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

by

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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)