

**Attitudes of the sexually active San men towards the use of the  
government supplied male condoms in Ghanzi District, Botswana**

by

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## **Declaration**

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Date: March 2013

## **Abstract**

This research presents findings from a study conducted in Ghanzi District, west of Botswana. The research aimed to explore and make meaning out of the resentment by sexually active San men in the district towards the use of male condoms supplied for free by the government. Findings from the study reveal that there is limited and often erratic condom distribution of the male condom brands. At the same time, the condom promotion interventions applied are also ad-hoc and inadequate. Even though they report to use condoms, most respondents emphasized they have never been taught on how to use condoms. Furthermore, there is also low-risk perception towards HIV and AIDS realised amongst the respondents as well as a strong belief in myths and misconceptions about HIV and AIDS. The major negative attribute about available standard sized condoms is that they are largely too big for their penis sizes. Other reasons were unpleasant condom smell and frequent breakage of the condom during intercourse. Issues relating to gender dynamics also came out of the study and affect the way they use the male condom with their partners. These have led them to not using the condoms correctly and consistently. Accordingly, these findings suggest a low condom usage amongst the study population which correlates with data available regarding increasing HIV incidence rates and high STI rates amongst the males in the district. This calls for more intensified, targeted condom promotions and distribution efforts in this part of Botswana.

**Keywords:** Access and availability; Low distribution; Male condom; Condom size; Risk perceptions; Condom use.

## Opsomming

Hierdie navorsing bied die bevindings van 'n studie wat in die Ghanzi-distrik, wes van Botswana, uitgevoer is. Die doel van die navorsing was om seksueel aktiewe San-mans in die distrik se teësin in die gebruik van manskondome wat gratis deur die regering verskaf word, te ondersoek en sin daarvan te maak. Die bevindings van die studie toon dat daar beperkte en dikwels wisselvallige verspreiding van manskondome is. Die intervensies gemik op die bevordering van kondoomgebruik is ook onreëlmatig en onvoldoende. Ongeag die feit dat die meeste respondente beweer hulle gebruik wel kondome, het hulle benadruk dat hulle nog nooit geleer is hoe om kondome te gebruik nie. Daar is voorts 'n persepsie van lae risiko van MIV en vigs onder die respondente, asook 'n sterk geloof in mites en wanopvattinge oor MIV en vigs. Die grootste negatiewe siening van beskikbare standaardgrootte kondome is dat dit oor die algemeen te groot is vir hul penisgroottes. Ander redes is die onaangename reuk van kondome en dat dit gereeld tydens omgang breek. Kwessies verbonde aan geslagsdinamiek het ook in die studie na vore gekom en beïnvloed die manier waarop hulle die kondoom met hul seksuele maats gebruik. Dit gee daartoe aanleiding dat hulle nie die kondome gereeld en konsekwent gebruik nie. Die bevindings toon vervolgens lae kondoomgebruik onder die studiepulasie, wat korreleer met beskikbare data oor stygende MIV-voorkomssyfers en hoë koerse van seksueel oordraagbare infeksies onder die mans in die distrik. Dit noodsaak meer intensiewe, toegespitste kondoomveldtogte en -verspreiding in hierdie deel van Botswana.

**Sleutelwoorde:** toegang en beskikbaarheid; lae verspreiding; manskondoom; kondoomgrootte; persepsies van risiko; kondoomgebruik

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## **Chapter 1: Background and rationale**

### **1.1. Background**

#### **HIV and AIDS in Botswana**

It has been almost 30 years since the existence of HIV. Sub-Saharan Africa continues to be the region hardest hit by the pandemic. As reported by UNAIDS, by the end of 2009, 22.5 million people were living with HIV in the region. This includes 2.3 million children. There were about 2 million new infections and 1.3 million deaths in the same year. In Botswana, there is an estimated 320 000 people living with HIV out of a population of about 2 million (UNAIDS, 2010).

Botswana has been one of the countries in Africa and indeed the developing world to aggressively address issues of HIV and AIDS with utmost commitment and political leadership especially in the area of clinical prevention. For example, Botswana was the first country in Africa to offer antiretroviral therapy (ART) for free at a national scale. The Prevention of Mother to Child Transmission Programme (PMTCT) has had 96-98% success rate over the years. The babies who were born to HIV positive mothers have just been under 4 %; comparable to the rates in the industrialized world (NACA, 2008). Other notable achievements include an increase in number of people accessing Voluntary Counseling and Testing Services (VCT) and Routine HIV Testing (RHT) and a major increase in condom supply and distribution among others.

The national HIV prevalence rates in Botswana have over the years decreased from 35% to the current 17%. The incidence rates however increased during the period under review. It has to be noted that although Botswana's success in confronting HIV and AIDS demonstrates a strategic orientation towards health facility based clinical interventions; outside the facility however the interventions especially those directed at behaviour change remain weak, small scale and without strategic and structural thrust (NACA, 2008).

Despite intensive and aggressive prevention campaigns, Botswana continues to be challenged by the epidemic. According to the Botswana AIDS Impact Survey III (BAIS III), 17.6% of the population aged 18 months and above was infected with HIV in 2008 compared to 17.1% in 2004 (NACA, 2012). The same report also indicates a strong gender dimension as HIV prevalence rate for females was 20.4% compared to 14.2% males. The HIV incidence rate also shows gender disparity where more females compared to males showed higher incidence (NACA, 2012)

## **Ghanzi District**

The research study was conducted in Ghanzi district of western Botswana. Ghanzi district is characterized by a spectrum of various ethnic and cultural groupings predominantly San co-existing together harmoniously as a unified entity. Culture still plays a major role in people's life. Most people of the same tribal root tend to associate together. For this reason, there tends to be a language barrier between people of different ethnicities. The two official languages that are predominantly used as a tool of communication are less comprehended or not understood at all. There is also rampant poverty in the district. Approximately 45% of the population is rural area dwellers (RADs) who live on welfare and marginal benefits (Gantsi District Council, 2011).

The district has an estimated of 35,421 inhabitants. Ghanzi district is a sparsely populated region. Unique to the district are a plethora of farms scattered over the entire area that are associated with the district but non-affiliated to any particular locality in the area. The farms are home to a third of the population in the district.

HIV prevalence in the district is among the lowest in the Botswana at 17.3%. However, Ghanzi district has the highest TB notification rate in the country of more than 1500/100 000 per population (BNTP, 2009). The data from the district profile indicates that less than 20% of the sexually active (15-49 years) population group know their HIV status.

Ghanzi district continues to experience increasing numbers of reported sexually transmitted infections (STI's) especially amongst males. The teenage pregnancy rates also stood at 30% by the end of 2010 (Gantsi District Council, 2011). Just in 2011 alone, there were a total of 2, 2182 new sexually transmitted infections treated at all the health facilities. This was a 21% increase from the 1,809 cases which were recorded in 2010; contrary to the national HIV and AIDS impact survey of 2008 which shows higher prevalence among females. Routine data for the same year shows the sero-prevalence of HIV among males tested was disproportionately higher than for females, i.e. 14% and 7 % respectively. As for the reasons for testing for HIV, STI's accounted for only 2.1% of those tested despite STI's accounting among the top 5 reasons for outpatient department at all the health facilities in the district (Gantsi District Council).

The report further highlights that teenage pregnancy is also on the rise in the district. In 2006, 18% of all pregnancies were teenagers in the age group 13-20 years. In 2007, the number increased to 23%. In the year 2008, the teenage pregnancy rate in the district rose to 30%. This is despite a reported increase in condom use with non-regular partners amongst 15-24 year olds (NACA, 2004). On the other hand, there are still problems that remain with female

empowerment to negotiate consistent condom use, with the scale and reliability of condom supply and distribution especially in remote areas and the uptake of female condoms (NACA, 2008).

## **1.2. Research problem**

Findings from unpublished programme reports in the district reveal that, there is resentment by the males in the district to use the male condom brand supplied for free by the government. This is the only service in the district which supplies condoms for free. Alternative sources of free condoms are limited due to costs and the socio-economic conditions of people in the district. The reasons to why they do not want to use this male condom brand supplied for free by the government are not known. There is currently no empirical evidence related to this particular geographic area to support these statements; rather based on anecdotal evidence as reported by the programme managers across various organizations. Therefore, the purpose of this study was to find out what are the reasons that San men in Ghanzi settlements do not want to use condoms supplied by the government? The study particularly focused on San men as they form part of the dominant population group residing in Ghanzi District.

## **Aims of the study**

The study aimed to determine reasons which make the san men in Ghanzi settlements not want to use the condom brands supplied by the government in order to come up with specific strategies to increase uptake and correct and consistent use of the male condom.

## **Objectives of the study**

- To establish the current status of access and availability of condoms services in the district.
- To identify the attitudes on the use of the male condoms amongst the sexually active males in Ghanzi settlements.
- To identify factors which hinder or promote the correct and consistent use of the male condoms.

- To propose strategies which could increase the uptake and correct and consistent use of the male condom amongst the sexually active males in Ghanzi district.

### **Significance of the study**

It is necessary and important to explore reasons to why this problem exists. This could potentially help curb factors such as the escalating rates of sexually transmitted infections, high rates of teenage pregnancies and the increasing HIV incidence rates. Ghanzi District is one of the regions with the lowest HIV prevalence rates in Botswana. The way forward then is to keep the prevalence rates from increasing; rather to lower them to the best possible rate and prevent new HIV infections. This requires studies like this which could provide an insight towards barriers which obstruct positive behaviour change and find ways of addressing them.

### **1.3 Structure of the research report**

Chapter 1: This chapter will present an in-depth background to the study to give the context to the study. Included are the problem studied, aims and objectives, and lastly the significance of the study.

Chapter 2: In this section, relevant literature relating to the study topic shall be presented. The previous studies are presented on different thematic areas.

Chapter 3: The chapter will describe the methodological approach to the study. The sampling procedure, target group, data collection techniques and instrumentation will be discussed. Details on the data analysis, ethical considerations as well as the limitation of the study will be presented.

Chapter 4: This chapter will include the presentation and discussion of findings. It will be qualitative in nature and will include relevant quotes from the respondents as well as cite appropriate reference from the literature available.

Chapter 5: This closing chapter will discuss the conclusions to the study and provide recommendations for relevant future studies and interventions.

## **Chapter 2: Literature review**

### **2.1. Male condoms**

The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections. The search for new preventive technologies such as HIV vaccines and microbicides continues to make progress, but condoms will remain the key preventive tool for many years to come (UNAIDS, 2004). Correct and consistent condom use is said to reduce the risk of sexual transmission of the AIDS virus and other infections by almost 99 % (Shreeniwas & Homan, 1993). This is if they are used correctly and consistently.

Despite the potential of condoms to greatly reduce the morbidity and mortality associated with STIs, levels of condom use remain low worldwide (Gardner, Blackbum, & Upadhyay, 1999). Many men and women prefer unprotected intercourse or using another contraceptive method rather than using a condom (Spruyit & Finger, 1998). According to the United Nations, the rate of women aged 15-46 using a condom as a means of contraception stands at 41.7% (UN, 2012). These observations are consistent with the case of Botswana, where the third national HIV/AIDS impact survey (BAIS III) revealed that the HIV incidence rates have shown to be on the increase currently at 2.9 %, and that of the males and females were 2.3 % and 3.5 % respectively.

This is despite the free provision of both male and female condoms by the government. Botswana's condom access programme is currently implemented through three initiatives namely: Free government distribution mainly spearheaded by Ministry of Health, Social marketing undertaken by Population Services International (PSI) and through the private sector commercial use.

For instance, one of the key drivers of the AIDS epidemic in Botswana is multiple and concurrent partnerships and within this context there has been a reported low use of condoms. Although self-reported rates of condom use are high, qualitative studies suggest that condoms are only used initially with a new partnership but as the partnership evolves, condoms are used less frequently and then not always correctly and consistently (NACA, 2012).

From the beginning of the AIDS epidemic, promoting condoms and their use has been a primary strategy. Social marketing projects which uses mass media, entertainment and other commercial marketing approaches, have led to large-scale changes in condom use, particularly in Africa (Finger, 1996). He even asserts that the best scientific data available suggest that the level of STD protection from condoms or spermicides is closely linked with consistent use. However, Maharaj and Cleland (2005) are of the view that the massive efforts to promote condom use were only targeting high-risk behaviours and focused on pre-marital and extra-marital sexual relationships.

On the contrary, Caldwell (1999) argues that condom use is still a long way from defeating the sub-Saharan African HIV and AIDS epidemic. Sub-Saharan Africans were probably more hostile to the use of condoms than people in any other major region of the world. African males typically complain of the loss of sensual enjoyment, and women have feared injury or ill-health, often citing stories of women who died of infection after condoms were sucked into their wombs.

## **2.2. Factors affecting condom use**

The factors that influence the consistent and correct use of male condoms have been widely documented. Available literature provides evidence to some of the surveys that have identified reasons affecting condom acceptability and use. The most frequent reasons people give for not using a condom relate to the following issues: lack of sensation or interrupted sexual pleasure; psychological and social factors, including couple communications and assumptions that condoms are for use in extra marital relationships and with prostitutes; lack of availability of condom distribution to the youth; and lack of confidence in the reliability of condoms (Spruyit & Finger, 1998).

The product choices, with regards to the materials used, the width of the condoms, thickness shape and texture have all been explored through studies to determine how they affect acceptability to condoms. From their analysis of these studies, (Spruyit & Finger ) argue that changes in product attributes do not appear to play an important role at this point in getting people to use condoms initially. They also argue that variations with width, thickness and latex formulation generally appear to have limited impact on acceptability. McNeill (1998) concurs that product attributes play a minor role in condom acceptance compared to strategies that influence individuals' perception of the importance of using condoms and cultural norms which support their use. Nevertheless; such assertions should be taken with extreme caution as they are

based on the limited data from these descriptive studies which have been conducted. The studies were not geographically balanced to allow for more conclusive assertions. These past studies as outlined by these two authors, do nonetheless provide an insight into various possible reasons why people would not want to use condoms.

A study conducted to estimate rates of condom use in four urban populations in sub-Saharan Africa to assess their association with levels of HIV infection and other sexually transmitted diseases (STDs); found that it was very low. A total of 2116 adults aged 15-49 years were interviewed in Cotonou (Benin), 2089 in Yaoundé (Cameroon), 1889 in Kisumu (Kenya) and 1730 in Ndola (Zambia). Prevalence rates of HIV infection were 3.4% in Cotonou, 5.9% in Yaoundé, 25.9% in Kisumu and 28.4% in Ndola. The adults reported condom use was low, with the proportions of men and women who reported frequent condom use with all non-spousal partners being 21-25%, for men and 11-24% for women (Lagarde, Auvert, Chege, Sukwa, Glynn, Weiss, Akam, Laourou, Carael & Buve, 2001).

Another study to determine the perceived social approval and condom use with casual partners among youth in urban Cameroon concluded that the frequency of condom use was affected by the respondents' attitudes toward condom use, the range of persons with whom they discussed reproductive health matters, whether they were enrolled in school, socio-economic status, their self-efficacy, perceived severity of AIDS, risk perception and sexual risk behavior (Van Rossem & Meekers, 2011).

Grady, Klepinger & Jog (1993) (as cited in Spruyit & Finger, 2012) reported that in a nationally representative sample of more than 3,000 U.S. men interviewed about condoms.; the most frequently cited negative reactions were: reduced sensation, requires being careful to avoid breakage, requires withdrawing quickly, embarrassing to buy, difficult to put on, often comes off during sex, embarrassing to discard, shows you think partner has AIDS, and makes partner think you have AIDS.

### **2.3. Condoms, culture and gender dynamics**

While sex is a deeply personal experience, condom use during intercourse is often tied to religious and cultural norms as well as personal beliefs. Such norms help people define their own concepts of sexual morality or to internalize acceptable behaviors (ICASO, 2007). Just by

studying the findings from the studies above, it becomes apparent that there are various reasons to why people choose to use condoms in relation to knowledge, attitude, self-efficacy, perceived risk and socio-economic status amongst others. Each population group, location or country will have reasons based on so many of these environmental factors. This can then lead us to acknowledge that definitions of sex and sexuality, the meaning of disease, awareness of messages, adoption and positive attributes to safe health practices are different among different cultures.

This view stated above is therefore even more critical in settings like that of Botswana where despite all the interventions which have been put in place over the years; the epidemic continues to be at devastating levels. A large part of the Botswana response has been public education and behavioral change messages about HIV and AIDS. The public education programmes have undeniably been weak in reaching the diverse populations and social groups of Botswana (Stegling, 2005).

The initial responses to the epidemic were rather reactive and took little regard to other causative factors leading to acquiring of the disease. An attempt to understand the definition of this disease within the social and cultural context of the different and specific locations was minimal. This was even exacerbated by many of the western authors who erroneously ascribed this lack of condom use in Africa to promiscuity, permissiveness and to a lack of moral and religious values, Caldwell and Quiggin (1989) (as cited in Van Dyk, 2001). This clearly illustrates a lack of understanding of the African philosophy behind sexuality and disrespect for African cultural beliefs. Apart from social and political problems, there are deep rooted cultural beliefs against the use of the condoms in some parts of Africa (Van Dyk, 2001).

For example, Taylor (1990) (as cited in Van Dyk, 2001) highlights that the resistances to condom use in Rwanda had nothing to do with ignorance, but with a very specific social and cultural dimension of Rwandan sexuality. Rwandans believe that the flow of fluids involved in sexual intercourse and reproduction represents the exchange of 'gifts of self' which they regard as being of utmost importance in a relationship. Furthermore, the "fertility conundrum" may also be one of the greatest cultural barriers to HIV protection and the promotion of the use of condoms, especially when women are looking to become pregnant. There is high value placed in on both fertility and quick procreation after marriage in addition to the importance of family and the social maturity and respect that is believed to come with having children (Scott, 2008).

Cultural norms that define sexual behavior often preclude communication between women and men about the desire and need to use protection, even when one partner is HIV-positive (McNeill, 1998). A lack of action on the part of couples may reflect the views of those dominant in societies, often men, so that condom use is not yet even a legitimate part of sexual discourse.

Such notions or practices rather, exacerbate the already existing gender disparities and gender imbalances on sexual relations between men and women. Whether or not protection is used—and what kind—is often decided by the man. Sometimes even the suggestion of using a condom will be seen as an accusation of the partner's infidelity, or an admission of adultery on the part of the woman herself. Such implications could provoke violence and silence a woman from speaking up, even if her partner's faithfulness is suspected (ICASO, 2007). To further elaborate this, Scott (2008) argues that the rapid transmission of HIV/AIDS in Botswana has been due to three main factors: the position of women in society, particularly their lack of power in negotiating sexual relationships; cultural attitudes to fertility, especially the cultural belief that single women have to have a child in order to prove that they are fertile and to clean their womb so that they are not deemed unclean; and social migration patterns that spread HIV/AIDS into isolated rural areas.

This observation can be related well to the current trends in Botswana. Multiple and concurrent partnerships, which is often referred to as "tolerated patterns of sexual relationships" and gender and sexual violence are amongst the key drivers of new infections in the country. Empirical evidence in the region suggests that gender violence and sexual abuse are on the rise and these could be associated with increased risk of HIV infection (NACA, 2012).

*The Gender Based violence indicators in Botswana provide an alarming statistics on the prevalence of gender based violence in the country. Almost 70% of women interviewed had experienced GBV at least once in their lifetime, and nearly 30% over the last year. This figure is 24 times higher than what is reported to the police.*

Such trends cannot be ignored as they have a bearing on the effectiveness of condom use. It must be emphasized that using or not using a condom is simply not a question of safer sexual behaviour; it is the outcome of a negotiation between potentially unequal partners. Condoms are not neutral objects about which a straightforward decision can be made on health grounds. Sexual encounters may be sites of struggle between the exercise and acceptance of male power, male definitions of sexuality and women's ambivalence and resistance (Lear, 1995).

Therefore, gendered sexual relations within a cultural context are an important factor to understand in an effort to promote safe, correct and consistent use of the male condom.

## **Chapter 3: Research design and methods**

### **3.1. Research design**

A phenomenological qualitative research approach was used for purposes of this study. This is a qualitative research method where the researcher attempts to understand and describe how one or more participants experience a phenomenon (Christensen, Johnson, & Turner, 2011). This is because the variables studied; condoms and attitudes towards their use require a more detailed description from the subjects in order for the researcher to come to a meaningful conclusion.

Qualitative research, which is primarily inductive and descriptive, provides rich contextual data to further our understanding of social phenomena. Its value is firmly established in behavioral sciences and not merely as a complement to quantitative research (Power, 1998). He further states that qualitative research has enabled us to appreciate the subtlety and complexity of HIV-related behaviours and the importance of lifestyle and culture in determining crucial factors, such as risk and negotiation.

Therefore, this study aimed to understand the reasons to why sexually active San men in Ghanzi district refuse to use the condom brands supplied by the government for free. A qualitative approach is therefore appropriate as it goes beyond numbers and attempts to explore, interpret, link and analyse the underlying factors which could be affecting such behaviours.

The semi-structured interviews and focus group discussions were methods used to collect the data. These two approaches were chosen based on the biographic profiling of the targeted group. They have a different mother tongue from that of the researcher; most of them also have low literacy levels. Based on the reasons stated above, any other method would have not been as effective.

### **3.2. Target group and sampling design**

This study focused on sexually active young San men who have been residing in Ghanzi settlements and farms in the last 12 months. Their ages ranged from 18 – 30 years of age. They came from four selected settlements/farms in Ghanzi District.

A total of 58 sexually active men in four Ghanzi settlements/farms participated in the study. Ten of the respondents were part of the individual in-depth interviews and 48 represented the 3 focus group discussions held in GrootLaagte, Isabella Farm and John Kemps Farm.

For the in-depth interviews, 10 men were randomly selected in each of the four selected settlements/farms. In two locations, 3 out of 24 men from two soccer teams were asked to volunteer to participate in the semi-structured interviews. In the other two locations, 2 out of 24 men from two soccer teams were asked to volunteer to participate in the semi-structured interviews. This selection took place during week days when the teams were conducting their practice sessions at the local soccer grounds. For the focus group discussions, there was between 13 and 19 participants in each of the 3 focus group discussions.

### **3.3. Data collection**

#### **Data collection procedure**

The researcher conducted the actual data collection in the field during the months of October and November 2012. The locations of the study were GrootLaagte, Isabella Farm, John Kemps Farm and D'Kar.

The researcher first made personal contact or telephone contact with the group leaders in each location. Upon their approval, there was contact session done with available team members the night before the scheduled interview and FGD dates. This was made to further explain the purpose of the study, exclusion and inclusion criteria and what is expected out of them. These contact sessions were made with the assistance of a competent translator. The translations were made from a san language dialect (*Naro or Sekaukau*) spoken by the respondents and translated into Setswana by the translator. Those who agreed were then identified for both the interviews and the FGD.

The interviews were conducted guided by the interview protocol guide developed. They were conducted in four locations and at a place convenient to the interviewees. For each interviewee, the purpose of the study was again explained to them guided by the informed consent form. This was explained in the participant's preferred language. Six of the ten interviews were conducted with the assistance of a competent san translator. All the interviews were recorded in an audio recorder and they lasted between 20-30 minutes each.

After all the interviews were conducted, the researcher studied the interviews by listening to the recordings in preparation for the FGD. The focus group discussions were conducted in GrootLaagte (15 males), Isabella Farm (13 males) and John Kempf's farm (19 males). The study was also explained to them through the informed consent form and also recorded in audio. The researcher was assisted by a competent san translator in all the FGDs. They lasted an average of about 1 hour 30 minutes each. This time was longer due to the translation process.

### **Data collection instruments**

A semi-structured interview protocol guide was used to collect the data from both the in-depth interviews and the focus group discussions. These were used to identify the participant's knowledge, attitudes and perceptions about particular male condom brands as well as establish factors which might hinder or promote the use of the identified condoms.

### **3.4. Data analysis**

The qualitative data generated through this study was analyzed by utilising the coding approach. First, the researcher studied the recorded data from the individual interviews and extrapolated emerging patterns from the respondents. These themes were then utilized during the focus group discussions. The purpose of using this approach was a means of verifying the validity of the individual respondents' against the focus group discussions in order to extrapolate more richer responses.

All the data was then transcribed into the computer. Afterwards, the data was then read over and over again to identify specific emerging themes which were then coded accordingly; to allow the researcher to complete analysis and draw conclusions.

### **3.5. Ethical considerations**

The ethical considerations for this study were made in accordance with acceptable requirements of human subject research. Permission to conduct this study was submitted to the Research Ethics Committee of the University of Stellenbosch by means of a research proposal which was later approved. The consent procedure was emphasized to all the participants:

anonymity, confidentiality and the right to refuse or withdraw from participating in the study without any consequences.

### **3.6. Limitations of the study**

The biggest constraint which affected conducting of this study was resources. Ghanzi district is a large with sparsely located settlements and farms. The researcher needed a 4x4 vehicle and camping equipment to reach all the locations and had to rely on the employer's project vehicles and accessories. Unfortunately the organisation was financially exposed for some time and this resulted in data collection in the field starting late after the situation normalized.

Sekaukau and Naro (San Languages) are not widely documented or written. Most of the time, the researcher relied on an experienced and competent translator when interacting with project participants. Due to the nature of the subject discussed, the researcher acknowledges that they might not have garnered the gist of some of the discussions due to substance lost in translation in three different languages: (San dialects-Setswana-English).

## Chapter 4: Presentation and discussion of findings

### 4.1. Access and availability of condoms

Health development literature shows us that the determinants of health include a broad range of interrelated factors, including biological, behavioral, cultural, political, legal and socio-economic. These factors will determine the levels of individual risk and vulnerability to HIV infection, including determining whether a person uses a condom correctly and consistently (Icaso, 2007). It is evident from the findings that there is an attempt by the government of Botswana to supply condoms in these locations.

The government supplies three condoms for free namely Lerato branded condom and other two types. The first one is branded with the national flag of Botswana and the other condom product is distributed in a white package with a visible made in Malaysia text and other manufacturer's specifications. Most of the respondents identify with these brands but the prominent ones are the Lerato condoms and the white packaged one which they referred to as "Malaysia". This is because the most visible text on the condom is the label "made in Malaysia" against the white background of the package.

The respondents source condoms from the local health posts, mobile clinics in the farms and from local non-governmental organisations (NGOs) during their outreaches. At only one location, respondents mentioned a local community health promoter as their source when they needed condoms. Few of the participants also fetched condoms from other health facilities when they visit Ghanzi Township and other locations. The respondents sometimes get the 'smile' branded condoms distributed by the Namibian government for free. Occasionally, people who make trips to Namibia or close to Mamuno boarder gate bring them along and they were popular with most respondents.

However, it is the access to condoms which is not consistent and most of the times erratic. Sometimes their condom supply is limited to a handful of condoms per individual from the government services because they will be told they ran out of stock in the district. Those men living in the farms will only get condoms if the mobile clinic services visited because they sometimes missed the scheduled visits.

*"Condoms are not there, they are not there at all. They are here sometimes".*

In GrootLaagte, respondents mentioned that some time back they used to buy expensive 'Lovers Plus' branded condoms at a local cooperative store, but have since stopped after

learning that the shop sold expired condoms. They might have been sold expired condoms because they are not bought as often in these locations since most respondents indicated that they cannot afford to buy condoms. Most of the respondents only knew the brand supplied for free by the government and had no knowledge of commercial brands being sold in local shops. Even if they had the knowledge, they will not buy them due to cost or not even use them because they did not know anything about them.

The responsibility to take the condoms from the facilities and actually utilise them for the right purposes was expressed by some respondents. They thought perhaps the reason they often did not find condoms at the facilities was because they were being punished for what happened in the past. This is what one respondent said:

*“I don’t blame the facilities when they don’t have condoms. Sometimes back some people came and taught us about condoms and they also left us with lots of condoms. After some days you could see unused condoms all over the settlement...children ended up playing with them using them as balloons.”*

Furthermore, promotion of condom and education is not adequate as most respondents are not comfortable with the use of the condoms. This has the potential to determine whether they use the condom or not. Some of the respondents said they have never been taught on how to correctly use the male condom they are given to use.

Based on the respondent’s experience, there is inadequate access to information services. Only six out of the 10 respondents from the in-depth interviews reported to have been taught on how to use a condom when they were still at school.

*“We are not educated people and two days of teaching is not enough. We need more and more teachings. When you talk to us Makaukau, when someone talks to them about condoms, they think you are insulting them. There needs to be more counseling and education on such issues.”*  
*(Makaukau is a plural name for a san language group from Botswana)*

As another respondent from the farm puts it,

*“When the mobile clinic comes here, they give us condoms but they never teach us on how to use it, so we use it the way we feel it’s okay”*

These factors combined do affirm the data from the district that suggests that use of the male condom correctly and consistently is low. This is largely attributed to the high levels of teenage pregnancies and high STI rates (Gantsi district council, 2011).

#### **4.2. Condom products acceptability**

Factors affecting acceptability of condoms can be thought of as a series of concentric circles that interact with each other—from the individual at the center to the couple, the health care system, the community and the entire world. An individual's knowledge attitudes, habits, perceptions, awareness of the need and other internalized factors are critical to condom use (Icaso, 2007).

##### **Knowledge**

A large part of the respondents had a good grasp of basic knowledge about HIV & AIDS particularly on how HIV is transmitted. Having unprotected intercourse with an infected partner and sharing needles contaminated with HIV were the most common reasons given. They also identified condoms as a means of a contraceptive to prevent pregnancy. Although there is some degree of accuracy from most respondents as to the correct information on condom use, their level of risk perception towards HIV & AIDS was generally low. Most respondents indicate that at times they are forced to have unprotected intercourse due to unavailability of condoms in their locations.

*“If they are not there, you just pray to god to help you out and just continue having sex without them”*

Even though they reported to always carry condoms when they anticipated to have sexual intercourse, this was mostly referred to in instances with partners other than their regular partners with whom they cohabit or have children with. Most men do have long-term stable sexual partners but also engage in sexual relations with other women.

*“With my life partner, there is no need to use it unless I am like let's say in Ghanzi Township and I have urgent sexual desires, that's when I could be forced to use it.”*

*“Especially when you have a family, you cannot carry condoms lest you get caught. Sometimes our partners know the amount of condoms in the house; you therefore cannot take a chance and take the condom out of the house. It causes problems in the family.”*

This statements above indicate an occurrence of multiple and concurrent partnerships (MCP). Holland, Ramazanoglu, Scott, Sharpe & Thompson (1990) ( as cited by MacPhail & Campbell, 2001) argue that by the need for men to engage in multiple sexual relationships combined with internalized negative attitudes towards condoms place their sexual health at risk. Health interventions have frequently encouraged young people to use condoms or to 'know' their partners. Among all young people, but young men in particular, there is the perception that they can filter out partners dangerous to their health. Partners can therefore be categorized as 'clean' or 'unclean' based on their social interactions and appearance so that decisions about making use of condoms can be made, Waldby, Kippax & Crawford, 1993 (as cited MacPhail & Campbell, 2001). *"When she is not sick, I can just have sex without using a condom"*

### **Product attributes**

There were mixed reactions about acceptability of the condom brands discussed. Some respondents were quite comfortable with the brands because they were the only ones they knew whilst others were not totally for them. The most preferred brand was Lerato condom brand supplied for free by the government as indicated earlier. They said it had a better smell than the "Malaysia brand" even though it was still not ideal. The other brand which was popular and named in all the discussions was the 'smile' condom brand from Namibia. They claim it smelled better and the latex used was thinner than the local brands they used.

On the other hand, there were more negative than positive attributes about the condoms during the discussions. The most prominent negative attribute discussed across all discussions was the condom sizes. A significant majority of respondents complained the standard sized condoms provided were too big for their penises. According to the respondents, both condoms are too big for their penis sizes and this affects their sex life as they are sometimes forced to "improvise" during intercourse. They have long raised this issue with government authorities when condoms were first introduced to them but the responsible authorities have never responded.

*"Even condoms the government used to supply us with before were still big especially when your penis is small. You will insert it in and then there will be some piece left at the end; you will have to improvise. That is why I am saying maybe we don't have the same penis sizes."*

Other negative attributes mentioned were the unpleasant smell of the condoms as well as the tendency of the condoms to break easily when used. Upon further probing and analysis on the latter, this condom breakage could emanate largely from the incorrect use of condoms. Correct

ways of using the male condom was identified as lacking on most of the respondents. This could mainly be due to limited knowledge and minimal occurrence of condom promotion activities.

Added reasons which contributed to the frequent condom breakage experienced by respondents could be attributed to the nature and the environment when the actual intercourse is performed. They stated reasons such as having intercourse under heavy influence of alcohol. Most men also stated that they prefer to have intercourse when it is dark with no lighting or under blankets. They prefer this to avoid exposing themselves to their partners as this could have undesirable consequences

*“You check the right side of the condom just using your hands, in the dark. Sometimes it’s because when you are in a new relationship and you allow her to see your penis, she might be scared and run away so it’s best to have sex in the dark. This is to avoid that”.*

Such practices could lead to condoms being used incorrectly because of poor visibility. There is a possibility to tear the condom when unwrapping or inserting it in the wrong way, which could promote these high incidences of breakage they cited. All respondents in this study did not use electricity as their source of lighting and only use paraffin lamps, torches and candles.

Other statements which were consistent across all the discussions were experiences to do with reactions on the body and some relate it to these condom brands. They report that these condoms cause itchy and painful reactions on them and their partner’s genitals. At times, such were the reasons they preferred not to use condoms during intercourse.

In fact, the responses from this study demonstrate consistent similarities with some of the literature on condom use and acceptability from around the world. Some of the common negative reasons relating to condom use were the size, lubrication, breakage of the condom during intercourse, partner’s poor communication or gender relations, condoms are not pleasurable as well as lack of confidence in the reliability of condoms among others (Spruyit & Finger, 1998). Nonetheless, it will be improper to generalize on such similarities as factors affecting acceptance are influenced by different contextual factors in each settings.

### 4.3. Myths and misconceptions

Despite demonstrating knowledge about HIV & AIDS and risk factors associated with it, most of the respondents' knowledge was also predisposed by their strong personal beliefs in myths and misconceptions about the condoms, HIV & AIDS as well as other sexually transmitted infections (STIs). This part of the questions caused heated debates and viewpoints to a level of absolute conviction across all FGDs.

To show this, below are some of the common myths and misconceptions which were consistent across all the discussions:

There is a belief that when you carry condoms most of the time, you will never succeed with your intentions of having sex, especially the condoms that you carry in your pockets as a man. So, it is best not to carry them to avoid this mishap.

*“Di a bouncisa....tse di bouncisang ke tse o di tsenyang mo pateng....you will never find anything. Just leave them in the house”. (This is a Setswana translation meaning that if one carries condoms with them in their pocket, they will never succeed with their attempts to have intercourse, so they have to be left in the house)*

*“This is no AIDS... the disease you talking about. When a woman is dirty and then you have sex with her, you can end up getting weaker... there is no AIDS; it is just dirt from the woman. The condom can protect you from this dirt from the woman”.*

According to the participants, if a man has sexual intercourse with a recent widow who has not yet undergone the traditional rituals, he will get “Diphate”.They believe that it is even more dangerous when she is on her periods and you can get makobonyane or a bloated penis. (*Diphate is a Setswana word used to describe this illness and makobonyane is a Setswana word for gonorrhoea*)

*“In our beliefs, there are diseases that you can get through sweat. When a woman just recently lost her man and you have sexual intercourse with her, even if you use a condom, you will contact this disease through sweat. The condom will protect the sexual parts but the disease will still transmit through sweat in other parts of the body”.*

According to most respondents, the symptoms of this disease are similar to that of other sexually transmitted infections.

*“They are as the same as not using a condom because you will be having sex under the blankets”.*

*“The symptoms of this disease include weak joints, fatigue, bleeding from the penis, sweating headache, losing weight and others”*

*“When you eat with someone who has HIV, you can get HIV from that infected person’s saliva.”*

The respondents stressed that when a person uses a cup that is not properly cleaned they can get HIV or when they cough without covering their mouth, they can get HIV by breathing in the virus.

#### **4.4. Gendered sexual relations**

Gender roles constitute part of the societal pattern and can be described as expectations or norms of appropriate female and male behaviour, and as such they also have an influence on what is expected concerning sexuality and sexual behaviour (Sida, 2007). Such, have a bearing on the sexual decisions made and how risk is perceived. It is also important to emphasise that such perceptions and attitudes are a result of the ever evolving dynamics and changing norms; largely influenced by socialization within communities and external influences.

Throughout the discussions, issues of gender dynamics pertaining in relation to sexual relations were evident. The choice of whether to use a condom or not was also influenced by the nature of the partners relationship; whether she is a regular partner or relating to issues of trust. For instance, a large part of the respondents said they only discussed issues of condoms and sex at the time of actual intercourse with their partners.

*“We only talk about sex during sex time on bed. The other thing is that both men and women , when they meet , they like asking such questions like don’t you trust me and she asks that don’t you trust me.. Then if one of you is not responsible enough, then this leads to unprotected sex”.*

Another constant discussion which dominated the responses related to the issues of power relations between men and their partners. Most of the respondents felt the responsibility

regarding sexual relations is always put on men only and women are distanced themselves from it.

*“If you watch television, listen to the radio, or read a newspaper, when they talk of abuse, they always mention men, when they talk of diseases such as HIV/AIDS; they say it is a result of men not using condoms. When condoms are not being used, the blame is on men. Men are blamed on all wrong things lest forgetting that women also have to be shown the importance of using condoms. It’s like they forget that they also have their own condom. What we want is for women to be reminded that they also do have their condoms and they must meet us halfway you see”.*

They also felt like the women were over protected when it came to sexual relations and some of their responses suggest that they could be exerting violence on their female partners due to these sentiments. *“They are treated like glass by the government. If they don’t listen to us men, we will take the law into our own hands... they (women) also have a role to play”.*

This particular comment came in after a respondent narrated his experience with his partner. He was working in the farms some time back and when he came back home, he found her partner pregnant with another man’s baby. Although the woman said the baby was his, he refused to accept it and the law authorities sided with her. Then, he responded with violence to his partner.

At the same time, some views expressed tended to also put the blame on women. They felt that women were the ones who spread the infections. *“Everything is blamed on a man that is why I tell you that everything is from women. Most of the infections are really from women, when she has that, you will get sick”.*

This was quite dominant during the focus group discussions. In contrast however, during the one-on-one interviews, respondents did acknowledge the responsibility they play in using a condom and preventing infections for them and their partners.

From these discussions, there is also evidence of instances when women partners to these men had control over decisions whether to use a condom or not. Literature about the San, particularly the Ju/hoansi of North West Botswana and parts of Namibia (respondents in GrootLaagte belong to the same language group); assert that women could insist that a man

uses a male condom, and she could withhold sex if he refused (Susser & Stein, 2000). To emphasise this argument, this is what one respondent had to say:

*“You see when a woman say she does not want to use a condom, she will refuse sex and if she wants a kid, she will accept it without a condom....when she does not want your kid, she will insist on using a condom ... just know that she wants your kid.”*

## **Chapter 5: Conclusion and recommendations**

### **5.1. Conclusion**

Condoms are one of the most effective tools available today used to help prevent the spread of new HIV infections and other sexually transmitted infections. This can only be possible if they are utilized consistently and correctly. For purposes of this study, the researcher aimed at determining reasons which make the San men in Ghanzi settlements not want to use the condom brands supplied by the government in order to come up with specific strategies to increase uptake and correct and consistent use of the male condom. Findings from this study reveal several factors which affirm this state of affairs. From an analysis of the findings, it is clear that condom promotion and distribution is grossly inadequate. The supply from health authorities is limited and most often erratic. There is also limited knowledge on the importance of condoms and sexuality education in general which correlates with the participants low risk perceptions on HIV & AIDS, strong beliefs in myths and misconceptions suggesting low male condom usage.

On the product attributes, the common negative attribute expressed by the participants is the standard size of the condom. They are too big for most of them. The condoms are also unappealing and poorly branded. These are findings come from a district in Botswana where literature reveals that less than 20% of the sexually active (15-49) years population group know their HIV status. There are also reports of increasing STI rates amongst males. These findings shed some light into the perceptions, gender norms and attitudes, social and structural barriers which have a bearing on the effectiveness of the condom interventions in these areas. However, the findings are not conclusive. Nonetheless they do show us areas where more research is needed in order to enhance condom promotion and distribution and ultimately correct and consistent usage in Ghanzi district.

### **5.2 Recommendations**

In light of the findings realised from this study, the following recommendations can be proposed:

More research is needed to scientifically affirm and understand the issue of condom size in relation to the San communities in Ghanzi district and elsewhere. Additionally, research is needed to further understand the relationship between the specific gender dynamics amongst the San which have changed over time due to such factors as modernization and their

implications on HIV and AIDS dynamics. The government of Botswana needs to develop more targeted and contextually relevant condom promotion interventions and move away from using blanket approaches developed at the central level. This should take into considerations; factors such as the current gaps as identified in this study.

The focus should be on more intimate, personalized promotion activities which take into account language specificity, socio-economic, socio-cultural and socio-geographic realities. Each geographic location, each language group, each culture has its own distinct dynamics which affect and shape norms, perceptions, attitudes and sexual relations. Until those specific dynamics are understood, there will be minimal change realised in attempts to stop new HIV infections in the future.

This has to be augmented by more robust distribution of condoms; both male and female. The distribution of condoms must go beyond the traditional health centres and explore other distribution channels. The government should also make every attempt possible to re-ignite its condom promotion activities by re branding the condoms supplied and also providing different sizes of condoms.

Lastly, the government must also ensure the policy recommendations on the national strategy for scaling up of HIV prevention interventions are actually implemented on the ground, particularly in rural areas.

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## **7. Appendices**

**A-Informed consent form**

**B-Interview protocol guide**

**C-University of Stellenbosch Ethics Committee approval form**



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**STELLENBOSCH UNIVERSITY**  
**CONSENT TO PARTICIPATE IN RESEARCH**

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**ATTITUDES OF THE SEXUALLY ACTIVE SAN MEN TOWARDS THE USE OF THE GOVERNMENT SUPPLIED MALE CONDOMS.**

You are asked to participate in a research study conducted by Armstrong Tingwane, from the Africa Centre for HIV/AIDS Management at Stellenbosch University. You were selected as a possible participant in this study because you are a male who was born and lived in this settlement in the last year. Your input therefore will be very valuable.

**1. PURPOSE OF THE STUDY**

Findings from unpublished programme reports in the district reveal that, there is a dislike by the males in the district to use the male condom brand supplied for free by the government. This is the only service in the district which supplies condoms for free. Alternative sources of free condoms are limited due to costs and the poor living conditions of people in the district. The reasons to why they do not want to use this male condom brand supplied for free by the government are not known.

It is necessary and important to explore reasons to why this problem exists. This could potentially help reduce factors such as the increasing rates of sexually transmitted infections, high rates of teenage pregnancies and the increasing number of new HIV infections. Ghanzi District is one of the regions with the lowest number of people living with HIV in Botswana. The way forward then is to keep these numbers from increasing; rather to lower them to the best possible rate and prevent new HIV infections. This requires studies like this which could provide

an understanding towards factors which prevent positive behaviour change and find ways of addressing them.

## **2. PROCEDURES**

If you volunteer to participate in this study, I would kindly ask you to do the following things:

Participate in an interview where I will ask you questions relating to why the study is done. I will ask for your permission to record the interview so that I do not miss anything we discuss. This interview will take about 20 to 30 minutes.

I will then request you to participate in a focus group discussion. This is where you and other men in your settlement will come together to further discuss the issues and experiences about the male condom. This discussion will only happen once and it is expected to last for about 1 to 1 and a half hours

## **3. POTENTIAL RISKS AND DISCOMFORTS**

There are no risks associated with the research interviews apart from certain questions that might be uncomfortable to answer. As for the focus group discussions, there might also be some discomfort because the session will be taped on a recorder and there can be questions which might not be comfortable to answer in a group setting.

## **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

There will be no direct personal benefits for participating in this research. However, your participation will benefit others by enabling programme planners in the district and beyond to better understand how men in this district perceive the condoms supplied by the government and what can be done to promote their use. This will help the planners to assist you and the communities in general with the best way to promote male condoms.

## **5. PAYMENT FOR PARTICIPATION**

There will be no compensation for participation, although the information you are providing will be of great benefit to the programme planners and the community at large.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain private and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of not using your names and actual locations. When the data is compiled and analyzed, there will be no use of your actual names rather codes. All the interviews and focus group discussion materials (including notes, recorded tapes) will be kept safely at the researcher's office in a lockable cabinet and it is only accessed by the researcher. The researcher is the only person who will have access to all the information you have provided. After the study is complete, all the research materials will be destroyed after one year.

The findings of the research study will be presented/ disseminated in a report without identifying any participant by name.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact Armstrong Tingwane on (72307198 or 6597050). Alternatively, you can contact Dr. Thozamile Qubuda on (021) 808 3999

## **9. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development in South Africa or contact the Health Research unit in Gaborone at telephone number 3632500 or contact the District Health Management team Head ( Dr. Simwanza) at 6597198.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to, \_\_\_\_\_ by [Armstrong Tingwane in Setswana and I am in command of this language or it was satisfactorily translated to *me*. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

*I hereby consent voluntarily to participate in this study. I have been given a copy of this form.*

---

Name of Subject/Participant

\_\_\_\_\_

**Name of Legal Representative (if applicable)**

\_\_\_\_\_

Signature of Subject/Participant or Legal Representative

Date

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_  
\_\_\_\_\_. He was encouraged and given ample time to ask me any questions. This conversation was conducted in Setswana language and [*no translator was used/this conversation was translated into \_\_\_\_\_ by \_\_\_\_\_*].

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Signature of Investigator

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Date

## Interview Protocol Guide

### Opening

After explaining the purposes of the study through the use of the informed consent form, I shall thank the interviewee once more for his participation. I will ask the interviewee questions about their experiences regarding the male condom brands supplied by the government in the district. I will also ask them about their knowledge on HIV and condoms as well as their experiences regarding access and availability of condoms in their community.

This interview should take about 30 minutes.

The interview will be semi-structured, guided by the following kinds of questions.

#### A. Questions on the access and availability of condoms services.

1. Do you know where to access condom services?
  - *Probe: How do you access condoms?*
2. How do you feel about the availability of condom services in your community?
  - *Probe: What types of condoms are available?*

#### B. Questions on the knowledge and attitudes towards the use of the condoms

1. What do you know about HIV?
  - *Probe: How is HIV passed from one person to another?*
2. What HIV services do you know are available?
3. What experiences do you have with accessing HIV services?
4. What puts someone at the risk for HIV?
  - *Probe: Is there anything a person can do to reduce their chances of becoming infected with HIV*
  - *Probe: If the answer includes condoms, then ask how they work. If the answer is no then follow-up with question 6.*
5. Generally, what are your feelings about condoms?
  - *Probe: If you do not use them, then how do you protect yourself from HIV and other Sexually transmitted diseases?*

6. Do you believe that condoms can prevent HIV? If yes why, if no, then why?
  - *Probe: How do you think people can use a condom to reduce their chances of getting HIV/AIDS?*
7. Have you ever been taught about the correct way of using a condom?
8. How do you determine when to use a condom?
9. Do you carry condoms when you are expecting to have sexual intercourse or you are now faced with a situation where you expect to have sex?
  - *Probe: If the answer is no, then what do you do in such situations?*
10. Do you discuss condoms with your sexual partners?
11. Are you aware of any incident in which a person you know had sex without using a condom?
  - *If yes, why did they do it?*
  - *Probe: Would you do the same? And why?*
12. Do you always use a condom? Why? Why not?

**C. Questions about the factors which hinder or promote the correct and consistent use of the male condoms**

1. What are your feelings about the condoms supplied for free by the government?
  - a. *Probe: Do you have a favorite type of condom and why?*
  - b. *Where do you get it?*
2. Where do you go for advices with matters related to condoms and HIV?
3. What is inhibiting access to condom services in your community?

**D. Questions on strategies which could increase uptake and correct and consistent use of the male condom**

1. What changes could be done to improve access to condoms?
  - a. *Probe: What information do you want?*
  - b. *Which other services related to condoms do you want?*
2. Are there any other matters regarding condom use that you would like to emphasise?



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10 August 2012

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Reference No. HS812/2012

Mr Armstrong Tingwane  
Africa Centre for HIV and AIDS Management, Stellenbosch University

Mr Tingwane

**LETTER OF ETHICS CLEARANCE: Approved with Stipulations**

With regard to your application, I would like to inform you that the project, *Attitudes of the sexually active San men towards the use of the Government supplied male condoms*, was approved with the following stipulations:

**Stipulations**

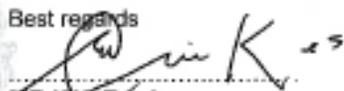
**1. Informed Consent Form:** Avoid technical terms in the informed consent form. The informed consent form must be translated into the relevant language.

**Applicants are reminded that they are expected to comply with the following proviso's:**

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.
5. This ethics clearance is valid for one year from 10 August 2012 to 09 August 2013.

We wish you success with your research activities.

Best regards

  
MR WA Beukes

REC Coordinator: Research Ethics Committee: Human Research (Humaniora)  
Registered with the National Health Research Ethics Council (NHREC): REC-050411-032



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