The level of HIV/AIDS knowledge amongst female young adults and factors that inhibits them from negotiating condom usage

by

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Declaration

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Abstract

HIV/AIDS knowledge is an important component of HIV/AIDS risk prevention strategies that may influence engagement in high risk behaviour. This qualitative study examines HIV/AIDS knowledge and factors that inhibit female young adults between ages 25-29 years old from negotiating condom usage with their sexual partners. A representative sample of 12 unemployed female young adults lived in Parkgate KwaZulu Natal, South Africa were used for this study. The main problem was that the HIV/AIDS rate was reported to be high amongst the age group of 25 to 29 years, especially in women as opposed to men.

There are lot of government's, NGOs and private sector interventions designed for the public using different modes of communication but the statistics show that these interventions somehow do not reach all intended audiences. For whatever reason people are still failing to use condoms. There is still lot of work that needs to be done in ensuring that awareness interventions reach all communities irrespective of their life status.

Data was analysed by identifying different categories and themes and coded. This study found out that most of the participants had inadequate knowledge about HIV/AIDS, how one can be infected and on how they can prevent themselves. The perceived risk of infection was high amongst many participants but there also lot of myths and disbelief about the existence. This study also found out that unemployment and fear to be beaten and dumped had lot to do with women failing to negotiate condom usage. Lack of communication skills among women due to cultural beliefs also has lot to do with the problem.

Opsomming

Kennis van MIV/Vigs is baie belangrik ten einde doeltreffende stategieë te voorkoming van die pandemie daar te stel. Hierdie kwalitatiewe studie ondersoek die kennisvlakke van jong vroulike volwassenes in die ouderdomsgroep 25 – 29 jaar en ondersoek meer spesifiek die redes waarom die jong dames dit moeilik vind om hulle vriende te oortuig om ‘n kondoom voor seksuele omgang te gebruik.

‘n Steekproef van 12 werklose jong dames van die die Parkgate area in Kwazulu Natal is gebruik.

Die studie het duidelik aangetoon dat die dames onvoldoende kennis van die pandemie het en dat hulle, hulself daarom onnodig blootstel aan infeksie. Die feit dat die dames werkloos is en ‘n gebrek aan behoorlike kommunikasievaardighede het verder tot die probleem bygedra. Daar is ook gevind dat daar verskeie gelowe en mites bestaan wat hierdie gedrag verder ondersteun.

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CHAPTER 1: INTRODUCTION

1.1 Background and rationale

South Africa's HIV epidemic is defined by the Joint United Nations Progamme on HIV/AIDS (UNAIDS, 2008) as being a hyper-endemic epidemic as a result of the country having more than 15% of the population aged 15-49 living with HIV (UNAIDS, 2008). UNAIDS estimated that in 2007, 33 million people were living with HIV globally. In the same year 2.7 million people became infected with HIV and 2 million people died of HIV related causes. Of the 2.7 million new infections it was estimated that 1.9 million occurred in sub-Saharan Africa (UNAIDS, 2008). The region accounts for two-thirds (67%) of the global total of 33 million people living with HIV. Southern Africa continues to bear a disproportionate share of the global burden of HIV with 35% of HIV infections occurring in this sub-region.

KwaZulu Natal (KZN) is more heavily affected and infected with HIV/AIDS than any other region in South Africa. Most of all new HIV infections occur in female young adults. UNAIDS AIDS epidemic update December 2009 reported that South Africa is still leading with high numbers of HIV/AIDS infections. The age group that has been reported to be highly infected is mostly found between the ages of 25 to 29 years old. Amongst this age group women seem to be more infected compared to males. Given the state of HIV/AIDS awareness campaigns that over the country one would expect to see the statistics drop and less pregnant women in anti-natal clinics. But the reality is different. There are still long queues at anti-natal clinics that show that women are not practicing safer sex.

The study was conducted using the community of Parkgate in KZN. Parkgate is semi-urban area that is full of government low cost houses which are 2 rooms and 4 rooms. This community is in KZN surrounding the city of Durban. This is a very small community of not more than 2000 families. Though these houses are small each house has not less than 4 people in each. Most people in this area are not working. There is one primary school, one clinic and no high school and community centre. The researcher had observed long queues in this one clinic with pregnant women.

Many people looked sick and there are a large numbers of deaths due to HIV/AIDS related opportunistic infections. These unemployed women have not just one child but two or three children. In the past having many children out of wedlock used to be an embarrassment but these days it has become an acceptable norm. One would think that they entertain themselves with sex because they are not working. Having so much time at hand can lead to boredom and may lead to more sexual engagement but then they have a choice to negotiate condom usage.

The message about HIV/AIDS has been all over media. The government institutions and NGOs are spreading the word of HIV/AIDS using different types of media. Surely the message should have reached all communities but the response seems to differ. In the midst of all interventions, women still act ignorantly.

1.2 Research problem statement

Government and NGOs are spending money on HIV awareness education to communities using different modes of communication like radio and TV. Everybody is expected to have received this message but the current situation proves otherwise. What is being seen in communities shows that people are either not receiving the message or maybe for whatever reason they have decided to ignore the existence of the disease. What the researcher does not know and wants to find out is why the HIV infection rate is high in the age group of 25-29, especially in women as opposed to men. Why this trend has shifted from the age group of 15-24 to the older group? Is it because they lack knowledge about HIV/AIDS or because they, for some reasons, have decided to ignore the existence of HIV/AIDS. If they do have knowledge about HIV/AIDS surely there are factors that inhibit them from negotiating condoms usage with their partners. The researcher wants to finds out which are those factors.

1.3 Research question

The research question for this research project was to determine the knowledge levels of HIV/AIDS amongst the unemployed young adults and factors that inhibit them from negotiating condoms usage with their partners.

1.4 Significance of the study

The significance of this study was to identify the underlying problems inorder to come up with suggestions and solutions to a problem. Apart from interventions by the government and contributions by the private sector, it is evident that HIV/AIDS is still a key challenge in South Africa. It does not only kill young people in the most productive years of their lives but it also affects the economy of the country. In as much as HIV prevalence in South Africa appears to be stabilizing after peaking in the 1990s and early 2000s, South Africa is still amongst the countries that are highly infected by HIV and has the largest Antiretrovial (ARV) Therapy Programme in the world (World Health Organisation). This means that the country is spending huge amount of money on treatment. If the reality was different this money would be used on building houses and curbing poverty.

It is possible that, for some reason/s, HIV awareness campaigns do not reach all communities or something is not done right to ensure women are empowered with right information to protect themselves. The results of this study will contribute towards implementing strategies which may empower them to make informed decisions about their lives while saving the economy of the country. This study will not only benefit the community of Parkagate but it will contribute in the fight against HIV/AIDS. Government institutions and NGOs will benefit from this study by knowing where the problem lies. This will facilitate strategies to provide solutions for interventions designed especially for this target population. The government and NGOs will also check whether the current HIV/AIDS interventions are actually working and reaching all communities in urban, semi-urban and rural communities.

1.5 Aim of the study

The aim of this study was to establish how much unemployed female young adults know about HIV/AIDS and what factors inhibits them from negotiating condoms usage with their partners in order to introduce more relevant HIV/AIDS interventions in the community.

1.6 Objectives of the study

The objectives of this study can be summarized as follows

- To find reasons behind failure to negotiate condoms usage with their partners.
- To establish the level of HIV/AIDS knowledge that they have.
- To establish what basic HIV/AIDS education or awareness programmes are available in the community.
- To identify a gap that exist between interventions that are available and what they know, and to also provide guidelines of relevant awareness programmes that can reach the entire community.

CHAPTER 2: LITERATURE REVIEW

Women are more susceptible to HIV/AIDS for biological reasons and more. Viral concentration in semen is higher than that in vaginal fluids, and women have a larger mucous surface, which is exposed to the virus for longer durations. However, this cannot explain the sudden acceleration of HIV prevalence among women and reasons why women fail to negotiate condoms with their partners, the socio-cultural context needs to be scrutinised for explanation. This literature review tries to explore what other researchers had discovered on the topic by looking at the state of HIV/AIDS in different age groups and gender, the vulnerability of women to HIV/AIDS infection, the usage of condoms as the prevention of HIV/AIDS infection and lastly the importance of education as the most valuable weapon that can be used in the fight against HIV/AIDS.

2.1 The state of HIV/AIDS across different age groups and gender

Young adults represent one of the groups at highest risk for HIV infection. Indeed, the results of a nationally representative household survey conducted in South Africa in 2003 revealed that more than 15% of young women and almost 5% of young men aged 15 to 24 years were infected with HIV but the trend has shifted from this age group to 25 -59 years old as per the study. Women in the age group 25-29 are the worst affected with prevalence rates of up to 40%. For men the peak is reached at older ages, with an estimated 10% prevalence among men older than 50 years. HIV prevalence among younger women (<20 years) seems to be stabilizing, at about 16% for the past three years (HIV/AIDS Strategic plan 2007-2011). The assumption of the reason for the shift may be that the government has put more focus 15-24 years old age group and less effort on older group of 25-29. It may also be that the trend has moved with age. The assumption is that those people who were between the ages of 15-24 years old in 2003 has grown up and shifted the trend to the age group of 24-29 hence the rate of new infection has declined between the age group of 15-24. The HSRC study confirms that in adults aged 25+ years, the HIV prevalence increased by 1.3% from 2002 –2008. It reports that the epidemic in young females aged 25-29 is at a high level of 33% and it has remained like that. For males, the epidemic has reached new peak of 25.8 % in those aged 30-34 years (Press Release, 2009). The latest South African statistics suggests that among antenatal

clinics attendance, about 70% of HIV positive pregnant women are below the age of 30 years (Department of Health Report, 2007:5).

Table 2.1: Percentage of women who are HIV positive per age range: Verulam and Tongaat

	HIV Positive		HIV Negative		P-Value
	No.	%	No.	%	
Age:					
17-24	**173**	**30**	**235**	**36**	**0.00**
25-34	**286**	**50**	**193**	**30**	
35-44	**95**	**17**	**152**	**23**	
45-54	**19**	**3**	**67**	**10**	
55-64	**1**	**0.2**	**5**	**0.8**	**0.06**
Mean SD	**29 (7.4)**		**31(9.7)**		
Total	**574**		**652**		

Table 2.1 illustrates the results of a study that was done by Evasen Raju (2008), on the prevalence and incidence of HIV in non-pregnant women in Tongaat and Verulam. This table shows clearly that the prevalence of HIV is particularly evident among women between aged between 17 and 34 years. 30% of the women aged between the ages 18 and 24 were HIV positive, while 50% tested HIV positive in the 25-34 range. Only 3.2 of women above the age 45 tested positive. According to this study, among women the prevalence tends to peak between the ages 25 to 29, with social and economic pressures encouraging high-risk sexual behavior at early ages.

2.2 Women and their vulnerability to HIV/AIDS infection

Women seem to be more vulnerable to HIV/AIDS infection as compared to man. In 2004 HIV/AIDS infection was the leading cause of death for black women aged 25-34 years, the third leading cause of death to women aged 35-44 years, the fourth leading cause of death to women aged 45-54 years, and the fourth leading cause of death among Hispanic women aged 35-44 years. High-risk heterosexual contact was the source of 80% of these newly diagnosed infections. Black and Hispanic women account for 81% of the women living with HIV/AIDS in 2005 who acquired HIV through high-risk heterosexual contact. Lack of HIV knowledge, lower perception of risk, poverty, drug or alcohol abuse, and different interpretations of safer sex may contribute to this disproportion (CDC report, 2008). In sub-Saharan as a whole, women account for approximately 60% of estimated HIV infections (UNAIDS, 2008). Women's vulnerability to HIV in sub-Saharan Africa stems not only from their greater physiological susceptibility to heterosexual transmission, but also to the severe social, legal and economic disadvantages they often confront. A recent comprehensive epidemiological review done in Lesotho found that sexual and physical violence is a key determinant of the country's severe HIV epidemic (Khobotlo, et al, 2009). According to a recent survey, 47% of men and 40% of women in Lesotho says women have no right to refuse sex with their husbands or boyfriends (Anderson et al., 2007). The risk of becoming infected is especially disproportionate for girls and young women. HIV prevalence generally tends to peak at a younger age for women than for men (Gouws et al., 2008), while men experience the highest level s of HIV infection in their late 30s and 40s (Macro International, 2008).

The gender dimensions relevant to HIV/AIDS penetrate the whole range of aspects of society, including the economic, legal, cultural, religious, political and sexual status of a woman. Riding on the back of existing gender inequalities, HIV/AIDS aggravates the situation of women, translating existing differences into harsher conditions on the ground and into higher HIV prevalence for women. The dynamics of gender and HIV/AIDS does this by creating multiple mechanisms that exacerbate the vulnerability of women both to contracting the virus, coping with the disease and caring for others infected and affected by the pandemic. High levels of violence against women and girls, particularly sexual violence, exacerbate the subordinate situation for women as well as creating situations where, if the perpetrator is HIV positive, the risk of transmission of the virus is higher. The existing high tolerance of violence against women and children increases their vulnerability to HIV infection (CHGA, 2004).

Women are economically dependent on the men in their family, be it their father or their husband, and therefore also depend on the men's goodwill for their upkeep and livelihood. Legally, women have less access to productive assets such as land and credit. Women's rights are generally not respected, and women enjoy minimal protection against abuse and exploitation. Girls are less educated, which again contributes to lower social status and lower ability to capitalize on available information. Social constructions of masculinity and femininity render women powerless to resist their husband's or partner's demands for unprotected sex. These and other gender dynamics underpin the spread of HIV in Africa, and lead to the present feminisation of the epidemic.

2.3 Condoms usage as the prevention method from HIV/AIDS infection

Heterosexual transmission of HIV and other sexually diseases (STDs) is a major threat to the nation's health. Strengthening the ability of women and their heterosexual partners to protect themselves from HIV/AIDS is a public health priority. The male condoms is effective in protecting against HIV and variety of STDs when used consistently and correctly (Stone et al, (1999). HIV/AIDS national survey done in South Africa in 2009 shows that condoms remain the most effective protection against HIV/AIDS and other sexually transmitted infections (STIs) for sexually active young adults. Most South African youths know that condoms prevent HIV, STIs, and unwanted pregnancies and

that it is important to use a condom every time they have sexual intercourse. In addition, in South Africa, condoms are provided free of charge by the government and are available to young adults through a number of venues, including public-sector clinics and youth centers; indeed, 87% of South African youths report that it would be "very easy" to obtain condoms if the need arose. In as much as condoms are freely available studies have shown that many men and women at risk of HIV/AIDS do not use condoms consistently , despite knowledge about STDs and the importance of condom usage (Thorburn et al, 2001). HIV remains disproportionately high for females overall in comparison to man, and it peaks in the 25-29 age group, where one in three were found to be HIV positive in 2008 (South African National HIV Survey, 2008).

Women's protection against HIV/AIDS and all other sexually transmitted diseases (STD) depends upon their ability to negotiate condoms use with all partners (Hosanna, 2000). This negotiation may encounter barriers, such as cultural and gender-role expectations. In their study on the Relationships Dynamics, Ethnicity and Condom use among Low-Income Women, Hosanna et al, they concluded that HIV prevention programs should emphasize discussions between partners and the development of condom-related self-efficacy and negotiation skills, and these programmes should customise prevention messages according to ethnicity and social context.

In the study of Black women and AIDS prevention, Fullilove et al,(1990) argued that the inability to negotiate condom use, particularly among women, is a major impediment to practicing safer sex behaviours. Getting one's partner to use a condom may not be easy for everyone. This is especially true for women because condoms are worn by men. Until other methods of HIV/AIDS prevention are widely available and affordable, improving the ability of heterosexual partners at risk of HIV/AIDS to negotiate and consistently use male condoms is essential (Thorburn et al, 2001).

A particularly robust finding is that individuals in committed relationships are less likely to use condoms consistently than persons in casual relationships, even if they do not know their partner's or their own HIV status (Misovich et al, 1997). Issues surrounding

trust and commitment may interfere with condom use in some heterosexual relationships. An incorrect AIDS prevention belief that trusted partners are safe partners may lead to the perception of decreased risk as trust develops in a relationship over time (Misovich et al, 1997). In their study, Thornburg et al, found that individuals in diverse samples frequently mention trust as a reason for not discussing or using condoms. proposing condom use to a partner may be considered a violation of trust because it suggest that one or both partners is engaging in sex outside of the relationship or has a sexual past that involves risk (Hamer et al., 1996). The potential for emotional, verbal, or physical abuse in response to requests to use condoms may also be a barrier to discussing and using condoms (Misovich et al,. 1997); O'Donnell et al., 1994); Wingood & DiClemente, 1997). Given such expectations about the outcomes of initiating condom use is perceived as difficult, especially for women.

In their discussion, CHGA 2004, emphasised that without economic independence, a woman is not in an equal position to negotiate condom usage with her partner. This interdependency of financial support of a woman from man makes it difficult for a woman to negotiate the use of condom or to say 'no' to unprotected sex.

2.4 Knowledge as one of the solution to HIV/AIDS

HIV/AIDS knowledge is an important component of HIV/AIDS risk prevention strategies that may influence engagement in high risk behaviour (Kermyt G. A. & A.M. Beutel, 2007). Knowledge one of the most important weapons that can be used in the fight of HIV/AIDS. Without knowledge people cannot be able to make informed choices about their lives. According to the South African National HIV Survey 2008, HIV knowledge has declined among the most risky population. For example, among African females age 20-34 combined knowledge declined from 43, 8% to 26, 1%, and among managed 25-49 it declined from 40, 6 percent to 28, and 0%. It is evident that HIV/AIDS programmes do not reach older segments of the population. More than a third of adults 50+ are not reached by any national programme, and even for adults aged 24-49 more than one in nine (16,4%) have no exposure to HIV communication programmes (SA National HIV Survey, 2008).

HIV/AIDS knowledge is an important factor influencing HIV/AIDS risk perceptions and risk behaviours. In a country with high HIV prevalence such as South Africa, understanding the factors influencing HIV/AIDS prevention knowledge has important policy implications. HIV/AIDS education and prevention programmes in high prevalence countries should pay particular attention to devising culturally sensitive ways to teach socially disadvantaged groups about HIV/AIDS, and to empower them to act upon their HIV/AIDS knowledge (Kermyt, 2007). Among other priorities, NSP 2007-2011 stipulates that it aims reducing the rate of new infections by 50% by 2011. The intention is to ensure that the large majority of HIV negative South Africans remain negative. They mentioned reducing vulnerability through poverty eradication, women empowerment, including reducing the rate of gender based violence, and use a wide range of communication modalities to improve health-seeking behaviour and adoption of safer sex practices. The South African National HIV Survey 2008 concluded by mentioning that there is a need for the country to re-double its efforts in the fight against HIV/AIDS if it is to turn the tide among the other age groups by 2011 as stipulated by National Strategic Plan (NSP) 2007-2011.

2.5 The need for female controlled methods of protection

In a study that was done by Raju Evasan (2008), he concluded that social, cultural and economic gender inequalities limits women's ability to protect themselves from infection, thus fueling the HIV/AIDS epidemic. The use of condoms, reducing the number of sexual partners, and treatment of STIs is not always feasible for many women. In terms of condoms usage this method of protection is not always easy for women as many of them are in relationships dominated by their partners, coupled with the fact that most of these women are economically dependent on their partners (Population Council Inc, and International Family Health, 2001). Reducing the number of partners is also not an option for women, as many of them are uneducated and jobless thus resorting to exchanging sex as a way of supplementing their income (Population Council Incl, International Family Health, 2001). Female condoms and vaginal microbicides are a possible answer but the

problem with female condoms is that they are more expensive than male condoms and complicated to use.

2.6 Socio-cultural values

Cultural and social norms often restrict women's access to basic information about sexual and reproductive health. Even when women have access to information and commodities like condoms, gender norms that prescribes an unequal and more passive role for women in sexual decision-making undermine women's autonomy and expose many to sexual coercion and prevent them from insisting on abstinence or condom use by their partners (UNAIDS, 2008). Most women in KZN still believe that a man is the head of the family and whatever he says goes. Due to this belief, women are scared to say no to other things they do not agree with thus failing to protect themselves. They are aware of risks of engaging to unprotected sex but the cultural believes had shaped the way they think and make healthy decisions.

Some men in this society still believe in dry sex and women go out of their way to dry their vaginal walls. They use drying agents such as herbal mixtures and towels to tighten their vaginas thus enhancing the sexual experience of their male partners. This experience might be painful to women and put their lives at risk but they still do it for their man. Polygamy is one culture that is highly practiced in KZN thus encouraging men to have as many wives and women lovers as they want. The practice of polygamy is accepted by many communities in KZN thus women do not have a say when a man wants to take the second or third wives.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter describes the research design and method of research used. The study adopted a qualitative research approach because of the nature of the topic. Data was collected from clinic patients, and health workers using focus group discussion, semi-structured interviews and in-depth interviews respectively. The coding was used to analyse the data. The choice of research design and data collection method in this study was based on the research objectives and aimed at understanding the level of education, exploring and describing the reasons why women fail to negotiate condoms. The quantitative approach was not seen as suitable for this study as it would not have allowed the emic perspective of participants that was studied.

3.2 Research design

Polit and Hungler (1999) describe a research design as an overall plan for obtaining answers to the questions being studied and a way of handling some difficulties encountered during the research process.

3.2.1 Qualitative Research

Denzin & Lincoln, 1994) describes qualitative research as an interpretative, multi-method approach that investigate people in their natural environment. The researcher intended to gain insight and understanding on how much knowledge is available to unemployed women about HIV and the reasons behind their failure of negotiating condoms with their partners. There was also a need to find out what awareness programmes are available in this community and whether those programmes are effective enough to inform and educate the community members to curb the infection and mortality rate of HIV/AIDS. Since the qualitative approach describes and allows for more understanding into situations, the researcher chose to use it for this study (Katzellenogen et al, 1997).

Johnson and Christensen (2000) define qualitative research as relying primarily on collection of qualitative data (non-numerical data such as words and pictures). Burns & Grove (2001) concur, describing qualitative research as a systematic, interactive, subject

approach used to describe life experiences and give them meaning. The researcher used a qualitative approach in this study based on Burns & Grove's (2001) and Johnson & Christensen's (2000) definitions, and the major characteristics of the qualitative research identified by Polit & Hungler (1999). These characteristics are Naturalistic inquiry, Holistic Perspective, Qualitative Data, Personal Contact and Insight, and lastly Empathetic/Neutrality.

3.2.1.1 Naturalistic inquiry

Naturalistic Inquiry is based on the ability of humans to shape and create their own experiences, and the idea that the truth is a composite of realities. Women in the study described their experiences and reasons for not negotiating condoms with their partners in the environment that they are familiar with. They were comfortable and open and talked about their own experiences and challenges that has led to them take decisions that they have taken regarding their relationships and health.

Data was collected in a naturalistic setting of the community environment and this facilitated communication. The focus group discussion and interviews were conducted in the researcher's home lounge. This was a friendly setting that allowed a free flow of communication. Other participants preferred to do one-on-one interviews in their own homes where they felt more comfortable and they did not have to walk to the researcher's home. The researcher observed and noted the participant's verbal and non-verbal communication throughout the data collection process. The tape recorder was also used with the consent of the participants to ensure that the researcher does not miss any information given out during data collection process. The medical staff were interviewed in their clinic environment.

3.2.1.2 Holistic perspective

A holistic approach is complex because it looks at different dimensions where the participants had to discuss and disclose their experiences and challenges which sometimes negatively affect their health and relationships with their partners. Data collection from the participants which are also the members of the community and the

medical staff that works in this community and see them almost every day gave meaning to the entire study. The merging of the two data collection methods (interviews and focus group discussion) and from different participants (patients and medical staff i.e. the nurse, doctor and clinic admin.) was done to understand the objectives of the study from different perspectives. A holistic approach was essential for this study to give answers to the research question.

3.2.1.3 Qualitative data

Data collection using focus group discussion and semi-structured interviews was flexible. The researcher used direct quotations of the research participant's responses and discussion to capture their experiences. Probing questions were also used to obtain more clarity during data collection process. Qualitative data collected from focus group discussion and interviews was complex. The researcher had to organize data, read through responses to become familiar with it. Different codes were identified and were related to the objectives of the study.

3.2.1.4 Personal contact and insight

The researcher personally collected and analysed data. There was direct contact with participants during interviews and focus group discussion. The process gave insight to the researcher and made it easier to manage the data during the analysis.

3.2.1.5 Empathetic/neutrality

By sharing experiences, the qualitative approach was effective in handling the emotional responses of the participants during focus group discussion. The researcher's line of work and personal experience in HIV/AIDS facilitated understanding of the discussions. The qualitative research approach is subjective because of the active participation of the researcher. Burns & Grove (2001) maintain that the qualitative approach assumes that subjectivity to understanding human experiences. The researcher was therefore actively involved throughout the whole research process.

3.2.2 Research target population

The target population for this study was unemployed females who were between the ages of 25-29 years old and live in the community of Parkgate in KZN. A separate group of females between the ages 15 and 24 were selected to make comparison in responses.

3.2.3 Sampling method

A purposive voluntary sample was obtained. The criteria for inclusion in a sample was that the person :

- must be unemployed and live in Parkgate;
- female between the age of 25 and 29; and female between ages 15 and 24
- have a child which is not more than 12 months old and/or expecting a child (pregnant);
- should be willing and available to participate in the study without payment
- should give informed consent to participate in the study and that the interview may be recorded on audio-cassette

The sample of 28 participants was selected from the target population that fitted the criteria. Among the 28 participants, 12 were used to conduct the semi-structured interviews. These were only between ages 25 and 29 years old. The remaining 16 were divided into two separate groups each with 8 participants. One group was for participants ranging between ages 15 and 24 and the other group was for the older group ranging between ages 25 and 29. The purpose of separating these age groups was to get insight of responses from different age groups and compare. The permission to access the participants was granted by the Ethekwini Region Department of Health and Ottawa Health Care Clinic.

Two more interviews were conducted with the medical workers. The purpose of interviewing medical workers was to get an expert's perspective on this issue as they work closely with the target population.

3.2.4 Data collection process

For the purpose of this study, the qualitative data collection method has been used. The reason to choose a qualitative approach was to investigate people in their natural environment, conduct face-to-face interviews and obtain enough information to answer the research problem. Data was collected using 3 tools:

1. Semi-structured interviews with 12 participants. Interviewing one participant at a time.
2. Two specific in-depth focus groups discussions each containing 8 participants.
3. Interviews with a health workers.

Interview schedules were prepared on time as a guide to control the session.

The researcher used the note pad to write data collected. The tape recorder was also used to ensure that the researcher did not miss any information given by the interviewee. The researcher conducted a maximum of 3 interviews a day. The interviewee was asked to sign the consent form prior the interview and everything was explained to them in a language that they understood. The interview was conducted in a language that the interviewee felt comfortable using and in the comfort of their homes but some preferred not to be in their homes for privacy purposes. Focus groups discussions took place at the researcher's home. Health workers were interviewed in their work environment.

3.2.4.1 Semi-structured interviews

For semi-structured interviews, a number of questions are prepared that between them cover the intended scope of the interview (Uwe Flick, 2011). For the purpose of the researcher need to develop an interview guide as an orientation for the interviewers. In contrast to questionnaires, interviewers can deviate from the sequence of the questions. The aim of the interview is to obtain the individual views of the interviewees on an issue. Interviewees are expected to reply freely and extensively as they wish. If their answers are not rich enough, the interviewer can probe further (Uwe Flick, 2011). For the purpose of this study the semi-structured interviews was used to get more views from an individual participant. The interview guide was also used as an orientation for the interviewer (as per Addendum A below).

3.2.4.2 Focus Groups Discussions

Denzin & Lincolin (2011) refers to focus groups discussions as collective conversations or group interviews that offer a particular fruitful method for "thinking through" qualitative research. They are designed to promote dialogue and to achieve higher levels of understanding of issues critical to the development of a group's interest and/or the transformations of conditions of its existence. Two focus groups discussions were held for this research study. One with younger group between ages 15 and 24 years and the other with older group between ages 25 and 29 years old.

3.2.5 Data analysis

Content of data collected from interviews and focus groups discussions was coded and analysed by identifying different categories and themes. From those categories and themes, the findings to the problem reached.

CHAPTER 4: DATA ANALYSIS AND FINDINGS

4.1 Introduction

Data analysis is the necessary step in the research process to reach conclusions regarding the results of the research that has been conducted, to achieve research objectives and to provide answers to the research question. In this study, the data from focus groups discussions was analysed and interpreted data that came from focus group discussion and interviews. The findings of the study are presented comparatively under the objectives of the study. Firstly the findings resulted from the interviews are presented then the findings resulted from the focus group discussion follow.

4.2 Reasons behind failure to negotiate condoms usage with their partners

The focus groups discussions with the participants had six specific questions on the condom usage which was meant to understand their believes about condoms usage, who should initiate it, when partners should stop using condoms and to share their own personal experiences. The results from the discussions were as follows; most participants from both groups believes in condoms usage as means to prevent infection from HIV/AIDS but some few on the older group believes sexual intercourse is not nice with a "plastic" (participants exact words". They mentioned that they believe that it is their partner's responsibility to initiate condoms as they also initiate sexual intercourse. If their partners do not initiate the condom usage they also go with the flow as they trust their partners. This statement brought a huge argument and discussion amongst the participants of the older group. Some mentioned that men can never be trusted as they were made to believe that sleeping with one woman is not enough. "I once suggested that we condomise but he said I am sleeping around with other men (*ngiyisifebe)* hence I want to protect myself from falling pregnant and not knowing who the father of the child is" (participants' exact words). Most participants had the similar incidents when they suggested the condom usage but their partners refused, accusing them, some threatened to leave them and other even went as far as opting for violence and other forms of physical and emotional abuse.

When they were asked what did they continued sleeping with their partners after they refused to use condom. One participant said "I was scared he was going to leave me for another woman". Other participants mentioned that their partners were more like their source of income as they are not working. They rely on their partner's financial support. When they were asked till when they are planning to rely on their partners for financial support and what have they done in trying to secure employment. The issue of high unemployment rate came up. One participant mentioned that she does work as a domestic worker from time to time but still that is not enough to support her and her three kids, she needs her partner to be around to survive. They also mentioned that the reason they do not mind having sexual intercourse without condoms is because they want to fall pregnant. "the more kids I have the more money I get from the government's child support grant, *imali yeqolo*", this was a response of one of the participants. This statement led to other participants mentioning that being HIV positive is better than having any other virus because at some stage government gives them "disability grants" when they reach a certain number of CD4 cell count and doctors can also write them letters to get such grants which becomes very helpful and subsidies the child grant which is less than R300 per child. They mentioned that HIV is no longer a killer disease, as long as an infected person takes ARVs and stay beautiful the partner will always be around while also getting the support from the government via the social grants.

Participants also mentioned that a man will always be a man and they demand respect at all costs. This brought the discussion about their cultural believes in failing to stand up for themselves and what they believe in. They mentioned that in as much as the world is evolving but there are things they cannot change and if they do try to change them they suffer in return. Some participants mentioned that culture does not condone violence and abuse but what fails them the most if the justice system. One participant mentioned that she was once beaten by her partner after refusing to sleep with him without a condom, when reporting the case to the police station she was told to visit the magistrate court to apply for protection order. This participant mentioned that this is a long process and by the time she got the court date she had already

forgiven her partner because he had stopped buying her food and clothes.

Amongst the participants there was one participant that admitted never had initiated condom usage with her partner because of the level of trust she has for him and do not want to destroy it. She also mentioned that using condoms prevent women from conceiving and that is not what she wants at her age. She mentioned that she had been with one partner for a long time and does not think he can cheat or infect her. This statement led to a probing question that at what stage in a relationship they think partners should stop using condoms and what leads to such a decision. There were many responses to this question; "We used condom for first three months in our relationship thereafter we just stopped *sashaya inyama enyameni*, we did not discuss it as we automatically thought we have grown to know and trust each other" (this is one of the participant's own words). Most participants agreed on three months into the relationship. Few mentioned that they went for HIV test before doing so, many of them confessed on going with the emotion and thinking with their hearts not minds. Some participants mentioned that they never used it at all and it was never part of the discussion, they just went with the flow. Respondents from the younger group's discussions were not too different from the older group's. One said that "*usugar daddy wami* knows *nginengculaza* but still he refused to condomise saying he needs to make children". She further mentioned that she did not mind because she is taking ARVs and also he is a provider, she does not lack anything.

The interviews held with women also had nine specific semi-structured questions which were aimed at probing for their personal believes, experiences and failure to negotiate condoms with their partners. This was a one-on-one interview session between the researcher and the interviewees. The responses were as follows; the most common response from the respondents was that their partners would think that they are accusing them of having other sexual relationships. Most respondents had fear of the unknown, "what if he thinks I am cheating on him, what if he thinks I am not committed to this relationship, what if he walks away to another woman who will give him what he wants, what if he thinks I don't trust him and that he sleeps

around". One of the respondents felt that she is not at risk of being infected because they have been together for some time with her partner and he can never cheat on her. When she was asked whether how certain she is that the partner can never cheat on her, she responded by saying "I know him well *ngamfaka ikorobela"*. She does not think that she is at risk because people who get infected are those that have multiple partners.

Many respondents know that they are at high risk of being infected because they do not condomise and they are not always where their partners are. But still they are not comfortable to negotiate condoms with their partners because of the fear of losing them. One of the respondent mentioned that her partner has a small private part and the first time they had sexual intercourse using a condom, the condom came out and she was afraid it might hurt her. She said they never used a condom afterwards and it has never been an issue of discussion though she is aware that her life is at risk. One respondent admitted having two sexual partners whom she sleeps with without a condom because they all support her financially and both of them do not want to use a condom. She mentioned that she did suggest condom to both of them but neither of them was interested so she left it like that. When she was asked whether she does not fear for her life she responded by saying "we all going to die some day as to how I don't know but I want to live a happy life while I still can". Other respondents also mentioned that their partners are too cultural and do not want to use condoms and believes in traditional way of doing things.

4.2.1 Discussion

Globally, young women are still most vulnerable to HIV/AIDS infection rates, twice as high as in young men. This disparity is most pronounced in sub-Saharan Africa, where 3.11 of young women are living with HIV, versus 1.31% of men their age (UNAIDS 2012). The large majority of women acquire the virus through heterosexual intercourse, mostly through unprotected sex with their husbands or long-term primary partners. This means that something needs to be done to empower women to negotiate safer sex. Condom use is a critical element of combination prevention and one of the most efficient technologies available to reduce the sexual transmission, but

unless women are empowered in all ways to stand up for themselves they will continue be infected with HIV.

Data collected from focus groups discussions as well as interviews points out that gender inequality, abuse and violence is still a contributing factor that inhibits women from negotiating condom use. This eliminates chances of women to protect themselves and thus putting their lives at risks. Women are not scared to engage into an unsafer sexual intercourse because they are afraid that they will be abused, because of the lack of financial independence. They continue putting their lives at risk even when they are aware that their partners are having sexual relationships outside their marriages and relationships. All of this goes back to the issue of gender inequality and not enough resources available to empower women financially and with information that they can use to protect themselves.

Some interviewees were aware of the risk of having an unprotected sexual intercourse but they still believe they are not at risk because they are either married or have been with their partners for long time. They look at marriage as haven where they are safe and they feel protected.

4.3 The findings related to the level of HIV/AIDS knowledge

The investigation of the level of HIV/AIDS knowledge was done through focus group discussion as well as one-on-one interviews. Most participants from both discussions mentioned that they had heard of HIV/AIDS and they also demonstrated good level of HIV/AIDS. They were more knowledgeable about HIV/AIDS transmission, prevention and treatment, symptoms and the cause. When they were asked about how HIV is spread, almost all participants mentioned vaginal sexual intercourse as the main risk factor of HIV transmission, while very few knew that anal and oral sexual intercourse can also cause HIV transmission. When they were asked about the risk of contracting HIV through anal and oral sexual intercourse versus vaginal sexual intercourse, few from the younger group mentioned that they heard that oral and anal sexual intercourse carried more risk compared to vaginal sexual intercourse. Most

participants from the older group admitted that they thought that there is no risk involved in oral and anal intercourse as they were told that vaginal intercourse is the one that is riskier. Having brought this issue up there was a huge debate amongst focus group discussion participants.

Similarly, there was high level of awareness of how to prevent HIV transmission. Almost all of the participants in both interviews and focus groups discussions mentioned condoms as an effective method to prevent HIV transmission, while very few mentioned abstinence and staying faithfully to one partner as an effective HIV prevention method. Those who mentioned abstinence and staying faithfully to one partner also mentioned that they do not trust condoms as they believe they are not 100% safe. Some participants mentioned that staying faithfully to one partner does not guarantee 100% safety as one partner can be faithful to the other but only to find that the other partner *uyafeba noma uyisoka (*participant's own words".

The majority of participants were aware that HIV could not be cured but can only be managed through antiretroviral therapy (ARVs/ HAART). There were few who mentioned that they do not believe in ARVs because of the side effects involved. They mentioned having belief in immune boosters like "module8, *ubhejane*, *vukuhlale*" and taking vitamin tablets like Centrum. They believe that taking immune boosters continuously can suppress the multiplication of the virus in the body and cause the person to live longer without going through the "stress" of taking ARVs that has lot of side effect. One participant in an interview admitted that it is not easy to take *umgqakazo* everyday but she is doing it inorder to survive.

They were a bit of confusion in understanding the difference between HIV and AIDS. Most women in the older group thought it is the same thing. Some called it HIV and other called it AIDS and others said it is the same thing. One participant said "all is just *ingculaza* no matter you call it HIV or AIDS*"*. This was expected by the researcher as many people are confused by the two terms. All of the participants in the study had tested for HIV during their pregnancy but very few knew their HIV

status or their partner's status before engaging into unsafer sexual intercourse and falling pregnant. They only learnt about their status when they started attending the ante-natal clinic. However, there were participants in the study who mentioned tested for HIV with their partners many times before into unprotected sex.

4.3.1 Discussion

From the findings from both the interviews and focus groups discussions it was evident that the participants had good level knowledge of HIV/AIDS. In as much as there were few false believes about the treatment and few arguments about the risks of transmission but the majority of the participants were well knowledgeable of the pros and cons of HIV. They all knew that using condoms, having only one sexual partner, and attending clinics for information and tests can help prevent the spreading of HIV/AIDS. This somehow proves that their lack of condom negotiating skill has nothing to do with lack of knowledge but more of gender inequality, violence and culture.

4.4 The availability of basic HIV/AIDS education and awareness programmes

This investigation was done by interviewing the participating women and also the medical staff. The interviews with participating young women had two specific questions about the availability of HIV awareness programmes in the community. The responses were as follows; apart from hearing HIV messages from community radios and TV, and reading from few charts that are posted on the clinic walls, there has not been anything the Department of Health has done to reach this community. One of the participants mentioned that the last time she got the more interactive education about HIV/AIDS was when she was at school but even there it was not so much in-depth as teachers always avoided to answer certain questions and other teachers was not well informed and always referred them to the internet to find more info.

Another participant mentioned that since she left school she has never been involved on the discussion about HIV/AIDS other than at the clinic or when watching it from

awareness advertisements and dramas from TV are which sometimes done in the language that she does not understand. She quoted one of the awareness ads that used to play on TV "your lover can transmit HIV from another partner who got it from another partner….scrutinize!". According to her this ad was spot on and delivered a good message but it was not clear as how to scrutinize. She suggested that such ads should be clear so that the receiver of information does not get confused. She also suggested the use of the language that people in that region would understand instead of communicating in a language that only few understand.

When they were asked what medium of commutation they would prefer to convey such messages, other participants mentioned that she prefers soapies as they are more exciting to her. She mentioned that if the local soapies can address more of such issues maybe more information will be passed to the community other than doing it once in 2-3 years. She mentioned the drama that used to play on TV called "soul city". She found this drama very educational but now it is no longer aired to address new developments on HIV/AIDS. Other interviewees were not in favour of the TV and radio as means of conveying such messages and education for reasons that other people do not have TVs or time to watch them. They mentioned that they would like to see the government take further step in introducing educational programmes in the communities.

The interviews with health workers also had specific questions on what they have done to create HIV awareness in this community and what has been the response from such awareness programmes if there are any. The health workers admitted that the local clinic has not done much in educating the community about HIV/AIDS except for putting charts on the clinic walls for the patients to read them when they visit the clinic. They also mentioned engaging to more discussion with patients when they are in consulting rooms but their job does not allow them to go out to the community to create awareness and conduct VCT as they do not have enough resources to do so. When they were asked that if their focus is on patients who visit the clinic, what happens to the community members that does not visit the clinic. The

response was that they are the small local primary health care clinic and they leave such initiations to the city or regional Department of Health as they have enough resources and capacity to conduct such programmes for the community.

4.4.1 Discussion

From this research study, it is evident that the government nor the public sector has not done enough in reaching poor communities. The information has been conveyed through different mediums of communication such as TV, radio and charts but clearly this information does not reach all the communities and leaves them with a gap and unanswered questions, hence their sexual behaviours and choices remains unchanged. UNAIDS 2012 Global Report mentions that age-appropriate sexuality education may increase knowledge and contribute to more responsible sexual behavior. However, there are significant gaps in even basic knowledge about HIV and its transmission. According to this report 26 of 31 countries with generalized epidemic in which nationality representative surveys were carried out, less than 50% of young women have comprehensive and correct knowledge about HIV (UNAIDS Global Report 2012). This shows that in as much as the information is there but there is a gap that exists that needs the public and the private sector to join forces in proving more education and awareness programmes in closing such gaps. Yes the information is readily available in different structures but not everyone can access it. And in as much as other people can access it, it becomes one of those things are life ignored until it is realized the forces have been joined to preach one word.

4.5 Interviews with health workers

Interviews with health workers were done in trying to find their perspective on the issue. Responses from health workers were as follows: people are still afraid of to talk openly about HIV hence there number of people who take condoms from the clinic is relatively low especially from the older groups. They mentioned that people don't feel free to take condoms while others are looking at them, they normally ask for condoms when they are inside the consulting rooms but there had been an increase in condoms demand from both sexes especially in younger age group. They mentioned

that the number of people who come for STIs treatment have dropped compared to the past years though there are still cases of STIs especially among women between ages 20 and 30. They mentioned the drop of teenage pregnancy as compared to previous years. When they were asked about the rate of people who come for VCT in the clinic the response was that the rate of people who test voluntarily is low. They normally test when they are seriously ill or during pregnancy as this is done to prevent transmission of HIV from mother to child and thus enroll the HIV positive patients to PMCT programme, other than that people are still scared. Their perspective on the failure to negotiate condoms usage was that women do not have powers to stand up for their rights for many factors such as culture, poverty and domestic violence.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

It can be concluded that gender inequality, domestic violence, poverty and cultural beliefs are the main contributing factors that inhibits women from negotiating condoms use with their partners. According to this study it is evident that poverty which is related to unemployment and individual economic and failure for provide for themselves leads women to compromise their rights to health inorder to survive and for some to live a good life.

We are living in a democratic country that boasts freedom for all and gender equalities but this study concludes that women as still oppressed., not only by their sexual partners by also by the system of the country. The more user friendly and cheaper condoms were designed for men hence give them the right to use or not to use them. They do not need consent of a partner but culture has given them the decision making powers which becomes difficult for women in other communities to say no to those decisions. Condoms that are available for women are not use friendly and they are expensive as compared the male condoms. This makes it impossible for a woman to make choices about her sexual preferences.

According to the findings of this study, it is evident that domestic violence cases do not receive immediate attention. When women report such cases they are told to get the court protection order against the partner, which does not get issued the same day. The women have to wait for court dates while her life is in jeopardy. Women choose not to report some of such cases because they are long and daunting.

According to the findings of this study, it is evident that the levels of knowledge of HIV/AIDS among young to older women is high but is not enough to empower them with safer sex negotiating skills with their partners. Those who are employed are better off because some employers see to it that HIV/AIDS awareness is created in the workplace being guided by HIV/AIDS workplace policies. The unemployed are left out hence they make uniformed decisions about their lives. This study shows that

there is a gap between knowledge and sexual behaviors. Knowledge is supposed to change behaviuors but in this study it is evident that the level of knowledge that unemployed women have is not enough to change their behaviours hence they still fail to negotiate condoms usage with their partners. Unless this gap is closed women will remain vulnerable to HIV infection and the government will continue spending more money on HIV treatment drugs and social grants. HIV/AIDS awareness programmes in all communities can play a major role in reaching all communities and empower women with information and skills that are vital for their well-being.

5.2 Recommendations

Media has played a major role in educating and creating awareness to wider communities of South Africa but it is evident that what have been done is not enough to change certain behaviours in other communities. The findings in the research shows that the information is out there to equip communities with knowledge but there is a lack of community-based interventions for further education and empowering vulnerable groups with the skills for behavior change. Creating a way forward from this study the researcher recommends that the government and the private sector join forces in making sure that all communities especially women are empowered with skills to make healthy benefits.

The private sector has the responsibility towards the communities in which they operate, their contribution in community intervention programmes will not only benefit the communities they operate in but it will ensure that they remain in business for longer. Husbands and boyfriends to these women works for private or public sector, awareness should be strengthened inside the organizations as well so that the information men learn at work can be practiced at home. The good example of such involvement is the Debswana response to the epidemic in Botswana. The local companies and non-profit organizations can learn a lot from Debswana's response.

The local NGOs and CBOs have the similar responsibility towards the communities. They should take responsibility for advocacy and social mobilization, the design and

implementation of innovative prevention and care programmes, as well as mobilizing resources for community. They are supposed to be closer to the community to meet their needs. Programmes that involves women discussion groups needs to be introduced. Involving these women in awareness programmes will not only empower them with skills to negotiate condoms usage with their partners but will also encourage them to change the way they look at life in general. They will also learn how to respond to factors such as violence, cultural misconceptions, and poverty.

It is understood that the unemployment rate in South Africa is currently high and it is not possible for the government and private sector to create jobs opportunities for everyone, but there are lot of things these women can do to fight poverty. The government introduced cooperatives programmes for such ranging from agriculture, poultry farming, sowing and many more businesses these women can be involved in instead of depending to their male partners for financial support but somehow the laziness has overcome them. Community-based interventions can further encourage these women to come together and form co-ops inorder to generate income while increasing their economic status.

The church, also known as the Faith-Based Organisations have historically played an important role in delivering health and social services in developing countries (WHO, 2007). Efforts are needed to encourage greater collaboration between the public health agencies and FBOs. They are a vital part of civil society and they must be encouraged to expand their role and to work in close partnership with government and NGOs.

5.3 Limitations of research

The results of this study cannot be generalised to the wider communities as the small sample was used. Had the larger sample that covered larger geographical area, the researcher would have got more diverse views in the research topic.

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ADDENDA

ADDENDUM A: INTERVIEW SCHEDULE FOR SEM-STRUCTURED INTERVIEWS

The interviewer will start the interview session by asking background information such as age, level of education, whether she was employed before and why she left the job, and how long she had been dating the her partner. This will be done to break the ice and warm-up the interviewee. Following interview schedule will be used as a guide but some questions will come up as the interviewee respond to some questions.

KNOWLEDGE

1. Have you ever seen or heard any messages about HIV/AIDS. If yes, where did you hear them from?
2. How long ago did you hear or see any message about HIV/AIDS and what was the message?
3. Has anyone ever provided you with education/information on HIV/AIDS at your community? If yes, from which institution did this person come from?
4. How long ago did this person provide this information at your community?
5. In your opinion, what causes HIV/AIDS?
6. Can you tell me whether you can be able to see from the outside whether the person is HIV positive or not? If yes, what are the symptoms?
7. Tell me how can you prevent yourself from being infected with HIV/AIDS?
8. tell me how long do you think a person can live if HIV/aids remains treated

BELIEFS AND ATTITUDES

9. In your opinion, who is at risk of HIV/AIDS infection in your community?
10. Do you also think you are at risk? If yes why?
11. In your opinion tell me what do you think about condoms usage to prevent HIV/AIDS infection?
12. Tell me when should couples stop using condoms when they are having sex?
13. How must it be done?
14. Before you fell pregnant did you plan to have the baby with your partner? If no what happened?
15. Did you and your partner go for an HIV test prior stopping using a condom? If no why not
16. Who do you think should initiate condom usage in a relationship?
17. Have you ever initiated condom usage with your partner? If yes, what was his response? If no what stops you from negotiating it with your partner?
18. Tell me why do you think women put their lives at risk by allowing their partners to sleep with them without a condom?

The interviews were ended by asking the interviewees whether they had anything more they wanted to add based on their personal experience.

ADDENDUM B: FOCUS GROUPS DISCUSSION SCHEDULE

1. Tell me what do you know about HIV/AIDS: how can one be infected and how can they prevent themselves from being infected, the symptoms and how long a person can live with disease if remains untreated and whether they know about ARTs
2. Their beliefs about condom usage as a method of protection.
3. Who should initiate a condom usage in a relationship?
4. They will be asked whether they had initiated condom usage in their relationship and what happened.
5. What happens if a partner says no to condom? They will be asked to share their personal experiences about this.
6. those that they had never negotiated a condom usage they will be asked to say why not, what factors that hindered them from negotiating a condom
7. Those that did negotiate will be asked to tell the group what happened and why did they continue sleeping with their partners without a condom? What factors that inhibited them from saying “no” to unprotected sex no matter what the outcome of that might be.

ADDENDUM C: INTERVIEW SCHEDULE WITH HEALTH WORKERS

Interview with medical staff was based on the following questions:

1. The average number of people who come for STI treatment
2. The degree in which condoms are taken from the clinic and which gender requests for condoms more and at what age group
3. The average number and age of people who come for VTC
4. The rate of pregnancy amongst the targeted population
5. What factors do they think are behind the failure of their patients to use/negotiate condoms with their partners.
6. What have they done as the local health facility to create HIV/AIDS awareness in this community

ADDENDUM D: PERMISSION REQUEST LETTER (DOH)

P.O.Box 921
Verulam
4043
22 July 2010

Area Manager
North Region Primary Health Care Clinics
Department of Health
Old Fort Place
Durban

Dear Mrs Msomi

APPLICATION FOR PERMISSION TO ACCESS ANTI-NATAL AND CHILD CARE PATIENTS AT OTTAWA CLINICS

I hereby request a permission to access anti-natal and child care patients at Ottawa Primary Health Care Clinic.

I am a Masters Degree student at the University of Stellenbosch enrolled for MPHIL HIV/AIDS Management programme. I am currently doing my research study which aims at investigating HIV/AIDS knowledge among female young adults and factors that inhibits them from negotiating condom usage with their partners. The sample of my study is females who are between the age of 25-29 years old, unemployed, pregnant or having a child that is less than 1 year.

The only identified place to get hold to my sample is in the primary health care clinic that is situated in Ottawa. I will then arrange with the participants the venue where we will conduct the interviews but it will not be in the clinic premises.

I am hoping that my request will reach your favourable consideration.

Yours sincerely
Veli Mnqayi (miss)
Contact number: 072 152 0414
velim@vodamail.co.za

ADDENDUM E: CONSENT FORM

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

HIV/AIDS KNOWLEDGE AMONGST FEMALE YOUNG ADULTS AND FACTORS THAT INHIBIT THEM FROM NEGOTIAITING CONDOMS.

You are asked to participate in a research study conducted by Carol Velile Mnqayi, from the Africa Centre for HIV/AIDS at Stellenbosch University. The results of the study will help the government and the private sector to identify HIV/AIDS knowledge gaps that exist in the community and come up with more relevant interventions that can help to minimise those gaps. The results of this study will also contribute to a thesis. You were selected as a possible participant in this study because you fit the inclusive criteria for the sample that is going to be used for this study, that is, you live in Parkgate, are either pregnant or have a child which is 12 months old or less, you are unemployed, female and you are between the ages of 18 and 29.

2 PURPOSE OF THE STUDY

The purpose of this study is to establish the level of HIV/AIDS knowledge that female young adults have and factors that inhibit them from negotiating condoms with their partners in order to introduce relevant HIV/AIDS interventions in the community.

3 PROCEDURES

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

1 Avail yourself for 60-90 minutes for an interview that will be held on a date and a venue that will be communicated to you by the researcher.
2 Avail yourself of 90 minutes for a focus group discussion that will be held at Parkgate Primary School hall on a date that will be communicated to you by the researcher.
3 Be willing to share your knowledge and experiences regarding the topic with the researcher.
4 Be willing to be honest at all times and keep other participant's names and information that they share during the focus group discussion confidential.
5 Sign the confidentiality agreement and return to the researcher.
6 Sign this form and return to the researcher.

4 POTENTIAL RISKS AND DISCOMFORTS

Risks of stigma and discrimination, and domestic violence are possible only if one of the participants of the study discloses any confidential information to other people not involved in the study. To avoid this from happening, you and all other participants who will be participating in the focus group discussion will be asked to sign the confidentiality agreement so that none of you shares the research participant's information with any other person not involved in the study. Some of questions might require you to share your personal experiences regarding the topic, and this might make you uncomfortable. The researcher ensures you that anything you share in an interview will remain confidential. In writing and publishing of the results, your names will not be sued.

5 POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

This research has no direct benefit to you as the participant.
The results of this research will benefit the community by introducing relevant HIV/AIDS interventions, empower women with relevant skills to negotiate condoms, and help in the fight against HIV/AIDS.

6 PAYMENT FOR PARTICIPATION

No payment will be received by the participant of this study. The participants are asked to volunteer as the researcher is a student and does not have funds to remunerate the participants.

7 CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of keeping this consent form in a locked safe so that nobody will know that you participated in this study except for the researcher. All data collected from interviews will be coded and stored in the researcher's private laptop with the password only known to the researcher and all notes and tapes will be kept in the safety box which only the researcher has an access to. The researcher is the only person who will have access to all information given by you.

This concern form will be released only to the Ethical Committee for the approval to commence the research study. Failure to furnish the committee with this form might result in the proposal not being accepted by the committee. The findings of this research will be analysed and the report will be submitted to the University of Stellenbosch Africa Centre for HIV/AIDS for grading of the whole project.

An audiotape will be used during the interview session as well as during the focus group discussions. This device will be used to ensure that no data is missed by the interviewer. You as the participant have a right to review the tape after the sessions. Only the researcher will have a right to access this tape. Once the researcher has analysed all data collected from the sessions, the audiotape will be erased. No further activities will be done with data in an audiotape.

If the University of Stellenbosch Africa Centre for HIV/AIDS decides to publish results of this research to the body of social science research, confidentiality will be maintained and your names will not be released or mentioned anywhere in the report.

8 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.

9 IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact
The Principal Investigator: Veli Mnqayi
Day and night contact number: 072 152 0414
Email address: velim@vodamail.co.za
Study leader: Dr. Gary Eva
Email address: geva2@telkomsa.net

10 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.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to_____by _____in English/Zulu and [*I am/the subject is/the participant is]* in command of this language or it was satisfactorily translated to [*me/him/her*]. [*I/the participant/the subject]* were given the opportunity to ask questions and these questions were answered to *[my/his/her]* satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may 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 _____ [*name of the subject/participant]* and/or [his/her] representative _____ [*name of the*

*representative]. [H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in English/Zulu and [*no translator was used/this conversation was translated into* _____ by _____].

Signature of Investigator_____Date_____

ADDENDUM F: CONFINDENTIALITY AGREEMENT 1 (THE RESEARCHER)

P.O. BOX 921
VERULAM
4339
Date_____

To the research participant Ms/Mrs_____

CONFIDENTIALITY AGREEMENT LETTER

This letter serves to ensure _____that any information she shares with the researcher Carol Velile Mnqayi will not be shared with any unauthorised person and that it will be kept safely so that her confidentiality is not compromised. When publishing the results of the study, the researcher also promises that no names will be mentioned. The results will remain totally anonymous.
Thank you for participating in this study, I am looking forward to work with you.
Yours Sincerely

Carol Velile Mnqayi

_____

The researcher

ADDENDUM G: CONFIDENTIALITY AGREEMENT 2 (RESEARCH PARTICIPANT)

_____

_____

_____

To the researcher Veli Mnqayi and other participants in the research

CONFIDENTIALITY AGREEMENT

I_____I.D.

No._____

Hereby agree and sign that I will not share with anyone any names and particulars of other participants in this study and I will keep to myself every personal information and experiences other participants share in focus group discussions. I am also aware that sharing other participant's information with any other unauthorised person will compromise that participant's right to confidentiality and it might put them into risk of domestic violence and any other type of stigma and discrimination. I will do this to the best of my ability because I also do not want my information to be shared with any other person other than those who are authorised by the researcher.

Signature of participant: _____

Place: _____

Date: _____

Name of the witness: _____

I.D. no. of the witness: _____

Place: _____

Date: _____

GLOSSARY OF TERMS

1. Sishaya inyama enyameni : means they are having sexual intercourse without a condom

2. Imali yeqolo : this is a term that is used for child support grants

3. usugar daddy wami : my sugar daddy (term that is normally used by young girls who are dating old and rich man

4. ingculaza : Zulu term given to HIV/AIDS

5. nginengculaza : I am HIV positive

6. ikorobela : love portion

7. ngamfaka ikorobela : I made him eat/drink love portion

8. isifebe : a woman who has more than one sexual partner

7. ngiyisifebe : I am a bitch

8. Isoka : a man who has many women lovers

9. ubhejane : traditional herbs mixture that is believed to suppress HIV

10. vukuhlale : mixed traditional herbs that is believed to boost immune system and fight opportunistic infections

11. umgqakazo : a Zulu term that is given to ARVs, this name originated from chickens dry food (corn/maize)