcher’s results indicate that attitudes about condoms were a poor predictor of intention to use condoms, while experience using condoms previously was a good predictor. They concluded from their findings that peer-based initiatives supporting consistent use were more likely to be successful over approaches to change attitudes and beliefs (Ross & McLaws, 1992). From an interpersonal perspective, Sacco and Rickman (1997) studied sero-concordant and sero-discordant gay and bisexual male partners to assess condom use. They found a difference during anal intercourse in condom use preference between the inserting partner and the receiving partner. The receptive partner’s preference for condom use influenced the couple’s decision to use a condom. Coupled with the finding that sero-discordant couples used condoms more frequently than sero-concordant couples, the researchers concluded that an interpersonal dynamic guiding decisions about condom use exists (Sacco & Rickman, 1996).

Condom studies targeting heterosexual couples are also relevant to female condom research. Bryan and Aiken (1997) looked at condom use in relation to acceptance of sexuality, level of control in a sexual encounter and perceived susceptibility to common STI. They found a positive relationship between these 3 variables and condom self-efficacy, which predicted condom use intention. The model also suggests that perceived susceptibility to STI predicted intention to use condoms. The researchers encourage the use of this model for other youth HIV/STI prevention efforts (Bryan, Aiken, & West, 1997).
It is not unusual to overhear a teenager brag to his or her peers about always having condoms with him/her. But is carrying a condom associated with condom use during sexual intercourse? One study suggests that there is no association. DiClemente, Windgood, et al. (2001) conducted a study of minority teenage females in Alabama, with the justification that minority teens are at an increased risk of contracting HIV/AIDS and because most condom carrying studies have targeted adults. Five hundred and twenty two sexually active African American females from a low-income community in Birmingham provided information on STI history and condom carrying. Eight % of the girls were treated for STI as part of the study carried condoms. Thus the investigators conclude that condom carrying is not associated with use (DiClemente et al., 2001).

**COMBINED FEMALE CONDOM AND MALE CONDOM STUDIES**

Several studies observe female condom use in conjunction with other barrier methods, including the male condom, while some studies focused on the female condom in and of itself. This section addresses both types of studies. One such study focused on women’s use of the male and the female condom following STI risk reduction counseling (Latka, Gollub, French, & Stein, 2000). This quasi-experimental design used a “hierarchal” teaching method to encourage male and/or female condom use at an inner city STI clinic. These women (STI patients) were selected into 3 observational cohorts. Group one received prevention messages about the male condom only; Group 2 ‘s message was about the female condom; and Group 3, the “hierarchy” group, received messages about both the male and the female condom and other barrier methods in descending order of efficacy. Group 3’s messages promoted first the male and the female condom, then the diaphragm and the cervical cap, and finally spermicides, and the withdrawal method. When the women returned at 2 week, 4 month and 6 months
interval, they were interviewed about methods use between the follow-up periods. From baseline to 6-month follow-up, the “hierarchy” group showed a significant increase in condom-protected acts compared to the condom only groups. The investigators suggest that their findings indicate positive outcomes, which encourages both male condom and female condom use over male condom use only (Latka et al., 2000).

Fontanet et al. (1998) conducted a randomized control trial with commercial sex workers in Thailand, which addresses male and female condom choice. They randomized sex establishments in 4 Thai cities into two study groups. In Group 1 the sex workers consistently used male condoms only, while Group 2 used female condoms if clients refused to use male condoms or were not able to because of no erection. The outcome variables tested in this study included the proportion of reported unprotected sexual acts and STI incidence rates. The study was conducted over a 24-week period. Ninety seven % of all sexual acts were engaged in with a condom in both groups. Likewise, the number of acts without a condom decreased dramatically for the male/female condom group (Group 2), primarily because of the addition of the female condom. In addition, female condoms were used consistently throughout the 24-week period and the sex workers experienced fewer broken condoms and decreases in certain STI (Fontanet et al., 1998).

Musaba, Morrison, Sunkutu, & Wong (1998) looked at long-term use of the female condom among Zambia couples at high risk of contracting HIV. Ninety nine couples diagnosed with symptomatic STI at a teaching hospital in Lusaka were enrolled in the study between 1993 and 1994. They received female and male condoms and spermacide to be used for each coital act. Of the initial 99 couples 51, 38 and 30 were followed up at 3, 6 and 12 months respectively. Results indicate that a majority of the couples used the female condom
methods per coital act. The study suggests that mixed methods can reduce risk of unprotected coital acts in high-risk couples (Musaba, Morrison, Sunkutu, & Wong, 1998).

**FEMALE CONDOM STUDIES**

Studies focusing specifically on the female condom have burgeoned considerably since its development, highlighting diverse populations worldwide and looking at numerous variables. These include studies specific to efficacy and effectiveness, acceptability and use, cost, marketing and distribution, and various behavioral, social, cultural, and economic issues surrounding acceptance and use facilitators and barriers to its use. These variables overlap extensively and also incorporate relevant issues like gender and empowerment of women, sexual communication, SES, government policy and spirituality. Following is a review of the major studies related to several of these issues.

**EFFICACY AND EFFECTIVENESS STUDIES**

Initial female condom effectiveness studies to prevent STI including HIV were measured indirectly using contraceptive outcomes. A study by Farr et al. (1994) had as its purpose to determine the contraceptive efficacy of the female condom among 328 participants from 6 sites in the United States and 3 sites in Latin America. The participants, women in mutually monogamous relationships, agreed to use the female condom exclusively for 6 months. Results showed an accidental pregnancy rate of 2.6% for the US participants and 9.5% for the Latin American participants who used the female condom consistently and correctly for 6 months. Another study of 147 women reporting 57% consistent and correct female condom use after 1 year, showed an 11% failure rate. A study by Gollub and Stein (1993) showed a failure rate that range from 5% for perfect users to 12% for average users.
The rates from these studies are consistent with other barrier methods including those of the male condom and have implications for STI/HIV/AIDS prevention.

More recently, in vitro studies have shown that the female condom can protect against particles smaller than the HIV virus. For example, studies have demonstrated the female condom blocked the passage of a bacteriophage smaller than the hepatitis B virus, the smallest of viruses known to transmit STI and one quarter the size of the HIV virus (Sakondhavat, 2002). One STI infection study of 104 women infected with chlamydia and/or trichomonas showed no re-infection of these STI in 54 of the women using the female condom consistently. This was in contrast to 14.7% and 14.0% trichomonas re-infection rates among non-compliant women and women in the control group respectively and 3 chlamydia re-infection in 3 non-compliant participants (Soper, Shoupe, Shangold, Shangold, Gutmann & Mercer, 1993 in Sakondhavat 2002).

The study among female commercial sex workers in Thailand by Fontanet et al., (1998) presented in the previous section randomized sex establishments into those using the male condom and those using the female condom. In relation to efficacy the study indicated the female condom led to “a 25% reduction rate in the geometric mean STI incidence rate in the sex establishments using the female condom compared with those using the male condom” (p 2). This translates to a 97.1% reduction in the risk of HIV infection for each act of intercourse after extrapolating from failure rates for correct and consistent use (Fontanet et al, 1998).

A 1997 study conducted in South Africa by UNAIDS showed a significant decrease in STI infection and number of unprotected coital acts following the introduction of the female condom (UNAIDS, 1999).
ACCEPTABILITY AND USE STUDIES

Choi et al, (2003) undertook a study to look at the level and frequency of female condom use among a cohort of 206 women living in San Francisco and Oakland. They recruited these women at family planning clinics between July 1998 and April 1999 and interviewed them at baseline and during a 3-month follow-up. Findings included a significant increase in female condom use during vaginal intercourse (82% reported using the female condom at least once), without a reduction in male condom use. However, only 17% of sexual acts during the period were protected by the female condom. In this study female condom use was associated with a positive attitude about the condom from one’s partner, suggestion of its use to partner and little concern about the looks of the condom. The findings suggest female condom use in concert with the male condom and the association between female condom use and attitudinal and communication factors.

A study conducted by Macaluso and colleagues (2000) in Birmingham and Huntsville, Alabama suggested that women at risk of STI including HIV accept the female condom as a prevention method and some use it consistently. The researchers followed 1,159 STI female patients for 6 months following interviews at their initial clinic visits. In addition to the interviews the women were given a physical exam, provided with condom information and given instructions to complete a sexual diary. Participants were divided into 3 condom-use groups: Group 1 used female condom exclusively; Group 2 used the male condom only; Group 3 used the female condom in conjunction with the male condom. Using a multiple regression, the researchers found that more than 32% of the participants used the female condom 10 times or more during the six months of the study, while 20% used it 5-9 times, 13% used it twice and 20% used the female condom only once. Seventy five % of the women who used condoms consistently used the male condom and the
female condom predominately suggesting that mixing the two types of condoms may facilitate consistent condom use (Macaluso, Demand, Artz, Fleenor et al, 2000).

A study that took place in Baltimore, New York City, and Seattle concluded that for health care professionals to encourage female condom acceptance, clients needed to be given information about the condom, shown correct use, and given an opportunity to practice insertion skills on themselves. The randomized controlled study involved 604 women at high risk for STI and HIV. A logistic regression showed that the strongest predictors of female condom use were exposure to the skills-training intervention, intention to use the female condom in the future, having asked the partner to use the condom in the previous 30 days, and opportunity to practice inserting the condom (Van et al, 2002).

In a similar study, 105 women were randomized into an intervention education about the female condom, motivated to use it and given behavioral skills relevant to its use or a control group which received a time-matched broadly defined women’s health education intervention. Women who received the behavioral skills intervention used the female condom more often than woman who received the health education intervention. In addition, women who reported sex with 1 male partner 6 months prior to being questioned were more likely to use the female condom than women with multiple partners, However, among both groups female condom use was negligible with only 1 in 5 uses during vaginal intercourse (Kalichman, Williams, & Nachimson, 1999).

A study in Thailand among commercial sex workers evaluated female condom acceptance among that community. During an 8-week follow-up, the researchers used structured questionnaires to collect data on female condom acceptability and use. Of the 148 women who were still participating in the program after 8 weeks, 68% were satisfied with the female condom. However, 37% reported pain caused by the inner ring, 31% had difficulty with insertion of the
condom, and 22% reported itching. The women cited perceived safety as the main reason for use and clients refusal as the main reason for non use (Jivasak-Apimas, Saba, Chandeying, Sadondhavat, et al., 2001).

In Shanghai, China Xu et al. (1998) administered a female condom questionnaire to 30 married couples in order to determine acceptability. Each couple used a female condom during 10 coital acts. Ninety % of the couples found it to be an acceptable method, while 87% rated it as good. In addition, women (80%) found it more pleasurable than men (73%) and 55% preferred the female condom to its male counterpart. However, the researchers suggest that a concerted effort would be essential in order to increase awareness in China (Xu et al., 1998).

UNAIDS and the World Health Organization (WHO) explored attitudes surrounding female condom use in a sample of 600 Vietnamese women who had contracted STI. These women were either married community women of reproductive age, female STI patients receiving treatment at local clinics or female sex workers linked to hotels, bars and massage parlors. They were provided with the female condom. Results showed that 84% of the sex workers intended to continue using them. In addition, the study highlighted examples of gender inequality, which prevents women from requesting that their sexual partners use the male condom for pregnancy and STI/HIV/AIDS prevention. Sex workers also find difficulty convincing their clients to do likewise. The researchers suggested that the female condom would be a viable alternative in this instance. They recommended that mass media efforts promoting the female condom be employed, that the female condom continue to be provided to sex workers and women with STI for free or at subsidized prices and that female condom use and acceptability studies be, and encourage acceptance and use of the female condom initiated on a larger scale (Varga, 1997).
Only a limited number of studies look at attitudes of heterosexual men toward the female condom. One such study was conducted by Seal and Ehrhardt (1999) in New York City between 1994 and 1995. Seventy one interviews were conducted with men recruited from an STI clinic and through word of mouth. The majority of the men had no or limited female condom knowledge (only 1 man had used it). In spite of limited knowledge after learning about the condom men were positive about its use for reason including support for a female-controlled condom, a woman’s right to use it, and the possibility of the female condom enhancing sexual pleasure, and interest in trying it out because of its novelty. Negative attitudes were associated with the condoms “strangeness” and “bigness”, its ability to prevent infections and pregnancy and its potential to decrease sexual pleasure (Seal & Ehrhardt, 1999).

**MARKETING, DISTRIBUTION AND PROGRAMMING**

A 5-year social marketing campaign in Zimbabwe looked at gender inequalities, social norms and roles in a socio-cultural context. This study, commissioned by the Zimbabwe Ministry of Health and Child Welfare and administered by Population Services International (PSI) involved questionnaires, in-depth interviews and focus groups covering 493 female and 633 male female condom users and 624 non-users. The results indicate that female condom users 1) are educated and in their middle to late twenties with access to household resources; 2) are married or in a long term partnership, rather than a casual commercial partnership; 3) initially began using the female condom because of its novelty; 4) began use as an experiment or for pregnancy prevention or prevention of STI/HIV/AIDS (33% of the men and 21% of the women); 5) perceive the female condom to be effective and reliable for pregnancy and STI/HIV/AIDS prevention; and 6) concur that women initiated discussion around its use more, decided on its use and procured it often than men. Furthermore, married women were more likely to discontinue use of either the female or the
male condom than single women and couples experiencing problems with insertion, discomfort during sex and excess lubrication. Also, according to the researchers’ findings single women and married men with outside partners are more likely to benefit from the introduction of the female condom. Furthermore, they suggested that female condom marketing efforts should be tailored to address particular needs of married women, who are more likely than single women to encounter partner resistance to female condom use (Kerrigan et al., 2000).

A mass-marketing female condom campaign was the focus of a study by Agha (2001) that addressed intention to use female condom among men and women in Labia, Zambia. Using a representative sample of people shopping at outlets selling and distributing male and female condoms, the researcher found a high level of awareness, but lower use of the female condom compared to the male condom following the 1-year campaign. However, intention to use the female condom was higher among respondents who had used only the female condom in the previous year. The researcher concludes that the female condom is more important to those who are unwilling or not able to use the male condom.

Agha (2001) also addressed use patterns following the same female condom marketing campaign in Labia, Zambia and compared it to female condom use to male condom use after 1 year. The researcher conducted interviews of male and female customers as they exited at a condom outlet. Results showed that male condom use was 5 to 8 times higher among married couples and couples in regular partnerships, than the female condom. In addition, among married couples and regular partners both male and female condom use increased as SES increased. However, among casual partners, male condom use increased as SES increased, while frequency of female condom use was associated with low SES. These findings corroborate those of other
condom studies and the study is particularly relevant to female condom use in impoverished areas such as Mpumalanga, where the present research was conducted.

**BEHAVIORAL, SOCIO-CULTURAL AND ECONOMIC STUDIES**

The Female Condom Attitude Scale is an instrument made up of 15 likert-scale items that measures women’s attitudes toward the female condom. Based on a 30-item instrument developed by Choi et al (2001), Nielands and Choi (2002) conducted exploratory factor analysis to extract 5 correlated factors around female condom attitudes. Their goal was to validate an already existing instrument and reduce the number of items on the instrument in order to develop a more effective instrument. 238 women from diverse backgrounds were recruited from 4 family planning clinics in the San Francisco Bay Area to take part in this 3-month longitudinal study. Demographic information was gathered at baseline from the women and follow-up interviews were conducted with the 218 women who returned after 3 months. The mean average age of the women was 25 years, 74 % were single and 71 % had some college education. In addition to demographic questions follow up interviews used the following instruments to measure condom related variables:

1) The Female Condom Attitudes Scale, a 30-item instrument that measures attitudes around the female condom (Choi et al, 2001)

2) Condom Self-Efficacy (CSE), which measure self-efficacy around male condom use (Marin, Gomez, Tshann, & Gregorich, 1997)

3) The Sexual Comfort Scale, a scale that measures women’s comfort level with insertion of contraceptive devices (Marin, Gomez, Tshann, & Gregorich, 1997)
4) The Male Condom Attitudes Scale (MCAS), which measures attitudes toward the male condom

5) A Female Condom Usage question that asked respondents to recall the number of times they use the female condom during the study period (Neilands & Choi, 2002).

The 5 extracted correlated factors around female condom attitudes were: Sexual Pleasure Enhancement, Inconvenience, Improved Prophylaxis, Sexual Pleasure Inhibition, and Insertion Reluctance (Neilands & Choi, 2002). This instrument is useful for accessing attitudes surrounding the female condom in different populations.

A related group of researchers in the San Francisco Bay Area conducted in-depth interviews with a multicultural group of 67 women to uncover facilitators and barriers to female condom use. The subjects were recruited from a family planning clinic. After analyzing their findings the researchers divided the identified facilitators and barriers into 4 distinct categories: mechanical, psychosexual, interpersonal and situational. A mechanical facilitator includes the ability to insert the condom prior to intercourse; one identified barrier was difficulty with insertion. Facilitators tied to psychosexual factors are the female empowerment implications and condom use norms; a psychosexual barrier was a male partner’s negative reaction to woman’s independence. Interpersonal facilitators and barriers are enhanced communication and partner’s refusal to have sex because of the condom, respectively. Finally, situational issues include limited or no access to female condom (barrier) or male partner’s enhanced pleasure (facilitator). The investigators suggest that these female condom categories are useful when attempting to define facilitators and barriers on a social, cultural and economic level (Choi, Roberts, Gomez, & Grinstead, 1999).
Marseille, Kahn, Billinghurst, Saba, (2001) assessed cost-effectiveness of the female condom in rural South Africa. The target population was commercial sex workers and other women with casual partners. Using a simulation model they calculated projected health and economic outcomes “assuming 5 years of HIV infectivity, 1 month of syphilis and gonorrhea infectivity and female condom use in 12% of episodes of vaginal intercourse” (Marseille, Kahn, Billinghurst, & Saba, 2001 p.135). They concluded through simulation that a well designed female condom effort targeting sex workers and women and their casual partners could be cost-effective (Marseille et al., 2001).

The bulk of the literature about behavior and condom use in South Africa refers to male condom use. However, a limited number of studies indicate high female condom use. Five key features of female condom use in South Africa were identified in a study by Mantell, Scheepers & Abdool Karim (2000). This study addressed the introduction of the female condom in the public health sector and used 5 positive features identified in studies in other developing countries: high level of acceptance, increased protected coital acts, increased locus of control, expanded range of contraceptive choice, and increased sexual communication and negation between partners (Ankrah & Attika, 1997; Hernandez, DeCaso, & Aguirre, 1996; Niang, 1996).

There is a select body of research examining the role of the female condom in relation to empowerment and gender equity issues. In “The Female Condom: Tool for Women’s Empowerment”, Gollub (2000) emphasized how the female condom has enhanced women’s ability to negotiate protection with partners, promote healthy behaviors, and increase self-efficacy, self confidence and autonomy in women worldwide (Gollub, 2000). However, Gollub points out cultural, policy and regulatory challenges that continues to impede the empowerment process.

These include cultural attitudes against females touching their own genitals, attitudes of health care
providers associated with these attitudes, and inability to introduce the female condom under optimal conditions. Gollub emphasizes the need for prioritizing community-based designs to address these and related issues. Such community-based designs are often influenced by the policies of the government.

**SOCIO-CULTURAL FACTORS LINKED TO FEMALE CONDOM USE**

**GOVERNMENT POLICY**

Indisputably, government and administrative policy and law exact the most influence on behavior change. Historical and contemporary examples of this influence abound in political, social and health arenas (e.g. civil/human rights laws, environmental protection legislation, disability acts, etc.). In the more than 20 years since the advent of the AIDS epidemic international, national, regional and local policy continues to evolve in response to the myriad of dynamic issues surrounding the disease. Sometimes policy is developed through extensive research contributed by public health professionals, foresight from policy makers and significant contributions from community members impacted by the disease. Some examples include safe sex advertising and risk reduction efforts among member of the gay communities. Other policies have been put in place through extensive protest and advocacy efforts on the part of infected or affected community members (e.g. free or subsidized drug treatment policies, housing and employment anti-discrimination policies, policies mandating inclusion of PLWA’s in significant decisions regarding drug treatment and allocation of AIDS funding, etc). The AIDS Coalition to Unleash Power (ACT UP) is one such advocacy initiative that uses “radical” and “attention getting” acts of civil disobedience to bring attention to relevant prevention, treatment and care issues such as
policies that force deportation of HIV infected immigrants, human rights abuses perpetrated upon sex workers, and global availability of treatment regimens (ACT UP, 2003).

Several policies have also sparked negative outcomes in relation to HIV prevention, treatment, and care efforts. During the early years of the epidemic support for policies to close baths houses, disclose names of sexual partners and quarantine infected persons drove members of communities who needed relevant prevention and treatment information underground. Even today in the U.S. policies have been enacted as a result of tremendous opposition to harm reduction efforts such as safe sex messages for youth and needle exchange programs for IV drug users. Fear and feigned morality guides many of these policy decisions.

Linked directly to government and administrative policy are the heads of state whose personal philosophy and leadership abilities can promote or impede HIV/AIDS prevention, treatment and care efforts in their respective countries. The need for government policy is often most appreciated in such circumstances when leadership is out of step with the overwhelming impact of the epidemic. With more than 20 years into the epidemic and with millions becoming infected each year, several governments have yet to assume leadership in promoting policy that protects the human right of persons living with HIV/AIDS in their countries.

Through policy, laws and personal philosophies, Heads of State in Africa, as elsewhere, have played a major role in either diminishing or perpetuating discriminatory practices and human rights abuses taking place among their citizens as a result of HIV/AIDS related stigma. Uganda, Senegal, Thailand, Cambodia, and Brazil are examples of countries whose leaders have dealt with the epidemic openly and directly, providing spaces for honest dialogue and compassion among its citizens. These decisions have helped tremendously to minimize HIV/AIDS-related stigma and its resultant discrimination and human rights abuses (Diop, 2000; Phoolcharoen, 1998).
However, this has not been the case for all countries in Africa. Some leaders until recently had turned a blind eye to the epidemic’s impact on their citizens. However, recently, two major conferences were convened in Africa to call Heads of African States to action in relation to HIV prevention, treatment and care: The economic commission for Africa’s African development forum in Addis Ababa, Ethiopia in December 2000 and the special conference of African heads of state convened by the Nigerian President Olusegun Obasanjo in Abuja, Nigeria in April 2001. These conferences were major steps in moving leaders to look at issues surrounding the epidemic including issues surrounding the presence or absence of National policy on HIV/AIDS. A closely related issue has been in the area of gender disparity in HIV/AIDS impact.

**GENDER**

Gender plays an important role determining the socio-cultural, political, economics and health effects of women worldwide. Ruth (1995) defines gender as a social concept that refers to “a complex set of characteristics and behaviors prescribed for a particular sex by society and learned through the socialization experience” (Ruth, 1995, p.17). Although the term gender is sometimes used interchangeably with the term sex, they differ in that sex, according to biologists and social scientists, is the biological distinction between female and male (Tiefer, 1998) and linked to “chromosomal patterns, hormonal makeup, and genital structure (Ruth, 1995, p.17). However, debate over the meanings of the two terms continues as Gentile (1998) indicates in his attempt to standardize definitions for the research community. In addition a significant factor that must be addressed when categorizing the term gender relates to the male (Gentile, 1998). For example, because of it’s feminist association, male gender dynamics have, until recently, had limited exposure to empirical investigation (Gupta, 2001), even though female and male gender cannot be separated. In other words, all the gender-related social, cultural, political, economic, and
health issues researchers investigate cannot be addressed in the absence of men. This research is especially imperative given that it is predominately men who perpetuate gender inequality.

Other ongoing discourse surrounding the concept of gender relates to its cultural construction. According to Gupta (2000) “there are significant differences in what women and men can or cannot do in one culture as compared to another” (p.6). Moreover, although social scientist have moved beyond a uni-dimensional, Western view of the concept to embrace cultural difference in relation to gender classification, misconceptions continue to be deconstructed. In her landmark analysis of the woman (italics added) in Yoruba society (West Africa) Oyewumi (1997) challenges 5 fundamental assumptions in Feminist Theory regarding gender:

1) gender categories are universal and timeless and have been present in every society at all times;

2) gender is the fundamental organizing principle in all societies and is salient and ubiquitous;

3) there is an essential, universal category “woman” that is characterized by the social uniformity of its members;

4) the subordination of women is universal;

5) the category “woman” is precultural, fixed in historical time and cultural space in antithesis to another fixed category -“man” (p. xi – xii).

Oyewumi argues these assumptions are based on the premise that in the West social categories “have a long history of being embodied (in physical and social bodies) and therefore gendered” (Oyewumi, 1997, p. xii). Contrasting these assumptions, she further argues that that social organization was determined by relative age and not by gender in Yoruba Society (vii). Her deconstruction of these socio-cultural assumptions has profound implications on gender discourse.
Gender is inextricably tied to sexuality. Koch (1995) terms sexuality as “a complex phenomenon affected by our biological, psychological, social, emotional, spiritual, and cultural make-up and surroundings” (p. 5). She suggests that gender identity (our view of ourselves as female or male) and gender role (how we are treated by our culture as female or male) greatly impact our sexuality (Koch, 1995). Likewise Gupta (2000) calls sexuality the “social construction of a biological drive” (p. 6) defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes” (p. 6). More than just sexual behavior, sexuality is also “multi-dimensional and dynamic” (p. 6) and in addition to gender is dictated by age, economic status, ethnicity and other factors.

Social learning theorists propose that sexuality is “no different from any complex (human) behavior” (p. 310). Similarly proponents of social role theory argue that “human cognitive processes organize patterns of behavior and attitudes into social roles and scripts, which reflect both social behaviors and thoughts about sexuality” (p. 312). Culture plays an important role in these processes.

“Power is fundamental to both sexuality and gender” (Gupta, 2000, p. 6). Generally, in male/female sexual relationships a power imbalance exists often in favor of the male. This dynamic is manifested in where, when and how sex takes place in addition to determining whose pleasure in the sexual interaction is given priority. Several psychosocial, cultural and economic factors encourage this imbalance.

Gender and its associated constructs of role, identity and power discussed above have major implications in HIV/AIDS prevention efforts. In Gupta’s article titled, “Gender, Sexuality, and HIV/AIDS: the What, the Why and the How”, Gupta highlights five factors that increases women’s vulnerability to HIV. First, through socialization women are “expected to be ignorant about sex
and passive in sexual interactions” (p. 6) limiting their knowledge of risk. Moreover, risk of being labeled “loose” if informed “can discourage them from being proactive in negotiating safe sex” (p. 6). A second factor associated with vulnerability is the norm of “virginity for unmarried girls.” In many societies this increases a girl’s risk of being pressured or raped because of the strong desire of some boys/men to “bust the cherry” (break the hymen). Third, because women are discouraged from asking questions, they may receive inaccurate or no information and limited or no needed treatment services. HIV vulnerability might be further increased in this instance because of associated risk from untreated STI such as chlamydia, as well as a woman’s fear of getting tested for the virus. Fourth, in some cultures where women are encouraged to have many children, safer sex methods could contradict their values and increase mistrust of health promotion staff. For example, as an AIDS prevention educator in Africa, one hears HIV prevention trainers tell of the difficulty of promoting condoms because it is seen as a ploy to get families to decrease family size.

Fifth, economic dependency in many settings makes it more likely that “women will exchange sex for money or favors, less likely that they will succeed in negotiating protection, and less likely they will leave a relationship that they perceive as risky” (p. 7). Finally, research indicates that the threat of physical and sexual violence against women by intimate partners is rampant. These volatile situations further compound safe sex negotiation and a woman’s ability to leave a relationship (Gupta, 2000).

Boys and men are also subjected to gender issues that make them vulnerable to HIV infection. For example there is an expectation and assumption that men are knowledgeable and experienced about sexual matters, which can discourage them from asking for information. In addition, there are norms worldwide that promote early sexual initiation and multiple sexual partners for males. The idea that a man should dominate a woman sexually also contributes to their
vulnerability in that their manhood is threatened if they don’t exhibit sexual prowess. Finally, the norms of self reliance and lack of suppressed emotion attributed to masculinity discourage men from engaging in healthy communication with their partners and from seeking outside assistance (Gupta, 2000). These issues of gender relations and power dynamics between men and women are salient in the context of the female condom use in Mpumalanga. More importantly gender relations and power dynamics are constructed and expressed within the context of culture.

CULTURE

The word culture was defined by Anthropologists as early as the late 19th Century. Tylor (1871) defined culture as the “complex whole, which includes knowledge, beliefs, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society.” Keesing (1981) expands Tylor’s definition to classify culture as “systems of shared ideas, …concepts, rules and meanings that underlie and are expressed in ways that human beings live” (p.68). Mazrui (1986) operationalizes culture as “a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society” (p. 239). More recently, culture has been identified as a set of implicit and explicit guidelines inherited by members of a particular society that tell them how to view the world, experience it emotionally, and to how to “behave in relation to other people, to supernatural forces or gods, and to the natural environment (Helman 1990, p. 2). In addition, through the use of language, symbols, art and rituals, culture uses these guidelines (i.e., a cultural “lens”) to transfer this system of perceiving and living in the world to the next generation. This cultural transfer or “enculturation” promotes and encourages the continuation of a particular group (Helman, 1990).

Hall (1994) categorizes “explicit” and “implicit” characteristics of culture into 3 levels: tertiary, secondary and primary. The “explicit” tertiary level is the basic level of a culture, i.e., the
“façade presented to the world at large”, which can be easily identified by an outsider. Examples of tertiary cultural level are a group’s cuisine, traditional dress, religious practices, festivals, social rituals, etc. The secondary and primary levels of culture are implicit levels that are more resistant to change than the tertiary level. At the secondary level are assumptions, beliefs and rules that incorporate the “cultural grammar” of a group, which members of that group are aware of, but which are rarely known to an outsider. The way a group codes a language to hide discourse from an outsider is an example of the secondary level of culture. For example, American slaves hid messages in Negro Spirituals to communicate escape plans without the knowledge of their owners. Or a group might redefine and apply a word with a standard meaning to fit a context for that group. (e.g., something “bad” can mean terrific or beautiful to a subculture of African Americans). In primary level culture, the deepest level, the rules are known and obeyed by all, but rarely stated. A group member is likely to be openly unaware of these even though he or she follows them because they function at the subconscious level.

In Health and Culture: Beyond the Western Paradigm, Airhihenbuwa (1995) advances the importance of culture in addressing health behaviors, stating that group or community-based interventions must start with culture. This is of particular relevance to design and communication of health methods focusing on behavior change. In this sense, he posits the cultural codes, symbols and values that make up a group’s cultural system “embody the essence of meaning people bring to the production and acquisition of knowledge” (p. 11). He further suggests the need for the public health interventionist to determine if a community’s health and illness behaviors are “rooted in (its) cultural values and beliefs” (p. 11). More importantly, language as the basis of culture has far reaching implications for health and illness behavior and communication of health information.
Cultural implications abound when addressing health and disease outcomes in an African context. This is particularly true for a disease like HIV/AIDS with its accompanying stigma. The role of the individual in relation to family and community is one major cultural factor that has implications for sexual behavior and HIV/AIDS prevention and control efforts. In contrast to the West, which generally emphasizes the individual and the nuclear family in relation to health behaviors, the extended family and community take precedence over the individual in traditional African societies. Undeniably, in the African setting the individual plays a key role in this dynamic, but group identity is more important (Airhihenbuwa, 1999). In this dynamic, characteristics such as loyalty, seniority, and emotionality can foster a positive response within an extended family and community (Airhihenbuwa, 1999). For example, the individual who sees himself/herself as a part of larger community is likely to be loyal to that community, and thus reluctant to engage in behaviors that could bring shame upon that community. Furthermore, a community might exhibit loyalty by embracing their “son” (community member) who returns to the village from the city with full-blown AIDS. Or a family takes in the young children of a neighbor who has died from AIDS. Community elders as established community members would act as key informants and conduits for disseminating reliable HIV/AIDS information and dispelling myths. In many cases these elders would more than likely be the village chief and his advisors. Finally, watching a community member die of AIDS might trigger prevention behaviors through emotionality (Airhihenbuwa, 1999).

In direct contrast to a positive community response can be negative reactions due to the stigma surrounding HIV/AIDS. As supportive as the traditional African extended family and community network can be, it can also turn its back on infected and affected community members. In the context of culture, if an individual is HIV infected or has AIDS, by extension that
individual’s family has AIDS (Caldwell, Orubuloye, & Caldwell, 1992). Negative reactions are linked to stigma, which can evoke fear and promote denial and silence or discrimination. Other stigma-related outcomes affecting health behavior include refusal to wear a condom, fear of being tested and unwillingness to disclose status (Caldwell, 2000). This behavior perpetuates culturally negative associations at the individual, family and community levels.

Historically, oral tradition has played an essential role in the lives of many African peoples. In this vein, Airhihenbuwa (1995) points out that people in oral traditional cultures “are accustomed to learning by listening” (p. 9). Thus ways of learning will vary from those of “seeing” cultures. This means that HIV/AIDS prevention efforts might incorporate methods that encourage storytelling in concert with Western methods, like posters and handbills (Airhihenbuwa, 1995). These are all the factors that will be examined in the Mpumalanga female condom project.

**THE MPUMALANGA FEMALE CONDOM PROJECT**

Based upon the above discussion factors such as government policy, gender, SES, spirituality and culture may be paramount to the success of a community-wide female condom initiative. A study which took place in Mpumalanga, South Africa used these and other variables to assess socio-cultural influences on acceptance, negotiation, and patterns of use of the female condom. The Mpumalanga Female Condom Project (MFCP), which began in 1997, is one of several community development projects conducted by The Mpumalanga Project Support Association (MPSA). MPSA’s mission is to reduce sexually transmitted infection (STI) including HIV/AIDS by fostering safer sexual practices, large-scale condom promotion and distribution and improved STI care through participatory dialogue. This was carried out through peer education
training, participatory learning, and distribution of male and female condoms through social networks and at fixed distribution points (UNAIDS, 2000).

The MFCP evaluation project was funded and conducted by the Southern and Eastern Africa Regional Office of UNAIDS, based in Pretoria, South Africa. It was initiated in response to positive feedback regarding acceptance and use of the female condom from local health workers and community members in Mpumalanga Province. In addition to determining condom acceptance and utilization patterns, the evaluation aimed to identify management, communication and negotiation strategies used by trainers and peer educators to highlight best practices regarding female condom promotion initiatives.

Using questionnaires, individual interviews, and focus groups, investigators gathered data from the project leaders, peer educators, trainers of the peer educators, and male and female users of the female condom. The interviewers gathered information from peer educators about community norms around sexuality and HIV/AIDS/STI knowledge and condom marketing skills gained during the peer education training activities. Male and female users of the female condom were questioned regarding religious and community norms, communication dynamics, gender relations, and condom negotiation skills.

**MFCP STRUCTURE**

The MFCP used a Train the Trainer (TOT) format that began with the training of its Project Manager, a nurse with degrees in commerce and business, who previously held the position of Deputy Director of Health Systems, Communicable Disease and HIV/AIDS in the Mpumalanga Department of Health. This training took place at the University of Zimbabwe where a similar peer education initiative had been implemented. The Project Manager training was followed by a
training activity for more than 30 coordinators from Mpumalanga held in 1997 and 1998. The coordinator training also took place at the University of Zimbabwe and included site visits to local peer education projects for a field-based orientation and training on formative needs assessment; mapping and zoning; field support; quality assurance; project monitoring and evaluation; and documentation. These trained coordinators returned to Mpumalanga to train over 500 educators. These peer training activities took place over 10 days and provided the peer educators with skills to address a variety of health and management issues and trained them on participatory approaches used to implement the MFCP activities. Additional weekly trainings took place following the initial 10-day training. Training modules covered hygiene, nutrition and wellness, the reproductive system, family planning, transmission, prevention and treatment of STI and HIV/AIDS, the impact of AIDS on women, and condom storage, use and disposal. Peer educators were trained to facilitate participatory approaches such as:

- One minute, incomplete role plays that leave key social issues unresolved, hanging frozen at a dramatic moment, allowing facilitator to invite the audience to discuss and resolve it;
- Coded pictures depicting important social problems relevant to the community, allowing facilitator to invite audience to discuss what they see, how common the problem is, related other problems that can arise out of the original problem and possible solutions to the problem;
- Short “trigger” dramas, which include live role plays and coded pictures that present a social problem relevant to the community and “trigger” participation; and
- Participatory games that directly confront the audience with issues surrounding HIV/AIDS in that community and invite discussion.
The MFCP is focused on behavior change and is measured by annually administered behavioral surveillance surveys that assess STI/HIV knowledge, individual risk perception, self-reported STI symptoms and male and female condom use with different partner categories.

The MFCP Project Manager supervises project facilitators who supervise project coordinators, zone leaders and peer educators. Eighteen peer educators were selected to begin the MFCP effort in Kriel based on the following criteria: community member, female, single, unemployed, and school dropout. These young women are trained to be community resource persons who disseminate STI/HIV information, promote behavior change communication and provide condoms in the low-income communities. Their efforts focused on work settings and at bus stops, truck and taxi parks, and beer halls. Other targeted “hot spots” include low-income areas and neighborhoods populated by sex workers.

The peer educators received 200 Rand (20 USD) per month even though their work was done on a volunteer basis. They were also provided with a uniform (a T-shirt identifying them as community health workers), jackets, shoes and bags to for transport materials during health promotion campaigns.

**UNAIDS MFCP STUDY**

The Mpumalanga Province Health Department imported more than 2 million female condoms as part of the MFCP community-based effort for STI and HIV/AIDS prevention and control. The main goal of the project was to reduce the incidence of HIV and AIDS by empowering women to accept and successfully negotiate the use of the female condom. Anecdotal evidence from health workers and community members suggested that the female condom was popular in the province and thus, the project was perceived as successful in gaining a positive perception of the female condom. In addition, continued requests for the female condom could not be met once
the stock was depleted. UNAIDS’ mission in advocating for worldwide action against HIV/AIDS is to lead, strengthen and support an expanded response to the epidemic. This response supports four goals to:

1. prevent the spread of HIV;

2. provide care and support for those infected and affected by the disease;

3. reduce the vulnerability of individuals and communities to HIV/AIDS;

4. alleviate the socioeconomic and human impact of the epidemic (UNAIDS, 2003).

In keeping with goals 1, 2 and 4, the Southern and Eastern Africa Regional Office of UNAIDS, based in Pretoria, commissioned a study to document the factors that contributed to the success of the Mpumalanga Female Condom Project (MFCP). In addition to determining condom acceptance and utilization patterns, the evaluation aimed to identify management, communication and negotiation strategies used by trainers and peer educators to highlight best practices regarding female condom promotion initiatives. This research project was designed to evaluate the success of the project by investigating the contextual issues that arise in the planning, negotiation and use of the female condom in Mpumalanga Province for the prevention of STIs and HIV/AIDS in South Africa. The study was designed to use the 5 contextual domains of the UNAIDS/Penn State communication framework for HIV/AIDS (UNAIDS/Penn State). These domains are: government policy, socio-economic status, culture, spirituality and gender relations (UNAIDS/Penn State, 2000). Other contextual issues that emerged as the study unfolded were identified and explained.
Between 1997 and 1999, UNAIDS funded The Pennsylvania State University with Collins Airhihenbuwa as PI and project director to develop a strategy to address HIV/AIDS prevention, care and support in the context of Africa, Asia, Latin America and the Caribbean. Five consultative meetings were held with a total of 103 researchers and practitioners with experience in communications and the behavioral sciences. Specifically there were 2 global meetings in Geneva and Washington, DC and 3 regional meetings (i.e., Abidjan, Cote Ivoire for African, Bangkok, Thailand for Asia, and Santo Domingo, Dominican Republic for Latin America and the Caribbean). The approach developed at these meetings, through a participatory effort, responded to the considerable need to develop HIV/AIDS prevention communication approaches that evolved from “within the meanings and values of infected affected populations” in Africa, Asia, Latin America and the Caribbean (UNAIDS/Penn State, 1999, Airhihenbuwa, Makinwa & Obregon, 2000). This approach followed a new direction taken up by institutions, scholars and practitioners in recent years to move away from individually-focused behavior change efforts that exclude context to factors affecting the individual within the context of the social and physical environment (Mrazek & Haggerty (1994), Mckinlay & Marceau, 1999). The Framework identifies 5 contextual domains that should be the focus of new activities in HIV/AIDS prevention, care and support: government policy, socioeconomic status (SES), gender relations, spirituality, and culture. Since its development, 4 African countries (Ethiopia, Lesotho, Ghana and Malawi) have initiated plans to begin the implementation of the Framework as part of their national strategic plan. Similarly, national AIDS programs in countries like Colombia and Mexico in Latin America are incorporating the framework into their national strategic communication plans. The UNAIDS Communication Framework provides an opportunity for teams of researchers and practitioners from multiple
sections and professions to collectively address social and behavioural change that can be measured at multiple levels, such as those presented in the context of the Mpumalanga Female Condom Project (MFCP). It is for these reasons that UNAIDS used the Framework to describe and analyse the MFCP evaluation findings. In the next section I will describe each of the 5 domains in detail, incorporating the MFCP evaluation results into their relevant domains as described by the evaluation’s researchers.

**UNAIDS FRAMEWORK CONTEXTUAL MFCP STUDY FINDINGS**

The UNAIDS/Penn State Communications Framework for HIV/AIDS offers five contextual domains as an interrelated network of influences for health decisions and actions. Airhihenbuwa et al. (2000) represent the Framework as a house with the structure designed in response to environmental conditions and social historical traditions of a community, region or country. The basic structure of a house (the framework) and each country will transform it into a home (community, region or country strategy) based on their unique and shared strategies for defining and responding to the epidemic. Thus, the framework is a “house to home” (see figure below) approach to HIV/AIDS prevention, care, and support (UNAIDS/Penn State, 1999). I will discuss each domain in the context of HIV/AIDS in Africa, Asia, Latin America and the Caribbean.
THE MFCP RESULTS & THE UNAIDS/PENN STATE FRAMEWORK

CONTEXTUAL DOMAIN # 1
GOVERNMENT POLICY

The government policy domain related to the MFCP in the following ways:
sound management principles, supportive referral system through Government
hospitals, co-ordination, resource mobilisation, sustainability, community mobilisation,
supportive government policy. Policy issues cut across all project participants: from
the Program Manager and other MFCP personnel to the men and women in the
community.
Sound Management Principles. Expertise and experience of the project team was found to be relevant to the activities of the project. The team was committed to fundraising from local companies and oversees funding agencies. Record keeping was well done to monitor the distribution of condoms and other resources. Some of the achievements of the project have been recognized by a wide range of organizations:

- The Health System Trust cited Mpumalanga Support Project Association (MPSA) as an outstanding model of Government-NGO partnership which accelerated service delivery,
- Lydenburg District which receives support from both the Department of Health and MPSA was chosen as South Africa’s best HIV/AIDS prevention district,
- UNAIDS cited MPSA as the global model of community mobilization and female empowerment through the use of female condoms,
- MPSA is facilitating peer education and home based care development in other provinces of South Africa and neighboring SADC countries.

Supportive Referral System. Supportive referral system through Government hospitals and health clinics enabled the clients to have easy access to information on health education and condoms.

Coordination. There was a well-established network that promoted collaboration with other regional organizations such as the University of Zimbabwe. At the local
level, project activities were well coordinated through the project manager, peer education facilitators, peer educators and the community members.

- **Resource Mobilization.** Government provided health personnel to the project and distributed male condoms. The government through hospitals and health clinics had already established much of the networks used by the project for distribution of both male and female condoms. Government also provided vital health statistics on prevalence of STI.

- **Sustainability.** Unless cure for HIV/AIDS was found soon the project would still be relevant. The commitment of the project team to succeed was likely to sustain the project. There was a low attrition rate among peer educators. Clients have accepted female condoms as viable alternative for prevention of STIs and HIV/AIDS and pregnancy. The female condoms are considered sturdy and more reliable than male condoms.

- **Community Mobilization.** Community members were provided with appropriate information about STIs and HIV/AIDS and on the best preventative methods. Peer educators accompanied members to health clinics to ensure they received proper treatment. Peer educators visited people in their residence and other public places. They also used local accessible language to communicate their message. The community members were made to feel as an important part of the campaign.
initiative and participated in the project activities. Appropriate strategies such as
drama, role-play, and videos were used during the campaigns.

♦ **Adequate Training of Peer Educators.** Low attrition rate of peer educators
guaranteed sustainability of peer education program. Ongoing training kept the peer
educators abreast with new strategies and knowledge of preventative health.
Discovery learning through participatory methods enabled the community members
to take appropriate action. The findings of the study confirm that peer education
becomes effective when the participants feel ownership of what they were doing
and when they could also identify with the people with whom they were involved.
Success of the peer education was being appreciated by other government
departments and organizations that were involved in health promotions activities as
is evident in their attempts to approach MPSA to help them start similar projects.

♦ **Deliberate Promotion of the Female Condom.** There was a deliberate effort to
promote female condoms as an alternative to prevention of STIs and pregnancy.
Female condoms were seen as a way of empowering women to take charge of their
sexual life. The community members were trained on negotiation and persuasion
strategies to use in introducing the female condoms to their sex partners.

At the same time, there were non-facilitative factors within the domain of
Government Policy including lack of collaboration with local religious institutions and
traditional healers, lack of staff to cover all areas, lack of government policy specific to
the female condom; over-concentration of activities in the Townships at the expense of
rural areas, and negative attitudes of health personnel towards STI patients (UNAIDS, 2002).

CONTEXTUAL DOMAIN # 2:  
SOCIO-ECONOMIC STATUS

This contextual domain was found to be strong but was more relevant to the clients of the project than any other beneficiary group. Four major issues came up.

♦ **Financial support from corporate organizations.** Funding from the private sector and donor agencies enabled the project leaders to finance the project activities. Peer educators were motivated by the few items and monthly allowance provided to them.

♦ **Low level of literacy, high unemployment and low family income.** Taking cognizance of the social status of the community members, the peer educators were able to conduct the health campaign successfully using accessible language and participatory methods. During community meetings women sought ways of uplifting themselves financially.

♦ **Free distribution of the female condom.** This could be considered the most important factor that contributed to the success of the female condom project. Recognition of the economic status of the community members was critical in the recruitment of the peer educators and organization of activities.
Planning around clients’ economic capability. Provision of uniforms and other items used by the peer educators during the health campaigns was important in giving them identification for a cause they had volunteered for. Organization of projects at various sites within the community reduced traveling costs. Thus the peer educators were accessible to the community members for information and for provision of the condoms.

CONTEXTUAL DOMAIN # 3:

SPIRITUALITY

Even though this domain is often very important, in the case of the Mpumalanga Female Condom project, was not specifically addressed. It only seemed more important on the part of the clients and less so on the part of the peer educators. Issues here were: supportive engagement of some religious leaders in the project, willingness of some churches to distribute condoms, invitation of peer educators by some church leaders to talk to their congregation on preventative methods of HIV/AIDS.

However, some non-facilitative factors minimized the impact of the domain of spirituality on the success of the project. These were,

- **The Role of the Church.** Church resistance to the use of condoms and other contraceptives.

- **The Role of Community.** There seemed to be lack of commitment by community members in practicing the Christian teaching of abstinence from sexual activities,
and discrimination in the church on the basis of marital status and age when discussing sexual matters.

CONTEXTUAL DOMAIN #4:

GENDER RELATIONS

Gender Relations refers to the status of women in relation to men in society and community and the influence on sexual negotiation and decision-making. The HIV/AIDS epidemic significantly impacts women worldwide, as women are more vulnerable to infection and stigmatization, and are significantly less empowered to control their environment than men. However, because most women are infected through sexual contact with men, interventions must begin to focus as equally on men as has been focused on women up to this point (Airhihenbuwa, Makinwa, Obregon, 2000). Furthermore, prevention messages push for monogamous relations to reduce infection, while 90% of HIV infected women are practicing monogamy. In addition, the female sex trade, usually blamed for the spread of the epidemic, exists primarily as a result of economics, power and desire orchestrated by men.

Gender relations proved to be a key factor in the success of the Mpumalanga female condom project. This domain was more important in the case of clients and peer educators more than it was for any other groups of individuals in the project. It was indeed the relationship between these two groups of people that the success of the project depended. Several factors can be drawn from the findings; female empowerment, peer educators home visits; follow up consultations with peer educators, positive negotiation skills, and positive parental involvement.
Female empowerment. Traditional gender roles put a woman at a disadvantage in the negotiation for use of preventative methods during sexual intercourse. Use of the female condom put a woman in control of her sexual life.

Peer educators’ visits. Visits to people’s residences enabled the peer educator to talk to both sex partners. Accompanying some of the community members to clinics for treatment boosted the confidence the community members had on the peer educators.

Follow up consultations. Provision of limited supply of female condoms to clients on first time was important in monitoring those who were serious users. Being members of their communities peer educators were available for help in using the condom.

Positive negotiation skills (on the part of the women). Training of women in negotiation skills was well done. Recognition of the cultural values and gender roles was critical in initiating discussion about sexuality among sex partners.

Positive parental involvement. Parents found it difficult to discuss some sexual matters with their children. Peer educators became handy for parents who wanted assistance to give accurate information to their children on sexual matters especially HIV/AIDS. However, some non-facilitative factors were; fear of
discussing sex with the opposite sex, ambiguous traditional gender roles, and negative attitude of health personnel.

**CONTEXTUAL DOMAIN #5**

**CULTURE**

The cultural domain refers to positive, existential, or negative characteristics that may promote or hinder prevention and care practices. Culture according to Mazrui (1986) is “a system of interrelated values active enough to influence and condition perception, judgment, communication, and behavior in a given society” (p. 239). In this light, culture has tremendous implications for health decisions and for the design of programs to address health outcomes. However, historically health interventions have tended to ignore or de-emphasize the role of culture. At best, when a population’s culture had been stressed, interventionist would typically highlight negative aspects of culture (e.g., high fat diets low fiber diets of African Americans) and ignore positive cultural components (i.e., consumption of vegetables). More recently public health interventionists have begun to identify a cultural strengths in conjunction with cultural barriers (i.e., weakness or negatives (Airhihenbuwa, 1995, 1999; Green & Krueter, 1999; Huff & Kline, 1999). For example, in African contexts positive cultural practices such as “Ukhusoma” (non-penetrative sex) practiced by some Zulu youth and the “age-grade” (extensive peer support) system in place in many West African societies can be emphasized when developing HIV/AIDS prevention, treatment and care strategies.

Culture played a key role in the project as well. The key to cultural practices was Sangomas whose role was not quite clear but whose potential as referral mechanisms for the project should not be lost. Some contentious issues such as the expectation that
women would obey men at all costs and times and the fact that men were not expected to be faithful to their spouses were issues that need further investigation.

♦ **Gap in behavior expectation between men and women.** There was still gender inequality in terms of societal behavior expectations on matters of sexuality. This put the women at a disadvantage when negotiating for safe sex practices. Negotiation techniques taught by peer educators to the women helped them greatly in convincing their partners to use condoms during sexual intercourse.

♦ **Perception of culturally sanctioned infidelity.** Although not clearly stated, it seemed that it was acceptable for a man to have more than one sex partner while it was considered infidelity for a woman to have extra sex partners. Female condoms became handy for women who suspected infidelity on the part of their sex partner (UNAIDS, 2002)

This cultural domain is the focus of the secondary analysis undertaken in the present study using PEN 3 which will be discussed in Chapter 3.
CHAPTER 3

METHODOLOGY

The purpose of this study was to conduct a secondary data analysis of socio-cultural findings from the Mpumalanga Female Condom Project evaluation using the PEN 3 Model, a framework developed to “centralize culture in health promotion interventions” (Airhihenbuwa, 1995, 1999). PEN-3 addresses the cultured context of behavior by applying the domains of community identity; relationships and expectations; and cultural empowerment to the development, implementation and evaluation of health promotion programs (Airhihenbuwa, 1999). In addition to HIV, the model has been used to address other diseases including a cancer prevention effort targeting African American women (Erwin, Spatz, Stotts et al., 1996) and a hypertension initiative targeting older African Americans (Walker, 2000). PEN 3 has also been used to explore socio-cultural variables of focus group findings from the Nelson Mandela/HSRC National Community-based HIV Prevalence Study conducted in South Africa in 2002 (Shishana & Simbayi, 2002).

TARGET POPULATION AND STUDY SAMPLE

Peer educators and male and female community members 18 years of age and older made up the target population for this study. A roster of the 54 Mpumalanga Female Condom Projects in the province was obtained from the project office in Bethal. The 54 projects were grouped into 3 regions of the Province (High Veld, Low Veld, and Eastern High Veld) using a proportionate stratified random sampling technique. Twenty-three projects representing about one third of all the projects were proportionately selected from the three regions. A list of the projects and the number of study participants (peer educators, male and female community members) is provided in Appendix B. An initial attempt to include a focus group of sex workers failed. However, peer
educators identified sex workers and invited them to take part in the study. A total of 288 peer educators and 296 community members (201 women and 95 men) took part in the study. The MFCP Project Manager and 4 project facilitators took part in open-ended interviews, while 23 focus groups discussions of peer educators and male and female community members were conducted.

**DATA COLLECTION INSTRUMENTS**

Using focus groups, questionnaires with closed and open-ended questions, and individual interviews, investigators gathered data from the project leaders, peer educators, trainers of the peer educators, and male and female community members. Focus groups were used to gather information on a range of socio-cultural issues surrounding female condom use and to facilitate the questionnaire design. Six interviewers with health promotion skills and academic training in public health were hired to administer the research instruments. They participated in an extensive one-day training activity lead by the project investigators. These interviewers were required to be fluent in at least 2 of the 4 languages spoken in Mpumalanga (i.e., Isindbele, Isizulu, Sepedi, and Siswati). Their training also focused on translating the instruments from the local languages into English; describing the study sample and location; recruiting for, organizing and conducting focus groups (including tape recording); and keeping accurate records of daily activities during the data collection period. Instrument reliability and validity was established through a pilot study conducted in of the Mpumalanga communities in January 2001 (UNAIDS, 2002).

The trained interviewers administered one questionnaire to the peer educators and a second questionnaire to male and female community members. The peer educator questionnaire accessed information from peer educators about community norms around sexuality and STI/HIV/AIDS knowledge and condom marketing skills gained during the peer education training activities. Male
and female community members were questioned about religious and community norms, communication dynamics, gender relations, and male and female condom use, in addition to HIV/AIDS/STI knowledge, attitudes and practices. The questionnaires included open-ended questions that attempted to access information similar to that accessed by the focus groups. Samples of the instruments used in the study are in provided in Appendix C.

SPSS was used to analysis the questionnaire data and descriptive statistics were used to describe the sample of the participants and the key variables. Relationships among variables that impacted the use of female condoms were determined using the Chi-square statistic. The focus group discussions contained in recorded cassettes were translated from the local languages into English and then transcribed. Findings resulting from the transcriptions of the focus groups results were coded and then categorized into groups based upon specific focus group questions. Focus group questions targeting peer educators addressed their role as peer educators in the context of the Mpumalanga community as well as their role as a community member. For example, questions about sexual attitudes and behaviors of community members, awareness campaigns and project sustainability related to the peer educator’s role as a part of the MFCP. Peer educators as community members responded to condom use questions associated with their own sexual partners and question about their own sexual attitudes. Specific categories are:

1. Adequacy of information and knowledge about STIs and HIV/AIDS
2. Beliefs, attitudes and norms regarding sexuality in the community
3. Communication skills and assertiveness relevant in initiating discussion about condoms in advance with sex partner
4. Negotiation skills with sex partners around female condom use
5. Community sensitization about HIV/AIDS
6. Awareness Campaigns before the start of the project
7. Government sponsored activities on health education and disease prevention in the community
8. Characteristics of women peer educators talked to about the female condom
9. Other community development projects addressing STI and HIV/AIDS prevention
10. Project sustainability

Focus group interview results from community members were placed into the following categories developed as a result of specific focus group questions:

1. Knowledge, beliefs, attitudes and norms regarding sexuality including
   a. Premarital sex
   b. Extramarital sex
   c. Discussion about matters related to sex

2. STI/HIV/AIDS and pregnancy prevention methods
3. Health seeking behaviors
4. Health services for the treatment of STIs and HIV/AIDS
5. Religious beliefs and sexuality
6. Sources of information about the female condom
7. Female condom acceptance

This analysis was incorporated into the UNAIDS final evaluation report along with results from the in-depth interviews of MFCP staff and the quantitative results from the questionnaires. Furthermore, the MFCP evaluation researcher applied these findings to the five domains (i.e.,
DATA ANALYSIS

A modified content analysis as an evaluative research method was used in this study. “Content analysis is a (qualitative) research tool used to determine the presence of certain words or concepts within texts or sets of texts. Researchers quantify and analyze the presence, meanings and relationships of such words and concepts, then make inferences about the messages within the texts, the writer(s), the audience, and even the culture and time of which these are a part” (Colorado State University, 2003). Text might include interviews and focus groups as well as books, newspaper headlines and articles, historical documents, speeches, conversations, etc. The text is broken down into manageable categories that might be based on words, word senses, phrases, sentences, or themes. This organized text is then examined using either conceptual or relational analysis, the basic content analysis methods. (Colorado State University, 2003).

“Culture is central to health behavior, particularly in shaping the social contexts of behavior” (Airhihenbuwa, et al. in press) and can be understood as high-context (collectivity) or low-context (individuality) (Markens et al, 2002). In addition, culture has been examined in the context of behaviors that may be shallow or deep in relation to culture (Coyne-Beasley and Schoenbach, 2000). Furthermore, culture is understood in terms of positive qualities that should be promoted, unique qualities that should be examined, and negative qualities that should be changed (Hall, 1989; Resinicow et al 1999). Airhihenbuwa’s PEN-3 model was developed to centralize culture in health promotion and disease prevention interventions in the African and African American communities (Airhihenbuwa, 1995, 1999). The model
emphasizes cultural identity as the key component related to behavior in general and health behavior in particular. It assists public health interventionists and communities with the planning, implementation, and evaluation of relevant culturally-based health interventions and helps interventionists analyze research findings.

PEN-3 is being used in the analysis of the Mpumalanga Female Condom Project Evaluation as a modified content analysis tool to frame the findings of the Mpumalanga community. This exercise involved categorizing of the community’s issues phrases, words, etc. into a matrix that will allow for a more strategic analysis of the information.

THE PEN 3 MODEL

PEN-3 addresses culture by applying three identifiable constructs or “domains” - 1) Cultural Empowerment, 2) Relationships and Expectations, and 3) Cultural Identity. Each domain incorporates 3 individual constructs. The name PEN 3 is derived from the acronyms of the concepts of each of these constructs (i.e., *Cultural Empowerment* - **P**ositive, **E**xistential, **N**egative; *Relationships and Expectations* - **P**erceptions, **E**nablers, **N**urturers; *Cultural Identity* - **P**erson, **E**xtended Family, **N**eighborhood).

The three domains of the PEN 3 Model incorporate specific constructs: *Community Identity* - *Person* - individual’s need to be empowered to make informed health decisions in relation to their role in their family and community; *Extended Family* - “extended kin” and the role they might play in health decisions of the individual; *Neighborhood* - promotion of health and prevention of disease in the neighborhoods and communities; *Relationships and Expectations* - *Perceptions* - knowledge, attitudes, values, and beliefs that may facilitate or hinder personal, family, and community motivation to change; *Enablers* -cultural, societal,
systematic or structural influences or forces that may enhance or be barriers to change; 

*Nurturers* - reinforcing factors that individuals receive from significant persons; **Cultural Empowerment** - *Positive* - beneficial health behaviors and empowerment, extended family, and community; *Existential* - indigenous cultural beliefs/practices/behaviors that have neutral characteristics; *Negative* - potentially harmful health beliefs/practices (Airhihenbuwa, 1995, 1999). The Cultural Empowerment and Relationships and Expectations domains are “diagnostic” domains used for cultural assessment. Community Identity is the “application” domain that helps the public health practitioner assist the community with identifying the point of entry of the intervention (i.e., person, extended family, neighborhood). The PEN-3 conceptual model is presented as Figure 2.

**Figure 2. PEN - 3-Model (Airhihenbuwa, 1999)**
What follows is a description of the 4 Steps used to frame qualitative data using the PEN-3 Community Empowerment and Relationships and Expectations domains. The reanalysis of the findings from the Mpumalanga Female Condom Project Evaluation, using Steps 1 through 3 is presented in Chapter 4. An example of how Step 4 (Community Identity Domain) could potentially be used is detailed in Chapter 5.

**Step 1** involves the development of a 3 X 3 Table, which crosses the Community Empowerment domain with the Relationships and Expectations Domains to form a 9 - celled matrix. Each cell is labeled from 1 through 9 representing the “marriage” of one construct from each of the 2 domains. For example, the first construct of the Relationships and Expectations domain is Perceptions and the first construct of the Cultural Empowerment domain is Positive. Combining these two constructs will form “positive perceptions”, Cell 1 of the table. Cell 2 will be formed by combining the Existential construct from Cultural Empowerment with the Perceptions construct from Relationships and Expectations, to form “existential perceptions.” This combining of the constructs continues until all 9 cells of the table are complete. Below is an example of the table with completed Cells 1 through 9.
Step 2 involved placing the relevant findings (issues, phrases, words, etc.) into 1 of 9 cells. This step can be seen as the preparation step to conduct a modified content analysis involving organizing the issues into the matrix for analysis as described above. In some cases a statement might be relevant to more than 1 cell. For example, in the context of the MFCP project as an organization, the peer educator’s role might be framed as an enabler. However, as a member of the community who influences community norms, a peer educator could also fit into the nurturer role. This placement of community issues, phrases, and words into appropriate cells continues until all the findings are classified into a relevant cell(s). An example of how this process was conducted using Mpumalanga findings is shown below. The actual reanalysis exercise as it was conducted is presented in the Chapter 4.
POSITIVE PERCEPTIONS

Positive knowledge, attitudes, values, beliefs affecting personal, family, community motivation to change behavior

Example: HIV is about what you do and not who you are

EXISTENTIAL PERCEPTIONS

Unique knowledge, attitudes, values, beliefs affecting personal, family, community motivation to change behavior

Example: In the African context we take care of the sick and dying

NEGATIVE PERCEPTIONS

Negative knowledge, attitudes, values, beliefs affecting personal, family, and community motivation to change a behavior

Example: People who have AIDS are being punished by the ancestors

POSITIVE ENABLERS

Positive cultural, societal, systematic, structural forces affecting change (resource availability, access, referrals, employer, government officials, skills, services

Example: The MFCP has helped decrease STI in the community

EXISTENTIAL ENABLERS

Unique cultural, societal, systematic, structural forces affecting change (resource availability, access, referrals, employer, government officials, skills, services

Example: Traditional medicines can improve some AIDS related illnesses

NEGATIVE ENABLERS

Negative cultural, societal, systematic, structural forces affecting change (resource availability, access, referrals, employer, government officials, skills, services

Example: Nurses in the government clinics disrespect STI patients, causing them to avoid the clinics

POSITIVE NURTURERS
Degree to which attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community positively

**Example:** Sticking with one sexual partner helps to prevent STI/HIV/AIDS transmission

**EXISTENTIAL NURTURERS**

Degree to which attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community in a unique way.

**Example:** Home-based care is customarily accepted in communities

**NEGATIVE NURTURERS**

Degree to which attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community negatively

**Example:** Peer educators were stigmatized initially as persons infected with HIV/AIDS

“Member checking” is a qualitative research concept that attempts to determine whether respondents viewpoints have been adequately interpreted by the researcher. In **Step 3** the researcher returns to the community to conduct “member checking” with original study participants. This researcher returned to the Mpumalanga community to conduct a “representative member checking” with relevant MFCP staff in order to corroborate his interpretation of the data reanalysis conducted in Step 2. This process involved presentation of the 3 X 3 table to eight MFCP staff (6 project coordinators, the project director, the director of research. The researcher first presented them with a brief description of the PEN-3 Model and instructed them on how to use the 3 X 3 Table, using examples to guide the process. The 8 participants were divided into teams of 2. Each team
received a set of placards containing the issue, phrases and words from the focus group and open ended question findings (each placard contained only one issue, phrase, etc.) A number from 1 to 9 was written on the reverse side of each placard representing the researcher’s analysis using the cells of the 3 X 3 Table. Each team was asked discuss each item on its placards and then place a number from 1 to 9 on the front of each placard, representing the team’s analysis of that phrase. Once the teams had completed this activity, the researcher was to guide discussion about the placement of the items, determine where the researcher and MFCP team’s concurred and discuss and implications for items of non-concurrence. It should be pointed out here that non-concurrence is not a failure in analysis on the part of the researcher or the participants, but can be attributed to difference in interpretation and individual and community perceptions and perspectives around the questions and responses. For example a response to a question related to sexual communication between partners could differ between peer educators, men and women.

The final activity in the member checking exercise was to solicit 2 to 3 salient issues in the analysis that can feasibly be addressed and discuss those issues in the context of the Community Identity domain, emphasizing the level of intervention entry. Unfortunately because of logistical constraints, the researcher was only given 1 hour instead of the required 2 hours to conduct the full member checking activity. Because of the limited time the researcher was not able to discuss where items differed or the level of intervention entry with the participants. However, the researcher addresses the issue of non-concurrence in Chapter 4 in detail and provides scenarios of intervention entry points in Chapter 5.

During the visit the researcher also obtained feedback from peer educators, community members at two project sites, Enzinomi and Kriel, and project coordinators
from Mpumalanga and neighboring provinces who were attending an in-service training. The site visit also allowed the researcher to fill in gaps on the project history and to review relevant reports, training materials, and marketing tools to gain a better understanding of the project operation.

**Step 4** uses the Community Identity domain of PEN-3 to determine the point of entry for an intervention. This step involves prioritizing the issues and deciding which ones can most feasibly be addressed. The central and critical point of PEN-3 is that intervention should not focus only on a negative health outcome. It should also encourage positive and recognized existential outcomes. Interventions can take place at the individual, family, community, or institutional level or at any combination of these levels depending upon the issue being addressed (Airhihenbuwa, 2002). For instance, in the example provided above concerning negative attitudes of nurses in government clinics toward STI patients, an intervention entry point might be a policy change to mandate training on how to treat patients. The training could emphasize the impact of staff negative behavior, pointing out patients’ reluctance to return to clinics for treatment and follow-up as a result of that behavior. As mentioned in a preceding paragraph, the researcher did not use the Community Identity domain for this analysis. However, detailed examples of how it could potentially be used in the context of the Mpumalanga Female Condom Project findings are provided in Chapter 5.

I will describe the analysis of findings from the MFCP focus groups, open ended questions and interviews using the Community Empowerment/Relationships and Expectations 3 X 3 Table, beginning with Cell 1 (Positive Perceptions) and going through Cell 9 (Negative Nurturers). Each question falls under one of seven categories developed based on the types of questions from the focus group items and the results of the questionnaires administered in the MFCP Evaluation. The
The researcher established these seven categories based on the specific issues coming out of each of the issues, phrases and words from the MFCP evaluation results. The seven categories and their relevant sub-categories are listed below:

1. Community beliefs, attitudes, norms about sexuality
   a. premarital sex
   b. extramarital sex
2. Sexual behavior and STI/HIV/AIDS knowledge, beliefs, attitudes and behaviors
   a. knowledge
   b. beliefs and attitudes
   c. health seeking behaviors
3. Sexual communication
   a. between partners
   b. between parents and children
   c. between community members
4. Religion and Sexuality
5. Gender relations and sexuality
6. Female condom issues
   a. communication about female condom with sexual partner
   b. female condom use behavior
   c. reasons for female condom use
7. MFCP Project planning, implementation, management and logistics
   a. project logistics and training
   b. project peer educators
In a few cases this researcher’s categories matched categories established by the MFCP evaluation researcher (e.g., community beliefs, attitudes and norms about sexuality and religion and sexuality). In addition, this researcher expanded other categories established by MFCP researcher. For example, female condom acceptance and sources of information about the female condom were incorporated into a larger female condom issues category. Finally this researcher established categories not used by directly by the MFCP evaluation researcher (e.g., gender relations and sexuality and MFCP project planning, implementation, management and logistics).

CONCLUSION

A major challenge in addressing HIV/AIDS prevention and control in the future has to do with the central role of culture in analyzing data and developing intervention strategies. Previously, most research and interventions addressing HIV/AIDS in Africa have been based on the assumption that behavioral analysis and intervention points should be focused on the individual with tangential reference to the role of culture. PEN 3 is a model that addresses culture in the development, implementation and evaluation of health promotion programs. It has been developed and presented to allow HIV/AIDS researchers and interventionists to conduct culturally-based research and develop interventions to effectively combat HIV/AIDS in Africa.
CHAPTER 4

STUDY RESULTS

This study uses a modified content analysis exercise to reanalyze the issues, phrases and words obtained from focus groups, opened–ended questions and interviews of Mpumalanga Female Condom Project staff and members from the Mpumalanga community. This reanalysis was conducted using the PEN – 3 Model to access female condom use and acceptance in the community from through a cultural lens. What follows is the framing of the MFCP evaluation findings using PEN-3’s Cultural Empowerment & Relationships and Expectations 3 X 3 matrix as described in Chapter 3.

Figure 3. Cultural Empowerment & Relationships/Expectations

<table>
<thead>
<tr>
<th>The Domains</th>
<th>Positive</th>
<th>Existential</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Enablers</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Nurturers</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

POSITIVE PERCEPTIONS

Positive knowledge, attitudes, values, beliefs affecting personal, family, community motivation to change behavior
EXISTENTIAL PERCEPTIONS

Unique, knowledge, attitudes, values, beliefs affecting personal, family, community motivation to change behavior

NEGATIVE PERCEPTIONS

Negative knowledge, attitudes, values, beliefs affecting personal, family, and community motivation to change a behavior

POSITIVE ENABLERS

Positive cultural, societal, systematic, structural forces affecting change (resource availability, access, referrals, employer, government officials, skills, services

EXISTENTIAL ENABLERS

Unique cultural, societal, systematic, structural forces affecting change (resource availability, access, referrals, employer, government officials, skills, services

NEGATIVE ENABLERS

Negative cultural, societal, systematic, structural forces affecting change (resource availability, access, referrals, employer, government officials, skills, services

POSITIVE NURTURERS

Degree to which attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community positively

EXISTENTIAL NURTURERS

Degree to which attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community in a unique way

NEGATIVE NURTURERS

Degree to which attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community negatively
COMMUNITY BELIEFS, ATTITUDES, & NORMS ABOUT SEXUALITY

In general, beliefs, attitudes and norms are in and of themselves individual, group or community perceptions. Statements and issues around perceptions of sexuality among Mpumalanga community members and peer educators came out of questions about pre-marital and extramarital sex.

“Sex before marriage is not acceptable to the community” Positive Perceptions

“Extramarital sex is associated with risk of STI/HIV/AIDS” Positive Perceptions

“Youth under 14 years old should be encouraged to abstain from sex” Positive Perceptions

“Condoms should be used when engaging in premarital or extramarital sex” Positive Perceptions

“One must try out sexual partners before marriage to gain experience and also to determine if (he or she) is a good fit” Existential Perceptions

“Women allow extramarital affairs because men won’t change” Negative Perceptions

“Men need more than one sexual partner…” Negative Perceptions

“Men have affairs because women don’t consider husband’s needs” Negative Perceptions

“A woman has an affair when her husband does not pay attention to her needs” Negative Perceptions

“Women have affairs in response to husbands’ affairs” Negative Perceptions

“An extramarital affair can potentially destroy a stable marriage” Negative Perceptions

“Extramarital affairs are caused by boredom or dissatisfaction with spouse” Negative Perceptions

“Extramarital affairs can destroy a stable marriage/relationship” Negative Perceptions

“Extramarital affairs sparked by revenge in response to spouse’s affair or dissatisfaction in the marriage” Negative Perceptions

“Extramarital affairs are caused by lack of communication between partners” Negative Perceptions
“Extramarital affairs occur because men prefer ‘school girls’ and younger women” **Negative Perceptions**

“Young girls get infected through rape and in turn infect men who infect their wives” **Negative Perceptions**

“Extramarital affairs are discouraged” **Positive Nurturers**

“Abstinence until marriage emphasized as a community norm” **Positive Nurturers**

“Having a child before marriage is proof of fertility, making a woman marriageable” **Existential Nurturers**

*Extramarital affairs can lead to divorce and divorced women have trouble finding a mate”** **Negative Nurturers**

“Premarital sex can lead to unwanted pregnancy and possible feuding between families” **Negative Nurturers**

Perceptions attached to beliefs, attitudes and norms around sexuality in the community focused on issues of fidelity, age at which sex should be initiated and the importance of condom use. By and large, community members’ perceptions of extra marital affairs and pre-marital sex are that they do occur in the community, even though it is not accepted by most. Respondents link extramarital affairs to several negative health and social outcomes, including an increase in STI/HIV/AIDS, family conflict, and divorce. Several issues are perceived to be responsible for extramarital affairs, including lack of communication between partners, boredom or dissatisfaction with spouse or partner, and lack of concern for the sexual needs of a partner. Several male and female community members support a premise that men have an innate need for a variety of partners, and that women should acquiesce to this need by allowing men to have affairs. Male respondents tended to place blame for extramarital affairs on women (e.g., “men have affairs because women don’t consider husband’s needs”), while women made men the culprits (e.g. “extramarital affairs occur because men prefer ‘school girls’ and younger women”).
A few male and female community members support sex before marriage with the idea that one has to gain sexual experience in order not to be embarrassed in the marriage. Some respondents feel that it is also necessary to try out a partner to make sure it is a good fit before committing to marriage. The need to determine if a woman is fertile also arose as an issue in support of pre-marital sex. This practice, also found in other cultures, assumes that the woman is fully responsible for a pregnancy and dismisses other bio-psychosocial factors (e.g., timing of intercourse, stress, male infertility, etc.). The idea of a woman’s responsibility is closely linked to the belief that the woman is also responsible for the sex of the child, another premise that is contradicted by science, but that remains imbedded in many cultures. These and similar beliefs have powerful gender-related negative implications for women (i.e., divorce, banishment, murder, etc.) and men (i.e., pressure to find “fertile” partner, powerful threats to manhood, etc.). These beliefs have obvious implications for STI/HIV/AIDS transmission in a community.

Although community members support fidelity in marriage and, except in a few cases, support the abstinence until marriage principle, they realize that Mpumalanga community members don’t practice both behaviors. In the presence of these behaviors, they support condom use to prevent STI/HIV/AIDS transmission and unwanted pregnancies.

**SEXUAL BEHAVIOR & STI/HIV/AIDS KNOWLEDGE, BELIEFS, ATTITUDES & BEHAVIORS**

Questions that guided this category focus on knowledge, beliefs and attitudes, and health seeking behaviors around STI/HIV/AIDS. The findings from this category were divided into responses based on 1) sexual behavior 2) STI/HIV/AIDS knowledge, 3) STI/HIV/AIDS beliefs and attitudes and 4) health seeking behaviors around STI/HIV/AIDS. These issues cut across several of the PEN-3 domains. For example, they address individual or community knowledge and
perceptions about transmission, which would place them under relationships and expectations. They can also be looked at in terms of group, family or community norms that might guide individual and community behavior.

“Most women would refuse sex with partner if he were abusive”  Positive Perceptions

“Community members aware that HIV/AIDS exists and that it is deadly”  Positive Perceptions

“Infection caused by having multiple sex partners and unsafe sex”  Positive Perceptions

“Condom use, abstinence and masturbation are prevention methods”  Positive Perceptions

“Most women would refuse sex with partner if he were abusive”  Positive Perceptions

“Female community members say there is communication between partners”  Positive Perceptions

“Being forced to use a condom should encourage one to stick to one partner”  Positive Perceptions

“A man can get sick if he has sex with a woman during her menstrual period”  Existential Perceptions

“STI/HIV/AIDS caused by witchcraft where ‘muti’ (voodoo) is involved”  Existential Perceptions

“PLWA’s thought to be bewitched or punished by ancestors”  Existential Perceptions

“HIV does not exist”  Negative Perceptions

“HIV is transmitted through infected condoms”  Negative Perceptions

“STI/HIV/AIDS caused by witchcraft where ‘muti’ is involved”  Negative Perceptions

“PLWA’s are thought to be bewitched or punished by ancestors”  Negative Perceptions

“Discharge or ‘drop’ (gonorrhea) occurs when a man has sex with a woman who takes certain tablets for reproductive treatment”  Negative Perceptions

“Contraceptive injection needle(s) (are) contaminated with HIV”  Negative Perception

“A man will become infected with an STI if he has sex with a woman who has not ‘cleaned herself’ after having just had sex with another man”  Negative Perceptions

“Pregnancy can lower a woman’s blood pressure”  Negative Perceptions
“Sexual abstinence causes increased pimples according to teens” Negative Perceptions

“Individuals who abstain from sex are regarded as ‘mentally retarded’” Negative Perceptions
“Community members get correct STI/HIV/AIDS information from MCFP peer educators” Positive Enablers

“Hospitals and clinics provide STI advice to community members” Positive Enablers

“Sangomas (traditional healers) do not pry into why people are sick during sessions” Positive Enablers

“Hospitals and clinics will not treat a person for an STI if the person’s partner is not also present for treatment” Positive Enablers

“Community members consult both traditional healers and clinics for STI treatment” Existential Enablers

“Community members consult traditional healers if STI symptoms persist following treatment at medical clinics” Existential Enablers

“Sangomas do not pry into reasons why persons are ill (i.e., how STI is contracted)” Existential Enablers

“Community members do not have confidence in medical clinics and therefore seek treatment from traditional healers” Negative Enablers

“Community members are treated poorly by clinic staff when they come for STI treatment” Negative Enablers

“Hospitals and clinics will not treat a person for an STI if the person’s partner is not also present for treatment” Negative Enablers

“Doctors encourage women to become pregnant in order to lower the blood pressure” Negative Enablers

“PLWA’s fear rejection by family, friends and community” Negative Nurturers

“Some community members attend clinics for STI treatment without informing sexual partners” Negative Nurturers

Mpumalanga community members know that HIV/AIDS is a disease that can lead to death and that it can be contracted through unsafe sex and sex with multiple partners. Abstinence and condom use are highlighted as specific prevention methods.
Several practices unique to the Mpumalanga communities were also brought to light in relation to the disease. One such practice is “muti” or the practice of traditional medicine, used by nearly 80% of South African Blacks (Los Angeles Times, Oct 27, 2002). “Muti” also connotes “the power traditional medicine has to 'protect', 'cast a bad omen' or 'bewitch' someone.” (Setshedi, 2003). In addition to seeking treatment for an illness, a person might go to a traditional healer to access 'muti' for personal, family or property protection or to seek revenge on someone for transgressing against them (e.g., stealing), through 'bewitching' by a traditional healer” (Setshedi, personal note June 20, 2003). Mpumalanga respondents pointed out that some community members believe a person infected with STI including HIV/AIDS, are victims of “muti” placed on them by an angry spouse, jilted lover or some other vengeful person. PLWA’s are also believed to be victims of witchcraft or displeased ancestors. In addition, there are still community members who believe that AIDS does not exist.

Other myths are in place that might encourage multiple sexual partners and unsafe sexual behaviors. These include the association between sexual abstinence and pimples (a myth also perpetuated other parts of the world) the belief that people who abstain from sex are retarded, and a myth that associates pregnancy with the lowering of blood pressure.

Men in this study tended to blame women for STI. For example one man believed that a woman could pass on “drop” (gonorrhea) to a man, which she contracts from a “tablet” she takes for a certain reproductive disease.” Another man expressed the belief that a man can get “sick” (an STI) when having sex with a woman during her menstrual period.

In the context of STI treatment respondents are skeptical of the care they receive at local government clinics. For example, some community members believe that HIV is transmitted through infected condoms or birth control injections given by clinics. In addition, the clinic will
provide information on STI but will not treat a person without the sexual partner being present. These issues along with the poor treatment community members receive from government clinic staff is undoubtedly associated with the low confidence and mistrust community members have in these clinics. It also accounts in part for the heavy reliance of “Sangomas” or traditional healers by many community members for treatment of a variety of health concerns, including STI and HIV/AIDS. The use of the Sangoma is also tied to a cultural practice that has been in place for generations as well as affordability. In addition, community members might feel they can trust the Sangoma, a community fixture, with information that they would not share at a clinic. Similarly, some community members feel that the Sangoma does not pry into their personal lives like clinic staff do. The documenting of the medical history by clinic staff is probably what community members might interpret as prying. Finally some community members who do receive treatment from government STI clinics still receive “muti” from the Sangoma as assurance that the illness is cured, especially if symptoms persist after beginning treatment from the clinic. In *Health and Culture: Beyond the Western Paradigm*, Airhihenbuwa (1995) discusses the importance of a concerted effort to integrate traditional and allopathic medicine. The reliance of Mpumalanga community members on both traditional healers and government clinics for treatment speaks to this need.

Another issue relates to HIV/AIDS-related stigma and its associated denial, exclusion and discrimination, which is relevant to the Mpumalanga communities. Research suggests that AIDS-related stigma is “expressed (in varying degrees) through social ostracism, and personal rejection of PLWAs, discrimination against them, and laws that deprive them of basic human rights (reference). For example, according to some respondents, PLWAs in the community fear rejection by family, friends and community members, which keeps them from disclosing their HIV-status and seeking
needed treatment. Furthermore stigma induced fear can permeate HIV/AIDS affected family and community members, discouraging them from supporting infected members or seeking HIV testing and counseling or other needed services.

**SEXUAL COMMUNICATION**

Issues related to sexual communication revolve around communication between sexual partners (spouses, boy/girlfriends, etc.), parents and children, peer educators and community members, peers, and different generations, including students and teachers. Communication as a behavior fits well into the nurturers domain of the PEN 3 as it relates to community norms, but might also be associated with perception when we discuss individual thoughts about level of communication.

“Female community members say there is communication between partners” **Positive Perceptions**

“Unmarried sexual partners communicate more than married couples” **Positive Perceptions**

“Discussion around sex more likely if couples communicate well with each other” **Positive Perceptions**

“Teachers and some parents discuss sex with youth” **Positive Perceptions**

“Discussion with peers from community easier for most women” **Positive Perceptions**

“STI rates have decreased since project was initiated” **Positive Perceptions**

“Sexual discussion between parents and children perceived as something that occurs in “White culture” and not among Blacks” **Existential Perceptions**

“Women wait for partners to initiate sex” **Existential Perceptions**

“Peer educators say communication between partners does not occur” **Negative Perceptions**

“Extramarital sex occurs because men don’t listen to their partners” **Negative Perceptions**

“Community members perceive minimal sexual communication between partners based on number of STI/HIV/AIDS cases” **Negative Perceptions**

“Less communication between married couples than unmarried partners” **Negative Perceptions**
“Female community members feel that initiating discussion about sex will jeopardize relationship with partner”  **Negative Perceptions**

“Some sexual issues difficult or upsetting to discuss with partners”  **Negative Perceptions**

“Women are accused of being perverted if they discuss sex with partner”  **Negative Perceptions**

“Elderly parents fear talking with youth about sex will encourage them to be sexual”  **Negative Perceptions**

“Youth find it difficult to discuss sexual issues with older community members”  **Negative Perceptions**

“Parents encourage their children to attend peer educator meetings to get accurate information about sex”  **Positive Nurturers**

“Teachers and some parents discuss sexual matters with youth”  **Positive Nurturers**

“Community women hold discussions among themselves about sexual issues, share knowledge and give advice”  **Positive Nurturers**

“Fathers should talk to sons and mothers should talk to daughters about sex”  **Positive Nurturers**

“A woman should refuse sex with husband if she suspects he has been with another woman”  **Positive Nurturers**

“A woman should refuse sex with husband if she suspects he has an STI/HIV/AIDS”  **Positive Nurturers**

“Most women would refuse sex with partner if they were pregnant”  **Existential Nurturers**

“Few parents discuss sexual matters with their children”  **Negative Nurturers**

“Women afraid to discuss sexual matters with husbands”  **Negative Nurturers**

“Youth have difficulty with discussion of sexual matters with adults”  **Negative Nurturers**

“Pastors/priests discuss sexual matters only with parents and not youth”  **Negative Nurturers**

Throughout the study both community members and peer educators share conflicting views among and between themselves regarding level of communication between male and female partners. For instance, some community members suggest that male/female partners communicate
about certain sexual matters. Those who perceive a high level of sexual communication support this perception with a belief that STI rates have decreased among community members since the advent of the MFCP Project. This view is in contrast to a perception by other community members and some peer educators that communication is still difficult between partners and that STI rates are still high. One reason for the discrepancy might be that both questionnaires and focus group data from the evaluation were obtained from communities throughout Mpumalanga province. In this sense STI rates and even level of partner communication as well other findings are likely to vary from one community to the next. In addition, a community’s knowledge level, communication skills, and health outcomes will probably correlate with educational level, training, skills and other peer educator variables in a community.

Community member perceptions in the study suggest that unmarried couples communicate more freely about sexual issues than married couples. Respondents also suggest that anxiety on the part of women among both married and unmarried couples fear that “rocking the boat” can lead to threats of violence or actual violence, pushing the partner to find women outside the relationship, or loss of the relationship altogether.

Another communication-related issue that stands out is the perception that women who discuss sex are seen as perverted. This negative perception could potentially stigmatize a woman, keeping her from being open with her partner about sexual issues. It can keep a woman from expressing her likes and dislikes in terms of sex and not allow men to explore their own desires.

In addition to partner communication the study addressed communication between other community members. The presence and availability of the peer educators appears extremely helpful for woman and youth in the community. For example, women find it easy to discuss sexual matters, including female condom use with peers and bring the peer educators in to mediate
discussions with male partners. Moreover, in their role as enablers, peer educators advocate for community members at STI clinics, where community members reportedly receive negative treatment from staff. In my return visit to the Emzinoni community, I learned that peer educators have educated local STI clinic staff and encouraged better treatment of community members. Parents trust peer educators as community members to provide accurate information about sexual issues to their children and addition female community members support each other by providing a network for where information and advice can be obtained.

Several inter-generational issues exist in relation to sexual communication. Similar to parents in other parts of the world, some Mpumalanga parents feel that discussing sex with young people encourages them to explore. In the same manner, although some parents and teachers are communicating with young people, overall they are reluctant to go to adults with sexual questions and concerns. This behavior might encourage youth to rely on their peers for sometimes, inaccurate information. However, recent follow-up information indicates that youth STI/HIV/AIDS education programs are taking place in schools and led by students being trained as peer educators. This change has provided more successful outcomes targeting youth.

**RELIGION AND SEXUALITY**

A majority of Mpumalanga community members are members of various Christian denominations. Therefore responses to questions around religion are associated more with the Christian doctrines. Specific questions on religion addressed issues of sexuality in general, family planning, STI/HIV/AIDS and condom use in the context of the church and the responsibility of church leaders to health and social condition of it congregants. The Christian Church as an institution is an enabler. However, church doctrine and norms fall under the nurturer domain because of it influence on the individual, family and community.
“Some church leaders encourage youth to use condoms” Positive Enablers

“Abstinence until marriage is emphasized in churches” Positive Enablers

“Extramarital affairs discourage by church doctrine” Positive Enablers

“STI/HIV/AIDS prevention and condom promotion discussed in some churches for sexually active members” Positive Enablers

“Some church leaders invite peer educators to present sexuality in churches” Positive Enablers

“Church leaders refer their members to peer educators for information and condoms” Positive Enablers

“Women discuss family planning and other sexuality issues at church meetings” Positive Enablers

“Women discuss family planning issues during women’s church meetings” Positive Nurturers

“Church leaders encourage condom use” Positive Nurturers

“Church leaders communicate only with adults and not youth about sex” Negative Nurturers

“Family planning discussion limited to married couples” Negative Nurturers

“Family planning education limited to “be fruitful and multiply” philosophy” Negative Nurturers

Christian doctrine can sustain health in the presence of STI/HIV/AIDS and healthy family planning. Associated church rules/norms include abstinence until marriage and fidelity in marriage. However, religious institutions in the Mpumalanga communities, like in other societies, had been reluctant in embracing issues affecting its members perceived to be in conflict with their religious teachings. This rigidity has been particularly relevant with family planning and STI/HIV/AIDS and family planning. However, because of the high incidence of STI/HIV/AIDS and teen pregnancy rates among its members and in the community, churches have been forced to adjust and become more flexible in its teachings and doctrines. For example, ministers and other church leaders invite peer educators to conduct open and honest discussions about relevant sexuality issues and encourage congregants to visit peer educators for information. They also promote condom use
among sexually active youth. The church setting also provides an opportunity for community women to discuss issues affecting their lives, including issues around sexuality.

In spite of the evolution of some churches in addressing sexuality issues in relation to STI/HIV/AIDS and family planning there are still church leaders who hold fast to rules in spite of the impact STI and HIV/AIDS and teen pregnancy rates among its members. This rigidity will continue to have a negative health impact. In their defense, however, it is extremely difficult to change century old doctrines in a short time period and even though individual church leaders may support change, they are limited church hierarchy. For example, the Catholic Church’s stance against family planning, including condom use limits a local priest’s ability to make changes.

GENDER RELATIONS AND SEXUALITY

Issues around gender relations and sexuality cut across several domains of the PEN 3 Model and focus on power imbalance between men and women and specific male and female roles in the community. For example, there are many perceptions about the sexual behavior of women and the roles that woman play in encouraging positive or negative sexual behavior of their male partners. Family and community attitudes (nurturers) around expected roles of woman and men also can promote negative or positive outcomes in relation to STI/HIV/AIDS prevention. In an institutional setting, a hospital or clinic for example, gender issues can be implicated in negative or positive health outcomes if one thinks about patient-client dynamics, particularly around issues of sexual behavior.

“A woman should not tolerate abuse from her husband or partner in order to keep the family together” Positive Perceptions

“Most male and female partners disagree that women should turn over their salaries to male partners” Positive Perceptions
“A woman insisting on female condom use would not anger her sexual partner, make him violent or make him refuse sex” **Positive Perceptions**

“Most men agree that a man should have final say about family decisions” **Existential Perceptions**

“In the case of divorce the child should be with its mother” **Existential Perceptions**

“A woman is forced to have sex with her partner even when she does not wish to” **Negative Perceptions**

“Women are afraid to refuse sex because partner will think she is unfaithful” **Negative Perceptions**

“Women see themselves as sexual providers for men regardless of consequences” **Negative Perceptions**

“Women are afraid to discuss sexual matters with their husbands” **Negative Perceptions**

“Single women give control of relationship to male partners in order to hold on to relationship” **Negative Perceptions**

“Women don’t deny their husbands sexually in order to keep them from having affairs” **Negative Perceptions**

“Women wait for partners to initiate sex and don’t feel comfortable telling him when they want sex” **Negative Perceptions**

“A man is entitled to get whatever he wants sexually from his wife” **Negative Perceptions**

“A woman should not tolerate abuse from her husband or partner in order to keep the family together” **Positive Nurturers**

“A woman’s role is to take care of the home and cook for the family” **Existential Nurturers**

“A man is entitled to get what he wants sexually from his wife” **Negative Nurturers**

“A woman is forced to have sex with her husband even if she does not want to” **Negative Nurturers**

“Single women give men control in order to keep the relationship” **Negative Nurturers**

Individual perceptions and community norms related to gender were predominately negative, even though several issues had positive implications. For instance, both male and female community members favor viewpoints that allow women to be self-determining (e.g., in control of
own finances, able to leave an abusive situation, etc.). Some traditional attitudes are in place, however, that may have neither positive nor negative implications, but are dependent upon individual circumstances. For example, community members believe the man in a relationship has the final say in family decisions. A related view is that the woman is responsible for home-related matters such as cooking and childrearing. On its own, role delineation can promote a stable family environment with positive outcomes. Negative outcomes in this regard occur in the presence of dogmatic views and inflexibility concerning these roles.

Because a woman has less control over her environment than a man, she is more vulnerable to STI/HIV/AIDS infection than men. This limited control is associated with the lack of power and control she has in her relationship with her spouse/partner. For example, if she feels that she will be forced to have sex with her partner she might be too intimidated to request condom use. Similarly, not wanting to be labeled unfaithful by her partner can encourage her to have sex even if she does not want to and she will likely be too intimidated to request a condom in this instance. This outcome can also be the result of a man who feels entitled to whatever he wishes from his wife/partner.

**FEMALE CONDOM ISSUES**

This category was guided by questions addressing sources of information, perceptions and attitudes, communication between partners around female condom use, and reasons for female condom use and nonuse. These dynamics cut across the several PEN 3 domains. Attitudes around use might be associated with perceptions, while community norms linked to acceptance are connected to individual and community behaviors. Still, condom logistics tied to health
department, NGO and funding entities, particularly issues of availability, is an excellent example of the enabler domain of the Model.

“Women feel confident with the female condom” **Positive Perceptions**

“Men feel confident with the female condom” **Positive Perceptions**

“Women more confident about communication with partners” **Positive Perceptions**

“A man can maintain an erection better with the female condom than with the male condom” **Positive Perceptions**

“Female condom more convenient than male condom” **Positive Perceptions**

“Female condom is convenient because it can be put in hours prior to sex” **Positive Perceptions**

“Female condom allows a woman to have control over her sexuality” **Positive Perceptions**

“Sometimes men don’t notice the female condom is in” **Positive Perceptions**

“A woman insisting on condom use does not lose the respect of a man” **Positive Perceptions**

“Female condom can put a woman in the mood for sex before partner approaches her” **Positive Perceptions**

“Using a condom is a sign of responsibility and not a reason of mistrust and infidelity” **Positive Perceptions**

“A woman carrying a condom does not necessarily mean that she is planning to have sex, is loose or is experienced” **Positive Perceptions**

“Female condom used mostly by single women” **Positive Perceptions**

“Female condom more pleasurable for men because men can maintain erection more easily (unlike with male condom)” **Positive Perceptions**

“Decision to use the female condom is the responsibility of both partners” **Positive Perceptions**

“Female condom can be used by any woman and not just sex workers” **Positive Perceptions**

“Insisting on female condom use would not anger one’s sexual partner or cause him to be violent or to refuse sex” **Positive Perceptions**

“Women initiate discussion about the female condom” **Positive Perceptions**
“Women are making an effort to use the female condom even when partner resists” Positive Perceptions

“Discussion about female condom is initiated by both partners” Positive Perceptions

“Female condom uncomfortable and painful for men” Negative Perceptions

“Female condom inconvenient to use” Negative Perceptions

“Female condom reduces sexual pleasure” Negative Perceptions

“Carrying a condom implies sexual experience and therefore increased risk of STI/HIV/AIDS” Negative Perceptions

“Female Condom can sink inside of the woman” Negative Perceptions

“Peer educators talk with couples, including resistant males about sex and condom use” Positive Enablers

“Peer educators arm women with various communication strategies to approach male partners about female condom” Positive Enablers

“Peer educators lead all male discussion groups about STI/HIV/AIDS and female condoms” Positive Enablers

“Women more confident about communicating with partners about female condom use with peer educator support” Positive Enablers

“Peer educators provide education at community members’ homes” Positive Enablers

“Youth learned of female condoms through friends” Positive Enablers

“Some men buy the female condom when they cannot find it for free” Positive Enablers

“Female condom can be put in hours prior to sex” Positive Enablers

“Female condom is stronger than the male condom and ‘one size fits all’” Positive Enablers

“Female condom can frighten a potential rapist” Positive Enablers

“Female condom can protect women from men who put holes in the male condom to attempt to get women pregnant or to infect woman with STI/HIV/AIDS” Positive Enablers
“Community members receive female condom information from radio, newspapers and television”

**Positive Enablers**

“Female condom more expensive than male condom” **Negative Enablers**

“Supply of female condom diminishing” **Negative Enablers**

“Community members not aware that MFCP project provides condoms” **Negative Enablers**

“Female condom inconvenient to use when one has not learned how to use it – need for training” **Negative Enablers**

“Female condom is painful to insert” **Negative Enablers**

“Female condom is greasy and noisy” **Negative Enablers**

“Women use support of peer educators and other female peers to discuss matter with partner”

**Positive Nurturers**

“Large percentage of men approve of the female condom” **Positive Nurturers**

“Female condom used for prevention of pregnancy and STI/HIV/AIDS” **Positive Nurturers**

“Youth learned of female condom from friends” **Positive Nurturers**

“A woman carrying a condom does not necessarily imply that she is planning to have sex, or is loose or is sexually experienced” **Existential Nurturers**

“Female condom used mostly by single women” **Existential Nurturers**

“Large proportion of males and females had either never used the female condom or used it only once” **Negative Nurturers**

“Few women with a steady partner use the female condom” **Negative Nurturers**

“Female condom is painful to insert and remove if not done properly” **Negative Nurturers**

Overall, both male and female community member expressed satisfaction with the female condom. Specifically women appreciate the ability to insert the condom prior to sex, putting them “in the mood” for sex before being approached by a partner. They also like that the opportunity to put the condom on prior to going to social settings where they might lose control of their faculties because of drinking. Further issues include protection against STI/HIV/AIDS and unwanted
pregnancy. Two unusual reasons women use the female condom are linked to the threat of rape and threat of males attempting to impregnate or infect a woman with an STI/HIV/AIDS. For example, women discussed the high incidence of rape in the community and the particularly vulnerable position women are placed in when hitchhiking (transportation is limited) or going places alone. They stated that the strangeness of the female condom to a rapist not expecting it could potentially frighten him. Also in case of rape women feel the female condom can protect them from an unwanted pregnancy and/or STI/HIV/AIDS infection. Women also discussed the ability of the female condom to allow them to be in control, protecting them from men who might put holes in the male condom to attempt to get them pregnant or infect them.

Men like the female condom for several reasons. First, the most common complaint about the male condom is that it can most effectively be put on and used during full erection. However, the tight fit of the condom can defeat this goal. In contrast, with the female condom the penis can be inserted into the vagina without being fully erect. Men also like the fact that the female condom is primarily the responsibility of the female partner. Unfortunately, this is another opportunity for the male to be free of the responsibility of family planning and other matters related to sexuality, which has been the case historically. Likewise it places the burden of family planning and sexuality on the female. Men and women on behalf of male partners also report pleasurable aspects of the female condom as well.

Women and men in the community stated that they feel confident using the female condom. Equally, because of the female condom women are more confident about communicating with their partners. This confidence is likely due to the contact with peer educators who provide one-on-one education and individual and group condom demonstrations throughout the community members.
Negative experiences associated with the female condom include difficult and painful insertion for some women and a painful experience for men. Some respondents also report that the female condom is greasy and noisy, though the researcher learned on the return visit that the noise can be avoided if condom is inserted 30 or more minutes prior to use.

As key components of the MFCP Project, peer educators are visible in the community and important as enablers, providing useful prevention information and female condoms to community members. Though female condom information is promoted in the community through radio, television and newspapers, community members go to peer educators for clarification and updates.

Female condoms are supplied by the Mpumalanga Government, which gets them from the South Africa Department of Health and private donors. Unfortunately they are in short supply or unavailable throughout the country. In fact during the return visit by the researcher lack of female condoms stood out as the number one concern of project staff, peer educators and community members. One project staff member emphasized the obvious by pointing out that a female condom project cannot be effective without female condoms.

**MPUMALANGA FEMALE CONDOM PROJECT MANAGEMENT ISSUES**

This category addressed planning, implementation and evaluation of the project, extensive peer educator training and management and logistics. Though most of the MFCP Project management issues fall into the enabler domain because of its status as an institution, the peer education focus of the project bring in nurturer dynamics. For example, peer educators are community members who influence condom use and behaviors that promote positive community health outcomes.
“Community members recognize “ladies in red T-shirts as sources of information on sex and providers of female condoms” Positive Enablers

“Women find it easier to talk with peer educators about sexual matters” Positive Enablers

“Project is peer driven effort with strong managerial support” Positive Enablers

“Project team made up of trained health professionals” Positive Enablers

“Project staff has experience in HIV/AIDS prevention, control and treatment” Positive Enablers

“Peer educators, coordinators and facilitators receive thorough, consistent and continuous training” Positive Enablers

“Project staff keeps good records of project activities including condom procurement and distribution” Positive Enablers

“Project cooperates with private and government entities in the province” Positive Enablers

“Project initiated and supported by major employer in the province” Positive Enablers

“Thorough and consistent training of coordinators, facilitators and peer educators” Positive Enablers

“Project uses relevant and useful training materials” Positive Enablers

“Project dependent upon free or subsidized female condom” Positive Enablers

“Project efforts limited to township residents; no efforts in rural communities” Negative Enablers

“Project not accepted by some local chiefs” Negative Enablers

“Project has limited funding for training peer educators” Negative Enablers

“Control of finances is at the head project level instead of controlled by individual projects” Negative Enablers

“Peer educators use community-based participatory approaches relevant to the community” Positive Nurturers

“Project not accepted by local chiefs” Negative Nurturers

“Peer educators initially stigmatized and labeled as HIV infected because of work” Negative Nurturers
The Mpumalanga Female Condom Project has a significant community-wide impact in relation to STI/HIV/AIDS knowledge, attitudes and practices. The project has changed norms around issues of sexuality and helped promote the use of the female condom throughout the community. These changes have taken place primarily through the use of peer educators, who as members of the communities they serve are keenly aware of community values and norms. As community members peer educators also know the most effective and relevant behavior change strategies to engage in their communities. These strategies include participatory community-based approaches.

Peer educators’ roles in addition to providing information and distributing both male and female condoms include acting as a mediator between couples around sexuality issues, training community members (usually women) how to approach their partners about female condom use and other relevant topics, and conducting group discussions in various arenas to help shape safe sex norms. Moreover, peer educators act as advocates on behalf of community members by mediating in STI hospitals and clinics, in schools and at workplaces.

Peer educators are identified in the community by the red T–shirts they wear. This identification makes it easy for community members to contact them for their own needs and to refer others needing STI/HIV/AIDS information and condoms. Peer education efforts are enhanced by the supervision they received from the MFCP Project Coordinators, continuous training and updates provided by the Project Facilitators, and constant feedback they get from fellow peer educators. The need for more peer educators in the community came through in the focus group discussions. However, funding was not available to support this need and was highlighted as a major challenge facing the project. A related challenge is the project’s focus on more populated townships and the little or no prevention efforts taking place in rural communities.
This problem is linked to the limited number of peer educators as well as limited funds for transportation to these distant areas.

At the beginning of the project peer educators were stigmatized by being labeled HIV infected on PLWA. This initially limited the effectiveness of their work because people did not want to be associated with them. However, this attitude changed as the project progressed and the positive impact was felt.

Another challenge involved some of the local chiefs in the communities, who did not accept the MFCP. Initially, this non-acceptance had a major impact on the project’s success as chiefs have a tremendous impact on opinions and behaviors of the community members they lead. Fortunately, the researcher’s return visit to the communities found that after several years the chiefs were fully on board with the project. Finally, the issue of the short supply of condoms was expressed as the most difficult and pressing challenge. This issue was detailed in the previous section under Female Condom Issues.

This secondary data analysis was carried out by placing the relevant findings from focus groups, open-ended questions, and interviews into appropriate cells of the PEN -3 Model 3 X 3 Table. Forty items were associated with positive perceptions, while eight items were linked to existential perceptions and forty-four items were categorized under negative perceptions. Thirty-eight, three and fourteen items were associated with positive enablers, existential enablers and negative enablers respectively. Seventeen items came under the heading of positive nurturers and five items were labeled existential nurturers, while negative nurturers had nineteen items. A presentation of this analysis showing the frequencies in a tabular format is presented in Table 1 and listed by the seven categories.
### TABLE 1. PEN 3 DATA ANALYSIS FREQUENCIES BY CATEGORIES

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<th>3 Negative Perception</th>
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**Step 3** of the reanalysis involved the researcher returning to the Mpumalanga community to conduct a “representative member checking” where the researcher engaged 8 members of the MFCP staff (4 groups of 2 persons) in the modified content analysis process using the same issues, phrases and words from the MFCP evaluation used by the researcher. The point of this exercise was to determine concordant and discordant responses. Following is the combined list of items where there was discordance. The items as classified by the researcher are written below the appropriate construct (i.e., positive perception, existential perception, etc.). The items as classified
by the MFCP participants in the representative member checking exercise are placed in parenthesis next to the statements. Table 2, which follows the written classification, shows the total number items classified by construct with the number of discordant classifications.

1. **Positive Perceptions**

   “Decision to use the female condom is the responsibility of both partners” *(Positive Enablers)*

   “Infection is caused by having multiple sex partners and unsafe sex” *(Negative Enablers)*

   “Abstinence and masturbation are effective HIV/AIDS prevention methods” *(Positive Enablers)*

   “Community members are aware that HIV/AIDS exists and is deadly *(Positive Enablers)*

   “Discussion around sexual issues more likely to take place if couple relates well with one another *(Positive Enablers)*

   “Sexual communication occurs between partners” *(Existential Nurturers)*

   “STI rates have decreased since the project began” *(Existential Nurturers)*

   “Female condom allows a woman to have control of her sexuality” *(Positive Enablers)*

   “Women feel more confident with the female condom” *(Positive Nurturers)*

   “A woman should not tolerate abuse from her husband or partner in order to keep the family together” *(Positive Enablers)*

   “Being forced to use a condom should encourage one to stick to one partner” *(Positive Enablers)*

   “A large proportion of men approve of female condom use *(Positive Enablers)*

   “Decision about female condom use is initiated by both partners” *(Existential Nurturers)*

   “Female condom is not for use only by sex workers, but for all sexually active women” *(Existential Enablers)*

2. **Existential Perceptions**

   “Women wait for partners to initiate sex” *(Positive Perceptions)*
“Sexual and dating discussion between parents and their children are perceived as occurring in ‘White culture’ and not among Blacks” (Negative Perceptions)

“Carrying a condom implies experience and therefore increased risk of STI/HIV/AIDS (Negative Perceptions)

“A man will become sick if he has sex with a woman during her menstrual period” (Negative Perceptions)

3. Negative Perceptions

“Community members perceived minimal sexual communication based on high number of STI/HIV/AIDS infection in the community” (Positive Perceptions; Positive Enablers)

“Extramarital affairs can destroy a stable marriage/relationship” (Existential Nurturers)

“Extramarital sex is sparked by revenge in response to spouses affair” (Positive Nurturers)

“Extramarital sex caused by lack of communication between partners” (Positive Perceptions)

“A man is entitled to get what he wants sexually from his wife (Positive Perceptions)

“Extramarital sex occurs because men don’t listen to their partners” (Existential Perceptions)

“Women see themselves as providers of sexual satisfaction for men at any cost” (Existential Enablers)

4. Positive Enablers

“Women find it easier to discuss sexual matters with peer educators (than with partners)” (Positive Perceptions)

“Some men purchased the female condom when they could not find it for free” (Existential Perceptions)

“Peer educators receive ongoing in-service training and updates (Negative Enablers)

“Community members get correct STI/HIV/AIDS information from peer educators (Positive Nurturers)

“Youth learned of female condom through friends” (Positive Nurturers)
“Churches allow condom promotion presentations by peer educators for sexually active members” (Existential Nurturers)

“(MFCP) project team composed of trained health promotion professionals from government and NGO community” (Existential Enablers)

“Peer educators help facilitate female condom use by talking with couples, including resistant male partners” (Positive Nurturers)

5. Existential Enablers

“Community members consult medical clinics or traditional healers for treatment or seek help from both” (Positive Perceptions)

“Sangomas do not pry into reasons a person is sick” (Negative Perceptions)

6. Negative Enablers

“Control of finances is at the head project level instead of controlled by individual projects” (Positive Nurturers)

“Female condom is more expensive than male condom” (Negative Perceptions)

“Project is dependent upon free or subsidized female condoms” (Positive Enablers)

7. Positive Nurturers

“Teachers and some parents discuss sexual matters with youth” (Positive Perceptions)

“Community women hold discussions on sexual issues among themselves and share knowledge and advice” (Existential Enablers)

“Parents encourage their children to attend peer educator meetings to get accurate information about sex” (Negative Perceptions)

“Abstinence until marriage is emphasized” (Positive Enablers)

“Extramarital affairs are discouraged” (Negative Perceptions)

“Women find it easier to discuss matters with peer educators (than with partners)” (Positive Perceptions)
8. Existential Nurturers

“A woman is responsible for taking care of the home and cooking for the family” (Positive Perceptions)

9. Negative Nurturers

“Single women give men control in order to keep the relationship” (Positive Perceptions)

“Youth have difficulty discussing sexual matters with older people” (Positive Enablers)

“MFCP project is not accepted by (some) local chiefs” (Negative Perceptions)

“Women are afraid to discuss sexual matters with their husbands” (Negative Enablers)

“Persons living with AIDS are afraid of being rejected by family, friends and community” (Negative Perceptions)

“Pastors/priests discuss sexual matters only with parents and not youth” (Negative Perceptions)

| TABLE 2. FREQUENCIES BY RESEARCHER ANALYSIS AND DISCORDANT RESPONSES |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| 1 Positive Perception | 2 Existential Perception | 3 Negative Perception | 4 Positive Enablers | 5 Existential Enablers | 6 Negative Enablers | 7 Positive Nurturers | 8 Existential Nurturers | 9 Negative Nurturers |
| RESEARCHER | 40 | 8 | 44 | 38 | 3 | 14 | 17 | 5 | 19 |
| MEMBER-CHECK PARTICIPANTS | 13 | 4 | 7 | 8 | 2 | 3 | 6 | 1 | 6 |

CHALLENGES FACED IN ANALYSIS PROCESS

A major challenge I faced in placing the MFCP findings within the 9 cells of the PEN 3 Model’s 3 X 3 table was that some statements/issues could fit into more than one cell depending upon the way one interpreted the statement/issue, how it was framed and what question was being addressed. This situation was challenging from the perspective of the researcher, but became even
more difficult with the group exercise where MFCP staff framed the findings. For example, I noticed the statement, “peer educators use community-based participatory approaches relevant to the community”, could be addressed in the context of the peer educator as employee or volunteers at the MFCP. In this context, the statement serves as an enabler (in this case as a positive enabler) because of the MFCP’s agency status (i.e., cultural, societal, systematic, structural forces affecting change resource availability, access, referrals, employer, government officials, skills, services). In another vein, public health research highlights numerous successful peer led initiatives, emphasizing the importance of the influence of individuals who share similar values and norms with the intervention group. The peer educator nature of the MFCP was designed based on this premise, selecting members from the Mpumalanga community to promote the project’s success. As influential community members, peer educators are nurturers and their use of community-based methods would place the statement into the positive nurturers cell (attitudes, beliefs and actions are influenced, mediated and nurtured by extended family, kin, friends, peers, and community).

While conducting the group exercise with 8 MFCP staff, questions that I had not anticipated also arose related to various ways to categorize the statements/issues depending on the perspective. For example, one person pointed out that a statement about an MFCP issue like condom availability presented by an MFCP staff person would differ from that of a community member’s statement addressing the same issue. The MFCP person might be able to speak with accuracy about the issue (enabler) while condom availability would more than likely be a perception for the community member.

Deciding how to frame some statements/issues as positive or negative in the context of Cultural Empowerment was also challenging. Issues like high level of community awareness
around STI/HIV/AIDS prevention methods or good communication between sexual partners are fairly simple to identify as positive. In the same way issues that discourage female condom use such as painful use or availability are easily associated with negative outcomes. In contrast are statements/issues around female condom use and women’s empowerment. On one hand a woman developing confidence and feeling in control of her sexuality is an obvious positive outcome. However, this new-found confidence could potentially result in a negative reaction from the woman’s partner in the form of verbal or physical threats or actual abuse, sexual coercion, etc. Examples of this behavior are cited throughout the literature. These issues would frame empowerment negatively. The point of this discussion is that certain issues are not easily framed in the context of the PEN 3 Model 3 X 3 Table.
CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to conduct a secondary data analysis of socio-cultural findings from the Mpumalanga Female Condom Project evaluation using the PEN 3 Model, a framework developed to “centralize culture in health promotion interventions” (Airhihenbuwa, 1995, 1999). PEN-3 addresses culture by applying the domains of community identity; relationships and expectations; and cultural empowerment to the development, implementation and evaluation of health promotion programs (Airhihenbuwa, 1999). Specifically my research uses focus group results and results from opened-ended questions from the surveys to determine the cultural appropriateness of the findings. The outcome of this activity is the cultural analysis of female condom use for the prevention of HIV/AIDS in Mpumalanga, South Africa. The specific research questions examined in this study were:

1. What is the relationship between culture, acceptance, and use of the female condom by women and men in Mpumalanga Province?

2. Using the PEN-3 Model how do peer educators and community members describe the relationship between culture and female condom acceptance by women and men in Mpumalanga Province?

Culture is identified as a set of implicit and explicit guidelines inherited by members of a particular society that communicate how to view the world, experience it emotionally, and how to “behave in relation to other people, to supernatural forces or gods, and to the natural environment:(Helman 1990, p 2). In addition, through the use of language, symbols, art and rituals, culture uses these guidelines (i.e., a cultural “lens”) to transfer this system of perceiving and
living in the world to the next generation. This cultural transfer or “enculturation” promotes and encourages the continuation of a particular group (Helman, 1990).

The role of culture in the health outcomes of a community has begun to be addressed recently in the public health field. However, by and large, these efforts have affixed culture to existing socio-behavioral variables or at best given it equal credence among those variables. The present study used PEN 3, a model that situates culture at the center of the determinants of health behaviors and places other determinants (e.g., government policy, SES, etc.) at its periphery. The PEN 3 model was used to culturally frame the focus group findings from the UNAIDS funded MFCP evaluation. The study examined the relationship between culture and female condom acceptance in the community and attempted to explain female condom use in the Mpumalanga community through a cultural lens.

**DISCUSSION**

This study identified the guidelines that determine the cultural system of the Mpumalanga community. Culture was framed in the context of female condom use, guided by 1) Community beliefs, attitudes and norms about sexuality 2) Sexual behavior and STI/HIV knowledge, beliefs, attitudes and behaviors 3) Sexual communication 4) Religion and sexuality 5) Gender relations and sexuality 6) Specific female condom issues 7) Mpumalanga Female Condom Project Issues. Below I will summarize relevant information appropriate to the research questions:

Gender Relations and Sexuality is the category most relevant to research question one, which examined the relationship between culture and female condom acceptance.
GENDER RELATIONS AND SEXUALITY

Gender plays an important role in determining the socio-cultural, political, economic and health effects of women worldwide. Ruth (1995) defines gender as a social concept that refers to “a complex set of characteristics and behaviors prescribed for a particular sex by society and learned through the socialization experience” (p.17). Koch (1995) terms sexuality as “a complex phenomenon affected by our biological, psychological, social, emotional, spiritual, and cultural make-up and surroundings” (p. 5). In the context of HIV/AIDS prevention, care and support Airhihenbuwa et al (1999) define gender relations as “the status of women in relation to men in society and community and the influence on sexual negotiation and decision making” (p.27). In the context of the Mpumalanga Female condom project, gender-relations stands out as the most salient culturally-based issue in relation to female condom acceptance. Furthermore, it overlaps with the other categories addressing female condom use (i.e., religion, community norms, health behaviors). For example, the assigned roles of women and men in a society are dictated by norms and values, which are guided by religious and other cultural beliefs that may diminish women’s ability to be self-determining. These norms and values promote the power imbalance fundamental to both sexuality and gender and tipped in favor of the male in male/female relationships. This power dynamic is dictated by certain psychosocial, economic, and cultural factors and determines where, when and how sex takes place determining in addition to whose pleasure in the sexual interaction is given priority (Gupta, 2000). This dynamic is played out repeatedly in Mpumalanga communities as indicated by findings from the study. Statements such as “a woman is forced to have sex with her partner even when she does not wish to” and “women see themselves as sexual providers for men regardless of consequences” support Gupta’s premise.
Gupta (2000) highlights several factors that can render a woman vulnerable to STI/HIV/AIDS and associated negative health and social outcomes. First, through socialization a woman is “expected to be ignorant about sex and passive in sexual interactions” (p. 6), limiting her knowledge of her risk of STI/HIV/AIDS. Moreover, she may fear the possibility of being labeled “loose” if she shows that she is informed about sexual matters. This fear can discourage her from negotiating female condom use. In the case of Mpumalanga this factor was both supported and refuted. For instance, a perception such as “carrying a condom implies sexual experience and therefore increased risk of STI/HIV/AIDS” is in line with the Gupta’s argument. On the other hand, some community members perceived that “a woman insisting on condom use does not lose the respect of a man”, that “using a condom is a sign of responsibility and not a reason for mistrust” and that “a woman carrying a condom does not necessarily mean that she is planning to have sex, is loose or is experienced.” These community perceptions indicate that this fear might not have as much of an impact in the Mpumalanga as in other places or that community attitudes and norms around this factor are changing, possibly as a result of the MFCP Project. Based on the researcher’s site visit changing norms appears to have happened.

A second factor in the contexts of positive and negative perceptions and nurturers is the value of “virginity for unmarried girls.” Where such value allows for the collective consent of women, it can serve as an effective measure of STI and HIV prevention. However, the reality is that this value produces vulnerability in women. In many societies this increases a girl’s risk of being pressured or raped because of the strong desire of some boys/men to “bust the cherry” (break the hymen). Although the virginity factor was not elaborated in the Mpumalanga focus group findings, the issue of abstinence until marriage was emphasized under, both the community norms, beliefs and attitudes as well as the religion and sexuality category. Actually, it is surprising that
this issue did not come up given contemporary public discourse around female virginity in relation to HIV/AIDS in South Africa. The recent increase in rape cases, including the rape of infants and children, is thought to be tied to a myth that sex with a virgin can cure AIDS. The practice of virgin certification of girls and young women conducted by designated community women is another related issue. Both of these factors increase vulnerability of girls and young women by exposing them, not only to sexual assault and related psychological ramifications, but also to possible STI/HIV/AIDS infection and unwanted pregnancies.

A third factor Gupta (2000) emphasizes is negative perceptions and nurturers whereby women are discouraged from asking questions. As a result they might receive inaccurate health related information or no information, as well as limited or no needed treatment services. Vulnerability to HIV/AIDS might be further increased in this instance because of associated risk from untreated STI. The fear of being tested for HIV is another relevant concern. The presence of the MFCP peer educators and their prevention efforts has minimized these concerns for Mpumalanga women. In addition to providing women accurate prevention information and female condom training, they accompany women to STI clinics, encourage them to be tested for HIV and provide them with communication strategies to discuss sexuality related issues with their husbands/partners.

A fourth factor relates to existential nurturer and enablers where women are encouraged to have many children. In this instance safer sex practices including female condom use could contradict community values around family planning and increase mistrust of health promotion staff that encourage these practices. For example, HIV prevention trainers in Africa speak of the difficulty of promoting the condom because it is perceived as a ploy to decrease family size. This mistrust is based on a long history of perceived dubious planning initiatives by western
development agencies. In the Mpumalanga context the incongruity between family planning and female condom use did not surface in the focus groups. However, in the researcher’s follow-up visit to Mpumalanga, community members and peer educators revealed the tension this conflict creates between married couples/sexual partners wanting children.

Another factor Gupta (2000) discusses is the economic dependency of women on men (negative enablers) that may encourage women to remain in abusive relationships or exchange sex for money or favors. Such situations can potentially limit a woman’s ability to negotiate safe sex, putting them at continued risk of STI/HIV/AIDS infection in addition to verbal and physical violence (Gupta, 2000). Some Mpumalanga community perceptions indicate support for Gupta’s assertions. For example, the statement that “female community members feel that initiating discussion about sex will jeopardize the relationship with their partner” is an indication that there is perceived threat that keeps a woman from being honest with her partner. However, statements like “women are making an effort to use the female condom even when the partner resists” and “insisting on female condom use would not anger one’s sexual partner or cause him to be violent or to refuse sex” are opposite perceptions.

Empowerment is a positively enabling and nurturing gender related concept that surfaced continuously throughout the study in relation to female condom acceptance. Rappaport (1984) defines empowerment as a process and the “mechanism by which people, organizations and communities gain mastery over their lives” (p.3). He suggests that individuals and communities are empowered to “influence conditions of life resulting from increased awareness, social support, and problem-solving skills.” Individual women (and men) in the community were empowered through STI/HIV/AIDS increased awareness gained through their exposure to the MFCP Project. They also developed condom use skills and the ability to problem-solve sexuality
issues with spouses and partners. For example, women and men feel confident with the female condom and “discussion about female condom (acceptance) is initiated by both partners.” Social support is relevant to the support community members (women, men, youth and parents) receive from the peer educators, fellow community members, and the church leaders.

Empowerment-related research by Gollub (2000) discusses how the female condom has enhanced women’s ability to negotiate protection with partners, promote healthy behaviors, and increase self-efficacy, self-confidence and autonomy in women. These factors support the findings in the Mpumalanga study. However, factors of negative nurturing continue to impede the empowerment process that Gollub addresses remain in place in Mpumalanga as well. The perception that “a woman is forced to have sex with her husband even if she does not want to” is such an example.

Self-efficacy, self-confidence and autonomy also improved for the MFCP Project peer educators, even though this was an unplanned outcome resulting from their association with the project. Most of the peer educators are high school dropouts, who were unemployed, idle, and living with parents, getting money from boyfriends (mostly older men) or engaging in commercial sex work. In fact, in one community where the MFCP Project is located, a majority of the current peer educators are former sex workers. Some of the women are HIV positive or have AIDS. In communicating with several peer educators the researcher learned that after being hired and trained as peer educators for the project the women bonded well and have become social and financial support systems for each other. In other words they transformed a situation where they were negatively nurtured as individuals into a collective positively enabling and positive nurturing entity. For example, they pool a portion of a meager monthly stipend to provide funds for the most needy peer educator. Specific needs could range from a pair of shoes (which wear out quickly from
all the walking throughout the communities) to money for a peer educator to bury a parent, sibling or child (many whose deaths are AIDS related). One young woman who started out as a peer educator moved into a coordinator position spoke of her desire to complete her high school education, something she said she had not thought about until beginning her work with the MFCP.

Gender related issues also impact males in the context of existential perception and nurture which could lead to negative outcomes such as STI/HIV/AIDS infection. For instance, men are expected and assumed to be knowledgeable and experienced about sexual matters. This can discourage them from asking for information. In addition, norms are in place, which promote early sexual initiation and multiple sexual partners for males. The idea that a man should dominate a woman sexually also contributes to a man’s vulnerability in that his manhood is threatened if they don’t exhibit sexual prowess. Finally, the norms of self reliance and lack of emotion attributed to masculinity discourage men from engaging in healthy communication with their partners and seeking outside assistance (Gupta, 2000). Negative perceptions that came out in the focus groups that are related to these topics include those such as “a man is entitled to get what he wants sexually form his wife” and that “men need more than one sexual partner....” Issues that are tangential, but still closely linked to male vulnerability in the context of this study have to do with myths encouraging these norms to remain in place and pressure supporting these norms. Labeling persons who abstain from sex as ‘mentally retarded’ and attributing pimples to sexual abstinence are example of such myths.

In answering Question 2, which poses how the PEN-3 Model helps explain culture and female condom in Mpumalanga Province, female condom issues overlapped with sexual communication came out as the most relevant themes surrounding this issue.
FEMALE CONDOM USE ISSUES AND SEXUAL COMMUNICATION

Several studies have been conducted to look at female condom use within various populations. Such studies are relevant to the Mpumalanga study in the context of culture and female condom use. The population of Mpumalanga is relatively poor with an unemployment rate higher than the 30% nation-wide rate. The community members and peer educators who took part in the focus groups were a good representative sample of community members: young, poor, and mostly single. This demographic make-up supports a female condom initiative of the magnitude of the MFCP Project. Agha’s (2001) research, which found that frequency of female condom use was associated with low SES and casual sexual partners, corroborates this opinion.

Choi et al (2003) looked at the level and frequency of female condom use among a group of San Francisco women and found that female condom use was associated with a positive attitude about the condom from one’s partner. In a study that took place in New York, men expressed positive views about the female condom including support for a female-controlled method, a woman’s right to use it, and the possibility of the female condom enhancing sexual pleasure for the woman (Seal & Ehrhardt, 1999). Results of the Mpumalanga focus groups presented similar findings indicating an overall positive attitude by men about the female condom. For example men reported feeling confident about the condom’s ability to prevent STI/HIV/AIDS and unwanted pregnancy and both men and women (on behalf of their male partners) reported pleasurable experiences. Men’s acceptance of the female condom and supportive attitude is likely to lead to consistent use. However, in a similar manner as the New York respondents, some Mpumalanga men expressed negative attitudes and experiences (e.g., the condom’s “bigness”, inconvenience,
noisiness, etc.), which can encourage resistance when being asked by the wife/partner to use the condom.

Van Devanter et al (2002) conducted a study in 3 major US cities, which linked frequency of female condom use to condom skills training and several opportunities to practice inserting the condom. These findings support the strategies of the MFCP Project where peer educators receive extensive training and in turn train community members on how to properly insert the female condom. Opportunities to practice insertion did not come up in the focus groups, as highlighted in the Van Devanter et al study. However, only a few women who took part in the focus groups complained of painful insertion (usually associated with improper insertion) an indication that most women had learned to insert the condom properly.

Prior to the introduction of the female condom in Mpumalanga communication between men and women around sexual issues was limited. Culturally, men and women do not discuss sexuality. Female condom has allowed this value to be transformed. Through promotion and encouragement from peer educators, the female condom has helped increase the level communication to where partners are able to discuss relevant sexuality issues. For example, it has opened up dialogue to the point where some partners discuss whether to use the male condom or the female condom, a practice that has been found to enhance consistent, long term use (Macaluso, Demand, Artz, Fleenor et al, 2000).

Communication between sexual partners (spouses, boy/girlfriends), parents and children, peer educators and community members, peers, and different generations, including students and teachers also occurs in the in Mpumalanga. Though there are barriers to communication (e.g., fear of losing a partner, fear of a violent response, suggestion of promiscuous behavior, etc.) community members do discuss STI/HIV/AIDS and female condom use. Additionally, through
communication female condom use has become a norm in the community. During discussions at
the return visit to Mpumalanga communities the researcher learned that peer educator initiatives
have been established in work settings and in secondary schools. This encourages ongoing
individual, family and community-wide communication. One positive outcome of the workplace
peer education effort is that most of the employees, (including the peer educators) who are men are
getting education and training relevant to their attitudes, beliefs and needs. This situation has
helped significantly to change sexuality and female condom use norms in and beyond the
workplace. For example, some men are educating their wives/partners about sexuality issues and
showing them how to insert the female condom, a skill they learned through training provided by
workplace peer educators.

**PEN 3 MODEL - COMMUNITY IDENTITY**

**Step 4** described in the methodology section (Chapter 3) uses the Community Identity
domain to determine the point of entry for an intervention. It involves prioritizing the issues and
deciding which issues can most feasibly be addressed. The central and critical point of PEN-3 is
that intervention should not focus only on a negative health outcome. It should also encourage
positive and recognized existential outcomes. Interventions can take place at the individual,
family, community, or institutional level or at any combination of these levels depending upon the
issue being addressed (Airhihenbuwa, 2002). An example of how this exercise is carried out is
provided below using issues that came out of the analysis.

*“Women are more confident about communicating with partners about female condom
use with peer educator support.* This is a positive enabler and should continue to be encouraged in
the community. It should continue to be addressed at the partnership level so that we have a better
understanding of the qualities and character of male partners who are supportive of their female
partners in sexual communication. We can also address this at the community level through appropriate community dialogue in public settings. Church leaders and other influential community members could be approached to work as community advocates extending the work of the peer educators.

“Female Condoms are in short supply” was a top priority for MFCP program staff, project coordinators, peer educators and community members. It was identified as a negative enabler under MFCP Project Issues because it is a logistical and procurement issue associated with the project. The majority of female condoms are supplied by the Mpumalanga Government, which gets them from the South Africa Department of Health. Some condoms come from private donors.

An obvious intervention point of entry would be at the community level. One approach would be to mobilize the community with direction from the MFCP Project to engage in advocacy efforts targeting the Department of Health, private donors and the private industry in the region. These efforts might include mobilizing the community to educate legislators about the project’s success and the importance and need for sustaining it. The community might also invite local and international donors agencies as well as government officials to visit the project and develop proposals to seek outside funds. Another effort could be to develop products from within the community to market, which would allow the community to earn money to buy condoms, even at a subsidized cost.

These suggestions for the point of intervention entry point come from me as the researcher, an outsider. To effectively implement a culturally-based intervention it is imperative that the community participate on the decision about the intervention entry point(s), as well as the approach. The role of the researcher might be to help to facilitate the process.
LIMITATIONS

This study had several limitations that must be addressed. First, the analysis can be specific to the Mpumalanga community only, particularly since it is a qualitative research approach. Furthermore, the focus groups were conducted in various communities throughout the province, which can be responsible for disparate views.

Secondly, this was as a secondary data analysis, which used focus group data collected by different sources. Therefore, I was limited by the research methods and data analysis techniques used by the original researcher. This is particularly relevant when using focus group data. In addition, the data collection issues are compounded by the fact the focus groups were conducted in African languages by several moderators with varying levels of interview skills. The data was then transcribed into English, complicating translation and interpretation issues further.

Lastly, although the PEN 3 Model has been used to classify analysis, the present analysis was a first attempt at operationalizing the PEN 3 Model using secondary data. In light of this, the researcher was limited by not having previous studies to help guide the process.

CONCLUSIONS

This study used Airhihenbuwa’s PEN 3 Model (1995, 1999) to reanalyze findings from focus groups of peer educators and community members related to female condom acceptance and use in Mpumalanga Province, South Africa. The following are the main findings:

1. Culture is associated with female condom acceptance and use in Mpumalanga, particularly within the context of gender relations.
2. The PEN-3 Model is a useful instrument for conducting a modified content analysis exercise to determine the role of culture in female condom use in the Mpumalanga community.

3. The Mpumalanga Female Condom Project has helped to positively shape attitudes and norms guiding prevention behaviors related to STI/HIV/AIDS in the Mpumalanga community.

These findings support the theory that critical analysis through a cultural framework is a key factor in promoting behavior change at the individual, family and community level.

**FUTURE RECOMMENDATIONS**

Further research into the relationship between culture and female condom use in Mpumalanga should focus on:

1. Using the findings from this study, develop a culturally-based questionnaire to accesses female condom acceptance and use in South Africa
2. Implementing a longitudinal study in Mpumalanga to determine the effectiveness of the MFCP using clinical measures (STI rates) in addition to behavioral measures as indicators
3. Designing a study in Mpumalanga to look at the role of the MFCP Project in empowering Peer Educators
4. Locating consistent and long term female condom resources and funding to support the current peer educators and train additional peer educators to help sustain the MFCP Project
5. Incorporating race and ethnicity into a female condom study, because of the continued racial dynamics in post-Apartheid South Africa.
6. Developing a computer package for PEN-3 that will simplify the analysis process.
REFERENCES


Setshedi, S., (personal communication, June 20, 2003)


UNAIDS. (1997). Launching and promoting the female condom in Eastern and Southern Africa


APPENDIX A

REPRESENTATIVES MEMBER CHECKING EXERCISE INSTRUCTIONS
INSTRUCTIONS FOR MFCP REPRESENTATIVE MEMBER CHECKING GROUP ACTIVITY (2 hours)

STEP 1

Present the MFCP Evaluation background and PEN-3 Model with domains and 3x3 table

Step 2

Discuss the 7 key categories based on questions

Step 3

Provide example of how to classify data in 9 cells of the 3x3 table. Use handout examples. Ask for concordance on example. Be certain that group members are clear on classification

Step 4

Divide groups into pairs

Step 5

Evenly distribute the placards with evaluation findings to each group of pairs

Step 6

Explain that they will write a number from 1 through 9 representing the 9 boxes of the 3 X 3 table on the front of the card
Step 7

Reconvene pairs into group. Have a member from each pair read the item and list the category. Ask other members to make a note if there is one they would like to discuss after all cards have been read.

Step 8

Get concordance from group in relation to all items. Any item not agreed upon should be noted and included in notes explained as part of analysis.

Step 9

After all items have been discussed have groups look on back of card and note differences between researcher’s choice and the pairs choice. Discuss discordant cards and attempt to reach concordance.

Step 10

Read off the categories of questions and have group select 3-5 issues (cards that stand out) that can realistically be tackled – point out that researcher has seen on this visit that some issues have been addressed since the evaluation.

Step 11

Discuss Community Identity Domain and get feedback on level where intervention should take place (individual, family, community, institutional or combination).
Step 12

Thank the group for helping and let them know you will get back to them with final outcome of the research

TIME FRAME FOR EXERCISE

STEPS 1, 2, 3  15 minutes
STEPS 4, 5, 6  45 minutes
STEPS 7, 8, 9, 10  45 minutes
STEPS 11, 12  15 minutes

TOTAL TIME  2 hours
APPENDIX B

MFCP EVALUATION DEMOGRAPHIC INFORMATION
List of projects studied and numbers of peer educators, and men and women who participated.

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Code</th>
<th>Peer</th>
<th>Women &amp; men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elukwatini</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Naas</td>
<td>12</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Block C</td>
<td>13</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Emtonjeni</td>
<td>14</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Ngodwana</td>
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<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Mazane</td>
<td>16</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>Kanyakamanzane</td>
<td>17</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>57</strong></td>
<td><strong>89</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 2</th>
<th>Code</th>
<th>Peer</th>
<th>Women &amp; men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ezimnoni</td>
<td>21</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Ermello</td>
<td>22</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>Delmas</td>
<td>23</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Embalenhle</td>
<td>24</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Kriel</td>
<td>25</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Witbank</td>
<td>26</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>97</strong></td>
<td><strong>45</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group 3</th>
<th>Code</th>
<th>Peer</th>
<th>Women &amp; men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standerton</td>
<td>31</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Volkrust</td>
<td>32</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Retief</td>
<td>33</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Amersfoort/Perdekop</td>
<td>34</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>56</strong></td>
<td><strong>51</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revisit</th>
<th>Code</th>
<th>Peer</th>
<th>Women &amp; men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breyten</td>
<td>35</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>Hendrina</td>
<td>36</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>ELeandra</td>
<td>37</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Middleburg</td>
<td>38</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Hotair</td>
<td>39</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Standerton2</td>
<td>40</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>78</td>
<td>114</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>288</strong></td>
<td><strong>299</strong></td>
<td></td>
</tr>
</tbody>
</table>
Frequencies of peer educators by project and gender

<table>
<thead>
<tr>
<th>Project</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naas</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>Block C</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Ngodwana</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Kanyamanzane</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Ezimnoni</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Ermello</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>Delmas</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Kriel</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Witbank</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Volrus</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Retief</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Amersfoor</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Breyton</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Elindrina</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Eleandra</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Middleburg</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Standerton</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>262 (95.3%)</td>
<td>13 (4.7%)</td>
</tr>
</tbody>
</table>

Distribution of Men and women by project

<table>
<thead>
<tr>
<th>Project</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Elukwatini</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Naas</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Block C</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Emtonjeni</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Ngodwana</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Kanyamanzane</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Ezimnoni</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Ermello</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Delmas</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Embalenhle</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Standerton 1</td>
<td>28</td>
<td>14</td>
</tr>
<tr>
<td>Retief</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>Breyton</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Elindrina</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Eleandra</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Middleburg</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Hotair</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Standerton 2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>201</td>
<td>67.9</td>
</tr>
</tbody>
</table>
APPENDIX C

MFCP EVALUATION FOCUS GROUP SCHEDULE AND QUESTIONNAIRES WITH OPEN ENDED QUESTIONS
Focus group schedule for peer educator

1. Would you consider the information and knowledge about sexually transmitted diseases including HIV/AIDS provided during training adequate and appropriate? Please explain.
2. Were provided with information about methods of prevention of pregnancy and transmission of STDs and HIV/AIDS? Please name them.
3. Describe your knowledge about beliefs, attitudes and norms regarding sexuality in your community.
4. Describe the communication skills and assertiveness relevant in the following contexts:
   a) Initiating discussion about condoms in advance with a sex partner.
   b) Negotiation skills with sex partners on use of condom.
   c) Refusing pressure to engage in unprotected sex.
   d) Sharing HIV-risk factors information with peers.
5. Do you think the community has been sensitised fully about HIV/AIDS? Do you think an awareness campaign was well done before the start of the project?
6. Are there government-sponsored activities on disease prevention that are taking place in your community? Explain.
7. Are there government actions that may have affected the success of the campaign?
8. Are you aware of government policy that protects women in commercial sex industries?
10. How would you rate the following characteristics of the women you talked to about female condom?
    - Household income
    - Education level
    - Region they come from i.e. urban, rural etc.
11. Is the female condom affordable to the women that you talked to?
12 Do you have local community development projects? Does any of them deal with health education on prevention of STIS including HIV/AIDS?
13 Does a woman in your community discuss sexual matters with partner?
14 Does the woman have control over when and where to have sex?
15 How do women negotiate about use of female condom with unwilling partners?
16 Do you think this project is sustainable in the future?
17 Were any plans made for sustainability of the project? Explain
Evaluation of the Mpumalanga Female Condom Project

Questionnaire for Peer educators

Introduction

The Mpumalanga female condom project is perceived by organizations involved in prevention programmes of STDs and HIV/AIDS as a success story in creating awareness for access and use of female condoms. The broad aim of this evaluation project is to identify lessons that can be learnt and used in implementing similar projects. More specifically the aims of this evaluation project is to identify management strategies used, use of peer educators, best practices, communication and negotiation strategies used by trainers and the peer educators in creating awareness and use of female condoms.

The planning, implementation and project activities will be reviewed. The evaluation will gather information from the project leader, peer educators, trainers of the peer educators, men and women involved in the education and use of the female condom.

To ensure anonymity and confidentiality of the information collected the name of the participant will not be required. However, it is important to note that the information provided will be used for planning other similar projects in South Africa and the Eastern and Southern African region.

Your honest response to all the questions and co-operation in this project will be greatly appreciated.
1. State your:
   a) Gender  1. Female  2. Male (select one)
   b) Age______________________
   c) Highest academic qualification attained__________________________
   d) Professional qualification__________________________
   e) Are you employed? 1 Yes  2. No (select one)
   f) Years of experience in your current job________
   g) Marital status (Select one )
      1. Married
      2. Separated
      3. Divorced
      4. Never married
      5. Widow
   g) Religion____________________
   h) Home language_______________________
   i) Your total income per month____________

2. State your occupation and current position.

3. How many sex partners do you have?_____________

4. State the occupation of your main partner.

5. Who supports your family? _______________

6. List in the following table the number of relatives that stay with you in your house

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Number</th>
<th>Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandfather</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandchildren</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. What is your opinion on the following statements?  
(Read these statements and circle only one response for each of them)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A man should have the final say in all family matters</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. If a woman works she should give her money to her husband/boyfriend</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. It is a woman’s job mainly to take care of the home and cook for her family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. There is nothing that a woman can do if her husband/boyfriend wants to have a girlfriend</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
5. A wife should tolerate being beaten in order to keep her family together

6. In case of a separation or divorce the children should remain in the custody of the man

7. I find some sexual matters too upsetting to talk about with my partner

8. It is easy for me to tell my partner what I do or don’t like to do during sex

**B. Indicate if you agree or disagree that a woman has good reason to refuse sex with her husband or boyfriend if:**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. She is pregnant</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Her husband/boyfriend beats her</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. She knows her husband/boyfriend has sex with other women</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. She has recently given birth</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. She is tired or not in good mood</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. She is afraid he will infect her with sexually transmitted diseases</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. She is afraid he will infect her with HIV</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**C. What is your opinion on the following statements?**

*(Read these statements and circle only one response for each of them)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I carry a condom, my partner will think that I am planning to have sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Using condom reduces sexual pleasure although it protects one from STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. A woman loses a man’s respect if she insists on using a condom</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. It is embarrassing to buy or ask for condoms</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Using a condom is a sign of not trusting your partner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Decision on to use or not to use condom is a man’s responsibility</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. If a person carries a condom it means they are experienced in sexual matters and at risk of being infected with STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Using a condom is a way of expressing responsibility for my partner and myself to protect ourselves from STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. I think that taking birth control pills for a woman sufficient if she has sex</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. A man should use a condom only when he has sex with a commercial sex worker to prevent STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Men need to have more than one sexual partner, often at the same time</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
12 It is okay for man to force his wife/girlfriend to have sex

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

13 It is alright for a woman to demand sex from her husband/boyfriend

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

14. It is okay for a woman to suggest condom use to the husband/boyfriend

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

15 A man feels proud if he has multiple sex partners

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

D. In the following questions I am going to ask your opinion about the use of female condoms. If you have never used a female condom, please answer the questions trying to imagine how you would feel in each case.

<table>
<thead>
<tr>
<th>1. Do you think a female condom should only be used by sex workers?</th>
<th>Yes</th>
<th>Probably Yes</th>
<th>Probably No</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

2. If you insisted on use of a female condom would your partner think you had had sex with someone else?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

3. If you insisted on use of a female condom would your partner get angry?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

4. If you insisted on use of a female condom would your partner get violent?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

5. If you insisted on using a female condom would your partner refuse to have sex with you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

6. If a woman has condoms with her, do you think she is willing to have sex with someone she just met?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
</table>

E

1. What were your sources of information about female condom?

__________________________________________________________

__________________________________________________________

2 How often do you use the female condom?

3 Who introduced the female condom to you?

4 Have you educated other people in your community about female condoms?
   1. Yes  2. No

5. Where do you or your partner get the female condom from?

6. Did you ever discuss use of female condom with your partner?
   1. Yes  2. No

7 Who initiated the discussion?
   1. Yourself  2. Your partner  3. Both
8. What did you talk about?
   a) Avoiding pregnancy?  1. Yes  2. No
   b) Disease prevention?  1. Yes  2. No
   c) Sex in general  1. Yes  2. No

9. Have you ever used female condom with your partner?
   1. Yes  2. No

10. Between you and your partner who decided to use female condom?
    1. Yourself  2. Your partner  3. Both

11. What reasons did you or your partner give for wanting to use female condom

________________________________________________________________________
Focus Group Interview schedule for Women/Men

1. Describe your knowledge about the beliefs, attitudes and norms regarding the following issues on sexuality in your community?
   a) Pre-marital sex
   b) Discussion on matters related to sex between people of different ages
   c) Discussion on matters related to sex between people of different sexes
   d) Discussion on sex between man and wife/girlfriend
   e) Extra marital sex

2. Name all the sexually transmitted diseases (STDS) that you know

3. What causes sexually transmitted diseases including HIV/AIDS?

4. If you suspected that you had sexually transmitted disease what would do?

5. If you suspected that you had sexually transmitted disease where would you go first to seek help or treatment?

6. Are you aware of any disease(s) that have similar characteristics to HIV/AIDS? Please name them

7. What methods do you know that are used for the prevention of sexually transmitted disease including HIV/AIDS?

8. What method do you use most of the time for:
   a) Avoiding pregnancy
   b) Prevention of sexually transmitted diseases

9. How often does your religious institution teach about issues related to sexuality?

10. What is the stance of your religion on:
    a) Premarital sex,
    b) Family planning,
    c) Use of condom (female condom) during sex?

11. Are you aware of any state funded health clinics that offer screening and check-up services for STDs or HIV/AIDS?

12. How popular are these clinics to the members of your community.

13. What were your sources of information about female condom?

14. Why do you like/dislike using the female condom?

15. What does your sex partner like about the female condom?
Evaluation of the Mpumalanga Female Condom Project

Questionnaire for Women/men involved in the project

Introduction

The Mpumalanga female condom project is perceived by organizations involved in prevention programmes of STDs and HIV/AIDS as a success story in creating awareness for access and use of female condoms. The broad aim of this evaluation project is to identify lessons that can be learnt and used in implementing similar projects. More specifically the aims of this evaluation project is to identify management strategies used, use of peer educators, best practices, communication and negotiation strategies used by trainers and the peer educators in creating awareness and use of female condoms.

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Your honest response to all the questions and co-operation in this project will be greatly appreciated.
1. State your:
   a) Gender  
      1. Female  2. Male (select one)
   b) Age__________
   c) Highest academic qualification attained_______________________
   d) Professional qualification__________________________
   e) Are you employed?  1 Yes  2. No (select one)
   f) Years of experience in your current job__________
   j) Marital status (Select one)
      6. Married
      7. Separated
      8. Divorced
      9. Never married
      10. Widow
   g) Religion_____________________
   k) Home language__________________________
   l) Your total income per month______________________

3. State your occupation and current position.

5. How many sex partners do you have?__________________

6. State the occupation of your main partner.

5. Who supports your family?______________________

6. List in the following table the number of relatives that stay with you in your house

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Number</th>
<th>Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandfather</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandchildren</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. What is your opinion on the following statements? 
(Read these statements and circle only one response for each of them)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A man should have the final say in all family matters</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. If a woman works she should give her money to her husband/boyfriend</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. It is a woman’s job mainly to take care of the home and cook for her family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. There is nothing that a woman can do if her husband/boyfriend wants to have a girlfriend</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
5. A wife should tolerate being beaten in order to keep her family together

6. In case of a separation or divorce the children should remain in the custody of the man

7. I find some sexual matters too upsetting to talk about with my partner

8. It is easy for me to tell my partner what I do or don’t like to do during sex

B. Indicate if you agree or disagree that a woman has good reason to refuse sex with her husband or boyfriend if:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. She is pregnant</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Her husband/boyfriend beats her</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. She knows her husband/boyfriend has sex with other women</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. She has recently given birth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. She is tired or not in good mood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. She is afraid he will infect her with sexually transmitted diseases</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. She is afraid he will infect her with HIV</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

C. What is your opinion on the following statements? (Read these statements and circle only one response for each of them)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I carry a condom, my partner will think that I am planning to have sex.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Using condom reduces sexual pleasure although it protects one from STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. A woman loses a man’s respect if she insists on using a condom</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. It is embarrassing to buy or ask for condoms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Using a condom is a sign of not trusting your partner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Decision on to use or not to use condom is a man’s responsibility</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. If a person carries a condom it means they are experienced in sexual matters and at risk of being infected with STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Using a condom is a way of expressing responsibility for my partner and myself to protect ourselves from STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I think that taking birth control pills for a woman is sufficient if she has sex</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. A man should use a condom only when he has sex with a commercial sex worker to prevent STDs and HIV/AIDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Men need to have more than one sexual partner, often at the same time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>Probably Yes</td>
<td>Probably No</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>-----</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>12</td>
<td>It is okay for man to force his wife/girlfriend to have sex</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>It is alright for a woman to demand sex from her husband/boyfriend</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14</td>
<td>It is okay for a woman to suggest condom use to the husband/boyfriend</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>A man feels proud if he has multiple sex partners</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

D. In the following questions I am going to ask your opinion about the use of female condoms. If you have never used a female condom, please answer the questions trying to imagine how you would feel in each case.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>Probably Yes</th>
<th>Probably No</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you think a female condom should only be used by sex workers?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>If you insisted on use of a female condom would your partner think you had had sex with someone else?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>If you insisted on use of a female condom would your partner get angry?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>If you insisted on use of a female condom would your partner get violent?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>If you insisted on using a female condom would your partner refuse to have sex with you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>If a woman has condoms with her, do you think she is willing to have sex with someone she just met?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

E:
1. What were your sources of information about female condom?
   ________________________________________________________________
   ________________________________________________________________

2. How often do you use the female condom?________________________

3. Who introduced the female condom to you?

4. Have you educated other people in your community about female condoms?
   1. Yes  2. No

5. Where do you or your partner get the female condom from?

6. Did you ever discuss use of female condom with your partner?
   1. Yes  2. No

7. Who initiated the discussion?
   1. Yourself  2. Your partner  3. Both
8. What did you talk about?
   d) Avoiding pregnancy? 1. Yes 2. No
   e) Disease prevention? 1. Yes 2. No
   f) Sex in general 1. Yes 2. No

9. Have you ever used female condom with your partner?
   1. Yes 2. No

10. Between you and your partner who decided to use female condom?
    1. Yourself 2. Your partner 3. Both

11. What reasons did you or your partner give for wanting to use female condom

_____________________________________________________________
_____________________________________________________________
EDUCATION

- 2003  Ph.D. Department of Biobehavioral Health, The Pennsylvania State University, University Park, Pennsylvania
- 1986  M.P.H. Department of Community Health Education, University of Minnesota School of Public Health
- 1983  B.A. 1983 Community Health Studies, University of Minnesota

PROFESSIONAL EXPERIENCE

- 2003  W.K. Kellogg Community Health Scholar, Department of Health Management and Policy, University of Michigan, School of Public Health, Ann Arbor, MI
- 2001  Fogarty International Center Research Fellow, UNAIDS, Pretoria, South Africa
- 1996 – 1999  Project Manager, Center for Pediatric Research, Eastern Virginia Medical School, Norfolk, VA
- 1989 – 1994 AIDS Program Manager /Health Officer, Africare, Lagos, Nigeria

TEACHING

- 1999-2003  Lecturer/Researcher/Teaching Assistant, Department of Biobehavioral Health, Pennsylvania State University, University Park, PA
- 1985-1989 Academic Advisor, General College and the College of Liberal Arts, University of Minnesota, Minneapolis, MN

SELECTED PUBLICATIONS

