

The Dual Risks of Unwanted Pregnancy and
HIV/AIDS: The case of KwaZulu-Natal, South Africa

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Thesis submitted for the degree of Doctoral of Philosophy
to the Faculty of Medicine, University of London



London School of Hygiene and Tropical Medicine
August, 2003



Acknowledgements

I am deeply indebted to my supervisor, Professor John Cleland, for his boundless support, invaluable advice and incredible patience throughout this thesis. Even in the most difficult of moments, he managed to broaden my understanding and encourage me to perceive things from a different perspective.

At the University of Natal, I would like to extend a heartfelt thank-you to Richard Devey, who was always there when I needed technical and statistical assistance. I also wish to thank my colleagues in the School of Development Studies for graciously allowing me to spend a considerable amount of time in London over the past three years.

My sincere gratitude goes out to the numerous organisations that provided financial support for my doctoral research, most especially the Lonmin Scholarship, Mellon Foundation, Simons Population Trust, Opportunities and Choices, and the World Health Organisation.

A special word of thanks to all the men and women of KwaDumisa and Ntuzuma that generously agreed to volunteer their time in order to participate in my study.
Ngiyabonga kakhulu.

I am eternally grateful to my father for the sacrifices he made to ensure his children's education. The support received from other members of my family is also much appreciated.

Finally, my deepest appreciation goes to my husband, Benjamin Roberts, for his love, understanding and tireless devotion. I would never have managed to complete this thesis without his encouragement.

Abstract

This thesis is divided into two parts. The broad aim of the first part of the study is to provide insights into the perspectives and behaviour of sexually active individuals and couples with regard to the prevention of unwanted pregnancy and HIV/AIDS in KwaZulu-Natal, South Africa. A combination of qualitative and quantitative data is used: focus group discussions, a survey of individuals and couples and in-depth interviews. The study found that knowledge of family planning is virtually universal. Most men and women approve of family planning as a method of fertility regulation, although women are more likely than men to report using a method of family planning. Family planning is seen as the woman's domain and as a result, the wife often takes the initiative in using a method of family planning, sometimes without her husband's knowledge. With regard to HIV, awareness is also virtually universal among men and women. Despite this, there is much resistance to condom use especially in marital unions. Condoms are more likely to be used in non-marital than marital unions. However, there are some encouraging indications that condom use in marital unions is occurring and the wife's risk perception is a major factor influencing use.

In the second part of the study, the emphasis shifts from the perspectives of individuals to the role of services. The broad aim of this part of the study is to consider how health services are responding to the needs of sexually active men and women by obtaining information from providers and clients. The study found that while condom promotion is an important component of integrated services, it is not consistently undertaken by providers. Moreover, in most health facilities, clients are only usually offered services for which they present at the health facility. Clients feel that they would benefit from additional information that will protect them against the dual risks of unwanted pregnancy and STIs/HIV.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARRM	AIDS risk reduction model
DHS	Demographic and Health Survey
EA	Enumeration Area
FP	Family Planning
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
MCH	Maternal and Child Health
PHC	Primary Health Care
SLT	Social Learning Theory
STIs	Sexually Transmitted Infections
TRA	Theory of Reasoned Action
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organisation

Chapter 1

Introduction and Background

1.1 Introduction

At the International Conference on Population and Development (ICPD) in Cairo held in 1994 delegates from more than 180 countries committed themselves to transforming and expanding existing family planning (FP) programmes to encompass a more comprehensive, client centred approach to reproductive health. The conference shifted the emphasis away from a narrow focus on demographic targets towards meeting the reproductive goals of individual men and women.

Traditionally, the primary focus of many FP programmes has been on reducing fertility and slowing population growth. During the 1950s and early 1960s the increasing concern about the adverse effects of rapid population growth on socio-economic development led to the widespread promotion of FP programmes (Donaldson and Tsui 1990). In many countries, particularly Asia, the rationale for FP programmes was an explicitly demographic one of reducing birth rates and slowing population growth (Cleland 1997). Over the past few decades, FP programmes in many parts of the world have made outstanding progress in expanding contraceptive use and reducing fertility rates. In the early 1960s, the total fertility rate, or the average total number of children a woman would bear in developing countries, was just over 6 children per women. Nearly four decades later, the total fertility rate for developing countries has fallen to about 3.0 children per women (Bongaarts and Johannson 2002). The number of men and women using contraception has also grown from 9 percent in the 1960s to 53 percent in 1999 (Fathalla 1992; Donaldson and Tsui 1990). At present, sterilisation, intra-uterine devices and oral contraceptives are the most widely used fertility control methods, accounting for 70 percent of contraceptive use worldwide (Fathalla 1992; Donaldson and Tsui 1990).

Despite the impressive progress in raising contraceptive use, in some parts of the African continent, fertility remains high and the use of family planning is relatively low. Recent surveys conducted under the Demographic and Health Survey found that a sizeable proportion of fecund women have an unmet need for family planning, meaning that they are not currently using any method of contraception but they want to delay or

avoid future pregnancies. In some countries surveyed between 20 percent and 30 percent of married women of reproductive age have an unmet need for contraception (Robey et al. 1996). In developing countries, almost one fifth of all live births are unwanted and many more are mistimed (Cleland 1997; Robey et al. 1996). Unwanted pregnancy is a major public health concern as it poses a serious threat to woman's health. Every year, approximately 50 million unwanted pregnancies are terminated and, in many cases, these pregnancies are terminated using unsafe procedures (Safe Motherhood 1998).

In sub-Saharan Africa the decline in fertility and the expansion in contraceptive use is occurring in the context of a high prevalence of HIV/AIDS. The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) estimated that globally during 2002, there were 3.1 million AIDS deaths and 5 million adults and children became infected with HIV. At the end of December 2002, there were 42 million living with HIV/AIDS (UNAIDS 2002). Sub-Saharan Africa is by far the most severely affected region in the world. It is estimated that more than two thirds of people living with HIV/AIDS are in sub-Saharan Africa (UNAIDS 2002). The primary route of HIV transmission in sub-Saharan African is through heterosexual intercourse (UNAIDS 2002). This is in direct contrast to other parts of the world where a considerable proportion of HIV infection is transmitted through other routes, including intravenous drug use as well as homosexual intercourse (UNAIDS 2002).

With the advent of the AIDS pandemic, there has been renewed interest in the prevention and control of sexually transmitted infections (STIs). STIs, which are a major public health concern in many parts of the world, were hitherto largely neglected (Lande and Rhinehart 1993; Mayhew 1998). In 1999, WHO estimated that there were 340 million new cases of STIs in the world (WHO 2001). The highest rate of new cases per 1000 population occurred in sub-Saharan Africa (WHO 2001). Apart from the morbidity caused by STIs, including infertility, abortions, ectopic pregnancies, prematurity and cervical cancer, STIs, particularly those that cause ulceration or lesions (such as syphilis and genital ulcers) appear to enhance the risk of acquiring and transmitting the HIV infection (Pham-Kanter et al. 1996; Mabey 1996). The link between HIV and STIs has highlighted the need for early detection and proper management of STIs. In 1995, a randomised control trial conducted in Mwanza, Tanzania demonstrated that community health education combined with improved

management of STIs reduced the incidence of HIV by 42 percent (Grosskurth et al. 1995).

The growing interest in, and practice of contraception and the high incidence of STI/HIV infections is likely to have profound implications for individuals, for services, for programmes and for policies (Zaba et al. 1997). The 1994 International Conference on Population and Development increased the impetus for integrated services. At the conference, countries were urged to “make accessible through the PHC system, reproductive health to all individuals of appropriate ages... [this] should include... treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions” (United Nations 1995). Partially as a response to the growing threat posed by the AIDS epidemic, the high levels of associated STIs and the absence of any other primary health care (PHC) services, there has been an emphasis on integrating HIV/STI services within mainstream maternal and child health (MCH) and FP programmes (Lush et al. 1999). This shift is based on the belief that combining FP/MCH services and STI/HIV services may be the most convenient and effective way of providing cost effective and better quality services to sexually active women. The focus of this study is on dual protection from the perspective of individuals, couples and services.

1.2 Literature Review

As the HIV epidemic continues to spread in many parts of the world the focus of FP programmes has shifted from an emphasis on pregnancy prevention to include disease prevention. Motivated by demographic objectives, many FP programmes in the past promoted the use of longer term, ‘more effective’ FP methods such as injectables and sterilisation with little or no attention to the protection against STIs (Awusabo-Asare 1995). However, with the advent of the HIV epidemic and the link between STIs and HIV, there is a growing awareness of the need to protect sexually active individuals against the risk of unplanned pregnancy and STIs (including HIV/AIDS).

1.2.1 Perception of Risk

Perception of Risk of HIV infection

Numerous studies in Africa document high levels of awareness of HIV/AIDS (Siziya et al. 1999; Gregson et al. 1998). Most studies concur that a large proportion of men and women are relatively well informed about the major routes of HIV transmission. However, studies show that there are several common misconceptions about modes of transmission (Lindan et al. 1991; Gregson et al. 1998; Wilson et al. 1991). Some researchers have been questioning the predictive value of knowledge (Kippax et al. 1993; Moore et al. 1993). Knowledge is best regarded as an important precondition, if not sufficient, for behavioural change.

An increasing number of studies show that men and women recognise their risk of HIV infection (Cleland 1995; Meekers 2000). However, sometimes people who are at risk of contracting STIs (including HIV) may not perceive their risk and are therefore less motivated to protect themselves. Sometimes the risk of AIDS may appear vague and distant (Gardner et al. 1999). For instance, in South Africa, underground workers on the gold mines did not use condoms because they perceived the risk of developing AIDS as minimal compared with the risk they face living and working on the mines (Campbell 1997). However, some men and women may perceive themselves at risk but feel unable to influence their situation (Lindan et al. 1991; Wilson et al. 1991; Varga 2001). Studies have shown that individuals who feel that they have little or no influence over what happens to them are more likely to engage in risky sexual behaviour (Gueye et al. 2001; Varga 2001). Most studies have found women are more likely than men to feel that they do not have control over their situation (Lindan et al. 1991; Varga 2001). In a recent study in South Africa, Varga (2001) found that sex workers often adopted a fatalist attitude to AIDS. However, in Zambia, Rutenberg et al. (2000) found little evidence of fatalism about contracting HIV. On the contrary, they found that most men and women clearly articulated ways to prevent HIV infection.

Studies show that risk perception varies by types of partnerships. The perceived risk of HIV infection is lower in long than short-term relationships (Klepinger et al. 1993). A number of studies suggest that in long-term relationships familiarity with sexual partners is accompanied by a decreased perception of risk, especially among men

(Temin et al. 1999; Rutenberg et al. 2000). In their study in Zambia, Rutenberg et al. (2000: p128) found that the main reason men felt that they were not at risk was because “they were ‘well-behaved’, they trusted themselves or they and their partner trusted each other.”

Men and women who engage in multiple sexual partnerships are more likely to perceive themselves at greater risk of HIV infection. Married men are more likely than married women to perceive themselves at risk of HIV infection because of their own sexual behaviour (Lindan et al. 1991; Pitts et al. 1991). However, many women who report that they are in mutually monogamous relationships are, in fact, at risk of STIs because of their partner’s involvement with other sexual partners (Finer et al. 1999; Lindan et al. 1991; Quigley et al. 1997; Rutenberg et al. 2000). Some men and women may perceive themselves at risk of HIV infection because their partners spend long periods of time away from home and evidence confirms that prolonged spousal separation is associated with enhanced risk behaviour (Makiwane 1996; Chimere-Dan 1996).

Perception of risk is associated with the level of HIV infection in the community. Some studies have shown that men and women living in communities with high levels of HIV infection are more likely to report a high level of perceived risk and as a result, are more likely to adopt self-protective behaviour (Klepinger et al. 1993; Gregson et al. 1998; MacIntyre et al. 2001; Ntozi and Kirunga 1997). In their study of Zimbabwe, Gregson et al. (1998) found that single women who perceived themselves at risk because a large proportion of their friends and relatives were dying of AIDS were more likely to adopt protective behaviour than those who did not. In Uganda, Ntozi and Kirunga (1997) also found that changes in sexual behaviour were related to number of AIDS patients and deaths known to the respondent. However, van Rossen et al. (2001) found that knowing someone who was HIV positive did not necessarily lead to protective behaviour.

Perception of Risk of Unwanted Pregnancy

Several studies in Africa have found a high level of awareness of a range of modern and traditional methods of family planning (Rutenberg et al. 2000; Lasee and Becker 1997). However, there appears to be a gap between knowledge and practice of a method of family planning. According to estimates from Demographic and Health Surveys (DHS) in 27 countries from 1990-1994, the level of unmet need varies from 11 percent to 37

percent (Westoff and Bankole 1995). Using data from a number of Demographic and Health Surveys, Bongaarts and Bruce (1995) found that the primary reasons for non-use are lack of knowledge, health concerns and fear of side effects and societal and familial disapproval. Wolff et al. (2000b), using the 1995-1996 Negotiating Reproductive Health Outcomes study in Uganda, found that partner opposition was found to result in lower levels of use of all methods of contraception. Moreover, disagreement with partners may result in the use of less effective, traditional methods of family planning.

In many instances, unwanted pregnancy is perceived as a major health problem (Bauni and Jarabi 2000; Hulton et al. 2000). In South Africa, numerous studies document high levels of unwanted pregnancies among young women (Kaufman et al. 2001; Preston-Whyte and Zondi 1992). Most of these pregnancies occur outside marriage. Earlier studies conducted in South Africa have found that many girls fall pregnant to demonstrate their fertility and many girls return to school after the birth of their child (Preston-Whyte 1988; Preston-Whyte and Zondi 1992). However, recent studies have found that young girls often do not desire to become pregnant at an early age and would prefer to delay childbearing (Kaufman et al. 2001; Varga and Makubalo 1996). However, sometimes girls feel pressured to engage in sexual activities by their partners. In their study in Zimbabwe, Gregson et al. (2002) found that younger women engage in sexual relationships with older men. These older men often provide the younger girls with gifts and money. In these relationships girls are not able to negotiate safer sexual practices and as a result, are at risk of an unwanted pregnancy.

Using the Ghana and Kenya DHS, Ngom (1997) found high levels of unmet need for family planning among men. However, potential demand seems to be lower among men than women. Ngom (1997:p199) goes on to argue “satisfying men’s unmet need for family planning may hasten African fertility transitions.” In Zimbabwe, Mbizvo and Adamchak (1991) found that men have considerable knowledge of family planning and are important actors in the fertility and family planning process. They found that men also play an important role in the decision to limit family size and in determining the number of children a couple should have.

1.2.2 Protective Behaviour and its Determinants

Sexual Behaviour

With the spread of HIV, there has been a greater emphasis on changing sexual behaviour. At the beginning of the epidemic most research focused on groups that were regarded as high risk of HIV infection. Since then a number of surveys have been conducted with the explicit purpose of providing descriptive information on sexual behaviour in the general population (Craiel et al. 1995). In several studies, large proportions of men and women report taking action to avoid HIV infection (Wilson et al. 1991; Lagarde et al. 1996). In rural Uganda, Kamali et al. (2000) found a decline in fertility among adolescents, which occurred largely because of the trend towards marriage at a later age for girls and a later age of sexual debut for boys. In their study in rural Senegal, Lagarde et al. (1996) found that 73 percent of men and 53 percent of women reported a change in their behaviour in order to reduce the risk of HIV infection. However, in general, self-reports of behavioural change are met with scepticism. MacIntyre et al. (2001:p163) has criticised reports of behavioural change as “unsubstantiated, poorly evaluated and largely anecdotal”. More generally, rising levels of HIV infection indicate low levels of behavioural change.

In many parts of Africa, sexual networking is fairly common. In Ekiti, Nigeria, 62 percent of male respondents and 47 percent of female respondents had concurrent sexual partners (Orubuloye et al. 1992). Also, in Nigeria, Olayinka and Osho (1997) found that most sexually active men and women had two or more sexual partners, but this proportion was considerably higher among men. In general, men are more likely than women to report having more sexual partners (Lansky et al. 1998; Orubuloye et al. 1992; Van Rossen et al. 2001; Adetunji and Meekers 2001; Siziya et al. 1999). Moreover, unmarried men and women are more likely than the married men and women to report having multiple sexual partners (Hunter et al. 1994). Surveys conducted in Africa have found that sex outside the marital relationship varied widely from country to country, ranging from 4 to 47 percent (Craiel et al. 1995).

In some countries, almost half of adults are living in unions that are not formally legitimised by marriage (Craiel 1995). In some sub-Saharan African countries, marriage is often a complicated process and may extend over a period of months or even years

(Bledsoe 1990). In Zulu culture, marriage is usually a long and complicated process, which usually involves an extended period of engagement and the payment of lobola (bride wealth) (Ngubane 1981). Lobola is intended to give the husband's family rights over the labour and reproductive rights of the women (Ngubane 1981; Kaufman et al. 2001).

Caldwell (1999) argues that the sexual culture of sub-Saharan Africa puts the society as a whole at risk of HIV infection. There is a commonly held belief that men have an insatiable desire for sex among men. Campbell (1997: p278) found that several people commented that "sex played a key role in the regulation of a balanced supply of blood and sperm and that regular sex was essential for the maintenance of a balanced supply of blood in the body". Caldwell (1999) argues that frequent sex with many partners is seen to be healthy and strengthening in African culture. In general, several studies have shown that the risk of HIV infection increases with the number of sexual partners (Hunter et al. 1994; de Zoysa et al. 1996). Some studies have shown that concurrent partnerships may play a critical role in accelerating the spread of STIs/HIV (Cohen and Trussel 1996). However, a study of four urban cities in sub-Saharan African found that concurrent sexual partnerships are not the major determinant of the spread of HIV. Instead, the study found that "the frequency of concurrent sex is one parameter of sexual behaviour that may determine the spread of HIV in a population" (Lagarde et al. 2001b:p882).

Condom Use

Apart from sexual abstinence and mutually monogamous relationships between uninfected partners, the use of condoms is currently the most effective strategy for preventing the transmission of HIV and other STIs (Cates 2001; WHO 2000). A number of studies found that consistent condom use is rare (Adetunji and Meekers 2001; Messersmith et al. 2000; Van Rossen et al. 2001). In their study, Adetunji and Meekers (2001) found that the consistency of use increases with number of sexual partners. Men who engage in risky sexual behaviours are more likely to report consistent condom use than men who do not. Those who specifically reported that they or their partners engaged in multiple relationships are also more likely to report higher levels of condom use for STI prevention than in the past (Finer et al. 1999). Men and women with non-regular partners may compensate for their risky lifestyle by using condoms more

frequently (Evans et al. 1997). A street survey of women from two inner city, minority neighbourhoods in Baltimore found that women with both a main partner and other partners were highly motivated to use a condom to protect their main partner from STIs or to avoid the potential embarrassment of bringing a disease back to their main partner (Santelli et al. 1995).

Numerous studies show that condoms are more likely to be used outside of marriage than within marriage (Adetunji and Meekers 2001; Meekers 1997; Preston-Whyte 1999). In the gold mining areas of South Africa, where men work and live for months away from home, about two of every three men used condoms during sex outside of marriage (Meekers 1997). In the 1994 Zimbabwe DHS, married men were five times more likely to report use of condoms during the preceding four weeks with a non-spouse (60%) than with a spouse (12%). Married women reported using condoms 38 percent of the time with non-spouses and 7 percent with husbands (Zimbabwe Central Statistical Office 1995). Similar results have been reported in Tanzania (UNAIDS 1998). Condom use is much higher among the unmarried than the married (Uganda DHS 1995; Laumann et al. 1994). According to the 1995 Uganda DHS, sexually active unmarried men and women were currently using condoms over twelve times more than the married respondents, perhaps to protect themselves from STIs (Uganda DHS 1996).

Condom use that occurs in a regular relationship may have different implications for prevention than condom use in casual relationships. Several studies have found that pregnancy prevention was the main reason for condom use in marital unions, while prevention of STIs/HIV was the main reason for condom use in non-marital unions (Adetunji and Meeker 2001; Anderson et al. 1999; Van Rossem et al. 2001). Using data from the 1996 National Household Survey on Drug Abuse in the United States, Anderson et al. (1999) found that condom use is highly influenced by the length and intensity of relationship. The longer the relationship lasts the greater the likelihood that condom use will be discontinued. People in established relationships may prefer methods that are more effective at preventing pregnancy. A number of studies suggest that familiarity with a partner is accompanied by a decreased perception of risk especially among men (Anderson et al. 1999; Temin et al. 1999). This may, to some extent, explain the non-use of condoms in ongoing, regular relationships.

A number of studies also provide convincing evidence that couples using the condom in combination with a highly effective method of contraception are less likely to use condoms consistently than couples using the condom alone (Santelli et al. 1992; Cushman et al. 1998). Both men and women in regular relationships are likely to believe that preventing pregnancy is more important than preventing disease. A study conducted in Florida in the USA to determine attitudes towards pregnancy versus HIV prevention found that preventing pregnancy was the dominant concern of sexually active individuals because of the perceived low level of HIV prevalence of their partners (Langer et al. 1994). In their study of college women, Poppen and Reisen (1999) found that women tend to adopt an 'either -or' choice about condoms and birth control pills. Most of the women perceived a high risk of pregnancy and therefore used protection to avoid that outcome. When women perceived themselves at greater risk of STIs, they acted to protect themselves from disease as well as conception by using the pill together with the condom. In South Africa, qualitative data from follow up interviews suggest that dual method use occurs when a man's desire to protect himself against HIV or other STIs coincides with his female partner's desire to prevent pregnancy (Myer et al. 2002).

The nature of the sexual relationship influences whether women simultaneously protect themselves against pregnancy and STIs. In their study of women at risk of HIV infection, Riehman et al. (1998) found that women in less committed relationships (i.e. those who are cohabiting or not living with their partner) are more likely than those who are married to protect themselves against both risks. In their study of African American men and women, Woodsong and Koo (2000) found a high level of agreement about the need for dual protection among both men and women. However, both men and women expressed concern about the potential conflict with their partner about the use of condoms as a second method because of the high levels of distrust regarding sexual fidelity.

Barriers to Condom Use

Studies in many parts of the world indicate that there are many reasons for not using condoms, including fear of partner's reactions/opposition, lack of confidence in the product, reduction in sexual pleasure, interruption of spontaneity and desire for more children (Mehryar 1995; Nzioka 1999; Varga 1999). These will be discussed in more detail.

Intimacy

Both men and women are resistant to the use of condoms in long-term, regular relationships (Blecher et al. 1995; Campbell 1995; Cohen and Trussel 1996; Worth 1989; Varga 1997a). This resistance to condoms was found to be strongly related to its negative association with prostitution (Caldwell 1999). In Brazil and Guatemala women interviewed were adamant that condoms are for 'women of the street, not the home' (Reid 1996). In their study of young people in a township in South Africa, MacPhail and Campbell (2001) found that young women encountered social pressure against carrying the condom. Women who carried condoms found that their reputations were tainted by gossip amongst their peers or other adults. This was confirmed by male participants who stated that they would not trust women who carried condoms. Condoms are not used in steady, ongoing relationships because they are regarded as a barrier to intimacy. This is most vividly illustrated by a study of commercial sex workers in South Africa, which found that sex workers acknowledge the wisdom of enforcing condom use with their clients but not with their personal partners. In the words of a sex worker, "condoms were made to keep flesh apart that isn't supposed to mingle" (Varga 1997a:p81). Both men and women say that asking a partner to use a condom is equivalent to admitting one's own infidelity or accusing one's partner of being unfaithful (Cohen and Trussel 1996; Worth 1989; Blecher et al. 1995). The subconscious message their presentation for use delivers is, "You are not the only one with whom I am having sex" (Worth 1989:p304).

Several recent studies report that individuals may engage in unprotected sexual activities even though they are aware of the potential negative consequences (Sibthorpe 1992; Pivnick 1993; Sobo 1993; Worth 1989). Even when economic survival is not the major determinant for engaging in risky sexual practices, women will not use a condom because of the emotional benefits of unprotected sex is perceived as more important than the risk of HIV infection (Sibthorpe 1992; Worth 1989; Pivnick 1993; Varga 1999). Pivnick (1993) found that condoms were not used even within relationships where one partner was infected with HIV because not using condoms implies love and affection. HIV infection was viewed as a potential, and in some cases, unavoidable cost incurred when entering into intimate sexual relationships; risk was part of the commitment made in what the author described as 'conjugal bonding'. In South Africa, Campbell (1997) found that men when questioned about their reluctance to use

condoms repeatedly reiterated their desire for flesh-to-flesh contact. Flesh-to-flesh sex was seen as the only pleasurable way of fulfilling male sexual desires, with condoms seen as cold and impersonal. Campbell (1997) suggests that the reason for the desire for flesh-to-flesh contact might be attributed to the broader social context of loneliness and reduced opportunities for intimate social relations.

Reduction in Sexual Pleasure

Both sexes surveyed in the WHO/GPA study reported that the most important reason for not using condoms was that they reduced sexual pleasure. In all countries but one, over half of all men who had used a condom said that doing so made sex less enjoyable (Mehryar 1995). In their study of condom use among stable heterosexual couples, Boldsen et al. (1992) found that a sizeable minority of respondents felt that the condom reduced the sensitivity of the penis, depending on the type of condom they used. A study in the United States by Sonenstein and Stryker (1997) found that young men who complained that condom use reduced sexual pleasure were also the less likely to use them.

Concerns about Health and Effectiveness

Concerns about the effectiveness of condoms also emerged in study after study. The WHO/GPA found that a large proportion of respondents thought that 'condoms can climb up into the womb or stomach' (Mehryar 1995). In many studies, concerns about the health effects for women emerged as significant factors hindering condom use (Kishindo 1995; Mehryar 1995). For example, Kishindo (1995) reports that some Malawians believed that condoms might slip off and enter a woman's womb causing sterility. It was found that health care workers expressed similar misgivings about condoms. In Zambia, some of the reasons why health workers felt that condoms were not effective included the likelihood of tearing, improper use, possibility of slipping off and inability to block the transmission of HIV (Mouli and Nyirenda 1993). The female condom may also be used for reducing the risk of unwanted pregnancy and the transmission of STIs, including HIV. A number of studies show that women are often eager to use a device that is under their control (Gollub et al. 1995; Preston-Whyte 1999b). However, Sly et al. (1997) found that female condom users may encounter similar problems to those of male condom users. Acceptability studies of the female condom found that specific concerns women often mention is the appearance and the

feel of the protruding outer ring. Other concerns about the device have included: difficulty with insertion; pain for both partners caused by the inner ring; the production of noise during sex; and compression of the device inside the vagina during intercourse (WHO 1997).

Access to Services

Individuals may experience difficulties when trying to obtain both male and female condoms. Nickerson (1990) points out that in the current social and political environment, sexuality is frowned upon and men may feel uncomfortable at being seen purchasing condoms. Makhaba (1994:p93) argues that because of the negative connotations of condoms “people cannot buy condoms without implying to those around them that something may be wrong or dangerous in their sex life”. In some instances, cost may be a significant barrier to increasing condom use, not only in developing countries. In the study of inner city youth in the United States, Stiffman et al. (1994) found that condom use was low because those in difficult financial circumstances could not afford to purchase condoms or travel to special clinics to obtain them.

The antagonistic attitudes of health staff may serve as a major deterrent to the use of condoms. In a study among adolescent men and women, it was found that the rude and judgmental attitude of providers discouraged young men and women from using condoms. For example, in KwaZulu-Natal young field workers posing as clients reported that some clinic providers resisted their requests for condoms and often failed to provide instructions about how to use condoms (Abdool Karim et al. 1992b, Abdool Karim et al. 1992c). Condoms were perceived as an unreliable method of contraception and their use was discouraged. In several instances, providers tried to convince clients to use more effective methods of contraception. Despite their awareness of AIDS, most providers perceived their role to be that of birth control providers and rarely consider the possibility of prescribing condoms in conjunction with a more effective contraceptive method. Another study in South Africa by Gilmour et al. (2000) found that access to condoms is not only limited by provider’s attitude, but also by the opening hours of the clinic and the inadequate clinic signs.

Desire for Childbearing

In some societies, the emergence of the AIDS epidemic has had a noticeable impact on fertility intentions. In their study in Zimbabwe, Gregson et al. (1998) found that almost half of the women said that they wanted fewer children since hearing about HIV/AIDS. In Zambia, Rutenberg et al. (2000) found that the large economic burden of raising many AIDS orphans was seen as a reason to curtail future childbearing. Moreover, they found that most married men and women felt that women who were infected with HIV should avoid pregnancy by using a condom.

The desire for childbearing may sometimes act as a barrier to condom use. Preston-Whyte (1999a:p143) observed that “the case of women seeking to become pregnant is, perhaps the most fundamental conundrum facing condom use”. Childbearing and motherhood are viewed as an important component of women’s role, conferring on them a sense of social identity and self worth (Kline et al. 1992). As a result, condoms may be rejected because they interfere with the natural process of conception (Kline et al. 1992). Surveys have shown that most couples throughout sub-Saharan Africa and in some countries still desire to have large families and that the continued use of condoms is not acceptable (Lightbourne 1985; Bankole and Singh 1998). The results from Demographic and Health Surveys conducted in 18 developing countries show that men and women in these countries desire fairly large families. At the aggregate level, however, husbands in sub-Saharan Africa are more likely than their wives to want a large family (Bankole and Singh 1998).

In African society, high emphasis is placed on the bearing of children (Krige 1936; Sundkler 1961; Berglund 1976; Ngubane 1977; Preston-Whyte 1999a). A marriage that does not produce children is not regarded as fully consummated (Preston-Whyte 1988). The success of a woman is usually measured in terms of the number of children she bears. A wife who does not have a child soon after marriage is often subject to questioning and ridicule and sometimes threatened with divorce (Preston-Whyte and Zondi 1992). However, marriage is not seen as necessary for childbearing. As a result, young unmarried women find themselves under enormous pressure to demonstrate their fertility by bearing children. For both men and women, the threat of childlessness may far outweigh the risk of acquiring or transmitting AIDS (Ulin 1992). In their qualitative study of premarital pregnancy among African teenagers, Preston-Whyte and Zondi

(1992) found that the fear of acquiring the reputation of being infertile mitigated against the use of condoms.

1.2.3 Partner Communication

A key factor in promoting safer and healthier sexual practices and shared decision-making is partner communication. Several studies have shown that partner communication is important for preventing pregnancy and STIs/HIV (Bawah 2002; Lasee and Becker 1997; Edgar et al. 1992; Freimuth et al. 1992; Salway 1994; van der Straten et al. 1995).

Partner communication is seen as the first step in the process of fertility decision-making (Lasee and Becker 1997). Communication is seen as important to avoid the consequences of unwanted pregnancy and a large family size (Lasee and Becker 1997). A number of studies have found a statistically significant association between couple's communication and their contraceptive use (Bawah 2002; Lasee and Becker 1997; Kimuna and Adamchak 2001). In Ghana, women who had discussed contraceptives with their husbands were twice as likely to be current users than those who had not (Salway 1994). A study conducted in Nigeria found that contraceptive use is associated with partner communication about family planning. The results showed that among educated men who discussed contraception with their partners, 60 percent used a method of family planning, compared with 10 percent who did not discuss contraception with their partners. Among the uneducated men, 27 percent who discussed contraception used a method, compared with only 4 percent who did not discuss contraception with their partners (Oni and McCarthy 1991).

Several studies have found that communication about family planning is minimal or non-existent (Balmer et al. 1995; Salway 1994). Usually, individual decisions are taken by the dominant partner, particularly when partners hold divergent values or do not believe in shared responsibility (Gage 1998). In some countries, the male has greater influence than his spouse over the decision-making process (Ezeh 1993; Karra et al. 1997; Wolff et al. 2000a). In Ghana, for example, the wife's attitude towards contraception is strongly influenced by her husband's attitude and background characteristics, but the husband's views are not similarly influenced by his wife (Ezeh 1993). In Uganda, Wolff et al (2000b: p135) found that even when discussion does

occur it may reflect “men’s attempt to impose their authority on their wives in fertility decision-making.”

Sometimes women do not use any method of contraception because they assume that their husbands disapprove of family planning (Lasee and Becker 1997; Smit and Venter 1991). In their study in KwaZulu-Natal, Smit and Venter (1991) found that 72 percent of men approved of family planning, but, significantly, only 19 percent of the women believed that their husband really approved. A recent DHS multi-country analysis of men from 15 countries suggests that men are likely to approve of family planning and to know about contraceptives. In fact, the data indicates that the reproductive preferences and attitudes of men and women toward family planning are relatively similar (Ezeh et al. 1996). It is thus important to determine the extent to which one partner accurately perceives the attitudes of the other.

Many women fear violence if they discuss family planning with their partners and may sometimes choose to use contraception without their partner’s knowledge. Covert use of contraceptives has been reported in many developing (Biddlecom and Fapohunda 1998; Castle et al. 1999; Njovana and Watts 1996; Rutenberg and Watkins 1997). In their study, Biddlecom and Fapohunda (1998) reported that women who found it difficult to approach their husbands about the topic of contraceptive use are nearly four times as likely to adopt covert methods of contraception than other women. These methods of contraception allow the woman to satisfy her own reproductive needs while avoiding direct confrontation with her partner. Wolff et al. (2000a) found that the high social costs of raising the issue of stopping childbearing may prevent some couples from broaching the topic. Some of the consequences may include creating suspicions of infidelity and loss of commitment to the relationship.

Recent research has suggested that lack of communication between partners, rather than male opposition may account for failure to use a method of family planning (Smit and Venter 1991). However, a number of studies demonstrate clearly that most people learn about their partner’s sexual needs from a combination of hints and non-verbal body language (Gardner et al. 1999; Balmer et al. 1995; Blanc et al. 1996). The 1995-96 Negotiating Reproductive Outcomes study in Uganda found that indirect forms of communication between partners predominate, contribute to the tendency of both men and women to overestimate each other’s demand for additional children (Wolff et al.

2000b). Doodoo et al. (2001:p198) also found that discussion does not necessarily improve knowledge of partner's attitude. Instead, they found that "increased frequency of discussion is associated with more correct reporting of approval but with less correct reporting of disapproval."

Many studies on communication about STIs and HIV/AIDS highlight the difficulties men and women experience in raising this issue. Rutenberg et al. (2000) found that many women found it difficult to raise the issue of HIV risk with their partner partially because they are worried that their partners would assume that they are unfaithful. A study in Zimbabwe found that respondents are reluctant to broach the subject with their partner because "a discussion is normally a prelude to an accusation" (Marindo 1999:p6). Van der Straten et al. (1995) found in Rwanda that when discussion is specific to condoms, couple communication is associated with increased condom use. Communication is also important for encouraging male participation (Drennan 1998). A street survey of women from two inner city, minority neighbourhoods in Baltimore by Santelli et al. (1995) shows that male support greatly facilitated women's attempt to use condoms and their attempts to use them consistently.

In some instances trust may be a prerequisite for communication. In the qualitative study of both men's and women's perspectives on condom use, Pliskin (1997) found that many couples do not talk about sexual matters until they have achieved a certain level of trust, usually after engaging in sexual activity. Social and cultural sanctions prevent men and women from talking about past sexual history and this appears to be such a powerful influence that couples will not risk violating them. This is consistent with the findings of a study in rural South Africa, which found that some respondents expressed concern that they may be seen as unclean or unfaithful (Harrison et al. 1997).

Many women do not communicate their personal preferences because of the threat of physical violence (Wood and Jewkes 1997; Hadden 1997). A majority of women in some communities face physical, sexual and psychological abuse from intimate partners. Based on data from 35 countries, the World Bank has reported that between one-quarter and one half of women have been physically abused by a current or former partner (Heise et al. 1994). Women who are abused do not assert their personal preferences because of fear of further abuse, economic loss and desertion (Preston-Whyte 1999b). Many women often submit to their partner's wishes for sex because

refusal to engage in sexual activity is likely to trigger physical violence. For women the threat of violence constitutes a major obstacle to sexual negotiation. Wood and Jewkes (1997) found that among Xhosa youth in South Africa it was common for male partners to enforce the conditions under which sexual relations occur often by violent means. Violence was accepted as an inevitable part of the relationship and “reinforced by female peers who indicated that ... submission was the appropriate response” (Wood and Jewkes 1998:p23). In some instances male violence was interpreted as indicative of affection or commitment.

Numerous studies report that culturally defined gender roles, which reinforce male dominance and female submissiveness, impacts significantly on sexual and reproductive decision-making and significantly limits [verbal] communication between partners on sexual matters (Varga 1999; van der Straten et al. 1995). Culturally defined gender roles define appropriate sexual behaviour and restrict women’s power to assert their personal needs and protect themselves against STIs (including HIV). For many women, broaching the subject of sex with a partner is taboo and attempting to negotiate condom use with sexual partners almost impossible. Women attempting to initiate a discussion of condoms in the context of such relationships are usually perceived as nonconformist, overly dominant and sexually available (Varga 1999; Lear 1995; Hadden 1997). In Zaire, Schoepf (1992) found that women are not able to insist on condom use even when they suspected their husbands of having multiple partners. The suggestion that the husband use a condom is likely to anger him on the specific grounds that he is being accused of being unfaithful and the broader grounds that his wife is controlling his life outside the home. Many studies have found that woman lack power in sexual decision-making. A study in South Africa among rural women and women in informal settlements showed that about half felt that they had no right to insist that their partner use condoms and they had no right to refuse sex if their partner objected to using them (Abdool Karim et al. 1991). Women feel unable to question their partners about their affairs with other women, to ask them to go for HIV testing, or to insist on monogamy or the use of condoms.

Several studies describe the cultural barriers faced by women in negotiating safer sex because of the general acceptability of the risky sexual practices of men (McGrath et al. 1993; Njovana and Watts 1996). For instance, McGrath et al. (1993) demonstrated that, in Baganda culture, men are permitted and even encouraged to have multiple sex

partners; women are powerless to change this situation despite concern over HIV infection. In a pilot study in KwaZulu-Natal, Varga (1999) found that young men characterise a man with many sexual partners as successful while a woman in such a situation is described as a 'bad girl' or a 'whore'. These sexual double standards constrain women from communicating their sexual desires and needs (Balmer et al. 1995).

A few studies challenge the prevailing assumptions about culturally defined gender roles as a major barrier to safer sexual practices (Awusabo-Asare et al. 1993; Kline et al. 1992; Orubuloye et al. 1997; Wolff et al. 2000a). In their study in Uganda, Wolff et al. (2000a:p303) found that "men generally have more influence over sex but women can and do refuse sex under a variety of circumstances." The findings of an exploratory study in Ekiti indicate that women have considerable power in the decision-making process due to their economic independence and strong lineage ties (Orubuloye et al. 1997). The majority of women believed in their right to control their sexual activity and felt able to refuse to engage in unprotected sexual relations with an infected partner. The ability of women to participate in decision-making not only enhances their bargaining power but significantly reduces their risk of STIs (including HIV). In her study in South Africa, Hadden (1997) found that even though women may have less access to economic resources and to political and sexual power they can take steps to protect themselves from STIs if given information, skills, a supportive environment and access to methods.

1.2.4 The Role of Reproductive Health Services

A comprehensive reproductive health package is regarded as essential for meeting the reproductive needs of sexually active men and women. Since 1994, there has been an emphasis on integrating FP/MCH and STI/HIV into a comprehensive reproductive health programme. Essentially, two sets of STI activities can be integrated into FP: those relating to STI/HIV prevention (Information, Education and Counselling (IEC) including condom promotion) and those relating to STI management (laboratory screening, clinical diagnosis, treatment or referral, partner notification). In addition, the promotion and distribution of condoms (or other barrier methods) may be introduced into FP as a new activity (Dehne and Snow 1998; Finger 1994; Lule et al. 1998; O'Reilly et al. 1999).

Several justifications have been put forward for the integration of FP/MCH and STI services. In countries where transmission of HIV is primarily heterosexual, FP/MCH services can provide essential health services both by counselling women on how to reduce their risk and by providing services to diagnose and treat STIs that may increase the risk of acquiring or transmitting STIs/HIV (Cates and Stone 1992). Moreover, FP/MCH programmes may be an appropriate place to provide STI prevention and treatment because they both treat conditions that are related to sexual activity and behavioural strategies learned about how to change unsafe sexual practices could be applied to reduce the risk of both unintended pregnancy and STIs/HIV (Fox et al. 1995; Pachauri 1994). Proponents of integrated reproductive health services also argue that it can lead to improved efficiency and effectiveness of the delivery system in relation to specified outcomes, such as enhanced contraceptive prevalence or declines in unplanned pregnancies, maternal mortality, or the incidence of STIs (Hardee and Yount 1995).

Combining reproductive health services may also improve efficiency by requiring fewer client-provider contacts, reducing duplication of services, ensuring continuity of care and training staff to perform multiple tasks (Fox et al. 1995; Foreit et al. 2002; Hardee and Yount 1995). A number of studies have shown that the integration of services has led to an increase in client satisfaction (Askew and Maggwa 1998; Mukaire et al. 1997). However, increasingly, integrated services may not be effective in reducing STIs and HIV/AIDS because FP/MCH services does not conventionally reach the most elusive groups of the population that are at greatest risk of acquiring and transmitting HIV (such as men; unmarried, sexually active women; and sex workers) (Lush et al. 1999; Askew and Maggwa 2002; Foreit et al. 2002).

Following ICPD, many countries have moved towards implementing integrated services, though patterns of integration varied considerably (Lush 2002). In assessing the progress made in implementing the Cairo Programme of Action, Hardee et al. (1999) found that substantial efforts have been made in placing reproductive health on national health agendas. However, while these countries have made great strides in formulating policies in the last few years, implementation of programmes is just beginning. In many countries, defining and formulating appropriate policies has been difficult because of the lack of clear guidelines on implementation (Lush et al. 1999). Despite international agreement on the need for integration, little consensus exists about

what is meant by integration (Cates and Stone 1992; Dixon-Mueller 1993; Foreit et al. 2002; Lush 2002). Integration means different things to different stakeholders (Lush et al. 1999; Lush et al. 2001).

STI Prevention Activities

A review of the literature reveals that STI prevention activities are much more frequently integrated into FP/MCH services than STI management activities (Dehne et al. 2000). The introduction of STI/HIV prevention activities into FP services can be traced to the late 1980s and early 1990s (Ching-Bunge 1995). A 1996 analysis of UNFPA country-level support for HIV/AIDS prevention revealed that, out of the 124 countries supported, 63 had planned or implemented an HIV/STI prevention component (UNFPA 1996). The aim of prevention activities is to inform, education and counsel clients on STIs, health seeking behaviour and behaviour to reduce the risk of transmission (Askew and Maggwa 2002; Dehne et al. 2000)

Condom Advocacy

Integrated services provide an ideal opportunity for promoting the condom as a method of dual protection against unwanted pregnancy and diseases. In some countries, condom distribution increased as a result of integrated services (Barnett 1997; Lule et al. 1998; Vernon et al. 1990). However, several studies conducted in Africa have found that clients often do not receive information about the benefits of dual protection (Miller et al. 1998; Adekun et al. 2002). A study conducted in five countries in Africa showed that fewer than one-third of family planning clients received information about the dual protection benefits of condoms (Miller et al. 1998). In some instances, the lack of adequate staff training and skill has been associated with the failure to promote dual protection messages. Sometimes providers may be reluctant to promote condoms because they are regarded as less reliable and effective method of contraception (Abdool Karim et al. 1992c). However, Adekun et al. (2002:p87) argue that while “providers and clients are key to transforming family planning to dual-protection services, the attitudes and behaviours of clients’ male partners must be considered in gauging the success of the dual protection intervention.”

A review of integration models suggests that condom promotion programmes have low potential, particularly if women are married and are in monogamous relationships

(Finger 2001). Advocating condom use therefore may not be a practical risk reducing strategy for women who are not able to negotiate the conditions under which they have sex (Askew and Maggwa 2002; Fox et al. 1995; Worth 1989).

STI Care Activities

Although STI prevention activities have often been added to FP services, few examples of full integration of STI prevention and care activities exist except in certain parts of Africa. Evidence shows great variability in the readiness of clinics and staff to provide these additional services. Some FP programmes in developing countries may not be in a position to offer STI services. Providing integrating reproductive services may be expensive, complicated and technically sophisticated (Pachauri 1994). The high cost of STI care is perhaps the most daunting challenge facing countries as they translate policies into programmes (Hardee et al. 1999).

Laboratory Diagnosis

In many developing countries screening programmes that rely on laboratory tests are not usually readily available to those at risk of infection (Mayaud et al. 1998). Even antenatal screening for syphilis, which is a simple, cheap and highly cost effective strategy for STI control, is seldom practised. The availability of laboratory tests varies by type and location. In Kenya, MCH-FP staff refer all clients with symptoms/signs suggesting a STI for laboratory testing. In their study of five African countries, Askew et al. (1998) report that almost two-thirds of hospitals offer on-site tests for syphilis and gonorrhoea, about half offer HIV and candidiasis testing and one-third offer chlamydia test. In most developing countries, the costs of maintaining laboratories, training staff and providing antibiotics may place additional burdens on health budgets that have already been stretched to the limit (Blaney 1998; Potts et al. 1999).

In most settings, HIV testing is not done on-site. Askew et al. (1998) found that clients who exhibit signs and symptoms of HIV/AIDS or specifically request a test are usually referred elsewhere for testing and counselling. Some clinics have established a referral arrangement with hospitals where clients may undergo HIV tests. Moreover, there may be delays in obtaining the results of a HIV test. In Botswana, results of the HIV test are usually available after approximately 18 days, thus delaying counselling (Askew et al. 1998). This is likely to deter clients from seeking further support and assistance.

Syndromic Management

In the absence of cheap and readily available laboratory tests, one of the main tools of the integration model is the syndromic management approach recommended by WHO. This approach uses algorithms or flow charts to identify and treat specific combinations of symptoms and clinical signs such as vaginal discharge, urethral discharge in men, genital ulcers and pelvic pain. Syndromic management of STIs was the intervention that appeared to reduce the incidence of HIV infection in rural men and women by almost 40 percent in the community randomised study in the Mwanza Region of Tanzania (Grosskurth et al. 1995). It is currently being used with some success in many countries including Botswana, Kenya and Uganda (Twahir et al. 1996; Finger and Barnett 1994; Mukaire et al. 1997). Shelton (1999) points out that the Mwanza programme may not be typical of clinical situations in MCH and FP programmes. It was a highly accessible, well-focused and well-executed, community based approach. Moreover, the locale had both relatively high STI prevalence and a high level of services for women. In many FP clinics, the prevalence of STIs is likely to be lower (Behets et al. 1998).

The syndromic approach makes sense in some urban and rural populations in sub-Saharan Africa, where up to 40 percent of antenatal clinic attenders may have an STI, but in populations with a lower STI prevalence the application of the syndromic management approach may lead to over-treatment when multiple antimicrobials are given to a patient with no or only one infection (Mayaud et al. 1998). This is likely to result in a serious wastage of limited resources as well as increasing drug resistance (Askew and Maggwa 2002). Moreover, a false positive diagnosis may place women at increased risk of abuse from their partners (Askew and Maggwa 2002). Sloan et al. (2000) found that women with gonorrhoea and chlamydia are usually asymptomatic and as a result cannot be recognised easily using the syndromic management approach and therefore it is not an effective mechanism with which to identify or manage these conditions.

While the syndromic approach appears to be relatively simple, it is not as easy to implement as many people thought it might be. It is cost effective in that it can avoid the high costs of laboratory tests but it may result in the loss of diagnostic precision (Dallabetta et al. 1998). In addition, although it may be useful in treating conditions such as urethral discharge in men and genital ulcers, studies have shown that it may not

be as reliable for diagnosing cervical infections such as gonorrhoea and chlamydia (Hudson 1999). Mayaud et al. (1998) argue that it is important to target men, who are perhaps at greater risk than their rural spouses, and in whom the symptoms and signs of STIs are easier to recognise. In many countries where the syndromic management approach has been introduced, even after intensive training, staff failed to implement the approach properly. Some of the deficiencies in implementation include failure of staff to ask about symptoms and/ risk factors, failure to follow the syndromic management algorithm, substituting clinical diagnosis and failure to examine clients properly (Hudson 1999). Poor compliance with syndromic management protocols could also be due to the complicated nature of the algorithms (Hudson 1999; Shelton 1999).

A pelvic examination is a critical procedure for STI diagnosis because it can be used to detect, through direct observation, signs that a woman may have but does not recognise (Olukoya and Elias 1996). A pelvic examination also increases the likelihood of finding cases of reproductive tract infections (Askew et al. 1998). In some of the programmes reviewed, FP staff were conducting physical examinations as part of their routine duties before integration, while other programmes incorporated systematic physical examinations as a new activity (Dehne et al. 2000). The proportion of new FP clients who received a general physical examination differed across five countries ranging from 31 percent to 62 percent (Askew et al. 1998).

Lush (2002: p74) argues that “ a key challenge in implementing integration is the lack of adequate legislative framework for ensuring that services are feasible”. Many providers are trained in the detection and management of STIs but refer clients with symptoms or signs of STIs to specialised clinics for treatment (Dehne et al. 2000). The right of nurses to prescribe drugs to combat STIs remains contentious (Twahir et al. 1996; Mayhew et al. 2000). In some countries, nurses in public sector clinics make a diagnosis and refer the client to the doctor who reviews their findings and prescribes treatment (Twahir et al. 1996). In other countries, nurses are allowed to prescribe drugs in the absence of the doctor (Mayhew et al. 2000)

The integration of diagnostic and treatment services for STIs into FP/MCH facilities depends on a number of major clinical and logistic resources (Mayhew et al. 2000). The lack of financial and other resources may impede effective and widespread implementation of integrated services. This is clearly illustrated in a study conducted in

KwaZulu-Natal which found that nurses had received training in the syndromic management approach; and there was a secure supply of modern drugs. However, despite availability in district storage facilities, drug and condom shortages in the primary care clinics were common (Wilkinson et al. 1998).

Drug availability and costs may also be serious impediments to effective STI control and management. Treatment for one case of urethral discharge, for example, may cost more than US \$10 for antibiotics, depending on dosage (Finger 1994). Data from situation analysis studies show that many health facilities do not have the first line drugs recommended for the management of vaginal discharge (Askew et al. 1998). As a result, service providers may use alternative medication, often of a poorer quality, to that of the recommended regimens, or send clients elsewhere to obtain the correct medication.

Programme staff may be reluctant to provide STI services because these services are highly stigmatised by many communities and combining these services might harm the image of FP. In a study concerned with STI management at work-based clinics in Cape Town, South Africa, researchers found that STI clinics are poorly utilised and service providers communicated almost uniformly negative and judgmental attitudes towards those patients who presented with an STI (Colvin et al. 1997). Service providers may dislike STIs patients and experience discomfort with the sexual dimensions of STIs/HIV. Health workers in sub-Saharan Africa have been reported to perceive themselves as being at high risk of HIV infection (Mkuye et al. 1991; Mungherera et al. 1997). In their study of health workers, Awusabo-Asare and Marfo (1997) found a general fear of infection stemming from the working environment and conditions, such as insufficient supply of basic items and inability to identify infected persons. The level of perceived risk may in turn influence the management of some diseases. In Nigeria, Adelekan et al. (1995) found that fear among staff of cross-infection with HIV led to failure to carry out proper clinical procedures when providing MCH/FP services related to sexual health.

Risk Assessment

Risk assessment, namely the identification through questions of risk behaviours, has been recommended as a useful tool to identify FP clients with a high risk of infection and to improve the predictive value of the syndromic management approach (Askew et

al. 1998). The risk assessment procedure may be used to substantiate clients' complaints, screen clients not aware of symptoms or determine further counselling needs (Fox et al. 1995). Risk assessment may be self administered or completed jointly by the provider and client and includes socio-demographic and behavioural information such as age, marital status, number of partners, time span since newest partner and symptoms of partners (Fox et al. 1995). A review of six studies at African sites examining the use of risk assessment combined with a clinical algorithm for STI screening of clinic attendees found that, although risk assessment appears to be a relatively easy way to integrate STI management into FP/MCH, it is not very effective for screening low risk populations (Welsh et al. 1997).

Results from several case studies reveal that providers do not routinely conduct risk assessment for STI screening purposes (Penxa and Blackie 1995; Twahir et al. 1996; Askew and Maggwa 1997). Twahir et al. (1996) found that providers do not ask clients about their sexual behaviour. Screening questions were only asked of clients if they complained of symptoms or explicitly presented with signs that suggested an STI. In Morocco few women admit to sexual risk behaviours and most clinicians found it difficult if not impossible to question all women about their sexual behaviours (Ryan et al. 1998).

Clinics may lack the personnel and resources needed to undertake a risk assessment. For example, at the Motherwell Clinic in Port Elizabeth clients are not asked routine questions to assist in determining their potential risk of having an STI/HIV infection and referred elsewhere for further management (Penxa and Blackie 1995). The client load makes it difficult for providers to provide counselling and screening for all their clients. In the Mkomani Clinic, Kenya, providers explained that the one reason they did not ask clients about their sexual behaviour, despite being trained to do so, was because their client load was so high that they did not have the opportunity to give each client that extra time (Maggwa 1997). An expanded package of reproductive health services is likely to increase the responsibilities of service providers.

Providers may also experience 'role expansion', being asked to undertake tasks for which they are not prepared. This may reduce workers' morale and motivation and can ultimately lead to a decline in the overall quality of the services. This is clearly evident in findings of case studies of four programmes in sub-Saharan Africa that explicitly

developed and implemented an integrated approach (Maggwa and Askew 1997). In their study in South Africa, Magwaza and Cooper (2002) found that the lack of planning, direction and co-ordination of services resulted in staff not being psychologically and physically prepared for providing integrated services.

Partner Notification

Partner notification is mentioned as an integral part of FP provider training for STI prevention and care (Dehne et al. 2000). Partner notification is the process by which a partner of a person known to have a STI is informed that he or she has been exposed to a STI and encouraged to seek medical assistance (Macke et al. 1998). Partner referral can be a highly effective strategy for ensuring that partners of patients infected with STIs receive prompt testing or treatment to avoid complications and eliminate asymptomatic infections (Macke et al. 1998; Gorbach et al. 2000). Many problems are associated with partner notification programmes. It may be difficult to treat many potentially exposed persons either because index patients are unable to recall or unwilling to provide accurate identifying information about partners to health care workers (Gorbach et al. 2000; Mayaud et al. 1998). Patient referral does not seem to be as effective in identifying casual contacts. In their study of two Rwandan towns, Steen et al. (1996) found all symptomatic patients received prevention education and condom demonstrations and were also urged to refer sexual partners to the clinic for a free examination. The study found that women were more likely than men to accept partner referral coupons and that the majority of partners referred by index partners were regular partners. In Kenya, clients who come into contact with the clinic are verbally requested to inform their partner and request them to come for a check up and treatment (Twahir et al. 1996). However, many women in polygamous relationships do not inform their spouses because they will be accused of being responsible for introducing the infection in the home, which may lead to divorce. Hence, the threat of divorce and social discrimination acts a major deterrent for women wanting to inform their partner about a STI.

Barriers to Integration

Some concern has been expressed that integration of reproductive health services as defined at ICPD may not be achievable. Lush et al. (1999:p771) argue that “integration is unlikely to succeed because primary health care and the political context within

which this approach is taking place are unsuited to the task.” Furthermore, they point out that the compromise between comprehensive rhetoric and selective reality has resulted in limited change to existing structures and processes. Mayhew (2000) also queried the efficacy of focusing integration efforts too narrowly on FP/STI integration. Focusing exclusively on the integration of STI and FP is seen as short-sighted. Foreit (2002: p105) contends that “not all services should be integrated in all situations, and that even some potentially integrable services should sometimes be offered separately”.

A number of studies have been conducted on integrated reproductive services in a variety of settings. Many of these studies show that there is not sufficient evidence of the benefits of integrating FP/MCH and STI/HIV services. Our review suggests that additional effort is needed to document the process of integration of STI/HIV services into FP/MCH from the perspective of clients and providers.

1.3 Rationale for the Study

This research breaks new ground by looking at the dual risks of unwanted pregnancy and HIV/AIDS. Despite the existence of a significant body of research on unwanted pregnancy and HIV/AIDS, most of the literature focuses exclusively on either the risk of unwanted pregnancy or the risk of STIs/HIV. Moreover, there is a tendency for the literature to concentrate predominantly on the individual, without due consideration of the impact of the service environment. This research is one contribution to understanding the individual and service interface.

Until relatively recently, most empirical studies on reproductive health have focused almost entirely on women. This approach is increasingly seen as problematic, for women do not act as autonomous individuals, operating independently of their partners and social context (Campbell 1995). There is a need for research into the perspectives of men, as well as women, as both have a role to play in ensuring good reproductive health. This is particularly important as the HIV epidemic continues to spread in many parts of the world. In these times, partner co-operation and men’s acceptance of barrier methods such as the male condoms are the best weapon in the fight against HIV/AIDS (Maharaj 2001). In this study, the focus will be equally on men and women.

Another shortcoming of current research is the limited number of studies that focus on the combined perspective of both men and women as a couple. Most of the studies on sexual behaviour consider the views and characteristics of only one partner, with little or no attention to the dynamics between the individuals. This provides an incomplete picture of a situation, which is by definition largely determined by the interactions between partners in sexual relations. This research recognises the limitations of these studies and attempts to fill this gap by collecting data from both partners.

Chapter 2

Aims, Conceptual Framework and Methodology

2.1 Introduction

The purpose of this chapter is to describe the aims of the study and to outline the conceptual and methodological framework for the study. The first section of the chapter begins by identifying the aims and objectives of the study. It then briefly describes the major theories used to explain behavioural change and thereafter outlines the conceptual framework of the study. The second and more detailed section focuses on the methodological framework of the two-part study. It begins by setting out the context in which the study occurs and then explains the rationale behind the selection of the study sites. The first part describes the quantitative and qualitative techniques that were adopted to gain an understanding of the needs, perceptions and behaviour of sexually active men and women in respect of unwanted pregnancy and STI/HIV. In the second part of the study, the emphasis shifts from demand-side to supply-side issues. It describes the qualitative and quantitative techniques that were applied to understand the process of integrating FP/MCH and STI/HIV services and its implications.

2.2 Aims and Objectives

The broad aim of the first part of the study is to provide insights into the perspectives and behaviour of sexually active individuals and couples with regard to the prevention of unwanted pregnancy and HIV/AIDS. The specific objectives of the first part of the study are as follows:

1. To ascertain the perspectives of sexually active individuals and couples about the risk of unwanted pregnancy and HIV/AIDS.

This objective describes the knowledge, attitudes and perception of risk with regard to the prevention of unwanted pregnancy and STIs/HIV. Risk perceptions are important because they may impact directly on sexual decisions and behaviour.

2. To investigate the strategies considered by sexually active individuals and couples as appropriate, practical and effective to cope with these risks.

This objective investigates the strategies to cope with the risk of unwanted pregnancy and HIV/AIDS and how perceived risk of unwanted pregnancy and HIV/AIDS affect circumstances under which sexual intercourse occurs – contraceptive adoption, choice and use and sexual behaviour.

3. To explore the opportunities for and constraints on changing behaviour, with particular emphasis on partner communication.

The objective is to develop a deeper understanding of the many barriers, both social and cultural that prevent individuals from adopting protective behaviour against unwanted pregnancy and HIV/AIDS. Levels of communication between partners about the risk of unwanted pregnancy and HIV/AIDS and their influence on sexual behaviour are also explored.

The broad aim of the second part of the study is to consider how health programmes are responding to the needs of individual men and women. The specific objectives of the second part of the study are:

1. To analyse current reproductive health policies in South Africa for dealing with the twin risks of unwanted pregnancy and STIs/HIV.

This objective examines more specifically the process of policy reform in South Africa. It examines past and current policies directly relating to FP/MCH and STIs/HIV.

2. To investigate the extent to which national policies are implemented at the provincial level, specifically in KwaZulu-Natal.

This objective examines the progress made in implementing policies, with specific focus on the extent to which STI/HIV activities are included in daily service delivery. It also focuses more specifically on information given to clients and compliance with treatment protocols.

3. Through the service provider's account, analyse the needs, opportunities and constraints for dealing with these twin risks.

The advent of the AIDS epidemic has involved a major reorientation in the role of FP. Instead of simply providing FP services, providers have had to extend their focus to include sexual and reproductive health services. This study investigates the perceptions, ability and preparedness of providers to include the promotion of sexual and reproductive health matters in their services.

2.3 Theories of Behavioural Change

A number of theories have been developed to explain behavioural change. The most widely known theoretical approaches focusing on the individual are the health belief model, the theory of reasoned action and AIDS risk reduction model and the social learning theory.

2.3.1 Health Belief Model (HBM)

The health belief model was developed in the 1950s as part of an effort to explain the widespread failure of people to participate in health screening and prevention programmes (Rosenstock et al. 1994). It was later used to provide a better understanding of other health-related behaviour (Rosenstock et al. 1994). The HBM focuses on behaviour under an individual's control and assumes that people act to maximise the net benefit of their actions. According to this model, numerous factors operate to either promote or prevent behavioural change. Knowledge is obviously an important, if not sufficient, condition for behavioural change. Perceived susceptibility to a particular health condition appears to be more important in motivating behavioural change. Individuals who are knowledgeable of behavioural risks and who feel that they are personally at risk may take action if they believe the health condition to have potentially serious health consequences. However, they must also feel that these changes will make a difference either by reducing their susceptibility to, or the severity of, the condition. Socio-demographic variables may also directly affect the individual's perceptions and thus indirectly influence health related behaviour. In making health decisions an individual weighs the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs.

2.3.2 Theory of Reasoned Action (TRA)

The theory of reasoned action (TRA) introduced by Fishbein and Ajzen links individual beliefs, attitudes, intentions and behaviour. The theory of reasoned action is similar to the health belief model but it includes the construct of behavioural intention as a determinant of health behaviour (UNAIDS 1999). It is based on the premise that humans are essentially rational and, when deciding what action to take, make systematic use of all information available to them (Fishbein and Middlestadt 1989). People consider the implications of their action in a given context at a given time before deciding whether or not to engage in a given behaviour and that most behaviours are under volitional control (Ajzen and Fishbein 1980). In the TRA, the individuals weigh the costs and benefits of engaging in a particular behaviour. The greater the perceived costs, the less likely the behaviour is to occur. This theory emphasises the role of personal intention in determining whether a specific behaviour will occur. Intention is determined by two major factors: the individual's attitude towards performing that behaviour and perceived social norms about the behaviour (Fishbein et al. 1994). Attitudes are a function of beliefs about the likelihood and evaluation of the consequences of carrying out the behaviour (outcome beliefs). Perceived social norms are a function of individuals' beliefs about the desires of specific salient referents and their desire to conform to these norms (normative beliefs) (Fishbein et al. 1994). Both attitudes and social norms influence an individual's intention to perform the behaviour.

2.3.3 AIDS Risk Reduction Model (ARRM)

The AIDS risk reduction model (ARRM) developed in the 1990s incorporates some of the key concepts from other behavioural models. The model identifies three stages to behaviour changes: behaviour labelling, commitment to change and taking action. According to the ARRM, change processes are not one directional or irreversible. The first stage involves labelling one's behaviour as risky in terms of HIV transmission. There are three elements that are central in this stage: knowledge of the sexual activities associated with HIV transmission, belief in personal susceptibility to contracting HIV and belief that having AIDS is undesirable. The second stage occurs when a commitment is made to change behaviour to reduce the risk of HIV infection, based on perceptions of whether the benefits outweighs the costs and also, whether they are capable of modifying behaviour. The third stage is reached when the individual takes

action to achieve this reduced risk. Catania et al. (1990a) point out that successful action is likely to occur when social support exists for it, when the change attempted involves the partner, and when the individual has good communication skills. However, it is recognised that “enacting solutions may require complex negotiations with one’s sexual partner (s) who may not have the same degree of commitment to pursuing change” (Catania et al. 1990a: p54). In addition to the three stages, this model identified internal (e.g., negative emotions) and external (e.g., external cues) factors that may facilitate movement between the stages.

2.3.4 Social Learning Theory (SLT)

The major theorist of the social learning theory (SLT), Bandura, explains behaviour in terms of triadic reciprocal causation (Bandura 1994). According to Bandura’s SLT, personal, environmental and behavioural factors all operate as interacting determinants of each other (Bandura 1994). Behaviours are learned in two ways: either by modelling the behaviours of others or by direct experience. There are four components for effective behavioural change. (1) an informational component to raise awareness and knowledge of health risks; (2) a component to develop the self-regulatory and risk-reduction skills needed to convert knowledge into effective preventive action; (3) a component to improve the level of these skills and individuals’ level of self-efficacy with respect to them; and (4) a component that creates and engages social support for the desired personal changes (Bandura 1994). Central to the SLT are two concepts: self-efficacy (the individual’s belief in their ability to exert control over their behaviour) and outcome expectancies (beliefs about outcomes). According to Bandura (1994:p26), “perceived self-efficacy is concerned with people’s belief that they can exert control over their own motivation, thought processes, emotional states and patterns of behaviour.” In Bandura’s formulation, individuals do not simply react to their environment but actively create as well as change them (Bandura 1977).

These models are limited in that they do not take into account the relational and wider social and cultural contexts in which sexual activity takes place (Ingham and van Zessen 1997). Sexual risk behaviours are not the result of a lack of knowledge, motivation and skills but instead have meaning within a given personal and socio-cultural context (Auerbac et al. 1994). In addition to these factors, cultural norms with regard to appropriate behaviour are likely to impact on their ability to negotiate safer sexual

behaviours. Another major limitation of these models is the assumption that individuals are acting in a volitional manner when engaging in a sexual activity. Aggleton (1996) points out that, in many cases, motivations for sex are complex, unclear and may not be thought through in advance. A further critique of these cognitive models comes from feminists who argue that, for many women, the decision to engage in sexual activity may not be out of choice but as a consequence of subtle coercion, economic transactions or a violent act of rape (Gomez and Marin 1996). Moreover, social disparities between partners may lead directly to a situation of unequal power within a relationship, which can, in turn, influence their ability to initiate and/or maintain safe sexual practices (Gage 1998; Preston-Whyte and Zondi 1992).

2.4 Conceptual Framework

Based on the objectives of the study, a conceptual framework is proposed that addresses the relationships between different levels of the study: the individual, couple and context. The conceptual framework for the study is influenced by individual models to explain and predict behavioural change. Figure 2.1 displays the main components and the hypothesised relationships between them.

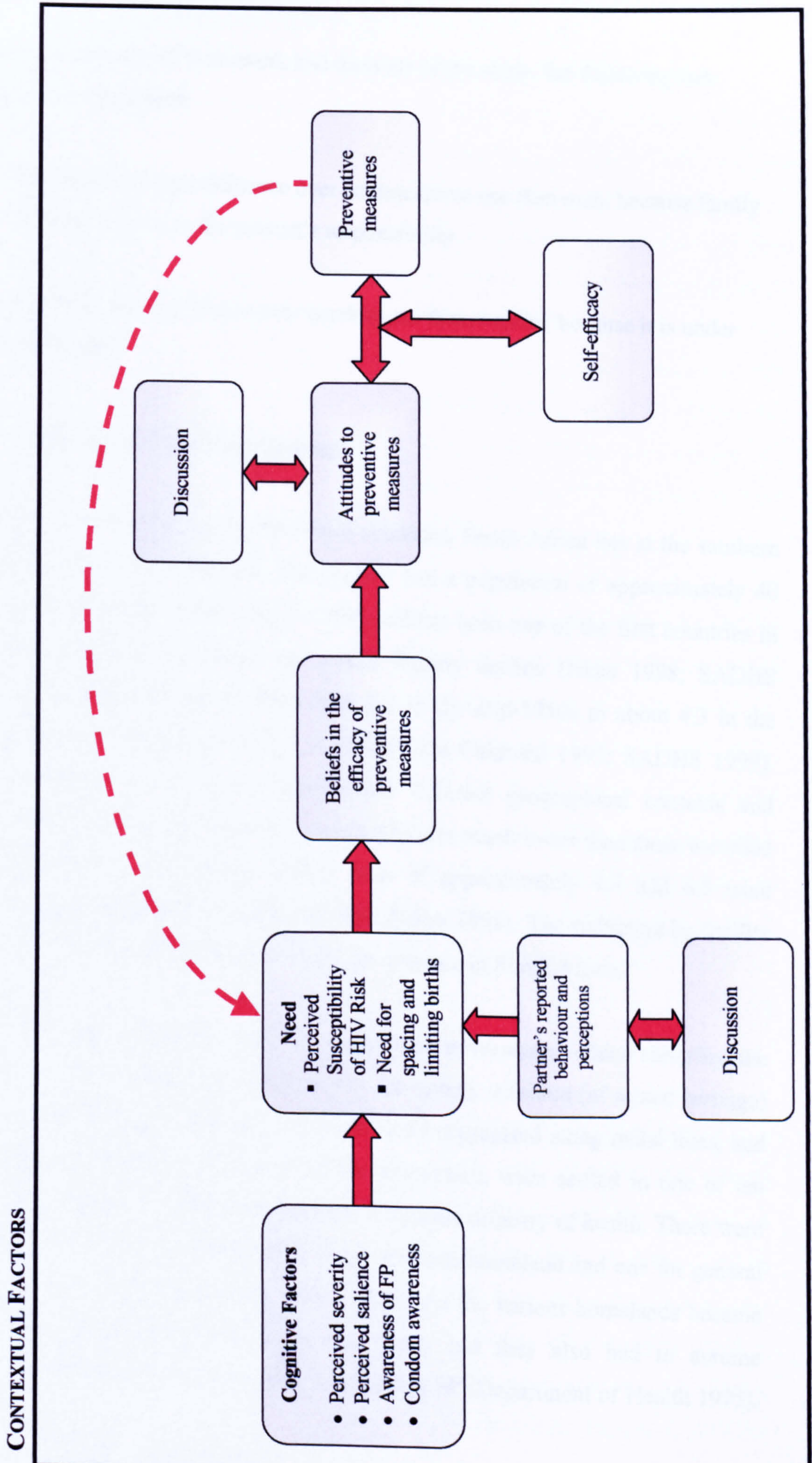
The framework assumes that individuals weigh the costs and benefits of engaging in a particular behaviour. Individuals who perceive the consequences as severe are more likely to take action to protect themselves against the risk. However, in order to be able to take action, individuals need to have information about the ways to reduce the risk of unwanted pregnancy and HIV. Individuals who perceive a greater vulnerability to HIV infection are more likely to be motivated to change their behaviour in order to protect themselves and their partners. Some individuals may perceive a higher risk of unwanted pregnancy and may act to protect themselves against this risk by using a method of preventing pregnancy. Other individuals may perceive themselves at risk of both unwanted pregnancy and HIV/AIDS and therefore act to protect themselves by using a barrier method with another method of contraception. An individual's perceived risk of HIV infection or need for spacing and/or limiting births is likely to be influenced by his or her partner's reported behaviour and perceptions. It is also likely that perceived risk of HIV and need for spacing and/or limiting births is influenced by discussion with partners and other people. The adoption of preventive measures is also likely to

influence risk perceptions. For example, individuals who are using preventive measures are less likely to perceive themselves at risk of HIV infection.

In order to adopt protective behaviour, individuals have to believe in the efficacy of preventive measures. One would expect that there are different beliefs and social norms attached to the use of particular methods, especially condoms. Many real and perceived barriers to condom are likely to influence use. According to this approach, an individual's intention to perform a specific behaviour will be influenced by their attitude to performing the behaviour and their perception of their partner's attitude. Individuals' intention to perform a particular behaviour will be shaped by their discussion with their partners. Individuals who have positive attitudes toward contraception but perceive their partners as having negative attitudes do not intend to use them. In that case, only those with positive attitudes and perceived positive norms will intend to use preventive methods. However, it is also likely that attitudes and discussion occur as a result of the adoption of preventive measures.

In order to adopt preventive measures, individuals must also feel that they have sufficient self-efficacy to take action to reduce their risk. It is worth noting that even when individuals are very well aware of the risks, aware of the efficacy of preventive methods and are motivated to adopt protective behaviour, factors in the broader social context may directly influence and sometimes place constraints on their choices and ability to take action (Chandra-Mouli 1999). Behaviour is likely to be influenced by a variety of contextual factors. Social norms and cultural values may influence the behaviour of women and men and the nature of the relationship in which sexual activity occurs. Numerous studies report that culturally defined gender roles define appropriate behaviour for men and women and any deviation from these gender roles may potentially place men and women in direct conflict (Auerbac et al. 1994; Varga 1999; van der Straten et al. 1995). For e.g., in some societies, the prevention of pregnancy may be seen as the responsibility of women and therefore women are expected to use a method to protect themselves against this risk. Also, social conditions, such as lack of access to an expanded range of services may limit individual choices and in turn, increase the risk of pregnancy and infection. Many of these contextual factors will be explored in greater detail in the in-depth interviews and focus group discussions.

Figure 2.1: Conceptual Framework



2.5 Study Hypothesis

Based on the conceptual framework and the aims of the study, the following two hypotheses are suggested:

- Women have more influence over contraceptive use than men, because family planning is seen as the woman's responsibility
- Men have more influence over condom use than women, because it is under their control

2.6 South Africa: The Study Setting

Considered one of Africa's most developed countries, South Africa lies at the southern most tip of the African continent. The country has a population of approximately 40 million people (Statistics South Africa 1998) and has been one of the first countries in sub-Saharan Africa to experience an overall fertility decline (Nkai 1998; SADHS 1999). The total fertility rate declined from 6.0 in the mid-1950s to about 4.3 in the 1980s and is now reported to be 2.9 (Caldwell and Caldwell 1993; SADHS 1999). Despite a certain amount of variation across different geographical contexts and demographic groups, the fertility rate in South Africa is much lower than those recorded elsewhere in Africa, where total fertility rates of approximately 4.2 and 6.5 were recorded for Southern and East Africa in 1995 (Nkai 1998). The reduction in fertility can be partially explained by an intensive FP programme in South Africa.

Prior to 1994 South Africa was ruled by an apartheid government, which classified the population into four race groups: white, Indian (or Asian), coloured (of mixed heritage) and black (or African). All areas in the country were segregated along racial lines, and all Africans, approximately 75 percent of the population, were settled in one of ten homelands or bantustans. Each homeland had a separate ministry of health. There were 14 departments of health in South Africa – one for each homeland and one for general affairs, Indians, coloureds and whites (Buch 1987). As the various homelands became territories they were granted self-governing rights and they also had to assume responsibility for their own health services, including FP (Department of Health 1975).

This led to unnecessary duplication and inadequate co-ordination of services and costs, which added to the fragmentation of the health system (Buch 1987).

FP services were offered by private agencies, chiefly the FP Association of South Africa, and funded by limited subsidies from the Department of Health (Chimere-Dan 1993; Brown 1987). In 1974, the Department of Health announced the establishment of the national FP programme. The state-sponsored FP programme was launched at a time of rising African unemployment, rapid African urbanisation and increasing resistance to the government (Kaufman 2000). The government promoted the FP programme as a means of improving the health and status of women and children while reducing the rate of population growth. The programme was relatively successful in facilitating the decline in fertility by increasing access to FP services and increasing contraceptive use. Levels of contraceptive use increased steadily since 1974 and were estimated to have reached 44 percent for Africans in 1991 (Kaufman 1998).

Contraceptive use in South Africa is high compared to the other sub-Saharan African countries. The findings from the 1998 South African Demographic and Health Survey shows that more than 60 percent of sexually active women are currently using any method of contraception (SADHS 1999). The major form of contraceptive use in South Africa consists of modern methods of contraception (SADHS 1999). The preferred family size is also declining. The preferred family size among African women surveyed in the late eighties was much lower in urban than rural areas. Over 60 percent of urban women wanted two or fewer children compared with 31.8 percent in rural areas (Department of Welfare and Population Development 1998). This is largely explained by increasing levels of education, income, better accessibility of services and greater involvement of women in the labour force (Nkau 1998).

Although support for contraception in South Africa is increasing, it is occurring in a vastly different health context from that of Asia and Latin America at the time of their fertility transitions. The prevalence of STIs in South Africa, and indeed sub-Saharan Africa as a whole, is notably higher than other regions of the world. A study in South Africa found that around 17 percent of antenatal clinic attenders have at least one urogenital tract infection and between 49 percent and up to 90 percent of women attending FP and antenatal clinics have at least one STI (Pham-Kanter et al. 1996). Historically, STIs did not warrant much attention in South Africa. However, with the

advent of the AIDS epidemic and the recognition of the role of STIs in enhancing HIV transmission, STI prevention and control have become a high priority. South Africa is currently experiencing one of the most rapidly progressing epidemics in the world. The results of antenatal surveys conducted on blood samples from women attending antenatal clinics show that HIV prevalence has risen from less than 1 percent in 1990 to almost 24 percent in 2001 (Department of Health 2002). The surveillance of antenatal clinic attenders is recognized as a good indicator for measuring HIV prevalence among the adult population. These surveys are carried out each year throughout the country in order to determine the point prevalence of HIV infection. It was estimated that in 2001 2.65 million women and 2.09 million men between the ages of 15 and 49 were living with HIV (Department of Health 2002). In South Africa, the province of KwaZulu-Natal has been most severely affected by the AIDS epidemic (Department of Health 2002).

Located on the country's eastern seaboard, KwaZulu-Natal is one of the most populated of South Africa's nine provinces, with a population of almost nine million people. An amalgamation of the former African homeland of KwaZulu and the province of Natal, the population is predominantly rural and African, with Zulu being the main home language (Development Bank of South Africa 1998). In 1998 the total fertility rate of KwaZulu-Natal was estimated at 3.3 children per women and the infant mortality rate was 52 per 1000 live births (SADHS 1999). KwaZulu-Natal has one of the highest rates of HIV infection in South Africa. According to the 1999 national HIV survey, 32.5 percent of women attending state antenatal clinics in the province were HIV positive (Department of Health 2000). Levels of HIV infection are much higher in urban areas than rural areas. However, a comparison of rural HIV prevalence estimates against overall rural and urban combined estimates reveals that the current rate at which the epidemic is growing is faster in rural areas as in urban areas (Abdool Karim 1997). Several socio-economic and political factors make KwaZulu-Natal particularly vulnerable to HIV infection. These include rapid urbanisation, a highly mobile work force, an international port, and high levels of poverty and unemployment (Whiteside et al. 1995).

This study was conducted in an urban and rural site in KwaZulu-Natal. Both the rural and urban sites are inhabited primarily by Zulu speaking people of low socio-economic status. The rural site is KwaDumisa- a sub-district of Umzinto-Vulamehlo District-

situated approximately 80 kilometres south west of Durban (see Figure 2.2). The population of KwaDumisa is approximately 30,000 (Statistics South Africa 1998). Varga (1999:p17) described KwaDumisa as "typical of impoverished rural hinterlands throughout South Africa". Many parts of the district are not readily accessible by public transport and a large proportion of the households do not have access to electricity or piped water (Mbhele 1998). The area is served by a mobile clinic and a fixed clinic situated in Jolivet, the area adjacent to KwaDumisa. For more serious problems residents usually travel to the nearest hospital either in Scottburg or Ixopo.

The urban site is the former African township of Ntuzuma – a sub-district of Port Natal-Ebhodwe – situated approximately 15km from the city of Durban. The population of Ntuzuma is approximately 450,000 (Development Bank of South Africa 1998). Ntuzuma is similar to other urban African townships in South Africa. Homes, roads and schools are in need of repair and electricity and water supplies are constantly interrupted (LeClerl-Madladla 1997). Unemployment in Ntuzuma is relatively high at about 20 percent (Development Bank of South Africa 1998). There are two public clinics and one private clinic for the entire population of Ntuzuma. For more serious problems residents usually travel to the nearest hospital in Durban.

Both KwaDumisa and Ntuzuma have been selected because of the high level of HIV infection among antenatal clinic attendees. In 1998, the level of HIV infection for KwaDumisa was between 25 percent and 33 percent and for Ntuzuma between 33 percent and 42 percent (Department of Health 1999).

Figure 2.2: Locality Map showing Survey Sites



2.7 Methodology: Part One

The aim of the first part of the study is to provide insights into the perspectives and behaviour of sexually active men and women and couples with respect to unwanted pregnancy and STI/HIV. This component of the study focuses specifically on the perception of risk of unwanted pregnancy and HIV/AIDS, strategies to combat these risks and the barriers and opportunities to implement these strategies. For this part of the study, a combination of qualitative and quantitative data was used. This part of the study formed part of a WHO multi-country project. Ethical approval for this part of the study was obtained from the University of Natal in South Africa. Countries participating in the study include Kenya, South Africa, Uganda, Zambia, Zimbabwe and Tanzania.

2.7.1 Focus Group Discussions

In the first phase of the study focus group discussions were conducted. The aim was to obtain contextual information and information on attitudes to family planning and issues related to sexual health in the community. Focus group discussions can offer insights into how a group thinks about an issue, about the range of opinions and ideas and the inconsistencies and variations that exist in a particular community in terms of beliefs and their experiences and practices (Dawson et al. 1993:p7). Moreover, the informality of the group setting encourages a degree of candidness and spontaneity that is not present in a one to one standardised interviews (Kline et al. 1992).

Sampling Design: The focus group discussions were conducted between June and July 1998. A total of 12 focus groups discussions were held: 6 in KwaDumisa and 6 in Ntuzuma. Focus group participants were recruited from several sources, including direct contact with individuals through treatment/service facilities and posters placed at public venues. The following criteria were used for recruiting participants for focus group discussions:

- Female Current Users of Modern FP methods (4 groups- 2 in urban and 2 in rural)
- Female Non-Users of FP (4 groups- 2 in urban and 2 in rural)
- Sexually Active Men (4 groups- 2 in urban and 2 in rural)

Field Procedures: At each session, one moderator and one note taker of the same sex as the participants were present. The moderator was responsible for facilitating and guiding group discussions while the observer's task was to record group activities and conversations. Both the moderators and observers had prior experience in focus group discussions and were fluent in the local language (Zulu). The moderators and observers received three days of intensive training before the actual focus group discussions. The moderators were given an interview guide containing approximately 10-15 questions. The guide contained an outline of the major questions to be asked of the group (see Appendix 1). The focus group discussion guide was constructed based on the literature review and a pilot study. Before the start of the first phase, a pilot study was conducted to test the guidelines.

Groups were made up of people with relatively similar socio-economic backgrounds in order to encourage openness as well as participation. This homogeneity encourages the group to speak about the subject without the fear of being judged by others. Each group contained between six to eight people. Participants were informed of the tape-recorder and the importance of recording the correct language and issues of concern to them. The moderator also assured participants of confidentiality and that anonymity will be maintained at all times. All the interviews were conducted in the local language (Zulu). The focus groups were held at a venue that was conveniently located for the participants and at the same, ensured maximum privacy. In most cases, the venue was a room in the community centre.

Data collection took approximately one month. The first two weeks of the study were spent visiting study sites and meeting with local government officials and enlisting their co-operation and support where necessary. The focus group discussions were then conducted over the course of the next two weeks. Each group contained between six to eight people. At each session one moderator and one note taker of the same sex as the participants were present. All the interviews were recorded and detailed notes were taken.

Data Analysis: The tapes were transcribed and translated into English by the moderator and the note taker. All the transcripts were read and reread and organised according to particular themes and assigned initial codes. Initial coding refers to "the process of breaking down, examining, comparing, conceptualising and categorising data" (Strauss

and Corbin 1990:p61). The analysis was conducted following the principles of grounded theory, in which categories within the data were identified, coded and analysed (Glaser 1992). After initial coding, all the data were assembled under particular themes. In the final analysis, the codes were modified and recurrent themes that emerged across the transcripts were identified. The aim was two-fold: firstly, to identify common themes and secondly, to identify issues of controversy and debate. The computer package, Ethnograph, was used to assist in data analysis. The transcripts are used to illustrate particular findings from the focus group discussions.

The results of the focus group discussions were used in designing the survey questionnaire for the second phase of the study. Since relatively little is known about the subject of the topic focus group discussions were deemed necessary to construct appropriate survey questions. The choice of this method is linked to its ability to generate a greater depth of understanding. The results from the focus group discussions were used to complement the information obtained from the survey data.

2.7.2 Household Survey

During this phase of the study, a household survey was conducted. The aim was to conduct interviews in 400 households in each site. A total of 200 men and 200 women were to be selected as index subjects and their co-resident partners were also to be interviewed. It was decided that 800 households would be able to provide sufficient information for this stage of the study. In view of the multiple objectives of the study, rigorous measures for deciding sample size, though power calculations, were inappropriate. Rather, the decision was a matter of judgement, in which the advantages of size were balanced against considerations of cost and feasibility. The purpose of the survey was to collect information on family planning and sexual health needs, which will be able to link knowledge, attitudes, needs to background variables. An important objective of the survey was to assess the level of response consistency between partners using matched data for individual men and women in a couple. The survey also provided the sample frame for the selection of individuals during the third phase of the study.

Sample Design: Within each urban and rural site, four sub-districts were identified and demarcated using cadastral maps. Within each designated sub-district in the urban area

all census enumeration areas (EAs) were identified and then five EAs were randomly selected for the study. Each EA consisted of about 100 to 250 households. In KwaDumisa, it was particularly difficult to demarcate boundaries of the EAs because of the lack of comprehensive maps. The interview team compiled the household listings in each of the 20 selected small areas. This involved walking around neighbourhoods, listing dwellings and inquiring about multiple occupancy. From these listings 23 households in each of the 20 areas were randomly selected for the study. In general, where street addresses were provided, the listing process was relatively simple and each household was listed according to its physical address. In KwaDumisa, where there were no street addresses, households were identified with the help of the local headman. The name of the household head was used to identify a particular household.

A household survey was then conducted. The household questionnaire provided information about all the people in the household over 15 years of age. Information was obtained about their age, sex, and relationship to the head of household and residential status. Other questions dealt with the circumstances of the household as a whole, for example, whether or not the household had access to electricity and piped water.

The household questionnaire was used to identify all eligible men and women in the household. The Kish grid (see Appendix 2) was used to randomly select the index person for the interview. In order to be eligible for the interview men had to be aged 20-49 years and women had to be aged 18-39 years and they had to be a resident of the household. The study excluded men younger than 20 and women younger than 18 as it was felt that they were more likely to be in more short-term, less stable relationships. At the beginning of the study, it was decided that only sexual partners that were formally married to, or living together with index respondents would be eligible to answer the questionnaire. If the index person selected had more than one sexual partner in the household, the partner who had borne a child most recently was interviewed. There were no age limits for the partner of the index person selected for the interview.

Men and women were asked a series of introductory questions and those who reported that they had ever had sexual relationships were considered eligible to continue to complete the full questionnaire. Men and women who were either formally married or living in a union were considered to be sexually active, and as a result, were automatically considered eligible to complete the full questionnaire. However, the never

married were asked if they had ever had sexual intercourse. Only men and women who had ever had sexual intercourse were regarded as eligible to complete the full questionnaire.

Questionnaire Construction and Design: The questionnaires were developed by a team at the London School of Hygiene and Tropical Medicine, WHO staff and the principal investigators of the six participating countries. At the end of the first phase of the study, the survey questionnaire was tested in a pilot survey. The pilot survey was conducted with 25 men and 25 women to identify problems with specific items or concepts that were not clearly understood and needed clarification and at the same time the range of answers given to questions (Fowler and Mangione 1990). The major complaint about the questionnaire was the length. At a workshop held in Uganda in 1998 the results of the focus group discussions and the pilot study were used to revise the questionnaire. It was also agreed that while there were problems associated with the administration of a long questionnaire, it would be counterproductive to shorten it. In total, three questionnaires were developed: a household questionnaire, a questionnaire for women and a questionnaire for men. The men's and women's questionnaires are similar, with minor exceptions. It was decided that the questionnaire should be pre-tested in order to refine the questions. Those questions that were not properly understood were revised so that they were more appropriate to the field situation. After pre-testing the questionnaire on 25 men and 25 women some of the questions were revised. The final questionnaires are presented in Appendix 3. After the questionnaire was finalised it was translated from English into Zulu with the assistance of health care professionals in South Africa.

Field Procedures: The fieldwork for this phase of the study took place from August 1999 to January 2000. Training for this phase of the study began at the end of July 1999 and lasted 10 days. Since the questionnaire was long and complex, highly competent and well-trained interviewers were needed. For this reason, interviewers with prior experience were recruited and trained. The main emphasis of the training session was on thoroughly briefing the interviewers on the interview schedule. All the interviewers were African and could communicate in the local language (Zulu). Although the interviewers had extensive research experience it was felt that it was necessary to familiarise them with the interview schedule. In the training session all questions were reviewed and interviewers were given reasons for asking particular questions and they also discussed problems that may arise during the interviews. Key word translation was

also undertaken by group consensus, as was group understanding of the meaning of questions.

Following the training sessions, four field teams were formed, each consisting of four interviewers (two males and two females). Two additional researchers (one male and one female) were employed to manage and supervise the fieldwork. These field managers had the responsibility of ensuring that households were correctly selected and that interviews were conducted according to plan. These field managers assisted the interviewers with any problems that arose in the field. Moreover, they also had the responsibility of checking the completed questionnaires at the end of each day.

A written consent form was prepared prior to the start of the research and the participants were asked to sign a form, which stated that they agreed to participate in the research. However, the use of consent forms was discontinued when it became clear that the respondents were not prepared to sign the form as it could jeopardise their confidentiality. Thus, only verbal consent was provided to the interviewer.

At the beginning of each interview respondents were briefed about the purpose of the interview. Respondents were then asked if they would be willing to participate in the study. Respondents were also assured of confidentiality. In general, each interview lasted approximately 45 minutes. Female and male respondents were interviewed by an interviewer of the same sex. Partners were interviewed separately and in some cases, concurrently but this was not always possible. At the end of the household survey, both men and women were asked if they would be willing to participate in the third phase of the study.

A total of 1145 interviews were held. Interviews were held with 622 women and 523 men. Fifty four percent of the respondents were female; the under-representation of males in our sample reflects difficulty interviewers had in locating eligible male respondents at home in the selected households. Totals of 240 men and 323 women were interviewed in Ntuzuma and 283 men and 299 women in KwaDumisa. The female respondents ranged in age from 15 to 49 while the male respondent ranged in age from 19 to over 50. Women were more likely to have older partners and men were more likely to have younger partners. Of the total sample, 47 percent were either married or cohabiting. As might be expected, older men and women were more likely to be married

or living with their partner. The mean age of this sub-sample was 35. Almost 96 percent of married women were living with their partner. According to the 1996 Census, 48.9 percent of the African population (aged 15 and over) in KwaZulu-Natal was either married or cohabiting (Statistics South Africa 1998). Polygamous marriages do not appear to be very common. In the household survey, only one man reported having more than one wife. Men were more likely than women to report having had sexual intercourse in their life. Women who were neither married nor cohabiting were asked if they had a regular partner. The vast majority of women (87.6%) reported having a regular partner. Most respondents had some formal education. Almost three-quarters had at least some secondary school education. A small percentage of men (7.8%) and women (9.8%) had higher than secondary school education. A large variety of religious groups were represented in the sample. Among the churches, the Roman Catholic religion had the highest following among men and women. Almost one-third of the respondents belonged to the Roman Catholic religion. Interestingly, almost 11 percent of women and 19 percent of men did not belong to any religious group. There are various languages spoken by respondents. However, for the majority of respondents (96%) Zulu was their home language.

The response rate for index men was 70.3 percent and 86.8 percent for women (Table 2.2.1). Of the successfully interviewed index respondents, 258 men and 285 women had an eligible partner (i.e. either a married or cohabiting partner). Interviews with 12 men and 40 women were terminated after the initial background questions because they had never engaged in sexual intercourse in their life. Interviews were completed with 242 female partners and 240 male partners giving response rates for eligible female partners of 93.8 percent and for eligible male partners of 84.2 percent. There were few refusals, though two male respondents did not complete the entire interview because they felt the questions were too intrusive. The main reason for the relatively low response rates for men was the difficulty in contacting them, despite multiple visits. Other studies have found that men may not be fully represented in surveys in areas characterised by high levels of labour migrancy (Hargreaves et al. 2002). It is likely that these men may report high risk sexual behaviour. However, Catania et al. (1990) argue that there is also the possibility that these non-respondents may report low risk sexual behaviour.

Table 2.2.1: Number of households, eligible male and female respondents and their partners and their response rates, by place of residence: Unweighted

	Men	Women
Individual Interviews		
Index person selected	383	394
Index person interview terminated	12	40
Index person successfully interviewed	270	342
Individual response rate:	70.3	86.8
Partner Interviews		
Eligible partner selected	258	285
Eligible partner successfully interviewed	242	240
Eligible partner response rate:	93.8	84.2

Data Management: Initially, the field managers checked all questionnaires for completeness and inconsistencies. However, it was necessary to carry out further coding and editing in the office prior to data entry. A standard data entry package was used to ensure that all country data sets have the same structure and have been subject to the same sets of range and consistency checks. Separate data files were created for men and women. The survey data was entered into Epi Info using the standard data entry package. For verification purposes, the data was double entered.

Data Analysis: The data was analysed using SPSS. The analysis was conducted separately for men and women. First, univariate analysis was conducted to describe and summarise the distribution of particular variables. In order to investigate the association between the main outcome of interest and the major explanatory variables, bivariate analysis was used. The chi-square test was used to determine the statistical association between variables. However, Fisher's exact was used when the sample size is small. The major exploratory variables are level of education, place of residence, age, and marital status and number of living children and desire for children. Throughout the analysis, extensive use is made of the multivariate technique of logistic regression. Logistic regression is usually used when the dependent variable is a dichotomous variable and independent variables are categorical variables. The ease of interpretation of the odds ratios produced by logistic regression is one of the appeals for using such models (Adetunji 2000:p197).

The analysis also focused on couples. The data were restricted to 238 couples in which both partners were interviewed. A couple file was created to compare the responses of

partners. The matched couple file was restricted to couples in which both partners reported that they were married or cohabiting. An important limitation of this approach is that it does not include the preferences and behaviour of couples who are neither married nor cohabiting. The analysis looked at the level of agreement at the aggregate level. Moreover, the kappa statistic was used to calculate the level of agreement net of other variables. Kappa values range from 0.0 to 1.0, with 0.0 representing no agreement beyond chance and 1.0 representing perfect agreement (Cohen 1960).

Though the sample was not designed to be representative of KwaZulu-Natal, the survey data were weighted to take into account the over-sampling of the urban population. According to the 1996 Census, 32 percent of the African population of KwaZulu-Natal is urban and 68 percent rural (Statistics South Africa 1998). In the analysis, the survey data were weighted to conform to the rural-urban proportions of KwaZulu-Natal recorded in the 1996 population census. The weights are then normalised so that, the total weighted number of cases is equal to the unweighted number of cases. Throughout the thesis, the results based on the weighted data are presented for the household survey. However, in the appendix some of the key unweighted denominators are presented (see Appendix 9).

2.7.3 In-depth Interviews

In the third phase of the study, in-depth interviews were conducted. The aim of the in-depth interview was to gain more insights into the needs and perceptions of users and non-users of contraception and of men and women with high and low risk sexual behaviour. In in-depth interviews, respondents are given substantial freedom to express their opinions concerning issues, which the researcher assumed to be important (Merton et al. 1956). Interviewers also have the opportunity to clarify ambiguous issues and cases of inconsistencies or to probe when insufficient information is provided (Richardson et al. 1965). The interview method also allows for greater flexibility in questioning the respondent. The interviewer is also able to pose additional questions to follow up on issues, which perhaps had not been anticipated and therefore not included in the questionnaire. Moreover, it allows the interviewer to explore important, unexpected issues that have not been originally considered.

Sampling Design: A total of 40 interviews were conducted. It was decided that 40 in-depth interviews would offer sufficient data for this stage of the research design. A non-probability quota sampling method was used to select respondents for the interviews. The sampling frame was limited to respondents who had agreed at the end of the second phase of the study to be interviewed in a follow-up phase. However, some of these respondents who were selected from the sampling frame were not available at the time of the interview.

Accordingly, the sample was purposively selected to represent high and low risk individuals. The individuals selected for the in-depth interviews were spread across five of the six risk categories across both study areas and, as far as possible, an attempt was made to obtain an equal distribution of men and women across a broad range of ages. The sample was divided into six groups:

Unwanted pregnancy	HIV/STI Exposure	
	High risk	Low risk
High risk	8	8
Medium risk	8	8
Low risk	8	0

The risk of an unwanted pregnancy was assessed from two questions: *Would you like to have a/another child? Are you using a contraceptive method?* A high risk of unwanted pregnancy refers to a situation where no more children are wanted and no contraceptive method is being employed. A medium risk of unwanted pregnancy applies to those cases where no more children are desired and a contraceptive method is being used. Finally, a low risk of unwanted pregnancy is assigned to cases where the respondent wants children. The level of exposure to HIV infection was assessed from two questions: *Have you had sex with a casual partner in the last three years? Did you and <name of casual partner> ever use condoms?* Individuals who had other sexual partners but were not using condoms are at a high risk of HIV infection. Individuals who have other sexual partners but are using condoms are at low risk of HIV infection. Moreover, a low risk of HIV/STI exposure is assigned to those who do not have other sexual partners. In terms of potential risk of HIV infection, an individual may be classified as indirectly at risk because of his/her partner's sexual behaviour.

Field Procedures: The fieldwork for this phase of the study took place at the beginning of February 2000. All the interviews were carried out over a period of one month. Most of the interviews took place during the weekends, although a few interviews were arranged during the weekdays. Usually interviews were arranged for the convenience of the respondents so that the distractions of work and family demands were minimised. This provided an environment that allowed for freedom of expression and the concentration that such an interview required. The length of each interview was approximately two hours in duration.

All the interviews were conducted in Zulu by the same interview team used in the survey. Male and female respondents were interviewed by same sex interviewers. The sequencing of questions followed the general outline used in the focus group discussion but aimed to close the gaps in data by providing greater depth and detail to the study (refer to Appendix 4). The interview guide consisted of specific areas for exploration, with general types of questions. All respondents were given a brief outline of the objectives of the study. Respondents were also assured that these responses would be kept strictly confidential and at no time would their names appear on the report. This gave them the assurance that there would be no negative comeback on them. Interviews were tape-recorded with the permission of the respondent.

Data Analysis: The tapes were transcribed and translated into English by the moderator and note taker. The transcripts of the in-depth interviews were analysed using the same methods outlined for the focus group discussions.

Broadly, the in-depth interviews were used to assess the validity of data collected in the focus group discussions and the survey. More specifically, the purpose of the in-depth interviews was to increase clarity and the depth of response.

2.8 Methodology: Part Two

In the second part of the study, the focus shifts from the individual to the role of services. It focuses on supply-side issues, specifically the progress made in implementing services for managing the twin risks of unwanted pregnancy and STI/HIV. A number of different techniques are used in order to obtain information about what services are integrated and how they are integrated and the implications of

this on the delivery of services. A triangulation of methods was utilised to ensure greater validity of data and also provide a more detailed understanding of the process of integration from the perspective of the client and the provider.

2.8.1 Document Analysis

The document analysis started with an evaluation of national policies in the light of globally endorsed reproductive health policies. The aim was to review briefly the content and context of past and present policies on the provision of FP/MCH and STI/HIV services. The starting point was a brief review of national policy statements, national policy guidelines and national training manuals related to MCH/FP and STIs/HIV. These documents were usually available from the national and provincial departments in the Ministry of Health, which was responsible for FP/MCH and STIs/HIV and were able to provide information about the official policy for dealing with STIs and HIV. Interviews with key informants were also used to fill in any detail required to better understand the policy situation. These interviews were useful in directing the researcher to documents that should be reviewed.

2.8.2 Inventory

Information on accessibility, physical infrastructure, supplies, equipment, and training, IEC material and staffing situation was collected at each facility. The aim of the inventory was to assess the operational capacity of health services currently providing FP/MCH services in order to determine the feasibility of providing integrated services (refer to Appendix 5). In each area, four government facilities were sampled. In Ntuzuma, three public clinics and one government hospital (that are most often used by residents) were selected for the study and in KwaDumisa, the two nearest public clinics and the mobile clinic and the nearest hospital in Scottburg were selected for the study. This study was limited to government facilities because the vast majority of African men and women rely on the government for meeting their health needs. In order to gain access to health facilities, permission was first obtained from the provincial department of health in KwaZulu-Natal to conduct the research. Ethical approval to conduct the study was first obtained before the department of health consented to the research. Once permission was obtained, telephonic appointments were arranged to visit the health facilities. The inventory was completed by observing the facilities that are available and

through discussions with senior staff at the health facility. In most facilities, it was possible to verify that the items exist by actually observing them.

2.8.3 In-depth Interviews with Senior Staff

In-depth interviews were held with senior staff at all government health facilities in the urban and rural site. The aim of the in-depth interviews was to provide a detailed picture of the integration process at the district level. The in-depth interviews provided information on the progress made in implementing policies at the district level, with specific focus on changes in training, administrative and operational systems. The in-depth interviews explored in detail the experiences of staff with programme activities and provided insights into the impact of national policies from the perspective of senior staff. The in-depth interviews also provided some information on the practical implications of implementing integrated services (refer to Appendix 6).

In each selected health facility, one senior staff member was interviewed. The senior member of staff was purposively selected based on their position within the organisation. In most cases, this was the person in charge of FP or MCH services. Informed consent was obtained prior to the interview. An appointment was arranged in order to avoid disrupting the normal activities at the health facility. The senior staff were assured that all their responses would be kept strictly confidential. All the interviews, apart from one who refused, were tape-recorded.

2.8.4 Focus Group Discussions

Focus group discussions were held with providers offering FP/MCH and STI/HIV services. The aim of the focus group discussions was to ascertain providers' perspectives on integrated services. With the advent of the HIV epidemic many FP/MCH providers have had to broaden their focus to include a wide range of reproductive health services. The focus group discussions generated information on their experiences and the advantages and disadvantages with providing integrated FP/MCH and STI/HIV services.

A total of four focus group discussions were held: two in the rural site and two in the urban site. The participants were recruited through direct contact with service providers

at treatment/service facilities. The interview guide for the focus group discussions was the same as the in-depth interviews. All the interviews were conducted in Zulu. The interview was tape-recorded and detailed notes taken during the interview.

The results from the focus group discussions are used to complement the information obtained from the in-depth and semi-structured interviews. It was hoped that the focus group discussions will add to our understanding of the perspective of providers of integrated FP/MCH and STI/HIV services.

2.8.5 Semi-structured Interviews with Providers

Semi-structured interviews with providers offering FP/MCH and STI/HIV services were used to complement the information obtained from the focus group discussions. The aim of the semi-structured interviews was to explore the content of service provision, type of services offered, providers' attitudes, knowledge and professional practices as this is likely to impact on the delivery of services. The semi-structured interviews were used to determine whether service delivery mechanisms deviated considerably from national guidelines. It looked more specifically at compliance with treatment protocols to determine the extent to which policies are implemented at district level. Questions asked of providers included knowledge of appropriate family planning methods, information about current screening practices, attitudes to discussing matters relating to sexual health, provision of information given to clients, training of providers, use of STI management procedures and actual and potential mechanisms for the integration of STI/HIV with FP/MCH services (refer to Appendix 7).

All of the providers interviewed were nurses. The forty providers interviewed had an average of 12 years of experience. All but two of the providers were women. All providers offering FP and MCH services were interviewed individually. In each area, interviews were held with 20 providers at health facilities. The providers selected for the interviews were spread across all the health facilities. All providers were approached individually and asked if they would be willing to participate in the study. All the interviews were conducted in private and the interviews were arranged at the convenience of the providers. Providers were assured that their responses would be kept strictly confidential. Each interview lasted approximately 20 to 30 minutes.

2.8.6 Structured Interviews with Clients

Interviews with providers may sometimes elicit responses that reflect idealised rather than actual behaviour (Simmons and Elias 1994). For this reason it was decided to conduct structured interviews with clients to compare information obtained from the providers with that obtained from clients. Exit interviews were held with 300 clients at health facilities. The sample consisted of 100 clients of FP services, 100 clients of MCH services and 100 clients of STI services. Of the 100 interviews with clients of FP services, 50 interviews were new clients and 50 interviews were re-supply clients. It was decided that the sample size was sufficient to allow for comparison between the different categories of users of services. In general, clients selected for the exit interviews were spread across all health facilities in both the rural and urban area.

The aim of the exit interviews was to provide information about their experiences of health services, the type of services they receive and the type of problems they encounter when they seek health care. It gave clients the opportunity to express their perceptions of the services they received and also provide an opportunity for discovering their expressed needs. Questions asked to clients included motive for the visit, information provided by the provider, types of questions asked by the provider, facilities that the client would like the clinic to provide and the acceptability of some services (refer to Appendix 8). The structured interviews with clients were used to compare the information given by providers with what actually happens in the clinic.

All clients were approached after they had completed their consultation with the provider and asked if they would be willing to participate in their study. The interviewer explained the purpose of the study and assured clients that they were not employed by the health facility. Clients were also given the assurance that their response would be kept strictly confidential. All the interviews took place in a private place, away from providers and other clients. Each interview lasted approximately 20 minutes. A major drawback of exit interview is that it excludes individuals who do not visit health facilities or who are turned away (Simmons and Elias 1994).

2.8.7 Methods of Data Analysis

The focus group discussions and in-depth interviews were tape-recorded and extensive field notes were compiled during fieldwork. The tapes were translated and transcribed. A considerable amount of time was spent reading and developing preliminary codes according to particular themes. The computer package, Ethnograph, was used to assist with data analysis. The data were organised according to advantages and disadvantages of integrated services. The transcripts are used extensively to illustrate particular findings and also provide some interpretations.

The quantitative data was entered using Epi Info and analysed using SPSS. First, univariate analysis was conducted, which consisted mostly of frequency distributions. Bivariate analysis was also used to investigate the association between the dependent and independent variables. The data for the exit interviews was analysed by type of service for which the client had visited the health facility.

2.9 Summary

This study makes use of a diverse range of data collection methods to address the research objectives. The rationale for such a study design was that the use of a combination of methods would complement each other and also enhances the validity and reliability of the study (Simmons and Elias 1994). Recently, there has been a growing awareness of the benefits of combining qualitative and quantitative data methods. The use of a number of data sources may allow for exploration of the some of the main areas of interest from a variety of angles and benefits from the unique insights offered by each (Simmons and Elias 1994). Qualitative methods are appropriate for providing an understanding of the meaning and context of behaviours and the processes that take place within social relationships (Brennan 1992). The research design is usually more open and flexible and this provides an opportunity to explore new avenues of inquiry as they emerge (Brennan 1992). Moreover, it provides an opportunity for exploring in more detail complex and sensitive issues that may not be possible in large-scale surveys. However, qualitative research methods typically rely on relatively small samples, which may not be generalisable (Simmons and Elias 1994). It may also be worthwhile using qualitative data to provide explanations and interpretations for certain results obtained in the quantitative analysis. Quantitative approaches rely primarily on

representative surveys, emphasising coverage and the ability to generalise to larger populations (Simmons and Elias 1994).

2.10 Organisation of the Thesis

This thesis is divided into two parts. The broad aim of the first part of the thesis is to provide insights into the perspectives and behaviour of sexually active individuals with regard to the prevention of unwanted pregnancy and HIV/AIDS. In the second part of the study, the emphasis shifts to the role of services. The broad aim of the second part of the study is to consider how reproductive health programmes are responding to the needs of sexually active men and women. Following this chapter, the next two chapters examine the extent of contraceptive use and the risk of unwanted pregnancy, with Chapter 3 focusing on sexually active men and women and Chapter 4 focusing on couples. Chapter 5 investigates the extent of, and the socio-demographic determinants, of condom use in marital and non-marital unions. The next two chapters look at the perception of risk of HIV infection and factors associated with behavioural change. The purpose of Chapter 8 is to determine the extent of dual protection and its correlates. Having addressed the demand side issues, the following two chapters examine the process of implementing integrated services by focusing more specifically on the perceptions and experiences of providers and clients. In the final chapter, conclusions and policy recommendations are drawn and presented.

Chapter 3

Family Planning and Unmet Need

3.1 Introduction

Recent studies have documented a remarkable decline in fertility in some parts of Africa (Dudley and Pillet 1998; Cohen 1998). At present, South Africa has one of the lowest estimated total fertility rates in sub-Saharan Africa (Kaufman et al. 2000). The decline in fertility is closely related to the increase in contraceptive use. The level of contraceptive use in South Africa is the highest in sub-Saharan Africa (Kaufman 1998).

Many studies have been conducted on the factors influencing adoption of family planning, but most have focused almost exclusively on women. This restriction reflects prevailing assumptions that it is women who bear the physical and emotional costs of childbearing and who are therefore more motivated than men to protect their own reproductive health (Drennan 1998). With a few notable exceptions, men have been viewed as irrelevant and uninvolved in fertility control. Where they have been seen as involved in reproduction, this involvement has usually been viewed negatively in terms of men as obstacles to women's contraceptive use (Greene and Biddlecom 1997).

In the past few years, appreciation has grown of the need to understand the role of men as well as women in family planning (Kimuna and Adamchak 2001; Mbivzo and Adamchak 1991). The major focus of what follows is the examination of the extent of family planning use among men and women and the factors influencing use. Before exploring the use of a method of family planning, it is important to first ascertain knowledge of family planning methods since this is an important precondition for use (Curtis and Neitzel 1996). This chapter begins with an appraisal of knowledge of, and attitudes to, family planning before moving on to past and current use of family planning. It then explores factors determining use in marital and cohabiting unions. Finally, the concept of unmet need is examined.

3.2 Knowledge of Family Planning

A series of questions were asked of sexually active men and women about family planning knowledge, ever use and current use. They were first given a definition of

family planning and then asked to name all the methods that they had heard about. For each method that they recognised, they were then asked if they had ever used this method and if they knew where a person could go to get this method. The intention was twofold: firstly, to clarify what was meant by the term 'family planning' and, secondly to provide information on the general level of knowledge and use.

Table 3.1 presents the percentage of respondents with specific knowledge of contraceptive methods. Respondents are considered to have knowledge of a method if they said that they had heard it either spontaneously or after prompting. It is clear at a glance that knowledge of family planning is universal among men and women, a finding consistent with the 1998 South Africa Demographic and Health Survey (SADHS 1999). Almost all sexually active men and women were able to identify at least one method of family planning. Respondents displayed a greater awareness of modern methods than traditional methods of family planning. Modern methods refer to the following: the pill, IUD, injection, vaginal methods (diaphragm, foam or jelly), condom, female sterilisation or male sterilisation. Traditional methods refer to the following: abstinence, withdrawal, rhythm method or inter-crural sex. Other methods refer to any other method mentioned by the respondent as a means of delaying and/or preventing pregnancy. With regard to knowledge of specific methods, the best known methods were the condom followed by injections and the pill, while the least known were the vaginal methods and the rhythm method. Knowledge of permanent methods was relatively low compared with other modern methods. With regard to permanent methods, more respondents had heard of female sterilisation than male sterilisation.

The injection was the most commonly known method among women and among men it was the condom. Almost 92 percent of respondents spontaneously identified the condom as a method of family planning and knowledge increased to 95 percent after prompting. The fact that some respondents did not spontaneously identify condoms as a method of family planning may be partly related to the association of the method with disease control.

Table 3.1: Percentage of sexually active respondents with knowledge of specific methods of contraception

Methods	Men %	Women %
Any Modern Method	99.4	100.0
Modern Method		
Pill	82.0	96.9
IUD	7.0	45.9
Injections	88.6	99.1
Implants	0.2	0.7
Diaphragm/Foam/Jelly	0.6	0.9
Condom	98.6	91.6
Female Sterilisation	33.3	25.4
Male Sterilisation	6.5	1.4
Traditional Method		
Abstinence	11.9	8.6
Withdrawal	13.3	8.4
Rhythm	0.6	0.7
Thigh Sex	27.6	40.9
Other	4.1	1.4
N	511	582

Apart from the condom, other male methods of family planning are less well known. While women are generally more likely than men to know about the methods that are used by women, it is somewhat surprising to note that men appear to be more familiar with female methods of family planning than male methods. For example, men were more likely to have heard of female sterilisation than male sterilisation. Generally, the withdrawal method was not a well known method and was, in fact, recognised by only 8.4 percent of women and 13.3 percent of men.

Other traditional methods of family planning were also relatively well known, but not as well known as modern methods. Among the traditional methods, thigh sex (a non-penetrative method of sex) was the best known method, which has a long tradition in Zulu sexual practices. Around 34 percent of respondents identified inter-crural or thigh sex as a method of family planning. Surprisingly, women also identified purgatives as a method of delaying or preventing pregnancy. This method is not usually associated with pregnancy prevention.

Breast-feeding was not recognised as a possible method of family planning and few respondents mentioned it. This is probably because, as other studies have reported, that

breast-feeding is associated with the normal responsibility of a mother/or wife and therefore not seen as a method of family planning (Nzioka 1998).

Knowledge of at least one method is an important condition for use of contraception, but knowledge of more than one method is required to make an informed choice and is associated with a greater probability of adopting and continuing use of a method of contraception (Rutenberg et al. 1991). It has been argued that knowledge of five or more methods constitutes a rigorous measure of comprehensive knowledge of contraceptive methods (Rutenberg et al. 1991). Almost 37 percent of respondents identified five or more methods of family planning. Among women, the mean number of methods reported was 4.4 and among men, the mean was 3.8. Table 3.2 presents the percentage of sexually active respondents who knew five or more methods by selected background characteristics. Interestingly, younger respondents were less knowledgeable than older respondents, but this difference was not significant for men. Respondents who were neither married nor cohabiting were also less likely than respondents who were either married or cohabiting to know of five or more methods of family planning. Urban respondents were significantly less likely to know of at least five methods than their rural counterparts. The less educated were also more likely than better educated to know five or more methods, but this difference was not significant.

Table 3.2: Percentage of sexually active respondents who knew five or more methods by selected background characteristics

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	317	25.2	439	41.7**
35 or more	194	31.1	143	55.9
Marital Status				
Married	149	32.2**	169	47.9**
Cohabiting	100	34.0	120	58.8
Neither	262	22.1	293	38.2
Place of Residence				
Urban	163	18.3**	186	25.8**
Rural	348	31.6	396	54.3
Level of Education				
Less than Secondary	138	29.0	188	50.5
Secondary or More	373	26.8	394	42.6
All	511	27.4	582	45.3

Note: **Significant at 1 percent

3.3 Source of Supply of Family Planning

While awareness of methods of family planning is essential, knowledge of a source of supply is also a natural prerequisite for their ultimate adoption and use (Mehyarar 1995). Respondents were asked if they knew where a person could go to get a family planning method. Generally, knowledge of source of family planning supply is very high, as is shown in Table 3.3. Virtually all the respondents who knew of any modern method could also identify a source of supply. Overall, females were slightly more likely than men to know about sources of family planning supply than men. However, the differentials in knowledge of a source of supply were minimal.

Table 3.3: Percentage of sexually active respondents who knew a source of supply for specific methods of contraception

Methods	Men %	Women %
Modern Method		
Pill	79.1	95.4
IUD	6.7	44.1
Injections	84.9	97.9
Implants	0.2	0.7
Diaphragm/Foam/Jelly	0.6	0.5
Condom	96.5	88.7
Female Sterilisation	26.4	22.2
Male Sterilisation	5.7	1.2
N	511	582

3.4 Attitudes to Family Planning

Attitudes to family planning were explored in a variety of ways. First, respondents were asked questions aimed at eliciting their own personal attitudes towards family planning. Nearly all studies have found that contraceptive use is higher among those who approve of family planning than those who disapprove. Respondents were asked if it is acceptable for a couple to use a method to have no more children or to space between births. As expected, women were more likely than men to believe that it was acceptable for a couple to use a method to delay and/or prevent pregnancy.

Table 3.4 shows that the majority of respondents expressed favourable attitudes to family planning. More than eight out of ten respondents felt that it was acceptable for a couple to use a method for spacing and limiting purposes.

Table 3.4: Percentage of sexually active respondents who agree with specific statements about family planning

Statement	Men %	Women %
It is acceptable for a couple to use a method for spacing purposes	87.5	93.7
It is acceptable for a couple to use a method for limiting purposes	85.5	92.1
It is acceptable for a couple to use a method for spacing and limiting purposes	79.1	90.2
N	511	582

Studies have found that one of the reasons women give for not using a method of family planning is partner disapproval (Bongaarts and Bruce 1995; Lasee and Becker 1997; Salway 1994). Respondents were asked whether their partner approves or disapproves of a couple using a method to delay or avoid pregnancy and the results are shown in Table 3.5. The respondent's perception of their partner's approval is surprisingly low given the high level of approval that they expressed towards family planning. Men were more likely than women to perceive their partner as approving of a couple using a method to delay or avoid pregnancy. Appreciable proportions of men and women do not know their partner's attitude to family planning. More than one-fifth of women stated that they did not know if their partner approved or disapproved of a couple using a method to delay or avoid pregnancy. This result suggests that many men and women have not discussed family planning with their partners.

Several studies done in Africa have shown that decisions on fertility are often not entirely an individual effort (Nzioka 1998; Agadjanian 2001). Inter-personal and social networks often influence the decisions made by individuals (Nzioka 1998; Agadjanian 2001). In fact, in rural areas, social networks may complement the activities of the media in accelerating the flow of information. Respondents were asked if they thought their friends or relatives approved of the practice of family planning. Table 3.5 shows that respondents perceived most people they know as approving of family planning, with little differences between men and women. However, appreciable proportions of men and women said that most people have mixed or no opinion about family planning.

Table 3.5: Percent distribution of sexually active respondents by perceived approval of family planning of partner and of 'most people'

Approval of Family Planning	Men %	Women %
Partner's approval of family planning		
Approve	66.0	42.8
Mixed/No Opinion	10.3	16.6
Disapprove	6.1	19.3
Do not know	17.5	21.4
N	509	581
Most people approve of family planning		
Approve	53.2	52.7
Mixed/No Opinion	28.0	34.1
Disapprove	6.9	5.4
Do not know	11.9	7.7
N	511	582

Some beliefs about family planning may serve as a barrier to use. Respondents were asked to state their agreement about two statements to investigate their beliefs about family planning: (A) *Family planning leads to promiscuous behaviour* (B) *It is acceptable for a man/woman to propose using a method to his/her partner*. Table 3.6 shows that men are more likely than women to hold negative beliefs about family planning. Almost two-fifths of men believe that family planning leads to promiscuous behaviour, compared with 24.5 percent of women. The majority of men and women felt that it is acceptable to propose a method of family planning to their partner. However, women were more likely than men to adopt this position.

Table 3.6: Percentage of sexually active respondents who agree with specific statements about family planning

Statement	Men %	Women %
Family planning leads to promiscuous behaviour	40.9	24.5
It is acceptable for a man/woman to propose using a method a method to his/her partner.	81.4	87.3
N	511	582

Attitudes to family planning were explored in some detail in the focus group discussions and in-depth interviews. Both users and non-users of a method of family planning expressed favourable attitudes to family planning as a method of delaying and/or preventing pregnancy. There was also strong support for fertility regulation among both

men and women. Their attitudes were therefore attuned to the idea of contraception being used for family limitation and, indeed, their interest in family planning was largely motivated by the desire to space between births and also to limit family size. When respondents in the in-depth interviews were asked to define family planning, they frequently mentioned birth spacing and preventing further pregnancies, as in the following excerpt:

Family planning means that one must not have one baby after another. One must use family planning to space between babies. When one has a baby, one must wait a few years before having another (Rural Female, IDI #10)

Family planning is used to space between children and also prevent couples from having many children (Urban Female, IDI #17)

Respondents gave many reasons for delaying and/or preventing pregnancy but the main reason is financial. They felt quite strongly that family planning gave them more control over their future. In the focus group discussions, participants pointed out that family planning allowed them to plan the number of children they had and in this way enabled them to lead a better life.

In the in-depth interviews, the majority of those using contraception also explained their use of contraception at the time of the interview largely in economic terms. Both men and women felt that parents should not have more children than they can afford to support and they pointed to the costs involved in raising children. Some of these costs include food, clothing, medical expenses and education.

I use family planning because I am unemployed and I cannot manage to support many children. (Rural Female, IDI #24)

I am using family planning because I do not want too many children, because I am not able to afford too many children (Rural Female, IDI # 23)

Many respondents explained that it is important for families to limit their family size if they want their children to have a secure and stable future. They stated that they wanted to postpone childbearing because it was expensive to raise several children.

The focus group discussions and in-depth interviews demonstrate that, although the majority of men and women expressed very positive attitudes towards family planning, some men are reluctant to use a method of family planning. It became clearer from their comments that the main reason for this reluctance is because they continue to regard family planning as the responsibility of women.

Family planning is a method females use to protect themselves against pregnancy (Rural Male, FGD)

Females should take responsibility for family planning. Guys have little influence on family planning. They do not have a concrete system that they can use for family planning (Urban Male, FGD)

While many respondents are very aware of the benefits of family planning some men feel that family planning leads to promiscuous behaviour. However, this attitude is slightly more prevalent among rural than urban men. These men worry that family planning encourages married women to be unfaithful to their partners without fear of getting pregnant. These sorts of attitudes are most clearly evident from comments in the focus group discussion such as:

Prostitute wives use family planning because they want to get money from other men (Rural Male, FGD)

Most females use family planning because they want to have sex without worrying about getting pregnant (Rural Male, FGD)

The use of family planning has also been hampered by the fear of adverse effects. Some methods of family planning may be perceived as having detrimental side effects. For this reason, some men feel that family planning is best avoided.

3.5 Communication About Family Planning

Partner communication on family matters may influence fertility regulating behaviour (Mbizvo and Adamchak 1991). Communication refers to the verbal exchanges, which occur between couples, and is strongly associated with the adoption and sustained use of

family planning (Nzioka 1998). Nzioka (1998) argues that communication allows couples to challenge strongly held beliefs and also provides them with the opportunity to discuss family size and achieve the desired number of children (Nzioka 1998). Analysis is confined here to married and cohabiting respondents.

In the survey, partner communication was measured by two questions: (A) *Have you and <name> ever discussed whether or not to have a child or how soon to have the next child?* (B) *Have you ever discussed family planning methods with <name>?* The responses of men and women are relatively similar concerning whether they had discussed having children or how soon to have the next child. Overall, 54.7 percent of men and 55.5 percent of women report having discussed whether or not to have a child or how soon to have the next child, as shown in Table 3.7. Of particular note is the large number of married and cohabiting men and women who reported having discussed their fertility intentions at least a few times with their partners. Yet appreciable proportions of married and cohabiting men and women reported not having discussed fertility intentions with their partner.

Table 3.7: Percent distribution of married and cohabiting respondents by the frequency of discussion pertaining to having another child and the spacing of the next child

Frequency of Discussion	Men %	Women %
Many times	30.5	32.2
Few times	22.2	19.1
Once	1.9	4.2
Never	45.3	44.5
N	243	289

Overall, the majority of men and women reported having discussed family planning methods with their partners. In general, men were more likely than women to report having discussed family planning methods, as shown in Table 3.8. Almost three-quarters of men reported that they had discussed family planning with their partners, compared with 59.2 percent of women. Men and women who reported having discussed family planning with their partners were then asked about the frequency of the discussion. Men were also more likely to report more frequent discussion about family planning methods.

Table 3.8: Percent distribution of married and cohabiting respondents by frequency of discussion on family planning methods with their partner

Frequency of Discussion	Men	Women
	%	%
Many times	41.0	23.3
Few times	27.4	27.1
Once	5.3	8.8
Never	27.3	40.8
N	246	289

Table 3.9 shows the percentage of married and cohabiting respondents who had discussed family planning methods with their partner several times by background characteristics. Communication is not significantly associated with age and marital status. Men and women with more than secondary education are significantly more likely to report having discussed family planning than those with less than secondary education.. Moreover, those living in the urban area are more likely to report having discussed family planning than those living in the rural area. However, this association is not significant for men.

Table 3.9: Percentage of married and cohabiting respondents who have discussed family planning methods with their partners at least a few times by select background characteristics

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	82	72.0	168	47.6
35 or more	164	65.2	121	54.5
Marital Status				
Married	147	66.0	169	54.4
Cohabiting	99	69.7	120	41.3
Place of Residence				
Urban	91	67.0	89	61.8*
Rural	155	67.7	200	45.0
Level of Education				
Less than Secondary	85	55.3**	136	39.7**
Secondary or More	161	73.9	153	60.1
All	246	67.5	289	50.5

Note: * Significant at 5 percent **Significant at 1 percent

It is also interesting to investigate whether communication with partner about family planning methods is related to respondent's own attitude to family planning and their perception of their partner's attitude. Table 3.10 shows that respondents are more likely to approve of family planning if they reported having discussed family planning at least a few times than respondents who do not approve of family planning or have mixed

opinions. Moreover, men and women who perceived their partners as approving of family planning are significantly more likely to report having discussed family planning than other respondents. Women who did not know their partner's attitude to family planning are more likely to report that they had not discussed family planning at least a few times than other women.

Table 3.10: Percentage of married and cohabiting respondents who have discussed family planning methods with their partner at least a few times, by approval of family planning

Approval of Family Planning	Men		Women	
	N	%	N	%
Respondent's approval of FP				
Approves	198	72.7**	263	52.9*
Mixed/ Disapprove	49	46.0	26	26.9
Partner's approval of FP				
Approve	173	82.1**	130	70.8**
Mixed/No opinion	20	50.0	57	36.8
Disapproves	21	23.8	58	48.3
Do not know	33	27.3	44	11.4
All	247	67.4	289	50.3

Note: * Significant at 5 percent **Significant at 1 percent

In the in-depth interviews many of the respondents stated that they did discuss family planning with their partner. Most of these discussions were indirect and occurred as a result of concerns about financial problems. It would seem that the economic costs of raising large families make it impossible for men and women to avoid the issue of family planning.

We discussed that I should not have another baby before getting employment, because we would encounter problems and we would not be able to resolve them (Urban female, IDI #18)

Some women felt that they would like to avoid some of the mistakes they had made in the past by planning for their children so that they could give their children a better quality of life. Most would like to postpone childbearing until they had the financial resources to support a child.

We discuss the need to plan for children...If you fall pregnant at any time you may not be able to afford to raise that child properly because you never planned for that baby (Rural female, IDI #5)

We have discussed how long we must wait before having another child and we must stop after we have a certain number of children (Rural female, IDI #16)

A few women reported not having discussed family planning with their partner. They did not see the need for involving the male partner in this decision.

It is my decision and not his. I decided to use contraception because I want to continue with my schooling. (Urban female, IDI #12)

Some mentioned that they have reached an agreement with their partner about their desired number of children and did not see the need to discuss family planning.

We haven't discussed family planning.... We are satisfied about the number of children we have (Rural male, IDI # 11)

Sometimes women feel that discussion with partners is seriously hampered by excessive social and economic demands. This has meant that many respondents are socially and spatially separated from their partners. In his study of men and women in Mozambique, Agadjanian (2001) also found that verbal exchanges do occur between men and women but they are usually brief and deal with socially acceptable, gender-neutral topics when couples are socially and spatially separated during the day. This severely limits the opportunity for shared decision-making, as is demonstrated in the following response:

We do not discuss it because he never has time. He is always at work, or sometimes at his mothers' home (Urban female, IDI #25)

Contrary to the popular belief that women are powerless in reproductive decision-making some women in the urban areas are able to assert their personal preferences. They are challenging culturally defined gender roles, which define men as the dominant role players in fertility decisions. These women gave reasons linked to their reproductive health and rights, and their own health. They felt it was their body and therefore it was their decision.

The decision is mine. I would not discuss it with him because it is my body (Urban female, IDI #5)

Some women said that they did not discuss family planning with their partner because they felt that men only wanted children. These women felt that men did not want to listen to them. Some women therefore do not broach the topic of family planning in order to avoid conflict with their partners.

We don't discuss family planning because men don't want women to use family planning (Rural female, IDI #4)

Some women prefer to use a method without discussing it with their partner. They perceive their partners as disapproving of family planning. Women who perceive their partners as disapproving are more likely to resort to covert use of a method of family planning.

3.6 Ever and Current Use of Family Planning

Ever use

Ever use refers to the use of a method at any time before the interview without any distinction between past use and current use. An ever user may have used more than one method. The level of ever use of a method of family planning was high with almost 76 percent of respondents having ever used a method with any partner. This meant that almost three out of four respondents have experimented with some method of family planning. Not surprisingly, men were more likely than women to report never having used any method of family planning. Almost 85 percent of women reported ever using a method of family planning, compared with 64 percent of men. The 1998 South Africa Demographic and Health Survey also found that almost three-quarters of all women had ever used a method of contraception (SADHS 1999).

For those who had ever used a method, modern methods have been more frequently used than traditional methods. The most commonly used method of family planning was the injection, followed by the condom and the pill. Levels of ever use of certain modern methods are very low. Few respondents reported using vaginal methods and male sterilisation. A small proportion of respondents also reported ever using traditional

methods. Among traditional methods, inter-crural or thigh sex was the most popular method.

Table 3.11 shows notable disparities between men and women in their reported use of various methods of family planning. The injection is the most widely tried method among women and the condom is the most widely tried method among men. Men have a bias towards reporting methods that require their involvement. The South African Demographic and Health Survey also found that the injection was the frequently cited method for all women (SADHS 1999).

Table 3.11: Percentage of sexually active respondents having ever used specific method of family planning

Methods	Men %	Women %
No Method	36.5	14.7
Modern Method		
Pill	8.6	25.9
IUD	0.8	4.3
Injections	19.0	57.7
Condom	46.1	32.3
Female Sterilisation	3.3	7.6
Male Sterilisation	0.6	0.0
Traditional Method		
Sporadic Abstinence	3.5	5.7
Withdrawal	5.5	4.8
Rhythm	0.2	0.2
Thigh Sex	10.4	5.7
Other	1.6	3.1
N	511	582

Current Use

Respondents who had ever used at least one method of family planning were asked if they, or their partner, were currently using any method to prevent or delay pregnancy and were then asked to identify the method and also asked whether any additional method was used. The term 'current' refers to the use of a method at the time of the survey. At the time of the survey, 85 percent of married and cohabiting respondents who reported ever using a method of family planning stated that they were currently using a method. In order for the results to be comparable with other sources, contraceptive prevalence for married and cohabiting respondents was computed. The most remarkable feature is the striking discrepancies in male and female reports of contraceptive use.

Reported contraceptive prevalence for females is considerably higher than their male counterparts. Almost three-quarters of women, compared with 52.5 percent of men, reported currently using a method. This difference will be explored in greater detail in the Chapter 4. The Demographic and Health Survey in South Africa also found high levels of contraceptive use among women. However, it found that 62 percent of women were using a method of contraception, almost all of which were modern methods (SADHS 1999).

Table 3.12 presents the percentage of married and cohabiting respondents who reported using specific methods of contraception. Modern methods are more commonly used than traditional methods. Of those men and women who are currently using a method of family planning, the majority are using a modern method. The most frequently used method of contraception is the injection, followed by the condom and pill. However, striking differences persist in reported use of various methods of family planning by men and women. The injection is the most commonly used method among women. Women are almost two times more likely than men to report using injection. The widespread availability and promotion of injections by the family planning programme under the apartheid government may explain much of the popularity of this method. The condom is the most frequently used method among men. Men are more likely than women to report condom use. It is highly likely that the use of condoms among men is related to its role in preventing STIs/HIV. Apart from the male condom, other methods that involve men are not widely used. Use of permanent methods is relatively low among both men and women. In many African societies, male sterilisation is not widely used so many couples rely on female sterilisation. It is therefore hardly surprising that respondents are more likely to report using female than male sterilisation. The use of a traditional method is minimal. Despite its low level of use, withdrawal is the most popular traditional method.

A few men and women also reported using more than one method. Almost 14 percent of men report using more than one method of family planning, compared with 7 percent of women. The most common combination is the use of the condom with another method of family planning. As Table 3.12 shows most combined use represents the use of the condom with the injection. A few men and women also reported using other methods of family planning for example withdrawal, intercrucal sex, etc.

Table 3.12: Percentage of married and cohabiting respondents currently using specific methods of contraception

Methods	Men %	Women %
No Method	47.5	26.4
Single Method		
Pill	1.8	8.6
IUD	0.3	0.4
Injections	14.7	38.4
Condom	15.0	1.6
Female Sterilisation	3.8	12.8
Male Sterilisation	0.3	0.0
Sporadic Abstinence	0.0	1.2
Withdrawal	2.1	3.8
Thigh Sex	0.5	0.0
Dual Methods		
Condom and Pill	2.4	1.0
Condom and Injection	6.5	3.8
Condom and other modern methods	1.2	0.3
Condom and traditional methods	1.6	0.0
Other	2.0	1.4
N	248	289

Education is usually expected to increase awareness and use of a method of contraception (Kimuna and Adamchak 2001; Koc 2000). The assumption is that educated women may desire a smaller family size than their less educated counterparts and, as a result, are more inclined to act on their preferences (Oppong 1983). The prominent role of education is clearly borne out by the large educational differentials in contraceptive prevalence, as shown in Table 3.13. Among men, the proportion using family planning increases dramatically from 39.5 percent among those with less than secondary education to 59.6 percent among those with secondary or higher education. Among women, the proportion using family planning increases dramatically from 65.4 percent among those with less than secondary education to 81.0 percent among those with secondary or higher education.

As expected, urban respondents surpass rural respondents in the use of a method of family planning but the differences are modest for both men and women. Current use of a method of family planning is usually expected to be lower among the younger respondents because they are more likely to have smaller families and desire more child (Curtis and Neitzel 1996). Table 3.13 shows that the extent of use does not vary drastically by age group.

Table 3.13: Percentage of married and cohabiting respondents currently using any method of family planning, by selected background characteristics

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	81	52.4	168	73.8
35 or more	167	52.6	121	73.6
Marital Status				
Married	149	50.7	169	76.9
Cohabiting	99	55.6	120	69.2
Place of Residence				
Urban	92	53.3	89	76.1
Rural	156	51.9	200	72.5
Level of Education				
Less than Secondary	87	39.5**	136	65.4**
Secondary or More	161	59.6	153	81.0
Desire for more children				
Yes	123	50.4	130	61.4**
No	84	54.8	128	83.6
Unsure	41	53.7	31	83.9
Number of living children				
0-1	95	51.6	121	61.2**
2-4	129	53.5	141	83.7
5 or more	24	50.0	28	75.0
All	248	52.5	289	73.6

Note: * Significant at 5 percent **Significant at 1 percent

With regard to marital status, cohabiting men are more likely than married men to be using a method, but the opposite is observed for women. Those who do not desire additional children are more likely to be current users than those who desire additional children. The relationship between future fertility intentions and use of a method of family planning follows the expected pattern. Current use of a method of family planning is higher among those who do not want more children than those who want children, but this association is not significant for men. The relationship between number of living children and current use of a method of family planning is complicated for women. The use of a method of family planning is highest among those with two to four children. However, those with less than two children and those with more than four children show lower levels of family planning use.

Table 3.14 shows the relationship between current use of a method of family planning and attitude and communication variables. As expected, use of a method of family planning is higher if respondents approved of family planning. Those who approve of

family planning are more likely to be using a method of family planning than those who do not but this relationship is not significant for women. However, the perception of partner as approving of family planning does significantly influence the use of family planning among men and women. The likelihood of contraceptive use is significantly higher if they perceive their partner as approving of family planning. However, it is worth noting that more than half of married and cohabiting women who reported using a method of contraception perceived their partner as disapproving of family planning. A study in Kenya also found that an individual's social network may also influence individual's fertility decisions (Nzioka 1998). The present study found that the use of contraception does not appear to be significantly affected by the attitudes of others towards family planning. In fact, the opposite is observed for men.

Numerous studies have demonstrated a positive association between partner communication on family planning and contraceptive use (Lasee and Becker 1997; Ngom 1997; Roudi and Ashford 1996). Results from Demographic and Health Surveys done in seven African countries have shown that the percentage of women using contraception is higher in the group that has discussed family planning with their partner than the group that has not (Roudi and Ashford 1996). Table 3.14 shows that spousal communication on family planning is associated with more frequent use of a method of family planning. However, it is important to note that contraceptive use is high even among women who have not discussed family planning with their partners.

Table 3.14: Percentage of married and cohabiting respondents currently using any method of family planning, by attitudes to and discussion about family planning

Respondent's approval of FP	Men		Women	
	N	%	N	%
Approve	199	56.8*	263	74.9
Mixed/ Disapprove	49	34.7	26	61.5
Partner's approval of FP				
Approve	173	63.6**	130	86.2**
Mixed/ No Opinion	19	21.1	57	66.7
Disapprove	21	38.1	58	67.2
Do not know	35	22.9	44	54.5
Other's approval of FP				
Approve	132	47.7*	154	75.3
Mixed/No Opinion	65	60.0	98	76.5
Disapprove	18	83.3	20	55.0
Do not know	33	39.4	16	62.5
Discussed FP				
Many	101	69.3**	67	85.1*
Few	65	58.5	78	80.8
Once	13	61.5	25	80.0
Never	67	20.9	118	61.0
All	248	52.5	289	73.6

Note: *Significant at 5 percent ** Significant at 1 percent

Having described the factors affecting the adopting of a method of family planning using bivariate analysis, the relationship between some of these factors and contraceptive use are explored using a standard multivariate logistic regression model. The analysis made use of a number of explanatory factors mainly socio-demographic characteristics. Some of the variables used in the bivariate analysis are not included in the multivariate analysis because of the ambiguity of causality. According to Bijleveld et al. (1998), a temporal ordering of events is needed to determine the direction of causality. It is difficult to determine the direction of causality of the communication and attitudinal variables using cross-sectional data.

Separate logistic regressions are conducted for men and women. In this model, the dependent variable is current use of any method of family planning with married or cohabiting partner. For each observation, the dependent variable takes the value of '1' if the respondent is using a method of family planning and '0' if the respondent is not using any method. The unadjusted logistic regression are used to determine the association of each individual variable without controls on current use of any method and adjusted logistic regression are used to determine the net effects of all variables on

current use of any method. As part of the analysis, all first order interactions are systematically assessed. However, no significant interactions are observed among the major components of the regression equation.

Table 3.15 presents the odds ratios for men and women currently using a method of family planning. The logistic regression shows that education is a significant predictor of the use of a method of family planning by men. Men with secondary or more education are 2.25 times more likely to be using a method of contraception than men with less than secondary education. The remaining explanatory variables do not seem to have a significant independent effect on the use of family planning. After controlling for the other variables, the effect of other characteristics on current use of family planning does not change drastically. Education remains the most powerful predictor of current use.

The level of education also has a positive effect on the current use of a method of family planning of women. Women with secondary or higher education are 2.26 times more likely to be using a method than women with less than secondary. After controlling for the other variables, the effect of education on current use of family planning does not change drastically. Although reported use of a method of family planning is considerably higher among women than men, there are significant variations in use among women with different socio-demographic characteristics.

Current use is directly associated with number of living children and fertility intentions. The analysis suggests that the use of contraception is influenced by the future fertility intentions of women. Women who do not want to have another child are 3.14 times more likely to use contraception than women who do want to have another child. After adjusting for other variables, the effect of fertility preferences on current use of any method of family planning remains significant.

Women with two to four children are more likely to be using a method than women with less than two children. The odd of using a method of family planning are 3.31 times higher among women with two to four children than women with less than two children. After controlling for other variables, the results remained essentially unchanged for women, suggesting that the number of living children, net of other variables, does have a significant effect on use.

Table 3.15: The odds ratios of married and cohabiting respondents currently using a method of family planning: results from logistic regression

Background Characteristics	Men		Women	
	Odds Ratios and 95% confidence intervals		Odds Ratios and 95% confidence intervals	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Age				
Less than 35	1.00	1.00	1.00	1.00
35 or more	0.99 (0.58-1.69)	1.12 (0.62-2.02)	0.99 (0.58-1.69)	0.54 (0.27-1.06)
Marital Status				
Married	1.00	1.00	1.00	1.00
Cohabiting	1.21 (0.73-2.02)	1.57 (0.83-2.98)	0.69 (0.41-1.16)	0.97 (0.50-1.88)
Place of Residence				
Urban	1.00	1.00	1.00	1.00
Rural	0.94 (0.56-1.58)	1.56 (0.84-2.27)	0.84 (0.47-1.49)	1.50 (0.71-3.18)
Level of Education				
Less than Secondary	1.00	1.00	1.00	1.00
Secondary or More	2.25 (1.32-3.84)	2.71(1.47-4.98)	2.26(1.32-3.87)	2.29 (1.16-4.52)
Desire for more children				
Yes	1.00	1.00	1.00	1.00
No	1.19 (0.68-2.07)	1.37 (0.69-2.72)	3.14(1.75-5.63)	3.30(1.51-7.24)
Unsure	1.13 (0.56-2.28)	1.16 (0.56-2.42)	3.49 (1.23-9.88)	3.06 (0.99-9.44)
Number of living children				
0-1	1.00	1.00	1.00	1.00
2-4	1.09 (0.64-1.84)	0.99 (0.53-1.86)	3.31 (1.85-5.91)	2.17 (1.06-4.45)
5 or more	0.91 (0.37-2.25)	0.90 (0.32-2.52)	1.92 (0.75-4.92)	1.21 (0.36-4.04)

3.7 The Level of Unmet Need

In this analysis data from the survey are used to estimate the magnitude of unmet need for contraception among married and cohabiting men and women. An estimate of unmet need is important because it provides family planning managers with useful baseline information on the potential demand for services (Becker 1999). The standard method for estimating unmet need was developed by Westoff (1988) and later refined by his colleagues (Westoff and Ochoa 1991; Westoff and Moreno 1992). In the standard formulation of unmet need, Charles Westoff (1988) includes all fecund, non-pregnant women who are either formally married or living in a union, who are not using any method of contraception but want to delay or postpone their next birth for two or more years or want to stop childbearing.

The standard definition of unmet need has been widely criticised for not taking into account the true extent of the need for family planning (Dixon-Mueller and Germain 1992). Dixon-Mueller and Germain (1992) argue that the standard definition of unmet need assumes that women who are using any form of contraception have their needs met, irrespective of whether the method is effective or ineffective, appropriate or inappropriate. Some contraceptive users could be considered as having an unmet need if they are using an inappropriate or ineffective method, using a method incorrectly or if the method causes unwanted side effects. The same researchers argue that it may be more appropriate to revise the standard measure of unmet need to include those who are using traditional methods but want to avoid or postpone childbearing. However, Bankole and Ezeh (1999:p4) point out that “when the will to limit fertility is strong, traditional methods can be used effectively”. It is true that in many parts of Europe, the declines in marital fertility occurred in the absence of modern methods (Coale and Watkins 1986). In this analysis, current users of any method of contraception (modern or traditional) are assumed to have a met need for family planning. The standard formulation of unmet need has also been criticised for relying exclusively on information pertaining to women and the failure to consider the fertility preferences of men (Becker 1999; Bankole and Ezeh 1999). It is therefore important to understand the extent of unmet need among men and women.

Individuals who are not using any method are classified into two categories: pregnant or amenorrheic and not pregnant or amenorrheic. In order to determine the current pregnancy status of women and the main partner of men, respondents were asked: *Are you (or <name>) currently pregnant?* Only those who answered ‘yes’ are regarded as pregnant at the time of the interview. The survey did not collect information on the wantedness of the current or last pregnancy. All currently amenorrheic women were identified by the response to the question: *Have your (or <name’s>) menstrual periods returned since your (her) last birth?* The amenorrheic category includes all women whose menstrual cycles had not returned. Women who were pregnant or amenorrheic are defined as currently not in need of contraception, as they were not susceptible to the risk of pregnancy (Bankole and Ezeh 1999).

Respondents are further classified into two separate groups: fecund and infecund. The assumption is that all men and women are fecund unless they declare themselves or

their partner's infecund in their response to the question on fertility intentions. Unmet need is separated into two categories: those with an unmet need for limiting births and those with an unmet need for spacing births. Those who do not want to have any more children and are not using a method are said to have an unmet need for limiting births. Those who want to wait for two or more years and are not using a method are said to have an unmet need for spacing births. Those who are either undecided about whether to have a child or when to have a child are regarded as having no unmet need for family planning. Pregnant, amenorrheic and infecund women are not currently susceptible to the risk of pregnancy and therefore have no need for contraception. Some respondents have no need for contraception because they want a child soon.

Figure 3.1 shows the distribution of married and cohabiting men according to their need for family planning. The figure shows that almost 80.8 percent of married and cohabiting men are not susceptible to the risk of unwanted pregnancy by their partner due to the following reasons:

- (1) currently using a method: 52.5%
- (2) pregnant, amenorrheic or infecund: 7.6%
- (3) want a child soon: 4.8%
- (4) undecided: 15.9%

The total unmet need among men is 19.4 percent; of which 6.5 percent have an unmet need for spacing and 12.9 percent have an unmet need for limiting. The level of unmet need for limiting is higher than the need for spacing.

The total demand for family planning is obtained by adding the total unmet need to the met need. The estimated total demand for family planning is therefore 71.9 percent (19.4 percent of unmet need and 52.5 percent of current contraceptive use). This suggests that if every person in a married or cohabiting union uses a method, the contraceptive prevalence rate will increase from 52.5 percent to 71.9 percent. It seems that there is a high demand for contraceptives among married and cohabiting men. Nevertheless, there would be a further increase in contraceptive use if those with an unmet need for limiting and spacing were using a method.

Figure 3.1: Estimates of unmet need for family planning among men

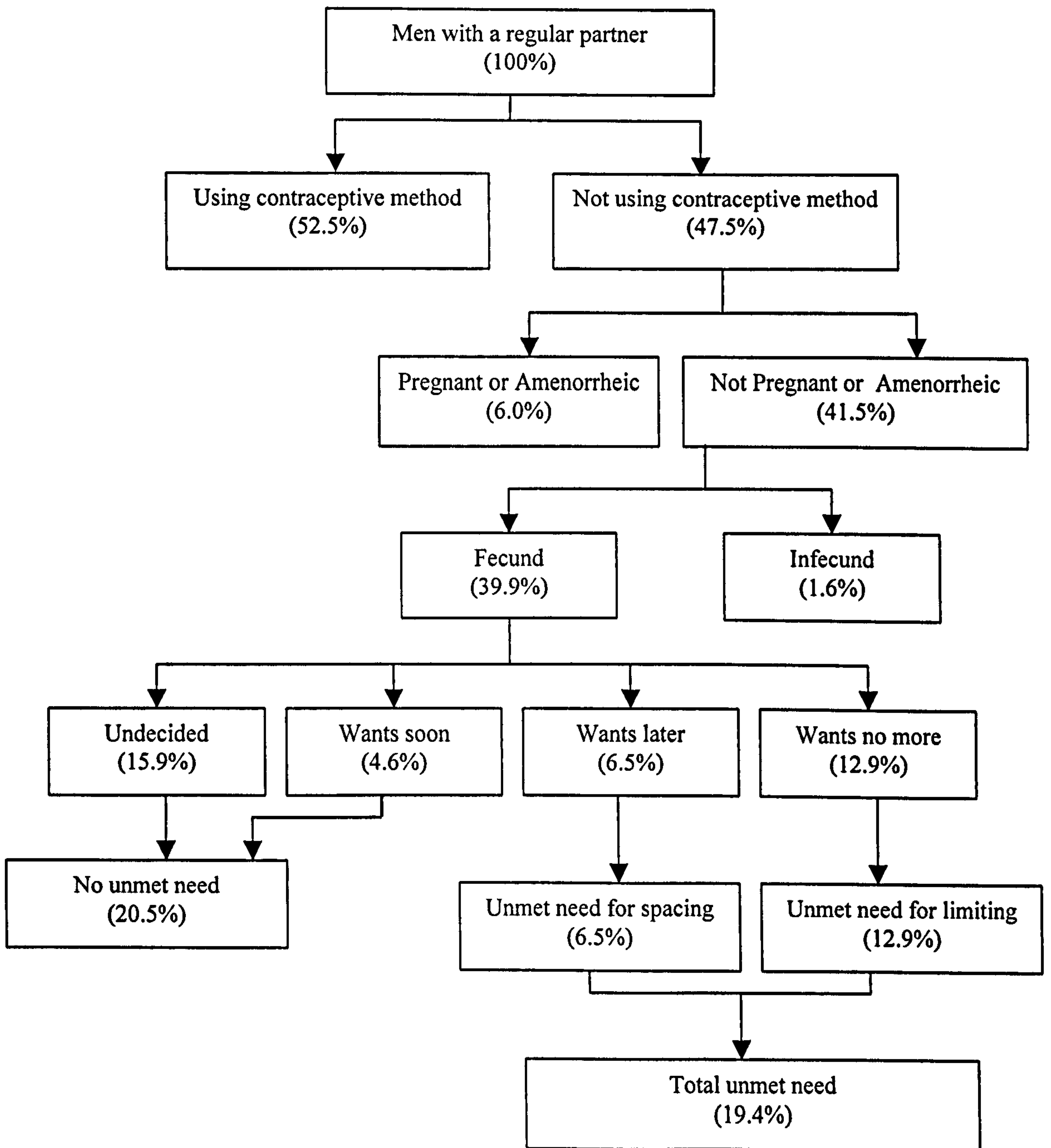


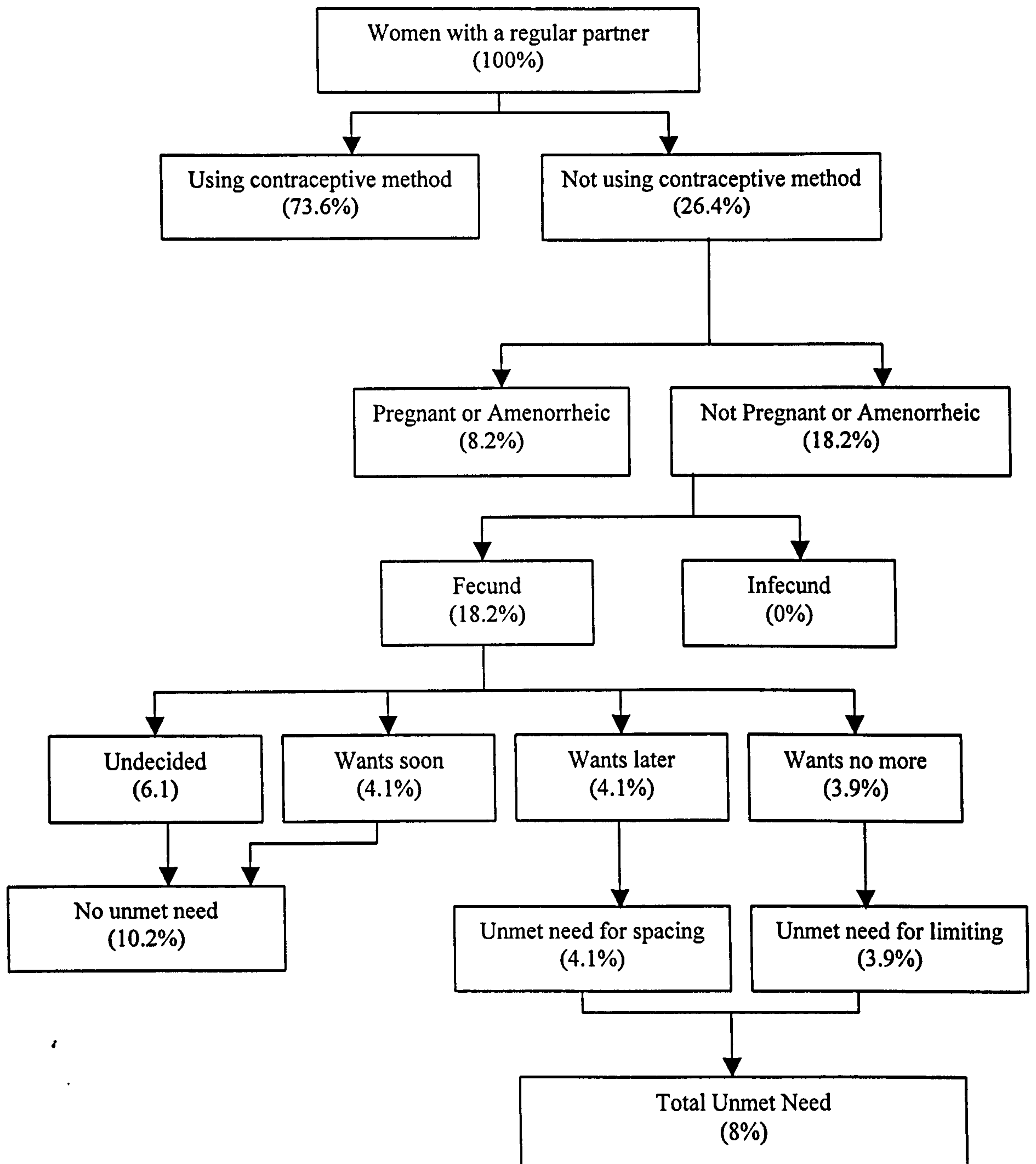
Figure 3.3 shows the distribution of women according to their need for family planning. The figure shows that almost 92 percent of married women are not susceptible to the risk of unwanted pregnancy due to the following reasons:

- (5) currently using a method: 73.6%
- (6) pregnant, amenorrheic or infecund: 8.2%
- (7) want a child soon: 4.1%
- (8) undecided: 6.1%

The total unmet need among married women is 8 percent; of which 3.9 percent have an unmet need for limiting and 4.1 percent have an unmet need for spacing. The level of unmet need for spacing is higher than the need for limiting.

The estimated total demand for family planning is therefore 81.6 percent (8 percent of unmet need and 73.6 percent of current contraceptive use). This suggests that if every married and cohabiting woman uses a method, the contraceptive prevalence rate will increase from 73.6 percent to 81.6 percent. It seems that there is a high demand for contraceptives among married and cohabiting women. Nevertheless, there would be a further increase in contraceptive use if those with an unmet need for limiting and spacing were using a method.

Figure 3.3: Estimates of unmet need for family planning among women



Several studies found that certain variables have significant effects on unmet need for contraception (Westoff and Ochoa 1991; Westoff and Moreno 1992). Table 3.16 gives a general picture of some of the socio-demographic determinants of unmet need among men. The level of unmet need among men varies somewhat by socio-demographic characteristics. Unmet need varies significantly by place of residence. Men in the urban areas are significantly more likely than men in the rural areas to have a higher unmet need. With regard to level of education, the level of unmet need is higher among men with secondary or higher education than men with less than secondary education, but this association is not significant. The level of unmet need increases with the number of children. Men with more than two children are significantly more likely than men with fewer than two children to have a higher unmet need. Married men are more likely than unmarried men to have a high level of unmet need, but this is not significant. Age is not a significant predictor of unmet need.

Table 3.16: Percentage of married and cohabiting respondents having an unmet need, by selected background characteristics

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	81	17.1	168	7.2
35 or more	167	20.8	121	9.1
Marital Status:				
Married	149	22.7	169	7.7
Cohabiting	99	14.1	120	8.4
Place of Residence:				
Urban	92	29.0**	89	9.1
Rural	156	13.5	200	7.5
Level of Education:				
Less than Secondary	87	16.1	136	9.6
Secondary or More	161	21.5	153	6.6
Number of living children				
0-1	95	10.4*	121	9.1
2-4	129	23.8	141	5.7
5 or more	24	33.3	128	14.3
All	248	19.4	289	8.0

Note: * Significant at 5 percent** Significant at 1 percent

The general impression is that socio-demographic differentials tend to be modest for women and none are statistically significant. The relationship between unmet need for family planning and attitude and communication are also analysed. As Table 3.17 shows

the level of unmet need among men is higher if they either disapproved or had mixed feelings about family planning. Among men, the level of unmet need is higher among those who reported that their partner had mixed feelings or they did not know their partner's attitude than other groups. Women who reported that they did not know their partner's attitude to family planning are more likely to have a higher unmet need than other women. Men who perceived others as approving of family planning are significantly more likely to report a higher unmet need than those who perceived others as disapproving of family planning. The level of unmet need is higher among those who reported not having discussed family planning with their partners, but this difference is not significant for women.

Table 3.17: Percentage of married and cohabiting respondents having an unmet need for family planning, by attitudes to and discussion about family planning

	Men		Women	
	N	%	N	%
Respondent's approval of FP				
Approve	199	18.1	262	8.0
Mixed/ Disapprove	49	24.5	26	7.7
Partner's approval of FP				
Approve	173	17.9	130	5.4
Mixed/ No Opinion	20	30.0	57	8.8
Disapprove	21	9.5	58	6.9
Do not know	35	28.6	44	15.9
Other's approval of FP				
Approve	132	26.5**	154	8.4
Mixed/ No Opinion	66	10.6	98	8.2
Disapprove	17	11.8	20	5.0
Do not know	33	15.2	16	6.3
Discussed FP				
Many times	101	19.8**	68	5.9
Few times	65	6.2	78	9.0
Once	13	15.4	25	4.0
Never	67	31.3	118	10.2
All	248	19.4	289	8.0

Note: * Significant at 5 percent **Significant at 1 percent

In order to obtain a better understanding of the determinants of unmet need, logistic regression is used. In this model, the dependent variable is unmet need for family planning. For each observation, the dependent variable takes the value of '1' if there is an unmet need and '0' if there is no unmet need. As part of the analysis, all first order interactions are systematically assessed. However, no significant interactions are observed among the major components of the regression equation. The results of the

logistic regression provide support for the important influence of place of residence and number of living children on the unmet need of men, as reflected in Table 3.18. The expectation that unmet need will be higher in the rural than the urban area is not supported. Among men, the odds of having an unmet need are higher in the urban than rural area. After controlling for the other variables, the relationship remains unchanged. In the logistic regressions, none of the variables emerge as significant predictors of unmet need among women.

Table 3.18: The odds of having an unmet need among married and cohabiting men and women: results from logistic regression

Background Characteristics	Men		Women	
	Odds Ratios and 95% confidence intervals		Odds Ratios and 95% confidence intervals	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Age				
Less than 35	1.00	1.00	1.00	1.00
35 or more	1.29(0.65-2.56)	0.70(0.31-1.57)	1.20(0.51-2.83)	1.11(0.42-2.90)
Marital Status				
Married	1.00	1.00	1.00	1.00
Cohabiting	0.56(0.28-1.10)	0.69(0.31-1.55)	1.17(0.50-2.74)	1.18(0.42-2.3.34)
Place of Residence				
Urban	1.00	1.00	1.00	1.00
Rural	0.38(0.20-0.72)	0.27(0.13-0.59)	0.78(0.32-1.89)	0.59(0.20-1.75)
Level of Education				
Less than Secondary	1.00	1.00	1.00	1.00
Secondary or More	1.39(0.70-2.75)	0.69(0.31-1.57)	0.70(0.30-1.66)	0.59(0.21-1.66)
Number of living children				
0-1	1.00	1.00	1.00	1.00
2-4	2.68(1.24-5.80)	3.07(1.27-7.38)	0.63(0.25-1.61)	0.70(0.25-1.99)
5 or more	4.37(1.50-12.75)	4.92(1.46-16.58)	1.63(0.47-5.64)	1.66(0.37-7.36)

3.8 Summary

It is interesting to observe that knowledge of family planning is virtually universal among men and women. The results show that almost all respondents are able to identify at least one method of family planning. These results are consistent with the results from the 1998 South African Demographic and Health Survey, which found equally high levels of knowledge (SADHS 1999). Respondents are more likely to have heard of modern methods than traditional methods of family planning. Among the most well known methods are the condom, injection and pill.

Respondents expressed overwhelmingly favourable attitudes to family planning. It became clear in the in-depth interviews and focus group discussions that both men and women are very aware of the economic costs of raising large families and they would prefer to have fewer children. They therefore felt quite strongly that family planning improved their quality of life and gave them greater control over their future. However, there are some negative beliefs about family planning, which has limited its acceptance especially among rural men.

It is somewhat surprising that while the vast majority of men and women said that they approved of family planning, a sizeable fraction perceived their partners as disapproving of family planning. Women are more likely than men to perceive their partner as disapproving of family planning. Nearly all studies have shown that the use of contraception is higher among women whose partner approves of family planning. There is a strong association between lack of communication and the belief that partner disapproves of family planning. Those who have not discussed family planning with their partner are more likely to perceive their partner as disapproving of family planning. However, it does not appear to impact negatively on women's contraceptive use. Contraceptive use remains high among women who perceived their partner as disapproving of family planning.

The survey found that communication is high among men and women. More than half of married respondents said that they have spoken to their partners about family planning. Men are more likely than women to report frequent discussion on family planning. In the in-depth interviews and focus group discussions, it became clear that most respondents recognised that communication is important because it allows couples to reach agreement about family planning. However, the results suggest that while it is important for men and women to discuss family planning, some couples usually make decisions without consulting their partners. Sometimes they may consult their partner but when differences occur, the woman's preference usually prevails. This is because most family planning programmes offer methods that woman can use without their partner's consent or knowledge- such as pills, injections etc.

Contraceptive use is high among men and women, although women are substantially more likely than men to report using a method of family planning at the time of the

survey. The percentages using any method are 52.5 percent and 73.6 percent for men and women respectively. Most men and women rely on modern methods rather than traditional methods of family planning. However, the mix of methods reported by women is different to that reported by men. Among women, the most commonly used method of family planning is the injection and among men, the most commonly used method is the condom. A number of potential explanations have been put forward to understand these discrepancies in reports of contraceptive use. Bankole and Singh (1998) attribute the discrepancies to the different fertility intentions of men and women. Other studies explain the differences in terms of lack of communication about reproductive intentions and contraceptive use as well as the use of a method by the woman without her partner's knowledge (Becker 1999, Biddlecom and Fapounda 1998). In the next chapter, male and female reports of contraceptive use will be explored in some detail using the matched data for the couple.

A multivariate analysis of the socio-demographic characteristics influencing the use of family planning was conducted for men and women. The analysis is confined to socio-demographic characteristics because it is difficult to make causal inferences from attitudinal and communication variables using cross-sectional data (Bawah 2002; Lasee and Becker 1997). Several studies have shown that education has a strong positive effect on the use of family planning (Kimuna and Adamchak 2001; Koc 2000). The results of the multivariate analysis show that education is a significant predictor of current use of a method of family planning among men and women. Those with higher levels of education are significantly more likely to report using a method of family planning than those with lower levels of education. The multivariate analysis of the determinants of current use of a method of family planning also show that, for women, use is closely related to fertility intentions. As expected, contraceptive use is lowest among women who want children. The desire to stop childbearing has a strong, positive effect on the use of contraception. Women who want to stop childbearing are more likely to report using a method than other women.

A small but not negligible minority of married and cohabiting women are at risk of an unwanted pregnancy. These women would like to avoid or delay childbearing and are at risk of pregnancy but are not using any method of family planning. The level of unmet need for spacing is higher than the unmet need for limiting, however the difference is small. The level of unmet need for family planning is high in sub-Saharan Africa.

Among countries surveyed by Demographic and Health Surveys, the level of unmet need ranges from 9 percent in Zimbabwe to 36 percent in Rwanda (Westoff 2001). In sub-Saharan Africa, the unmet need for spacing exceeds that for limiting (Westoff and Ochoa 1991 and Westoff and Moreno 1992; Westoff 2001). However, there is some evidence that the unmet need for limiting is increasing in sub-Saharan Africa. The increase has been the most dramatic in Kenya, where it grew from 15 percent in 1977 to 30 percent in 1984 and 46 percent in 1993 (Westoff and Bankole 2000). Urban areas in many developing countries are often associated with higher levels of education, better access to health facilities, family planning and other social services (Kimuna and Adamchak 2000). One would therefore expect that the level of unmet need would be lower in urban areas. In fact, the opposite is observed. The level of unmet need is higher among urban than rural men. The level of unmet need is also higher among those with a larger family size. Men with more than two children are significantly more likely than men with fewer than two children to have a higher unmet need.

This is one of few studies, which has examined unmet need among men. The results suggest that the level of unmet need is higher among men than women. A number of reasons may be advanced to explain the high level of unmet need among men. The overall impression is that family planning is regarded as the female's domain. As a result, some men may not be aware that their partner is using a method of contraception. Moreover, the results suggest that while it is important for men and women to discuss family planning, some couples usually make decisions without consulting their partners. For a variety of reasons, therefore, men may not be aware that their partner may be using a method for delaying and/or preventing and as a result, their level of unmet need may be higher.

Chapter 4

Family Planning and Fertility Preferences: Insights from Matched Couples

4.1 Introduction

In the past few years the importance of focusing on the couple as a means of understanding fertility and family planning has become apparent (Bawah 2002; Ezeh 1993). A study conducted in Nigeria found that “fertility-related estimates of unwanted pregnancies or unmet contraceptive needs may be overstated, when based on data collected from one spouse only” (Bankole 1995:p328). Some studies have found that women who say they want no more children may not protect themselves from the risk of pregnancy because of their partner’s desire to have additional children (Westoff and Bankole 2000). Even when women are educated and highly motivated to use contraception, they may not do so because of opposition from their partners and this can be an important cause of unmet need (Bankole and Singh 1998). Such findings suggest the need for including the contraceptive status and fertility preferences of both men and women in estimating the magnitude of unmet need and its nature.

The main purpose of this chapter is to estimate the magnitude of unmet need and try to understand the main reasons for unmet need among couples. Ezeh (1993:p163) argues that “focusing on the couple offers a unique opportunity to explore how the separate activities and experiences of husbands and wives are unified to produce an outcome”. This chapter uses matched data to analyse response consistency between husbands and wives in relation to contraceptive use, fertility preferences, communication and attitudes to family planning. In addition, it looks more specifically at the role of men in influencing fertility and family planning decisions. As argued by Becker and Costenbader (2001), the ability to assess the male partners’ reports alongside those of their female partners potentially provides a more complete picture of couples’ contraceptive use.

This chapter begins by developing a detailed profile of contraceptive reporting. In so doing, the matched data for husbands and wives are used to explore discrepancies in reporting and the possible explanatory factors that underpin these. This is followed by a section addressing the fertility preferences of husbands and wives. Once again,

comparative analysis is performed to identify differences in husband-wife perceptions and preferences. The section also investigates communication between couples, which is considered to be a salient determinant of fertility preferences. The third section compares and contrasts the attitudes of husbands and wives towards family planning as a method of delaying and/or preventing pregnancy, and examines the influence that communication has with regard to shaping these attitudes. Having done this, the fourth section estimates total unmet need for family planning among couples by relying upon women's accounts of contraceptive use and fertility preferences. The final section of the chapter concentrates on the explanatory factors influencing unmet need.

4.2 Patterns of Contraceptive Reporting

In the survey, men and women were asked: *Are you and <name> currently doing something or using any method to delay or avoid getting pregnant?* Contraceptive prevalence was calculated separately for husbands and wives. As Table 4.1 shows, large discrepancies are found between husbands and wives individual reports of current use of family planning, with women generally reporting greater use than men. Almost three-quarters of wives report that they are currently using contraception, compared with 50.8 percent of husbands. Only 59.3 percent of couples gave consistent responses about their current contraceptive use. In 17.2 percent of couples, both partners said that they are not using a method, while in 42.1 percent both said they are using a method. The kappa index is 0.2, which suggests a poor level of agreement among spouses, although they differ significantly from zero indicating greater agreement than would be expected by chance alone.

Table 4.1: Percent distribution of couples by whether they were using a method of family planning to prevent and/or delay pregnancy

Using a Method of Family Planning	%
Both using	42.1
Wife only	31.9
Husband only	8.8
Neither using	17.2
N	238

Note: Kappa value: 0.2

As with most studies, one spouse's perception of the other's contraceptive use may be quite different from what the other spouse actually reports. Among men who report

using a method of family planning, more than four-fifths of their wives concur with them. Among men who report not using a method of family planning, more than two-thirds (68%) of their wives report that they are indeed using a method. While several possible explanations exist for this discrepancy, the most likely cause is that a large proportion of men do not know that their wife is using a method of family planning.

Table 4.2 shows the methods that are used by men and women. A comparison of the methods that men and women report currently using also reveals large discrepancies. The methods used are almost identical to those already discussed in Chapter 3.

Table 4.2: Percentage of respondents using specific methods of contraception

Type of Method	Husbands %	Wives %
No Method	49.2	25.9
Single Method		
Pill	2.0	9.9
IUD	0.3	0.5
Injections	14.3	37.8
Condom	14.2	1.1
Female Sterilisation	3.8	13.1
Male Sterilisation	0.3	0.0
Withdrawal	2.0	4.4
Abstinence	0.0	0.8
Thigh Sex	0.6	0.0
Dual Methods		
Condom and Pill	2.5	1.2
Condom and Injection	6.3	3.6
Condom and other modern methods	0.8	0.0
Condom and traditional methods	1.7	0.0
Other	2.1	1.7
N	238	238

Note: Other refers to combinations excluding condoms

Table 4.3 presents a more detailed cross-classification of the husband's reported use of specific methods of contraception with the wife's reported use of specific methods of contraception. The husband's reported use of a method is often confirmed by the wife's report when a female oriented method is used. However, agreement is lower for couples where husbands reported using condoms. Of those husbands who report using the condom, less than one-fifth of their wives corroborate their report. A large proportion of wives whose husbands' report that they are relying on the condom report that they are using other methods of family planning.

Table 4.3: Percent distribution of specific contraceptive methods reported by wives, by method specific use reported by husbands

Husband's Report	Wife's Report									Total
	Pill	IUD	Injection	Condom	Female Sterilisation	Withdrawal	Abstinence	Thigh Sex	None	
Pill	69.2	0.0	15.4	0.0	0.0	0.0	0.0	0.0	15.4	13
IUD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	1
Injection	4.1	0.0	73.5	0.0	6.1	4.1	0.0	0.0	12.2	49
Implants	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Condom	6.2	0.0	26.2	18.5	7.7	1.5	1.5	0.0	38.5	65
Female Sterilisation	0.0	0.0	0.0	7.1	85.7	7.1	0.0	0.0	0.0	14
Male Sterilisation	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	1
Withdrawal	0.0	20.0	40.0	0.0	0.0	0.0	0.0	0.0	40.0	5
Abstinence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	1
Thigh Sex	25.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	75.0	4
N	17	1	57	13	21	4	1	0	40	154

Note: some men reported using more than one method of contraception

These discrepancies in the reporting of contraceptive use between husbands and wives are attributable to a range of different factors. Some of these explanations include:

- 1) husbands may be over-reporting and wives under-reporting condom use because they may be interpreting the question differently;
- 2) husbands may be reporting condom use for purposes other than preventing and/or delaying pregnancy;
- 3) husbands are providing socially desirable responses, resulting in an over-reporting of condom use with spouse;
- 4) husbands may be under-reporting the use of other family planning methods because of the belief that family planning is the woman's responsibility;
- 5) husbands may not be aware that their wives are using a method of family planning;
- 6) wives may be over-reporting contraceptive use.

With regard to the first possibility, husbands and wives may be interpreting the time reference of the question on current contraceptive use differently and therefore may be responding differently. In particular, the question may not be clear to those people who use condoms but not consistently. As queried by Becker and Costenbader (2001), it is

uncertain whether or not a couple that often uses condoms but did not at the last sexual act consider themselves current users of the method. In many surveys, it is likely that men may be reporting condom use with other sexual partners. However, this possibility should not be relevant in this study because the survey instrument explicitly asked about use with main named partner.

Second, husbands may be reporting the use of condoms for purposes other than delaying or preventing pregnancy. Both husbands and wives were asked in section seven of the questionnaire following a long series of questions on HIV/AIDS if they had ever used a condom with their spouse. Those who responded positively were then asked about frequency of use, the response categories being 'always', 'occasionally' and 'at the beginning'. As Table 4.4 shows, a high aggregate level of agreement is observed between husbands and wives. More than four-fifths of husbands and wives provide consistent responses about their condom use. Moreover, the kappa statistic shows a moderate level of agreement that exceeds the kappa value for current contraceptive use. It is hardly surprising that few women report using condoms to prevent pregnancy. Condoms are promoted primarily as a method of disease- rather than pregnancy-prevention. Moreover, some studies in South Africa have shown that, in some health facilities, providers do not recommend condoms because they are seen as a less effective method of preventing pregnancy (Abdool Karim et al. 1992c). For these reasons, it is likely that condoms are used for disease-prevention than for pregnancy-prevention.

Table 4.4: Percent distribution of couples who ever used a condom with spouse

Ever used a condom	%
Both using	13.5
Wife only	7.6
Husband only	6.7
Neither using	72.2
N	238

Note: Kappa value: 0.5

The results of the qualitative data provide further evidence that husbands may not be using condoms primarily for preventing and/or delaying pregnancy. Most respondents feel that condoms are acceptable in casual relationships but not in long-term stable relationships. If condoms are used, they are more likely to be used at the beginning of the relationship, because of the uncertainty about the partner's faithfulness and the fear

of acquiring a STI/HIV. Most men and women associate condoms with disease- rather than pregnancy-prevention. This association is a major socio-cultural factor discouraging their use outside of short-term, casual relationships.

You can use it if you don't trust your partner but condoms are not important to married people (Rural Male, IDI #21)

I do not use a condom with my regular partner...I trust her, so there is no need to use a condom with her (Rural Male, IDI #13)

Thirdly, the husband's report of condom use may be influenced by the social desirability of responses. In further exploration, the husband's reports of condom use for family planning is cross-tabulated with his report of frequency of condom use with his spouse as reported in section seven in the questionnaire. Of those husbands who report currently using the condom for family planning, only 52.5 percent report using condoms 'always' or 'occasionally' and 31.1 percent report never having used condoms with their spouse. It is possible that husbands may be over-reporting condom use for family planning in an attempt to appear more modern and more approving of condoms, in which case the spouse's report is more likely to be closer to the truth. Other studies have found that social desirability bias is most likely to occur within an environment that provides extensive publicity in favour of contraception (Zenilman et al. 1995).

Table 4.5: Percent distribution of husbands reporting condom use with their spouses by their reported use of condoms for family planning

Current Condom Use for Family Planning	Report of Frequency of Condom Use in Section Seven					N
	Always	Occasionally	Beginning	Never	%	
Yes	8.2	44.3	16.4	31.1	100	61**
No	0.0	2.2	1.7	96.1	100	177
N	5	31	13	189	100	238

Note: **Significant at 1 percent

Fourthly, given the pervasive belief that family planning is the woman's responsibility, it is highly plausible that husbands may be reluctant to admit to using methods of family planning. It was clear that a sizeable fraction of husbands regard family planning as the responsibility of their wives. The belief that it is the responsibility of women to use family planning to prevent pregnancy also emerges as a factor that discourages open

communication between husbands and wives, as is illustrated by the following comment:

I don't know anything about it [family planning]. My partner uses it. I have heard about it. I just ignore it because it is not my concern (Urban Male, IDI # 32)

The belief that family planning is the woman's responsibility is also confirmed in the survey. Men and women were asked: *Who usually has more influence over whether or not to use a family planning method: the man, the woman or both have equal influence?* Table 4.6 shows that the distribution of responses generally favours wives over husbands. Wives are more likely to report that women have greater influence over family planning and husbands are more to report that family planning is the woman's decision or a joint decision. Less than one-tenth of husbands and wives feel that the man has more influence over family planning. This result suggests that women play a more influential role in the couple's contraceptive use than men.

Table 4.6: Percent distribution of respondents by general influence over family planning

Who usually has the most influence over whether or not to use a FP method?	Husbands %	Wives %
Man	8.9	7.5
Woman	49.2	72.8
Equal	36.0	14.2
Do not know	5.9	5.4
N	238	238

Fifthly, another explanation for the inconsistencies in reporting contraceptive use is that wives may be using a method without their partner's knowledge. Obviously, as Biddlecom and Fapohunda (1998) argue, it is difficult to obtain reliable information on secret use since behaviour that is hidden from the spouse may also be hidden from the interviewer. However, an attempt was made to measure secret use by asking women if their partner knew they were using a method. Females may use a number of methods without their partner's knowledge including the pill, injectables, the IUD, implants, female sterilisation and the rhythm method. Secret use accounts for a large proportion of contraceptive use. Almost one-fifth of wives who are using a method are doing so without their husband's knowledge. This figure is consistent with other studies that have found that covert use by women accounts for between 7 and 20 percent of contraceptive

use in sub-Saharan Africa (Blanc et al. 1996; Rutenberg and Watkins 1997, Biddlecom and Fapohunda 1998).

Among those husbands who reported using any method, almost 11.8 percent of their wives said that they are doing so without their husbands' knowledge while among those husbands who reported not using any method, almost 18.4 percent of their wives said that they are doing so without their husbands' knowledge. Women who say they are using a method of contraception without their partner's knowledge are mostly using injectables, followed by the female sterilisation and the pill, as shown in Table 4.7. Only women who report using female oriented methods were asked if their partner knew that they were currently using a method.

Table 4.7: Percent distribution of wives' contraceptive use by method and type of use

Method	Secret Use	Open Use
	%	%
Pill	13.4	17.5
IUD	1.7	0.5
Injections	68.4	56.9
Female Sterilisation	16.5	23.3
Other	0.0	1.8
N	34	115

Note to the table: The category 'other' includes other methods including withdrawal, abstinence and the condom

In some cases where the wife reports secret use, the husband does not know about the use of contraception. However, in other cases, husbands report that they are indeed currently using a method of contraception. Table 4.8 shows that almost 38.9 percent of the spouses of secret users report that they are using a method of contraception. It is also important to note that 39.0 percent of the spouses of women who are using a method openly report that they are not using a method.

Table 4.8: Husband's Contraceptive Status by Wife's Contraceptive Status (Overt, covert and non-use)

Wife's reported contraceptive use	Husband's contraceptive use		Total	N
	Not Using	Using		
	%	%		
Using openly	39.0	61.0	100	146
Using secretly	61.1	38.9	100	34
Not using	66.1	33.9	100	58
N	117	121	100	238

In their study, Biddlecom and Fapohunda (1998) also found that more than half of the partners of covert users contradicted the perception of secrecy and reported that they were using contraception with their wives but most did not name the same method as their wives. They suggest four explanations for this:

- 1) wives are using a method without their husbands' knowledge and husbands are guessing;
- 2) husbands may have provided socially desirable responses based on what they thought the interviewer wanted to hear or because they wanted to project a modern image to the interviewer;
- 3) husbands may have used the method mentioned with other partners (though the survey question was specific to the union);
- 4) the discrepancies may be due to gender differences in what husbands and wives describe as contraceptive practices.

It is also possible that lack of communication may have contributed to the discrepant responses. Other studies have found that discussion of family planning may also influence the consistency of reporting of contraceptive use. For example, Ezeh (2000) found that an important factor in the consistency of reporting includes whether or not the couple discussed family planning.

Respondents were asked: *Have you ever discussed family planning methods with <name>?* Consistent with the results in Chapter 3, Table 4.9 shows that husbands are more likely than wives to report more frequent discussions on family planning. Among those husbands who reported having discussed family planning at least a few times, almost 40 percent of their wives report that they have not. Moreover, a substantial proportion of husbands whose wives report having discussed family planning state that they have not discussed family planning. These inconsistencies between the wives' and husbands' reports on discussion of family planning suggest that, in some cases, the discussion may have not have been intense and may have had little impact on behaviour, a finding similar to that observed in Ghana (Salway 1994).

Table 4.9: Percentage of wives' reporting having discussed family planning by husbands' reporting of having discussed family planning

Husband's report	Wife's report				%	N
	Many Times	Few Times	Once	Never		
Many Times	33.3	35.4	6.3	25.0	100	97
Few Times	25.8	21.0	11.3	41.9	100	62
Once	21.4	28.6	7.1	42.9	100	14
Never	7.7	26.2	10.8	55.4	100	65
N	56	70	21	92	100	238

Note: Kappa value: 0.09

Consistency of reporting of contraceptive use is greatly enhanced when both partners mention having discussed family planning, as shown in Table 4.10. However, the level of agreement is greatly reduced if only the husband or the wife reports having discussed family planning. It is perhaps worthwhile observing that among those couples where both the husband and wife report not having discussed family planning, use is considerably higher among wives than husbands.

Table 4.10: Level of agreement about having used family planning by level of agreement about having discussed family planning

Discussion on family planning	Contraceptive Use				%	N
	Both Using	Wife Only	Husband Only	Neither Using		
Both report discussion	58.5	22.9	9.3	9.3	100	118**
Wife only	24.1	55.2	3.4	17.2	100	29
Husband only	39.3	28.6	14.3	17.9	100	56
Neither report discussion	5.7	48.6	2.9	42.9	100	35
N	100	76	21	41	100	238

Note: Kappa value: 0.2

Finally, it is possible that wives may be over-reporting their contraceptive use. However, there is no body of evidence to suggest that women may be exaggerating their contraceptive use. Moreover, a number of studies have shown that contraceptive use in South Africa is high among women (SADHS 1999; Kaufman 1998).

To summarise, numerous factors may explain the widespread inconsistencies in the reporting of contraceptive use. The findings suggest that many of these inconsistencies are the result of the over-reporting of condoms and the under-reporting of other methods of family planning by men. Some of the over-reporting of condom use may be traced to the differential interpretation of the reference period for condom use. However, it is also

possible that husbands may be over-reporting condom use because they want to appear modern and because they are using for other purposes. Husbands may be under-reporting the use of other methods of family planning because they feel that it is the woman's responsibility to prevent pregnancy. Moreover, some husbands are under-reporting the use of female methods of family planning because they have not discussed family planning with their wives and as a result, do not know if their wives are using a method of family planning. In addition, some women are secretly using a method to delay and/or prevent pregnancy. On balance, it appears that when it comes to contraceptive use the wife's testimony is the more reliable account of the couple's contraceptive use for the following reasons:

- 1) husbands' reports of condom use are not consistent across sections of the questionnaire;
- 2) family planning is seen as the woman's responsibility by both husbands and wives;
- 3) a large proportion of contraceptive use by the wife occurs without her husband's knowledge.

4.3 Fertility Preferences

An important measure of fertility preferences is whether or not the respondent intends to have another child. Studies have found that fertility intentions are important predictors of contraceptive behaviour (Hopflinger and Kuhne 1984; Bankole and Singh 1998). To determine their future intentions, husbands and wives were asked whether they would like to have another child or if they would prefer not to have any more children. In over one-third of couples, as shown in Table 4.11, both husbands and wives want a child. In general, however, husbands are more likely than wives to state that they want another child and wives are slightly more likely than husbands to state that they want no more children. A sizeable proportion of husbands and wives are also uncertain about their fertility intentions.

Table 4.11: Percent distribution of couples by whether they want another child

Fertility Preferences	%
Both want a child	36.2
Wife only	8.8
Husband only	15.5
Neither want a child/ Do not know	39.5
N	238

Note: Kappa value: 0.4

A cross-tabulation of the fertility preferences of couples shows a moderate level of agreement about fertility intentions. As Table 4.12 shows, among husbands who desire a child, more than two-thirds of their wives concur with them. Agreement is higher among couples that do not want a child. Among husbands who report not wanting children, 74.7 percent of their wives concur with them. However, more than one-fifth of wives, whose husbands want a child, report that they do not want a child or they are unsure.

Table 4.12: Wife's fertility preferences by the husband's fertility preference

Husband's Preference	Wife's Preference			%	N
	Wants child	Wants no more	Do not know		
Wants child	69.9	21.1	8.9	100	123
Wants no more	10.7	74.7	14.7	100	75
Do not know	32.5	45.0	22.5	100	40
N	107	110	31	100	238

Note: Kappa value: 0.4

Husbands and wives who wanted more children were asked: *How long would you like to wait from now before the birth of (a/another) child with <name>?* Men and women who want to have a child in less than two years are said to want a child soon. Those who want to wait for two or more years are said to want a child later. In general, the level of agreement about the timing of the next birth is relatively low. Table 4.13 shows that among husbands who want a child soon, one-quarter of their wives want to delay childbearing. Moreover, a large proportion of husbands and wives are not sure about the timing of the next birth. Wives are more likely than husbands to report that they do not know how long they would like to wait before the next birth.

Table 4.13: Wife's preference about the timing of their next child by the husband's fertility preference about the timing of their next child

Husband's Preference	Wife's Preference			%	N
	Want soon	Want later	Do not know		
Want soon	45.5	25.0	43.8	100	16
Want later	2.7	51.4	45.9	100	37
Do not know	15.2	39.4	45.5	100	33
N	11	36	39	100	86

Note: Kappa value: 0.12

Husbands' perceptions of wives' fertility preferences are compared with wives' reports of fertility preferences. As Table 4.14 shows, husbands' perceptions of wives' fertility preferences differ somewhat from wives' actual reports. Among husbands who report that their wives want a child, more than 70 percent of their wives concur with them. However, almost one-fifth of wives report that they do not want a child. Among husbands who report that their wives do not want a child, almost three-quarters of their wives concur with them. However, nearly one-quarter of their wives report that they want a child or are undecided. Among husbands who report that their wives are undecided about whether or not to have a child, more than half of their wives report that they do not want more children. It is also important to note that substantial proportions of husbands do not know their wives' preferences, which suggests that husbands and wives do not discuss fertility preferences. However, it is also possible that wives may have changed their views over time and this is likely to have influenced husbands' perceptions of their wives' fertility preferences.

Table 4.14: Wife's fertility preferences by the husband's perception of his wife's fertility preference

Husband's Perception	Wife's Preference			%	N
	Wants child	Wants no more	Undecided		
Wants child	71.0	18.3	10.8	100	93
Wants no more	14.5	72.6	12.9	100	61
Undecided	22.7	59.1	18.2	100	21
Do not know partner's desires	44.4	41.3	14.3	100	63
N	107	100	31	100	238

Wives' perceptions of husbands' fertility preferences are compared with the husbands' reports of fertility preferences. As Table 4.15 shows, wives' perceptions of husbands' fertility preferences differ somewhat from husbands' actual reports. Among wives who report that their husbands want a child, more than 70 percent of their husbands concur

with them. However, almost 30 percent report that they do not want a child or are undecided. Among wives who report that their husbands do not want a child, almost 68 percent concur with them. However, nearly one-third of their husbands report that they want a child or are undecided. Among wives who report that their husbands are undecided about whether or not to have a child, half of their husbands report that they do want more children. It is also important to note that substantial proportions of wives do not know their husbands' preferences and that, in this group, nearly two-thirds of husbands report that they want a child. However, it is also possible that husbands may have changed their views over time and this is likely to have influenced wives' perceptions of their husbands' fertility preferences.

Table 4.15: Husband's fertility preferences by the wife's perception of her husband's fertility preference

Wife's Perception	Husband's Preference			%	N
	Wants child	Wants no more	Undecided		
Wants child	71.3	12.6	16.1	100	87
Wants no more	13.2	67.6	19.1	100	68
Undecided	50.0	42.9	7.1	100	14
Do not know partner's desires	65.2	17.4	17.4	100	69
N	123	75	40	100	238

An important factor influencing future childbearing intention is communication between couples. Communication is likely to contribute to a better understanding of fertility preferences. Husbands and wives were asked if they had discussed with their spouse whether or not to have another child or how soon to have the next child. Husbands and wives are almost equally likely to report having discussed fertility preferences with their spouse. Overall, 53 percent of wives and 56.2 percent of husbands report having discussed their fertility preferences with their spouses. Much less agreement is observed about the frequency of discussion on fertility preferences. Among husbands who report having discussed fertility preferences several times with their wives, more than 40 percent do not concur with them, as shown in Table 4.16. Moreover, almost half of the spouses of men who report never having discussed fertility preferences with their wives, report having discussed fertility preferences with their spouses.

Table 4.16: Wife's report of discussion of fertility preferences, by the husband's report of discussions of fertility preferences

Husband's Report	Wife's report				%	N
	Many Times	Few Times	Once	Never		
Many Times	36.1	18.1	2.8	43.1	100	72
Few Times	30.2	26.4	0.0	43.4	100	53
Once	0.0	0.0	25.0	75.0	100	4
Never	27.7	15.8	5.0	51.5	100	101
N	70	43	8	109	100	230

Note: Kappa value: 0.09

Table 4.17 suggests that the frequency of discussion on fertility preferences is a more important factor determining whether husbands correctly predict their wives' fertility preferences than the fact that discussion actually takes place. As evidence for this, those husbands who report having had discussions on a few occasions are actually slightly less likely to correctly predict their spouses' fertility intentions than those husbands who report either having had discussions once only or not at all. In contrast, almost 74 percent of husbands who report frequent discussion on fertility preferences are able to correctly predict their wives' fertility intentions, which is approximately twice as high as for those who report having discussions a few times or once/never. This is quite telling and points to how fundamental it is that discussion needs to happen on a frequent basis.

Those husbands that state that they never/once discussed fertility preference with their spouses appear either to know exactly their wives' preferences or to specify that they do not know. Very few appear to venture guesses as to their wives' preferences. In contrast, it would seem that discussing fertility preferences on a few occasions gives a fair number of husbands a false sense of understanding of what their wives want. Others merely admit that they do not know their wives' desires.

Table 4.17: The ability of husbands to predict wives' fertility preference, by frequency of discussion on fertility preferences

Husband's report of discussion	Perception of Wife's Fertility Preferences			%	N
	Correctly predicting spouses' fertility preferences	Incorrectly predicting spouses' fertility preferences	Do not know partner's desires		
Many Times	73.6	23.6	2.8	100	72**
Few Times	37.0	33.3	29.6	100	54
Once/ Never	40.6	17.9	41.5	100	106
N	116	54	62	100	238

Note: **Significant at 1 percent

Table 4.18 appears to indicate that for wives, in contrast with husbands, discussion itself rather than the frequency of discussion is the important determinant of wives correctly predicting their husbands' fertility preferences. The percentage of wives who are correctly able to predict their husbands' fertility preferences varies quite substantially between those that have never or only once discussed fertility preferences and those who have discussed it more than once. However, the gap between those who discussed it a few times and many times is relatively narrow. As the frequency of discussion increases, so does the extent to which wives report on their husbands' preferences. Wives who report discussing fertility preferences are more likely to report their husbands' fertility preferences, while wives who have not discussed their fertility preferences are more likely to report that they do not know their husbands' desires. However, wives who report more frequent discussions on fertility preferences are more likely to incorrectly predict their husbands' fertility preferences than those who report less frequent discussions.

Table 4.18: The ability of wives to predict husbands' fertility preference, by frequency of discussion on fertility preferences

Wife's report of discussion	Perception of Husband's Fertility Preferences			%	N
	Correctly predicting spouses' fertility preferences	Incorrectly predicting spouses' fertility preferences	Do not know partner's desires		
Many Times	58.7	37.3	4.0	100	75**
Few Times	51.2	20.9	27.9	100	43
Once/ Never	36.4	19.8	43.8	100	120
N	60	109	69	100	238

Note: **Significant at 1 percent

To summarise, a moderate level of agreement is observed between the fertility preferences of husbands and wives. In general, husbands are more likely than wives to be pronatalist, although the difference is modest. Among couples in which there is disagreement, the husband usually wants more children and the wife usually wants no more children. The level of agreement about the timing of the next birth is much lower. A clear gender difference is evident among couples about the timing of the next birth. Husbands are more likely than wives to want the next child sooner. Husbands' and wives' perceptions of their spouses' fertility preferences differ somewhat from their actual reports. Moreover, a substantial proportion of husbands and wives do not know their spouses' fertility preferences. The frequency of discussion on fertility preferences is an important factor determining whether husbands correctly predict their wives fertility preferences. However, discussion itself, rather than frequency, is an important determinant of wives correctly predicting husbands' fertility preferences.

4.4 Attitudes to Family Planning

Husbands and wives were asked about their own approval of family planning as a method to delaying and/or preventing pregnancy. As Table 4.19 shows, and as discussed in Chapter 3, the level of approval of family planning among husbands and wives at the aggregate level is high. In general, however, husbands are less approving of family planning than wives. Almost 80 percent of husbands and 91 percent of wives approve of family planning. At the couple level, the level of agreement is also high. Almost three-quarters of husbands and wives approve of family planning.

Table 4.19: Percent distribution of couples by whether they approve of family planning

Approval of Family Planning:	%
Both approve	74.3
Wife only	17.3
Husband only	6.3
Neither approve	2.1
N	237

Table 4.20 presents the wife's attitude to family planning by the husband's perception of the wife's attitude. Among husbands who perceive their wives as approving of family planning, 92 percent of their wives concur with them. However, among husbands who perceive their wives as disapproving of family planning, all their wives report that they

approve of family planning. Almost 15 percent of husbands do not know their wives' attitude to family planning.

Table 4.20: Wife's attitude to family planning by the husband's perception of the wife's attitude to family planning

Husband's perception of his wife's attitude to FP	Wife's Attitude to Family Planning			%	N
	Approve	Disapprove	Mixed/ No Opinion		
Approve	92.0	1.2	6.7	100	163
Disapprove	100.0	0.0	0.0	100	19
Mixed/ No Opinion	85.0	0.0	15.0	100	20
Do not know	88.6	2.9	8.6	100	35
N	217	3	17	100	237

Table 4.21 presents the husband's attitude to family planning by the wife's perception of the husband's attitude. Among wives who perceive their husbands as disapproving of family planning, more than three-quarters of their husbands report that they approve of family planning, while 22.7 percent report that they were unsure. Again, almost 16 percent of wives report that they do not know their husbands' attitude to family planning. Although in many couples, both husbands and wives appear to hold similar attitudes towards family planning, wives are more likely to perceive their husbands as not approving or undecided.

Table 4.21: Husband's attitude to family planning by the wife's perception of her husband's attitude to family planning

Wife's perception of her husband's attitude	Husband's Attitude to Family Planning			%	N
	Approve	Disapprove	Mixed/ No Opinion		
Approve	83.0	0.9	16.1	100	112
Disapprove	77.3	0.0	22.7	100	44
Mixed/ No Opinion	79.5	0.0	20.5	100	44
Do not know	78.4	2.7	28.9	100	37
N	191	2	44	100	237

Men and women were asked if they had discussed family planning with their spouse. Level of communication about family planning is relatively high. In general, husbands are more likely to report more frequent discussion on family planning than their wives. As Table 4.22 shows, having discussed family planning on a few occasions increases the extent to which wives are able to correctly predict their spouses' attitudes to family planning, compared with those that have discussed family planning once or not at all. Furthermore, the frequency of discussion on family planning has a negative association

with wives incorrectly predicting their husbands' attitude to family planning. Therefore, wives who report discussing family planning on a few occasions are more likely to incorrectly report their husbands' attitudes than couples that had discussed family planning more frequently and less likely than couples that have never or only once discussed family planning. Given the notably high levels of incorrect reporting of spousal attitudes, it may also be noted that discussion does not ensure that respondents are able to correctly predict their spouses' attitudes. In fact, almost 40 percent of wives who report discussing family planning at least a few times are unable to correctly predict their spouses' attitude to family planning.

Table 4.22: The ability of wives to predict husbands' attitude to family planning, by frequency of discussion

Wife's Report of discussion	Wife's perception of husbands' attitude			%	N
	Correctly predicted husband's attitude	Incorrectly predicted husband's attitudes	Do not know partner's desire		
Many Times	66.1	32.1	1.8	100	56**
Few Times	54.3	40.0	5.7	100	70
Once/Never	24.0	46.4	29.5	100	112
N	98	102	38	100	238

Note: **Significant at 1 percent

As shown in Table 4.23, discussing family planning with their spouses at least a few times substantially improves the ability of husbands to correctly predict their wives' attitudes to family planning. More specifically, those who have discussed family planning a few times with their wives are more than twice as likely to correctly report their partner's attitude compared with those husbands who state they had either once or never communicate with their wives on issues of family planning. However, having discussed family planning many times only slightly improves the ability of husbands to correctly predict their wives' attitudes and marginally reduces incorrect predictions relative to those husbands that report discussing family planning a few times. Almost one-third of husbands who have only once or never discussed family planning with their spouse report that they do not know their partner's attitude to family planning. It is also worthwhile observing that almost one-third of husbands who report having discussed family planning less than a few times correctly predict their spouses' attitudes to family planning.

Table 4.23: The ability of husbands to predict wives' attitudes, by frequency of discussion on family planning

Husband's report of discussion	Husband's perception of wife's attitude			%	N
	Correctly predicted wife's attitude	Incorrectly predicted wife's attitudes	Do not know partner's desire		
Many Times	81.3	14.6	4.2	100	96**
Few Times	75.8	16.1	8.1	100	62
Once/Never	34.6	33.3	32.1	100	78
N	152	50	34	100	236

Note: **Significant at 1 percent

To summarise, the level of approval of family planning at the aggregate and couple level is high. In general, wives are more approving of family planning as a method of preventing and/or delaying pregnancy than husbands. However, wives are more likely than husbands to perceive their spouses as disapproving of family planning. Moreover, a substantial proportion of wives do not know their spouse's attitude. Frequency of discussion is an important factor determining whether husbands and wives correctly predict their spouse's attitudes. However, discussion does not guarantee that wives and husbands are able to correctly predict their husbands' attitude. Husbands who report discussing family planning less than a few times are also able to correctly predict their wives' attitude, though to a lesser extent.

4.5 Prevalence of Unmet Need

The prevalence of the risk of unwanted pregnancy or unmet need is calculated using the woman's account of contraceptive use and her fertility preferences. Figure 4.1 shows the distribution of women according to their need for family planning. The figure shows that almost 92.7 percent of couples are not susceptible to the risk of pregnancy due to the following reasons:

- 1) currently using a method: 74.1%
- 2) pregnant, amenorrheic or infecund: 8.1%
- 3) want a child soon: 3.4%
- 4) undecided: 7.1%

The total unmet need among couples is 7.4 percent based on the wife's report; of which 3.4 percent have an unmet need for limiting and 4.0 percent have an unmet need for spacing. The estimated total demand for family planning is therefore 81.5 percent (7.4 percent of unmet need and 74.1 percent of current contraceptive use).

Figure 4.1: Estimates of unmet need for family planning among couples

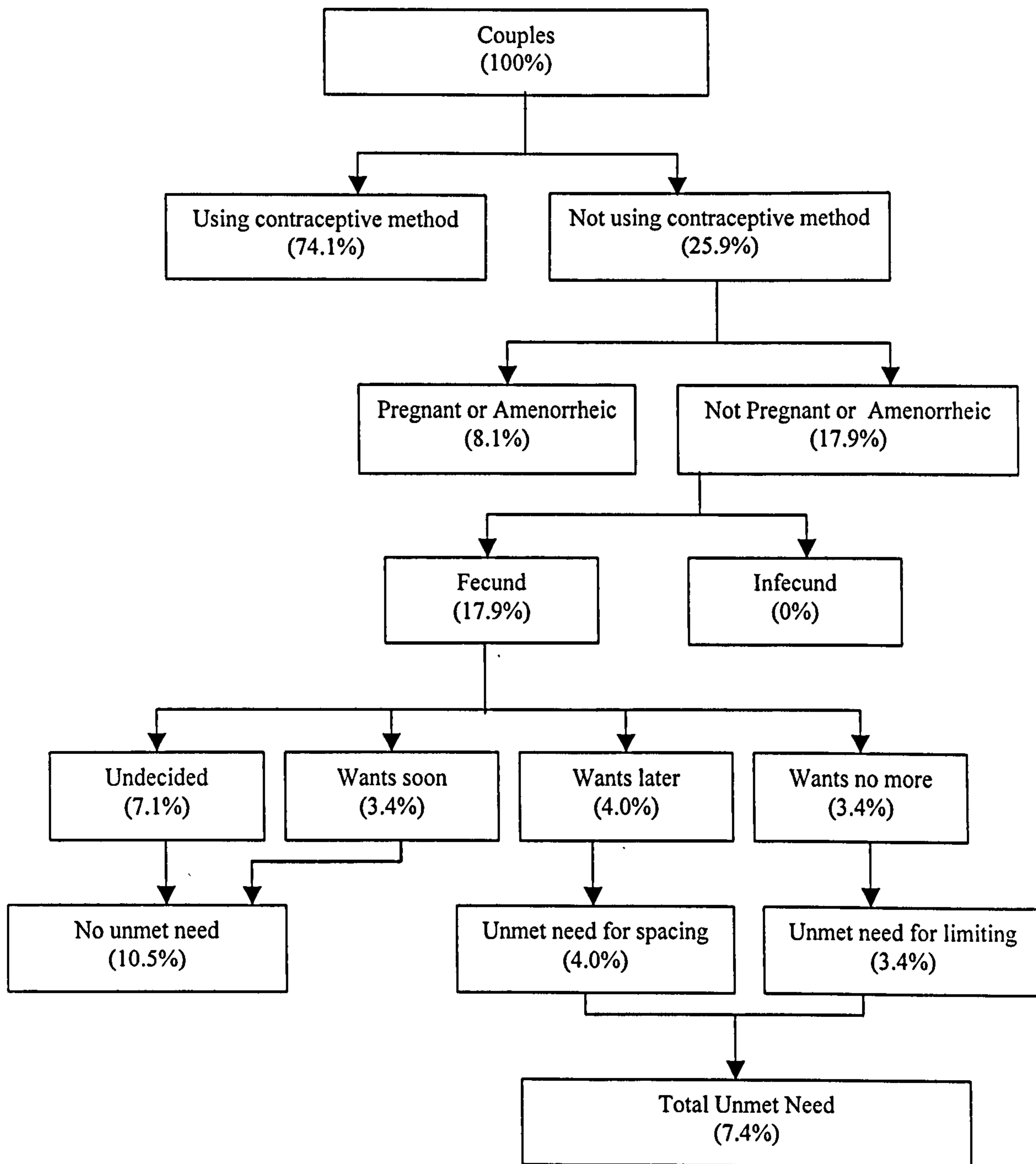


Table 4.24 shows the percentage of unmet need according to socio-demographic characteristics. The general impression is that socio-demographic differentials tend to be modest. Older women have a higher unmet need than younger women, but this is not significant. Overall, the level of unmet need is higher among married than cohabiting women. Moreover, those with four or more children have a higher unmet need than those with less than four children. As expected, the level of unmet need is higher among those with less than secondary education than those with secondary or higher education. In addition, the expectation that unmet need will be higher in the rural than the urban area is supported, but this relationship is not significant.

Table 4.24: Percentage of couples with an unmet need by selected background characteristics

Background Characteristics	N	%
Age		
Less than 35	139	5.0
35 or more	99	10.1
Marital Status		
Married	141	7.8
Cohabiting	96	6.3
Place of Residence		
Urban	76	6.6
Rural	162	8.0
Level of Education		
Less than Secondary	109	9.2
Secondary or More	129	6.2
Number of living children		
0-1	96	7.3
2-3	89	5.6
4 or more	53	9.4
N	238	7.4

Note: NS

Table 4.25 further explores the determinants of unmet need in relation to the husband's views, the wife's perception of these and discussion. None of the associations are statistically significant. Furthermore, many of the observed differences do not accord with theoretical expectations or evidence from other studies. For instance, neither the husband's desire for another child nor the wife's perception of such a desire are linked to an elevated unmet need. Similarly, frequency of discussion shows little systematic relationship with the extent of unmet need. Among couples where the husband reports that he disapproves of family planning, unmet need is slightly higher than for other

couples. However, the wife's perception of his approval is not similarly linked to unmet need.

Table 4.25: Percentage of couples with an unmet need by attitudinal and communication variables

	N	%
Husband's Fertility Intentions		
Wants soon	22	4.5
Wants later	66	3.0
Want no more	75	9.3
Undecided	75	10.7
Wife's perception of husband' fertility preferences		
Wants a child	88	8.0
Undecided	13	0
Wants no more	68	10.3
Do not know partner's desires	69	5.8
Wives' report of having discussed Fertility Intentions		
Many times	75	10.7
Few times	43	4.7
Once/Never	120	5.8
Husband's attitude to FP		
Approves	191	6.3
Disapproves/ Mixed Opinion	46	10.9
Wife's perception of husband attitude to FP		
Approves	113	6.2
Disapproves	43	4.7
Mixed/No Opinion	44	11.4
Do not know	38	10.5
Wife's report of having discussed FP		
Many Times	56	5.4
Few Times	70	10.0
Once/Never	112	7.1
N	238	7.4

Note: NS

In order to confirm the bivariate results, logistic regression is used. In this model, the dependent variable is unmet need for family planning. For each observation, the dependent variable takes the value of '1' if there is an unmet need and '0' otherwise. As part of the analysis, all first order interactions are systematically assessed. However, no significant relationships are observed among the major components of the regression equation, as shown in Table 4.26.

Table 4.26: The odds of having an unmet need by selected background characteristics and husbands' attitudes and preferences: results from logistic regression

	Odds Ratios and 95% confidence intervals	
	Unadjusted	Adjusted
Age		
Less than 35	1.00	1.00
35 or more	2.01(0.75-5.38)	2.00(0.66-6.12)
Marital Status		
Married	1.00	1.00
Cohabiting	0.76(0.28-2.11)	0.95(0.25-3.68)
Place of Residence		
Urban	1.00	1.00
Rural	0.83(0.29-2.44)	0.87(0.33-3.33)
Level of Education		
Less than Secondary	1.00	1.00
Secondary or More	0.67(0.25-1.78)	0.84(0.19-3.63)
Number of living children		
0-1	1.00	1.00
2-3	0.66(0.20-2.19)	0.59(0.15-2.36)
4 or more	1.34(0.42-4.27)	0.84(0.19-3.63)
Husband's Fertility Intentions		
Wants soon	1.00	1.00
Wants later	0.32(0.02-4.26)	0.29(0.02-4.44)
Want no more	0.40(0.09-1.87)	0.42(0.08-2.32)
Undecided	1.18(0.38-3.71)	1.29(0.35-4.74)
Husband's attitude to FP		
Approves	1.00	1.00
Disapproves/Mixed	1.95(0.67-5.68)	1.80(0.58-5.57)

In the focus group discussions and in-depth interviews, unwanted pregnancy was seen as a problem mainly affecting adolescents. Pregnancy was described as being fashionable among young girls. Respondents point to the strong emphasis that is placed on bearing children and the role of social networks in influencing fertility outcomes.

It is a fashion. Many girls say they want a baby but if you look at her background she is not working and her boyfriend may have other girlfriends. She wants a baby because her friends have babies (Urban Male, IDI #23)

The in-depth interviews showed that, although most respondents saw unwanted pregnancy as a problem that mainly affects the youth, it was not confined to them. Many of the women had personal experiences of an unwanted pregnancy: they had fallen pregnant when they did not want a child.

My last pregnancy happened by mistake. I was using a method of family planning, but unfortunately I fell pregnant (Rural Female, IDI #16)

In marriage, it is unlikely that the pregnancy would be regarded as unwanted. Pregnancies are accepted even if they are mistimed or unwanted. Most men recognise that the pregnancy would place an enormous burden on them but they felt it would not be a complete disaster.

In marriage a child is a blessing from God no matter whether you plan for it or not (Urban Male, IDI # 23)

A number of factors may explain the existence of unmet need among women. The results from the in-depth interviews suggest that the principal reasons for not using a method of contraception are male opposition to contraceptive use, lack of access to health services and fear of health effects.

Some women did not want another child but they were not using any method of contraception and therefore were at risk of an unwanted pregnancy. They perceived their partners as wanting more children and were afraid to use a method of contraception. These women reported that they gave in to their partner's demand for more children because of the fear of physical violence

Many women who are abused by men who force them to have children and then don't provide support for their children (Urban Female, IDI#37)

Some women who were at medium risk of an unwanted pregnancy also reported that their husbands refused to listen to them and became angry with the subject of contraceptive use, as is demonstrated by the following comment:

He does not want me to use contraceptives. If I try to tell him that I want to use contraceptives, he just becomes angry (Rural Female, IDI#17)

However, sometimes women who do not want another child may use a method without their partner's knowledge in order to avoid possible conflict in their relationship. Secret

use allows women to assert their personal preferences while avoiding direct confrontation with their partner.

Some women who were at high risk of an unwanted pregnancy were dissuaded from using any method because they experienced side effects from using contraception, as is demonstrated by the following comment:

I have used a number of methods. I experienced some problems with some of the methods that I was using. I started to use an injection called Depo but that injection was not right for me because for two days after using it my feet became so swollen that I could not walk. Then I decided to stop using it (Rural Female, IDI#3)

In South Africa, the cost of purchasing contraceptives is not a contributing factor to unmet need. However, inadequate access to health facilities is a major problem, especially in the rural areas. In the rural area, a mobile clinic visits the community once a month. The fixed clinics are situated some distance from their place of residence and respondents often have to incur travel costs in order to get to the nearest health facility. In the in-depth interviews, several women complained that the providers often shout at clients and generally, do not treat them with respect. They perceived providers as rude and unhelpful and reluctant to assist with their problems.

4.6 Summary

The level of contraceptive use is indeed encouraging, with the majority of men and women in a couple reporting currently using a method to delay and/or prevent pregnancy. However, consistent with other studies conducted in sub-Saharan Africa, this study found fairly large discrepancies in reports of current use of contraception among couples (Becker 1996; Bankole and Singh 1998; Ezeh and Mboup 1997; Koenig, et al. 1984). Contraceptive prevalence for women is higher than that for men. A tendency to over-report male methods and under-report female methods is observed among men. Other surveys have also found that the husband's sole report of condom use accounted for much of the discrepancies (Becker and Costenbader 2001; Koenig et al. 1984).

Several reasons have been put forward to explain these discrepancies. One possibility is that men and women are interpreting the reference period for condom use differently. It is also possible that men are over-reporting condom use because they want to appear more modern to the interviewer. Moreover, given the strongly held belief that family planning is the woman's responsibility, men may be reluctant to admit to using other methods of family planning. Some of the under-reporting of other methods of family planning may be attributed to the use of a method of family planning by the wife without her husband's knowledge. Lack of communication may also have contributed to the discrepancies in reporting of contraceptive use. For a variety of reasons, therefore, the focus is on the woman's report of contraceptive use. Consistent with other studies, it was found that the woman's account is the more accurate and reliable for estimating the couple's contraceptive use (Becker and Costenbader 2001; Biddlecom and Fapohunda 1997).

At the aggregate level, husbands are more likely than wives to want more children, but the difference is modest. A number of studies have found that men tend to desire a larger family size than women (Lasee and Becker 1997; Isiugo-Abaihe 1994). Studies have found that in the case of disagreement between the husband and wife about desired family size, the husband's views usually prevail (Bankole and Singh 1998; Ezeh 1993). However, the present study found that women exert a greater influence over family planning and fertility decisions than men. This is probably because both men and women perceive family planning as the woman's responsibility. In addition, women control a number of highly effective methods of preventing pregnancy.

The survey found that both men and women express favourable attitudes to family planning. Family planning is seen as an acceptable method of spacing and limiting births. However, wives are more likely than husbands to perceive their spouses as disapproving of family planning. Frequency of discussion on family planning does significantly improve the ability of husbands and wives to correctly predict their spouses' attitudes to family planning. Nevertheless, discussion does not guarantee that they are able to correctly predict their partner's attitude.

A small but not negligible minority of couples are at risk of an unwanted pregnancy. However, it is difficult to detect statistical significance because of the sample size and the small number with unmet need. The focus group discussions and in-depth interviews

reveal that unwanted pregnancy is perceived as a major problem, especially among adolescents. However, many of the women admit that they had personal experiences of an unwanted pregnancy. In South Africa, early childbearing is very common among young unmarried women (Makiwane 1998; Preston-Whyte and Zondi 1992). The White Paper on Population Policy for South Africa cited the high incidence of unwanted pregnancy and high teenage fertility as one of the country's major population concerns (Department of Welfare and Population Development 1998).

Studies have found that the level of unmet need is higher among wives whose spouses' disapprove of family planning and among wives who perceive their spouse as disapproving (Casterline et al. 1998). Moreover, studies have found that men are seen as barriers to contraceptive use because they generally desire more children than women (Biddlecom and Fapounda 1998; Isiugo-Abaihe 1994). However, the present study found that none of these associations are statistically significant. Moreover, many of the observed differences are not consistent with the other studies.

A range of factors may contribute to the non-use of contraception by some women who want to avoid or delay children. The qualitative data showed that some women do not broach the subject of family planning because they fear their partner's disapproval. However, some women who perceive their partner as disapproving may use a method secretly in order to avoid possible conflict in their relationship. A study conducted in Uganda found that women felt that open disagreement with their husbands had high social costs and covert use was a way of circumventing an unwanted pregnancy and the social costs of directly opposing their husbands' wishes (Blanc et al. 1996). Some women also reported not using a method because of the fear of side effects. Some methods are associated with weight fluctuations and other painful and sometimes frightening changes, a similar finding to that observed in Kenya (Rutenberg and Watkins 1997). Services may exist, but they are not accessible to clients. Providers may act as barriers to health services. Several women complained about the poor interpersonal relationships between clients and providers. Health facilities have an important role to play in helping women make informed choices.

Chapter 5

Condom Knowledge, Attitude and Use

5.1 Introduction

As the level of HIV infection continues to increase, the condom has an important role to play in curbing the intensity and future impact of the epidemic (Kapigo et al. 1995). Laboratory and epidemiological studies have shown the latex condom to be an effective barrier against HIV and other STIs, if used correctly and consistently (CDC 1998; Cates 2001). A recent NIH report on condom effectiveness concluded that correct and consistent use of male latex condoms effectively reduces the risk of HIV infection in men and women while incorrect, inconsistent use, breakage and slippage inevitably reduce effectiveness against HIV transmission (Cates 2001). When the condom is used correctly, it is also a very effective means of preventing pregnancy, with an estimated 12-month failure rate of 3 percent (Trussel 1998). However, with typical use, the 12-month pregnancy rate is 14 percent, highlighting the importance of consistent and correct use (Trussel 1998). The male condom is the only widely used device that offers dual protection against pregnancy and disease (WHO 2000).

In the mid-1980s, when AIDS first appeared as a major public health problem, relatively small proportions of sexually active individuals in most countries were using condoms (Mehryar 1995). However, recent surveys conducted in a number of countries suggest that condom use is increasing (Ezeh et al. 1996; Kamya et al. 1997; Gregson et al. 1998). The increase in condom use is particularly evident in areas with highly visible condom promotion campaigns (Kamya et al. 1997). Most surveys indicate that condom use is increasing faster in non-marital than marital relationships (Adetunji 2000; Preston-Whyte 1999). Globally, the condom is one of the least frequently used methods of contraception by married couples (Gardner et al. 1999; Ali et al. 2001). In 30 countries with generalised HIV epidemics, the percentage of couples using condoms for contraceptive purposes remained static at about 8 percent between 1983 and 1997 (Ali et al. 2001).

This chapter presents an examination of the extent and determinants of condom use in marital and non-marital relationships among men and women. Identifying the determinants of condom use is crucial for developing appropriate and effective

prevention programmes. Before exploring the use of condoms, it is important to first explore knowledge of condoms since this is a necessary prerequisite for use. This chapter starts by examining knowledge of condoms and sources of supply before moving on to attitudes to condoms. It then explores ever and current use of condoms and identifies significant socio-demographic predictors of condom use among different types of partnership.

5.2 Awareness of Condoms

The survey collected information on knowledge about condoms. Respondents were first asked to name all methods of family planning that they had heard of. If the condom was not mentioned as a response, then a one-line description of the condom was provided and thereafter respondents were asked again if they had heard of it. Respondents are considered to have heard of condoms if they said that they heard of it spontaneously or after prompting.

Table 5.1 shows that knowledge of condoms is almost universal. Nearly 95 percent of respondents had heard of condoms when prompted and unprompted responses were combined. Men were more likely than women to have heard of the condom. As might be expected, the urban group has substantially higher levels of awareness than the rural group. This level of knowledge was similar to the 1998 Demographic and Health Survey conducted in South Africa, which reported that almost 90 percent of women had heard of the condom (SADHS 1999).

Table 5.1: Percentage of respondents who have ever heard of condoms and knew where to obtain them

	Men	Women
Heard of Condoms	%	%
Yes	98.8	91.6
No	1.2	8.4
Know where to obtain condoms		
Yes	96.6	89.6
No	3.4	11.4
N	511	582

A person who has heard of condoms may nevertheless not know much about them, including how to use them correctly (Gardner et al. 1999). This distinction is more clearly demonstrated by the following response made by one male participant in the

focus group discussions: “ *I have never used it [condom] before because I do not know how to use it.*” (*Rural Male, FGD*). Surveys conducted elsewhere in Africa have also found this to be a problem. For example, a study conducted in Uganda revealed that while virtually every respondent had heard of condoms, only about 10 percent knew how to use one correctly (Kamya et al. 1997).

Knowledge of a source of supply is also important for the use of the condom (Mehyar 1995). Respondents who reported knowledge of condoms were asked whether they knew where they could be obtained. The overwhelming majority of respondents who had heard of condoms knew where they could be obtained. However, men were more likely than women to know where to obtain condoms.

5.3 Belief in Condom Efficacy

The belief that condoms can prevent pregnancy and STIs/HIV is an essential first step for their acceptance and subsequent use (Renne 1993). Respondents were asked questions aimed at eliciting their beliefs about the efficacy of condoms in preventing HIV and pregnancy. In general, condoms are seen as more effective at preventing HIV infection than pregnancy (Table 5.2). Nearly 86 percent of respondents agreed that condoms are effective at preventing HIV and 78.2 percent of respondents agreed that condoms are effective at preventing pregnancy.

Table 5.2: Percentage of respondents who agree with specific statements about the effectiveness of condoms

Statement	Men %	Women %
Condoms are effective at preventing HIV	89.4	82.5
Condoms are effective at preventing pregnancy	82.1	74.4
Condoms are effective at preventing HIV and pregnancy	78.9	70.2
N	511	582

Condoms are widely recognised as a method of dual protection against the risk of pregnancy and HIV. Most respondents agree that condoms are effective at preventing both pregnancy and HIV/AIDS. However, men are more likely than women to agree that condoms provide dual protection against the risk the unwanted pregnancy and HIV.

5.4 Attitudes to Condoms

Numerous studies have found that beliefs, both positive and negative, concerning condoms are important determinants of use (Stiffman et al. 1994; Kapiga et al. 1995). Respondents that had heard of condoms were asked to reveal their perception of, and attitudes towards, the condom by expressing their agreement or disagreement with specific statements. Table 5.3 presents the percent distribution of respondents that agreed with these statements.

Table 5.3: Percentage of respondents who agree with specific statements about the use of condoms

Statement	Men %	Women %
It is acceptable for a married couple to use a condom	42.8	53.7
It is acceptable for a married woman to ask her husband to use a condom	46.8	68.7
It is acceptable for a woman who is not married to ask her partner to use a condom	84.6	89.2
To protect themselves against HIV/AIDS or STIs, a married couple can use condoms every time they have sex	47.0	59.4
It is acceptable to use a condom with someone at the beginning of the relationship	86.2	92.4
The only reason to use a condom is because you do not trust your partner	53.5	60.7
Condoms encourage promiscuous behaviour	48.8	32.6
N	511	582

Interesting differences are observed in the perceived appropriateness of the use of condoms within marriage. Many respondents feel that it is acceptable for a married couple to use a condom. However, equally large proportions feel it is not. Men are more likely than women to believe that condoms are not appropriate for use within marriage. Attitudes to condom use depend on the nature of the relationship. It is considered more acceptable for an unmarried woman to ask her partner to use a condom than it is for a married woman to ask her husband. When asked if they considered it acceptable for a married woman to ask her husband to use a condom, 46.8 percent of men and 68.7 percent of women found such behaviour acceptable. By contrast, 84.6 percent of men and 89.2 percent of women said it is acceptable for an unmarried woman to ask her partner to use a condom. More than half of all sexually active respondents feel that the only reason to use a condom is because you do not trust your partner. Women are more likely than men to possess this attitude. This may explain why the majority of

respondents believe that it is easier to use a condom with someone at the beginning of a relationship.

In order to summarise attitudes to condoms, a score was created from responses to seven statements. These items are rated on a three point likert scale that ranges from 1 (disagree) to 2 (mixed/no opinion) to 3 (agree), with negatively worded statements reversed in their scoring. The scores were then summed to provide an overall estimate of attitudes to condoms. The scores range from 7 to 21, with high scores indicating more positive attitudes and low scores indicating less positive attitudes. Reliability analysis was conducted using the cronbach alpha coefficient and corrected item-item total correlation.

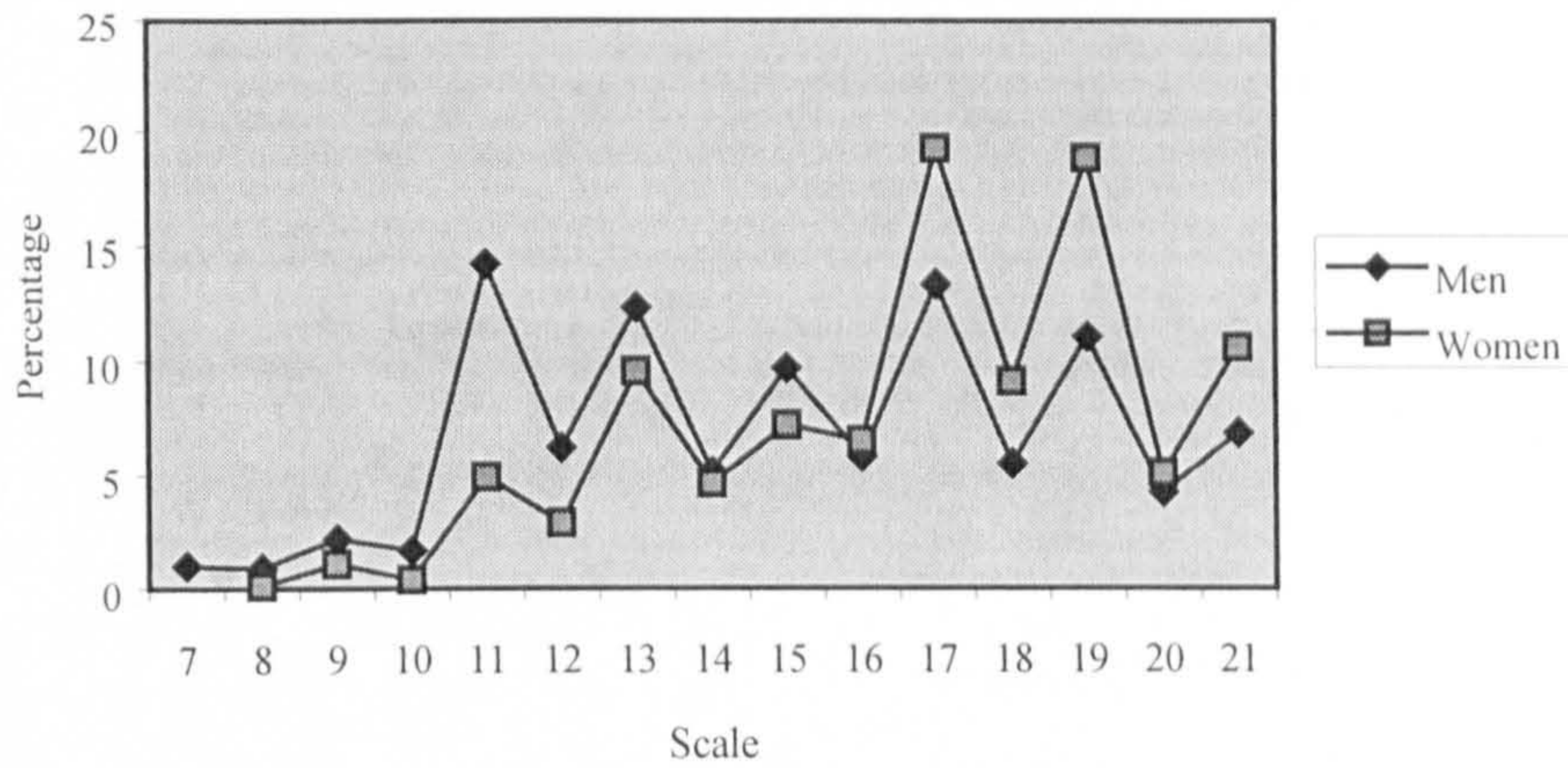
The cronbach alpha coefficient is used to assess the internal consistency of the items of the scale (Cronbach 1951). The scale has an internal consistency reliability coefficient of 0.7. Alpha coefficients range in values from 0 to 1, with higher scores indicating a greater reliability of the scale (Nunaly 1978). The corrected item-item total correlation is an estimate of the degree to which a single item score correlates with the total scale score with that item removed (Binkley et al. 1999). Table 5.4 shows the correlation between each item and the sum of the score ranged from 0.2 to 0.6 but the alpha-if-deleted score showed virtually little variation, ranging between 0.6 and 0.7. It was therefore decided to retain all items in a single summary scale.

Table 5.4: Item-Item Total Correlation and Alpha if deleted for specific statements on condoms

Statement	Item-Item Total Correlation	Alpha if item deleted
It is acceptable for a married couple to use a condom	0.6	0.6
It is acceptable for a married woman to ask her husband to use a condom	0.6	0.6
It is acceptable for a woman who is not married to ask her partner to use a condom	0.3	0.7
To protect themselves against HIV or STIs, a married couple can use condoms every time they have sex	0.4	0.6
It is acceptable to use a condom with someone at the beginning of the relationship	0.2	0.7
The only reason to use a condom is because you do not trust your partner	0.3	0.7
Condoms encourage promiscuous behaviour	0.4	0.6

A quick glance at Figure 5.1 shows that women tend to hold more positive attitudes to condoms than men. The scores for women are considerably higher than the scores for men, indicating more favourable attitudes to condoms. Men tend to dominate at the lower end of the scale while women tend to dominate at the higher end of the scale.

Figure 5.1: Percent distribution of scores on an attitudinal scale



In order to determine the factors influencing attitudes to condoms, an analysis of variance (ANOVA) was conducted. The mean scores for males and females are shown in Table 5.5. With regard to age, one would expect more favourable attitudes among younger respondents. The mean scores of younger respondents are higher than the mean scores of older respondents, but this relationship is not significant for men. The mean scores of the unmarried are higher than the married. Among both men and women, those who are not living with their partner had higher mean scores than those who were living with their partner. Education is a significant predictor of more positive attitudes to condoms. Those with secondary or higher education have higher mean scores than those with less than secondary education. Similarly, the urban-rural differentials conform to expectations. Those living in the urban area have higher mean scores than their rural counterparts. The same difference is observed for men and women. However, this relationship is not significant for men.

Table 5.5: Mean scores on attitudes to condoms by selected background characteristics

Background Characteristics	Men	Women
Age		
Less than 35	15.16	16.92*
35 or more	15.10	16.23
Marital Status		
Married	14.86	16.10**
Cohabiting	15.13	16.60
Neither	15.29	17.17
Place of Residence		
Urban	15.34	17.37*
Rural	15.04	16.40
Level of Education		
Less than Secondary	14.29**	15.42**
Secondary or More	15.45	17.30
N	511	582

Note: *Significant at 5 percent **Significant at 1 percent

Attitudes to condoms were explored in more detail in the focus groups and in-depth interviews. The condom is widely recognised as a method of preventing pregnancy and disease but it is not a popular method. Condoms are more likely to be associated with disease- rather than pregnancy-prevention.

Both men and women expressed a variety of fears about condoms. A common complaint is that condoms interrupt sexual activity, cause discomfort and ruin the excitement of flesh-to-flesh contact.

I used it once but I was so embarrassed. I did not enjoy what I was doing. Your mind tells you that you are wearing a plastic (Urban Male, FGD)

I tried to use it once but I couldn't feel anything. I couldn't enjoy what I was doing. When using a condom you cannot reach a climax and enjoy sex (Rural Male, FGD)

Condoms need to be changed after each and every round of sex (Rural Male, IDI #20)

Some men expressed scepticism about the effectiveness of condoms as a strategy for preventing HIV transmission because, they argued, of their tendency to tear or break during sexual intercourse.

Condoms are not 100 percent safe. They can have holes and may burst during sexual intercourse (Urban Male, FGD)

They feared that condoms could be damaged during sexual intercourse and become lodged in a woman's body and they worried about the potential side effects and health risks for women.

Condoms may tear or burst inside a vagina and may lead to death (Rural Male, FGD)

Some women also argued that men dislike condoms because it reduces sexual pleasure and interferes with the male desire to have many children.

We beg our boyfriends to use condoms but they say that they don't want to throw their babies in the bin. Others say they won't eat a sweet in a plastic (Rural female, FGD)

Some women feel that condoms are less effective at preventing pregnancy because they are controlled by men. Many women feel that they would prefer a method they could control, as it allows them to satisfy their own needs while avoiding direct confrontation with their partner.

Most contraceptive methods are largely for use by women and hence are compatible with the commonly held view that the prevention of pregnancy is the woman's responsibility. As a way around the problem, female respondents expressed the need for female condoms. As one female participant stated:

We know about condoms and some people use them. We would like to see those for females also made readily available (Rural Female, FGD)

Many women see female condoms as providing women with greater control over their sexuality and also, an alternative should their partners refuse to use a condom.

Condoms are more commonly associated with non-regular rather than regular relationships. In regular relationships, many people do not consider themselves at risk because they trust their partners.

I do not use a condom with my regular partner...I trust her, so there is no need to use a condom with her (Rural Male, IDI # 13)

Both men and women feel that it is important to always use condoms with non-regular partners because of the fear of STIs (including HIV/AIDS).

I would always use condoms because casual sexual partners might be dishonest. He may have lots of other girlfriends (Rural Female, IDI # 17)

A major disadvantage of condoms is that use depends heavily on both partners' cooperation. Many of the female respondents reported negative attitudes on the part of their partners to the use of condoms.

Our partners refuse to wear condoms. They say they don't want plastic. They want flesh-to-flesh. They don't trust us when we tell them about condoms (Rural Female, FGD).

Resistance to condoms is not exclusively a male phenomenon. The focus group discussions found that the women's complaints mirrored the men's in that both sexual satisfaction and issues of trust played a part.

Girls say that they need not eat a sweet that is still wrapped in plastic (Rural Male, FGD)

Sometimes if you use a condom with your girlfriend she will think that you don't trust her. Sometimes you will want to please her so you won't use a condom (Urban Male, FGD)

Condoms are far more likely to be used in the beginning of a relationship or in relationships where trust has not been established. Condoms are less acceptable in marital unions because of their association with infidelity. For some respondents, condoms are not acceptable in marital unions unless they perceive a need for protection against infection.

Condoms need to be used if your husband is in love with several women and staying in another place. When he comes back home, I will need to protect myself from him (Rural Female, IDI #23)

The perception that condoms encourage promiscuity is likely to contribute to their image as unsuitable for long-term, ongoing sexual relationships. In both urban and rural areas, men are more likely than women to associate condoms with promiscuity. It became clear that women who request condom use are frequently viewed in a negative light. They are usually perceived as promiscuous. As one male participant indicated:

If my girlfriend gave me a condom I cannot accept it. This means she is a prostitute (Rural Male, FGD)

Women who suggest condom use are often seen as sexually available or ready for sex. Such beliefs have been found to produce a strong negative attitude to past condom use and to current condom use (Edem and Harvey 1995).

Many respondents specified that condoms are only acceptable in marriage for the purpose of preventing pregnancy.

It is important to use a condom with a regular partner if you do not want a baby (Urban Female, IDI#18)

A man uses a condom with his regular partner when he does not want to have children (Rural Male, IDI#6)

One urban male respondent stated that he used the condom with his wife to prevent pregnancy because she was not able to use another method of family planning.

Some rural females stated that they would consider using condoms because it provides dual protection against unwanted pregnancy and STIs/HIV.

I would be happy to use it because the condoms serve both purposes, whereas family planning methods only prevent pregnancy, not STIs/HIV (Rural female, IDI #34)

I will feel safe because I am protected against unwanted pregnancy and AIDS (Rural female, IDI#29)

Some men felt that they did not need to use condoms because they are in a monogamous relationship and their partner is using a highly effective method of preventing pregnancy.

I don't need to use a condom with my regular partner because we trust each other and we are using the injection for protection against pregnancy (Rural Male, IDI#1)

I don't see the need of using condoms if she is using a method of contraception to avoid getting pregnant. I am not sleeping around and my partner is not sleeping around (Urban Male, IDI#23)

5.5 Communication about Condoms

In the survey, information was obtained on two aspects of communication about condoms: occurrence and frequency. Respondents that had heard of condoms were asked if they had ever discussed condoms with their partner and also, the frequency of the discussion (see Table 5.6). Couple communication about condoms is relatively uncommon. Less than half of respondents had ever discussed condoms with their married or cohabiting partners. The differences between men and women in reporting discussing condoms are small and not statistically significant.

Table 5.6: Percent distribution of married and cohabiting respondents according to frequency of discussion of condoms with their married or cohabiting partner

Frequency of Discussion	Men	Women
	%	%
Many Times	12.5	10.7
Few Times	24.8	24.5
Once	8.8	10.2
Never	53.9	54.6
N	248	289

Communication on condoms does not occur frequently. Few respondents report having discussed condoms many times with their partner. Of those who have discussed condoms, almost a third report having arguments or disagreements about condom use. Women were more likely than men to admit to having arguments or disagreements about condom use. Table 5.7 shows the percentage of respondents who have ever discussed condoms with their married or cohabiting partner by selected background characteristics. Among men and women, younger respondents are more likely to report having discussed condoms with their partner than older respondents. However, this relationship is not significant. Married respondents are less likely than cohabiting respondents to have discussed condoms with their partners, but this relationship is only significant for men. Education and place of residence emerge as significant predictors of communication. The urban and more educated respondents are significantly more likely than rural and less educated respondents to have discussed condoms with their partners.

Table 5.7: Percentage of married and cohabiting respondents who have ever discussed condoms with their married or cohabiting partner

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	81	51.3	168	49.1
35 or more	167	43.7	121	40.5
Marital Status				
Married	149	39.6*	169	41.4
Cohabiting	99	56.1	120	50.8
Place of Residence				
Urban	92	69.6**	89	72.7**
Rural	156	32.3	200	33.5
Level of Education				
Less than Secondary	87	25.6**	136	23.5**
Secondary or More	161	56.9	153	64.7
N	248	46.1	289	45.5

Note: *Significant at 5 percent **Significant at 1 percent

The focus group discussions and in-depth interviews found that couples rarely discuss matters related to sexual and reproductive health. Condoms are not seen as an appropriate topic of discussion. Powerful social and cultural taboos prevent men and women from talking about condoms.

We don't talk about condoms because she knows that I will ask her who is teaching her that (Rural Male, FGD)

For many women, negotiating condom use depends on the strength of the ties that bind their partners to them. It is easier for a woman to ask her partner to use a condom when they are not married.

I can ask him to use a condom and I don't think that he would refuse because I am not his wife (Rural Female, FGD)

The introduction of condoms in a stable, on-going relationship may undermine the partner's trust and sometimes lead to accusations of infidelity. If a man should ask his regular partner to accept a condom, it may imply that she has been unfaithful.

I will not use a condom with my wife. If I have a casual relationship or if I have lots of girlfriends then I will use a condom (Urban Male, FGD)

I trust my wife and she trusts me therefore I will not use a condom with her. Condoms indicate that we do not trust each other (Rural Male, FGD)

Communication usually occurs from the man to the women, and when the woman suggests condom use it is likely to lead to conflict, misunderstanding and suspicions of infidelity and violence.

If the husband does not want to use a condom she can refuse to have sex but men are all the same. The man might beat her or demand sex. You end up having sex eventually (Urban Female, FGD)

You cannot refuse because he might leave you and go for other women (Rural Female, FGD)

If the woman was to suggest condom use, her male partner would think that she suspected him of having other sexual partners and this may create misunderstandings and conflict in the relationship. If she is wrong and accuses him unjustly there is the risk of offending him and him reacting violently.

Some women felt that they are able to convince their partners to use a condom. However, they admitted that they are likely to face some resistance to condom use.

He may at first refuse to use a condom but, in the end, if I explained why I wanted him to use it, he might listen to me and agree to use a condom (Rural female, IDI#33))

A few women said that they would refuse to have sex with their partners if they were not able to convince them to use a condom. Contrary to the popular belief that women lack power in reproductive decision-making, some women are able to assert their personal preferences. They feel that they had the right to protect themselves against HIV infection.

I have a right to refuse sex when I do not feel like it. I should have sex when I want to (Urban Female, IDI#28)

In the focus group discussions, some urban males also reported experiencing resistance from their female partners. Faced with partner resistance to condom use, some men are forced to resort to covert measures to protect themselves and their health and may use condoms without the knowledge and consent of their partner. In this way, he is able to avoid direct confrontation with his partner.

Sometimes you feel you need to use it but the other person won't feel comfortable about it. In some cases, I will use it and put it on while I am in the toilet or under the blanket. Some others wait until it is dark (Urban Male, FGD)

Some men and women declared their right to adopt condoms, irrespective of what their partners felt, given their responsibility to protect themselves against HIV. For them, condom use is non-negotiable. They feel quite strongly that they should assert their

needs and assume control over their lives. For these people, the desire to protect themselves against the risk of HIV infection is the major reason for condom use.

5.6 Ever and Current Condom Use

Ever Use

A distinction is usually made between two forms of condom use: ever use and current use. Almost two-fifths of respondents reported using the condom at least once with any partner. Not surprisingly, the level of ever use reported by men far exceeds that reported by women. Table 5.8 shows that the largest male-female differences in condom use is found in the rural area, where the number of men reporting ever use outnumbers women by a factor of almost 2 to 1. The sex differentials favouring men, in reporting ever use, holds across both urban and rural areas.

It might be expected that condom use will increase with age, simply because of cumulative lifetime exposure to opportunity and need (Mehyar 1995). The study, however, found the opposite. The younger age group record a higher level of condom use than the older age group. Generally, men and women under 35 years are more likely than older respondents to have tried condoms. This pattern suggests that condom use is a relatively new phenomenon.

Table 5.8: Percentage of sexually active respondents who have ever used a condom with any partner by selected background characteristics

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	317	57.1**	439	36.4**
35 or more	193	28.0	143	19.6
Marital Status				
Married	149	20.1**	169	18.9**
Cohabiting	100	43.0	120	30.8
Neither	262	62.2	293	40.6
Place of Residence				
Urban	163	50.9	186	46.8**
Rural	348	44.0	396	25.5
Level of Education				
Less than Secondary	138	26.8**	188	11.2**
Secondary or More	373	53.1	394	42.4
All	511	46.3	582	32.2

Note: *Significant at 5 percent **Significant at 1 percent

Mehyar (1995) argued that if condoms are used mainly for family planning purposes, one would expect that condom use would be much higher among the currently married. However, in this study, experience of condoms is much lower among married than among cohabiting and single respondents. Urban, educated populations with their greater exposure to new ideas are expected to have a higher propensity to use condoms. Results conform to these expectations. Table 5.8 shows that condom use is generally significantly higher among the urban, educated than the rural and less educated. Respondents with secondary and higher education are almost twice as likely as those with lower than secondary education to report ever using the condom. The same general pattern is observed for men and women. Similarly, a larger proportion of urban respondents than rural respondents report ever having used a condom. However, the relationship between ever use of condom and place of residence is not statistically significant for men.

Current Use

In order to assess current use of condoms, information was used from two separate sections of the survey questionnaire. In section four of the survey questionnaire, information was obtained on family planning knowledge, attitude and use. In this section, respondents were instructed to report on all the methods they used for contraceptive purposes. Respondents were asked: *Are you and <name> currently doing something or using any method to delay or avoid getting pregnant? Which method are you using?* At the start of section seven, following a battery of questions about AIDS knowledge, attitude and risk, respondents were asked the following questions: *Have you and <name> ever used a condom? Do you use a condom always, occasionally or only at the beginning of the relationship?*

Men are more likely than women to report condom use for family planning purposes. Table 5.9 shows that 25.7 percent of men and 6.3 percent of women reported using the condom for delaying and/or avoiding pregnancy. As discussed in Chapter 4, the discrepancies in the reporting of condom use may be due to a range of factors.

Table 5.9: Percentage of married and cohabiting respondents currently using a condom with their married and cohabiting partner to prevent and/or delay pregnancy

Currently using a condom for preventing and/or delaying pregnancy	Men	Women
	%	%
Yes	25.7	6.3
No	74.3	93.7
N	248	289

Note: Kappa: 0.2

It is highly plausible that some men may be over-reporting condom use in an attempt to appear more modern and more approving of condoms. A comparison of husbands' reports of condom use for preventing and/or delaying pregnancy with reports of frequency of condom use with their spouses in section seven showed major discrepancies in husbands' reports of condom use. It is possible that men may be reporting condom use with other sexual partners, but the survey instrument explicitly asked about the use with the named spouse. Given the strongly held belief that family planning is the woman's responsibility, men may be reluctant to admit to using other methods of family planning, except perhaps male methods of family planning. For the most part, women reported using more effective, female controlled methods for family planning purposes. This is hardly surprising since condoms are not frequently promoted as a method of delaying and/or preventing pregnancy. Another explanation may be the use of condoms for purposes other than delaying or preventing pregnancy. This became clear when respondents were asked specifically if they had ever used a condom with their married and cohabiting partner.

In contrast to the huge discrepancies between men and women in the reporting of condom use for family planning, the answers of men and women to the questions in section seven are rather similar in the aggregate. As Table 5.10 shows, men and women are almost equally likely to report ever using the condom. Overall, however, the level of use with the married and cohabiting partner is low. Almost one-fifth of men and women reported having ever having used a condom with their married and cohabiting partner.

Table 5.10: Percent distribution of married and cohabiting respondents according to frequency of condom use with married or cohabiting partner (section seven)

Frequency of condom use	Men %	Women %
Always	1.9	4.9
Occasionally	12.5	12.4
Beginning	6.3	3.5
Never	79.3	79.2
N	248	289

The low levels of condom use in more regular partnerships are consistent with results from other studies conducted in sub-Saharan Africa, which have found that condom use is largely reserved for sexual relations outside of marriage (Adetunji and Meekers 2001). Condoms are also not consistently used within the marital union. Few respondents report that they always use a condom with their married or cohabiting partner.

To summarise, women instructed to report on methods that they had used for family planning purposes seldom mention condoms because this method is not used primarily for delaying and/or pregnancy prevention. Women are more likely to rely on methods that are perceived as more effective at preventing/or delaying pregnancy. Condoms are more likely to be used for purposes other than family planning and therefore information obtained in section seven specifically on frequency of condom use with married and cohabiting partners in the context of HIV/AIDS is seen as a more reliable measure of condom use. Moreover, although consistent use offers the best protection against HIV infection, the low number of those reporting ‘always’ using condoms prompted the combining of the categories ‘always’ and ‘occasionally’. Respondents who use condoms either ‘always’ or ‘occasionally’ are therefore considered condom users and all others as non-users.

5.7 Condom Use in Marital Unions

Condom use varies significantly by socio-demographic characteristics for men and women. Table 5.11 shows that the current use of condoms (as defined in the preceding paragraph) is statistically associated with social and demographic factors. The use of condoms increases with level of education. Condom use is considerably higher among the better educated than the less educated. Use is also higher among urban than rural

respondents. Those living in an urban area are almost three times more likely to use a condom with their married or cohabiting partner than those living in rural areas.

Table 5.11: Percentage of respondents using condoms in marital unions by selected background characteristics

	Men		Women	
	N	%	N	%
Age				
Less than 35	81	21.3*	168	20.4
35 or more	167	10.8	121	13.2
Marital Status				
Married	149	11.4	169	12.4*
Cohabiting	99	19.2	120	24.2
Place of Residence				
Rural	156	8.3**	200	11.0**
Urban	92	25.0	89	31.5
Level of Education				
Less than Secondary	87	2.3**	136	5.3**
Secondary or More	161	21.1	153	28.1
Desire for more children				
Yes	122	17.2	128	17.7
No	84	11.9	128	14.1
Unsure	42	11.9	32	28.1
Number of living children:				
0-1	94	16.0	121	22.3
2-4	129	13.2	141	14.2
5 or more	24	12.5	27	11.1
Two or more sexual partners				
Yes	44	22.7	19	10.5
No	203	12.8	270	17.8
All	248	14.4	289	17.3

Note: *Significant at 5 percent **Significant at 1 percent

Condom use varies considerably according to marital status. Condom use occurs more frequently among cohabiting than married respondents. However, this association is not significant for men. For both men and women, the use of condoms declines with increasing age. Adetunji and Meekers (2001) argue that the number of children may also influence risk perceptions. Moreover, those who do not want any more children may use condoms for family planning purposes. However, in this study the opposite is observed. The use of condoms declines as the number of children increases. Condom

use is higher among those who desire more children than those who do not, perhaps because the latter are more likely to be using a highly effective method of contraception.

The risk of HIV depends, among other things, on the number of sexual partners. Information was collected on the number of partners of men and women in the last three years. Men are more likely than women to report having other sexual partners. People who engage in sexual relations with more than one partner are obviously at higher risk than those who have a long-term partner within a mutually monogamous relationship. Men with multiple sexual partners are more likely than those who are monogamous to report using a condom. The opposite is observed for women. However, these differences do not attain statistical significance.

The relationships between condom use and attitudes and communication variables are also analysed. As expected, the likelihood of condom use is higher among those with positive attitudes than those with less positive attitudes (Table 5.12). For both men and women, frequent spousal discussion on condoms is associated with more frequent use. The use of condoms consistently increases with the frequency of discussion. Those who have discussed condoms several times are significantly more likely to be using it than those who have not.

Table 5.12: Percentage of respondents using condoms in marital unions by their attitudes to condoms and whether they have discussed condoms

	Men		Women	
	N	%	N	%
Attitudes to Condoms				
Positive	93	29.0**	135	27.4**
Neutral	55	5.5	17	0.0
Negative	89	5.6	102	12.7
Discussed Condoms				
Many Times	31	45.2**	31	54.8**
Few Times	62	30.6	71	42.3
Once	21	14.3	29	10.3
Never	133	0.0	158	0.0
All	248	14.4	289	17.3

Note: **Significant at 1 percent

In order to investigate more rigorously the predictors of condom use, logistic regression is used. The analysis made use of a limited number of explanatory variables, mainly socio-demographic characteristics. This is because it is difficult to determine the

direction of causality of the communication and attitudinal variables using cross-sectional data, as discussed in Chapter 3.

In the models, the dependent variable is the use of condoms either 'always' or 'occasionally'. For each observation, the dependent variable takes the value of '1' if the respondent is using the condom (either alone or with another method) with their married or cohabiting partner and '0' otherwise. Logistic regressions are run for men and women separately. As part of the analysis, all first order interactions are systematically assessed. However, no significant interactions are observed among the major components of the regression equation.

In the first stage of model building the effects of each of the socio-demographic factors are analysed independently. The unadjusted model in Table 5.13 shows that education is the strongest predictor of condom use among men. Men with more than secondary education are almost 12 times more likely than men with less than secondary education to be using a condom. Age also exerts a significant impact on the likelihood of condom use. Men who are less than 35 years are two times more likely than men who are older than 35 years to be using a condom. Similarly, the odds of using a condom are significantly higher in the urban than the rural area. Condom use does not vary significantly by the number of partners of men. The unadjusted results for women are similar to those for men. Place of residence, level of education and marital status are significant predictors. Age, however, is less strongly associated with condom use and is not a significant correlate.

Table 5.13 shows that once variables are adjusted for each other, the influence of level of education remains dominant. For both men and women, the pattern of results are the same, namely that the more educated, urban respondents are more likely to be using a condom than the less educated, rural respondents. However, after adding controls, age is no longer significant for men and marital status is no longer significant for women.

Table 5.13: The odds of using condoms in marital unions by selected background characteristics: results from logistic regression

	Odds Ratios and 95% confidence intervals		Odds Ratios and 95% confidence intervals	
	Men		Women	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Age				
Less than 35	1.00	1.00	1.00	1.00
35 or more	0.45 (0.22-0.93)	0.50 (0.21-1.21)	0.58 (0.30-1.11)	0.68 (0.30-1.53)
Marital Status				
Married	1.00	1.00	1.00	1.00
Cohabiting	1.84 (0.90-3.75)	1.39 (0.53-3.59)	2.32 (1.25-4.33)	2.03 (0.90-4.56)
Place of Residence				
Rural	1.00	1.00	1.00	1.00
Urban	3.84(1.82-8.09)	2.77(1.16-6.61)	3.65(1.95-6.85)	2.18(1.03-4.60)
Level of Education				
Less than Secondary	1.00	1.00	1.00	1.00
Secondary or More	11.55 (2.66-50.13)	9.36 (2.00-43.87)	7.07 (3.08-16.27)	5.37 (2.15-13.40)
Desire for more children				
Yes	1.00	1.00	1.00	1.00
No	0.69 (0.31-1.54)	0.50 (0.17-1.45)	0.77 (0.40-1.51)	0.94 (0.37-2.38)
Unsure	0.64 (0.22-1.85)	0.47 (0.14-1.54)	1.76 (0.71-4.36)	2.24 (0.73-6.93)
Number of living children				
0-1	1.00	1.00	1.00	1.00
2-4	0.80 (0.38-1.69)	1.29 (0.50-3.30)	0.57 (0.30-1.51)	0.58 (0.24-1.40)
5 or more	0.70 (0.18-2.73)	2.19 (0.40-12.01)	0.47 (0.14-1.60)	0.87 (0.18-4.18)
Two or more sexual partners				
Yes	1.89(0.83-4.32)	2.09 (0.79-5.50)	0.47 (0.10-2.25)	0.20 (0.04-1.08)
No	1.00	1.00	1.00	1.00

5.8 Condom Use in Non-Marital Unions

A good measure of risky sexual behaviour is the extent to which those who engage in sexual relations outside the primary regular partnership use condoms (Adetunji 2000). Condom use was estimated on the basis of the proportion of respondents who had sexual intercourse with non-marital sexual partners in the last three years, and the proportion of respondents who said that they had used a condom with that partner. Respondents were asked to provide information about all their sexual partners in the last three years. Those who reported not having other sexual partners were asked a series of questions to verify their answers. Those who reported having other sexual partners were

asked how long ago they had intercourse with that sexual partner. Detailed information was only obtained for sexual relationships that occurred within the last three years and was restricted to a maximum of three partners. The analysis is based on the partnership file that was created to capture all sexual relations outside the marital union.

In general, there is a low level of reporting of sexual partnerships. Men are more likely than women to report having more than one sexual partner, as shown in Table 5.14. Few women report multiple sexual partners. The unmarried are more likely than the married to report having non-marital sexual partners. It is not entirely clear why a large percentage of men report having one sexual partner, as the qualitative data suggests that a large proportion of men have more than one sexual partner. This prompts some concern about the veracity of the reports by men. It is highly probable that the emphasis that prevention programmes place on avoidance of sex with multiple sexual partners may have discouraged them from reporting these behaviours.

Table 5.14: Percent distribution of men and women according to number of sexual partners in the last three years

Marital Status	Number of Partners			N
	0	1	2+	
Men				
Married	88.0	11.3	0.7	150
Cohabiting	69.0	26.0	5.0	100
Neither	3.7	40.3	56.0	273
%	40.3	29.3	30.4	100
Women				
Married	98.8	1.2	0.0	169
Cohabiting	85.7	14.3	0.0	120
Neither	19.2	61.9	18.9	333
%	53.7	36.2	10.1	100

Table 5.15 shows information on condom use outside the marital and cohabiting union. Condom use is considerably higher in non-marital than marital and cohabiting unions. Men are more likely than women to report using condoms with non-marital partners. Condoms are used in more than half of all sexual encounters with the non-marital partners of men, compared with 37.5 percent for women. The use of condoms is also more consistent in sexual relations in non-marital unions. For the purposes of subsequent analysis, respondents who used condoms either 'always' or 'occasionally' are considered condom users and all others non-users.

Table 5.15: Percent distribution of non-marital partnerships according to frequency of condom use

Frequency of condom use	Men	Women
	%	%
Always	37.9	15.6
Occasionally	12.8	17.9
Beginning	4.3	4.0
Never	45.0	62.5
Number of Partnerships	496	353

In non-marital partnerships, use of condoms varies significantly by socio-demographic characteristics, as presented in Table 5.16. Condom use is significantly higher among the more educated and urban residents than the less educated and rural residents. The use of condoms declines with increasing age. Those who are less than 35 years also have a significantly greater likelihood of using condoms than those who 35 or more years. Men and women who are neither married nor cohabiting are significantly more likely to use condoms than those who are either married or cohabiting. Men who have children with their partner are significantly more likely to use condoms than those who do not. The opposite is observed for women, but the relationship is not significant.

The relationship between condom use and desire for more children and number of sexual partners is not significant. Condom use is higher among more regular relationships than less regular relationships. Men and women are more likely to report using condoms with a former spouse or regular partner than a short-term partner or someone they had recently met, but this relationship is not significant for women. Moreover, the length of the relationship influences condom use among men. One would expect that condoms are more likely to be used with partners that they know for less than a year. In fact, the inverse is observed. Among men, condom use is significantly higher with sexual partners that they have known for more than a year than partners they have known for less than a year.

Table 5.16: Percentage of non-marital partnerships in which condoms were used, by selected background and partnership characteristics

	Men		Women	
	N	%	N	%
Age				
Less than 35	416	53.4*	328	34.5
35 or more	78	37.2	25	20.0
Marital Status				
Married/Cohabiting	50	36.0*	19	10.5*
Neither	445	52.4	333	34.8
Place of Residence				
Rural	337	46.6	241	29.5
Urban	159	59.7*	112	42.0*
Level of Education				
Less than Secondary	105	33.0**	65	13.8**
Secondary or More	390	55.4	288	37.8
Desire for more children with partner				
Yes	259	55.6	194	35.6
No	180	46.1	106	34.9
Unsure	56	42.9	53	22.6
Number of living children with partner				
0	309	42.7**	212	34.9
1+	186	64.0	141	31.2
Two or more sexual partners				
Yes	389	50.1	131	27.5
No	107	53.3	222	36.9
Type of Partner				
Former Spouse	31	54.8**	57	22.8
Regular Partner	376	54.8	269	37.2
Short Term	58	32.8	24	20.8
Recently Met	30	30.0	3	0.0
Duration of the Relationship				
Less than one year	97	33.0**	94	34.0
One year or more	398	55.0	259	33.2
All Partnerships	496	50.7	353	33.5

Note: *Significant at 5 percent **Significant at 1 percent

In non-marital relationships, condom use is significantly higher among men and women with positive attitudes to condoms than men and women with negative attitudes. It is interesting to note that condom use is lowest among women with neutral attitudes to condoms. It would also appear that communication is important for condom use in non-

marital relationships. Use is higher among those who have discussed condoms than those who have not.

Table 5.17: Percentage of 'non-marital' partnerships in which condoms were used, by attitudes to condoms and whether they had discussed condoms with their non-marital partner

	Men		Women	
	N	%	N	%
Attitudes to Condoms				
Positive	191	67.5**	228	42.1**
Neutral	96	41.7	26	7.7
Negative	203	39.9	80	25.0
Discussed Condoms				
Yes	128	64.8**	142	51.7**
No	109	7.3	211	6.3
All Partnerships	496	50.7	353	33.5

Note: **Significant at 1 percent

Logistic regression was applied to the data on condom use in non-marital unions. In the model, the individual and main effects of each of the socio-demographic factors are analysed. Again, no significant interactions are found. Separate logistic regressions are conducted for men and women. For the purpose of analysis, relationships are categorised as regular and non-regular. The term 'non-regular' partner is used to denote partners who are either short-term or someone they had recently met.

The results of the multivariate analysis for men show that some socio-demographic variables have statistically significant effects on condom use. The analysis indicates that the nature of the relationship influences condom use. It is expected that condom use would be higher in non-regular than regular relationship. However, the opposite is observed. Condom use is higher in regular than non-regular relationships. As the level of education increases, condom use also increases. Men with secondary or higher education are 2.46 times more likely to be using a condom than men with less than secondary education. Condom use is also higher among those who are not married and not cohabiting than those who are married or cohabiting. Unmarried men are almost twice as likely to be using a condom than married and cohabiting men. The use of condoms depends to a large extent on place of residence. Men residing in the urban area have a higher odds of using a condom than their rural counterparts. The odds of use for those less than 35 years are higher than the 35 years and older. The analysis also suggests that number of living children influences the use of condoms. Those who do

have children with their partner are significantly more likely to use condoms than those who do not have children with their partner. Moreover, condom use is higher among those who do not want children with their partner, but this is of borderline significance. Table 5.18 shows that, after adjustment for other variables, many of the socio-demographic characteristics are no longer significantly associated with use. After controlling for other variables, two variables remain significant predictors of condom use in non-marital unions: level of education and number of living children. All the other variables are no longer significant, although place of residence and nature of the partnerships are close to achieving a significant effect at the five percent confidence level.

The results of the multivariate analysis for women show that three socio-demographic variables have statistically significant unadjusted effects on condom use: level of education, marital status and place of residence. Marital status emerges as the strongest predictor of condom use outside the marital and cohabiting relationship. Unmarried women are 5.57 times more likely than married and cohabiting women to use a condom. Those with secondary or higher education have a higher odds of using a condom than those with less than secondary education. Those living in the urban area are 1.72 times more likely to be using a condom than those living in the rural area. Condom use does not depend on the number of sexual partners. Table 5.18 shows that, after adjustment for other factors, many of the socio-demographic characteristics are no longer significantly associated with use. After controlling for other variables, education remains the strongest predictor of condom use. Place of residence and marital status ceases to have significant effects after controlling for other variables.

Table 5.18: The odds of using condom use in non-marital unions by selected background and partner characteristics: results from logistic regression

	Odds Ratios and 95% confidence intervals		Odds Ratios and 95% confidence intervals	
	Men		Women	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Age				
Less than 35	1.00	1.00	1.00	1.00
35 or more	0.51 (0.31-0.84)	0.57 (0.32-1.00)	0.52(0.20-1.37)	0.51(0.18-1.45)
Marital Status				
Married/Cohabiting	1.00	1.00	1.00	1.00
Neither	1.94 (1.06-3.55)	1.15 (0.57-2.31)	5.57(1.12-27.66)	3.04(0.55-16.85)
Place of Residence				
Rural	1.00	1.00	1.00	1.00
Urban	1.70(1.16-2.49)	1.45(0.95-2.22)	1.72(1.08-2.74)	1.61(0.98-2.67)
Level of Education				
Less than Secondary	1.00	1.00	1.00	1.00
Secondary or More	2.46 (1.56-3.86)	2.13 (1.30-3.50)	3.71(1.78-7.74)	3.15(1.46-6.83)
Desire for more children with partner				
Yes	1.00	1.00	1.00	1.00
No	0.68 (0.46-1.00)	0.96 (0.60-1.53)	0.97(0.59-1.59)	1.08(0.62-1.88)
Unsure	0.60 (0.33-1.07)	0.75 (0.40-1.40)	0.53(0.26-1.07)	0.59(0.18-1.24)
Number of living children with partner				
0	1.00	1.00	1.00	1.00
1+	2.38 (1.64-3.46)	2.16 (1.43-3.28)	0.42(0.15-1.13)	0.84(0.50-1.41)
Two or more sexual partners				
Yes	0.88 (0.57-1.35)	1.17 (0.71-1.92)	0.66(0.4-1.05)	0.61(0.36-1.04)
No	1.00	1.00	1.00	1.00
Nature of Relationship				
Regular	1.00	1.00	1.00	1.00
Non-Regular	0.38(0.23-0.62)	0.58(0.31-1.07)	0.42(0.15-1.13)	0.62(0.19-2.00)
Duration				
0	0.40(0.25-0.64)	0.74(0.41-1.32)	1.04(0.63-1.72)	1.31(0.73-2.35)
1+	1.00	1.00	1.00	1.00

5.9 Summary

Awareness of condoms and supply sources is almost universal among men and women. Condoms are widely recognised as a method of dual protection against unwanted pregnancy and HIV/AIDS. Despite this, condoms are not a popular method of contraception. Many problems are associated with condoms that have limited its

acceptability and utilisation. Both men and women worry that condoms inhibit sexual enjoyment. Other studies have also found similar reservations expressed about condoms, especially about reduction in pleasure (Abdool Karim et al. 1992a; Campbell et al. 1998). In their study, Abdool Karim et al (1992a: 108) found that respondents graphically described these objections to condoms as: 'What is the use of eating a sweet still wrapped in paper, while the taste is in the sweet itself?' Men in other countries have expressed concerns about condoms breaking or becoming lodged inside women. Surveys in Cote d' Ivoire and Togo found that 61 percent and 45 percent respectively of the men interviewed perceived this as a significant problem (Mehryar 1995).

Communication is important for good reproductive health and shared decision-making. However, discussion between men and women on condom use is not very common. Less than half of the married and cohabiting respondents stated that they had discussed condoms with their partner. Condoms are not considered an acceptable topic of discussion, especially in marital relationships. It may be easier for women to negotiate condom use with their unmarried than married partner. The focus group discussions and in-depth interviews found that some women are afraid to even ask their partner to use a condom because they fear endangering their relationship, perhaps resulting in the disintegration of their marriage. A wife asking her husband to use a condom may imply that she has been unfaithful. Women who request condom use are usually viewed in a very negative light. If the woman was to suggest condom use it is likely to lead to conflict, misunderstanding and suspicions of infidelity and violence. Some men also complained that they faced resistance from female partners who are opposed to the use of condoms. Since condoms are highly emotive it is therefore not surprising that many couples choose to take risks in order to avoid the embarrassment or punishment of having to discuss condoms with their partners. However, there are some contrary signs. Some men and women felt that they had the right to use condoms, irrespective of what their partners felt, in order to protect themselves against the risk of HIV infection.

Consistent with other studies, condom use was found to vary substantially between marital and non- marital partners (Preston-Whyte 1999a; Adetunji and Meekers 2001). Men and women are more likely to report using the condom in non-marital than marital relationships. Somewhat surprisingly, the level of current condom use reported by women in marital relationships exceeds that reported by men, but the differences are modest. Few respondents report using the condom consistently. This is consistent with

the findings of a national study of men investigating male attitudes and practices. According to this study, while 75 percent knew about condom use for STI/HIV prevention, current and consistent use was reported by 24 percent (Matshidze et al. 1998). Many respondents do not see the need for condoms with their married partners because they feel certain that they can trust their partners. This is probably because men and women in stable, ongoing relationships may perceive a higher risk of unwanted pregnancy than disease. In casual relationships, men may perceive a higher risk of HIV and are therefore more motivated to protect themselves by using a condom. A study conducted by Evans et al. (1997) found that men and women with non-regular partners might compensate for their increased risky lifestyle by using condoms more frequently. Prevention programmes have an important role to play in promoting condom use in all sexual relationships.

Married men and women may also not want to jeopardise their relationship, especially because the introduction of condoms in a long-term relationship may raise suspicions of infidelity. For both men and women, condom use is often interpreted as offensive and suggestive of a lack of trust and infidelity. As a result, condoms are seen as less acceptable in marital unions. This finding is also supported by the study by Blecher et al. (1995), which found that condoms are perceived as representing a lack of trust between partners or suggesting that one partner might have a STI, which are seen to create tensions, anger and confrontation. Other studies have also found widespread resistance to the use of condoms, especially within marriage (Blecher et al. 1995; Campbell 1995; Cohen and Trussel 1996; Worth 1989). Often the resistance to condoms is strongly related to its negative association with illicit sex and prostitution (Caldwell 1999; Reid 1996).

The majority of respondents report that they are not using condoms. Also, condoms are not used consistently in sexual relationships. However, there are some encouraging signs that condom use may be increasing in marital relationships. The multivariate analysis found that condom use in marital unions corresponds strongly with level of education and urban residence. The more educated are more likely than the less educated to use condoms. However, the level of condom use is lower in relationships defined as marriage than cohabitation. In non-marital unions, education also emerged as a strong predictor of condom use. Condom use is higher among men who have children with their partners than men who do not. They may be more motivated to protect

themselves against pregnancy in non-marital relationships. The number of sexual partners does not seem to influence condom use in marital and non-marital relationships. The prevention programmes have an important role to play in promoting consistent condom use with all sexual partners.

Chapter 6

Perception of Risk of HIV Infection among Married and Cohabiting Individuals

6.1 Introduction

In order to develop appropriate HIV interventions, a greater understanding of risk perceptions is important. Several studies have found that perception of risk is strongly related to the increase in self-protective behaviour (Lindan et al. 1991; Adih and Alexander 1999; Akwara et al. 2001). This is largely because the adoption of protective behaviour is unlikely to occur unless the person is aware of the risk. Studies on risk have focused on groups that are assumed to be at a high risk of HIV infection, such as sexually active single people. However, a number of studies conducted in sub-Saharan Africa have begun to show that the level of HIV infection is higher among married than unmarried individuals (Craiel et al. 2001; Lindan et al. 1991). Some individuals are directly at risk of HIV infection because of their own sexual behaviour. However, a significant and growing proportion of all HIV infections are transmitted through unprotected sexual intercourse with a stable sexual partner (de Zoysa et al. 1996). A study in Uganda has shown that men are twice as likely as women to bring an HIV infection into a marriage, emphasising that the risk of HIV and other STIs for married women is more likely to come from their husbands' behaviour than from their own (Kengeya-Kayondo et al. 1999).

The overall aim of this chapter is to investigate how married and cohabiting men and women define risk and also to identify the factors that influence risk perceptions. It starts by examining levels of knowledge of both the causes of, and precautions that can be taken against, HIV infection. This is followed by a section that details personal perception of risk and encompasses both direct and indirect risk behaviour. This leads into the concluding section of the chapter, which focuses on the influence of these perceptions on general vulnerability to HIV. It also explores the predictors of perceived personal risk of HIV by means of logistic regression analysis, comparing and contrasting the results obtained for men and women.

6.2 Knowledge of HIV/AIDS

Appropriate and correct knowledge is regarded as an important, if not sufficient, precondition for behavioural change. Prevention programmes have been very successful at creating public awareness of HIV/AIDS. Among men and women, awareness is virtually universal. In the survey, almost all respondents said that they had heard of HIV/AIDS. The high levels of awareness of HIV/AIDS is consistent with the findings of the 1998 South African DHS, which reports that 97 percent of women said that they had heard of HIV/AIDS (SADHS 1999).

It is widely assumed that if people are adequately informed about the risk of HIV infection, they are more likely to adopt protective behaviour. In order to assess knowledge about HIV/AIDS, respondents who had heard of it were asked a series of questions about modes of transmission and prevention of HIV/AIDS. These questions, perhaps more than any other set of questions, are important because they indicate how well the respondent understood the risks associated with HIV/AIDS (Balk and Lahiri 1997).

Causes of HIV

The qualitative study showed that basic knowledge of HIV/AIDS is fairly widespread. Most respondents are familiar with some of the major routes of transmission. In the in-depth interviews, knowledge of HIV/AIDS is explored by asking the following questions:

- *In your view, what causes HIV/AIDS?*
- *What are all the things that people can do to avoid getting HIV/AIDS?*
- *How, if at all, can people get rid of HIV/AIDS once they have it?*

Most respondents knew that HIV/AIDS is transmitted through sexual intercourse. However, few respondents specified more precisely unprotected sexual intercourse.

Multiple sexual partnerships are described as a potential method of transmitting the virus. Respondents stated that people with many sexual partners have an increased risk of infection.

HIV/AIDS is caused by someone sleeping with several partners. The person may sleep with one person today and another person tomorrow (Rural Female, IDI #17)

Some respondents also reported that an individual with one partner is equally at risk of HIV infection as individuals with many partners. An individual may be at risk of becoming infected because of their partner's sexual behaviour. This attitude is most clearly illustrated in the following comments:

You may find that a person who does not sleep around may get HIV from a partner who does sleep around (Urban Female, IDI #18)

A person with one sexual partner can get HIV and also a person with many sexual partners. (Urban Female, IDI #27).

Some respondents also mentioned that the use of contaminated blood or blood products may be another way of transmitting the virus. This can happen through sharing of contaminated instruments (especially sharing the same needle and sharing razors for ritual scarring). In the in-depth interviews, some men reported that they had heard that the virus is transmitted through blood but were confused about the actual mode of transmission.

Some say you get HIV by touching the blood of the person you have sex with. That confuses me! (Rural Male, IDI #21)

Another major route of transmission of HIV/AIDS is from mother to child. However, relatively few respondents mentioned mother to child transmission. This is somewhat surprising given the ongoing discussion in the media at that time about making anti-retroviral drugs available to pregnant women.

Although basic knowledge of HIV/AIDS is fairly high, there are some common misconceptions about the transmission of HIV. A commonly held belief is that HIV is spread by certain groups of people, namely foreigners, sex workers, and whites. Men are more likely than women to hold such beliefs. Such beliefs are likely to serve as a barrier for adopting appropriate prevention strategies and contribute to a greater stigma

of people living with HIV/AIDS. These beliefs are most clearly illustrated in the following comment:

AIDS becomes a problem when people fail to control themselves by having sex with people from different races and people from different countries. These people get infected with different diseases and then come back and infect their partners (Urban Male, IDI #32)

Preventing HIV

Respondents identified a number of precautions that can be taken to eliminate or reduce the risk of HIV. The three principal measures to avoid infection are to use a condom, abstain from sexual intercourse and reduce the number of sexual partners.

Some respondents felt that if a woman is not able to convince her partner to use a condom then she must refuse to have sex with him. Some respondents also mentioned abstinence as an effective method of avoiding infection. However, for many people abstinence, even for a short period of time, is not an alternative.

I would prefer not to have sex but I am not sure for how long I can abstain from sex (Rural Male, IDI #20)

You must avoid having sex because it increases your chances of getting AIDS (Urban Male, IDI #38)

The other frequently cited strategy to avoid infection is to reduce the number of sexual partners. Most respondents stressed the importance of having one sexual partner. Having unprotected sex with multiple partners increases the risk of contracting HIV. By decreasing the number of partners the risk of infection is decreased. Many respondents also emphasised the need for trust in sexual relationships. However, relatively few specified that the partner should be a *faithful* sexual partner.

They should trust each other and love each other. Men always want to have more than one sexual partner but one partner is enough (Rural Female, IDI #11)

People must behave themselves by having one partner. If they want to have sex they should use a condom (Urban Male, IDI #15)

The survey confirms the results of the focus group discussions and in-depth interviews. In order to determine knowledge of HIV prevention measures, respondents were asked: *If a man/woman fears HIV/AIDS but still wants to play sex, what can he/she do?* With regard to prevention, respondents mentioned a number of ways to avoid infection, as shown in Table 6.1. The condom was identified as the single most important means of avoiding HIV infection. In general, men were more likely than women to mention condoms as a preventive measure against HIV infection.

Table 6.1: Percent distribution of respondents who mentioned a number of ways to prevent HIV/AIDS

Ways to avoid HIV/AIDS	Men %	Women %
Pill	0.2	0.0
IUD	0.4	0.0
Injections	1.8	2.9
Condom	89.2	79.9
Withdrawal	4.9	4.3
Thigh Sex	14.9	2.7
Other	10.2	5.1
None	4.7	16.3
N	511	582

Some misconceptions exist about the methods that may be used to protect against HIV infection. Some respondents suggested that hormonal contraceptives and the IUD might offer protection against HIV. Intercrural sex was also suggested as a way of avoiding HIV. Some respondents mentioned behavioural change as a way of reducing the risk of HIV. Interestingly, a substantial proportion of women reported that there was nothing one can do to avoid contracting HIV.

According to the health belief model, the readiness to adopt action is dependent on the individual's perception of the potential severity of the consequences (Rosenstock et al. 1994). Beliefs about the severity of AIDS might influence one's attitude towards

adopting preventive action. In the survey, respondents were asked whether they agree, disagree or have mixed feelings about the following statement: *There is no cure for AIDS*. The majority of respondents knew there is no cure for AIDS, as Table 6.2 shows. Men were more likely than women to agree that there is no cure for AIDS, but the differences were modest.

Table 6.2: Percent distribution of respondents by their response to the following statement: There is no cure for AIDS

There is no cure for AIDS	Men	Women
	%	%
Agree	88.6	84.0
Mixed/No Opinion	3.5	6.6
Disagree	7.9	9.4
N	511	582

The in-depth interviews found that most respondents knew that there is no cure for AIDS, as is demonstrated in the following comments:

There is nothing that they can do to get rid of AIDS. The only thing is for them to accept that they have it (Urban Male, IDI #12)

They can go to the clinic or doctors so that they can live longer. The sad thing about AIDS is that once you have it you know that you will definitely die (Urban Male, IDI #22)

Many of the respondents also knew of the long latency period of HIV. They seem to know that people do not die soon after becoming infected. However, respondents stressed that it is important to lead a healthy lifestyle.

This disease does not kill you quickly, but stays in your body for years. After years you might see the symptoms of it...you become shocked to see a healthy or fat person who has this disease suddenly thin or very ill. You see that the infected person is unhealthy, then after some time he becomes better (Rural Female, IDI #10)

*AIDS has no cure but it does not mean that you will die immediately. You can live a long time with AIDS if you follow a correct diet and undergo counselling.
(Urban Male, IDI #23)*

It became clear that some respondents believe that traditional healers are able to cure HIV/AIDS. This is clearly illustrated in the following comments:

I: Are there people who can get rid of HIV?

R: Yes

I: How can they get rid of it?

R: They must use traditional herbs and they will get rid of it

I: Do you think that AIDS can be cured?

*R: Yes, there are people that are able to cure AIDS. However, sometimes people hide their illness. They must try and get help before it is too late
(Urban Male, IDI #14)*

Some respondents are not certain that there is a cure for AIDS. However, they had heard from other members of the community that there is a cure for AIDS.

I: What can people do to get rid of AIDS once they have it?

R: I heard from my mother that there is somebody who has a cure for AIDS, even if you have lost weight.

I: Who is this person?

R: He uses traditional medicine (Inyanga). He lives at Port Shepstone. I heard that he is able to help people who already have AIDS (Urban Female, IDI #28)

Such rumours are circulating everywhere and whether respondents believe in a cure or not, news of treatments and cures is likely to create some confusion. Such beliefs are likely to serve as a barrier to the adoption of self-protective behaviour.

6.3 Risk Behaviour

Perception of risk was explored in some detail in the in-depth interviews. Respondents were asked the following questions which were designed to assess whether or not they felt at risk of contracting HIV.

How worried are you that you will get and die of HIV/AIDS?

Why are you (or are you not) worried?

Some of the male respondents who were at a high risk of HIV infection stated that they were very concerned about HIV and were forthright in declaring that they felt at risk because of their own sexual behaviour.

I am worried because I am attracted to other women. I may get AIDS in this way. I cannot guarantee that I will not get AIDS (Urban male, IDI, #2)

Most men at high risk of HIV infection admitted in the in-depth interviews to having more than one sexual partner. However, some of the men who did not report having other sexual partners in the survey admitted to having multiple sexual partners in the in-depth interviews. It would seem that it is relatively common for men to have multiple sexual partners. In some cases, these relationships are short-term in nature. This is most graphically illustrated in the following comment:

A week or three...then I am through with her...It proves my manhood, as it is no use eating the same kind of food everyday (Rural Male, IDI #29)

Some men who were at low risk of HIV infection were not worried because they believed that they were not at risk. They did not have other sexual partners and also, they did not perceive their regular partner as presenting a risk. Some men stated that they have restricted sexual intercourse to their regular partners because of the fear of contracting HIV.

I don't know what to say because I don't have casual relationships. I do not have casual relationships because I am afraid of AIDS (Rural male, IDI #20)

Other men who were at low risk of HIV infection said that they had changed their behaviour in response to the HIV epidemic. They always use condoms with their casual partners and therefore feel protected against the risk of HIV infection.

I am not worried because I stay with my wife and I use a condom if I have a sexual relationship outside of marriage (Urban male, IDI #9)

The statements from some of the male respondents suggest that men are changing their sexual behaviour. This is indeed encouraging but should perhaps be interpreted with some caution. In many surveys substantial proportions of men and women report that they had already changed their behaviour in response to the threat posed by the AIDS epidemic, but there is little or no evidence to support these findings (Cleland 1995). It is highly probable that reports of behavioural change are exaggerated and men are merely giving socially desirable responses. This is certainly the impression that is given by female respondents.

Many of the female respondents who were at low risk of HIV infection because of their own sexual behaviour felt that they were at risk of HIV because of their partner's sexual behaviour. They felt that they could not trust their partner to remain faithful to them. Men with multiple sexual partners may not use a condom and may infect their regular partners.

I have a regular partner but he has other girlfriends. When I am not around, he sleeps with his other women. I am scared that I might get a disease from him (Rural Female, IDI #17).

Sometimes women may rely on men for financial support and this increases their risk of HIV infection. These women are afraid to confront their partners because they fear endangering their relationship, perhaps resulting in the disintegration of their marriage.

Some women have sex with men for money. Women like to have sex with men who can support them financially. These women sleep with men not because they love them but because of their money (Rural Female, IDI #17)

Some women were at high risk of HIV infection because of their partner's behaviour. Some of these women were worried because they felt that there was nothing they could do to change their situation. In these relationships, women lack the power and autonomy to negotiate safer sexual practices.

If the husband does not want to use a condom she can refuse to have sex but men are all the same. The man might beat her or demand sex. You end up having sex eventually (Urban Female, FGD)

You cannot refuse because he might leave you and go for other women (Rural Female, FGD)

Sometimes men may use physical violence in their sexual relationships in order to force their partners to submit to them. Some women are therefore powerless to refuse sexual intercourse or to convince their partners to use a condom in order to protect themselves against the risk of contracting HIV.

Direct Risk: Survey Evidence

The qualitative data suggests that individuals' perception of risk of HIV is influenced by their own sexual behaviour. This is called 'direct risk'. Married men and women with other sexual partners are considered directly at risk of HIV infection. In the survey, men and women were asked if they had sex with anyone other than their married or cohabiting partners. People who engage in sexual activities with partners they do not know well are at relatively high risk compared with those who engage in sexual activities with a long-term partner within a mutually monogamous relationship (Tanfer et al. 1993). For the purpose of analysis, respondents are divided into two groups: those who are at elevated risk because of their own behaviour and those who are not at such direct risk. The risk group is composed of respondents who reported that they had sexual intercourse with more than one partner in the last three years. The lower risk group is composed of respondents who did not report other sexual partners in the last three years.

Overall, 12 percent of married and cohabiting respondents reported behaviour that put them at risk of HIV infection. The term 'married' is used to describe marital and

cohabiting relationships, unless stated otherwise. Men are almost three times more likely than women to be at risk of HIV because of their own sexual behaviour. Table 6.3 shows the percentage of married respondents who are at risk of HIV infection by selected background characteristics. Marital status is positively correlated to reported risk behaviour. Interestingly, the level of risk is significantly higher among cohabiting than married respondents. This pattern holds for men and women. Cohabiting men are almost two times more likely than married men to report having other sexual partners. In their study in Uganda and Lusaka, Carael et al. (2001) found that cohabitation was a strong and statistically significant predictor of non-regular or casual sexual relationships. The present study found that the probability of having other sexual partners declines with age. Younger respondents are at greater risk than older respondents. However, this relationship is not statistically significant. Level of education is inversely related to the risk behaviour of men, but not for women.

Table 6.3: Percentage of married respondents who are at direct risk by selected background characteristics

Background Characteristics	Men		Women	
	N	%	N	%
Age				
Less than 35	82	22.0	168	8.9
35 or more	166	15.1	121	3.3
Marital Status				
Married	149	12.1*	169	1.2*
Cohabiting	99	26.0	120	14.3
Place of Residence				
Urban	92	17.4	89	10.1
Rural	156	17.8	200	5.0
Level of Education				
Less than Secondary	87	20.7	136	5.9
Secondary or More	161	16.1	153	7.2
All	248	17.5	289	6.8

Note: *Significant at 5 percent

Men and women may perceive themselves at risk not only because of their own behaviour, but also because of “the past or current, perceived or real behaviour of their sexual partner” (UNAIDS 1999:p11). Respondents who reported having sexual partners outside the marital partnership were asked: *As far as you know, is (was) this partner having sex with anyone else during your relationship?* This question is used to assess the sexual behaviour of non-marital partners. As shown in the Table 6.4, women are

more likely than men to report that their 'non-marital' partner had other sexual partners. More than half of all women with a 'non-marital' partner reported that their partner had other sexual partners. Men are less likely than women to admit that their 'non-marital' partner had other sexual partners. It is worth noting that more than three-quarters of men reported that they did not know if any of their 'non-marital' partners had other sexual partners.

Table 6.4: Percentage of non-marital partnerships in which respondents thought that their 'non-marital' partner had other sexual partners

	Men	Women
Partner has other partners	%	%
Yes	9.7	51.6
No	15.0	11.4
Do not know	75.4	37.1
Number of non-marital partnerships	50	19

Note: a few men reported having more than one sexual partner outside the marital union.

Respondents who reported 'non-marital' sexual partners were also asked: *During your relationship were you concerned that you might contract HIV from him/her?* This question is used to assess whether respondents perceived themselves at risk because of their 'non-marital' partner's sexual infidelity. Over half of the married respondents reported that they are not concerned about contracting HIV from their partner. Married respondents are unlikely to report that they are very concerned about contracting HIV from their 'non-marital' partner. However, a sizeable proportion of respondents report that they are somewhat concerned about contracting HIV from their partner. The pattern of the results in Table 6.5 is somewhat puzzling. One would expect that women who are more likely than men to report that their 'non-marital' partner had other sexual partners, would be more concerned than men about contracting HIV from that partner. However, the level of concern among men and women is broadly similar. Of course, the number of women reporting an extra-marital partner is very small and so little weight can be attached to these responses.

Table 6.5: Percentage of married respondents who are concerned about contracting HIV from their 'non-marital' partner

Level of Concern	Men	Women
	%	%
Very concerned	3.9	2.9
Somewhat concerned	40.6	45.5
Not concerned	55.6	51.6
N	50	19

Perception of their 'non-marital' partner's sexual behaviour is likely to have an impact on respondent's risk perceptions. Men and women who thought that their 'non-marital' sexual partner had sex with someone else are significantly more likely to be concerned about the risk of contracting HIV than other men and women. Also, a sizeable proportion of men and women who said that they are not sure if their partner had other sexual partners also reported greater concern about HIV than those who thought that their partner had no other sexual contacts, as shown in Table 6.6.

Table 6.6: Percentage of married respondents who are concerned about contracting HIV from their 'non-marital' partners, by perception of 'non-marital' partner's behaviour

Partner had other sexual partners	Men		Women	
	N	%	N	%
Yes	5	80.0	10	80.0*
No	7	14.3	2	0.0
Do not know	38	44.7	7	28.6
All	50	44.0	19	52.6

Note: Fisher's Exact: *Significant at 5 percent

Perception of risk is also likely to be influenced by the use of condoms. The use of condoms may lower perceptions of risk of HIV. However, it is also likely that the use of condoms may have been prompted by concern about the 'non-marital' partner's sexual behaviour. Table 6.7 shows that men and women who are concerned about contracting HIV from their 'non-marital' partner are more likely to be using condoms than those who are not, though the difference is very small for men and not significant for either men and women.

Table 6.7: Percentage of married respondents who report using condoms, by whether they are concerned about contracting HIV from their non-marital partner

Concern about contracting HIV	Men		Women	
	N	%	N	%
Yes	23	39.1	9	22.2
No	27	33.3	10	0.0
Number of partnerships	50	36.0	19	8.7

Note: Fisher's Exact: NS

Indirect Risk from Spouse

Men and women do not evaluate their risk of contracting HIV simply on the basis of their own sexual behaviour. Other factors, such as whether the person perceives themselves at risk because of the sexual activities of their spouse, may also influence risk of HIV. Respondents were asked: *During your marriage/ relationship do you think that your partner had sex with anyone else?* This question is used to assess the sexual behaviour of marital partners. Women are more likely than men to report that their marital partner had other sexual partners, as shown in Table 6.8. It is also worth noting that a large proportion of women said that they did not know if their partner had other partners.

Table 6.8: Percent distribution of married respondents who report that their partner had other sexual partners

Partner had other sexual partners	Men	Women
	%	%
Yes	6.9	26.0
No	73.6	21.3
Do not know	19.5	52.7
N	246	287

Respondents were also asked: *During your relationship with your partner have you ever been concerned that you might contract HIV from him or her?* Table 6.9 shows that the majority of respondents stated that they are not concerned about contracting HIV from their spouse. Men are more likely to report that they are not concerned about contracting HIV from their spouse, while women are more likely to report that they are concerned about contracting HIV from their spouse. Men and women who report that they are 'very' or 'somewhat' concerned about contracting HIV from their marital partner are regarded as indirectly at risk of infection from their partner.

Table 6.9: Percent distribution of married respondents who are concerned about contracting HIV from their spouse

Level of Concern	Men	Women
	%	%
Very concerned	6.8	26.0
Somewhat concerned	16.1	30.9
Not concerned	77.0	43.0
N	246	287

Perception of their married partner's sexual behaviour is also likely to impact on the respondent's risk perception. Table 6.10 shows that men and women who thought that their spouse had sexual intercourse with someone else are significantly more likely to be concerned about contracting HIV from their spouse. Also, a sizeable proportion of men and women who said that they are not sure if their spouse had other sexual partners also report a greater concern about contracting HIV from their spouse than those who consider their spouse to be faithful. This may be because they suspect their partner of infidelity but are not certain.

Table 6.10: Percentage of married respondents who are concerned about contracting HIV, by perception of 'marital' partner's behaviour

Partner had other sexual partners	Men		Women	
	N	%	N	%
Yes	17	41.2**	75	77.9**
No	181	16.6	61	39.3
Do not know	48	40.4	151	53.6
All	246	22.9	287	56.9

Note: **Significant at 1 percent

It is also interesting to examine whether those who perceive themselves at direct risk because of their own sexual behaviour are also likely to perceive themselves at indirect risk from their marital partners. As few women reported having 'non-marital' partners the analysis is confined to men. The dominant impression from Table 6.11 is that there is a relationship between direct and indirect risk. Men who are directly at risk of HIV because of their sexual behaviour are significantly more likely to feel concern about contracting HIV from their marital partners.

Table 6.11: Percentage of married men who had other sexual partners by concern about contracting HIV/AIDS from their married partner.

Direct Risk	Concerned about contracting HIV/AIDS	
	N	%
Yes	44	34.9*
No	202	20.2
N	246	22.8

Note: *Significant at 5 percent

6.4 Perceived General Vulnerability to HIV Infection

Perceived personal vulnerability is often viewed as a precondition for translating knowledge into behaviour change (MacPhail and Campbell 2001). Catania et al. (1990a) suggested that, for individuals who exhibit risky sexual behaviours, perceived vulnerability is required before commitment to changing risk behaviour can occur. Following the questions about the prevalence of HIV/AIDS in the community, respondents were asked if they had ever thought about their own chance of contracting HIV. Fewer than half of the respondents had ever thought about their risk of HIV. Men were less likely than women to have thought of their risk of contracting HIV.

Research has shown that the more concerned individuals are about becoming infected, the more likely they are to engage in protective behaviour (Lindan et al. 1990; Adih and Alexander 1999; Peltzer 2000). Respondents were asked the following question to assess their own risk of HIV: *Considering all things, do you consider your chance of getting HIV to be high, medium, low or no chance at all?* For the purpose of analysis, respondents are divided into medium-high, low or no chance of risk. The majority of respondents perceive themselves at some risk of HIV. Overall, almost one-third perceive their chances as medium or high. The key results are presented for men and women in Figure 6.1. The figure shows that women are more likely than men to report themselves at any risk of HIV and also more likely than men to perceive themselves at medium or higher risk.

Figure 6.1: Percent distribution of married respondents by general concern about contracting HIV

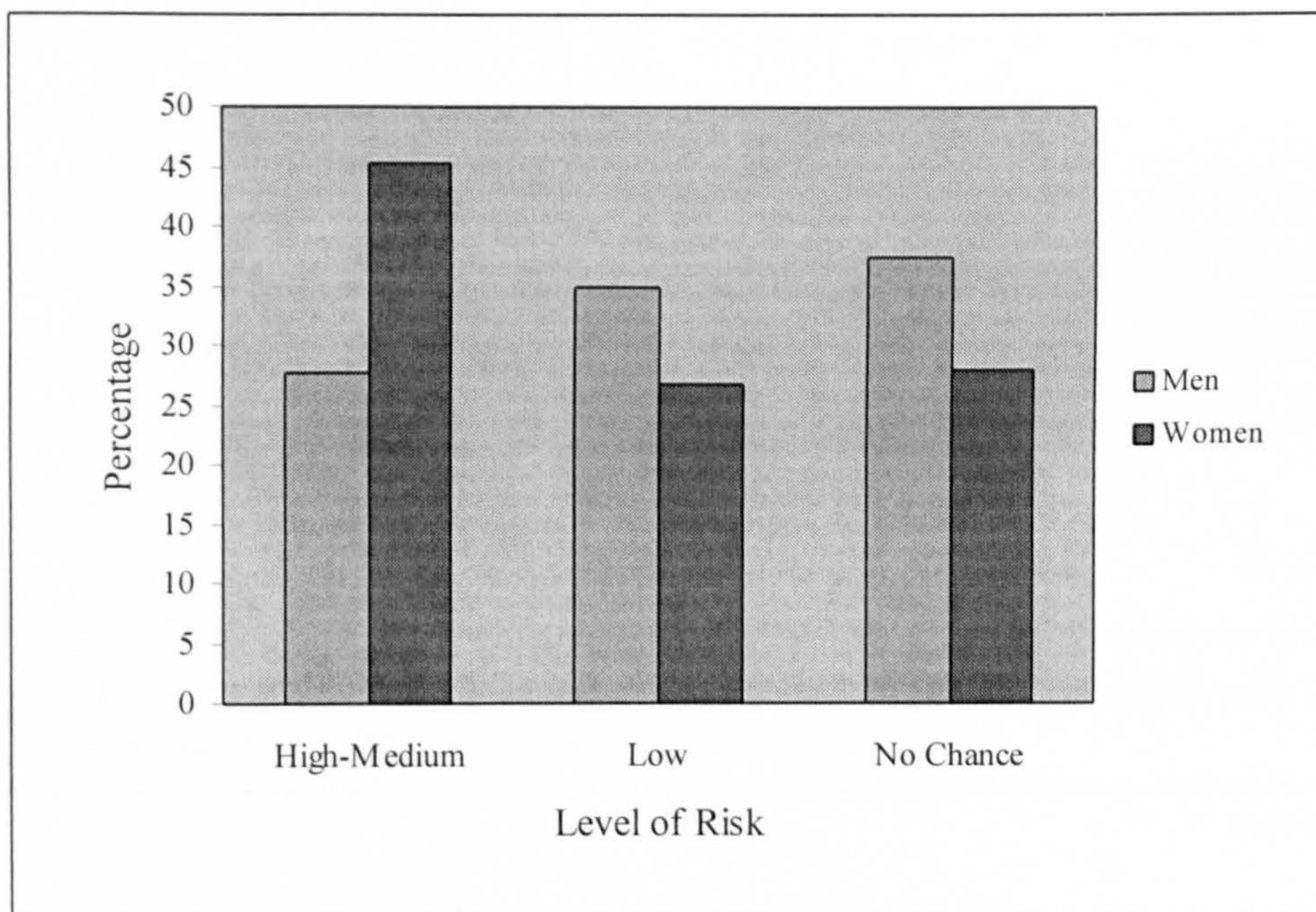


Table 6.12 shows the percentage of respondents who perceive themselves at medium or high risk of HIV by selected background characteristics. The risk of HIV varied significantly by selected demographic characteristics. In general, younger respondents are more likely to perceive a moderate or high risk than older respondents, but this relationship is not significant either for men or women. Risk perceptions vary considerably by marital status. Overall, those who are married are less likely than those who are cohabiting to report a medium or high level of risk, but this difference is only significant for men. One would expect that perceived risk will be higher in urban areas because the antenatal sentinel surveys show that the level of infection is higher in urban than rural areas. However, the opposite is observed. Urban residents are significantly less likely to perceive a medium or high risk than rural residents. Differences by education are small and not significant.

It is important to establish how reported sexual behaviour influences risk perception. The more sexual partners a person has the greater the likelihood of encountering a partner who is infected with and may transmit the virus (Finer et al. 1999). It is assumed that respondents with multiple sexual partners are more likely to perceive themselves at risk of HIV. Respondents consider their number of sexual partners when they evaluate their vulnerability to HIV. Among both men and women, the expected link between

reported risk behaviour and perceived risk may be observed. The link between self-reported behaviour and perceived risk is statistically significant for men, but not for women. It is also interesting to note that a sizeable fraction of respondents with reported risk behaviour do not perceive themselves at risk of HIV.

Respondents may also consider the sexual behaviour of their partner when they evaluate their risk of HIV. Those men and women who perceive themselves to be at risk of HIV infection from their marital partner are significantly more likely to perceive a greater vulnerability to HIV than those who do not.

Table 6.12: Percentage of respondents who consider themselves at medium or high risk of HIV by socio-demographic characteristics and risk variables

	N	Men		Women	
		N	%	N	%
Age					
Less than 35	82		35.4	168	47.6
35 or more	166		24.1	118	42.4
Marital Status					
Married	149		21.5*	168	43.9
Cohabiting	99		37.4	118	47.5
Place of Residence					
Urban	92		17.4*	89	34.8*
Rural	156		33.8	197	50.5
Level of Education					
Less than Secondary	87		32.2	133	48.9
Secondary or More	161		25.3	153	42.5
Direct risk					
Yes	44		47.7**	19	63.2
No	202		23.4	266	44.4
Indirect risk					
Yes	56		57.1**	163	60.3*
No	190		18.9	123	24.6
All	248		27.7	286	45.5

Note: *Significant at 5 percent **Significant at 1 percent

In order to investigate more rigorously the predictors of perceived risk of HIV, logistic regression analysis is conducted. In this model, the dependent variable is perceived risk of HIV. For each observation, the dependent variable takes the value of '1' if the perceived risk of HIV is medium or high and '0' otherwise. Two separate models are fitted. Model 1 contains the effects of each variable without controls. Model 2 presents the odds ratios for the same variables after adding controls. As part of the analysis, all

first order interactions are systematically assessed. However, no significant interactions are observed among the major components of the regression equation.

Table 6.13 shows the odds ratios of medium-high risk of HIV infection among men. The results of Model 1 show that four variables have statistically significant unadjusted effects on the perceived risk of HIV of men. Men living in the rural areas are significantly more likely to perceive a greater vulnerability to HIV than men living in urban areas. This finding may reflect greater condom use among urban men (see Chapter 5). Cohabiting men are significantly more likely than married men to perceive a greater vulnerability to HIV, perhaps because they are more likely to have multiple sexual partners. Those who report risk behaviour have a greater perceived vulnerability to HIV than those who report no risk behaviour. The odds of perceiving a greater vulnerability to HIV is 3.01 times higher among men who had other sexual partners than men who did not. Men who said that they are concerned about contracting HIV from their partner are significantly more likely to perceive themselves at greater risk than men who said that they are not. The odds of perceiving a medium-higher vulnerability to HIV are 5.74 times higher among men who are concerned about contracting HIV from their married partner than men who are not.

Table 6.13: The odds ratios for men who consider themselves at medium- high risk of HIV: results from logistic regression

	Odds Ratios and 95% confidence intervals	
	Model I Unadjusted	Model 2 Adjusted
Age		
Less than 35	1.00	1.00
35 or more	0.59(0.33-1.04)	0.76(0.39-1.47)
Marital Status		
Married	1.00	1.00
Cohabiting	2.20(1.25-3.87)	1.49(0.76-2.91)
Place of Residence		
Urban	1.00	1.00
Rural	2.38(1.26-4.47)	2.06(0.98-4.32)
Level of Education		
Less than Secondary	1.00	1.00
Secondary or More	0.72(0.40-1.27)	0.91(0.46-1.82)
Direct risk		
Yes	3.01(1.53-5.92)	2.47(1.17-5.23)
No	1.00	1.00
Indirect risk		
Yes	5.74(3.02-10.88)	4.39(2.20-8.75)
No	1.00	1.00

After adding controls, two variables remain significant. Men who report risk behaviour are more likely to perceive a greater vulnerability to HIV than those men who do not. Also, men who are concerned about contracting HIV from their married partner are significantly more likely to perceive a greater vulnerability to HIV than men who are not. After adding controls, marital status is no longer significant and place of residence is of borderline significance.

Table 6.14 shows the odds ratios for women at medium-high risk of HIV infection. The results of Model 1 show that only two variables have statistically significant effects on perceived risk of HIV. Those living in the rural area are significantly more likely than those living in the urban area to perceive a medium or high vulnerability to HIV. The odds of perceiving a medium or higher vulnerability are 1.91 times higher among rural than urban women. Also, women who are concerned about contracting HIV from their partner are significantly more likely to perceive a high vulnerability to HIV than women who are not. The odds of perceiving a greater vulnerability are 4.28 times higher among women who are concerned about contracting HIV from their partner than women who are not.

Table 6.14: The odds ratios for women who consider themselves at medium-high risk of HIV: results from logistic regression: results from logistic regression

	Odds Ratios and 95% confidence intervals	
	Model 1 Unadjusted	Model 2 Adjusted
Age		
Less than 35	1.00	1.00
35 or more	0.82(0.51-1.32)	0.91(0.53-1.58)
Marital Status		
Married	1.00	1.00
Cohabiting	1.12(0.70-1.79)	1.02(0.59-1.79)
Place of Residence		
Urban	1.00	1.00
Rural	1.91(1.14-3.21)	2.08(1.10-3.92)
Level of Education		
Less than Secondary	1.00	1.00
Secondary or More	0.78(0.49-1.25)	0.93(0.53-1.64)
Direct risk		
Yes	2.01(0.78-5.20)	2.00(0.90-7.48)
No	1.00	1.00
Indirect risk		
Yes	4.28(2.57-7.12)	4.56(2.69-7.71)
No	1.00	1.00

In contrast to men, no significant link is observed between perceived risk of HIV and reported risk behaviour. The difference is large but the standard errors are also large due to the small number of women reporting having an extramarital sexual partner. This association does not change after adjusting for other variables. After adjusting for other variables, place of residence remains a significant predictor of risk of HIV.

6.4 Summary

The results are, to some extent, encouraging. Knowledge of HIV/AIDS is almost universal. Almost all respondents had heard of AIDS. The level of understanding of the major routes of transmission of HIV/AIDS is fairly good. Most respondents are also aware of the seriousness of AIDS. They know that there is no cure for AIDS. However, there are some common misconceptions with regard to the means of preventing HIV infection. For example, a few men and women believe that hormonal methods are effective at preventing HIV transmission. Moreover, a few married respondents mistakenly believe that traditional healers are able to cure AIDS. The belief in traditional medicine is common in Southern Africa and traditional healers often attribute disease to spiritual, rather than biological, causes (Wilson et al. 1990). Such beliefs are likely to serve as a barrier for adopting protective behaviour.

The results suggest that a large proportion of respondents consider themselves at medium or high risk of HIV infection. Women are more likely than men to perceive a greater vulnerability to HIV. Almost 46 percent of women consider themselves at medium or high risk of HIV. It is disturbing to note that large proportions of men do not feel at risk of HIV infection. Less than one-third of men perceive themselves at risk of HIV, even though perception of risk is considered a precondition for behavioural change. Men are significantly more likely to consider themselves at risk of HIV infection because of their risky sexual practices. The majority of men consider their number of sexual partners when they evaluate their risk of HIV infection. Men with extramarital sexual partners are significantly more likely to perceive a greater vulnerability to HIV.

Men are more likely than women to report extra-marital sexual partners. However, in general, few men and women reported extra-marital sexual partners. The reliability of self-reports of sexual behaviour is questionable. Numerous factors may serve as barriers

to accurate reporting of sexual behaviour. It is highly possible that social desirability could have led men and women to report fewer sexual contacts. Catania et al. (1990b) point out that privacy, embarrassment and fear of reprisals are some of the reasons that may motivate people to conceal their true sexual behaviour. Moreover, it is possible that some respondents have trouble recalling how often and with how many people they have had sexual relationships (Catania et al. 1990b).

A large proportion of women reported that they are concerned about contracting HIV from their marital partner. This is because they know or suspect that their marital partner has other sexual partners. Men are less likely to report that either their marital or non-marital partner has other sexual partners. Few men reported that they are at risk of HIV because of their marital or non-marital partner's sexual behaviour. The belief that they are not vulnerable to HIV may increase their risk of HIV and also result in failure to adopt preventive behaviour. Interventions have an important role to play in improving men's perceptions of risk. Men and women may be faithful to their regular partner but their partner may not be faithful to them. Perception of risk is also likely to be influenced by condom use. Men and women who are concerned about contracting HIV from their non-marital partner are more likely to be using condoms than those who are not. The use of condoms may reduce the perceived risk of HIV infection but it is also likely that men and women use condoms because of their perceived risk of HIV. Men and women need to be encouraged to limit risky sexual behaviour, which places them directly at risk of HIV. Those who have unprotected sexual intercourse should be made aware that their behaviour carries some risk of HIV infection.

Place of residence is an important predictor of perceived vulnerability to HIV. After controlling for the effects of risk behaviour, the influence of place of residence on risk perception is pronounced. Women living in the rural areas are significantly more likely than women living in the urban area to perceive a greater vulnerability to HIV. This is probably because they are less likely to feel that they may be able to take action to protect themselves against the risk of HIV. In rural areas, women generally have less access than men to education, training and resources and, as a result, are more likely to perceive themselves at risk of HIV.

Chapter 7

Behavioural Change among Married and Cohabiting Respondents

7.1 Introduction

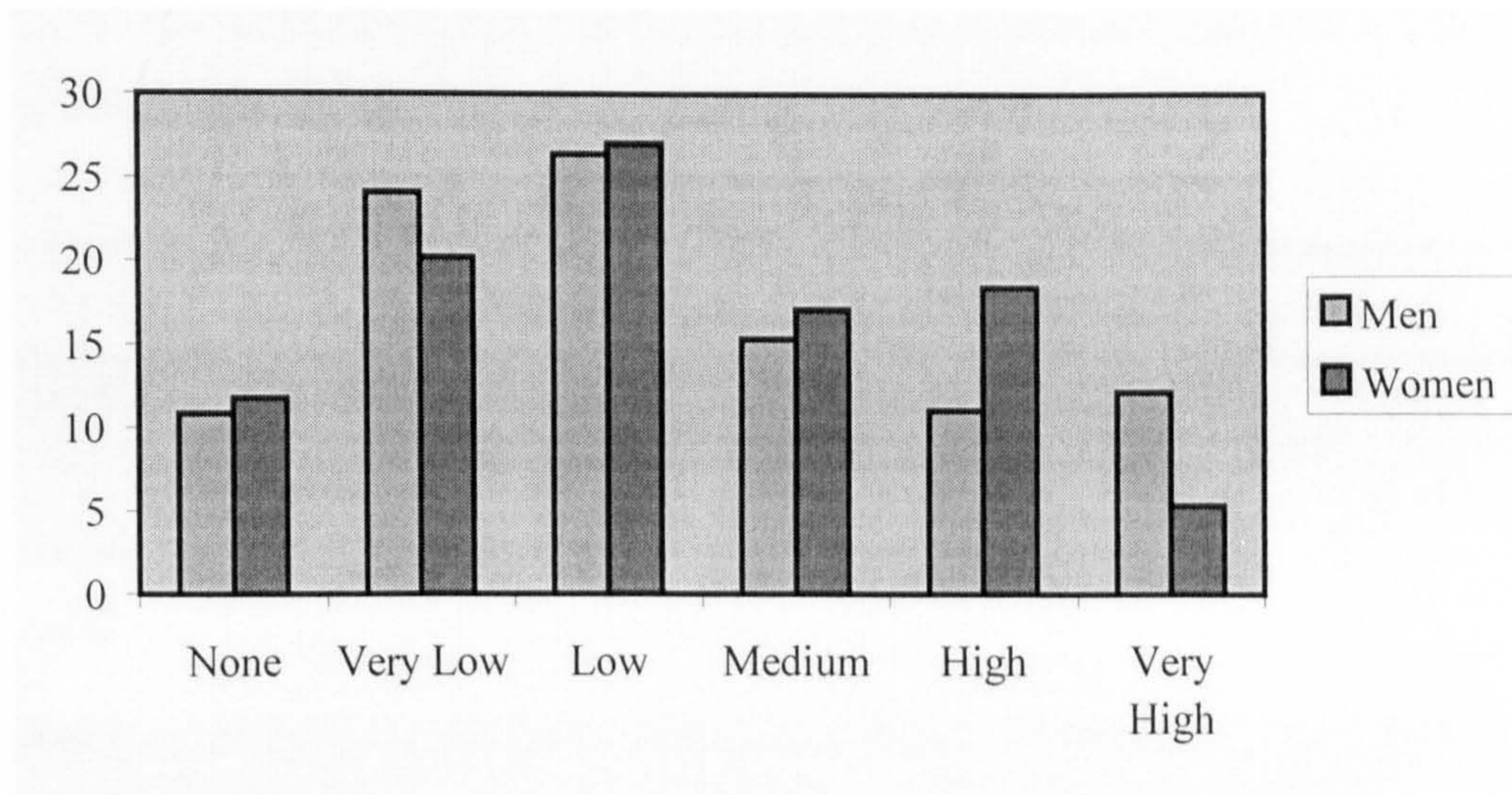
As the AIDS epidemic enters its third decade, it is necessary to assess its impact on behavioural change. In the absence of a cure for AIDS, behavioural change remains the most powerful strategy in the fight against AIDS. The literature shows that a range of factors influences the decision to change sexual behaviour. The overall aim of this chapter is to explore the psychosocial determinants of behavioural change among married men and women and also to describe the association between risk perceptions and behavioural change.

A number of models of behavioural change attempt to explain the factors that motivate a person to adopt HIV preventative action. According to these models, individuals are more likely to adopt AIDS preventive behaviours if they have information about the ways to reduce risk, feel that the infection would have serious consequences, feel personally susceptible to HIV infection, feel that they have sufficient self-efficacy to change their behaviour and believe that preventive steps are effective (Bandura 1977; Becker 1974). In order to reduce HIV transmission, an improved understanding of the factors that promote behavioural change is necessary. This chapter explores some of the preconditions that are often deemed important, if not sufficient, for behavioural change and focuses more specifically on the influence that these factors have on reported behavioural change.

7.2 Perceived Prevalence of HIV/AIDS

The perceived prevalence of HIV/AIDS is also likely to influence behavioural change. In order to assess respondent's perception of the prevalence of HIV/AIDS in their community, respondents in the survey were asked a number of questions. First, respondents were asked to choose from a set of drawings with shaded human figures, ranging from '1' (little or none) to '6' (very high), the one that best described the prevalence of HIV/AIDS in their community (see Figure 7.1).

Figure 7.1: Percent distribution of respondents according to perceived prevalence of HIV/AIDS in the community



Despite the high levels of HIV/AIDS in both the urban and rural areas, the figure reveals substantial dispersion of opinion with regard to perceived prevalence of HIV/AIDS, with a noticeable tendency towards understating the impact on the community. Nearly two-thirds of respondents perceive a low level of prevalence in their community, a trend that differs only modestly between men and women. This is indicative that there is widespread denial of HIV/AIDS in the community.

In order to determine the factors influencing perceived prevalence of HIV/AIDS, an analysis of variance (ANOVA) was conducted. One of the key assumptions underpinning ANOVA is that the data follows a gaussian (normal) distribution. First, the normal probability plot was applied to the residuals in order to determine whether they followed a Gaussian distribution. The results indicated that the residuals approximate a straight line. In addition, the box plot revealed a slight skewness in the peripheral areas but it was still normally distributed. Given this evidence we can be fairly confident that ANOVA is a suitable analytical technique. The mean scale score is 3.14 for women and 3.16 for men. The mean scores of the perceived prevalence of HIV/AIDS by background characteristics of men and women are shown in Table 7.1. The general impression is that socio-demographic differentials tend to be modest. Men gave higher estimates than women, although these differences are not large. The most striking deviation is for urban men. Their perception of prevalence is significantly lower than any other group. Younger respondents are more likely to perceive a higher prevalence than older respondents. Cohabiting men are more likely than the married

men to perceive a lower prevalence of HIV/AIDS, but this relationship is not significant. Women who are cohabiting are more likely to perceive a higher prevalence of HIV/AIDS than married women, but this relationship is also not significant. Opinions did not vary significantly by level of education.

Table 7.1: Mean scores on the perceived prevalence of HIV/AIDS in the community

Background Characteristics	Men	Women
Age		
Less than 35	3.57*	3.41*
35 and more	3.14	3.06
Marital Status		
Married	3.34	3.14
Cohabiting	3.19	3.44
Place of Residence		
Urban	2.98*	3.26
Rural	3.46	3.27
Level of Education		
Less than Secondary	3.45	3.17
Secondary or More	3.19	3.35
N	248	287

Note: *Significant at 5 percent

In order to determine the perceived prevalence of HIV/AIDS in the community, respondents were asked two additional questions to determine if they knew someone with AIDS: (A) *Has a member of your family or a friend ever suffered or died from AIDS?* (B) *In the last 12 months, have you attended a funeral of someone who died from AIDS?* These questions are used to assess the impact of knowing someone with AIDS on behaviour.

Table 7.2 shows that respondents are more likely to report having attended the funeral of someone with AIDS than report knowing someone close to them who had ever suffered or died from AIDS. Less than one-fifth of respondents report knowing someone close to them who has ever suffered or died from AIDS whereas more than a third of respondents report having attended the funeral of someone who died from AIDS. Responses of men and women are almost identical.

Table 7.2: Percentage of respondents who know someone who suffered or died of AIDS and who attended the funeral of someone who died from AIDS

	Men %	Women %
Has a member of family or a friend suffered or died from AIDS	16.3	16.5
Has attended the funeral of someone who died from AIDS	39.7	38.5
N	248	289

The link between the personal impact of AIDS (i.e. the death of a family member or friend and attendance at the AIDS-related funeral) and the perceived prevalence of HIV/AIDS in the community is examined, but differences are small and none are statistically significant (data not shown).

In the in-depth interviews and focus group discussions, respondents are asked about the most serious health problems in their area. The majority of respondents recognised AIDS as a serious health problem. It is perhaps significant that most urban respondents only identified AIDS as a serious health problem after prompting.

The high levels of HIV infection are seen to be demonstrated by the increase in the number of people unable to care for themselves, and the increasing number of people dying from AIDS.

AIDS is the biggest problem because young people are dying of AIDS on a daily basis. If the person is still alive he cannot do anything for himself because he does not have the energy and ends up being dependent on other people (Rural male, FGD)

Many of the respondents are aware of the link with STIs and they feel that the AIDS epidemic has been exacerbated by the high incidence of STIs and the lack of accessible health services for the management of STIs.

STIs are a big problem and youth have died of them. STIs can lead to AIDS. The clinic is far from here. We have to spend large amounts of money to hire a car to take a patient to a clinic (Rural Male, FGD)

Some respondents reported that it was difficult to state that AIDS is a major problem because there is such a stigma that is attached to AIDS. This may explain why people living with AIDS are afraid of disclosure.

I would even kill myself if I heard that I was HIV+.... People living with AIDS are usually isolated and criticised for not valuing their life (Rural female, IDI #3)

Discrimination against people living with AIDS is widespread and is often expressed in ostracism, rejection and isolation. Nevertheless, for those respondents who know someone living with HIV/AIDS there is no denying that AIDS is a serious health problem.

7.3 Perceived Self-Efficacy

To adopt measures to reduce their risk, people must believe that they can take preventive measures to reduce their risk (Tanfer et al. 1993). A person's confidence to carry out a specific behaviour has been found to be strongly related to a number of health behaviours, including behaviours to prevent HIV transmission (Adih and Alexander 1999). People who have a strong sense of self-efficacy are more likely to feel that they are active agents of their own actions and therefore more likely to adopt preventive behaviour (Schwarzer and Fuchs 1995).

In order to measure self-efficacy for married respondents, a composite indicator was created from two items. Respondents were asked to state their agreement with the following statements: (A) *There is not much use in trying to prevent HIV: if you are going to get it, you will get it eventually no matter how much you try;* (B) *If a wife/husband gets HIV or STIs from outside the marriage, there is nothing the husband/wife can do to avoid getting infected him/herself.* These items relate to confidence in one's ability to protect against the risk of HIV. Those who agree with both these statements are categorised as having a low perceived self-efficacy. Those who disagree with both these statements are categorised as having a high-perceived self-efficacy, while other combinations of responses form the medium category.

Table 7.3: Percent distribution of married respondents by perceived self-efficacy

Self-efficacy	Men %	Women %
Low	18.9	21.8
Medium	46.4	52.2
High	34.7	26.0
N	248	286

Table 7.3 shows that perceived self-efficacy varies somewhat between men and women. Overall, men are more likely than women to demonstrate a high perceived self-efficacy. Women are more likely than men to believe that there is not much use in trying to prevent AIDS: if you are going to get it, you will get it no matter how much you try. However, a large proportion of men feel that if a wife gets HIV or STIs from outside the marriage there is nothing the husband could do to avoid getting infected.

7.4 Belief in Condom Efficacy

In order to adopt preventive action, respondents also need to have knowledge of the means to protect themselves. As shown in Chapter 5, respondents are well informed of condoms. Knowledge of condoms is very high, with the majority of respondents reporting that they had heard of condoms. Beliefs about the efficacy of condoms might influence one's attitude towards use. Studies have shown that the belief that condoms effectively prevent HIV is predictive of consistent condom use (Adetunji and Meekers 2001; Wilson et al. 1991).

Despite the widespread knowledge of condoms as an effective strategy against HIV infection, many problems are associated with it, as discussed in more detail in Chapter 5. Table 7.4 shows that less than half of men and women feel that it is acceptable to use condoms in marriage. The use of condoms in non-marital relationships appears to be more acceptable. Men display greater opposition to the use of condoms within marriage than women. Almost 44 percent of men and 65 percent of women believe that it is acceptable for a married woman to ask her husband to use condoms. Both men and women are more supportive of unmarried than married women proposing condom use. More than four-fifths of men and women believe that it is acceptable for a woman who is not married to ask her partner to use condoms. These beliefs about condoms are likely to serve as a major barrier to their use in marital relationships. However, the direction of

causality may be difficult to ascertain. It is also likely that these beliefs may occur as a result of condom use.

Table 7.4: Percentage of married respondents who agree with specific statements about condoms

Statements	Men %	Women %
It is acceptable for a married couple to use condoms	41.1	49.0
It is acceptable for a married woman to ask her husband to use condoms	44.0	65.3
It is acceptable for a woman who is not married to ask her partner to use a condom	82.0	86.6
N	243	264

Note: respondents who had not heard of condoms were not asked about their attitudes to condoms.

7.5 Communication on HIV/AIDS

Studies have shown that many men and women do not adopt self-protective behaviour, in part because they find it difficult, if not impossible, to discuss with their partners' issues related to sexuality (Best 2002; Whitaker et al. 1999). In the survey, men and women were asked if they had talked to their married partner about the risk of HIV. The majority of men and women have talked to their partner about the risk of HIV. In general, men are more likely than women to report having discussed HIV.

Interestingly, men and women who reported that their married partner had other sexual partners are more likely than others to have discussed the risk of HIV, as shown in Table 7.5. Similarly, those who report higher levels of concern about contracting HIV from their married partner are also more likely to have discussed this topic.

Table 7.5: Percentage of married respondents who talked to their spouse about HIV, by whether they thought that their spouse had other sexual partners and whether they were concerned about contracting HIV from their spouse

	Men		Women	
	N	%	N	%
Partner has other sexual partners				
Yes	18	77.8	74	78.4**
No	179	63.7	60	54.2
Do not know	47	66.0	151	53.4
Concerned about contracting HIV from spouse				
Yes	56	94.6**	163	72.4**
No	188	56.1	122	41.8
N	244	65.1	285	59.3

Note: **Significant at 1 percent

Men and women who report that their 'non-marital' partner had other sexual partners were more likely than others to have discussed the risk of HIV, as shown in Table 7.6. Similarly, those who report higher levels of concerns about contracting HIV are also more likely to have discussed this topic.

Table 7.6: Percentage of married respondents who have talked to their non-marital partner about HIV, by whether they thought that their non-marital partner had other sexual partners and whether they are concerned about contracting HIV from their non-marital partner

	Men		Women	
	N	%	N	%
Partner has other sexual partners				
Yes	5	100.0**	10	30.0
No	7	75.0	2	0.0
Do not know	38	86.5	7	28.6
Concerned about contracting AIDS				
Yes	22	95.5	9	55.6*
No	28	77.8	10	0.0
N	50	85.8	19	31.6

Note: Fisher's Exact: *Significant at 5 percent

In the in-depth interviews, many respondents stated that they had discussed HIV with their partner. However, most of these discussions were often indirect and occurred as a result of concerns about the high prevalence of HIV.

We usually talk about the importance of remaining faithful to each other. We saw on TV the number of people living with AIDS and the number dying of AIDS. It really shocked us! (Urban Male, IDI #7).

Most tended to talk about HIV in a general sense, which often was not related to their particular sexual relationship. In most cases, couples discuss the importance of fidelity in sexual relationships and the use of condoms in casual sexual encounters.

We did speak about AIDS but we usually speak about the things that happened to other people. It is a bad disease. Diseases that are not curable are bad diseases. If you have these diseases you can expect to die (Rural Female, IDI #3).

We were discussing about the dangers of AIDS. We need to protect ourselves because there is no cure for AIDS (Urban Male, IDI #22)

In some cases, however, the discussion on HIV/AIDS was specific to their particular sexual relationship. Most respondents stated that they encouraged their partner to use a condom if they had other sexual partners.

We discuss that if I go outside I must use a condom....I mean that if I have sex with another women during my partner's absence (Rural Male, IDI #13)

We spoke about HIV and the importance of trust. If you get HIV from someone outside the home you will be robbing your partner of a fulfilling life (Urban Male, IDI # 9)

Women reported a greater willingness to talk about HIV than men. However, when women initiate discussion on HIV it is likely to result in conflict and may end with one partner accusing the other of being infected.

In most cases I'm the one who usually starts discussing it and then he doesn't want to talk much about this because he's got this belief that when I talk about AIDS it is because I know that sometimes he has affairs (Urban Female, IDI #27)

Some men and women claimed that they had never considered discussing HIV with their sexual partner. However, they felt that there was nothing preventing them from discussing HIV with their married partner. They stated that they did not have a reason for discussing HIV because their partner was trustworthy.

No, we did not discuss AIDS. I trust my partner. My partner is not sleeping around (Urban Male, IDI # 8)

7.6 Behavioural Change

As mentioned at the start of this chapter, behavioural change is the most effective strategy for reducing the risk of HIV. Accordingly, it is important to understand whether individuals are changing their behaviour in response to HIV/AIDS and if so, the main factors determining these changes. Respondents who said that they were concerned about contracting HIV from their married partner were asked: *Did you try anything to reduce the chance of getting HIV from him/her?* The number of men and women reporting behavioural change to reduce their risk was relatively low. Less than 30 percent of respondents who said that they were concerned about contracting HIV from their partner reported that they had adopted some measure to reduce their chance of getting AIDS. Women were more likely than men to report behavioural change, but the differences are modest.

Respondents were asked: *What did you do to reduce the chance of getting HIV?* A number of measures were reported. The most commonly reported change was the use of the condom, as shown in Table 7.7. Some typical responses were to advise their partner to limit their sexual partners, be faithful, avoid sex with multiple sexual partners, and be careful in choosing sexual partners. One man also reported having an HIV test.

Table 7.7: The measures taken by respondents who were concerned about contracting HIV/AIDS from their spouse

Measures	Men %	Women %
Injection	6.3	0.0
Condom	50.0	80.9
Withdrawal	6.3	2.1
Abstinence	0.0	8.5
HIV Test	6.3	0.0
Other	25.0	14.9
N	17	51

Note: Respondents who were not concerned about contracting HIV from their partner were not asked what they did to reduce the chance of getting HIV.

Studies examining predictors of testing have shown that those at highest risk are more likely to seek HIV testing than those with lower levels of risk (Berrios et al. 1993; De Rosa et al. 2001). HIV testing is an important component of prevention efforts (De Rosa et al. 2001). People infected with HIV who are asymptomatic may not be aware of their status without getting testing. Once a person knows their status they are able to adopt preventive measures to avoid transmitting the virus to others. In the survey, respondents were asked: *Have you ever had a test for HIV/AIDS?* Almost 30 percent reported that they were tested for HIV. Women were more likely to report higher rates of HIV testing than men. This is hardly surprising because in South Africa women attending antenatal services are actively encouraged to undergo HIV testing. However, in the survey there is no way of knowing for sure that respondents were told the result of their test.

It is not clear from the survey whether men and women use a HIV test as a means of protecting themselves. Table 7.8 shows that men did not necessarily have a HIV test because they perceived themselves at risk of HIV from their spouse. Other studies have documented various reasons why people have HIV tests. For example, Lupton et al. (1995) found that HIV testing may have symbolic meanings, including greater commitment or fidelity in sexual relationships, or the beginning or end of a relationship. In these instances, HIV testing may be result of the desire to no longer use the condom.

Table 7.8: The percentage of married respondents who had a HIV test by whether they are concerned about contracting HIV/AIDS from their spouse

Concerned about contracting AIDS	Men		Women	
	N	%	N	%
Yes	56	25.3	163	38.7
No	190	25.0	123	30.1
N	246	25.2	286	35.0

Note: NS

The two fundamental ways individuals can protect themselves from HIV/AIDS is by limiting their number of partners and using a condom (Ulin 1992). As discussed previously, few men reported having more than one sexual partner. In contrast, information gleaned from the qualitative data suggests that multiple sexual partnerships are very common among men. It is therefore difficult to attach much credence to self-reports of behaviour change. As in other studies, self-reports of sexual behaviour may not be completely reliable and should therefore be viewed with some caution. Numerous studies have found that considerable changes in behaviour are reported as a response to the threat of AIDS (Cleland 1995; Diclemente et al. 1990). However, reports of behavioural change do not correspond to the level of HIV infection. It may therefore be necessary to monitor changes in the number of partners over time in order to assess whether men and women are reducing their actual risk of HIV infection.

7.7 Condom Use

As mentioned previously, apart from sexual abstinence, condom use is the single, most effective strategy against AIDS. For a number of reasons, therefore, condom use may be a more appropriate measure of behavioural change. Information was obtained about condom use in marital relationships. Following the exploratory analysis in Chapter 5, those men and women who reported using the condom either 'always' or 'occasionally' at the time of the survey in answer to Q704 are considered condom users and all others as non-users. First, the factors affecting the use of condoms among married respondents are analysed using bivariate analysis. Having described the factors affecting the use of condoms using bivariate analysis, the relationship between some of these factors and condom use are explored using a standard multivariate logistic regression model. Having explored the socio-demographic factors influencing condom use in marital unions in Chapter 5, the purpose is to explore the psychosocial factors influencing

condom use in marital unions. In this model, the dependent variable is condom use with married partner. For each observation, the dependent variable takes the value of '1' if the married respondent reported using the condom either 'always' or 'occasionally' and '0' otherwise. The independent variables included psychosocial factors such as perceived severity of AIDS, perceived prevalence of HIV/AIDS, perceived vulnerability to HIV, belief in the efficacy of condoms and self-efficacy to use condoms. Separate logistic regressions are conducted for men and women. As part of the analysis, all first order interactions are systematically assessed. However, no significant interactions are observed among the major factors of the regression equation.

In general, women are more likely than men to report condom use, although the differences are modest. The bivariate analysis in Table 7.9 shows that perceived prevalence of HIV/AIDS in the community does not significantly increase condom use. Other studies have found that men and women who perceive the consequence of AIDS as severe are more likely to adopt protective behaviour (Adetunji and Meekers 2001). However, the present study found that knowing that AIDS is incurable does not lead to an increase in condom use among men and women. In fact, the opposite is observed. However, the direction of causality may be difficult to ascertain. It is also likely that these beliefs may have occurred as a result of condom use. Beliefs about the efficacy of condoms may also influence use. Those who know that condoms protect against HIV infection are more likely to report use than those who do not. Beliefs about one's ability to adopt preventive action also influences condom use. Those with a higher perceived self-efficacy are more likely to report using a condom than those with a lower perceived self-efficacy. Men who are at direct risk because of their own extramarital partnerships are more likely to use a condom than men who are not. However, this relationship is not significant. Concern about partner's behaviour does heighten the resolve to use a condom. Men and women who are concerned about contracting HIV from their partner are significantly more likely to report condom use than those who are not.

Table 7.9: Percentage of married respondents using a condom by psychosocial predictors

	Men		Women	
	N	%	N	%
Perceived Severity of AIDS				
Low	29	34.5**	45	17.8
High	217	12.0	243	17.3
Perceived Prevalence of AIDS				
Low	87	14.9	91	18.7
Medium	103	13.6	125	16.0
High	58	15.5	68	17.6
Perceived Self-Efficacy				
Low	47	17.0	62	14.5*
Medium	114	9.6	149	14.1
High	86	19.8	75	26.7
Belief in condom efficacy				
Low	61	9.8	27	7.4
High	184	15.8	236	20.3
Direct Risk				
Yes	44	22.7	19	10.5
No	203	12.8	269	17.8
Indirect Risk				
Yes	57	22.8*	164	25.0**
No	190	12.1	124	7.3
All	248	14.4	289	17.3

Note: *Significant at 5 percent **Significant at 1 percent

Table 7.10 shows that the variables that are individually significantly associated with condom use among men are perceived severity of AIDS and perceived self-efficacy. Men who perceived a low severity of AIDS are significantly more likely to use a condom than men who perceived a higher severity of AIDS. The odds of using a condom are 2.47 times higher among men with high self-efficacy scores than men with low self-efficacy scores. However, after controlling for the other variables, it is no longer significant. Table 7.10 shows that concern about contracting HIV from marital partners is a significant predictor of condom use among women. Women who are concerned about contracting HIV from their spouse are significantly more likely to be using the condom than women who are not. The odds of using condoms are 4.33 times greater for women who are indirectly at risk of HIV infection from their spouse. The odds of using a condom are higher among women with high self-efficacy scores than women with low self-efficacy scores. Condom use does not appear to be related to the

risky sexual behaviour of men and women. After controlling for the other variables, this relationship remains unchanged.

Table 7.10: The odds ratios of using a condom by psychosocial predictors: results from logistic regression

	Men		Women	
	Odds Ratios and 95% confidence intervals		Odds Ratios and 95% confidence intervals	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Perceived Severity of AIDS				
Low	1.00	1.00	1.00	1.00
High	0.26 (0.11-0.62)	0.29 (0.12-0.74)	0.96 (0.42-2.22)	0.66 (0.26-1.70)
Perceived Prevalence of HIV/AIDS				
Low	1.00	1.00	1.00	1.00
Medium	0.88 (0.38-2.00)	0.91 (0.38-2.20)	0.83 (0.41-1.69)	0.66 (0.30-1.45)
High	1.09 (0.44-2.74)	1.11 (0.40-3.08)	0.91 (0.40-2.06)	0.79 (0.32-1.94)
Perceived Self-Efficacy				
Low	1.86 (0.68-5.07)	1.93 (0.68-5.46)	1.06 (0.46-2.45)	1.01(0.41-2.49)
Medium	1.00	1.00	1.00	1.00
High	2.47 (1.09-5.62)	2.03 (0.83-4.97)	2.22 (1.11-4.43)	2.17 (1.01-4.69)
Belief in condom efficacy				
Low	1.00	1.00	1.00	1.00
High	1.68(0.39-7.31)	1.65 (0.36-7.49)	3.13(0.73-13.35)	2.85 (0.64-12.75)
Direct Risk				
Yes	1.89 (0.83-4.32)	1.78 (0.73-4.35)	0.47 (0.10-2.25)	0.41 (0.08-2.13)
No	1.00	1.00	1.00	1.00
Indirect Risk				
Yes	2.11 (0.98-4.51)	1.50 (0.63-3.61)	4.33 (2.01-9.34)	5.35 (2.38-12.06)
No	1.00	1.00	1.00	1.00

7.8 Summary

HIV/AIDS is recognised as a serious health problem in the community. However, denial of HIV/AIDS in the community is still widespread. There is very limited recognition of people living with AIDS. Denial has the potential of lowering self-perceived risk of HIV and also the need for self-protective behaviour (Campbell 2000). Respondents are more likely to report having attending the funeral of someone who had died of AIDS than report knowing someone close to them who had ever suffered or died from AIDS. Knowing someone with AIDS is likely to make the disease more salient in one's life and serve to promote protective sexual practices (Mansergh et al. 2000; Adetunji and

Meekers 2001). A study conducted in Zimbabwe found that single women who perceived themselves at risk because a large proportion of friends and relatives were dying of AIDS were more likely to adopt preventative measures than those who had low risk perceptions (Gregson et al. 1998).

Condoms are widely recognised as a highly effective method of prevention against HIV infection. Despite this, there is widespread distrust of condoms, especially in marriage. Condoms are not seen as appropriate for use in marital relationships. Both men and women expressed strong negative attitudes to the use of condoms in marital relationships. It is more acceptable to use condoms in non-marital than marital relationships. The association of condoms with lack of trust has had a detrimental effect on condom use in marital unions. Studies have found that negative attitudes to condom use are strongly predictive of non-use (Kapiga et al. 1995; Adih and Alexander 1999). Prevention programmes have an important role to play in providing greater acceptance of the condoms, especially in marital relationships.

A large fraction of men and women reported that they had discussed HIV with their partners. However, the results from the focus group discussions and in-depth interviews suggest that communication between men and women is fairly limited. In most cases, couples tend to talk about HIV in a general sense without relating it to their own sexual relationship. Sometimes discussion on HIV may descend into arguments with one partner accusing the other of being infected. This obviously serves as a major barrier to communication between partners. Men and women may be afraid of bringing up the subject because of the fear of being suspected of having HIV. Communication is important because it can help individuals' learn about their partner's risk of HIV (Whitaker et al. 1999). The survey found that men and women who have spoken to their partners about HIV are more likely to report that their partner had other sexual partners and that they are concerned about contracting HIV from their partner.

The multivariate analysis shows that perceived vulnerability to HIV is an important predictor of condom use among women. Women who perceive themselves at risk of HIV from their partner are more likely to report adopting protective behaviour than women who do not. Consistent with other studies, respondents with a higher self-efficacy are more likely to report condom use than those with a lower self-efficacy (Adih and Alexander 1999). In order to adopt protective behaviour, men and women

require some degree of control over decisions about condom use. Prevention programmes have an important role to play in instilling a sense of personal power to use condom consistently (Adih and Alexander 1999). Men and women who feel that they are able to exert personal control are more likely to adopt preventive behaviour.

Chapter 8

Dual Protection: Evidence from Matched Couples

8.1 Introduction

The traditional focus of family planning programmes has been on the promotion of highly effective methods of preventing pregnancy. However, with the rapid spread of HIV, a growing awareness has emerged that family planning programmes have an important role to play in preventing not only pregnancy but also disease. This became most apparent at the International Conference on Population and Development, which emphasised the integration of STI and FP services. Increasingly, dual protection, which refers to the simultaneous prevention of unwanted pregnancy and STIs/HIV, is promoted as the dominant preventive approach in reproductive health (Myer et al. 2002). Apart from sexual abstinence and non-penetrative sex, dual protection may also be achieved either by the consistent use of the condom alone or by the simultaneous use of the condom with another method of contraception (IPPF 2000).

The World Health Organisation, UNAIDS and United Nations Population Fund recently issued a joint statement emphasising that the condom, when used correctly and consistently, provides dual protection against pregnancy and disease (WHO 2000). Condoms used alone are highly effective, if used consistently and correctly, at preventing pregnancy and disease, but are associated with relatively higher pregnancy rates than most other modern methods during typical use because they are often not used correctly or consistently (Best 2001). Non-barrier methods (such as the pill, injectables, implants, IUD, and sterilisation) are highly effective at preventing pregnancy but provide little or no protection against STIs (including HIV/AIDS) (Best 2001). Thus, simultaneous use of the condom with a highly effective method for pregnancy prevention is recommended (Best 2001).

A number of factors may influence the propensity to practise dual protection in either of its two forms. Some of these factors function at the individual level to increase knowledge and alter risk perceptions, as argued by MacIntyre et al. (2001). However, some factors such as the attitudes of the partner in the sexual relationship, the level of communication and the larger context may also exert some influence over dual protection. Most studies have focused on men and women separately. However, it is

becoming increasingly evident that the dynamics of the reproductive processes and safe sex practices cannot be properly understood as long as researchers continue to base their conclusions on data collected from one partner (Bankole 1995).

The purpose of this chapter is to determine the factors influencing dual protection among couples. The first section of this chapter explores beliefs about HIV/AIDS and its salience. It begins by focusing on the perceived severity of the consequences of contracting HIV/AIDS. This is followed by an examination of the perceived level of HIV infection in the community, knowledge of someone who has suffered or died of HIV/AIDS and attendance at the funeral of someone who died from AIDS. The second section addresses perceived personal risk of HIV infection. This is achieved by analysing husbands' and wives' reports of their own sexual behaviour as well as their spouses' sexual behaviour. In particular, wives' perception of their husbands' infidelity is compared with husbands' report of extra-marital relationships and vice versa. The third section focuses on the acceptability of condoms in marital relationships and the extent to which discussion on condoms influences attitudes. The fourth section explores condom use within the marital context. This entails a thorough comparison of the reports of husbands and wives in relation to condom use for family planning purposes as well as the frequency of condom use. The final section explores significant correlates of condom use among couples.

8.2 Beliefs about HIV/AIDS and its salience

As stated previously, knowledge of HIV/AIDS is virtually universal among men and women, with the majority reporting that they had heard of HIV/AIDS. It is likely that the perceived severity of the disease influences the extent to which individuals are likely to engage in risk avoidance behaviour. The majority of husbands and wives perceived the consequences of AIDS as fatal. At the couple level, there also appears to be high level of agreement about the consequences of AIDS, as shown in Table 8.1. Almost three-quarters of husbands and wives share the view that the consequences of AIDS are severe.

Table 8.1: Percent distribution of couples by perception of severity of HIV/AIDS

Perceived severity	%
Both perceive as severe	75.1
Only wife perceives as severe	10.1
Only husband perceives as severe	12.6
Neither perceives as severe	2.2
N	237

Individuals who perceive the level of HIV infection to be medium-high in the community might be expected to be more concerned about HIV and therefore more likely to take action to protect themselves. At the aggregate level, husbands are more likely than wives to perceive a medium-high prevalence of HIV/AIDS in their community. At the couple level, more than half of husbands and wives share the view that the level of HIV/AIDS is medium or high in their community. Rosenstock (1974) suggested that a cue to action might be necessary to trigger appropriate health behaviour. Knowing someone with AIDS may serve as a cue to action. At the aggregate level, wives are more likely than husbands to report knowing someone who has suffered or died of AIDS and husbands are more likely than wives to report having attended the funeral of someone who died from AIDS. From a couple perspective, husbands and wives are more likely to show a higher level of concurrence with regard to attending the funeral of someone who died from AIDS than knowing someone close to them who suffered or died from AIDS (Table 8.2).

Table 8.2: Percent distribution of couples by whether they know someone who suffered or died of AIDS, attended the funeral of someone who died from AIDS and perceived prevalence of AIDS in the community

	Both Positive	Only wife positive	Only husband Positive	Neither positive	%	N
Perceive the level of HIV/AIDS in the community as medium-high	51.7	17.1	14.5	16.7	100	234
A member of family or a friend suffered or died from AIDS	5.1	11.8	10.1	73.0	100	237
Attended the funeral of someone who died from AIDS	16.7	22.3	22.3	38.7	100	233

Note: Totals do not tally because of missing data on a number of variables

An indicator score was created from these three items to measure the level of salience of the risk of HIV infection. The scores were then summed to provide an overall estimate of the salience of HIV infection. The overall score ranges from 3 to 9, with high scores

indicating high salience and low scores indicating low salience. The cronbach reliability coefficient for the indicator is 0.6 for men and women. Finally, the distribution of scores is divided into two categories of zero and one. A total score of less than four is coded as zero and any higher score is coded as one. As Table 8.3 shows, at the couple level, the level of agreement is relatively high. More than half of the couples report a high salience of HIV. However, wives are slightly more likely than husbands to report a high salience of HIV.

Table 8.3: Percent distribution of couples by whether they perceive a high salience of HIV

Perceived salience	%
Both perceive a high salience	57.3
Only wife perceives a high salience	15.8
Only husband perceives a high salience	13.2
Neither perceive a high salience	13.7
N	234

8.3 Perceived Vulnerability to HIV Infection

As discussed previously, risk perceptions may influence the motivation to adopt protective behaviour. Perception of risk of HIV infection is likely to be influenced by own sexual behaviour and partner's sexual behaviour. Husbands are more than two times more likely than wives to report having other sexual partners in the last three years (18% versus 7%). Obviously, there is a difficulty in obtaining information about sexual partners, particularly from married respondents. Koenig et al. (1984:p281) argue that "because of the personal nature of this issue, responses are likely to be intricately tied to perceived cultural norms and taboos". These results may therefore suffer from under-reporting and therefore should be regarded as lower bound estimates.

Respondents were also asked about their spouse's sexual behaviour. The most remarkable feature of Table 8.4 is the striking differences between the reports of husbands and wives. Wives are more likely than their husbands to report that their spouse has other sexual partners. At this juncture, it may be worthwhile observing that, in KwaZulu-Natal, it is more acceptable for the husband than the wife to have other sexual partners. This gender inequality may have contributed to the husband's reticence to state that their wife has other sexual partners.

Table 8.4: Percentage of husbands and wives who report that their spouse had other sexual partners

Partner had other sexual partners	Husbands	Wives
	%	%
Yes	7.0	24.4
No	74.3	22.7
Do not know	18.7	52.9
N	236	236

Table 8.5 compares the wife's perception of the husband's infidelity with the husband's report of extra-marital sexual relationships. The relationship between husband's behaviour and wife's perception is in the expected direction. Specifically, wives whose husbands report having extra-marital partners in the last three years are less likely to perceive their spouses to be faithful and more likely to be unsure than other wives, though this difference is not statistically significant. The dominant impression remains, however, that the link between reported behaviour and spousal perception is rather weak, either because of misreporting of behaviour or misperception by wives.

Table 8.5: Wife's perception of her husband's infidelity compared with the husband's reporting of extra-marital sex

Husband's Report	Wife's Perception				
	Yes	No	Unsure	%	N
Yes, last three years	23.3	16.3	60.5	100	43
Yes, more than three years	22.1	25.0	52.9	100	68
No	25.6	24.0	50.4	100	125
N	57	54	125	100	236

Note: NS

Table 8.6 compares the husband's perception of the wife's infidelity with the wife's report of extra-marital sexual relationships. The relationship between the wife's behaviour and the husband's perception is not in the expected direction. Specifically, husbands whose wives report having extra-marital partners in the last three years are not more likely to perceive their spouses to be unfaithful. Only 12 percent of husbands whose wives had other sexual partners correctly perceived them to be unfaithful. However, almost one-fifth of husbands whose wives report having other sexual partners more than three years ago are unsure about their spouses' faithfulness.

Table 8.6: Husband's perception of the wife's infidelity compared with the wife's reporting of extra-marital sex

Wife's Report	Husband's Perception				
	Yes	No	Unsure	%	N
Yes, last three years	11.8	64.7	23.5	100	17
Yes, more than three years	8.2	70.5	21.3	100	61
No	6.3	76.6	17.1	100	158
N	17	175	44	100	236

Note: NS

Perceived vulnerability to HIV infection from spouse is likely to be a major factor in the adoption of protective behaviour within marriage. In 13.6 percent of couples, both partners said that they are concerned about contracting HIV, while in 34.9 percent both said they are not. Table 8.7 shows that wives are more likely than husbands to be concerned about contracting HIV from their spouse. Almost 56.6 percent of wives said that they are concerned about contracting HIV from their partner, compared with 22.1 percent of husbands.

Table 8.7: Percent distribution of couples by whether they are very and somewhat concerned about contracting HIV/AIDS from their spouse

Perceived Concern	%
Both concerned	13.6
Wife only	43.0
Husband only	8.5
Neither concerned	34.9
N	236

Table 8.8 compares the wife's perception of her husband's infidelity with the wife's concern about contracting HIV from him. Wives who perceive their husbands as unfaithful are much more likely to feel concern about contracting HIV from them than other wives. Table 8.8 shows that the 'unsure' are really intermediate between the positive and negative groups. A little over half of the wives (52.8%) who report that they are unsure about their husbands' infidelity are very or somewhat concerned about contracting HIV from them, compared with 82.8 percent of the wives who believe their husbands to be unfaithful and 40.7 percent of those who believe that they are faithful.

Table 8.8: Wife's perception of spouse's infidelity and concern about HIV infection from spouse

Wife's perception of spouse's infidelity	Wife's Level of Concern				
	Very	Somewhat	Not	%	N
Yes	55.2	27.6	17.2	100	58**
No	14.8	25.9	59.3	100	54
Unsure	16.8	36.0	47.2	100	125
N	61	75	101	100	237

Note: **Significant at 1 percent

Table 8.9 compares the husband's perception of the wife's infidelity with the husband's concern about contracting HIV from her. The relationship is in the expected direction and statistically significant. Of those husbands who perceived their wives as unfaithful, almost two-fifths report that they are very or somewhat concerned. However, more than half of husbands who suspect their wives of infidelity report that they are not concerned about contracting HIV from her. Also, 36.3 percent of husbands who are unsure about their spouses' fidelity are very or somewhat concerned about contracting HIV from them. Husbands who perceive their wives as faithful are significantly less likely to be concerned about contracting HIV from their spouses than other husbands.

Table 8.9: Husband's perception of spouse's infidelity and concern about HIV infection from spouse

Husband's perception of spouse's infidelity	Husband's Level of Concern				
	Very	Somewhat	Not	%	N
Yes	18.8	18.8	62.5	100	16**
No	5.1	11.4	83.4	100	175
Unsure	4.5	31.8	63.6	100	44
N	14	37	184	100	235

Note: **Significant at 1 percent

Perception of risk of HIV infection from spouse is also likely to be influenced by the perceived prevalence of HIV/AIDS in the community and personal knowledge of someone with AIDS. Table 8.10 shows, that husbands and wives with a high salience are significantly more likely to be very or somewhat concerned about contracting HIV from their spouses than husbands and wives with a low salience.

Table 8.10: Percent distribution of couples by perceived salience of HIV and concern about contracting HIV

Level of Concern	Husbands		Wives	
	High %	Low %	High %	Low %
Very Concerned	7.9	1.4*	27.5	20.6*
Somewhat Concerned	18.2	11.3	35.1	23.8
Not Concerned	66.3	87.3	37.4	55.6
N	165	71	171	63

Note: *Significant at 5 percent

8.4 Acceptability of Condoms

In order to protect themselves against the risk of HIV, husbands and wives need to be well-informed about the means of protecting themselves. As Table 8.11 shows the level of knowledge of condoms is high among husbands and wives, similar to the results from Chapter 5. More than 9 out of 10 husbands and wives have both heard of condoms. However, husbands are more likely than wives to have heard of the condom. Knowledge of a source of supply of condoms is also high among husbands and wives, as shown in Table 8.11. Most husbands and wives report that they know where to obtain condoms, though husbands are more knowledgeable than wives. As discussed previously, knowledge by itself is not sufficient to explain the use of condoms. Other factors, such as awareness of condom efficacy, may also influence use.

Table 8.11: Percent distribution of couples by whether they had heard of condoms and knew where to obtain them

	Both Knowledge- able	Wife Only	Husband only	Neither Knowledge -able	%	N
Heard of condoms	89.5	2.5	8.0	0.0	100	238
Know where to obtain condoms	84.0	4.6	11.0	0.4	100	238

Condoms are widely recognised as an effective method for preventing HIV infection. At the aggregate level, knowledge of condoms as an effective method of HIV prevention is high. However, husbands are more likely than wives to perceive condoms as effective at HIV infection. The level of agreement is also high among couples, as shown in Table 8.12. More than 70 percent of spouses share the same view about the benefits of condoms in preventing HIV.

Table 8.12: Percent distribution of couple by agreement that condoms are effective at preventing HIV

Condoms are effective at preventing HIV	%
Both agree	71.3
Wife only	17.7
Husband only	9.7
Neither agree	1.3
N	237

Resistance to the idea of condoms in marital relationships is likely to be a deterrent to their use in marital relationships. Respondents who had heard of condoms were asked to reveal their perception of, and attitudes towards, the use of condoms in marriage by expressing their agreement or disagreement with some statements. In the aggregate, husbands and wives hold differing views, with husbands consistently reporting more negative attitudes to the use of condoms in marriage than wives. Table 8.13 shows that couples are more likely to share the view that it is acceptable for an married woman to ask her spouse to use a condom and less likely to share the view that it is acceptable for a married couple to use condoms. Less than one-fourth of spouses share the view that it is acceptable for a married couple to use condoms every time they have sex.

Table 8.13: Percent distribution of couples by agreement with specific statements about condoms

Statement	Both Agree	Wife only	Husband only	Neither Agree	%
It is acceptable for a married couple to use condoms	26.3	23.4	16.8	33.5	100
It is acceptable for a married woman to ask her husband to use condoms	32.9	32.9	12.8	21.6	100
To protect themselves against HIV and STIs, a married couple can use condoms every time they have sex	23.8	31.5	17.0	27.7	100

In order to summarise attitudes to the use of condoms in marriage, scores were created from responses to these statements. The scores were then summed to provide an overall estimate of attitudes to the use of condom in marital relationships. The overall attitude score ranges from 3 to 9, with high scores indicating more positive attitudes and low scores indicating less positive attitudes. Reliability analysis was conducted using the cronbach alpha coefficient. The scale has an internal consistency reliability coefficient of 0.6 for women and 0.8 for men. Finally, the scale was divided into three categories:

positive, negative and neutral. Table 8.14 examines the distribution of couples by whether they hold positive attitudes to condoms in marriage. At the aggregate level, wives have a more positive attitude than husbands to condom use in marital relations. At the couple level, one-fifth of husbands and wives share a positive attitude to the use of condoms in marital relationships.

Table 8.14: Percent distribution of couples by positive attitudes to the use of condoms in marital relationships

Attitudes to Condoms	%
Both positive	20.8
Only wife positive	27.1
Only husband positive	11.6
Neither positive	40.5
N	207

Note: Respondents who had not heard of condoms were not asked about their attitudes to condoms

Partner communication is likely to be an influential factor determining the use of condoms in marital relationships. Almost 44 percent of husbands and 47 percent of wives said that they had discussed condom use with their partners. In general, 70.9 percent of couples gave consistent responses about their discussions on condoms. In 31.3 percent of couples, both partners said that they had discussed condoms while in 39.7 percent both said that they had not. Table 8.15 shows substantial disagreement with regard to the frequency of discussion on condom use. The kappa index is 0.2, which suggests a poor level of agreement among spouses, although it differs significantly from zero indicating greater agreement than would be expected by chance alone. Among those husbands who reported having discussed condoms at least a few times, more than one-quarter of their wives reported that they had not. Among those husbands who reported never having discussed condoms, 27.8 percent of their wives reported that they had. Some of the discrepancies may be explained by differences between men and women in recall or interpretation of what constitutes discussion, as argued by Blanc and Wolff (2001).

Table 8.15: Percentage of wives' reporting of frequency of discussion on condoms, by husbands' reporting of frequency of discussion on condoms

Husband's Report	Wife's report				%	N
	Many Times	Few Times	Once	Never		
Many Times	17.9	42.4	10.7	28.6	100	28
Few Times	10.9	40.0	20.0	29.1	100	55
Once	36.4	13.6	13.6	36.4	100	22
Never	6.0	15.8	6.0	72.2	100	133
N	27	58	25	128	100	238

Note: Kappa: 0.02

It is expected that willingness to discuss condoms will be associated with positive attitudes. Table 8.16 shows that discussion of condoms is strongly associated with more positive attitudes to condoms. Wives who report having discussed condoms many times are more likely to report more positive attitudes to condom use in marriage than wives who report having discussed it a few times. Also, almost half of wives who reported not having discussed condoms reported neutral attitudes to condoms.

Table 8.16: Wife's attitude to condom use in marital relationships, by frequency of discussion on condoms with spouse

Discussed condoms	Attitudes to condom use in marital relationships				%	N
	Positive	Neutral	Negative			
Many Times	73.1	23.1	3.8		100	26**
Few Times	56.7	38.3	5.0		100	60
Once	66.7	29.2	4.2		100	24
Never	30.8	50.0	19.2		100	104
N	101	88	25		100	214

Note: Significant at 1 percent

The same general pattern is also observed for husbands. Table 8.17 shows that husbands who report having discussed condoms with their spouse at least a few times are more likely than others to have a more positive attitude to the use of condoms in marital relationships. However, having discussed condoms only once with spouse is strongly associated with negative attitudes to condoms. It is possible that that this discussion ended in conflict and as a result, it was not resumed. Also, almost two-fifths of husbands who report never having discussed condoms with their spouses also report negative attitudes to the use of condoms in marital relationships.

Table 8.17: Husband's attitude to condom use in marital relationships, by frequency of discussion on condoms with spouse

Discussed condoms	Attitudes to condom use in marital relationships				
	Positive	Neutral	Negative	%	N
Many Times	37.0	48.1	14.8	100	27**
Few Times	46.4	33.9	19.6	100	56
Once	25.0	25.0	50.0	100	20
Never	20.5	37.0	42.5	100	127
	67	84	79	100	230

Note: Significant at 1 percent

Almost 63 percent of husbands and 59 percent of wives report having discussed the risk of HIV with their spouses. In general, 64 percent of couples gave consistent responses about their discussions on the risk of HIV. In 42.6 percent of couples, both partners report having discussed the risk of HIV, while in 21.3 percent both report not having discussed, as shown in Table 8.18. The kappa index also suggests a poor level of agreement among spouses. As shown in Chapter 6, the topic of discussions may be general in nature as well as personal.

Table 8.18: Percent distribution of couples by whether they have discussed the risk of HIV

Discussed the risk of HIV	%
Both report having discussed	42.6
Only wife	15.7
Only husband	20.4
Neither report having discussed	21.3
N	238

Note: Kappa: 0.3

Table 8.19 shows the percentages of wives reporting having discussed the risk of HIV by their level of concern about the risk of HIV infection. Wives who report having discussed the risk of HIV with their spouses are more likely to express a degree of concern about the risk of HIV infection than wives who have not (70% versus 38%). The same relationship holds for husbands (see Table 8.20).

Table 8.19: Wives' level of concern about the risk of HIV, by frequency of discussion on the risk of HIV with spouse

Discussed the risk of HIV	Level of Concern			%	N
	Very Concerned	Somewhat Concerned	Not Concerned		
Yes	37.4	33.1	29.5	100	139**
No	8.4	29.5	62.1	100	95
N	60	70	100	100	234

Note: **Significant at 1 percent

Table 8.20: Husband's level of concern about the risk of HIV, by frequency of discussion on the risk of HIV with spouse

Discussed the risk of HIV/AIDS	Level of Concern			%	N
	Very Concerned	Somewhat Concerned	Not Concerned		
Yes	9.5	23.1	67.3	100	147**
No	0.0	3.5	96.5	100	85
N	14	37	181	100	232

Note: **Significant at 1 percent

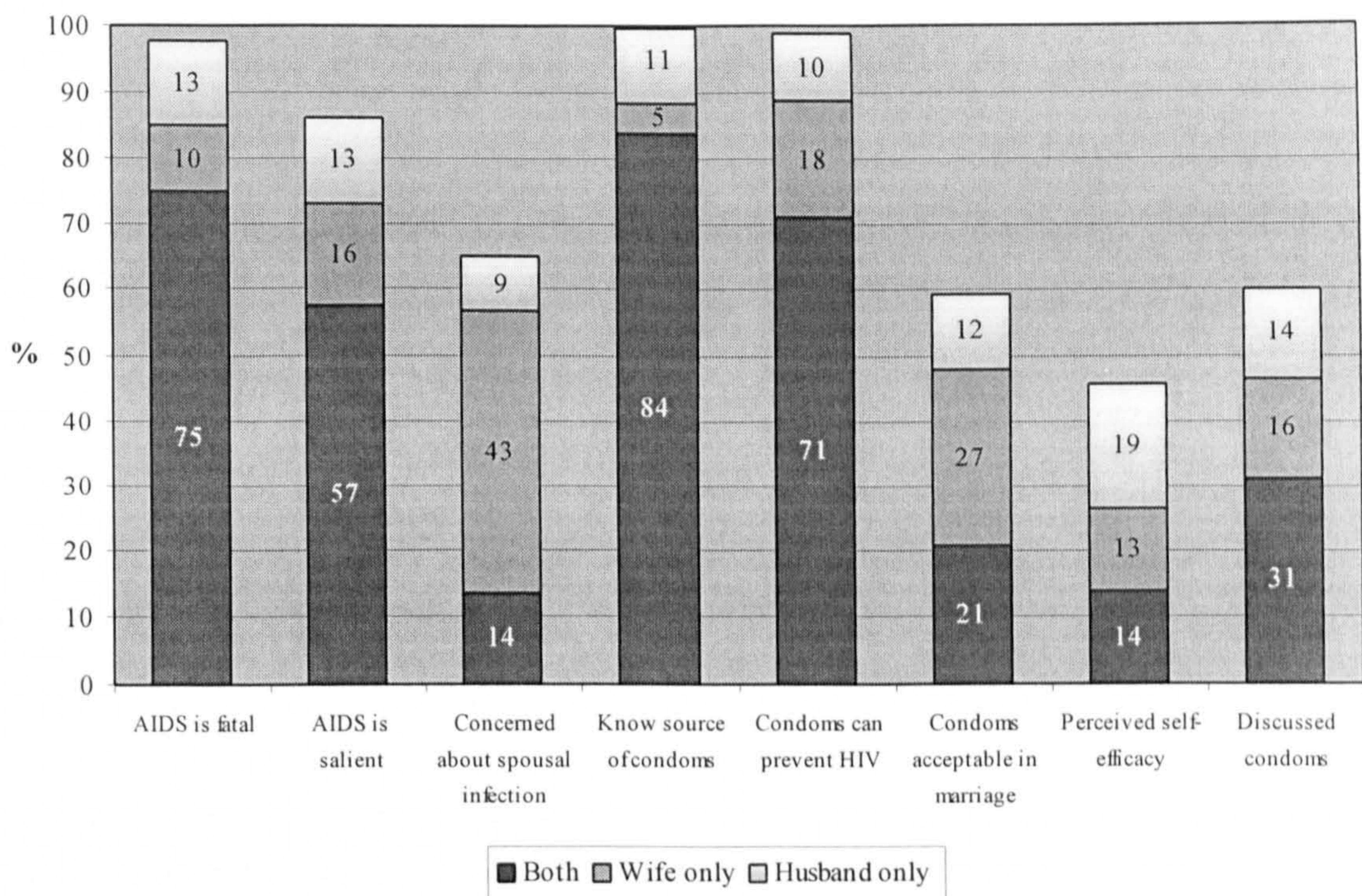
In order to reduce their level of risk of HIV infection, individuals have to have confidence in their ability to protect themselves. A composite indicator of perceived self-efficacy was created, as explained in Chapter 7. Table 8.21 shows that perceived self-efficacy vary somewhat between husbands and wives. Overall, husbands display greater confidence in their ability to protect themselves against the risk of HIV than their wives. Wives are more likely than husbands to report that there is not much use in trying to prevent HIV: if you are going to get it, you will get it no matter how much you try. However, husbands are more likely than wives to believe that if a wife gets HIV from outside the marriage, there is nothing the husband can do to avoid getting infected himself. At the aggregate level, about one-third of husbands and one-quarter of wives are classified as possessing a high perceived self-efficacy. At the couple level, few husbands and wives perceived a high self-efficacy, as shown in Table 8.21.

Table 8.21: Percent distribution of couples by whether they have a high perceived self-efficacy

Perceived self-efficacy	%
Both have a high self-efficacy	13.7
Only wife has a high self-efficacy	12.8
Only husband has a high self-efficacy	19.2
Neither have a high self-efficacy	54.3
N	234

To summarise, knowledge of HIV/AIDS is virtually universal among men and women. Husband and wives perceive the consequences of AIDS as severe. Almost three-quarters of husbands and wives share the view that AIDS is fatal, as shown in Figure 8.1. In couples, more than half of husbands and wives perceived a high salience of HIV. Wives are more likely than husbands to perceive a high salience of HIV. Few husbands and wives report having other sexual partners. However, wives are more likely than husbands to perceive their spouse as unfaithful. As a result, it is not surprising that wives are more likely than husbands to feel at greater risk of HIV infection in their marital relationships. Knowledge of condoms is very good. Most husbands and wives have heard of condoms and also, know of a source of supply of condoms. Condoms are widely recognised as a highly effective method of protection against HIV infection. However, there are many barriers to condom use in marital relationships. Condoms are seen as less acceptable in marital than non-marital relationships. However, wives are more likely than husbands to hold positive attitudes to condoms in marriage. Communication on condom use is fairly limited among couples. Husbands are more likely than wives to report more frequent discussion on condoms. In order to protect themselves, husbands and wives must believe that they have the ability to take action. However, husbands are more likely than wives to have a high self-efficacy.

Figure 8.1: Summary Indicators on Dual Protection



8.5 Condom Use within Marriage

As discussed in Chapter 4, in order to explore condom use, respondents were asked two questions. The first focused more specifically on the use of any method for preventing and/or delaying pregnancy. Respondents were asked: *Are you and <name> currently doing something or using any method to delay or avoid pregnancy? Which method are you using? (Q411)*. The second focused more specifically on frequency of condom use. Following a battery of questions on AIDS, respondents were asked: *Have you and <name> ever used a condom? (Q703) Do you use a condom always, occasionally or only at the beginning of the relationship? (Q704)*

A myriad of possible definitions of condom use could conceivably be developed based upon the responses to these questions. Nonetheless, for the purpose of this study, four categories have been developed. Three of these are considered ‘generous’ definitions, in that they adopt a more expansive, inclusive approach. The first of these ‘generous’ definitions was formed by including cases where either the husband or the wife reported in Q411 current use of condoms for preventing and/or delaying pregnancy with their spouse or either the husband or the wife reported using a condom either ‘always’ or ‘occasionally’ with their spouse in Q704. The second and third definitions are derivatives of the first, one focusing exclusively on the husband’s testimony of having

used condoms for preventing and/or delaying pregnancy or using a condom either 'always' or 'occasionally', while the other focuses on the wife's testimony. Apart from these three 'generous' definitions of condom use, one narrow definition was employed that was based on the second set of questions. This was constructed by including cases where *both* husband and wife mentioned that they either 'always' or 'occasionally' used condoms with their spouse.

Couples' reports of their condom use using these definitions are shown in Table 8.22. Among one-third of couples, either the husband or the wife report using the condom with their spouse. In general, husbands are more likely than wives to report condom use with their spouses: (27% versus 18%). Not unexpectedly, condom use is much lower (10%) when applying the more restrictive criterion that both spouses report use.

Table 8.22: Percent distribution of couples according to their reports of condom use with their spouses

Condom Use	%
Either husband or wife report condom use	32.6
Only wife reports condom use	17.9
Only husband reports condom use	27.0
Both report condom use	9.9
N	238

It is clear that condom use may be defined in a number of ways and that different definitions yield widely contrasting estimates of use. The possible reasons have been outlined in Chapter 4. It was therefore necessary to carry out some exploratory analysis to seek explanations for the discrepancies and arrive at the most defensible measure. First, condom use for family planning purposes is examined using husbands' and the wives' reports, as shown in Table 8.23. Husbands have a greater tendency to report condom use for contraceptive purposes than wives. Almost 26 percent of husbands report using the condom for contraceptive purposes, compared with 5.9 percent of wives. As Table 8.23 shows, the level of agreement is low when husbands' report of condom use for contraceptive purposes are compared with wives' report of condom use for contraceptive purposes. Among husbands who reported using condoms for delaying and/or preventing pregnancy, less than one-fifth of their wives concurred with them.

Table 8.23: Percent distribution of wives' reporting use of condoms for preventing and/or delaying pregnancy with their spouses, by their husbands' reported use of condoms for preventing and/or delaying pregnancy with their spouses

Husband's report	Wife's report			
	Yes	No	%	N
Yes	18.7	81.3	100	61
No	1.7	98.3	100	177
N	14	224	100	238

Note: Kappa: 0.2

Secondly, frequency of condom use reported in Q703/4 is examined using husbands' and wives' reports. At the aggregate level, there is a high level of agreement about condom use. Overall, 20 percent of husbands and 21 percent of wives report ever using the condom with their spouses. In general, 85.7 percent of couples gave consistent responses about their ever use of condoms. In 13.5 percent of couples, both partners said that they had ever used the condom, while in 72.2 percent both said they had not. Much less agreement about the frequency of condom use is observed, as shown in Table 8.24. Wives are more likely than husbands to report more frequent use of the condom. Of the five husbands who reported using condoms 'always', none of their wives concurred with them but two gave the 'occasional' response. Of the 31 husbands who reported using condoms occasionally, more than half concurred with them and an additional 19.4 percent said that they 'always' used condoms.

Table 8.24: Percent distribution of wives' reporting frequency of condom use with their spouses, by their husbands' reporting frequency of condom use with their spouses

Husband's Report	Wife's Report				%	N
	Always	Occasionally	Beginning	Never		
Always	0.0	40.0	20.0	40.0	100	5
Occasionally	19.4	51.6	6.5	22.6	100	31
Beginning	15.4	23.1	7.7	53.8	100	13
Never	2.1	5.3	2.6	90.0	100	189
N	12	30	8	188	100	238

Note: Kappa: 0.4

As discussed in Chapter 4, the large discrepancies in husbands and wives reports of condom use in preventing and/or delaying pregnancy raises questions about the validity of their responses. In further exploration, the husband's reports of condom use for family planning in Q411 is compared with his reports of frequency of condom use with his spouse in Q704. Table 8.25 shows major discrepancies in husbands' reports of condom use. Also, of the 61 husbands who report using the condom for family planning

purposes, only 52.5 percent report currently using the condom ‘always’ or ‘occasionally’ in Q704 and 31.3 percent report never having used condoms with their spouse. It is possible that husbands may be reporting condom use with other sexual partners. However, the survey instrument explicitly asked about use with named spouse.

Table 8.25: Percent distribution of husbands’ reporting frequency of condom use with their spouses, by their reporting of condom use for family planning with their spouses

Condom use for family planning	Frequency of condom use				%	N
	Always	Occasionally	Beginning	Never		
Yes	8.2	44.3	16.4	31.1	100	61
No	0.0	2.2	1.7	96.1	100	177
N	5	31	13	189	100	238

The wife’s report of condom use for family planning is also compared with her report of frequency of condom use with her spouse. As Table 8.26 shows, wives who report using condoms for family planning purposes are also likely to report using condoms with their spouses in Q703. Of those wives who report using condoms for family planning purposes, all report using condoms either ‘always’ or ‘occasionally’ with their spouses. It is worth noting that almost 13 percent of wives who report not using condoms for family planning report using condoms either ‘always’ or ‘occasionally’ with their spouses.

Table 8.26: Percent distribution of wives’ reporting frequency of condom use with their spouses, by their reporting of condom use for family planning with their spouses

Condom use for family planning	Frequency of Condom Use				%	N
	Always	Occasionally	Beginning	Never		
Yes	50.0	50.0	0.0	0.0	100	14
No	2.2	10.7	3.6	83.6	100	224
N	12	30	8	188	100	238

Husbands’ reports of condom use for family planning in Q411 are compared with wives’ reports of frequency of condom use in Q704. As Table 8.27 shows, among husbands who report using condoms as a method of family planning, about half of their wives concur with them. This indicates that a substantial proportion of men who report condom use for family planning are indeed using condoms but nevertheless the testimonies of husbands and wives differ in nearly 50 percent of couples.

Table 8.27: Percent distribution of wives' reporting frequency of condom use with their spouses, by their husbands' reporting of condom use for family planning with their spouses

Husband's report of condom use for family planning	Wife's report of frequency of condom use				%	N
	Always	Occasionally	Beginning	Never		
Yes	13.1	32.8	3.3	50.8	100	61
No	2.3	5.6	3.4	88.7	100	177
N	12	30	8	188	100	238

To summarise, men are more likely than women to report using condoms for family planning, while women are more likely to report using more effective methods for this purpose. This is hardly surprising given the strongly held belief that family planning is the woman's responsibility. It is therefore likely that husbands are over-reporting condom use for family planning. Moreover, comparison of husbands' reports of condom use for preventing and/or delaying pregnancy with their reports of frequency of condom use in Q704 with their spouse showed substantial discrepancies. Among the husbands who reported using the condom for family planning purposes, only half reaffirmed this in Q704. This raises further questions about the validity of husbands' reports of condom use. In addition, husbands are more likely to report using condoms for family planning than for other purposes. It would appear that men are more willing to admit to condom use for family planning than to report use in the context of preceding questions about HIV/AIDS. It is possible that men are over-reporting condom use for family planning purposes because they want to appear modern. For a variety of reasons, therefore, the woman's report of condom use is seen as a more reliable account of the behaviour of the couple. For our analysis, couples are defined as condom users if the wife reports using condom either 'always' or 'occasionally' in Q704.

8.6 Correlates of Condom Use

As mentioned at the start of the chapter, the simultaneous use of dual methods has been recommended as the most effective way of protection against the risk of unwanted pregnancy and STIs/HIV (IPPF 2000). On the basis of their responses, couples are divided into two categories of users: condom users and dual method users. An overwhelming majority of women who reported using condoms also reported using another method for preventing and/or delaying pregnancy. Overall, 17.9 percent of women reported using condoms but 15.9 percent of these reported using the condom in conjunction with another method of contraception. As only 2 percent of women

reported sole use of condoms, these are amalgamated with the dual method users for the purpose of analysis.

Table 8.28 shows the percentage of couples using condoms 'always' or 'occasionally' by the socio-demographic characteristics of husbands and wives. Education is an important correlate of condom use. The proportion using condoms increases dramatically from 7.4 percent among wives with less than secondary to 26.4 percent among wives with secondary or higher education. The husband's level of education is another important correlate of condom use. Wives whose husbands have more than secondary education are more likely to use condoms than wives whose husbands have less than secondary education. As expected, urban residence is significantly associated with higher condom use. With regard to marital status, condom use occurs more frequently among cohabiting than married couples. Condom use is significantly associated with the wife's fertility intentions. Condom use is considerably higher among wives who are undecided about their fertility intentions than other wives. The association between age and condom use is not significant.

Table 8.28: Percentage of couples using condoms by selected socio-demographic characteristics

Background Characteristics	Husband's Characteristics		Wife's Characteristics	
	N	%	N	%
Age				
Less than 35	81	22.2	139	20.1
35 or more	157	15.9	99	14.1
Marital Status				
Married	144	13.3*	142	12.7*
Cohabiting	94	24.5	96	25.8
Place of Residence				
Urban	76	30.3**	76	30.3**
Rural	162	12.3	162	12.3
Level of Education				
Less than Secondary	90	7.8**	109	7.4**
Secondary or More	238	24.3	129	26.4
Fertility Intentions				
Wants soon	21	22.7	18	16.8*
Wants later	66	21.2	53	9.4
Wants no more	75	17.3	100	13.0
Undecided	75	14.7	66	31.8
All	238	17.9	238	17.9

Note: *Significant at 5 percent **Significant at 1 percent

The link between cognitive and attitudinal factors and condom use is examined in Table 8.29. The association between condom use and perceived severity of HIV infection is weak. Knowing that there is no cure for AIDS does not increase condom use. In addition, perceiving a high salience of HIV/AIDS does not significantly increase condom use among couples. In fact, the opposite is observed. Among couples, husbands and wives who perceive themselves at risk of contracting HIV/AIDS are more likely to use condoms than husbands and wives who do not, but this difference is not significant for husbands. Beliefs about condom efficacy are positively associated with condom use among couples, though this relationship attains statistical significance only for the wife's beliefs. Wives who have a higher self-efficacy are more likely to protect themselves by using a condom than wives who have a lower self-efficacy, but this difference is not significant. The self-efficacy of husbands has no association with use.

Table 8.29: Percentage of couples using condoms by selected psycho-social predictors

	Husband's Report		Wife's Report	
	N	%	N	%
Perceived severity of HIV/AIDS				
Yes	201	17.4	209	17.2
No \ Do not know	36	22.2	28	25.0
Perceived salience of HIV/AIDS				
Low	71	22.5	63	20.6
High	167	15.6	171	17.0
Perceived risk of HIV from partner				
Yes	52	21.2	135	25.9**
No	184	16.3	102	7.8
Beliefs about condom efficacy				
Low	25	8.0	44	4.5*
High	211	19.0	194	21.1
Perceived self-efficacy				
Low	44	15.6	48	14.6
Medium	116	19.0	126	15.1
High	78	17.9	62	27.4
All	238	17.9	238	17.9

Note: *Significant at 5 percent **Significant at 1 percent

Table 8.30 shows that condom use is strongly associated with positive attitudes to condoms. Condom use is considerably higher among couples in which husbands and wives have positive attitudes to condoms. It is important to note that the effects of the husband's attitudes on condom use may be understated due to the reliance on the wife's report. Furthermore, use is significantly related to husbands' and wives' report of having discussed condoms, with significant associations in the expected direction.

Table 8.30: Percentage of couples using condoms by attitudinal and communication variables

	Husband's Reports		Wife's Report	
	N	%	N	%
Attitudes to Condoms				
Positive	68	35.3**	102	27.5*
Neutral	84	11.9	88	15.9
Negative	79	11.4	25	4.0
Discussed Condoms				
Many Times	27	25.9**	27	59.3**
Few Times	55	34.5	59	42.2
Once	21	19.0	25	8.0
Never	134	8.2	127	0
All	238	17.9	238	17.9

Note: *Significant at 5 percent **Significant at 1 percent

Having described the factors affecting condom use among couples using bivariate analysis, the relationship between some of the factors and condom use are explored using a standard multivariate logistic regression models. The analysis made use of a number of explanatory factors. The socio-demographic factors included age, marital status, level of education and place of residence and wife's fertility intentions. Other factors include the husband's attitude to condoms, the wife's perceived risk of HIV and the wife's belief in condom efficacy. The logistic regressions include only those independent variables that had statistically significant effects on condom use in the bivariate analysis. Some of the factors used in the bivariate analysis are not included in the multivariate analysis because of the ambiguity of causality. It is difficult to determine the direction of causality of the communication and attitudinal variables. Similarly, the wife's perceived self-efficacy and her attitudes to condoms are omitted. Note, however, that the husband's attitude to condoms is retained because it is measured independently of the wife's report of condom use.

In this model, the dependent variable is condom use. For each observation, the dependent variable takes the value of '1' if the woman reported using the condom either

'occasionally' or 'always' and '0' otherwise. Three separate models are fitted. Model 1 examines the effects of each variable without controls. Model 2 contains the net effects of selected characteristics of husbands and wives. Model 3 presents the net effects of all the variables. As part of the analysis, all first order interactions are systematically assessed. However, no significant interactions are observed among the major components of the regression equation.

Table 8.31 shows the odds ratios for condom use. The results of Model 1 show that eight variables have statistically unadjusted significant effects on condom use among couples. Husbands' attitude to condoms emerges as the strongest predictor of condom use. The odds of using a condom are 4.29 times higher among wives whose husbands express positive attitudes to condom use in marriage than wives whose husbands do not. Those who know that condoms prevent HIV infection have a higher likelihood of using condoms. Furthermore, wives who perceived themselves at risk because of their spouses' behaviour are 4.17 times significantly more likely to report condom use than wives who do not. Those living in the rural area are significantly less likely than those living in the urban area to report using a condom. The odds of using a condom among couples increase with the level of education of husbands and wives. Also, cohabiting couples are significantly more likely than the married couples to be using a condom. Those who want to delay or prevent childbearing are significantly less likely to be using condoms. This relationship probably reflects the fact that they are more likely to be using another method for preventing pregnancy. In model 2, after adjusting for socio-demographic characteristics of husbands and wives, two variables emerge as significant predictors of condom use among couples: the wife's level of education and marital status, though the effect of husband's level of education comes close to significance at the 5 percent confidence level. The effect of residence is severely attenuated and loses significance, almost certainly because of the link between education and place of residence.

Table 8.31 shows that once variables are adjusted for each other, the wife's perception of risk of HIV infection remains the dominant influence on condom use. The odds of using condoms are 3.92 times higher if the wife perceives herself at risk of HIV infection from her spouse. Awareness of the efficacy of condoms has a strong effect on condom use, although it is of borderline significance. This relationship is not of great substantive importance because rather few wives do not believe in the efficacy of

condoms to prevent HIV infection. In Model 3, the odds ratios for marital status decreased by almost three-quarters (odds ratios from 2.41 to 1.71). The addition of other variables increases the odds ratios for place of residence. This may be because wives in urban areas have a greater self-efficacy and are more motivated to use condoms. The effect of the husband's attitudes to condom use is severely reduced in effect in Model 3. It may be that the wife's concern about contracting HIV overrides his objection to condom use.

Table 8.31: The odds ratios of couples using condom: results from logistic regression

Background Characteristics:	Odds Ratios and 95% Confidence Intervals		
	Model One Unadjusted	Model Two Adjusted	Model Three Adjusted
Age			
Less than 35	1.00	1.00	1.00
35 or more	0.65 (0.32-1.31)	0.79 (0.35-1.80)	0.99 (0.39-2.53)
Marital Status			
Married	1.00	1.00	1.00
Cohabiting	2.35 (1.20-4.61)	2.41 (1.09-5.34)	1.71 (0.69-4.21)
Place of Residence			
Rural	1.00	1.00	1.00
Urban	3.17 (1.61-6.26)	1.59 (0.73-3.48)	2.26 (0.91-5.62)
Wife's Level of Education			
Less than secondary	1.00	1.00	1.00
More than secondary	4.42 (1.96-9.94)	2.67 (1.04-6.87)	2.47 (0.88-6.92)
Husband's level of education			
Less than secondary	1.00	1.00	1.00
More than secondary	3.81 (1.61-9.00)	2.34 (0.89-6.21)	2.24 (0.74-6.78)
Wife's perceived risk of HIV from spouse			
Yes	4.17 (1.82-9.52)		3.92 (1.52-10.31)
No	1.00		1.00
Wife's belief in condom efficacy			
Low	1.00		1.00
High	5.53 (1.30-23.62)		4.55 (0.96-21.49)
Husband's attitudes to condoms			
Positive	4.29 (1.81-10.17)		1.56 (0.55-4.39)
Negative	1.00		1.00
Neutral	1.09 (0.42-2.87)		0.60 (0.20-1.82)
Wives' Fertility Intentions			
Wants soon	0.51 (0.14-1.84)		0.79 (0.18-3.53)
Wants later	0.24 (0.09-0.69)		0.35 (0.10-1.18)
Wants no more	0.34 (0.15-0.73)		0.29 (0.11-0.80)
Undecided	1.00		1.00

Having completed the multivariate analysis, another approach is to look at some of the factors influencing condom use at the aggregate level. Studies have shown the urban, educated are often the vanguard of change in family planning (Kimuna and Adamchak 2001; Koc 2000). It is therefore reasonable to assume that this is also the case for condom use. For the purpose of analysis, the sample is divided into four strata: urban educated, less educated, rural educated, rural less educated. The less educated refers to those with less than upper secondary and the more educated refers to those with upper secondary or higher education. Table 8.32 shows that perceived risk does not vary significantly by level of education and place of residence. Also, belief in condom efficacy does not vary, except for one stratum. However, the urban, educated are significantly more likely than other groups to have a higher self-efficacy. This suggests that self-efficacy is important for condom use. Communication on condoms is higher among the more educated than the less educated wives. More educated, rural wives are almost two times more likely than less educated, rural wives to report having discussed condoms. Similarly, more educated, urban wives are significantly more likely than rural, less educated wives to have more positive attitudes to condoms. Moreover, they are more likely to have spouses with positive attitudes to condoms, but this association is not significant. Condom use is also significantly higher among the urban, educated wives. Almost one-third of urban, educated wives report using condoms.

Table 8.32: Wife's level of education and place of residence by specific statements

Statement	Urban		Rural	
	More Educated %	Less Educated %	More Educated %	Less Educated %
AIDS is fatal	81.4	77.8	91.2	85.8
AIDS is salient	71.4	75.0	82.4	71.7
Perceived risk from spouse	55.9	50.0	58.8	58.3
Belief in condom efficacy	89.7	82.4	87.9	76.0
Wife believes that condoms are acceptable in marital unions	57.6	55.6	64.5	35.2*
Husband believes that condoms are acceptable in marital unions	33.9	29.4	31.2	27.0
Perceived high self-efficacy	37.9	22.2	24.2	22.2*
Discussed condoms	79.7	52.9	54.5	28.1**
Using condoms	33.9	17.6	17.6	10.9**
Unweighted N	94	28	24	92

Note: *Significant at 5 percent ** Significant at 1 percent

8.7. Summary

Awareness of HIV is high among couples. Most couples share the view that AIDS is fatal. Over half of all couples perceive a high salience of HIV. Wives are more likely than husbands to report a higher salience. Knowledge of the means to protect themselves against HIV infection is also high. Most couples are relatively well informed about the means of protecting themselves against HIV infection. Awareness of condoms and their source of supply are high among couples. In general, husbands are more knowledgeable than wives. Lack of knowledge does not appear to be a barrier to condom use.

Beliefs about condoms may serve as a barrier to condom use. Condoms are seen as less acceptable in marital unions. Husbands are more likely than wives to hold negative attitudes to condom use in marriage. Attitudes to condom use in marriage are related to frequency of discussion on condom use. In general, husbands and wives who report more frequent discussion on condoms are more likely to report more positive attitudes to use in marriage. However, somewhat surprisingly, husbands who report having discussed condoms once with their spouses are more likely to hold more negative attitudes to condom use in marriage. It is therefore possible that discussion on condoms ended in conflict and misunderstandings.

Condom use within the marital relationships was examined based on responses to questions on the use of any method for delaying and/or preventing pregnancy and the frequency of use of condoms with spouse. Large discrepancies are observed in the reports of condom use for family planning purposes among couples. A tendency to over-report condom use for preventing and/or delaying pregnancy was observed for husbands. However, at the aggregate level, reports of frequency of condom use with spouse yielded a higher level of agreement among couples. Almost half of husbands who reported using condoms for family planning purposes reported not having used condoms consistently with their spouses. However, wives who reported using condoms for family planning also reported using condoms consistently with their spouses. This raised questions about the validity of husband's report of condom use. Men are more likely to report condom use for family planning purposes and less likely to report condom use in the context of HIV/AIDS. On balance, the woman's account of condom

use is therefore seen as a more reliable and accurate account of the couple's condom use.

The level of condom use, either alone or with another method, is low. Less than one-fifth of wives and husbands report using condoms either alone or with another method. This is consistent with a recent study conducted in South Africa among clients attending public health facilities across South Africa which found that almost 16 percent of men and women had used a condom and another method of contraception at their most recent sexual encounter (Myer et al. 2002). The present study found that few couples report using condoms alone. Condoms are more likely to be used in conjunction with another method of family planning. This is in sharp contrast with other studies, which have found that men and women are more likely to use one method (Santelli et al. 1992; Cushman et al. 1998). In South Africa, family planning is firmly entrenched. As a result, many women are likely to be using a highly effective method for preventing pregnancy. Condoms are therefore more likely to be used in conjunction with another highly effective method of family planning.

Condom use is strongly associated with level of education and place of residence. The level of condom use is significantly higher among the more urban, educated than the rural, less educated couples. Moreover, condom use is higher among cohabiting than married couples. Beliefs about the acceptability of condoms in marital relationships also serves as a barrier to condom use in marital relationships. Husbands and wives who have less positive attitudes to condom use in marriage are less likely to report condom use. Not surprising, couples who report having discussed condoms are significantly more likely to report condom use.

Few husbands and wives report having other sexual partners. There are problems associated with self-reports of sexual behaviour particularly among married men and women. Men and women may be reluctant to admit to other sexual partners because, in most instances, this behaviour is hidden from their spouse and there is the fear of detection. Other studies have also found that a strong emphasis is placed on faithfulness in marriage, particularly for women, with severe consequences of infidelity, even though multiple partners for men may be more readily accepted (Fapohunda and Rutenberg 1999; Orubuloye et al. 1991). Moreover, studies have also found that, owing to the association of multiple sexual partners and HIV infection, there has been a

tendency to underreport number of sexual partners (Mnyika et al. 1997; Catania et al. 1990b).

Perceived vulnerability to HIV infection emerges as a significant predictor of condom use. Wives who perceive themselves at risk of HIV infection are significantly more likely to take action to protect themselves than wives who do not. Wives are more likely than husbands to be concerned about contracting HIV from their spouses. This is because wives are more likely to perceive their husbands as unfaithful and husbands are more likely to perceive their wives as faithful. This is consistent with the findings of other studies that, for many women their male partner's sexual behaviour, and not their own, is the major risk factor influencing condom use (Hunter et al. 1994). Husbands and wives who have discussed the risk of HIV infection with their spouses are more likely to report concern about contracting HIV. This suggests that their discussion was specific to their sexual relationship. However, appreciable proportions of husbands who have discussed the risk of HIV are not concerned about the risk of infection from their wives.

Other studies have found that husbands' attitudes to condoms may serve as a major barrier to condom use. For example, Kapiga et al. (1995) found that the majority of women in their study reported not using condoms because of partner opposition. The present study found that condom use is significantly higher among those wives whose husbands approve of condoms than other wives. However, the wife's perceived risk of HIV infection overrides the husband's resistance to condom use in marital relationships. Condom use is high among those who believe that condoms are effective at preventing HIV infection. Prevention programmes have an important role to play in emphasising the effectiveness of preventive measures (Wilson et al. 1990).

The relationship between education and urban residence with condom use is in the expected direction. Condom use is significantly higher among the urban, educated than the rural, less educated. The urban, educated are significantly more likely to have a higher self-efficacy and therefore are more likely to use condoms. Moreover, the urban, educated respondents are more likely to have discussed condoms with their spouses and as a result, are more likely to use condoms. It is possible, as argued by Lagarde et al. (2001a:p1407), "the association of condom use with education could reflect increased exposure to condom prevention campaigns or greater skills in negotiating condom use."

Chapter 9

Integration of FP/MCH and STI/HIV Services: The Provider's Perspective

9.1 Introduction

At the 1994 International Conference on Population and Development in Cairo, more than 180 countries pledged support for the provision of a comprehensive range of reproductive health services including the prevention and treatment of STIs. In addition to FP, reproductive health care includes MCH, prevention and treatment of STIs, safe abortion, and infertility counselling, among other services (Keller 1995). The integration of STI/HIV into FP/MCH services was proposed as a more comprehensive response to meeting the reproductive health needs of sexually active men and women (Askew and Maggwa 1998).

For a variety of historical reasons, publicly funded health services have generally been implemented through vertical programmes administered by separate departments in government ministries (Pachauri 1994). In many countries, FP and STI programmes have been assigned very different status by the international health community and also fell under separate physical, financial and organisational structures (Mayhew 1998). However, compared with FP, STI programmes have historically been under-funded and poorly resourced (Field 1997; Mayhew 1998; Lande and Rhinehart 1993). STI programmes were largely neglected and had limited coverage. They were predominately “specialist, medically oriented services dependent on a reliable drug supply, targeting and reaching primarily high risk, urban and male population” (Mayhew 1998:p1). However, the increasing awareness of the serious health problem of STIs (including HIV) in developing countries, particularly in sub-Saharan Africa, reinforced the need for the integration of FP and STI/HIV services (Askew and Maggwa 2002). Moreover, recent epidemiological evidence demonstrating a link between STIs and HIV and the finding that treating symptomatic STIs may systematically reduce the incidence of HIV infection has added urgency to the need for STI control programmes (Grosskurth et al. 1995).

The focus of FP programmes has shifted away from an emphasis on controlling fertility towards helping individuals achieve their reproductive goals. By the early 1990s it became increasingly evident that the impact of AIDS on mortality in many African countries would be enormous (Lush 2002). At the same time, concern over the adverse effects of population growth began to diminish, partly because of the decline in fertility in many countries (Lush 2002). Advocates for women were also calling for a shift in the rationale of FP programmes away from meeting the demographic goals of limiting fertility towards improving the situation of women (Caldwell and Caldwell 2002; Lush 2002). As FP together with MCH services are often women's primary, and sometimes sole, contact with the health care system, they offer ideal opportunities for reaching sexually active women of reproductive age with information about HIV and other STIs.

Having addressed the demand side issues by exploring the needs, perceptions and behaviour of sexually active men and women in respect to unwanted pregnancy and HIV/AIDS, it is important that sufficient attention be devoted to supply side issues in order to obtain a more complete picture of the situation. The purpose of this chapter is to examine the policy shift towards integrated services and issues of implementation in South Africa. The focus is on past and current policies directly related to the integration of FP/MCH and STIs/HIV services and the progress towards the implementation of these policies. A number of methods were used to obtain information from providers, including an inventory of health facilities, in-depth interviews, focus group discussions and semi-structured interviews. As the primary point of contact between clients and reproductive health programmes, providers are not only an important source of information, but also ultimately the agents for improving service delivery (Hardee et al. 1999). This chapter draws heavily on interviews conducted with providers in order to understand their perspectives of, and experiences with, providing integrated FP/MCH and STI/HIV services. Interviews with providers may, as previously mentioned, elicit idealised rather than actual behaviour. It is therefore important to compare information from providers with that obtained from clients. Consequently, the next chapter focuses more explicitly on clients' perspectives of integrated service provision.

9.2 Policy Developments Towards Integration in South Africa

Prior to 1994, South Africa was ruled by an apartheid government, which classified the population into four race groups: white, Indian (or Asian), coloured (or Mixed Heritage)

and black (or African). All areas in the country were segregated along racial lines, and most of the Africans who comprised the majority of the population were assigned citizen rights in one of ten homelands or bantustans. Each homeland had a separate ministry of health. There were 14 departments of health in South Africa- one for each homeland and one each for general affairs, Indians, coloureds and whites (Buch 1987). As the various homelands were granted self-governing rights, they also had to assume responsibility for their own health services, including FP (Department of Health 1975). This led to unnecessary duplication and inadequate co-ordination of services, which added to the fragmentation of the health system (Buch 1987).

The newly elected ANC government was faced with the daunting challenge of transforming a fragmented, and discriminatory health care system into one with the capability of delivering health care to all citizens, particularly those previously disadvantaged under apartheid legislation (Tollman and Rispel 1995). Since 1994 the democratically elected government has expended considerable effort on restructuring health services in South Africa. One of the most notable changes was the creation of a single National Department of Health, which was responsible for strategic policy development and technical guidance (Lush 2000). At the same time, nine provincial health departments were created and tasked with the responsibility for ensuring effective implementation of national policy.

One of the foremost changes to the Health System made by the National Department of Health has been the adoption of the district based system, which would become the principal instrument for the delivery of comprehensive PHC services (Magwaza and Cooper 2002). The principles of PHC encouraged a move away from traditional vertical and autonomous health care programmes towards “an integrated (health) infrastructure capable of providing both general and specialised health care effectively to entire populations in relations to their main needs” (Smith and Bryant 1988:p910-2). Under the ANC government, commitment to delivering an integrated system of service delivery and management is strong and explicit moves to integration have taken place (Lush 2000). The aim of integration was to bring previously separate and independent reproductive health service functions into a new single structure (Magwaza and Cooper 2002). In the past, FP in South Africa was to some extent a vertical programme, as were STIs. STI services fell within the scope of responsibility of local authorities, with little national co-ordination or standardisation of STI preventive and curative services

(Coetzee and Ballard 1996). Problems of STIs were usually treated either in public sector primary care clinics by nurses or by private sector general practitioners. In both the public and private sector, no preventative activities were undertaken (information, education and counselling on reducing the risk of acquiring a STI) nor was there any system of contact tracing or partner notification or management (Coetzee and Ballard 1996).

The goal of the district health policy is the provision of equitable, effective and effective health services (McCoy and Engelbrecht 1999). This was to be achieved through decentralised management systems and localised service provision (Magwaza and Cooper 2002:33). To implement this policy, changes in strategic, structural and administrative and human resource management and development have had to occur at all levels of health care (national, provincial, regional, district) in the country (Magwaza and Cooper 2002). The major advantage of the district health approach lies in the organisational and management framework it provides for local health service delivery, and for linking the primary care level to the secondary and tertiary levels (Tollman and Rispel 1995). The delivery of health services occurs at sub-district level, primarily through health posts, clinics and larger health centres (Tollman and Rispel 1995).

9.3 The Process of Integration

The integration of services may take different forms. At the service level, the definitions of integration have ranged from the supermarket approach, in which clients see a single provider for all their reproductive needs on a single visit at a single delivery site, to the teamwork approach, in which the provider refers clients to separate services at the same delivery site or another site (Lush et al. 1999).

In most health facilities, services are either partially or fully integrated. In some health facilities, clients see one provider for all their reproductive health needs.

The providers see all types of clients: those clients with STIs, those who are pregnant and those for FP. In the past services were separated. There were different providers for the different type of services (Urban, IDI#1)

In other health facilities, especially the larger clinics and hospitals, clients often have to queue separately for separate services.

All the services are provided at this health facility but clients have to queue separately for FP and other services. This is because the consultation rooms are so small that they cannot accommodate all the clients. Clients for FP go to one room and clients for STIs go to another room. They get all services they need at the polyclinic on one day (Urban, IDI#2)

All the facilities claimed to offer a complete range of services on a daily basis but this was not always the case. For example, some facilities were not providing antenatal services on the day the inventory was conducted. Antenatal services are usually offered on specific days of the week.

9.4 Perceived Benefits and Barriers to Integration

Much research has focused on the benefits and barriers to integration of FP/MCH and STI/HIV services. In general, the majority of providers in the semi-structured interviews expressed favourable attitudes to integration. They felt that clients should be able to see one provider for all their health needs. However, a sizeable minority of providers (15 out of 40, or 38%) would prefer that there should be separate providers for separate services.

In the in-depth interviews, providers also expressed favourable attitudes to integration. Integrated services are seen as a more client-centred approach because they serve the needs of clients more efficiently and effectively and as a result, are likely to contribute to greater client satisfaction. Some providers felt that integrated services allow the client to develop a relationship of trust with the provider. Clients have all their reproductive needs met by one provider, which helps to prevent duplication and ensure greater continuity in services.

I think it is good that FP/MCH and STI/HIV services are provided by one provider. Often providers gain the confidence of clients and clients feel free to discuss their problems with the providers. They don't have to discuss the same problem with different providers (Urban, FGD#1)

The client does not have to see different providers for their health needs. They also don't have to join different queues for different health needs. The client receives all the services that they require from one provider at one health facility (Urban, FGD#1)

Integrated services are seen as benefiting clients because it reduces their travelling times. Clients are saved the inconvenience of coming to the clinic on many separate occasions. Moreover, the provision of integrated services reduces the waiting time of clients. Clients no longer have to join separate queues for separate services.

Clients are offered a full range of services at the clinics. They receive all the services that they need on one day. They don't have to come to the clinic on different days (Rural, IDI#6)

A major concern has been the stigma traditionally associated with some services and its implications for attendance. Some providers have suggested that the provision of integrated services may reduce the stigma attached to STI services. Moreover, integrated services has the potential of reaching under-serviced segments of the population, for example, young girls coming to the health facility for FP services would be able to do so without fear of being perceived as sexually active, as is demonstrated in the following comment:

People do not want others to know that they are receiving these services. For example, teenagers don't want others to know that she is using contraceptives. If everybody sits in one queue only the health worker and the client knows the reason for the visit (Urban, FGD#1)

Some of the senior staff reported that some providers were initially resistant to integration because they had to handle their existing workload as well as new activities. Moreover, there was some confusion about what services should be integrated and how they would be integrated. In the absence of clear guidelines, many providers had to rely on their own instincts for delivering integrated services. As a result, the implementation of integrated services was unstructured and unplanned.

Most providers are very negative about integration. If you talk to them you will realise that most of them don't understand the concept of integrated services. They don't understand how it is going to be possible to provide different kinds of services. However, I don't have a problem with integrated services because I have seen it happen in other health facilities (Urban, IDI#2)

In the beginning, most of the resistance to integration came from older providers, particularly those who had performed their work in a certain way over many years. The older providers were more accustomed to providing specialist services and as a result, associated themselves with specific activities (for example, FP). Health facilities were able to overcome some of these earlier difficulties, as providers became more comfortable with providing integrated services.

At the beginning it was very difficult. We didn't understand what integration meant but now we are very happy about it. We don't have a problem with it now (Urban, FGD#1).

In the past, FP programmes have been successful in increasing the level of contraceptive use. Some providers felt that FP services suffer under the integrated approach. The new approach entails longer sessions with each client and this sometimes may lead to the loss of FP clients. Some providers also felt that clients are often given information they do not always feel is relevant to them.

The problem is that we lose many FP clients. They leave before receiving their contraceptives because they don't want to wait for a long time before receiving services. If there were more staff we could have a fast queue (Urban, FGD#1)

A number of problems at the health facilities are hampering the integration process. The severe shortage of providers has resulted in increased workloads. Some providers feel that they had to take on greater responsibilities without additional compensation, which has created some resentment and has led to low morale. The feeling that providers are becoming demoralised is demonstrated by the high turnover.

A major problem is the large number of staff that are leaving this health facility. A person may work for three months, gain some experience and then decide to

leave. The health facility suffers a severe setback because it means that they need to find someone else to fill the position. The 'new' person will have to be trained and there is no guarantee that they will remain at the health facility (Rural, IDI#5)

The heavy client load makes it difficult for providers to offer personalised, specialised services to clients. At some health facilities the situation is so serious that clients may be turned away without receiving services. In the urban area, some health facilities have experienced a heavy client load because they often have clients from other districts. They are finding it difficult to shake off their image as specialist clinics.

Clients are told that all clinics are providing a range of services but they still continue to come to us for STI services. They regard us as a STI clinic. We get clients from other areas. We are finding it difficult to cope but there is nothing we can do but treat them (Urban, FGD#2)

Some providers also expressed dissatisfaction and frustration with their working conditions. Some of their frustration derived from their inability to change the lives of people suffering from HIV/AIDS. Often the training of providers did not incorporate HIV management.

Sometimes people who have tested positive for AIDS are in a desperate financial situation. We try to help them out. We try to give them some financial assistance but this is usually not enough. Many people living with AIDS don't have any money to buy food. Sometimes they ask us to visit them at home and we go to their house. We feel like we are not doing our jobs. We don't know how to help. Providers are leaving the profession because they can't live with the stress (Urban, FGD#2)

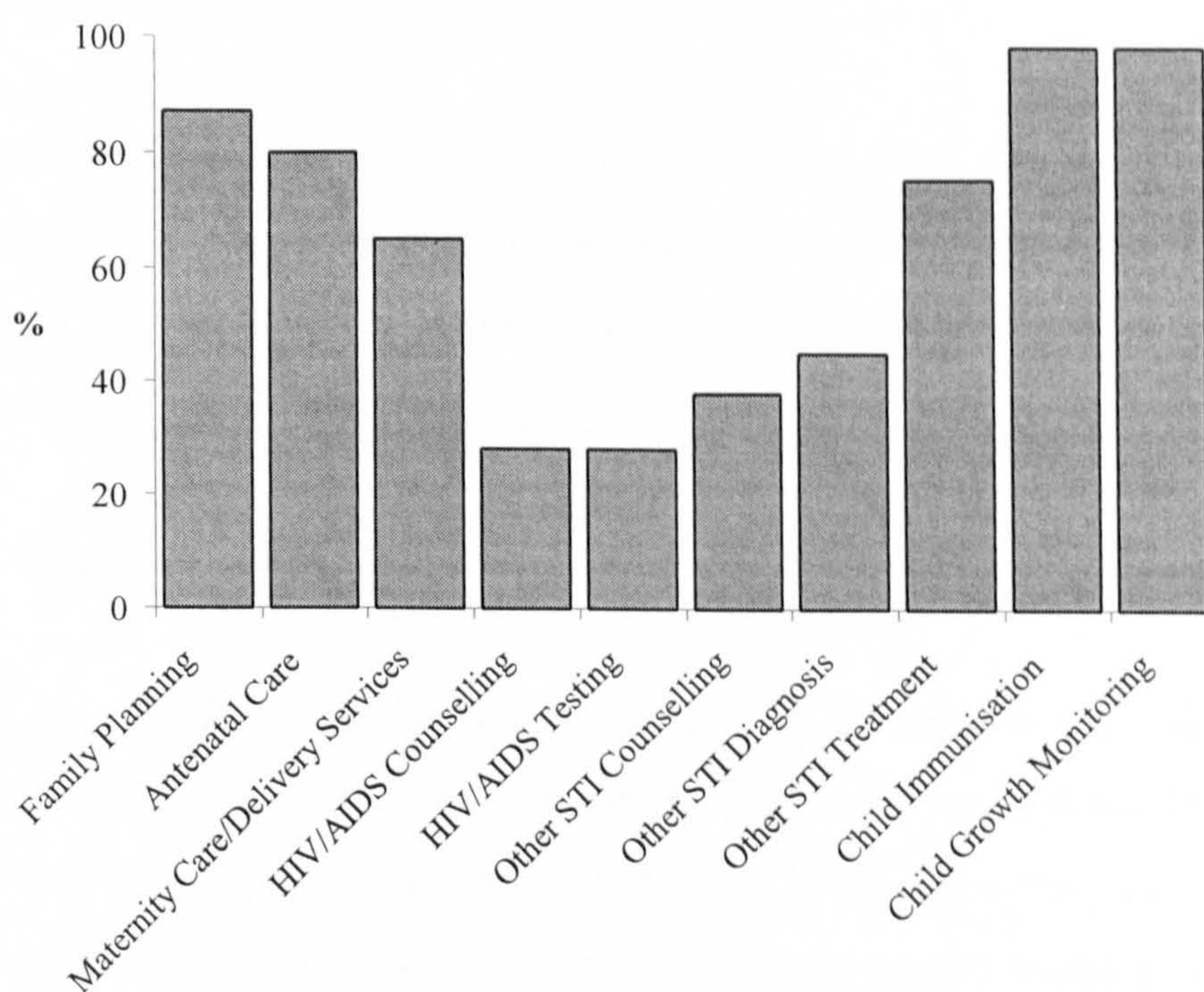
9.5 Training

One of the rationales for the integration of FP/MCH and STI/HIV services was that providers of these services require similar skills for addressing the needs of clients (Pachauri 1994). Providers are assumed to have the basic skills required for the delivery of integrated services. On average, providers had been working for almost four years at

the health facility. More than half of all the respondents had completed their training 10 or more years ago, which is too long ago to adequately equip them to provide integrated services competently.

Figure 9.1 shows the percent of providers who received training in FP, MCH and STI services. In most cases, providers had receiving training in delivery of FP and MCH services. Fewer providers had received training in the delivery of STI and HIV/AIDS services. This is obviously likely to impact on the services that are offered to clients. Other studies have observed that the skills required for managing STIs and HIV change rapidly, hence there is an urgent need for refresher training programmes for providers (Africa OR/TA Project II 1999). Adequate training of providers is essential for health facilities to be able to offer integrated reproductive services.

Figure 9.1: Type of training received by providers (n=40)



Providers were asked if they think that there is a need for additional training. The majority of respondents (72%) felt that there was a need for additional training in order to deliver integrated services. As shown in Table 9.1, most providers felt that they would benefit from training in STIs and HIV/AIDS. Fewer respondents felt that there was a need for training in FP and MCH.

Table 9.1: Percentage of providers who felt that there is a need for additional training in particular services

Type of Service	%
FP	31.0
Antenatal care	3.4
Maternity Care/ Delivery Services	10.3
HIV/AIDS counselling	72.4
HIV/AIDS testing	34.5
Other STI counselling	41.4
Other STI diagnosis	65.5
Other STI treatment	6.9
Child Immunisation	3.4
Child Growth Monitoring	3.4
Other	27.6
N	29

The in-depth interviews confirmed that providers felt that they would benefit from additional training. Providers of integrated services are often expected to be multi-skilled and be able to deliver a range of services. Providers may be constrained in the advice that they can offer by their lack of training.

In the past there were health providers that were trained to only provide FP. However, providers are expected to offer a range of services. You will find that a health worker first attends to a FP client, followed by an antenatal client and a STI client (Urban, FGD#1)

9.6 Logistical Dimensions

One of the justifications for the integration of services is that the basic physical environment required to provide STI and HIV/AIDS services are similar to that required for FP/MCH services (Africa OR/TA Project II 1999). However, the physical structure of the health facility may impose severe limitations on the delivery of services. Some providers complained about the limited working space in health facilities. Some of the health facilities were not built to accommodate large numbers of people. As a result, the queues sometimes extend outside the building.

Our waiting area is very small. We cannot accommodate all our clients. Sometimes clients sit in the veranda. Sometimes you will find a provider working

in an open space although we try to ensure there is some confidentiality. We need more consultation rooms and a larger waiting area (Urban, FGD#1)

The shortage of adequate space may result in a lack of privacy and confidentiality. Sometimes other clients may listen in on the consultation and clients in the consultation may feel uncomfortable revealing the real reason for visiting the clinic. Most of the providers maintained that they tried to ensure auditory privacy but this was difficult given the limited space. This lack of privacy may affect clients' willingness to provide sensitive information. In the short term, the feasibility of the integrated approach is dependent on the adequacy of the existing infrastructure (Hardee et al. 1999).

In the rural areas, access to health services is more limited. A mobile clinic provides select services at least once a month. However, the mobile clinic may experience difficulties reaching these areas. Often poor weather conditions make the roads inaccessible and the mobile clinic has to postpone their visit.

The mobile clinic usually visits the rural area once a month. However, sometimes the roads are flooded and it may not be safe to drive on these roads. The mobile clinic may have to cancel their visit. Clients have to wait a long time before they receive services (Rural, IDI#7)

The shortage of drugs is another problem that is impeding the efficient delivery of services in the rural areas. Staff reported drug stockouts and delays in the delivery of drug supplies. Another problem was the failure to deliver the requested drugs.

A major drawback for the delivery of services is the shortage of drugs and delays in delivery. People sometimes don't get their medication on time (Rural, IDI#6)

The essential equipment required for providing good quality services was not always adequate in most of the health facilities, especially in the rural area. All of them had a blood pressure machine, needles, syringes, and the speculum. However, some health facilities were missing essential equipment. For example, two out of the three health facilities visited in the rural area did not have any sterilising equipment, a matter of particular concern to staff. Furthermore, essential equipment was not functioning

properly. Moreover, where the equipment was available, it was sometimes shared between various sections. The shortage of essential equipment is likely to have serious implications for the delivery of services.

One of the problems that the mobile clinic faces is the shortage of equipment. The shortage of equipment affects the delivery of services (Rural, IDI#7)

9.7 Condom Advocacy

Condom promotion is a particularly important component of integrated services because of their unique role in offering dual protection. In most health facilities condoms are available in boxes in the waiting room. Providers report that an increasing number of clients are coming to the clinic to ask for condoms.

There are many men who are very afraid of becoming infected with HIV. They are prepared to change their behaviour in order to avoid AIDS. They don't want to have many sexual partners. There are also a number of women who are requesting condoms from us. There is no fear that people will laugh at them if they carry condoms (Rural, IDI#6)

Staff who had provided FP services in the last three months were asked about the methods that they had actually supplied or recommended. The fact that more than 70 percent of the providers had recommended condoms is indeed encouraging.

Table 9.2: Method recommended by providers for clients in the last month

Method	%
Pill	75.0
IUD	5.0
Injection	85.0
Diaphragm/Foam/Jelly	2.5
Condom	72.5
Female Sterilisation	32.5
Male Sterilisation	7.5
Periodic Abstinence	25.0
Other	2.5
N	40

Providers were asked: *Which methods of family planning would you recommend for most women who would like to delay or space their next birth, assuming there were no contraindications?* The injection was by far the most popular method among providers. Almost nine out of ten providers reported that they would recommend the injection for women who would like to delay or space their next birth. Fewer providers (20 out of 40) reported that they would recommend the condom as a method of preventing and/or delaying pregnancy. Providers were also asked: *Which methods of family planning would you recommend for clients with a STI?* The condom is the most commonly recommended method to clients who present with STIs. Almost eight out of ten providers reported that they would recommend the condom for preventing STIs. Somewhat surprisingly, a few providers said that they would recommend other methods of family planning, which are more effective at preventing pregnancy rather than infection. For instance, almost one-quarter of providers reported that they would recommend injections to clients with a STI. This suggests that there exist some misconceptions about methods that may be used to protect against STIs.

The in-depth interviews and focus group discussions found that condoms are widely recognised as a method of preventing pregnancy and STIs. Despite this, condoms are not widely promoted for contraceptive purposes. Condoms are more likely to be associated with STIs/HIV. Condom use depends on the male partner's co-operation and some women may experience difficulty convincing their partner to use a condom. As providers are aware that women may face obstacles from their male partners they recommend methods that they can use without consulting their partners.

Women who come for STI treatment are encouraged to use condoms with their partners. However, women report that they are not able to convince their partners to use condoms. They complain that sex with a condom is not pleasurable. Men say that they can't eat a sweet wrapped in paper (Rural, IDI#6)

There are many women who come to the clinic without telling their husbands. They don't tell them husbands that they are using a method of contraception (Rural, IDI#5)

9.8 STI Diagnosis, Counselling and Treatment

Providing sexually active men and women with services that can enable them to more effectively manage their risk of STI infection, treat existing infections and reduce transmission through sexual partners is an important component of integrated health services (MacNeil 1996). The management of STIs in KwaZulu-Natal includes the syndromic approach and laboratory investigations.

9.8.1 Syndromic Management

In order to improve the effectiveness of treatment of STIs, the policy of syndromic management of STIs as well as the integration of STI services into the general primary health care services was adopted in the early 1990s in South Africa (Abdool Karim 1999; Harrison et al. 1998).

The syndromic management approach does not appear to be widely practised. Providers were asked: *If you think that a client has a STI, on the basis of reported symptoms what would you recommend?* Table 9.3 shows that clients are rarely treated syndromically. Only 10 of the 40 providers reported that they would undertake diagnosis themselves, after a clinical examination though an additional 12 reported that they would treat on the basis of symptoms alone. Providers were equally likely to refer clients for diagnosis to another provider at the same health facility and in a few cases would refer the client for diagnosis to another health facility. It would seem that providers are poorly equipped to diagnosis and treat clients with STIs.

Table 9.3: Measures taken by providers for clients suspected of a STI

Measures	%
Undertake diagnosis yourself, after a clinical examination	25.0
Refer for diagnosis to another provider at this facility	27.5
Refer for diagnosis to another facility	5.0
Refer specimen for laboratory analysis	12.5
Treat on the basis of reported symptoms	30.0
N	40

In the in-depth interviews it became clear that most providers had heard about syndromic management. However, the syndromic management approach is used in only a few health facilities.

The syndromic management approach is part of the policy of the clinic. It is used to determine the medication that is suitable for clients (Rural, IDI#6)

Some of the providers were not familiar with the principles underlying the syndromic management approach. Confusion between treatment based on symptoms alone and syndromic management is clearly evident. The use of the syndromic management approach could be enhanced by the greater availability of guidelines and also training.

I have heard about the syndromic management approach but I am not able to explain it. It is part of our policy but it is not implemented (Umzinto, Senior Staff)

9.8.2 Risk Assessment

In the absence of pelvic and speculum examinations or laboratory facilities, risk assessment is the cornerstone of syndromic diagnosis as developed by WHO (Dehne and Snow 1999). Opinions of providers were divided about the need for assessing the client's risk of STI. Some providers obtain a comprehensive reproductive history of each client. They screen potential users of family planning methods for STIs.

In most cases, patients don't just come to us and say that they have a STI. Providers ask clients certain questions to determine whether or not the client has a STI (Rural, IDI#5)

Some feel that verbal screening of all clients is difficult to implement because it requires asking clients several questions. Time constraints and heavy client loads make it difficult to screen all clients.

There are about 300 or more clients that visit this health facility everyday. We are not able to provide clients with the services that we are supposed to provide them. The services we offer are largely determined by the size of the queue. We are always looking at the queue to see when we are likely to finish (Rural, IDI#7)

Moreover, clients may resent being asked questions about their sexual behaviour. They may not see the relevance of the screening process. They would rather receive services for which they came to the health facility.

Clients complain that we ask them too many questions. They say that we would be of more help if they get the treatment for which they came to the clinic (Urban, FGD#2)

Some providers felt that they are protecting the client's right to privacy by not screening them for STIs. However, some clients may be embarrassed to raise sexual health matters unless they are asked by the providers.

Moreover, they were not comfortable discussing sexual matters with their clients, largely because their training did not prepare them for counselling on sensitive issues. Older providers may feel embarrassed to discuss sexual health matters with younger clients, as do female providers faced with male clients.

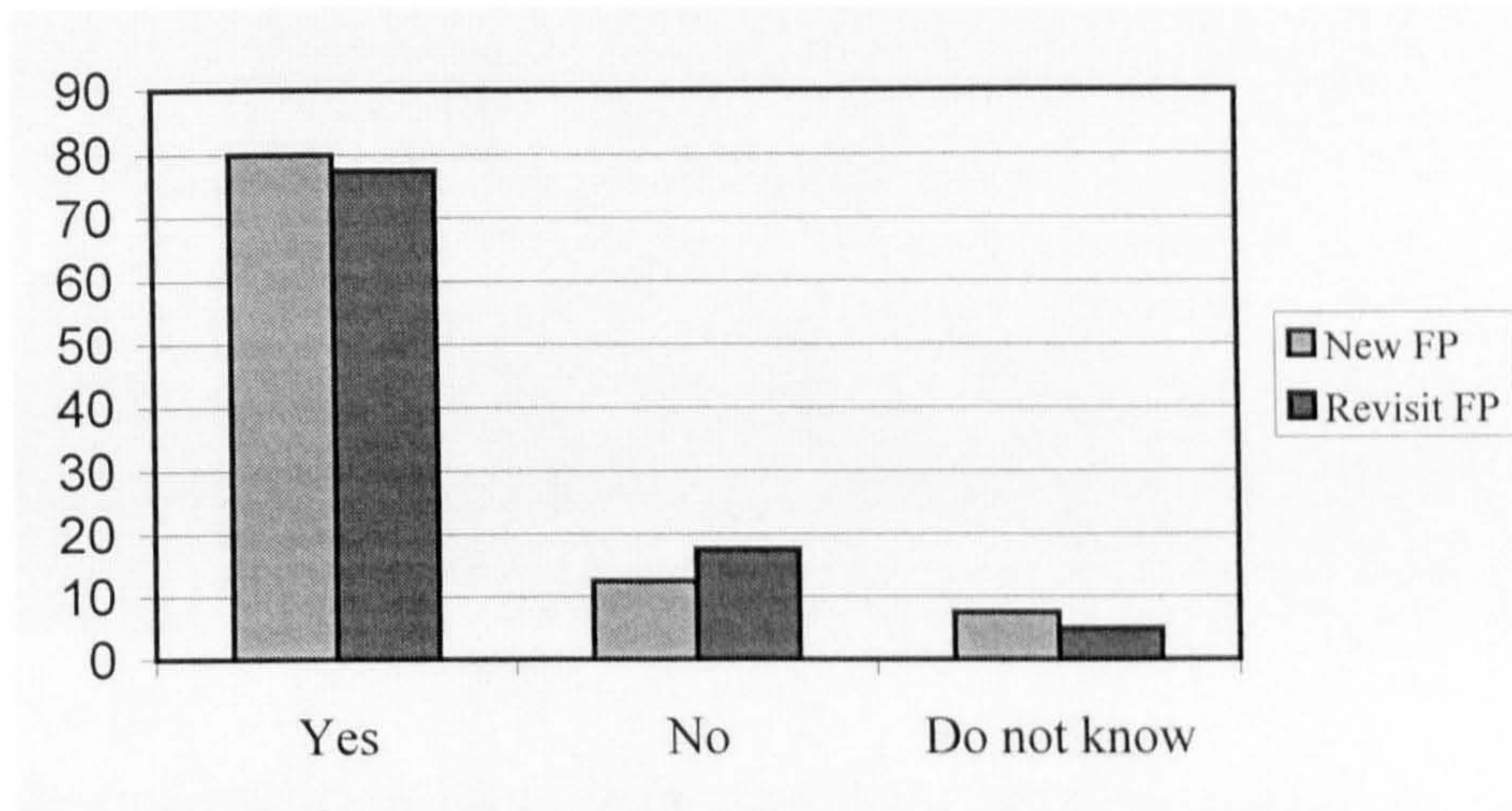
Some may feel that the client is closer to their child's age and may feel embarrassed to discuss sexual matters with the client (Rural, IDI#7)

Male providers may not feel comfortable asking female clients sensitive questions and female clients may not wish to reveal their sexual problems to male providers. Female clients are not as free with male providers as they are with female providers (Rural, IDI#6)

9.8.3 Physical Examination

Providers were asked if all new and revisit FP clients should undergo routine pelvic examination as part of their FP consultation. Figure 9.2 shows that the majority of providers felt that a pelvic examination should be part of a FP consultation for new and re-visit FP clients.

Figure 9.2: Percentage of providers who felt that a pelvic examination should be a part of FP consultation for new and re-visit clients (n=40)



In the in-depth interviews it became clear that many of the providers recognise the benefits of physical examination. Many providers felt that a physical examination will allow them to correctly diagnose and treat clients. However, in most cases, physical examinations of FP clients do not routinely occur in many of the health facilities. They are usually only conducted on the basis of the client's complaints because they assume that clients will not be willing to have a routine physical examination as part of their FP consultation.

Clients coming for FP would not be willing to have a routine gynaecological examination. It is difficult for them to consent to a Pap smear, even after we explain to them the purpose. I don't think they will consent to an examination (Rural, IDI#5)

Sometimes clients may be in a hurry and they do not see the relevance of a physical examination. Also, some procedures may lead to discomfort and clients may want to avoid embarrassment. However, if clients suspect that they have a STI they may be very willing to undergo an examination.

I feel that people are always in a hurry and they don't really want to be examined. Sometimes they just tell you that they came for FP and they don't want other services. However, if they suspect there is something wrong with them they would not mind having an examination (Urban, IDI#2)

9.8.4 Laboratory Testing and Referral

Laboratory testing facilities are usually not available in smaller health facilities. Laboratory facilities tend to be expensive and therefore are usually concentrated in the large health facilities. Clients who are suspected of being infected with HIV are therefore usually referred to the larger health facilities for testing.

Problems with referring clients to other health facilities are encountered because some health facilities may not accept referred clients. Some health facilities are reluctant to accept referred clients because of the shortage of trained personnel. In some cases, health facilities may accept referred clients only if prior arrangements have been made with the senior person in charge of the health facility.

We used to refer clients to a hospital in Phoenix but they say that they don't have doctors. We also used to refer them to another hospital but they say they don't want referred clients. You have to phone first and speak with the registrar who will give you permission to send clients (Urban, IDI# 3)

Referral of blood samples to hospital laboratories for testing does not always function efficiently. Blood samples may not be collected promptly and therefore results are not returned promptly. Sometimes the results of the blood test may get lost during the transportation process, necessitating repeat tests.

The whole process is very disorganised. Sometimes blood gets lost. This has a very negative effect on clients. They lose trust in providers. Sometimes the providers need to take blood for the second time. This creates an enormous amount of unhappiness among clients (Urban, IDI#2)

Referrals may sometimes lead to delays in diagnosis and treatment. Clients also have to make two separate visits: one for the specimen to be taken and the other to obtain the results of the test. As a result, clients are not able to receive prompt treatment. In some cases, clients do not return for the test results.

Sometimes people are given counselling, they have the blood test and they don't come back for their test results. I think they are scared to come back for their results because they are afraid that they are HIV positive (Rural, IDI#7)

Sometimes blood samples are taken from women without explaining the purpose of the test and this may lead to misunderstandings.

Sometimes clients undergoing tests for syphilis may assume that they are tested for HIV/AIDS. As a result, if the results are positive, clients assume they are HIV positive. Clients are not given appropriate information and counselling about the purpose of the blood test (Rural, IDI#7)

9.8.5 Partner Notification

Providers recognise the importance of treating the partners of clients with STIs. Contact cards are usually given to clients to get their partners to come to the health facility for treatment.

Clients are encouraged to bring their partners for treatment. If the person has two partners they are given two contact cards. It is important to treat partners. Some people do bring their partners for treatment. However, it is not easy to get partners to come for treatment (Rural, IDI# 6)

Partner notification has not been very successful because many of the clients often failed to bring their partners for treatment. Providers were asked if it is easy to get male partners to come for treatment for STIs. The majority of providers reported that women are not able to get their partners to come for treatment.

In the in-depth interviews, providers reported that women may be willing to visit public health facilities but often are unable to convince their partners to come for treatment. Often women do not inform their partners that they have a STI because they are afraid that it may create conflict with their sexual partners. They fear that their partner might suspect them of extra-marital relationships.

Women don't want their partners to know that they have a STI. They are afraid of their partner's reaction. They are scared of their partner rejecting them. Most women are not working and they are financially dependent on their partners. Men have the final say in the household (Rural, IDI# 5)

Sometimes they are not able to bring their partner for treatment because their partner is not able to visit the clinic during the opening hours. Moreover, a few men work some distance from home and so they only come home during weekends.

Some women don't live with their partners. They may not tell their partners. Others tell us that their partners are working. They don't have time. We advice them to tell their partner to go to the nearest clinic (Urban, FGD# 1)

Sometimes clients may have many sexual partners and, as a result, may not be able to identify the source of infection. They may not be able to get into contact with all their partners because some may have been casual or anonymous.

9.9 HIV Counselling, Testing and Management of HIV/AIDS

Providers were asked: *if you think a client has HIV/AIDS what would you normally do?* The majority of providers reported that they would discuss the possibility of a HIV test with the client (see Table 9.4). However, almost one-third reported that they would refer the client to another provider at the same facility. Some respondents felt that they would also provide counselling to clients suspected of having HIV.

Table 9.4: Measures adopted by providers who suspect a client of having HIV/AIDS

Measures	%
Discuss the possibility of a HIV test	62.5
Refer to someone at this health facility	30.0
Other	7.5
N	40

In the in-depth interviews and focus group discussions providers reported that, if they suspect a client of being infected, the first approach is to provide counselling to the client. Some providers reported that they would refer the client to someone else at the

health facility. However, in some cases, the provider would refer the client to another health facility.

We tell them about the importance of AIDS counselling and blood tests so that they can find out about their status. They have the final decision on whether or not to go for the blood test (Rural, IDI#7)

Management of HIV/AIDS does not appear to be a major focus of facilities. Providers feel that they are not able to provide sufficient support to people living with HIV/AIDS. Moreover, many providers have not been trained to manage clients with HIV/AIDS.

Sometimes if you suggest that the client has a HIV test they become extremely distraught. If the results come back positive they have difficulty in coming to terms with their status. They don't know how to tell members of the family. Staff are placed in a difficult situation. They want to provide support but don't know how to provide this support (Rural, IDI#7)

9.10 Summary

Following ICPD, there has been a move towards the integration of FP/MCH and STI/HIV services. In principle, most staff favour the integration of services. However, in terms of practical implementation, there is a lack of clarity about the precise form integration should take. The process of implementation of integrated health has been extremely varied. In most health facilities, services are either partially or fully integrated. In some health facilities, clients see one provider for all their health needs, while in other health facilities, clients see different providers for different services. Services are more likely to be fully integrated in smaller health facilities, while services are more likely to be partially integrated in the larger health facilities.

One of the arguments in favour of integration is that quality, or effectiveness, of services would be improved through the delivery of integrated services. However, effective implementation is hindered by a host of logistical problems. Many of the common complaints are very similar to those mentioned in many different settings, and included insufficient space; high case loads, lack of adequate staff preparation and training, shortage of equipment and infrastructure, as well as poor morale, low pay and

high turnover (Magwaza and Cooper 2002; Lush et al. 2001). Another problem is inefficient referral system which means that clients do not receive services promptly.

Demand side constraints may also hinder the effective integration of reproductive health services. Clients coming to the health facility solely for one service may resent intrusive questions designed to assess their risk of STIs. They would rather receive the service for which they came to the health facility. Moreover, clients may object to the additional time spent queuing for services.

The general impression is that staff are better equipped and more comfortable with the traditional focus on FP and MCH and less confident with the focus on STIs and HIV. Some providers feel that vertical structures are more effective because they are more targeted and have evolved into highly specialised structures. As a result, any addition or modification to such systems, it is believed, could severely jeopardise their efficacy.

A key area of concern is the lack of staff understanding of syndromic management of STIs, which is currently promoted as the most effective method for STI management in the absence of laboratory facilities (Mayhew et al. 2000). Often staff training does not include syndromic management. As a consequence, health facilities are missing opportunities for detecting and treating STIs in clients. Moreover, the high level of HIV infection has engendered a sense of hopelessness among staff, which is affecting their capacity to deliver integrated services. In most cases, staff training does not incorporate HIV management.

The evidence on condom promotion is mixed. Condoms are widely recognised as a method of dual protection against unwanted pregnancy and STIs/HIV. Staff also point to an increase in the distribution of condoms at health facilities. However, not all clients are counselled on the dual benefits of condoms. Condoms are more likely to be promoted as a method of disease- rather than pregnancy-prevention. More effective methods of contraception are recommended for preventing pregnancy. This is consistent with the findings of a study conducted in the earlier 1990s, which found that most providers discouraged clients from using condoms because they were seen as a less reliable method of contraception (Abdool Karim et al. 1992c).

One of the major challenges facing integrated programmes is the need to reach men. Integrated services have the potential for reaching men and providers reported that men are increasingly coming to the clinic for services. However, most services are not usually available outside working hours, which means that they are not easily accessible to men who are currently in paid employment. Moreover, in many of the health facilities, most providers are female, resulting in some reluctance by men to receive services. Historically, the primary focus of FP programmes has been on married women of childbearing age. As a result, nearly all types of clinical facilities provide services mainly to women. Clearly, there is a need for male personnel so that men feel more comfortable receiving services at health services.

Chapter 10

Integration of FP\MCH and STI\HIV services: The Client's Perspective

10.1 Introduction

The ICPD vision, as described in the Programme of Action, calls for all individuals to have access to a safe, effective, affordable and acceptable range of services. The recommendation was to provide a comprehensive package of reproductive health services – including the management of STIs- through existing MCH and FP programmes (United Nations 1995). However, by general consensus, the major challenge will be the implementation of integrated reproductive health services (Hardee et al. 1999). This analysis seeks to expand knowledge about the implementation of integrated services from the perspective of the client. A number of studies have documented the progress made in implementing the recommendations of ICPD (Mayhew et al. 2000; Lush 2002). However, relatively few have focused on the perception of clients of integrated FP/MCH and STI/HIV services.

This chapter draws on data collected from exit interviews with 300 clients at health facilities. Exit interviews were held with 100 clients of FP services, 100 clients of MCH services and 100 clients of STI services. Of the 100 interviews with clients of FP services, 50 interviews were new clients and 50 interviews were re-supply clients. The aim was to determine clients' experiences and perceptions of integrated services. More specifically, the degree of exposure of clients to a range of reproductive health services is examined. Of primary concern is the extent to which FP/MCH and STI/HIV services are integrated. In addition, information obtained from clients is used to complement that obtained from providers.

For the exit interviews, stratified sampling was used. To get a stratified sample, clients were organised by type of services and then appropriate numbers of FP, MCH and STI clients were selected. An attempt was also made to ensure that clients were spread evenly across all health facilities in the rural and urban area. By design, half of the respondents were living in the urban area and half were living in the rural area. As Table 10.1 shows the majority of the 300 clients (81%) were women. This aspect of the sample was anticipated, because women are more likely to visit health facilities for FP and MCH services. Men are more likely to visit health facilities for STI services. At the

time of the survey, the majority of clients interviewed were not married. Only 27 percent of clients were either married or living with their partner. The mean age of clients was 24.7 and the mean number of children was 1.4. Almost 30 percent of clients did have any children. The majority of clients reported wanting to continue childbearing. More than half of all clients expressed their desire for a child.

Table 10.1: Percentage distribution of clients by selected background characteristics

Background Characteristics

Sex	
Male	18.7
Female	81.3
Type of Client	
FP	33.3
MCH	33.3
STI	33.3
Age	
Less than 30	84.0
More than 30	16.0
Marital Status	
Married	11.7
Cohabiting	15.7
Neither	72.6
Place of Residence	
Urban	50.0
Rural	50.0
Desire for more children	
Yes	55.3
No	30.7
Unsure	14.0
Number of living children	
0-1	63.4
2-3	29.0
4 or more	7.7
All	300

The first part of the chapter looks at clients' perceptions of the quality of services at health facilities. Some concern has been expressed that the integration of FP/MCH and STI/HIV services will lead to a decrease in the quality of care (Maggwa 1997; Mukaire et al. 1997). A number of studies show that the quality of care is likely to influence sustained use of services (Jain 1989; Bruce 1990). The second part of this chapter explores the type of services offered to clients at health facilities.

10.2 Quality of Care

One of the primary objectives of the Department of Health in South Africa is “to reduce disparities and inequities in health service delivery and increase access to improved and integrated services, based on primary health principles” (Department of Health 1997:p14). Improving quality of care has emerged as one of the priority objectives of the Department of Health (Ibid). The quality of care is likely to dramatically affect the use of reproductive health services (Best 1998).

Several studies show that clients who feel that they are treated with respect, have had their questions fully answered and have received appropriate guidance are more likely to correctly and consistently use FP and other reproductive health services (Bruce 1990; Outlook 1999). Relations between providers and clients are influenced by the ability of the providers to demonstrate empathy, respect and understanding of clients’ needs. Clients were asked to reveal their perception of providers by expressing their agreement or disagreement with specific statements. In general, clients expressed positive feelings towards providers. Most clients perceive providers as friendly and helpful and felt that they were treated with respect. The majority also felt that the providers were easy to understand. However, urban clients were more likely than the rural clients to express satisfaction with their treatment by providers, as shown in Table 10.1. These results should be interpreted with some caution. Simmons and Elias (1994) argue that interviewing clients in close proximity to health posts may lead to courtesy bias, whereby clients do not want to be perceived as rude and ungrateful. Other studies have also found a tendency among clients to report high levels of satisfaction with services, even when service quality may be poor or marginal (Simmons and Elias 1994; Harrison et al. 1998).

An important component of interpersonal relationship is making clients feel comfortable enough to be able to ask questions (Miller et al. 1998). Clients were asked about their perception of inter-personal relationships with providers. A sizeable minority (23%) reported that they were not provided with all the information they wanted during the consultation. Interestingly, a substantial proportion of clients felt that there was not sufficient time to ask questions and providers did not answer all their questions to their satisfaction. Moreover, they felt that providers did not give them the opportunity to ask

questions about health issues that they thought were important. More than two-fifths of clients felt that the providers were too busy to answer their questions. Clients presenting at rural facilities were more likely than clients presenting at urban facilities to express dissatisfaction with their interaction with providers, as shown in Table 10.2.

Table 10.2: Percentage of clients agreeing with specific statements about the services that they received from providers

Statement	Urban %	Rural %
Staff were friendly and helpful	80.0	64.7**
The staff treat me with respect	84.0	62.7**
Staff were difficult to understand	6.7	31.3**
Staff were helpful in providing information	76.7	65.3**
I felt that there was insufficient time to ask questions	37.3	53.3**
Staff are usually too busy to answer my questions	29.3	56.0**
Staff answered all my questions to my satisfaction	60.0	32.0**
Staff gave me the opportunity to ask questions	59.3	12.7**
N	150	150

Note: **Significant at 1 percent

A common complaint is the lack of privacy during consultations. A lack of privacy may prevent some clients and providers from participating in a full exchange of information during the consultation (Askew et al. 1994). More than one-fifth of clients felt that there was not sufficient privacy during their consultation, as shown in Table 10.3. A substantial proportion of clients also felt that the waiting time for the consultation was unreasonably long. Long waiting times have been shown to be an important reason for the relatively high rates of programme- and method-discontinuation and may sometimes serve to discourage potential clients from seeking services, as shown by Huntington and Schuler (1993).

Clients were asked to judge the overall quality of care that they had received on their visit to the health facility. Over half of clients felt that they had come away from the health facility feeling that they had received good quality care.

Table 10.3: Percentage of clients agreeing with specific statements about the services that they received from providers

Statement	Urban %	Rural %
There was insufficient privacy during the consultation	10.7	34.0**
The waiting time for the consultation was reasonable	54.0	32.7**
I came away from the clinic feeling that I had received good quality of care	63.3	58.0**
N	150	150

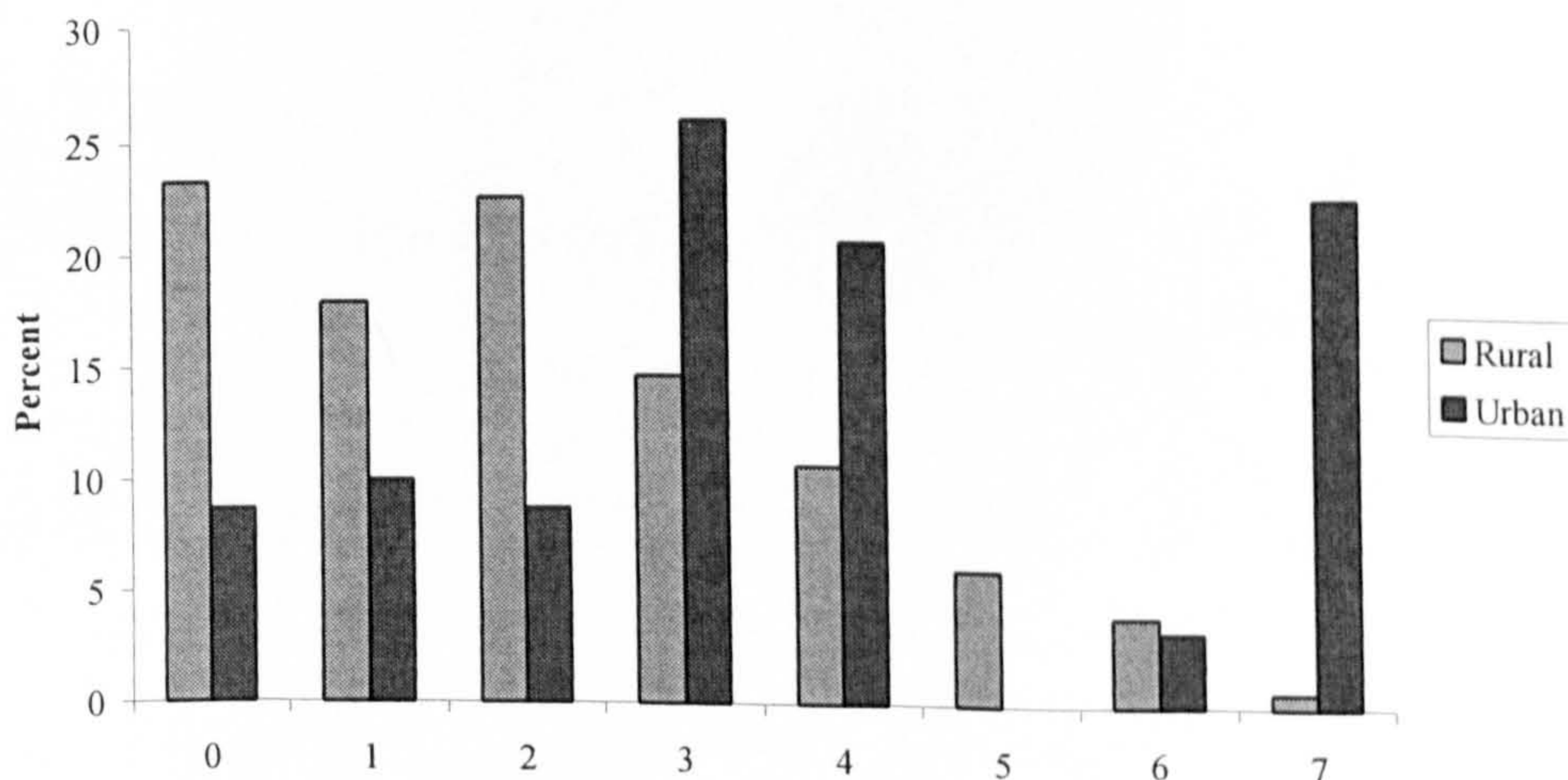
Note: **Significant at 1 percent

10.3 Information, Education and Counselling

IEC is a key component of the reproductive health package. The ICPD programme of action states: “information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services” (United Nations 1995:7.32). An important objective of IEC is to inform and educate clients about the range of services. Several media may be used including posters, flipcharts, distribution of printed materials, group talks and individual counselling.

Clients were interviewed about their exposure to IEC material during their visit to the health facility. Figure 10.1 shows the percentage of clients who had been exposed to a number of IEC materials by place of residence. More than half of all clients had been exposed to four or more IEC materials, though this proportion is higher in the urban than in the rural area.

Figure 10.1: Percentage of clients reporting exposure to a number of IEC items, by place of residence



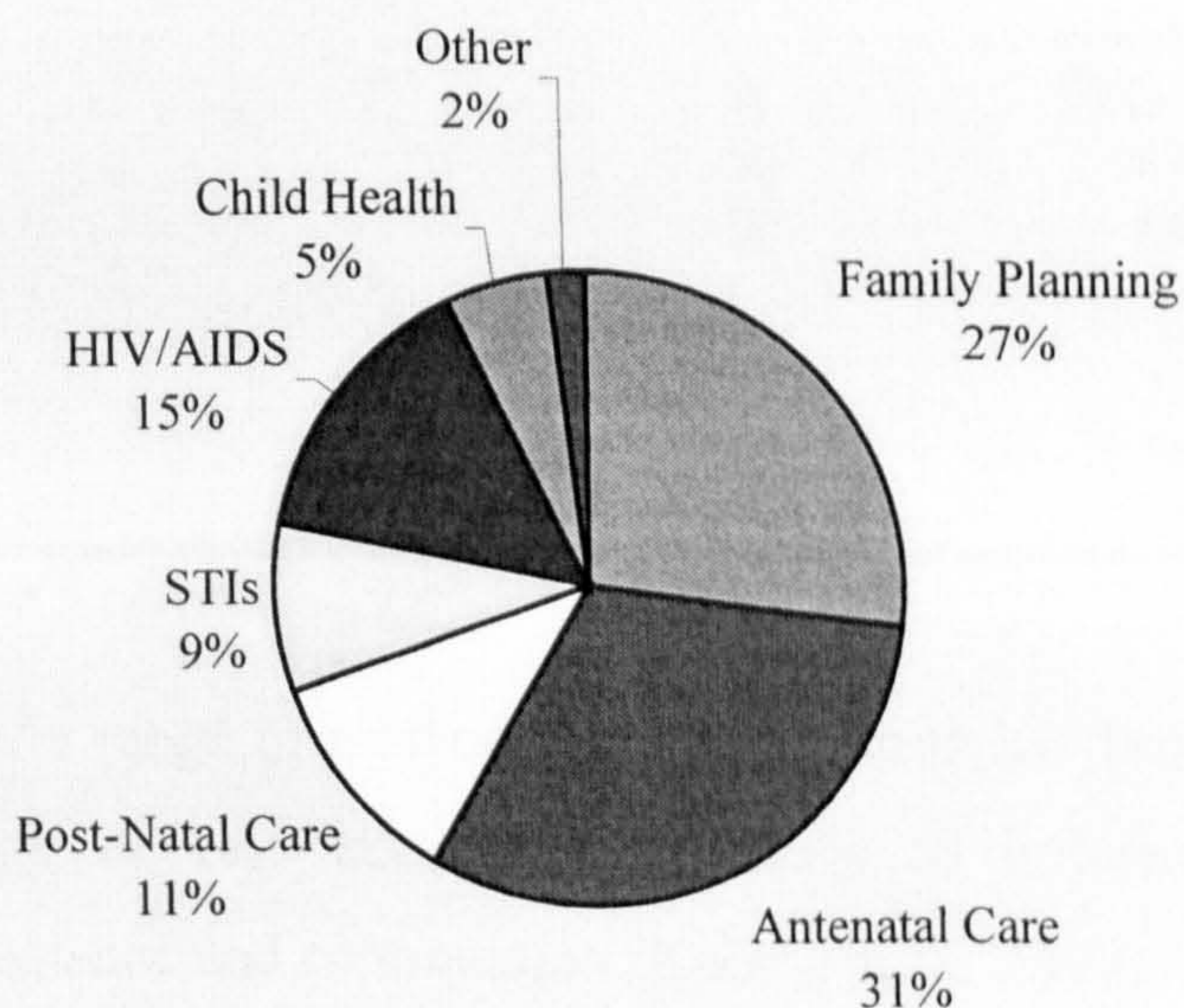
Clients were most likely to report having seen posters displayed on the walls and less likely to report having seen pamphlets, brochures or information sheets (Table 10.3). Written materials were in short supply at health facilities. Few clients reported receiving written material to take home during their visit. It is encouraging to observe that more than 60 percent of clients reported having seen a sample of condoms during their visit.

Table 10.4: Percentage of clients reporting exposure to IEC materials during their visit to the health facility

	%
Posters	71.7
Brochures/Pamphlets/Information Sheets	30.7
Group Talk	18.3
Sample of Condoms	63.7
N	300

A minority of clients (18%) reported that they had attended a group talk. A number of topics were covered in the group talks including FP, post-natal care and HIV/AIDS. Clients were more likely to have received information about antenatal care and FP than about STIs and HIV/AIDS, as shown in Figure 10.2.

Figure 10.2: Percentage of clients reporting exposure to specified topics at the group talk during their visit to the health facility (n=300)



10.4 Exposure of FP Clients to STIs and HIV/AIDS

Clients whose primary purpose for visiting the health facility was FP were interviewed about their exposure to information on STIs and HIV/AIDS. The aim was to investigate whether health services are taking the opportunity to address the needs of FP clients for information on STI and on HIV/AIDS. Clients were asked two separate questions to determine if they received information on STIs and on HIV/AIDS during their visit to the health facility. However, clients who received information about STIs invariably also received information about HIV/AIDS and therefore answers have been combined. Firstly, clients were asked if they had seen IEC material on STIs and HIV/AIDS during their visit. Overall, the majority of FP clients reported exposure to IEC material on STIs and HIV/AIDS (Table 10.5). Re-visit FP clients were more likely than new FP clients to report exposure to such IEC and urban clients more likely than rural clients. In general, few FP clients reported receiving information on STIs and HIV/AIDS, as shown in Table 10.5. New FP clients were slightly more likely than re-visit clients to have received information on STIs and HIV/AIDS and urban clients more likely than rural clients.

Table 10.5: Percentage of FP clients exposed to STI and HIV/AIDS during their visit to health facilities, by place of residence and type of clients

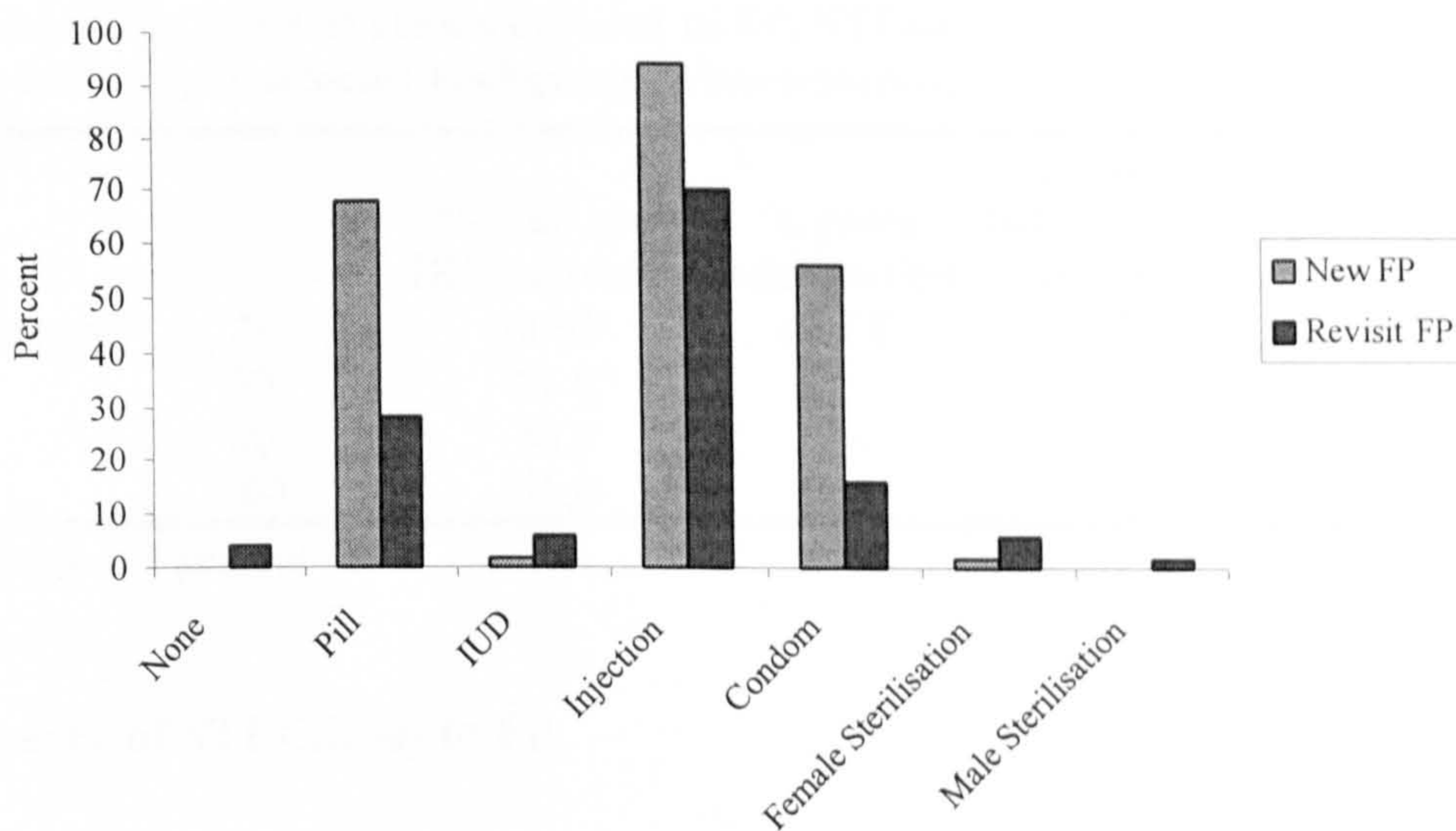
Type of Client	N	% who saw IEC materials on STIs/HIV	% given information on STIs/HIV
New FP	50	64.0	10.0
Re-visit FP	50	66.0	6.0
Place of Residence			
Urban	50	76.0*	2.0*
Rural	50	54.0	14.0
N	100	65.0	8.0

Note: * Significant at 5 percent

The availability of a range of methods of contraception has been considered a central element of quality of care because it is likely to influence client satisfaction, contraceptive acceptance and continuation (Koenig et al. 1997). The choice of methods of contraception offered to FP clients was fairly limited. The vast majority of FP clients were told of at least one method. Only two clients did not receive information on any method during their visit to the health facility. New clients were more likely than re-visit FP clients to receive information about more than one method. Of the new FP clients, 24 percent received information about one method, 34 percent about two

methods and 42 percent three methods or more. Of the re-visit clients, 72 percent received information about one method, 18 percent on two methods and 6 percent of three or more methods and 4 percent did not receive any information. The most commonly mentioned methods were the injection, followed by the pill and the condom.

Figure 10.3: Percentage of FP clients receiving information about particular methods



An important component of an integrated approach in a setting with a severe HIV epidemic is the promotion of condoms as a method of dual protection against unwanted pregnancy and STIs/HIV. Clients were asked whether the provider had discussed condoms. Providers were much more likely to mention condoms to new FP clients than re-visit clients. It is encouraging to note that over half of new FP clients were given information about condoms. Clients were also asked whether the provider had discussed dual method use. Less than one-third of clients reported that the provider had mentioned that condoms may be used in combination with other methods. Providers were more likely to mention dual method use to new FP clients than re-visit clients.

10.5 Exposure of MCH Clients to FP, STI and HIV/AIDS

Clients whose primary purpose of the visit was MCH were interviewed about their exposure to information on FP and STIs and HIV/AIDS. The aim was to investigate whether health services are taking the opportunity to meet the needs of MCH clients for information on these topics. First, clients were asked if they had seen any IEC material during their visit. Clients were more likely to recall having seen IEC materials on STIs

and HIV/AIDS than FP. Urban clients were more likely than rural clients to report exposure to IEC material during their visit. Clients were also asked if the provider had mentioned FP, STI and HIV/AIDS during their visit. Less than 20 percent of MCH clients reported receiving information on FP, STIs and HIV/AIDS during their visit but urban clients were more likely than rural clients to have received information on STIs/HIV, as shown in Table 10.6.

Table 10.6: Percentage of MCH clients exposed to FP, STI and HIV/AIDS during their visit to health facilities, by selected background characteristics

Place of Residence	N	% who saw IEC materials on FP	% given information on FP	% who saw IEC materials on STIs/HIV	% given information on STIs/HIV
Urban	50	62.0*	13.0	76.0	24.0*
Rural	50	40.0	9.0	60.0	6.0
All	100	51.0	11.0	68.0	15.0

Note: *Significant at 5 percent

10.6 Exposure of STI Clients to FP

Clients whose primary purpose for the visit was STIs were interviewed about their exposure to FP information. The aim was to investigate whether health services are taking the opportunity to provide STI clients with information on FP. Almost half of STI clients recalled having seen IEC materials on FP, with urban clients almost two times as likely to be exposed than rural clients (Table 10.7). However, few STI clients (6%) reported receiving information on FP during their visit. STI clients are rarely given information on FP during their consultation.

Table 10.7: Percentage of STI clients exposed to FP during their visit to health facilities, by selected background characteristics

Place of Residence	N	% who saw IEC materials on FP	% given information on FP
Urban	50	64.0*	10.0
Rural	50	36.0	2.0
N	100	50.0	6.0

Note: *Significant at 5 percent

10.7 Screening of FP and MCH Clients for STIs

Clients of FP and MCH are usually sexually active and at risk of STIs and should ideally be screened (Miller et al. 1998). The detection and management of STIs in individuals who present to health facilities is an integral part of STI control strategies. Providers also have the opportunity for advising clients on the importance of adopting risk-reducing strategies to protect themselves against STIs. As many women in developing countries routinely attend antenatal, FP and maternal and child health clinics these are potentially important opportunities to detect and manage STIs more effectively (Thomas et al. 1996).

Risk assessment is one of the main components of the integration model (Twahir et al. 1996). An essential aspect of risk assessment requires the provider to ask clients about their sexual relations. FP and MCH clients were rarely asked any behavioural questions to identify high-risk behaviours, as shown in Table 10.8. Another inexpensive method of assessing risk is interviewing clients about the presence of symptoms (Keller 1995). Few clients reported that the provider asked them about the presence of symptoms of STIs, though more MCH than FP clients responded positively. In addition, few FP and MCH clients were asked if they have any concerns about getting STIs or whether they had discussed STIs with their partner.

Table 10.8: Percentage of FP and MCH clients that were screened in specified ways for STIs.

	FP	MCH
	%	%
Number of sexual partners	1.0	4.0
Partner's other sexual partners	1.0	1.0
Presence of STI symptoms	6.0	12.0
Client's concern about STIs	5.0	5.0
Discussed STIs with partner	5.0	2.0
Perform a pelvic examination	0.0	5.0
N	100	100

In general, the screening of FP and MCH clients for STIs does not routinely occur. The lack of screening of FP and MCH clients is particularly disturbing given the high prevalence of HIV in the community.

A pelvic examination is a recommended procedure for identifying and treating STIs. Ideally, all new contraceptive users, as well as women who experience contraceptive side effects and other reproductive health problems should undergo a pelvic examination (Chowdhury et al. 1999). In most cases, a pelvic examination is not carried out on FP and MCH clients. Less than 5 percent of FP and MCH clients reported that they had undergone a pelvic examination. Miller et al. (1998) argue, that in many contexts, pelvic examinations may be frightening, invasive, or simply uncomfortable for clients. For this reason, they point out that if a pelvic examination is carried out on a client, it is extremely important that the provider eases concerns by explaining the purpose of the procedure beforehand and informing clients of the outcome afterwards. Those clients who did undergo a pelvic examination reported that they were informed about the examination beforehand and also told of the results.

10.8 Assessment of FP needs among MCH and STI clients

Understanding clients' FP needs is an integral element of the assessment of clients seeking MCH and STI services (Baakile et al. 1996). Providers have an important role to play in informing clients about FP. According to Westoff and Bankole (1995), women who have knowledge of contraceptive methods and are aware of sources of supplies are less likely to have unmet need. During their consultation with clients, providers are expected to identify fertility intentions and needs and encourage those with an unmet need to seek services (Ndhlovu 1999). This usually involves asking clients about their sexual relations, fertility intentions and past contraceptive use. MCH and STI clients were asked if the provider mentioned anything about FP during their visit. Table 10.9 shows that few MCH clients were provided with individual information about FP during their consultation and even fewer STI clients.

Table 10.9: Percentage of MCH and STI clients asked questions to determine FP needs

	MCH	STI
	%	%
Desire for children	13.0	2.0
Desire to space between birth	7.0	0.0
Interest in FP	16.0	9.0
Ever use of FP	13.0	3.0
Concern about using any method	7.0	4.0
Discussed FP with partner	3.0	2.0
N	100	100

Moreover, information was rarely collected about client's current and past contraceptive use or about relations with their partners. In most cases, clients were also not asked if they had ever used a method of contraception or if they were interested in using a method of contraception. Moreover, clients were not asked if they have any concerns about using any method or if they had discussed family planning with their partner.

10.9 Missed Opportunities

Having established that little active integration of services is taking place, it is also important to assess objectively and subjectively the need for integrated services. A major rationale for the integration of STI/HIV into FP/MCH services is that many women of reproductive age visit these facilities on a regular basis. Consequently, it is seen as a convenient venue for disseminating information on STI transmission, prevention and treatment (Askew et al. 1998). An attempt was made to determine if providers were taking advantage of opportunities to inform and educate FP and MCH clients about for STIs.

Objective versus Subjective Need for STI Services

Men and women who engage in multiple sexual partnerships are more likely to be at risk of STIs and as a result, are more likely to have a need for STI services. Clients were asked two questions to determine their risk of STIs: *(A) How many sexual partners have you had in the past 12 months? (B) Did you have sex with any new partner(s) in the past 12 months?* Almost 16 percent of FP and MCH clients reported having more than one sexual partner in the last year. Invariably, clients who reported having more than one sexual partner in the last year also reported having sexual intercourse with a new partner in the last year. Clients were also asked: *Considering all things, do you consider your chance of contracting HIV to be high, medium, low or no chance at all?* A positive association was found between self-reported risk behaviour and general perceived vulnerability to HIV infection. Almost one-third of FP and MCH clients who reported having more than one sexual partner also reported a medium or high vulnerability to the risk of HIV infection.

Clients who perceived themselves at medium or high risk of HIV infection are assumed to have an objective need for STI/HIV services. Almost two-thirds of FP and MCH clients are not at risk of HIV infection and therefore assumed to have less need for STI

services. Clients who reported having received any information on STIs and HIV during their visit are assumed to have a met need for STI services. Table 10.10 shows that new FP clients are more likely than re-visit FP clients to have received information on STIs. However, more than one-quarter of FP and MCH clients have an objective (unmet) need for STI services.

Table 10.10: Percentage of MCH and STI clients by their ‘objective’ need for STI services

Need for STI services	New FP %	Re-visit FP %	MCH %
No need	70.0	66.0	68.0
Met need	4.0	0.0	5.0
Unmet need	26.0	34.0	27.0
N	50	50	100

In order to determine subjective need for STI services, clients were asked the following questions: (A) *Do you need any (more) information or advice about STIs/HIV?* (B) *Would you have welcomed (more) information or advice on STIs/HIV?* Most FP and MCH clients felt that they needed and would have welcomed more information on STIs/HIV. Table 10.11 shows that MCH clients were more likely than FP clients to report that they needed and would have welcomed more information on STIs/HIV.

Table 10.11: Percentage of FP and MCH clients by their ‘subjective need’ for STI services

Type of Client	N	%
New FP	50	70.0
Re-visit FP	50	66.0
MCH	100	72.0

Overall, almost 60 percent of FP and MCH clients with an objective need for STIs also had a subjective need for STIs/HIV services. Of those with an objective need for STIs/HIV services, almost 70 percent of new FP clients and 53 percent of re-visit FP also had a subjective need for STIs/HIV services (data not shown). Of those with an objective need for STI/HIV services, almost three-quarters of MCH clients also had a subjective need for STI/HIV services (data not shown). Interestingly, however, almost 40 percent of FP and MCH clients with an objective need felt that they did not need and would not have welcomed information on STIs/HV.

Objective versus Subjective Need for FP

Providers have an important role to play in providing MCH and STI clients who want to limit childbearing with information about long-term methods, whereas if they wanted to delay childbearing with information about methods that will allow them to space between births (Miller et al. 1998). An attempt was also made to determine whether providers are taking advantage of the opportunity to assess the need for FP among MCH and STI clients.

Information was obtained about the fertility intentions and contraceptive use of clients. Essentially, those who want to delay or prevent childbearing and are exposed to the risk of pregnancy but are not using a method of contraception are defined as having an unmet or objective need for FP. The exit interviews did not collect information on the amenorrheic status of women and the partners of men and thus, exposure to the risk of unwanted pregnancy may be slightly over-estimated. As shown in Table 10.11, the level of unmet or objective need for FP is higher among STI (18%) than MCH (14%) clients. Almost 33 percent of MCH and 12 percent of STI clients have less need for FP either because they want a child or they are undecided.

Table 10.12: Percentage of MCH and STI clients by their 'objective' need for FP

Need for FP	MCH	STI
	%	%
No need	33.0	12.0
Met need	53.0	70.0
Unmet need	14.0	18.0
N	100	100

In order to determine the extent of subjective need, clients were asked the following questions: (A) *Do you need any (more) information or advice about FP?* (B) *Would you have welcomed (more) information or advice on FP?* Most MCH and STI clients felt that they needed and would have benefited from additional information about FP. Table 10.13 shows that more than half of MCH and STI clients felt that they needed and would have welcomed more information on FP.

Table 10.13: Percentage of MCH and STI clients by their 'subjective' need

Type of client	N	%
MCH	100	58.0
STI	100	56.0

Overall, almost 63 percent of MCH and STI clients with an objective need for FP also had a subjective need for FP. Of those MCH clients with an objective need for FP, almost half also had a subjective need for FP (data not shown). Of those STI clients with an objective need, almost three-quarters also had a subjective need for FP (data not shown). However, more than one third of MCH and STI clients with an objective need felt that they did not need and would not have welcomed information on FP.

10.10 Summary

In general, clients described providers as friendly and helpful. However, the quality of services appears to vary somewhat between rural and urban areas. Urban areas show a greater advantage than rural areas in the quality of services. Clients visiting urban health facilities were more likely to report greater satisfaction with services than clients visiting rural health facilities. A sizeable fraction of clients complained that they did not get an opportunity to raise concerns with providers. This finding is consistent with other research conducted in South Africa's public health services, which found that client-provider interactions were limited to terse instructions and cursory explanations by providers (Mathews et al. 1998). Given the widely held belief that quality of services influences reproductive goals, an urgent need exists for improving client-provider interaction at health facilities.

Clients are exposed to IEC materials during their visit to the health facility. However, in many health facilities, a range of IEC materials are not usually available but even when they are, they are rarely used to improve the client's understanding and assist them to make more fully informed decisions (Haberland et al. 1998). Clearly, providers are not taking adequate advantage of opportunities to inform and educate clients on how to avoid the future risk of unwanted pregnancy and STIs/HIV. Moreover, in many health facilities, there was a shortage of print materials, which could assist in counselling clients.

The interviews with clients leaving health facilities revealed several missed opportunities. Providers do not offer clients an expanded range of contraceptive methods, which would assist them to choose the most appropriate and effective method that meets their reproductive goals. In most health facilities, condoms are widely available and stockouts are rare. However, there is a great deal of variability with regard to provider's willingness to mention condoms. Providers are more likely to recommend highly effective methods of preventing pregnancy to FP clients that offer little or no protection against STIs/HIV. Clients may need protection not only against pregnancy but also STIs (including HIV/AIDS). Most clients would have welcomed a more active form of integration. However, it is worth noting that a few clients feel that they do not need and therefore would not welcome this information.

The results suggest that few clients are actively screened by providers. Clients are rarely asked the important behavioural questions to determine their risk of STIs. Many clients often leave the health facilities without receiving all the information that they require on STIs. Most clinics claimed to be offering integrated FP/MCH and STI/HIV services. However, virtually all FP and MCH clients reported not undergoing any of the STI detection procedures, which usually includes taking a medical history, performing a general physical examination, asking the client risk assessment questions, and also, performing a pelvic examination (Askew et al. 1998). Clients are also rarely asked many important behavioural questions to determine their need for FP. Many clients often leave health facilities without receiving all the information they require on FP. The majority of clients reported that they were not asked about their fertility intentions and contraceptive use. Providers are missing opportunities for providing clients who may be at risk of pregnancy with a method of contraception. However, some clients feel that they do not need and therefore would not welcome this information.

Chapter 11

Conclusion and Policy Implications

This research had two broad aims. The broad aim of the first part of the study was to provide insights into the perspectives and behaviour of sexually active individuals and couples with regard to the prevention of unwanted pregnancy and STIs/HIV. This component of the study focused specifically on the perception of risk of unwanted pregnancy and HIV/AIDS, strategies to combat these risks and the barriers and opportunities to implement these strategies. A combination of qualitative and quantitative data was used in this part of the study. In the first phase of the study, focus group discussions were conducted. The aim of the focus group discussions was to obtain contextual information and information on attitudes to FP and issues related to sexual health in the community. In the second phase of the study, a household survey was collected. Areas of research focus include sexual negotiation, attitudes to risk taking and the perception of risk, and how these differ when it comes to pregnancy risk and risk of HIV/AIDS. In the third phase of the study, in-depth interviews were conducted.

In the second part of the study, the emphasis shifts from the perspectives of individuals to the role of services. The broad aim of the second part of the study was to consider how reproductive health programmes are responding to the needs of sexually active men and women. The focus was specifically on the progress made in implementing services for managing the twin risks of unwanted pregnancy and STI/HIV. It provides a detailed understanding of the process of integrating FP/MCH and STI/HIV services from the perspective of the client and the provider. A range of methods was used to obtain information from providers and clients including an inventory of health facilities, in-depth interviews, focus group discussions and semi-structured interviews.

This chapter starts by briefly synthesising the major findings of the research and then briefly assessing the usefulness of using a number of different research techniques. It ends with a number of policy implications and a set of recommendations for future research.

Principal Findings

Avoidance of Unwanted Pregnancy

Knowledge of family planning is virtually universal among men and women, with almost all having heard of at least one modern method. The high levels of knowledge is perhaps not surprising given the strong family planning programme in South Africa. Approval of family planning is widespread. Men and women are aware of the high costs of raising a large family and want to limit their family size. Contrary to the popular belief that men disapprove of family planning, the majority expressed very favourable attitudes to family planning as a method of delaying and/or preventing pregnancy. However, both men and women see family planning as the woman's responsibility. A partial explanation for this is that, in the past, family planning programmes placed such an emphasis on woman-controlled methods, which discourages shared responsibility for family planning.

It is worth noting that while the majority of men approved of family planning, a sizeable fraction of women perceive their partners as disapproving of it. Respondents who do not report frequent discussion on family planning are significantly more likely to report that their partner disapproves of family planning or they do not know their partner's attitude. Clearly, some women are poorly informed about their partner's attitudes and preferences. However, it is interesting to note that, in contrast to other studies, the woman's perception of her partner as disapproving did not impact negatively on contraceptive use. Other studies in sub-Saharan Africa have found that men often exert great influence over family planning and fertility decisions (Mbizvo and Adamchak 1991; Ezeh 1993). In their study in Zimbabwe, Mbizvo and Adamchak (1991) found that the actual decision to use or not to use contraception ultimately rested with the husband. The present study found that contraceptive use remains high among women who perceive their partners as disapproving of family planning. The results suggest that while it is important for men and women to discuss family planning, many women make decisions without consulting their partners. Sometimes they may consult their partner but when differences occur, the woman's preference usually prevails. This is partly because the woman can use a method without her partner's consent or knowledge.

The reported level of contraceptive prevalence is higher among women than men. The percentages using any method are 52 percent and 73 percent for men and women respectively. One would expect a high consistency of reporting among couples because of their daily associations and common living conditions (Miller et al. 2001). However, even among couples, substantial discrepancies are observed between husbands' and wives' reports of contraceptive use. Wives are considerably more likely than husbands to report contraceptive use. An important source of the discrepancies is the over-reporting of condoms and the under-reporting of other methods by men. A number of studies in other countries have also found large discrepancies between men's and women's reports of contraceptive use (Miller et al. 2001; Becker and Costenbader 2001; Ezeh and Mboup 1997).

The individual data found large disparities between men and women in their reporting of contraceptive use, consistent with numerous other studies (Miller et al. 2001; Becker and Costenbader 2001; Ezeh and Mboup 1997). The data from matched couple allows us to explore in greater detail the reasons for the discrepancies in reporting of contraceptive use. The ability to examine husbands' reports alongside those of their wives is particularly useful for assessing the reliability of responses. The discrepancies in reporting of condom use for contraceptive purposes between husbands and wives may be attributable to a range of factors. An appreciable minority of contraceptive use consists of secret use. Almost one-fifth of wives who are using a method are doing so without their husbands' knowledge. Wives may underreport condom use because of reticence to mention a male method associated with disease-prevention. It is also possible that husbands' reports of condom use may be influenced by social desirability bias: they may be trying to project a modern image to the interviewer. This is the most likely explanation because substantial proportions of husbands and wives subscribe to the belief that family planning is the responsibility of women. It is therefore unlikely that such a large percentage of husbands would be using condoms to prevent pregnancy. For a variety of reasons, therefore, family planning is generally under the woman's control and the woman's account is seen as a more reliable account of the couple's contraceptive use.

A small but not insignificant number of couples (7.4%) are at risk of an unwanted pregnancy. The level of unmet need for spacing is higher than the unmet need for limiting, but this difference is small. The 1998 South African Demographic and Health

Survey estimated that the unmet need for family planning among all sexually active women was 9.6 percent (SADHS 1999). Other parts of sub-Saharan Africa are characterised by high levels of unmet need and low levels of contraceptive use (Westoff 2001). The qualitative data suggests that unwanted pregnancy is a major problem only among adolescents. Several studies document high levels of pregnancy among young, unmarried women (Craig and Richter-Strydom 1983; Preston-Whyte 1988; Kaufman et al. 2001). This study acknowledges the importance of understanding the extent of unmet need among the unmarried, non-cohabiting, as premarital fertility is very common in sub-Saharan Africa (Bledsoe and Cohen 1993; Meekers 1994). However, the focus of this study was on men and women in regular sexual relationships.

The level of unmet need is not higher among wives who perceived their husbands as desiring more children. The level of unmet need is slightly higher among couples where husbands themselves state that they disapprove of family planning than other couples. However, it is not higher among couples where wives *perceived* their husbands as disapproving of family planning. The findings are consistent with the hypothesis that family planning is under the control of the woman. The husband does not have greater influence than his spouse over fertility and family planning decisions. In fact, the opposite is observed. The attitudes and preferences of the wife are the major factor determining use. Family planning is seen as the woman's domain and as a result, wives often take the initiative in using a method of family planning, sometimes without their husbands' knowledge. Hence, contrary to the popular belief that women are powerless in reproductive decision-making, women play an instrumental role.

Risk of HIV Infection

Awareness of HIV/AIDS is virtually universal among men and women, with the majority having heard of it. Most respondents were relatively well informed about the major routes of transmission of HIV infection. Sexual transmission is identified as the major route of HIV transmission. However, there are some common misconceptions about transmission. In both the urban and rural area, AIDS is recognised as a health problem in the community but there is a tendency to understate the level of HIV infection. Denial is still relatively widespread. Although most respondents knew that AIDS is fatal, a few expressed uncertainties about whether a person will die of this

condition. This suggests that, while awareness of the severity of HIV/AIDS is high, it is not universal.

Risk perceptions vary substantially between men and women. In general, men have a lower self-perceived risk of HIV infection than women. Men are more likely to consider themselves at risk because of their own sexual behaviour while women are more likely to consider themselves at risk because of their spouses' sexual behaviour. It is also worth noting that large proportions of men and women who are uncertain if their spouse has other sexual partners report a greater concern about the risk of HIV infection. However, the relationship between the husband's reported behaviour and wife's perception of his behaviour is rather weak.

Alongside sexual abstinence and mutually monogamous relationships between uninfected partners, the use of condoms is currently the most effective strategy for preventing the transmission of HIV and other STIs. Awareness of condoms is virtually universal. The majority of men and women had heard of condoms and knew where to obtain them. Knowing that condoms protect against pregnancy and HIV/AIDS is a necessary precondition for acceptance and use. However, such knowledge is not in itself sufficient for, although the male condom is widely accepted as an effective method of dual protection against the risk of pregnancy and HIV/AIDS, it is not very popular. Condoms are seen as interrupting sexual activity, causing discomfort and ruining the excitement of flesh-to-flesh sex, as found in countless other studies (Mehyar 1995; Boldsen et al. 1992; Preston-Whyte 1999a). These serve as barriers to condom use in sexual encounters.

The nature of the sexual relationships also influences condom use. Condoms are clearly less acceptable in marital than non-marital relationships. Nearly 14 percent of men and 17 percent of women reported using condoms in marital relationships, compared with 50.7 percent of men and 33.5 percent of women in non-marital relationships. Consistent with other studies, condoms are more likely to be used outside rather than inside marriage (Mehyar 1995; Boldsen et al. 1992; Preston-Whyte 1999a). The association with lack of trust has reduced the acceptability of condoms in marital relationships. Men are more likely than women to display strong opposition to condom use in marriage. In marital and non-marital unions, condom use is closely associated with level of education and place of residence.

The individual data shows large disparities between men and women in their reporting of condom use for family planning. In general, men are more likely than women to report condom use for contraceptive purposes. However, in section seven of the question, men and women are almost equally likely to report condom use. The data from matched couples allows us to evaluate reliability of husbands' and wives' reports in order to explain the differences in the reporting of condom use. The results suggest that men are more likely to report condom use for family planning and less likely to report use in the context of preceding questions about AIDS. For a variety of reasons, therefore, the woman's report of condom use is seen as a more reliable account of the couple's condom use.

In general, condom use is low among couples. Most other studies have shown that condom use in marital relationship is low and is one of the least frequently used methods of contraception (Gardner et al. 1999; Ali et al. 2001). Condom use corresponds closely with level of education and place of residence. The more educated, urban respondents are much more likely than the less educated, rural respondents to use condoms 'always' or 'occasionally'. Almost one-third of urban, educated wives reported using condoms within marriage and is suggestive of change in attitudes. Condoms are a highly effective mechanism of preventing pregnancy and STIs/HIV. However, few couples reported relying on condoms alone. Among couples, condoms are nearly always used in conjunction with another method of family planning. It has been hypothesised that when it comes to HIV protective behaviour men have greater influence over whether or not the condom is used. In contrast to other studies, the present study found that women are not powerless in sexual decision-making (Varga 1997b; Blanc and Wolff 2001). In fact, women exert considerable influence over condom use within marriage. The wife's perceived risk of HIV infection is the most influential factor determining condom use in marriage. Condom use is considerably higher among couples in which the wife perceives a risk of HIV infection. This suggests that wives who perceive a risk of HIV infection are more motivated to avoid that outcome by using a condom and are able to translate this concern into protective behaviour. Other studies have also found that disease prevention was the dominant concern because of the perceived high HIV prevalence of their partner (Poppen and Reisen 1999). The husband's attitude to condoms is also important and may serve as a barrier to use. Husbands were more likely than wives to demonstrate negative attitudes

to condom use in marriage. However, the wife's perception of risk of HIV infection overrides the husband's objection to condom use, suggesting that women can and do exert enormous influence over condom use. The findings do not provide support for the hypothesis that men have more influence over condom use than women. This is in sharp contrast to other studies, which found that men have greater influence than women over condom use (Blanc and Wolff 2001; Varga 1997b).

Service Environment

The interviews with providers offer a detailed understanding of their perspectives and experiences of integrated services. As mentioned previously, interviews with providers may sometimes elicit idealised rather than actual behaviour. The interviews with clients allowed for a comparison of the provider and the client's experiences of integrated services. With the advent of the HIV epidemic many providers have had to broaden their focus to include a wide range of reproductive health services. The results suggest that providers are more comfortable with the traditional focus on FP and MCH and less confident with the provision of an expanded range of services. The interviews with clients suggest that existing efforts to integrate services has had limited success. Clients are rarely offered an expanded range of services during their visit. In most cases, clients only receive services for which they present at the health facility.

Condom promotion is an important component of integrated services but is not consistently undertaken by providers. Condoms are more likely to be associated with disease- rather than pregnancy-prevention. As a result, STI clients are more likely than FP clients to receive information about condoms. FP clients are more likely to receive information about more highly effective methods of preventing pregnancy. This is consistent with another study in South Africa that found that condoms are not seen as an effective method of family planning (Abdool Karim et al. 1992c). In addition, clients visiting health facilities are rarely offered a comprehensive range of services that will protect them against the risk of unwanted pregnancy and STIs/HIV. Some providers may be constrained in the advice they can offer by their lack of adequate training. As a result, they are unable to offer clients a comprehensive range of services. Moreover, the large client loads make it difficult for providers to offer additional information to clients. Many clients would have welcomed a more active mode of integration and they would like providers to provide information on FP and STIs/HIV. However, it may not be feasible for overburdened providers to offer additional information.

There are a number of barriers to integrated reproductive health services. To implement the integrated approach, changes in strategic, structural, administrative and human resource management have had to occur. In the past decade the health system in South Africa has undergone enormous changes. Some of the problems with integrated services may have originated from the inherited health system with its inequities (Magwaza and Cooper 2002). In addition, human resource constraints such as staff shortage and heavy work overloads, as well as lack of trained providers poses a serious challenge to the effective implementation of integrated services. The lack of a clear blueprint for implementing integrated services has also led to a great deal of confusion about roles and responsibilities. The absence of a clear conceptual understanding of integration among providers is adversely affecting the implementation of integrated services. The slow progress in implementation is, in turn, likely to impact on levels of STIs and HIV among clients.

Methodological Issues

In this study a diverse range of qualitative and quantitative research techniques were used in order to explore the research objectives. The rationale for such a study design was that the use of a combination of methods would complement each other and also allow for exploration of some of the main areas of interest from a range of angles. The combination of qualitative and quantitative methods has clear advantages. In general, qualitative methods are more exploratory and are mostly used to gain insights into an individual's perception of a particular issue (Spradley 1979; Bernard 1994). In contrast, quantitative methods are more confirmatory and are mostly used to examine causal associations related to a particular outcome of interest (Campbell et al. 1999).

The advantages of combining qualitative and quantitative methods were also demonstrated in this study. The survey was particularly useful in providing information about the factors influencing family planning and condom use. The focus group discussions and in-depth interviews were particularly useful in providing an understanding of the social meanings attached to family planning and condom use. The focus group discussion and in-depth interviews highlighted some of the problems associated with condoms and the difficulties in negotiating condom use in marital and non-marital relationships.

Since numerous factors may influence the reliability of survey data on sensitive issues a mix of methods is beneficial to compare methods as well as confirm or validate results (Dare and Cleland 1994). The high levels of HIV infection in South Africa suggest that a great deal of sexual networking is occurring. However, there is some concern that the survey instrument did not capture all high-risk sexual encounters. In the survey, relatively few men and women reported multiple sexual partners. Married respondents were less likely than unmarried respondents to report a high number of sexual partners. It is highly plausible that reports of behavioural change are exaggerated and men and women are providing socially desirable responses. Indeed, the qualitative data suggest that, among men, sexual networking is fairly common. This prompts concern about the veracity of self-reports of behavioural change.

It is difficult to determine the direction of causality of the some key variables using cross-sectional data. For example, rather than predicting contraceptive use positive attitudes to contraception may have occurred after contraceptive acceptance. Moreover, it is not possible to determine on the basis of cross-sectional data, as argued by Bawah (2002:p186), “whether spousal discussion of reproductive matter precedes contraceptive use or whether the use of contraceptives engenders discussions.” As a result, some of the variables used in the bivariate analysis are not included in the multivariate analysis because it is difficult to determine the direction of causality.

In order to examine condom use, respondents were asked two questions. The first focused specifically on the use of any method for preventing and/or delaying pregnancy and the second focused specifically on condom use with spouse. A number of possible definitions of condom use could conceivably be developed based upon responses to these questions. Moreover, these definitions yield widely contrasting estimates of condom use. After exploratory analysis, the focus was on the use of condoms with spouse. However, as a result of the low number of men and women reporting using condoms consistently men and women who reported using condoms either ‘always’ and ‘occasionally’ were regarded as condom users. However, for condoms to be effective as a preventive measure against the transmission of unwanted pregnancy and STIs and HIV, it is necessary to use them consistently (CDC 1998).

The combination of qualitative and quantitative methods proved invaluable. It allowed for the exploration of a range of issues from a number of different angles. Moreover, it

allowed us to compare responses in several direct and indirect ways. One approach would therefore not have been adequate to address the multiple aims of the study.

Policy Implications

- A number of policy implications emerge from this research. Prevention programmes have been relatively successful in improving awareness of the means of protecting against HIV infection. Most people are aware that condoms are effective against HIV infection. However, condom use is lower in marital than non-marital relationships. Prevention programmes have an important role to play in promoting condoms in all sexual encounters (marital and non-marital). The findings of this study could perhaps be used for advocacy purposes. Condoms are often seen as unacceptable in marriage. However, this study found that condom use in marriage is occurring and is suggestive of change.
- Communication is important to encourage better understanding of each partner's preferences in order to reduce some of the consequences of poor communication such as unintended pregnancy and the transmission of STIs/HIV. Moreover, communication allows individuals to express their fears and insecurities, receive feedback and reassurance and obtain vital information (Green et al. 1995). Communication is also important for shared decision-making and necessary to overcome the false perception that men disapprove of family planning.
- Health facilities have an important role to play in reducing mistimed and unwanted pregnancies as well as STIs/HIV. In South Africa, family planning is firmly entrenched and it may therefore be better to promote dual method use i.e. the use of condoms with a highly effective method of preventing pregnancy. This is in sharp contrast to other African countries where the level of modern contraceptive use is low and there is a heavy reliance on traditional methods of family planning.
- In many health facilities, providers are overburdened with heavy client loads and as a result, are often unable to undertake individual counselling. A strong case therefore exists for appropriately selected and trained lay counsellors to inform and educate clients about a range of reproductive health issues.

Future Research

- The findings from this study have important implications for future investigations. The study revealed large discrepancies –some of which were considerable- in the reproductive preferences and behaviour of husbands and wives. To improve our understanding of reproductive health issues, research must continue to expand the focus on the couple.
- As mentioned previously, behavioural change remains the most effective strategy for curbing the further spread of the HIV epidemic. Surveys have an invaluable role to play in monitoring changes in behaviour as well as evaluating the impact of reproductive health programmes. However, in surveys there is the danger that respondents may provide socially desirable responses. It is therefore important that a combination of methods is used in order to check the consistency of self-reports.
- The study suggests that condom use in marriage is occurring. However, more research is needed on the plausible reasons for condom use in marital relationships. This will entail a more thorough understanding of the process of negotiating condom use in marriage.

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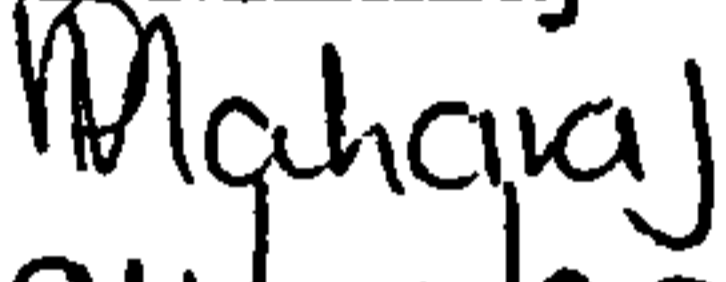
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Letter of Declaration

I certify that the Thesis entitled "The Dual Risks of Unwanted Pregnancy and HIV/AIDS: The Case of KwaZulu-Natal" and submitted for the degree of Doctor of Philosophy is the result of my own work. Part of the thesis is based on the South African component of the World Health Organisation's multi-country study, entitled Family Planning and Sexual Behaviour in the Era of HIV/AIDS, for which I was principal investigator. The questionnaires for the focus group discussions, household survey and in-depth interviews for this part of the study were designed in collaboration with staff at the WHO, LSHTM and the principal investigators from each of the six participating countries. For the South African country study, I was directly responsible for refining and adapting the instruments to the local context after pretesting. Moreover, I was solely responsible for the analysis of the South African data, the results of which are presented in a number of chapters in the thesis.

Name: P Maharaj
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Date: 04/08/2003

Appendices

Appendix 1: Guidelines for Focus Group Discussions

Appendix 2: Instructions to enumerators for selecting persons to interview in the household

Appendix 3: Household, Men's and Women's Questionnaires

Appendix 4: Guide for In-depth Interviews

Appendix 5: Inventory for Facilities Available and Services provided at the Service Delivery Point

Appendix 6: Guide for Focus Group Discussions with Providers

Appendix 7: Semi-Structured Interview with Staff

Appendix 8: Guide for Exit Interviews

Appendix 9: Denominators

Appendix 1

Guidelines for Focus Group Discussions

1. What are the most important health issues affecting adult (men\women) in this area?

(Probe: What else? The focus is on adult men and women. Please note: ask men about men, women about women, make clear we are not interested in kids or old folks)

2. If not mentioned above, how serious a problem is HIV/AIDS for men/women in this area?

(Probe: What causes HIV/AIDS? What are the kinds of things people in this area do to avoid HIV/AIDS? Can HIV/AIDS be treated or cured?)

3. If not mentioned, how serious a problem are STDs for (men \ women) in this area?

(Probe: What are the terms used for STDs in this area? What are the kinds of thing people in this area can do to avoid STDs? Can STDs be treated or cured?)

Now I'd like to talk about family planning. What is meant by family planning?

(Probe: What kind of people use family planning in this area? How big a problem is unwanted pregnancy in this area? Are condoms known and accepted in this area?)

When is it acceptable to use condoms? (is it ever acceptable...?)

(PROBE: If at the beginning of a relationship, when do you stop? What are the problems with using condoms? Is it ever acceptable for a married couple to use a condom? Can condoms be used as a method of family planning?)

Now I have an example of a married couple. The woman is having injections to space between births. The husband travels away from home for long periods of time for his work. The wife fears that he is having affairs with women while he is away, and she especially fears that he will bring her STDs or even worse, HIV/AIDS. If this happened in this community what could she do to protect herself if she fears being infected by her partner?

(PROBE: Can she ask him to use a condom? What are the consequences? Can she refuse to have sex with him? What are the consequences? Can she talk about it with him? What are the consequences? Is there anything the wife could do to change her husband's behavior so she doesn't have to worry so much when he comes home from trips?)

6. Let's say that the man stays at home, but the wife has just had a child and wants to wait before resuming sex. In this area, how long could she wait before the man will start to look for women on the outside?

7. What kinds of things can a (woman\man) do if (she\he) wants to have sex but doesn't want to (get pregnant\make his partner pregnant)?

(Probe: anything else?)

The second last question is about how man and women talk to each other about health concerns and family planning. When it comes to deciding to use family planning or stop having children, do men and women usually discuss this with each other?

(Probe: Is there anything that prevents men and women in this area from discussing family planning if they want to? Is there anything that prevents men and women from discussing HIV\AIDS or STDs with each other?)

9. Would people in this area accept using condoms instead of other methods of family planning as a response to the threat of HIV\STDs?

(Probe: Would they accept using condoms at the same time as other methods to prevent against unwanted pregnancy and HIV or STDs?)

Appendix 2

Instructions to enumerators for selecting persons to interview in the household

List all persons aged 18 and over in the household in the grid below, recording their sex and age in the columns provided. Cross off the list any female aged 40 or over, and any male aged under 20, and any male aged 50 or over. Number the individuals remaining on the list, starting with 1 from the top.

Names of persons aged 18+ in the household	Sex	Age	Serial number

Total number of people remaining on the list
 (If there is only one person remaining, that person must be interviewed.)

Look at the serial number of the household, as recorded on the front sheet of the household schedule. Write down the last digit of this number

Find the square on the grid below which lies in the column headed by this digit and the row corresponding to the total number of people remaining on your list above. The person with the serial number shown in this box must be interviewed.

Number of persons remaining on list	Last digit of household serial number									
	1	2	3	4	5	6	7	8	9	0
one	1	1	1	1	1	1	1	1	1	1
two	1	2	1	2	1	2	1	2	1	2
three	2	3	2	1	3	1	2	1	3	2
four	3	1	2	4	1	3	4	3	2	1
five	4	4	5	3	1	5	3	2	1	4
six	1	3	4	5	6	1	2	4	3	5
seven	5	6	3	7	2	7	5	1	4	6
eight	4	5	1	6	1	4	3	7	2	8
nine	7	9	4	8	6	2	1	5	6	3
ten or more	8	2	4	1	3	6	5	10	7	9

Write down the serial number and the name of the person selected for interview on the form below.

Serial number selected	Name of person selected for interview	Appointment time

Ask if this person's husband or wife or informal sexual partner lives in the household. Record the answer below, and if it is yes, write down the name of the partner.

Partner lives in household	Name of partner selected for interview	Appointment time
Yes / No		

Please note that the partner might not have a serial number, or might not even be on your first list, because he or she is too young or too old. This does not matter, we still want to interview the partner as well as the first person selected.

Appendix 3

Household, Men's and Women's Questionnaires

WORLD HEALTH ORGANIZATION
FAMILY PLANNING - AIDS SURVEY
HOUSEHOLD SCHEDULE

IMPLEMENTING INSTITUTION _____

ENGLISH LANGUAGE VERSION

IDENTIFICATION	
COUNTRY (Kenya=1, S. Africa=2, Tanzania=3, Uganda=4, Zambia=5, Zimbabwe=6).....	<input type="checkbox"/>
PLACE NAME _____	
NAME OF HOUSEHOLD HEAD _____	
CLUSTER NUMBER.....	<input type="checkbox"/>
HOUSEHOLD NUMBER.....	<input type="checkbox"/>
REGION	<input type="checkbox"/>
URBAN/RURAL (urban=1, rural=2).....	<input type="checkbox"/>

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY <input type="checkbox"/>
				MONTH <input type="checkbox"/>
				YEAR <input type="checkbox"/>
INTERVIEWER'S NAME	_____	_____	_____	NAME <input type="checkbox"/>
RESULT*	_____	_____	_____	RESULT <input type="checkbox"/>
NEXT VISIT: DATE	_____	_____	TOTAL VISITS WOMAN <input type="checkbox"/>	TOTAL VISITS MAN <input type="checkbox"/>
TIME	_____	_____		TOTAL VISITS <input type="checkbox"/>

<p>*RESULT CODES:</p> <ol style="list-style-type: none"> 1 COMPLETED 2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT 3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD 4 POSTPONED 5 REFUSED 6 DWELLING VACANT OR ADDRESS NOT A DWELLING 7 DWELLING DESTROYED 8 DWELLING NOT FOUND 9 OTHER _____ (specify) 	<p>TOTAL IN HOUSEHOLD <input type="checkbox"/></p> <p>TOTAL ELIGIBLE FEMALES <input type="checkbox"/></p> <p>TOTAL ELIGIBLE MALES <input type="checkbox"/></p> <p>LINE NO. OF KISH RESPONDENT <input type="checkbox"/></p> <p>PARTNER RESIDENT? Y...1 N...2</p> <p>KISH RESP. INTERVIEWED? Y..1 N..2 PARTNER INTERVIEWED? Y..1 N..2</p> <p>SEX OF KISH RESPONDENT? FEMALE..... 1 MALE..... 2</p>
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SUPERVISOR	OFFICE EDITOR	KEYED BY
NAME _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DATE _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Now we would like some information about the people over 15 years of age who usually live here or are staying with you now.

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD*	USUAL RESID.	SEX	AGE	ELIGIBILITY	KISH TABLE	KISH SELECT	FOR KISH-SELECTED RESPONDENT ONLY	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	Please give me the names of the people aged 15 and over who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.	What is the relationship of (NAME) to the head of the household?	Does (NAME) usually live here?	Is (NAME) male or female?	How old is (NAME)? ESTIMATE	CIRCLE LINE NUMBER OF ALL RESIDENT WOMEN AGED 18-39 & ALL RESIDENT MEN AGED 20-49	WRITE ORDER NUMBER OF ALL ELIG. RESPOND	CIRCLE LINE NUMBER OF SELECT RESP.	Does (NAME)'s partner live in this household?	CIRCLE LINE NUMBER OF ALL RESPONDERS
			YES NO	M F	IN YEARS			(FIRST MAKE KISH SELECT. BELOW)	YES NO	
01			1 2	1 2		01	—	01	1 2	01
02			1 2	1 2		02	—	02	1 2	02
03			1 2	1 2		03	—	03	1 2	03
04			1 2	1 2		04	—	04	1 2	04
05			1 2	1 2		05	—	05	1 2	05
06			1 2	1 2		06	—	06	1 2	06
07			1 2	1 2		07	—	07	1 2	07
08			1 2	1 2		08	—	08	1 2	08

LINE	RESIDENTS/VISITORS	RELATIONSHIP	RESID.	SEX	AGE	ELIG. RESP.	ORDER NUMB.	SELECT RESP.	FOR ELIGIBLE RESP.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10) (11)
09			1 2	1 2		09	—	09	1 2 09
10			1 2	1 2		10	—	10	1 2 10
11			1 2	1 2		11	—	11	1 2 11
12			1 2	1 2		12	—	12	1 2 12
13			1 2	1 2		13	—	13	1 2 13
14			1 2	1 2		14	—	14	1 2 14
15			1 2	1 2		15	—	15	1 2 15

KISH SELECTION WORKSHEET

- TICK HERE IF CONTINUATION SHEET USED
- 1) LAST DIGIT OF HH ID NUMBER
- 2) TOTAL NUMBER OF ELIGIBLE RESPONDENTS (HIGHEST # IN COL 8)
- 3) KISH SELECTION NUMBER
- 4) CIRCLE MATCHING KISH NUMBER IN COLUMN 8 AND LINE NUMBER IN COLUMN 9 TO SELECT RESPONDENT

Just to make sure that I have a complete listing:

1) In addition, are there any other people who may not be members of your family, such as domestic servants, lodgers, or friends who usually live here? YES ENTER EACH IN TABLE

* CODES FOR Q.3: RELATIONSHIP TO HEAD OF HOUSEHOLDS

- 01 - HEAD
- 02 - WIFE OR HUSBAND
- 03 - SON OR DAUGHTER
- 04 - SON-IN-LAW OR DAUGHTER-IN-LAW
- 05 - GRANDCHILD
- 06 - PARENT
- 07 - PARENT-IN-LAW
- 08 - BROTHER OR SISTER
- 09 - CO-WIFE
- 10 - OTHER RELATIVE
- 11 - ADOPTED/FOSTER/STEP CHILD
- 12 - NOT RELATED

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
12	Does your household have:	YES NO	
	Electricity?	ELECTRICITY.....1	2
	A radio?	RADIO.....1	2
	A television?	TELEVISION.....1	2
	A refrigerator?	REFRIGERATOR.....1	2
13	Does any member of your household own:	YES NO	
	A house?	HOUSE.....1	2
	A bicycle?	BICYCLE.....1	2
	A motorcycle?	MOTORCYCLE.....1	2
	A car?	CAR.....1	2
14	Does your household own any land?	YES.....1	
		NO.....2	
15	Does your household own any livestock?	YES.....1	
		NO.....2	
16	What kind of toilet facility does your household have?	FLUSH TOILET	
		OWN FLUSH TOILET.....11	
		SHARED FLUSH TOILET.....12	
		PIT TOILET/LATRINE	
		TRADITIONAL PIT TOILET.....21	
		VENTILATED IMPROVED PIT	
		(VIP) LATRINE.....22	
		NO FACILITY/BUSH/FIELD.....31	
		OTHER _____ 96	
		(SPECIFY)	
17	MAIN MATERIAL OF THE ROOF	THATCH.....1	
	RECORD OBSERVATION.	IRON/TIN.....2	
		TILES.....3	
		MULTI-STORY DWELLING.....4	
		OTHER _____ 6	
		(SPECIFY)	
18	MAIN MATERIAL OF THE FLOOR	EARTH.....1	
	RECORD OBSERVATION.	CEMENT.....2	
		TILE.....3	
		OTHER _____ 6	
		(SPECIFY)	

WORLD HEALTH ORGANIZATION
FAMILY PLANNING AND AIDS SURVEY
INDIVIDUAL MEN'S QUESTIONNAIRE

IDENTIFICATION	
COUNTRY (Kenya=1, S. Africa=2, Tanzania=3, Uganda=4, Zambia=5, Zimbabwe=6).....	<input type="checkbox"/>
RESPONDENT ID _____	
CLUSTER NAME _____	
CLUSTER NUMBER.....	<input type="checkbox"/>
HOUSEHOLD NUMBER.....	<input type="checkbox"/>
RESPONDENT LINE NUMBER	<input type="checkbox"/>
SEX OF RESPONDENT (Male=1, Female=2).....	1
URBAN/RURAL (urban=1, rural=2).....	<input type="checkbox"/>
NATIVE LANGUAGE OF RESPONDENT? _____	

INTERVIEWER VISITS										
	1	2	3	FINAL VISIT						
DATE	_____	_____	_____	DAY <input type="checkbox"/>						
LANGUAGE OF INTERVIEW	_____	_____	_____	MONTH <input type="checkbox"/>						
INTERVIEWER'S NAME	_____	_____	_____	YEAR <input type="checkbox"/>						
RESULT*	_____	_____	_____	NAME <input type="checkbox"/>						
NEXT VISIT: DATE	_____	_____	_____	RESULT <input type="checkbox"/>						
TIME	_____	_____	_____	TOTAL NO. OF VISITS <input type="checkbox"/>						
<p>*RESULT CODES:</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">1 COMPLETE</td> <td style="width: 50%;">4 NO RESPONDENT PRESENT OR ABLE TO ANSWER QUESTIONNAIRE</td> </tr> <tr> <td>2 INCOMPLETE</td> <td>5 HOUSEHOLD NOT FOUND</td> </tr> <tr> <td>3 REFUSED INTERVIEW</td> <td></td> </tr> </table>					1 COMPLETE	4 NO RESPONDENT PRESENT OR ABLE TO ANSWER QUESTIONNAIRE	2 INCOMPLETE	5 HOUSEHOLD NOT FOUND	3 REFUSED INTERVIEW	
1 COMPLETE	4 NO RESPONDENT PRESENT OR ABLE TO ANSWER QUESTIONNAIRE									
2 INCOMPLETE	5 HOUSEHOLD NOT FOUND									
3 REFUSED INTERVIEW										

SUPERVISOR		OFFICE EDITOR	KEYED BY
NAME _____ <input type="checkbox"/>		NAME: _____ <input type="checkbox"/>	NAME: _____ <input type="checkbox"/>
DATE _____ <input type="checkbox"/>			

PARTNER INTERVIEW STATUS (CIRCLE APPROPRIATE CODE)

- NO ELIGIBLE PARTNER IN HH..... 1
- RESPONDENT INTERVIEWED BEFORE PARTNER..... 2
- RESPONDENT INTERVIEWED AFTER PARTNER..... 3
- ELIGIBLE PARTNER NOT INTERVIEWED..... 4

HH LINE NUMBER OF ELIGIBLE PARTNER

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

SECTION 1. BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	<p>RECORD THE TIME.</p> <p>Thank you for taking the time to talk to me. I would like to ask some questions about you and your household</p>	<p>HOUR..... <input type="text"/> <input type="text"/></p> <p>MINUTES..... <input type="text"/> <input type="text"/></p>	
102	<p>In what month and year were you born?</p>	<p>MONTH..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW MONTH.....98</p> <p>YEAR..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW YEAR.....98</p>	
103	<p>What was your age at your last birthday?</p> <p>COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.</p>	<p>AGE IN COMPLETED YEARS..... <input type="text"/> <input type="text"/></p>	
104	<p>Have you ever attended school?</p>	<p>YES.....1</p> <p>NO.....2</p>	107
105	<p>What is the highest level of school you attended: primary, lower secondary, upper secondary or higher?</p>	<p>PRIMARY.....1</p> <p>LOWER SECONDARY.....2</p> <p>UPPER SECONDARY.....3</p> <p>HIGHER.....4</p>	108
106	<p>Did you complete that level?</p>	<p>YES.....1</p> <p>NO.....2</p>	108
107	<p>Can you read and understand a letter or newspaper easily, with difficulty, or not at all?</p>	<p>EASILY1</p> <p>WITH DIFFICULTY2</p> <p>NOT AT ALL.....3</p>	
108	<p>What is your religion?</p>	<p>ROMAN CATHOLIC.....10</p> <p>PROTESTANT.....20</p> <p>BORN AGAIN.....21</p> <p>PROTESTANT, SPECIFY.....22</p> <p>PROTESTANT, SPECIFY23</p> <p>PROTESTANT, SPECIFY24</p> <p>PROTESTANT, SPECIFY25</p> <p>MUSLIM.....30</p> <p>HINDU.....40</p> <p>TRADITIONAL.....50</p> <p>NO RELIGION.....60</p> <p>OTHER.....96</p> <p>(SPECIFY)</p>	
109	<p>What is your native language? ALTERNATIVE: What is your mother tongue?</p>	<p>COUNTRY SPECIFIC CODES.....01</p> <p>.....02</p> <p>.....03</p> <p>.....04</p> <p>.....05</p> <p>OTHER.....96</p>	
110	<p>What other languages can you speak easily?</p>	<p>English.....10</p> <p>French.....20</p> <p>Kiswahili.....30</p> <p>COUNTRY SPECIFIC CODES.....01</p> <p>.....02</p> <p>.....03</p> <p>.....04</p> <p>.....05</p> <p>OTHER.....96</p>	
111	<p>What is your main occupation, that is, what kind of work do you do most of your time?</p>	<p>(SPECIFY) <input type="text"/> <input type="text"/></p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
115	Are you currently married or living with a woman?	MARRIED.....1 NOT MARRIED, LIVING TOGETHER....2 OTHER, SPECIFY.....6	<input type="checkbox"/> 118 <input type="checkbox"/>
116	What is your current marital status?	NEVER MARRIED.....1 ENGAGED.....2 WIDOWED.....3 DIVORCED.....4 SEPARATED.....5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 201
117	Have you ever had sexual intercourse with a woman in your life?	YES.....1 NO.....2	<input type="checkbox"/> 201 <input type="checkbox"/> 802
118	How many wives or partners live with you? IF NONE ENTER 0		<input type="text"/>
119	Do you have a wife or a partner who lives elsewhere? IF YES How many? IF NO ENTER 0		<input type="text"/>
120	CHECK 118 ONE OR MORE WIVES/ COHABITING PARTNERS <input type="checkbox"/>	RESPONDENT HAS NO WIVES/ COHABITING PARTNERS <input type="checkbox"/>	<input type="checkbox"/> 201
121	NAME OF EACH COHABITING WIFE OR PARTNER	122 How many years ago did you start a regular relationship with NAME? IF LESS THAN ONE YEAR ENTER 00	123 ORDER [INTERVIEWER: SEE BELOW FOR INSTRUCTIONS]
	A _____	<input type="text"/>	A <input type="text"/>
	B _____	<input type="text"/>	B <input type="text"/>
	C _____	<input type="text"/>	C <input type="text"/>
	D _____	<input type="text"/>	D <input type="text"/>
	NAME OF EACH NON-COHABITING WIFE		
	E _____	<input type="text"/>	E <input type="text"/>
	F _____	<input type="text"/>	F <input type="text"/>
	G _____	<input type="text"/>	G <input type="text"/>
	H _____	<input type="text"/>	H <input type="text"/>
STARTING WITH COHABITING WIFE/PARTNERS, ENTER 'ONE' AGAINST NAME WITH SHORTEST DURATION: ENTER 'TWO' AGAINST NAME WITH NEXT SHORTEST DURATION ETC. IN THE ABOVE RIGHT COLUMN.			
IF THERE ARE LESS THAN THREE COHABITING WIVES/PARTNERS CONTINUE NUMBERING OF NON-COHABITING WIVES UNTIL YOU REACH 'THREE'			

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
152	Are you engaged to or do you plan to marry <NAME>?	ENGAGED.....1 PLAN TO MARRY.....2 NO.....3 NOT SURE.....4] - 201
153	What type of wedding ceremony did you have (do you expect to have)?	CHRISTIAN.....1 MUSLIM.....2 HINDU.....3 TRADITIONAL.....4 OTHER (SPECIFY _____) 5 DON'T KNOW.....8	
154	Has any brideprice been negotiated?	YES.....1 NO.....2	- 201
155	Is/was the brideprice mostly in terms of cash, cattle, or smaller gifts such as clothes, shoes, or food?	MOSTLY CASH.....1 MOSTLY CATTLE.....2 MOSTLY SMALLER GIFTS.....3 Other (specify) _____ 6	
156	Has the brideprice been completely paid?	YES.....1 NO.....2	

SECTION 2 MOBILITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Now I would like to ask a few questions about your travel away from home.		
201	For most of the time until you were 12 years old, did you live in a city, a town, or the village?	CITY.....1 TOWN2 VILLAGE.....3	
202	How long have you lived continuously in your current residence? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOX	MONTHS\YEARS M Y ALWAYS.....97	
203	Have you ever travelled away from home for 1 night or more in the last 12 months?	YES.....1 NO.....2	206
204	What was the longest continuous amount of time you spent away from home in the last 12 months? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOX	DAYS\WEEKS\MONTHS D W M	
205	Where did you go at that time? PROBE FOR TYPE OF PLACE IF MORE THAN ONE MENTIONED, INDICATE MOST DISTANT CIRCLE TYPE OF PLACE (TOP PANEL) AND LOCATION (BOTTOM PANEL)	SAME VILLAGE, TOWN, CITY.....0 OTHER VILLAGE/AREA.....1 OTHER TOWN.....2 OTHER CITY.....3 SAME DISTRICT.....1 OTHER DISTRICT.....2 DIFFERENT COUNTRY.....3	
206	CHECK 130 <input type="checkbox"/> SAME HOUSEHOLD NOT LIVING TOGETHER <input type="checkbox"/>		301
207	Has <NAME> ever travelled away from home for 1 night or more in the last 12 months?	YES.....1 NO.....2 DONT KNOW.....8	301
208	What was the longest continuous amount of time she spent away from home in the last 12 months? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOX	DAYS\WEEKS\MONTHS D W M DON'T KNOW.....98	
209	Where did she go at that time? PROBE FOR TYPE OF PLACE IF MORE THAN ONE MENTIONED, INDICATE MOST DISTANT CIRCLE TYPE OF PLACE (TOP PANEL) AND LOCATION (BOTTOM PANEL)	SAME VILLAGE, TOWN, CITY.....0 OTHER VILLAGE/AREA.....1 OTHER TOWN.....2 OTHER CITY.....3 SAME DISTRICT.....1 OTHER DISTRICT.....2 DIFFERENT COUNTRY.....3	301

SECTION 3 FERTILITY HISTORY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
300	CHECK 118 ONE OR MORE WIVES/ COHABITING PARTNERS <input type="checkbox"/>	NO WIVES/ COHABITING PARTNERS <input type="checkbox"/>	401
301	Is <NAME> currently pregnant?	YES.....1 NO.....2 UNSURE.....3	
302	How many children has <NAME> given birth to with you? IF NONE, CIRCLE 00	<input type="text"/> NO BIRTHS.....00	310
303	How many of these children are still alive? IF NONE CIRCLE 00	<input type="text"/> NONE.....00	
305	What is the month and year of <NAME's> most recent birth? ESTIMATE YEAR	MONTH..... <input type="text"/> DON'T KNOW MONTH.....98 YEAR..... <input type="text"/> YEAR IS ESTIMATE.....1	
306	CHECK 305 CHILD BORN IN 1997 OR LATER <input type="checkbox"/>	CHILD BORN BEFORE 1997 <input type="checkbox"/>	310
307	Is this child currently breastfeeding?	YES.....1 NO.....2 CHILD DIED.....3 DON'T KNOW.....9	
308	Have <NAME's> menstrual periods returned since her last birth?	YES.....1 NO.....2 DON'T KNOW.....9	
309	How long after the birth of this child did you wait before resuming regular sexual relations with <NAME>? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOX	WEEKS\MONTHS W M <input type="text"/> STILL ABSTAINING.....97	
310	What do you think is the ideal time for a man to wait after the birth of a child until resuming sex with his partner? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOX	WEEKS\MONTHS W M <input type="text"/>	
311	Who usually has the most influence over when to resume regular sex after child birth: the man, the woman, or both have an equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 DON'T KNOW/IT DEPENDS.....8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
312	<p>CHECK 303</p> <p><NAME> HAS LIVING CHILDREN <input type="checkbox"/></p> <p><NAME> HAS NO LIVING CHILDREN <input type="checkbox"/></p> <p>If you could go back to the time you did not have any children with <NAME> and could choose exactly the number of children to have in your whole life how many would that be?</p> <p>If you could choose exactly the number of children to have in your whole life with <NAME> how many would that be?</p> <p>PROBE FOR A NUMERIC RESPONSE.</p>	<p>NUMBER..... <input type="text"/></p> <p>OTHER _____ 96 (SPECIFY)</p>	
313	<p>CHECK 301</p> <p><NAME> NOT PREGNANT OR UNSURE <input type="checkbox"/></p> <p><NAME> PREGNANT <input type="checkbox"/></p> <p>Now I have some questions about the future. Would you like to have (a/another) child with <NAME> or would you prefer not to have any (more) children?</p> <p>Now I have some questions about the future. After the child <NAME> is expecting now, would you like to have another child or would you prefer not to have any more children with <NAME>?</p>	<p>HAVE (A/ANOTHER) CHILD.....1</p> <p>UNDECIDED.....2</p> <p>NO MORE/NONE.....3</p> <p>SAYS SHE IS STERILE.....4</p>	<p>315</p> <p>401</p>
314	<p>How much would it matter if you did have another child?</p>	<p>Very Much.....1</p> <p>Somewhat.....2</p> <p>Not Much.....3</p>	<p>-316</p>
315	<p>CHECK: 301</p> <p><NAME> NOT PREGNANT OR UNSURE <input type="checkbox"/></p> <p><NAME> PREGNANT <input type="checkbox"/></p> <p>How long would you like to wait from now before the birth of (a/another) child with <NAME>?</p> <p>After the child <NAME> is expecting now, how long would you like to wait before the birth of another child?</p> <p>CIRCLE CORRECT UNIT AND ENTER NUMBERS IN BOXES</p>	<p>MONTHS/YEARS <input type="text"/></p> <p>M Y</p> <p>OTHER _____ 96 (SPECIFY)</p> <p>DON'T KNOW.....98</p>	
316	<p>What do you think is the ideal time to space between births?</p>	<p>MONTHS/YEARS <input type="text"/></p> <p>M Y</p> <p>OTHER (Specify) _____ 96</p>	
318	<p>CHECK 301:</p> <p><NAME> NOT PREGNANT OR UNSURE <input type="checkbox"/></p> <p><NAME> PREGNANT <input type="checkbox"/></p> <p>Do you think <NAME> would like to have a/another child or would she prefer not to have any (more) children with you?</p> <p>After the child she is expecting now, do you think <NAME> would like to have another child or would she prefer not to have any more children with you?</p>	<p>HAVE (A/ANOTHER) CHILD.....1</p> <p>UNDECIDED.....2</p> <p>NO MORE/NONE.....3</p> <p>DON'T KNOW PARTNER'S DESIRE....9</p>	<p>320</p>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
319	<p>CHECK: 301</p> <p><NAME> NOT PREGNANT OR UNSURE <input type="checkbox"/></p> <p><NAME> PREGNANT <input type="checkbox"/></p> <p>How long would <NAME> like to wait before the birth of (a/another) child?</p> <p>After the child she is expecting now, how long would <NAME> like to wait before the birth of another child?</p> <p>CIRCLE THE CORRECT UNIT AND ENTER THE NUMBERS IN BOXES</p>	<p>MONTHS/YEARS</p> <p>M Y</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p> <p>DON'T KNOW.....98</p>	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>		
320	<p>Have you and <NAME> ever discussed whether or not to have another child or how soon to have the next child?</p>	<p>YES.....1</p> <p>NO.....2</p>	<p>323</p>		
321	<p>Have you discussed this many times, a few times, or only once in the last year?</p>	<p>MANY.....1</p> <p>FEW.....2</p> <p>ONCE.....3</p>			
322	<p>Have you and <NAME> ever disagreed or had arguments about whether or not to have another child, or how soon to have another child?</p>	<p>YES.....1</p> <p>NO.....2</p>			
323	<p>Have you ever spoken with anyone (else) about whether or not to have another child/or how soon to have another child? (CIRCLE ALL MENTIONED)</p> <p>PROBE: Anyone else?</p>	<p>MALE FRIENDS/NEIGHBOURS.....01</p> <p>FEMALE FRIENDS/NEIGHBOURS.....02</p> <p>BROTHERS.....03</p> <p>OTHER MALE RELATIVES.....04</p> <p>SISTER.....05</p> <p>OTHER FEMALE RELATIVES.....06</p> <p>FAMILY PLANNING/HEALTH WORKERS.07</p> <p>OTHER (SPECIFY) _____ 08</p> <p>OTHER (SPECIFY) _____ 09</p> <p>OTHER (SPECIFY) _____ 10</p>			

SECTION 4A. FAMILY PLANNING

Now I would like to talk to you about family planning.
 By family planning, I mean methods that you can get at the clinic or drugstore,
 things or advice that you can get from traditional healers and herbalists, or things that you can do at
 home with your partner to delay or to avoid a pregnancy.

INSTRUCTIONS TO INTERVIEWER:

1. ASK Q401 FIRST, PROBING FOR ALL METHODS RESPONDENT HAS HEARD OF INCLUDING TRADITIONAL METHODS.
2. AFTER COMPLETING Q401, ASK Q402 AND Q403 IN ORDER FOR EACH METHOD RESPONDENT HAS HEARD OF.

401	What ways or methods have you heard about? PROBE: What other methods? PROBE: What (other) traditional methods? CIRCLE YES or NO IN FIRST COLUMN, IF MENTIONED. IF YES ASK 402 AND 403	Q401 Heard of?	Q402 Have you ever used this method?	Q403 Do you know where a person could go to get this method?
a)	PILL.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
b)	IUD.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
c)	INJECTIONS.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
d)	IMPLANTS.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
e)	DIAPHRAM/FOAM/JELLY.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
f)	CONDOM.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
g)	FEMALE STERILIZATION.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
h)	MALE STERILIZATION.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
i)	RHYTHM.....	YES.....1 NO.....2	YES.....1 NO.....2	
j)	WITHDRAWAL.....	YES.....1 NO.....2	YES.....1 NO.....2	
k)	ABSTINENCE.....	YES.....1 NO.....2	YES.....1 NO.....2	
l)	OTHER (SPECIFY) _____ <input type="checkbox"/>	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
m)	OTHER (SPECIFY) _____ <input type="checkbox"/>	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
n)	OTHER (SPECIFY) _____ <input type="checkbox"/>	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
404	CHECK 401 NOT HEARD OF CONDOMS <input type="checkbox"/>	HEARD OF CONDOMS <input type="checkbox"/>	406
405	Have you ever heard of condoms? I mean a rubber sheath that a man puts on during sexual intercourse? NO <input type="checkbox"/> YES <input type="checkbox"/>	CORRECT THE CONDOM LINE OF 401 AND ASK 402/403	
406	CHECK 402 NEVER USED ANY METHOD <input type="checkbox"/>	EVER USED AT LEAST ONE METHOD <input type="checkbox"/>	411
407	Just to check that I have this right, have you ever used any method or done anything to avoid getting your partner pregnant? Yes <input type="checkbox"/> NO <input type="checkbox"/>	ASK FOR METHOD AND AMEND 401, 402, 403, 405A	414
408	CHECK 118 ONE OR MORE WIVES/ COHABITING PARTNERS <input type="checkbox"/>	NO WIVES OR COHABITING PARTNERS <input type="checkbox"/>	417
409	CHECK 402 g AND h MAN AND <NAME> NOT STERILIZED <input type="checkbox"/>	MAN OR <NAME> STERILIZED <input type="checkbox"/>	411
410	Are you and <NAME> currently doing something or using any method to delay or avoid getting pregnant?	YES.....1 NO.....2	413
411	Which method are you using? PROBE: What else? CIRCLE ALL MENTIONED CIRCLE '07' FOR FEMALE STERILIZATION. '08' FOR MALE STERILIZATION.	PILL.....01 IUD.....02 INJECTIONS.....03 IMPLANTS.....04 DIAPHRAGM/FOAM/JELLY.....05 CONDOM.....06 FEMALE STERILIZATION.....07 MALE STERILIZATION.....08 RHYTHM.....09 WITHDRAWAL.....10 SPORADIC ABSTINENCE.....11 OTHER _____ 96 (SPECIFY)	413 413
412	Does <NAME> know that you are currently using a method?	YES.....1 NO.....2	414
413	Have you ever used a method to delay or avoid <NAME> getting pregnant without <NAME's> knowledge?	YES.....1 NO.....2	
414	Have you ever discussed family planning methods with <NAME>?	YES.....1 NO.....2	416
415	Did you discuss this many times, a few times, or only once in the last year?	MANY.....1 FEW.....2 ONCE.....3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
416	Do you think <NAME> approves, or has mixed feelings or no opinion, or disapproves about a couple using a method to delay or avoid pregnancy?	APPROVES.....1 MIXED/NO OPINION.....2 DISAPPROVES.....3 DON'T KNOW.....8	
417	Who usually has more influence over whether or not to use a family planning method: the man, the woman, or both have equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 IT DEPENDS.....4	
418	Would you say that most of the people you know approve of the practice of family planning, disapprove of it, or have no opinion?	MOST APPROVE.....1 MOST DISAPPROVE.....2 MOST HAVE NO OPINION.....3 DON'T KNOW.....8	
419	For the next set of questions, say whether you agree, disagree, or have no opinion about the following statements: READ OUT: It is acceptable for a couple to use a method to space between births.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	
420	It is acceptable for a couple to use a method to have no more children.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	
421	If a woman gets pregnant but strongly does not want to have another child, she can consider having an abortion instead.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	
422	If a couple has more children than they can afford, they can always rely on relatives for help raising children.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	
423	It is acceptable for a man to propose using a method to his partner.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	
424	It is acceptable for a woman to use a method without telling her partner about it.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	
425	Family planning leads to promiscuous behaviour.	AGREE1 MIXED/NO OPINION.....2 DISAGREE3	

SECTION 4B. OTHER WIVES OR PARTNERS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
430	CHECK 118 MORE THAN 1 WIFE/PARTNER LIVING WITH <input type="checkbox"/>	NO WIFE/PARTNER OR ONLY 1 WIFE/PARTNER LIVING WITH <input type="checkbox"/>		501
431	CHECK 121 ENTER NAME OF WIFE/PARTNER NUMBER 2 AND NAME OF WIFE/PARTNER NUMBER 3 (IF ANY) ASK 432-443 - ABOUT WIFE/PARTNER 2 AND THEN ASK THE SAME - ABOUT WIFE/ PARTNER 3 (IF ANY)	WIFE/PARTNER 2 NAME	WIFE/PARTNER 3 NAME	
432	What is your relationship with <NAME>? PROBE	LEGAL MARRIED.....1 TRAD. MARRIED.....2 ENGAGED.....3 COHABIT.....4	LEGAL MARRIED.....1 TRAD. MARRIED.....2 ENGAGED.....3 COHABIT.....4	
433	How many surviving children do you have with <NAME>? ENTER NUMBER OF CHILDREN IF NONE, CIRCLE 00	OTHER.....6 <input type="text"/> None.....00 →435	OTHER.....6 <input type="text"/> None.....00 →435	
434	What is the month and year of <NAME's> most recent birth? ESTIMATE YEAR	MONTH <input type="text"/> DON'T KNOW MONTH...98 YEAR <input type="text"/> YEAR IS ESTIMATE....1	MONTH <input type="text"/> DON'T KNOW MONTH.98 YEAR <input type="text"/> YEAR IS ESTIMATE....1	
435	Would you like to have (more) children with <NAME>?	HAVE ANOTHER.....1 UNDECIDED.....2 NO MORE.....3 - 437 <NAME> STERILE....4 - 440	HAVE ANOTHER.....1 UNDECIDED.....2 NO MORE.....3 - 437 <NAME> STERILE....4 - 440	
436	How long would you like to wait from now before the birth of a (another) child with <NAME>? CIRCLE UNIT OF TIME AND ENTER NUMBER OF MONTHS OR YEARS IN BOX.	MONTHS/YEARS 1 2 <input type="text"/> SOON.....95 OTHER.....96 DON'T KNOW.....98	MONTHS/YEARS 1 2 <input type="text"/> SOON.....95 OTHER.....96 DON'T KNOW.....98	
437	Have you or <NAME> ever used any method to delay or avoid getting pregnant?	YES.....1 NO.....2 - 440	YES.....1 NO.....2 - 440	
438	Are you or <NAME> currently using any method?	YES.....1 NO.....2 - 440	YES.....1 NO.....2 - 440	
439	Which method are you or <NAME> currently using? INTERVIEWER: SEE CODES FOR 411 AND ENTER IN BOX	<input type="text"/>	<input type="text"/>	
440	Have you ever discussed family planning method with <NAME>?	YES.....1 NO.....2	YES.....1 NO.....2	
441	Have you and <NAME> ever used a condom?	YES.....1 NO.....2 - 443	YES.....1 NO.....2 - 443	
442	Did you use a condom always, occasionally or only at the beginning of the relationship?	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3	ALWAYS.....1 OCCASIONALLY....2 BEGINNING.....3	
443	Have you ever talked with <NAME> about the risk of contracting AIDS?	YES.....1 NO.....2	YES.....1 NO.....2	

SECTION 5 SEXUAL HISTORY

NO. | QUESTIONS AND FILTERS || CODING CATEGORIES | SKIP

It sometimes happens that men have sexual relations with partners other than their regular partners. I would like to ask you about relationships with other women.

INTERVIEWER INSTRUCTIONS: Questions 501, 507-525 are repeated for the last 3 non-regular partners in the last 3 years. Record answers for the most recent partner in the first column below & in answer sheet for 507-525. Then return to Q501 and ask about the previous non-regular partner, recording answers in the second column of the answer sheet, etc.

501	CHECK: 118 ONE OR MORE WIVES/ COHABITING PARTNERS <input type="checkbox"/>	NO WIFE OR COHABITING PARTNERS <input type="checkbox"/>
	You have already told me that you havewives/ cohabiting partners. How long ago did you last have sex with a woman apart from <NAME 1> <NAME 2> or <NAME 3> (or the one we just talked about)?	How long ago did you last have sex with a woman (apart from the one we have just talked about)?
	PROBE AND ESTIMATE AND RECORD ANSWER BELOW	
	CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOX	

502 | CHECK: 501
 LAST SEX WITH NON-REGULAR PARTNER WITHIN 3 YEARS?

NO.	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP
501	PARTNER 1		PARTNER 2		PARTNER 3	
	<input type="text"/> <input type="text"/> DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95	502	<input type="text"/> <input type="text"/> DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95	601	<input type="text"/> <input type="text"/> DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95	601
502	CHECK 501 3 YEARS OR MORE <input type="checkbox"/>		CHECK 501 3 YEARS OR MORE <input type="checkbox"/>		CHECK 501 3 YEARS OR MORE <input type="checkbox"/>	
	LESS THAN 3 YEARS <input type="checkbox"/>	507	LESS THAN 3 YEARS <input type="checkbox"/>	507	LESS THAN 3 YEARS <input type="checkbox"/>	507
	SKIP TO 601		SKIP TO 601		SKIP TO 601	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
503	Just to check that I have this right, have you ever had a sexual relationship that lasted for one night or a very short time?	YES.....1 NO.....2	506
504	Have you ever had sex with anyone other than a regular partner when you were travelling away from home?	YES.....1 NO.....2	506
505	Have you ever had sex with anyone other than a regular partner at a party or a social or cultural event?	YES.....1 NO.....2	506
506	IF YES TO EITHER 503, 504, OR 505: How long ago was the most recent time something like this happened? CORRECT RESPONSE IN 501, GO TO 502	IF NO TO ALL QUESTIONS	601

NO.	QUESTIONS AND FILTERS	SKIP
507	What is her first name or initial?	
508	How long have you had a relationship with <PNAME>? ESTIMATE	
509	Is your relationship to <PNAME> still continuing?	
510	What was your relationship to this woman? PROBE	
511	Was she younger about the same age, or older than you? IF YOUNGER, more than 5 years? more than 10? more than 20?	
512	Did you ever live with <PNAME>?	
513	Did you have any children with her?	
514	Did (do) you want to have a child with <PNAME>?	
515	During your relationship with <PNAME> were you concerned that she might get pregnant when you did not want her to get pregnant?	
516	Did you and <PNAME> ever discuss family planning methods?	
517	Did you or <PNAME> ever use any method to delay or prevent pregnancy? IF YES Always or sometimes?	
518	What was the main method that was used?	
519	Did you and <PNAME> ever use condoms? IF YES Always, occasionally or only at the beginning of the relationship?	
520	Did you ever use condoms together with another method of family planning with <PNAME>?	
521	Who first proposed using condoms, you or <PNAME>?	
522	Did you and <PNAME> ever discuss using condoms?	
523	As far as you know, is (was) she having sex with anyone else during your relationship?	
524	Did you ever talk with <PNAME> about the risk of getting AIDS? IF YES: did you discuss this before you first had sex or later?	
525	During your relationship with <PNAME> were you concerned that you might contract AIDS from her? If YES were you very or somewhat concerned?	
526	INTERVIEWER NOW RETURN TO 501 FOR OTHER PARTNER(s)	

NO.	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP
507	NAME/INITIAL _____		NAME/INITIAL _____		NAME/INITIAL _____	
508	DAY\WEEK\MONTH\YEAR <input type="text"/> <input type="text"/> 1 2 3 4		DAY\WEEK\MONTH\YEAR <input type="text"/> <input type="text"/> 1 2 3 4		DAY\WEEK\MONTH\YEAR <input type="text"/> <input type="text"/> 1 2 3 4	
	SINGLE TIME.....97	510	SINGLE TIME.....97	510	SINGLE TIME.....97	510
509	YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3	
510	FORMER WIFE.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY.....6		FORMER WIFE.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY.....6		FORMER WIFE.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY.....6	
511	OLDER.....1 SAME.....2 5 YEARS YOUNGER OR MORE.....3 10 YEARS YOUNGER OR MORE.....4 20 YEARS YOUNGER OR MORE.....5		OLDER.....1 SAME.....2 5 YEARS YOUNGER OR MORE.....3 10 YEARS YOUNGER OR MORE.....4 20 YEARS YOUNGER OR MORE.....5		OLDER.....1 SAME.....2 5 YEARS YOUNGER OR MORE.....3 10 YEARS YOUNGER OR MORE.....4 20 YEARS YOUNGER OR MORE.....5	
512	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
513	YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3	
514	YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3	
515	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
516	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
517	ALWAYS.....1 SOMETIMES.....2 NEVER.....3	519	ALWAYS.....1 SOMETIMES.....2 NEVER.....3	519	ALWAYS.....1 SOMETIMES.....2 NEVER.....3	519
518	METHOD <input type="text"/> <input type="text"/>		METHOD <input type="text"/> <input type="text"/>		METHOD <input type="text"/> <input type="text"/>	
519	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 NEVER HEARD OF CONDOM.....3	522 523	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 NEVER HEARD OF CONDOM.....3	522 523	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 NEVER HEARD OF CONDOM.....3	522 523
520	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
521	RESPONDENT.....1 PARTNER.....2 DON'T KNOW.....3		YOU.....1 PARTNER.....2 DON'T KNOW.....3		YOU.....1 PARTNER.....2 DON'T KNOW.....3	
522	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
523	YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3	
524	YES, BEFORE.....1 YES, AFTER.....2 NO.....3		YES, BEFORE.....1 YES, AFTER.....2 NO.....3		YES, BEFORE.....1 YES, AFTER.....2 NO.....3	
525	VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3		VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3		VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3	
526	RETURN TO 501		RETURN TO 501		GO TO 601	

SECTION 6. AIDS KNOWLEDGE AND RISK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	How old were you when you first heard of AIDS?	Years <input type="text"/> DON'T KNOW.....98 YOUNG CHILD.....97 NEVER HEARD OF AIDS.....99	701
602	Has a member of your family or a friend ever suffered or died from AIDS?	YES.....1 NO.....2	
603	In the last 12 months, have you ever attended a funeral of someone who died from AIDS	YES.....1 NO.....2	
604	How many children, if any, are you supporting whose parents have died from AIDS? IF NONE, CIRCLE 00	<input type="text"/> NONE.....00	
605	DISPLAY PICTURE: Here is a picture of 6 communities. People in GREY signify carriers of HIV/AIDS. Which picture best describes your community at this time?	1 2 3 4 5 6 (CIRCLE ANSWER)	
606	Before today, have you ever thought about your own chance of contracting HIV/AIDS?	YES.....1 NO.....2	
607	Considering all things, do you consider your chance of getting HIV to be high, medium, low, or no chance at all?	HIGH.....1 MEDIUM.....2 LOW.....3 NO CHANCE.....4	
608	CHECK 118/121 AND ENTER NAME OF WIFE/PARTNER NUMBERED ONE: NAME _____ ONE OR MORE WIVES/ COHABITING PARTNERS <input type="checkbox"/>	NO WIVES/ COHABITING PARTNERS <input type="checkbox"/>	614
609	During your marriage / relationship with <NAME> do you think that she had sex with anyone else?	YES.....1 NO.....2 UNSURE.....3	
610	Have you ever talked with <NAME> about the risk of contracting AIDS?	YES.....1 NO.....2	
611	During your relationship with <NAME> have you ever been concerned that you might contract AIDS from her? IF YES very or somewhat concerned?	VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3	614
612	Did you try anything to reduce the chance of getting AIDS from her?	YES.....1 NO.....2	614
613	What did you do? PROBE: WHAT ELSE?	<input type="text"/> <input type="text"/> <input type="text"/>	
614	Have you ever had a test for HIV/AIDS?	YES.....1 NO.....2	616
615	Do you know where to go for a test for HIV/AIDS?	YES.....1 NO.....2	
616	Have you ever talked with any partner about getting a test for HIV/AIDS?	YES.....1 NO.....2	

Say whether you agree, disagree or have mixed feeling or no opinion about the following statements:

617	There is not much use in trying to prevent AIDS: if you are going to get it, you will get it eventually no matter how you try.		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

618	Only irresponsible or immoral people get AIDS; it cannot reach normal people who are careful.		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

619	Very few people in this area changed their behaviour because of AIDS		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

620	There is no cure for AIDS		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

621	If a wife gets HIV or STD from outside the marriage, there is nothing the husband can do to avoid getting infected himself.		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

622	A man needs to have more than one partner.		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

623	To protect themselves against HIV\AIDS or sexually transmitted infections, a married couple can use condoms every time they have sex.		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

624	A man can be satisfied with only one partner.		AGREE	1	
			MIXED\NO OPINION.....	2	
			DISAGREE	3	

625	If a man fears AIDS but still wants to play sex, what can he do? PROBE: What else?				
	A _____				
	B _____				
	C _____				
	D _____				
	He can do nothing.....		98	SKIP TO 701	

626	Do you know anyone who has done this?		A	1	
			YES.....	1	
			NO.....	2	
			B		
			YES.....	1	
			NO.....	2	
			C		
			YES.....	1	
			NO.....	2	
			D		
			YES.....	1	
			NO.....	2	

627	Have you ever done this?		A	1	
			YES.....	1	
			NO.....	2	
			B		
			YES.....	1	
			NO.....	2	
			C		
			YES.....	1	
			NO.....	2	
			D		
			YES.....	1	
			NO.....	2	

SECTION 7 CONDOMS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 404/405 EVER HEARD OF CONDOMS <input type="checkbox"/>	NEVER HEARD OF CONDOMS <input type="checkbox"/>	801
702	CHECK 118/121 AND ENTER NAME OF WIFE/PARTNER NUMBERED ONE: NAME _____ ONE OR MORE WIFE/COHABITING PARTNER <input type="checkbox"/>	NO WIVES/COHABITING PARTNERS <input type="checkbox"/>	708
703	Have you and <NAME> ever used a condom?	YES.....1 NO.....2	706
704	Do you use a condom always, occasionally or only at the beginning of the relationship?	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3	
705	Did you and <NAME> ever use a condom together with another method of family planning?	YES.....1 NO.....2	
706	Have you and <NAME> ever discussed using condoms? IF YES: Many times, a few times, or only once in the last year?	MANY TIME.....1 FEW TIMES.....2 ONCE.....3 NEVER.....4	708
707	Have you and <NAME> ever disagreed or had arguments about using condoms?	YES.....1 NO.....2	
708	Do you know anyone who regularly uses a condom and any other family planning method together at the same time?	YES.....1 NO.....2	
709	Who usually has the most influence over whether or not to use a condom: the man, the woman, or both have equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 DON'T KNOW.....4	
710	Say whether you agree, disagree, or have mixed feelings or no opinion about the statements: Using condoms is an effective way of preventing AIDS.	AGREE1 MIXED\NO OPINION.....2 DISAGREE3	
711	Condoms encourage promiscuous behaviour.	AGREE1 MIXED\NO OPINION.....2 DISAGREE3	
712	Using condoms is an effective way of preventing pregnancy.	AGREE1 MIXED\NO OPINION.....2 DISAGREE3	
713	The only reason to use a condom is because you don't trust your partner.	AGREE1 MIXED\NO OPINION.....2 DISAGREE3	
714	Say whether you think the following actions are acceptable or unacceptable in your own view, or if you have mixed feelings or no opinion. Is it acceptable or unacceptable.. for a married couple to use a condom?	ACCEPTABLE.....1 MIXED\NO OPINION.....2 UNACCEPTABLE.....3	
715	For a married woman to ask her husband to use a condom?	ACCEPTABLE.....1 MIXED\NO OPINION.....2 UNACCEPTABLE.....3	
716	For a woman who is not married to ask her partner to use a condom?	ACCEPTABLE.....1 MIXED\NO OPINION.....2 UNACCEPTABLE.....3	
717	To use a condom with someone at the beginning of a relationship.	ACCEPTABLE.....1 MIXED\NO OPINION.....2 UNACCEPTABLE.....3	

SECTION 8. CONCLUSION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	As a continuation of this research, we would like to conduct a few in-depth interviews over the next few weeks to learn more about how people live in this area. Only a few people will be selected to take part in this follow up phase. Would you be willing to be interviewed?	YES.....1 NO.....2	
802	RECORD THE TIME. Thank you for your answers. Again, we can assure you that all this information about you and your household will remain confidential.	HOUR..... <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>	

WORLD HEALTH ORGANIZATION
FAMILY PLANNING AND AIDS SURVEY
INDIVIDUAL WOMEN'S QUESTIONNAIRE

IDENTIFICATION

COUNTRY (Kenya=1, S. Africa=2, Tanzania=3, Uganda=4, Zambia=5, Zimbabwe=6).....	<input type="checkbox"/>
RESPONDENT ID _____	
CLUSTER NAME _____	
CLUSTER NUMBER.....	<input type="checkbox"/>
HOUSEHOLD NUMBER.....	<input type="checkbox"/>
RESPONDENT LINE NUMBER	<input type="checkbox"/>
SEX OF RESPONDENT (Male=1, Female=2).....	<input type="checkbox"/> 2
URBAN/RURAL (urban=1, rural=2).....	<input type="checkbox"/>
NATIVE LANGUAGE OF RESPONDENT? _____	

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY <input type="checkbox"/>
LANGUAGE OF INTERVIEW	_____	_____	_____	MONTH <input type="checkbox"/>
INTERVIEWER'S NAME	_____	_____	_____	YEAR <input type="checkbox"/>
RESULT*	_____	_____	_____	NAME <input type="checkbox"/>
				RESULT <input type="checkbox"/>
NEXT VISIT: DATE	_____	_____		TOTAL NO. OF VISITS <input type="checkbox"/>
TIME	_____	_____		

*RESULT CODES:

- | | |
|---------------------|---|
| 1 COMPLETE | 4 NO RESPONDENT PRESENT OR ABLE TO ANSWER QUESTIONNAIRE |
| 2 INCOMPLETE | 5 HOUSEHOLD NOT FOUND |
| 3 REFUSED INTERVIEW | |

SUPERVISOR		OFFICE EDITOR	KEYED BY
NAME _____		NAME: _____	NAME: _____
DATE _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PARTNER INTERVIEW STATUS (CIRCLE APPROPRIATE CODE)

- NO ELIGIBLE PARTNER IN HH.....1
- RESPONDENT INTERVIEWED BEFORE PARTNER.....2
- RESPONDENT INTERVIEWED AFTER PARTNER.....3
- ELIGIBLE PARTNER NOT INTERVIEWED.....4

HH LINE NUMBER OF ELIGIBLE PARTNER

SECTION 1. BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME. Thank you for taking the time to talk to me. I would like to ask some questions about you and your household	HOUR..... <input type="text"/> MINUTES..... <input type="text"/>	
102	In what month and year were you born?	MONTH..... <input type="text"/> DON'T KNOW MONTH.....98 YEAR..... <input type="text"/> DON'T KNOW YEAR.....98	
103	What was your age at your last birthday? COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.	AGE IN COMPLETED YEARS..... <input type="text"/>	
104	Have you ever attended school?	YES.....1 NO.....2	107
105	What is the highest level of school you attended: primary, lower secondary, upper secondary or higher?	PRIMARY.....1 LOWER SECONDARY.....2 UPPER SECONDARY.....3 HIGHER.....4	108
106	Did you complete that level?	YES.....1 NO.....2	
107	Can you read and understand a letter or newspaper easily, with difficulty, or not at all?	EASILY1 WITH DIFFICULTY2 NOT AT ALL.....3	
108	What is your religion?	ROMAN CATHOLIC.....10 PROTESTANT.....20 BORN AGAIN.....21 PROTESTANT, SPECIFY.....22 PROTESTANT, SPECIFY23 PROTESTANT, SPECIFY24 PROTESTANT, SPECIFY25 MUSLIM.....30 HINDU.....40 TRADITIONAL.....50 NO RELIGION.....60 OTHER _____ 96 (SPECIFY)	
109	What is your native language? ALTERNATIVE: What is your mother tongue?	COUNTRY SPECIFIC CODES.....0102030405 OTHER _____ 96	
110	What other languages can you speak easily?	English.....10 French.....20 Kiswahili.....30 COUNTRY SPECIFIC CODES _____ 01 _____ 02 _____ 03 _____ 04 _____ 05 OTHER _____ 96	
111	What is your main occupation, that is, what kind of work do you do most of the time?	(SPECIFY) _____ <input type="text"/> _____ _____	
112	Do you receive any payment in cash or kind for this work?	YES.....1 NO.....2	115

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
113	Do you receive payment in cash or kind for any other work besides your main occupation? IF YES:what kind of work?	YES.....1 (Specify work) NO.....2	115
114	Who mainly decides how to spend the money that you earn? You, your partner, or someone else?	SELF.....1 PARTNER.....2 TOGETHER WITH PARTNER.....3 PARENTS.....4 OTHER.....6	
115	Are you currently married or living with a man?	MARRIED.....1 NOT MARRIED BUT LIVING WITH.....2 NO.....3	120 117
116	Do you normally live with your husband?	YES, LIVE WITH.....1 NO.....2	120
117	What is your current marital status?	NEVER MARRIED.....1 ENGAGED.....2 WIDOWED.....3 DIVORCED.....4 SEPARATED.....5	120
118	Have you ever had sexual intercourse with a man in your life?	YES.....1 NO.....2	802
119	Do you currently have a regular sexual partner? That is, someone you have been having sex with for a year or more?	YES.....1 NO.....2	201
120	CHECK 115 & 116 <input type="checkbox"/> NOT LIVING TOGETHER <input type="checkbox"/> LIVING TOGETHER		133
130	When he is not travelling or away at work where does your husband/partner usually live?	SAME HOUSEHOLD.....1 SAME AREA.....2 OUTSIDE LOCAL AREA.....3	133
131	How often do you usually stay together?	MOST DAYS OF A WEEK.....1 AT LEAST ONCE A WEEK.....2 AT LEAST ONCE A MONTH.....3 AT LEAST SEVERAL TIMES A YEAR...4 LESS OFTEN.....5	
132	How long ago did you last stay together? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	DAYS/MONTHS/YEARS AGO D M Y <input type="text"/>	
133	What is the first name of your husband/partner?	NAME _____	
134	Does <NAME> have any other wives or regular partners besides yourself?	YES.....1 NO.....2 DON'T KNOW.....8	139
135	How many other wives/partners does he have?	NUMBER..... <input type="text"/> DON'T KNOW.....98	
136	What is your order among his wives? First, second, third, or more?	NUMBER..... <input type="text"/> DON'T KNOW/CAN'T SAY.....98	
137	Do any of his other wives/partners live in this household?	YES.....1 NO.....2	139

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
138	Do any of his other wives/partners know about your relationship?	YES.....1 NO.....2	
139	How old was <NAME> at his last birthday? ESTIMATE	AGE IN COMPLETED YEARS..... <input type="text"/> <input type="text"/> AGE ENTERED IS ESTIMATE.....1	
140	Did he ever attend school?	YES.....1 NO.....2 DON'T KNOW.....8	143
141	What is the highest level of school <NAME> attended: primary, lower secondary, upper secondary or higher?	PRIMARY.....1 LOWER SECONDARY.....2 UPPER SECONDARY.....3 HIGHER.....4 DON'T KNOW.....8	144 143
142	Did he complete that level?	YES.....1 NO.....2 DON'T KNOW.....8	
143	Can he read and understand a letter or newspaper easily, with difficulty, or not at all?	EASILY1 WITH DIFFICULTY2 NOT AT ALL.....3	
144	What is his main occupation?	(SPECIFY WORK) _____ _____	
147	In what month and year did you start a regular relationship with <NAME>?	MONTH..... <input type="text"/> <input type="text"/> DON'T KNOW MONTH.....98 YEAR..... <input type="text"/> <input type="text"/> DON'T KNOW YEAR.....98	
148	How old were you when you started a regular relationship with <NAME> ESTIMATE CONSULT 103 AND CHECK CONSISTENCY BETWEEN 147 AND 148	AGE..... <input type="text"/> <input type="text"/>	
149	CHECK 115 <input type="checkbox"/> OTHERS	MARRIED <input type="checkbox"/>	153
150	Has he ever met your parents or family elders?	YES.....1 NO.....2	
151	Have you ever met his parents or family elders?	YES.....1 NO.....2	
152	Are you engaged or do you plan to marry <NAME>?	ENGAGED.....1 PLAN TO MARRY.....2 NO.....3 NOT SURE.....4	201
153	What type of wedding ceremony did you have (do you expect to have)?	CHRISTIAN.....1 MUSLIM.....2 HINDU.....3 TRADITIONAL.....4 OTHER (SPECIFY) _____5 _____ DON'T KNOW.....8	
154	Has any brideprice been negotiated?	YES.....1 NO.....2	201
155	Is/was the brideprice mostly in terms of cash, cattle, or smaller gifts such as clothes, shoes, or food?	MOSTLY CASH.....1 MOSTLY CATTLE.....2 MOSTLY SMALLER GIFTS.....3 Other (specify) _____6 _____	
156	Has the brideprice been completely paid?	YES.....1 NO.....2	

SECTION 2 MOBILITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Now I would like to ask a few questions about your travel away from home.		
201	For most of the time until you were 12 years old, did you live in a city, a town, or the village?	CITY.....1 TOWN2 VILLAGE.....3	
202	How long have you lived continuously in your current residence? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	MONTHS\YEARS M Y <input type="text"/> <input type="text"/> ALWAYS.....97	
203	Have you ever travelled away from home for 1 night or more in the last 12 months?	YES.....1 NO.....2	206
204	What was the longest continuous amount of time you spent away from home in the last 12 months? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	DAYS\WEEKS\MONTHS D W M <input type="text"/> <input type="text"/> DON'T KNOW.....98	
205	Where did you go at that time? PROBE FOR TYPE OF PLACE IF MORE THAN ONE MENTIONED, INDICATE MOST DISTANT CIRCLE TYPE OF PLACE (TOP PANEL) AND LOCATION (BOTTOM PANEL)	SAME VILLAGE, TOWN, CITY.....0 OTHER VILLAGE/AREA.....1 OTHER TOWN.....2 OTHER CITY.....3 SAME DISTRICT.....1 OTHER DISTRICT.....2 DIFFERENT COUNTRY.....3	
206	CHECK 120 <input type="checkbox"/> LIVING TOGETHER NOT LIVING TOGETHER <input type="checkbox"/>		301
207	Has <NAME> ever travelled away from home for 1 night or more in the last 12 months?	YES.....1 NO.....2 DONT KNOW.....9	301
208	What was the longest continuous amount of time he spent away from home in the last 12 months? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	DAYS\WEEKS\MONTHS D W M <input type="text"/> <input type="text"/> DON'T KNOW.....98	
209	Where did he go at that time? PROBE FOR TYPE OF PLACE IF MORE THAN ONE MENTIONED, INDICATE MOST DISTANT CIRCLE TYPE OF PLACE (TOP PANEL) AND LOCATION (BOTTOM PANEL)	SAME VILLAGE, TOWN, CITY.....0 OTHER VILLAGE/AREA.....1 OTHER TOWN.....2 OTHER CITY.....3 SAME DISTRICT.....1 OTHER DISTRICT.....2 DIFF COUNTRY.....3	301

SECTION 3 FERTILITY HISTORY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Are you currently pregnant? IF NONE, CIRCLE 00	YES.....1 NO.....2 UNSURE.....3	
302	Altogether how many children have you given birth to? IF NONE, CIRCLE 00	<input type="text"/> <input type="text"/> NO BIRTHS.....00	310
303	How many of your children are still alive? IF NONE, CIRCLE 00	<input type="text"/> <input type="text"/> NONE.....00	
304	How many of these children is <NAME> the father of? IF NONE, CIRCLE 00	<input type="text"/> <input type="text"/> NONE.....00	
305	What is the month and year of your most recent birth? ESTIMATE YEAR	MONTH..... <input type="text"/> <input type="text"/> DON'T KNOW MONTH.....98 YEAR..... <input type="text"/> <input type="text"/> YEAR IS ESTIMATE.....01	
306	CHECK 305 CHILD BORN IN 1997 OR LATER <input type="checkbox"/>	CHILD BORN BEFORE 1997 <input type="checkbox"/>	310
307	Is this child currently breastfeeding?	YES.....1 NO.....2 CHILD DIED.....3	
308	Have your menstrual periods returned since your last birth?	YES.....1 NO.....2	
309	How long after the birth of this child did you wait before resuming regular sexual relations? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	WEEKS\MONTHS W M <input type="text"/> <input type="text"/> STILL ABSTAINING.....97	
310	What do you think is the ideal time for a woman to wait after the birth of a child until resuming sex with her partner? CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	WEEKS\MONTHS W M <input type="text"/> <input type="text"/>	
311	Who usually has the most influence over when to resume regular sex after child birth: the man, the woman, or both have equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 DONT' KNOW/IT DEPENDS.....8	

312 | CHECK 303

HAS LIVING CHILDREN | NO LIVING CHILDREN

If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life how many would that be?

If you could choose exactly the number of children to have in your whole life how many would that be?

NUMBER.....

OTHER _____ 96
(SPECIFY)

PROBE FOR A NUMERIC RESPONSE.

313 | CHECK 301

NOT PREGNANT OR UNSURE | PREGNANT

Now I have some questions about the future. Would you like to have (a/another) child or would you prefer not to have any (more) children?

Now I have some questions about the future. After the child you are expecting now, would you like to have another child or would you prefer not to have any more children?

HAVE (A/ANOTHER) CHILD.....1
UNDECIDED.....2 | 315
NO MORE/NONE.....3
SAYS SHE IS STERILE.....4 | 401

314 | How much would it matter if you did have another child?

Very Much.....1
Somewhat.....2 | -316
Not Much.....3

315 | CHECK: 301

NOT PREGNANT OR UNSURE | PREGNANT

How long would you like to wait from now before the birth of (a/another) child?

After the child you are expecting now, how long would you like to wait before the birth of another child?

MONTHS/YEARS
M Y

OTHER _____ 96
(SPECIFY)

DON'T KNOW.....98

CIRCLE CORRECT UNIT AND ENTER NUMBERS IN BOXES

316 | What do you think is the ideal time to space between births?

MONTHS/YEARS
M Y

OTHER (SPECIFY) _____ 96

CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES

317 | CHECK 119, 120

HAS REGULAR PARTNER/LIVING WITH | NO REGULAR PARTNER/NOT LIVING WITH 401

318 | CHECK 301:

NOT PREGNANT OR UNSURE | PREGNANT

Do you think <NAME> would like to have a/another child or would he prefer not to have any (more) children with you?

After the child you are expecting now, do you think <NAME> would like to have another child or would he prefer not to have any more children with you?

HAVE (A/ANOTHER) CHILD.....1
UNDECIDED.....2
NO MORE/NONE.....3
DON'T KNOW PARTNER'S DESIRE....9 | 320

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
319	<p>CHECK: 301</p> <p>NOT PREGNANT OR UNSURE <input type="checkbox"/></p> <p>PREGNANT <input type="checkbox"/></p> <p>How long would <NAME> like to wait before the birth of (a/another) child?</p> <p>After the child you are expecting now, how long would <NAME> like to wait before the birth of another child?</p> <p>CIRCLE THE CORRECT UNIT AND ENTER THE NUMBER IN BOXES</p>	<p>MONTHS/YEARS</p> <p>M Y <input type="text"/> <input type="text"/></p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p> <p>DON'T KNOW.....98</p>	
320	<p>Have you and <NAME> ever discussed whether or not to have another child or how soon to have the next child?</p>	<p>YES.....1</p> <p>NO.....2</p>	323
321	<p>Have you discussed this many times, a few times, or only once in the last year?</p>	<p>MANY.....1</p> <p>FEW.....2</p> <p>ONCE.....3</p>	
322	<p>Have you and <NAME> ever disagreed or had arguments about whether or not to have another child, or how soon to have another child?</p>	<p>YES.....1</p> <p>NO.....2</p>	
323	<p>Have you ever spoken with anyone (else) about whether or not to have another child/or how soon to have another child? (CIRCLE ALL MENTIONED)</p> <p>PROBE: Anyone else?</p>	<p>MALE FRIENDS/NEIGHBOURS.....01</p> <p>FEMALE FRIENDS/NEIGHBOURS.....02</p> <p>BROTHERS.....03</p> <p>OTHER MALE RELATIVES.....04</p> <p>SISTER.....05</p> <p>OTHER FEMALE RELATIVES.....06</p> <p>FAMILY PLANNING/HEALTH WORKERS.07</p> <p>OTHER (SPECIFY) _____ 08</p> <p>OTHER (SPECIFY) _____ 09</p> <p>OTHER (SPECIFY) _____ 10</p>	

SECTION 4. FAMILY PLANNING

Now I would like to talk to you about family planning.
 By family planning, I mean methods that you can get at the clinic or drugstore,
 things or advice that you can get from traditional healers and herbalists, or things that you can do at
 home with your partner to delay or to avoid a pregnancy.

INSTRUCTIONS TO INTERVIEWER:

1. ASK Q401 FIRST, PROBING FOR ALL METHODS RESPONDENT HAS HEARD OF INCLUDING TRADITIONAL METHODS.
2. AFTER COMPLETING Q401, ASK Q402 AND Q403 IN ORDER FOR EACH METHOD RESPONDENT HAS HEARD OF.

401	What ways or methods have you heard about? PROBE: What other methods? PROBE:What (other) traditional methods? CIRCLE YES or NO IN FIRST COLUMN, IF MENTIONED. IF YES ASK 402 AND 403	Q401 Heard of?	Q402 Have you ever used this method?	Q403 Do you know where a person could go to get this method?
a)	PILL.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
b)	IUD.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
c)	INJECTIONS.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
d)	IMPLANTS.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
e)	DIAPHRAM/FOAM/JELLY.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
f)	CONDOM.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
g)	FEMALE STERILIZATION.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
h)	MALE STERILIZATION.....	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
i)	RHYTHM.....	YES.....1 NO.....2	YES.....1 NO.....2	
j)	WITHDRAWAL.....	YES.....1 NO.....2	YES.....1 NO.....2	
k)	ABSTINENCE.....	YES.....1 NO.....2	YES.....1 NO.....2	
l)	OTHER (SPECIFY) _____ <input type="checkbox"/>	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
m)	OTHER (SPECIFY) _____ <input type="checkbox"/>	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
n)	OTHER (SPECIFY) _____ <input type="checkbox"/>	YES.....1 NO.....2	YES.....1 NO.....2	YES.....1 NO.....2

404 | CHECK 401
 | NOT HEARD OF
 | CONDOMS | | HEARD OF
 | CONDOMS | | 406

405 | Have you ever heard of condoms?
 | I mean a rubber sheath that a man puts on during sexual intercourse?
 | NO | | YES |
 | | | | | CORRECT THE CONDOM LINE OF 401 AND ASK 402/403

406 | CHECK 402
 | NEVER USED
 | ANY METHOD | | EVER USED
 | AT LEAST ONE
 | METHOD | | 411

407 | Just to check that I have this right, have you ever used any method
 | or done anything to avoid getting pregnant?
 | Yes | | NO | | 414
 | | | | | ASK FOR METHOD AND AMEND 401, 402, 403, 406

408 | CHECK 119, 120
 | HAS REGULAR
 | PARTNER/LIVING
 | WITH | | NO REGULAR
 | PARTNER/NOT
 | LIVING WITH | | 417

409 | CHECK 402 g & h
 | MAN AND WOMAN
 | NOT STERILIZED | | MAN OR WOMAN
 | STERILIZED | | 411

410 | Are you and <NAME> currently doing something or using
 | any method to delay or avoid getting pregnant? || YES.....1 |
 || NO.....2 | 413

411 | Which method are you using? || PILL.....01 |
PROBE: Anything else?		IUD.....02
	INJECTIONS.....03	
	IMPLANTS.....04	
	DIAPHRAGM/FOAM/JELLY.....05	
CIRCLE ALL MENTIONED		CONDOM.....06
CIRCLE '07' FOR FEMALE STERILIZATION.		FEMALE STERILIZATION.....07
'08' FOR MALE STERILIZATION.		MALE STERILIZATION.....08
	RHYTHM.....09	
	WITHDRAWAL.....10	413
	SPORADIC ABSTINENCE.....11	
	OTHER.....96	
	(SPECIFY)	

412 | Does <NAME> know that you are currently using a method? || YES.....1 |
 || NO.....2 | 414

413 | Have you ever used any method of delaying or avoiding
 | a birth without your partner's knowledge? || YES.....1 |
 || NO.....2 |

414 | Have you ever discussed family planning methods with
 | <NAME>? || YES.....1 |
 || NO.....2 | 416

415 | Did you discuss this many times, a few times, or only
once in the last year?		MANY.....1
	FEW.....2	
	ONCE.....3	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
416	Do you think <NAME> approves, has mixed feelings or no opinion or disapproves about a couple using a method to delay or avoid pregnancy?	APPROVES.....1 MIXED\NO OPINION.....2 DISAPPROVES.....3 DON'T KNOW.....8	
417	Who usually has more influence over whether or not to use a family planning method: the man, the woman, or both have equal influence?	MAN.....1 WOMAN.....2 EQUAL.....3 IT DEPENDS.....4	
418	Would you say that most of the people you know approve of the practice of family planning, disapprove of it, or have no opinion?	MOST APPROVE.....1 MOST DISAPPROVE.....2 MOST HAVE NO OPINION.....3 DON'T KNOW.....8	
419	For the next set of questions, say whether you agree, disagree, or have mixed feelings or no opinion about the following statements: READ OUT It is acceptable for a couple to use a method to space between births.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
420	It is acceptable for a couple to use a method to have no more children.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
421	If a woman gets pregnant but strongly does not want to have another child, she can consider having an abortion instead.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
422	If a couple has more children than they can afford, they can always rely on relatives for help raising children.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
423	It is acceptable for a woman to propose using a method to her partner.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
424	It is acceptable for a woman to use a method without telling her partner about it.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
425	Family planning leads to promiscuous behaviour.	AGREE1 MIXED/NO OPINION2 DISAGREE3	

SECTION 5 SEXUAL HISTORY

NO. | QUESTIONS AND FILTERS || CODING CATEGORIES | SKIP

It sometimes happens that men and women have sexual relations with partners other than their regular partners. I would like to ask you about relationships with other men.

INTERVIEWER INSTRUCTIONS: Questions 501, 507-525 are repeated for the last 3 non-regular partners in the last 3 years. Record answers for the most recent partner in the first column below & in answer sheet for 507-525. Then return to Q501 and ask about the previous non-regular partner, recording answers in the second column of the answer sheet, etc.

501 | CHECK: 119, 120

<p>HAS REGULAR PARTNER <input type="checkbox"/></p> <p>How long ago did you last have sex with a man apart from <NAME>? (and the one we have just talked about?)</p>	<p>NO REGULAR PARTNER <input type="checkbox"/></p> <p>How long ago did you last have sex with a man (apart from the one we have just talked about)?</p>
--	---

PROBE AND ESTIMATE AND RECORD ANSWER BELOW

CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES

502 | CHECK: 501
IF LAST SEX WITH NON-REGULAR PARTNER WITHIN 3 YEARS?

NO.	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP
501	PARTNER 1		PARTNER 2		PARTNER 3	
	<input style="width: 40px; height: 20px; margin: 0 auto;" type="text"/>		<input style="width: 40px; height: 20px; margin: 0 auto;" type="text"/>		<input style="width: 40px; height: 20px; margin: 0 auto;" type="text"/>	
	DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95 ----->	502	DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95 ----->	601	DAY/WEEKS/MONTHS/YEARS D W M Y NEVER.....95 ----->	601
502	CHECK 501 3 YEARS OR MORE <input type="checkbox"/>		CHECK 501 3 YEARS OR MORE <input type="checkbox"/>		CHECK 501 3 YEARS OR MORE <input type="checkbox"/>	
	LESS THAN 3 YEARS <input type="checkbox"/> ----->	507	LESS THAN 3 YEARS <input type="checkbox"/> ----->	507	LESS THAN 3 YEARS <input type="checkbox"/> ----->	507
	SKIP TO 601		SKIP TO 601		SKIP TO 601	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
503	Just to check that I have this right, have you ever had a sexual relationship that lasted for one night or a very short time?	YES.....1 NO.....2	— 506
504	Have you ever had sex with anyone other than a regular partner when you were travelling away from home?	YES.....1 NO.....2	— 506
505	Have you ever had sex with anyone other than a regular partner at a party or a social or cultural event?	YES.....1 NO.....2	— 506
506	How long ago was the most recent time something like this happened? CORRECT RESPONSE IN 501, GO TO 502	IF NO TO ALL QUESTIONS	— 601

NO.	QUESTIONS AND FILTERS	SKIP
507	What is his first name or initial?	
508	How long have you had a relationship with <PNAME>? ESTIMATE CIRCLE CORRECT UNIT AND ENTER NUMBER IN BOXES	
509	Is your relationship to <PNAME> still continuing?	
510	What was your relationship to this man? PROBE	
511	Was he younger about the same age, or older than you? IF OLDER, more than 5 years? more than 10? more than 20?	
512	Did you ever live with <PNAME>?	
513	Did you have any children with him?	
514	Did (do) you want to have a child with <PNAME>?	
515	During your relationship with <PNAME> were you concerned that you might get pregnant, when you did not want to get pregnant?	
516	Did you and <PNAME> ever discuss family planning methods?	
517	Did you or <PNAME> ever use any method to delay or prevent pregnancy? IF YES Always or sometimes?	
518	What was the main method that was used?	
519	Did you and <PNAME> ever use condoms? IF YES Always, occasionally or only at the beginning of the relationship?	
520	Did you ever use condoms together with another method of family planning with <PNAME>?	
521	Who first proposed using condoms, you or <PNAME>?	
522	Did you and <PNAME> ever discuss using condoms?	
523	As far as you know, is (was) he having sex with anyone else during your relationship?	
524	Did you ever talk with <PNAME> about the risk of getting AIDS? IF YES: did you discuss this before you first had sex or later?	
525	During your relationship with <PNAME> were you concerned that you might contract AIDS from him? If YES very or somewhat concerned?	
526	INTERVIEWER NOW RETURN TO 501 FOR OTHER PARTNER (s)	

NO.	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP	CODING CATEGORIES	SKIP
507	NAME/INITIAL _____		NAME/INITIAL _____		NAME/INITIAL _____	
508	DAY\WEEK\MONTH\YEAR <input type="text"/> <input type="text"/> D W M Y		DAY\WEEK\MONTH\YEAR <input type="text"/> <input type="text"/> D W M Y		DAY\WEEK\MONTH\YEAR <input type="text"/> <input type="text"/> D W M Y	
	SINGLE TIME.....97	— 510	SINGLE TIME.....97	— 510	SINGLE TIME.....97	— 510
509	YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3	
510	FORMER HUSBAND.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY _____ 6		FORMER HUSBAND.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY _____ 6		FORMER HUSBAND.....1 REGULAR PARTNER.....2 SHORT-TERM PARTNER.....3 RECENTLY MET.....4 OTHER SPECIFY _____ 6	
511	YOUNGER.....1 SAME.....2 5 YEARS OLDER OR MORE.....3 10 YEARS OLDER OR MORE.....4 20 YEARS OLDER OR MORE.....5		YOUNGER.....1 SAME.....2 5 YEARS OLDER OR MORE.....3 10 YEARS OLDER OR MORE.....4 20 YEARS OLDER OR MORE.....5		YOUNGER.....1 SAME.....2 5 YEARS OLDER OR MORE.....3 10 YEARS OLDER OR MORE.....4 20 YEARS OLDER OR MORE.....5	
512	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
513	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
514	YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3		YES.....1 NO.....2 UNSURE/DK.....3	
515	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
516	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
517	ALWAYS.....1 SOMETIMES.....2 NEVER.....3 — 519		ALWAYS.....1 SOMETIMES.....2 NEVER.....3 — 519		ALWAYS.....1 SOMETIMES.....2 NEVER.....3 — 519	
518	METHOD <input type="text"/> <input type="text"/>		METHOD <input type="text"/> <input type="text"/>		METHOD <input type="text"/> <input type="text"/>	
519	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 — 522 NEVER HEARD OF CONDOM.....3 — 523		ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 — 522 NEVER HEARD OF CONDOM.....3 — 523		ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3 NEVER.....4 — 522 NEVER HEARD OF CONDOM.....3 — 523	
520	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
521	RESPONDENT.....1 PARTNER.....2 DON'T KNOW.....3		YOU.....1 PARTNER.....2 DON'T KNOW.....3		YOU.....1 PARTNER.....2 DON'T KNOW.....3	
522	YES.....1 NO.....2		YES.....1 NO.....2		YES.....1 NO.....2	
523	YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3		YES.....1 NO.....2 DON'T KNOW.....3	
524	YES, BEFORE.....1 YES, AFTER.....2 NO.....3		YES, BEFORE.....1 YES, AFTER.....2 NO.....3		YES, BEFORE.....1 YES, AFTER.....2 NO.....3	
525	VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3		VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3		VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3	
526	RETURN TO 501		RETURN TO 501		GO TO 601	

SECTION 6. AIDS KNOWLEDGE AND RISK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	How old were you when you first heard of AIDS?	Years <input type="text"/> DON'T KNOW.....98 YOUNG CHILD.....97 NEVER HEARD OF AIDS.....99	— 701
602	Has a member of your family or a friend ever suffered or died from AIDS?	YES.....1 NO.....2	
603	In the last 12 months, have you ever attended a funeral of someone who died from AIDS?	YES.....1 NO.....2	
604	How many children, if any, are you supporting whose parents may have died from AIDS? IF NONE, CIRCLE 00	<input type="text"/> NONE.....00	
605	DISPLAY PICTURE: Here is a picture of 6 communities. People in GREY signify carriers of HIV/AIDS. Which picture best describes your community at this time?	1 2 3 4 5 6 (CIRCLE ANSWER)	
606	Before today, have you ever thought about your own chance of contracting HIV/AIDS?	YES.....1 NO.....2	
607	Considering all things, do you consider your chance of getting HIV to be high, medium, low, or no chance at all?	HIGH.....1 MEDIUM.....2 LOW.....3 NO CHANCE.....4	
608	CHECK 119, 120 HAS <input type="checkbox"/> REGULAR PARTNER	NO REGULAR PARTNER <input type="checkbox"/>	614
609	During your marriage / relationship with <NAME> do you think that he had sex with anyone else (apart from co-wives)?	YES.....1 NO.....2 UNSURE.....3	
610	Have you ever talked with <NAME> about the risk of contracting AIDS?	YES.....1 NO.....2	
611	During your relationship with <NAME> have you ever been concerned that you might contract AIDS from him? IF YES very or somewhat concerned?	VERY CONCERNED.....1 SOMEWHAT CONCERNED.....2 NOT CONCERNED.....3	— 614
612	Did you try anything to reduce the chance of getting AIDS from him?	YES.....1 NO.....2	— 614
613	What did you do? PROBE: WHAT ELSE?	<input type="text"/> <input type="text"/> <input type="text"/>	
614	Have you ever had a test for HIV/AIDS?	YES.....1 NO.....2	— 616
615	Do you know where to go for a test for HIV/AIDS?	YES.....1 NO.....2	
616	Have you ever talked with any partner about getting a test for HIV/AIDS?	YES.....1 NO.....2	

Say whether you agree, disagree or have mixed feelings or no opinion about the following statements:

617	There is not much use in trying to prevent AIDS: if you are going to get it, you will get it eventually no matter how you try.	AGREE1 MIXED/NO OPINION2 DISAGREE3
618	Only irresponsible or immoral people get AIDS; it cannot reach normal people who are careful.	AGREE1 MIXED/NO OPINION2 DISAGREE3
619	Very few people in this area have changed their behaviour because of AIDS.	AGREE1 MIXED/NO OPINION2 DISAGREE3
620	There is no cure for AIDS	AGREE1 MIXED/NO OPINION2 DISAGREE3
621	If a husband gets HIV or STD from outside the marriage, there is nothing the wife can do to avoid getting infected herself.	AGREE1 MIXED/NO OPINION2 DISAGREE3
622	A man needs to have more than one partner.	AGREE1 MIXED/NO OPINION2 DISAGREE3
623	To protect themselves against HIV/AIDS or sexually transmitted infections, a married couple can use condoms every time they have sex.	AGREE1 MIXED/NO OPINION2 DISAGREE3
624	A man can be satisfied with only one partner.	AGREE1 MIXED/NO OPINION2 DISAGREE3

625	If a woman fears AIDS but still wants to play sex, what can she do? PROBE What else?		626	Do you know anyone who has done this?	627	Have you ever done this?
A	_____	<input type="checkbox"/>	A	YES.....1 NO.....2	A	YES.....1 NO.....2
B	_____	<input type="checkbox"/>	B	YES.....1 NO.....2	B	YES.....1 NO.....2
C	_____	<input type="checkbox"/>	C	YES.....1 NO.....2	C	YES.....1 NO.....2
D	_____	<input type="checkbox"/>	D	YES.....1 NO.....2	D	YES.....1 NO.....2
	She can do nothing.....	98		SKIP TO 701		

SECTION 7 CONDOMS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 404/405 EVER HEARD OF CONDOMS	NEVER HEARD OF CONDOMS	801
702	CHECK 119, 120 HAS REGULAR PARTNER	NO REGULAR PARTNER	708
703	Have you and <NAME> ever used a condom?	YES.....1 NO.....2	706
704	Do you use a condom always, occasionally or only at the beginning of the relationship?	ALWAYS.....1 OCCASIONALLY.....2 BEGINNING.....3	
705	Did you and <NAME> ever use a condom together with another method of family planning?	YES.....1 NO.....2	
706	Have you and <NAME> ever discussed using condoms? IF YES: Many times, a few times, or only once in last year?	MANY TIMES.....1 FEW TIMES.....2 ONCE.....3 NEVER.....4	708
707	Have you and <NAME> ever disagreed or had arguments about using condoms?	YES.....1 NO.....2	
708	Do you know anyone who regularly uses a condom and any other family planning method together at the same time?	YES.....1 NO.....2	
709	Who usually has the most influence over whether or not to use a condom: the man, the woman, or both equally?	MAN.....1 WOMAN.....2 EQUAL.....3 DON'T KNOW.....4	
710	Say whether you agree, disagree, or have mixed feelings or no opinion about the statements: Using condoms is an effective way of preventing AIDS.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
711	Condoms encourage promiscuous behaviour.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
712	Using condoms is an effective way of preventing pregnancy.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
713	The only reason to use a condom is because you don't trust your partner.	AGREE1 MIXED/NO OPINION2 DISAGREE3	
714	Say whether you think the following actions are acceptable or unacceptable in your own view, or if you have mixed feelings or no opinion. Is it acceptable or unacceptable.... For a married couple to use a condom?	ACCEPTABLE.....1 MIXED/NO OPINION2 UNACCEPTABLE.....3	
715	For a married woman to ask her husband to use a condom?	ACCEPTABLE.....1 MIXED/NO OPINION2 UNACCEPTABLE.....3	
716	For a woman who is not married to ask her partner to use a condom?	ACCEPTABLE.....1 MIXED/NO OPINION2 UNACCEPTABLE.....3	
717	To use a condom with someone at the beginning of a relationship.	ACCEPTABLE.....1 MIXED/NO OPINION2 UNACCEPTABLE.....3	

SECTION 8. CONCLUSION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	As a continuation of this research, we would like to conduct a few in-depth interviews over the next few weeks to learn more about how people live in this area. Only a few people will be selected to take part in this follow up phase. Would you be willing to be interviewed?	YES.....1 NO.....2	
802	RECORD THE TIME. Thank you for your answers. Again, we can assure you that all this information about you and your household will remain confidential.	HOUR..... <input type="text"/> <input type="text"/> MINUTES..... <input type="text"/> <input type="text"/>	

Appendix 4. Guide for In-depth Interviews

1) What are the biggest health problems affecting adult men in this area? What about the biggest health problems affecting women in this area? What important health problems affect you directly and how?

2) **If not mentioned above:** Above, you did not mention HIV as a problem in your area. How serious is the problem of HIV/AIDS in your area and to you personally?

If mentioned above: Above, you mentioned that HIV is a problem in your area.

- How serious a problem is HIV/AIDS for men in this area?
- How serious a problem is HIV/AIDS for women in this area?
- How serious is the problem of HIV/AIDS to you personally?

- In your view, what causes HIV/AIDS?
- What are all of the things that people can do to avoid getting HIV/AIDS?
- **Probe:** What else can they do?
- How, if at all, can people get rid of HIV/AIDS once they have it?
- How many relatives, friends, or neighbours of yours have HIV/AIDS?
- How many of your relatives, friends, or neighbours of yours have died of HIV/AIDS?
- How worried are you that you will get and die of HIV/AIDS?
- **If at all worried:** Why are you worried about yourself?
- **If not at all worried:** Why are you not worried about yourself?

3) Now let's talk about diseases which can be transmitted through sexual intercourse, commonly known as STDs.

If not mentioned in question 1: Above, you did not mention STDs as a problem in your area. Are STDs, other than HIV/AIDS, a problem in your area? If yes, how serious a problem are STDs in your area?

If mentioned in question 1: Above, you mentioned that STDs were a problem in your area. How serious a problem are STDs in your area?

- How serious a problem are STDs for men in this area?
- How serious a problem are STDs for women in this area?
- What are the local names for STDs that you can think of? **Probe:** What else?
- How does someone get an STD?
- How does someone avoid getting an STD?
- If one were to get an STD, how could one get rid of it?
- And how serious a problem do you think STDs are in your area? Why do you feel this way?

- Have you yourself ever gotten an STD? If yes,
- How many times?
- When did you last get an STD?
- What kind of STD was it? **If informant cannot name the particular STD:** Please describe what it was like.
- How do you think you got the STD?

- What were all of the things that you did about it? What else did you do about it? (Be certain to get the full sequence of events)
- In general, how worried are you about getting an STD?
- **If at all worried:** Which ones are you most worried about getting, and why? How would you feel if you found out that you had an STD?
- How worried are you about STD/HIV during a regular relationship or in your marriage?
- **If worried,** how do you address this issue?
- **If not worried,** why not?
- How worried are you about STD/HIV during a casual relationship?
- **If worried,** how do you address this issue?
- **If not worried,** why not?

4) Now, I'd like to talk with you about family planning.

- What do you understand by the term "family planning"?
- What are all of the family planning methods that you and your partner have tried?
- **If tried any method:** What are/were your reasons for using family planning?
- **If not tried any method:** What are/were your reasons for not using family planning? Would you and your partner like to try using family planning?
- How often do women in this area become pregnant when they do not want to?
- How many of your daughters or other female relatives have gotten pregnant when they did not want to?
- How often, if ever, has this happened to you and your partner?
- **If yes,** how many times has this happened to you/your partner?
- **If yes,** what did you/your partner do?
- How worried are you about (your partner) getting pregnant when you do not wish (her) to become pregnant?
- How worried are you about (your partner) getting pregnant during a regular relationship or in your marriage?
- **If worried,** how do you address this issue?
- **If not worried,** why not?
- How worried are you about (your partner) getting pregnant during a casual relationship?
- **If worried,** how do you address this issue?
- **If not worried,** why not?
- What do men here think about condoms?
- And what about women, what do they think about condoms?
- When in a relationship are people most likely to use condoms? **Probe:** At the beginning or end or throughout?
- With which kinds of women would men use condoms? Why?
- In what situations would a man use condoms with his regular partner? Why?
- How important is it to use the condom with your regular partner or wife?
- And how important is it to use the condom with a casual sexual partner?

- If you were to use the condom with a casual sex partner, would you always, sometimes, or rarely use the condom? Why would you do so?
- How important is the condom for protection against unwanted pregnancy and sexually transmitted diseases?

- When, if ever, do you use condoms?
- When, if ever, have you used condoms with your regular partner? How often do you use them now?
- **If stopped:** When did you stop using condoms and what were the reasons for stopping?
- In what situations would you use condoms outside of marriage? How often would you use them outside of marriage? When, if ever, would you stop using condoms with someone that you were having sex with outside of marriage?

For condom users:

- What were all of your reasons for choosing to use condoms?
- What problems, if any, have you had using condoms? What else?
- How serious were these problems to you?
- Have these problems ever made you stop using condoms?
- If no, why not?

For condom non-users:

- What were all of your reasons for choosing not to use condoms?
- What are the problems with using condoms? What else?

- How would you feel about using condoms *instead of* other methods of family planning in order to prevent getting HIV/STDs? Why do you feel this way?
- What are all of the things that condoms protect against?
- How would you feel about using condoms *at the same time as* other methods to prevent pregnancy and HIV/STDs?
- If negative: What makes you feel this way?
- Do you and your partner perceive the risk of either unwanted pregnancy or contracting HIV/AIDS/STDs?

5a) Female informants: Now I would like to describe a situation to you. You are having injections to space between births. Your partner travels away from home for long periods of time for his work. You believe that he is having sexual relations with other women while he is away. Has this ever happened to you? If not, let's suppose this happened ...

- What would be (has been) your biggest concerns about him having sexual relations with other women?
- **Probe:** What about health concerns, what health concerns would (did) you have?
- What about STDs or HIV? How concerned would you be (were you) of getting STDs/HIV?
- What would (did) you do to avoid getting an STD or HIV from him?
- Would (Did) you ever ask your partner to use a condom? What do you think his reaction would be (or What was his reaction?)?
- Would you consider refusing (did you ever refuse) to have sex with him? Why, or why not?

- What would be (were) the consequences of talking with him about his behaviour?
- What could (did) you do to change your husband's behavior so you would not have to worry so much when he comes home from trips?
- Would your partner inform you if he thought he was infected?
- Has this ever happened, i.e., did he ever tell you that he was infected?
- Would your partner protect you by either not having sex or using the condom if he thought he was infected?
- Did he ever do so?

5b) Male informants: Now I have an example. Your wife is having injections to space between births. She travels away from home for long periods of time for her work. You believe that she is having sexual relations with other men while she is travelling

Has this ever happened to you? If not, let's suppose this happened

- What would be (has been) your biggest concerns about her having sexual relations with other men?
- **Probe:** What about health concerns, what health concerns would (did) you have?
- What about STDs or HIV? How concerned would you be (were you) of getting STDs/HIV?
- What would (did) you do to avoid getting an STD or HIV from her?
- Would (Did) you ever ask your partner if you could use a condom? What do you think her reaction would be (or What was her reaction)?
- Would you consider refusing (did you ever refuse) to have sex with her? Why, or why not?
- What would be (were) the consequences of talking with her about her behaviour?
- What could (did) you do to change your partner's behaviour so you would not have to worry so much when she comes home from trips?
- Would your partner inform you if she thought she was infected?
- Has this ever happened, i.e., did she ever tell you that she was infected?
- Would your partner protect you by either not having sex or using the condom if she thought she was infected?
- Did she ever do so?

6) Let's say that both of you are staying at home, but you/your wife have/has just had a child and want(s) to wait before resuming sex.

- How long would you/your wife wait before starting to have sex again? Explain.
- Would you/your partner have affairs with other people during that period? If yes, why? If no, why not?

7) What kinds of things can you do if you want to have sex but you don't want to get pregnant/make your partner pregnant? How often do you do these things? **Probe:** what else can you do?

8) Now I would like to ask you about some of the things that you and your partner talk about.

- When it comes to using family planning or to stop having children, do you discuss this with your partner?
- **If yes:** What exactly did/do you discuss?

- **If no:** What are all the reasons for not discussing family planning? What, if anything, prevents you from discussing family planning with your partner if you want to?
 - When it comes to STDs or HIV, do you discuss this with your partner?
 - **If yes:** What exactly have you discussed?
 - **If no:** What, if anything, has prevented you from discussing HIV/AIDS or STDs with your partner?
- 9) Now I would like to ask you a few more questions about sexual intercourse.
- What do you understand by quality sex?
 - Before you have sex, during the sex act, and after sex, do you consider the feelings of your partner?
 - **If yes:** Which feelings do you consider and what do you do about them?
 - **If no:** Why not?
 - Concerning number of partners for sexual intercourse, what would you advise to:
 - a) single men and women?
 - b) married partners?
 - c) cohabiting partners?
 - d) commercial sex workers?
 - How best can your advice be implemented? **Probe:** can laws/social sanctions be formulated to enforce some of these recommendations?
 - And concerning protection against unwanted pregnancy and STDs/HIV, what would you advise to:
 - a) single men and women?
 - b) married partners?
 - c) cohabiting partners?
 - d) commercial sex workers?
 - How best can your advice be implemented? **Probe:** can laws/social sanctions be formulated to enforce some of these recommendations?
- 10) In your view, how possible is it to enjoy sex and at the same time not worry about HIV/AIDS?
- **If not possible:** Why is this not possible?
- 11) Now I would like to know more about the services that are available in your area.
- What sexual health services are available and accessible to those who need them in this area?
 - Where do people get information about sexual health?
 - What would be your reaction to having sexual health services provided at the same time and place as family planning services?
 - **If positive:** Why would you like them together?
 - **If negative:** Why would you not like to have them provided together?
- 12) Finally, I would like to ask you about sexual partners?
- Do you think having sex with several partners is risky?
 - Do you have more than one partner at a time?
 - **If yes,** why do you like to have sex with several partners? **Probe:** does it have anything to do with quality sex?
 - **If more than one partner,** do you use condoms when having sex with casual partners?
 - Are you worried about getting infected from the partners?

- Are you concerned that you may infect your wife/husband/regular partner?
- Does your regular partner/wife/husband know that you have sexual partner(s) other than her/him?
- Between unwanted pregnancy and STDs/HIV/AIDS, which one is of main concern to you?
- If none, why not?
- In general, how long do your sexual relationships last with a casual partner?
- With whom are you most likely to use a condom: (a) commercial sex worker; (b) casual partner, but not a commercial sex worker; (c) regular partner; and (d) wife.

Do you have any other information to add with regard to the issues we have discussed?
If yes, please go ahead.

Thank you very much for your cooperation.

Appendix 5
Inventory for Facilities Available and Services provided at the Service Delivery Point

1. SDP visited (Name): _____
2. District (Name): _____
3. Date of Interview: _____
4. Name of Interviewer: _____
5. Type of SDP:

Hospital	1
Health Centre	2
Clinic	3
Other	4
6. Locality of Facility

Rural	1
Urban	2

Section One

1. What is the official opening time for this health facility?
2. What is the official closing time for the health facility?
3. How many days of the weeks are the following services offered? (read 1-4)

	Number of days
1. MCH	
2. FP	
3. STI	
3. HIV/AIDS	

4. Are these services offered on the same days or on different days?

Same day	1
Different day	2 → Go to Q6

5. (If answer to q4 = 1) Do the clients have to do any of the following?

	Yes	No
1. Queue separately for separate services	1	2
2. Use separate rooms for separate services	1	2
3. See separate staff for the separate services	1	2

→ Skip to Section 2

6. (If answer to q4 =2) Are the staff providing these services the same or different?

- Same 1
- Different 2

Section Two

7. Was there a group health talk at the facility today?

- Yes 1
- No 2

8. What was the subject of the group talk?

- Family Planning 1
- Antenatal Care 2
- Post-Natal Care 3
- STIs 4
- HIV/AIDS 5
- Child Nutrition 6
- Other (Specify) 7

9. Are the health talks held

- Daily 1
- Once a week 2
- More than once a week 3
- Once a month 4
- More than once a month 5

10. Did you see any of the following today?

	Yes	No
1. FP Poster	1	2
2. STI Poster	1	2
3. HIV/AIDS Poster	1	2
4. FP Pamphlet/ Brochure/ Information Sheet	1	2
5. STI Pamphlet/ Brochure/ Information Sheet	1	2
6. HIV/AIDS Pamphlet/ Brochure/ Information Sheet	1	2
7. Sample of Condoms	1	2

Section Three: Equipment and commodities inventory

11. Are the following types of equipment available and working in the MCH/FP unit, and/or in the stockroom?

	Tick if available
1. Sterilising equipment in MCH/FP unit	
2. Sterilising equipment outside MCH/FP unit (shared)	
3. Angle poise/gynaecology lamps/torch	
4. Blood pressure machines	
5. Adult weighing scale	
6. Child weighing scales	
7. Scissors	
8. Antiseptic lotions	
9. Stethoscope	
10. Refrigerator for EPI (immunisation)	
11. Examination couch	
12. Thermometer	
13. Needles	
14. Syringes	
15. Microscope	
16. Cotton wool	
17. Gauze	
18. Dettol	

12. How many of the following types of equipment are available and working in the MCH/FP unit and/or in the stockroom for MCH/FP services?

	Count
1. Sponge holding forceps	
2. Uterine sounds	
3. Specula	
4. Tenacula	
5. Non-disposable gloves (number of pairs)	
6. Disposable gloves (number in pairs)	

13. Does the MCH/FP unit usually provide each of the following contraceptive methods? (Read 1-9)

	If method is usually provided, physically check and tick if commodities available today	(If methods are usually provided) Has there been any stock-out the last six months? (Tick if yes)
1. Combined pill		
2. Progestin-only pill		
3. IUD		
4. Injectable		
5. NORPLANT		
6. Condom		
7. Diaphragm		
8. Spermicide		
9. Other		

14. Does the health facility (including the MCH/FP unit) usually provide the following services or counselling? (Read 1-6)

	Services	Counselling
1. Female Sterilisation		
2. Vasectomy		
3. Natuaral Family Planning Counselling		
4. Exclusive Breastfeeding counselling (LAM)		
5. Dual Methods Counselling		
6. Emergency Contraception		

Section Four: Screening and diagnostic facilities

15. Is there any laboratory testing for STIs, HIV, or pregnancy offered at this SDP?

Yes 1
No 2

16. Is there a test for (read 1-7) available at this MCH/FP unit or at this health facility, or are client's specimens, or the clients themselves, sent elsewhere?

	A. Tick if test available at health facility	B. Tick if clients or specimens are sent elsewhere
1. Syphilis		
2. Gonorrhoea		
3. Chlamydia		
4. HIV		
5. Candida		
6. Cervical cancer (pap smear)		
7. Pregnancy		

Section Five: Immunisation services

17. Does this health facility usually provide the following immunisation services?
Read 1-6.

1. BCG	
2. Polio	
3. DTP	
4. Measles	
5. Hepatitis B	
6. Tetanus for ANC clients	

Section Six: Commodity management

18. Is there a written inventory for the following commodities and supplies?
(Read 1-4 and tick if yes)

	Tick if yes
1. FP contraceptives	
2. Drugs for STI treatment	
3. Vaccines	
4. Other medicines	

Section Seven: Record-keeping

19. How are the client's record cards maintained at this facility?

- Kept in clinic 1
- Kept by client 2
- No cards 3
- Other 4

20. In what condition is the record-card system?

- Well-ordered 1
- Partially ordered, still usable 2
- Disordered, not usable 3

21. Is there a common daily activity register for all the MCH/FP services provided by this health facility?

- Yes for all services 1
- Yes for some of the services 2
- Separate register for each of the services 3
- No daily activity register for any of the services 4

Section Eight: Service statistics

	22. How many new clients received the following services in the past 12 months? Read 1-7	23. How many repeat clients received the following services in the past 12 months? Read 1-7
1. Family planning		
2. Antenatal services		
3. Delivery services		
4. Postnatal services		
5. HIV/AIDS services		
6. STI services		
7. Child welfare		

Appendix 6

Guide for Focus Group Discussions with Providers

1. What are some of the major health problems in this area?

2. If not mentioned, do you think that unwanted pregnancy is a big problem in this area?

(Probe: If a man or woman wants to delay or stop pregnancy, what advice would you give them? If mention family planning: What are some of the main methods of contraception that are provided?)

3. If not mentioned, do you think that STIs are a major problem in this area?

(Probe: Do you think that STIs are a serious problem for men in this area? Do you think that STIs are a serious problem for women in this area? How common are STIs among FP clients?)

4. If a man or woman wants to avoid getting STIs what could they do?

(Probe: If condoms mentioned: Are men using condoms? If no, what is preventing them from using condoms? Can women talk to men about condoms? What can women do to protect themselves against STIs? How can medical/paramedical staff help?)

5. Are condoms promoted as a method of dual protection against unwanted pregnancy and STIs/HIV?

(Probe: Are FP staff able to persuade clients to change to condoms or to use a dual method of protection? Would they accept using condoms at the same time as other methods to prevent against unwanted pregnancy and HIV or STDs?)

6. Are men and women changing their sexual behaviour?

(Probe: Has AIDS affected the attitudes of men and women towards sex? Are men and women discussing sexual matters? Would clients be willing to receive counselling/education on STIs/HIV and AIDS?)

7. Are the clients who use the STI/HIV services the same or different from your other clients?

(Probe: Are men coming to the clinic? Are men willing to talk about their sexual problems? What attempts are being made to reach men with information and services?)

8. Is it common for couples to come to the clinic together in order to obtain treatment for STIs?

(Probe: If a man or woman had a STI, would he/she inform his/her (regular) partner? What procedures exist for tracing/treating the partners of people infected with STIs? Is it easy to get partners to come for treatment for STIs)

9. How can STI management and treatment be improved?

(Probe: What do you think about routine screening for STIs? How well would it work? Would clients coming for a family planning consultation be willing to have a routine gynaecological examination as part of their family planning consultation? What about the syndromic management approach? How well does it work?)

10. Should STI/ HIV services be included in the current work of the clinic?

(Probe: What changes will need to be made for integrating FP/MCH and STI/HIV services? What will this involve in terms of operations, workloads, resources, and infrastructure? Does the staff have the ability to manage the delivery of different kinds of services? Are there any aspects of STI/HIV management that would be difficult to implement?)

11. Should HIV/AIDS testing and counselling be included in the current work of the clinic?

(Probe: Are clients willing to have an HIV/AIDS test or to receive counselling on HIV/AIDS? Would you staff be able to provide HIV testing and counselling? What would this entail?)

12. Are there any suggestions for ways in which FP/MCH and STIs/AIDS services could be integrated more effectively?

Appendix 7

Semi-Structured Interview with Staff

<p>1. SDP visited (Name): _____</p> <p>2. District (Name): _____</p> <p>3. Date of Interview: _____</p> <p>4. Name of Interviewer: _____</p> <p>5. Type of SDP:</p> <table style="width: 100%; border: none;"> <tr><td>Hospital</td><td style="text-align: right;">1</td></tr> <tr><td>Health Centre</td><td style="text-align: right;">2</td></tr> <tr><td>Clinic</td><td style="text-align: right;">3</td></tr> <tr><td>Other</td><td style="text-align: right;">4</td></tr> </table>	Hospital	1	Health Centre	2	Clinic	3	Other	4	<p>6. Designation of Staff Member:</p> <table style="width: 100%; border: none;"> <tr><td>Doctor</td><td style="text-align: right;">1</td></tr> <tr><td>Nurse</td><td style="text-align: right;">2</td></tr> <tr><td>Nurse-midwife</td><td style="text-align: right;">3</td></tr> <tr><td>CBD</td><td style="text-align: right;">4</td></tr> </table> <p>7. Locality of Facility</p> <table style="width: 100%; border: none;"> <tr><td>Rural</td><td style="text-align: right;">1</td></tr> <tr><td>Urban</td><td style="text-align: right;">2</td></tr> </table> <p>8. Time of Interview</p> <p>Beginning of the Interview: _____</p> <p>End of the Interview: _____</p>	Doctor	1	Nurse	2	Nurse-midwife	3	CBD	4	Rural	1	Urban	2
Hospital	1																				
Health Centre	2																				
Clinic	3																				
Other	4																				
Doctor	1																				
Nurse	2																				
Nurse-midwife	3																				
CBD	4																				
Rural	1																				
Urban	2																				

9. How long have you been working here at this facility? Estimate.

Years

If less than one year enter 00

10. How many years ago did you finish your basic training? Estimate

Years

If less than one year enter 00

11. What did this training include? (Read out)

	Yes	No
1. Family Planning	1	2
2. Antenatal Care	1	2
3. Maternity Care /Delivery Services	1	2
4. HIV/AIDS counselling	1	2
5. HIV/AIDS testing	1	2
6. Other STI counselling	1	2
7. Other STI diagnosis	1	2
8. Other STI treatment	1	2
9. Child Immunisation	1	2
10. Child Growth Monitoring	1	2

12. Have you received any (additional) training in the past year?

Yes 1

No 2 – Go to q16

13. What did this training include? (Read out).

	Yes	No
1. Family Planning	1	2
2. Antenatal Care	1	2
3. Maternity Care /Delivery Services	1	2
4. HIV/AIDS	1	2
5. STI	1	2
6. Child Immunisation	1	2
7. Child Growth Monitoring	1	2
8. Other	1	2

14. If training included STI, did it include (Read out)

	Yes	No
1.Syndromic Management	1	2
2.Pelvic Examination	1	2
3.Behavioural Assessment	1	2
4 Behavioural.Diagnosis	1	2
5.Counselling	1	2
6.Drug Treatment	1	2
7. Partner Notification	1	2
8.Other (Specify)	1	2

15. If training included HIV/AIDS, did it include (Read out)

	Yes	No
1. HIV Testing	1	2
2.HIV Counselling	1	2
3.Other (Specify)	1	2

	16. Is this facility able to provide the following (Read out 1- 6)			17. How important is for this service to be included in the facility?		
	Yes	No	DK	Very	Somewhat	Not
1.Syphilis Testing	1	2	3	1	2	3
2.HIV Counselling	1	2	3	1	2	3
3.HIV Testing	1	2	3	1	2	3
4.STI Diagnosis	1	2	3	1	2	3
5.STI Counselling	1	2	3	1	2	3
6.STI Treatment	1	2	3	1	2	3

18. I'd like to ask you about services you provide to clients at this facility In the last three months, have you yourself provided clients at this health facility with any of the following? (Read out)

Services	Yes	No
1.Family Planning	1	2
2.Antenatal Care	1	2
3.Maternity Care /Delivery Services	1	2
4.HIV/AIDS counselling	1	2
5.HIV/AIDS testing	1	2
6.Other STI counselling	1	2
7.Other STI diagnosis	1	2
8.Other STI treatment	1	2
9.Child Immunisation	1	2
10.Child Growth Monitoring	1	2

19. If yes to item 1 in Q18, in the last 3 months, which methods have you yourself actually provided or recommended? (Read out)

Methods	Yes	No
1.Pill	1	2
2.IUD	1	2
3.Injections	1	2
4.Implants	1	2
5.Diaphragm/Foam/Jelly	1	2
6.Condom	1	2
7.Female Sterilisation	1	2
8. Male Sterilisation	1	2
9. Periodic Abstinence	1	2
10. Other (specify):	1	2
11. Don't Know	1	2

Methods	20. Which methods of family planning would you recommend for most women who would like to delay or space their next birth, assuming there were no contraindications? Any others?	21. Which methods of family planning would you <i>not</i> recommend for most women who would like to delay or space their next birth, assuming there were no contraindications? Any others?
	Mentioned	Mentioned
1.Pill	01	01
2.IUD	02	02
3.Injections	03	03
4.Implants	04	04
5.Diaphragm/Foam/Jelly	05	05
6.Condom	06	06
7.Female Sterilisation	07	07
8. Male Sterilisation	08	08
9. Sporadic Abstinence	09	09
10. Other (specify):	10	10
11.Don't Know/None	11	11

Methods	22. Which methods of family planning would you recommend for clients with a STI? (Probe: Any other method?)	23. Which methods of family planning would you <i>never</i> recommend for clients with a STI? (Probe: Any other method?)
	Mentioned	Mentioned
1. Pill	01	01
2. IUD	02	02
3. Injections	03	03
4. Implants	04	04
5. Diaphragm/Foam/Jelly	05	05
6. Condom	06	06
7. Female Sterilisation	07	07
8. Male Sterilisation	08	08
9. Abstinence	09	09
10. Other (specify):	10	10
11. Don't Know/None	11	11

24. If a client who is currently using the pill comes for a check up or re-supply and she appears to be at high risk of a STI or HIV/AIDS, what advice would you normally give her? Would you advise her to (read through list)? Circle one answer only.

1. Continue using the pill	1
2. Continue using pill but also use a condom	2
3. Switch from the pill to the condom	3
4. Stop using method	4
5. Other (Specify)	5

25. If you think that a client has an STI on the basis of reported symptoms what would you normally recommend for him/her? Circle appropriate answers **READ OUT**

A. For Diagnosis: Would you (read out)	
Undertake diagnosis yourself, after a clinical examination	1
Refer for diagnosis to another provider at this facility	2
Refer for diagnosis to another facility	3
Refer specimen for laboratory analysis	4
Treat on the basis of reported symptoms	5
B. For Treatment: Would you (read out)	
Treat yourself	6
Refer for treatment at this facility	7
Refer for treatment to another facility	8
C. For Counselling: Would you (read out)	
Provide counseling yourself	9
Refer for counselling at this facility	10
Refer for counselling at another facility	11
D. For Partner notification: Would you	
Issue a contact or partner notification slip	12
Ask patient to refer partner	13
Other (specify)	14

→ If circled, skip to C

26. If you think that a client has HIV/AIDS what do you normally do? (Circle one answer)

Discuss the possibility of an HIV test	1
Take a blood sample for an HIV test	2
Refer to someone at this facility	3
Refer to another facility	4
Other (Specify)	5

I am going to read some statements. For each one, please tell me whether you agree, disagree or neither.

No.	For the next set of questions, say whether you agree, disagree or have no opinion about the following statements	Agree	Disagree	Mixed / No opinion
27.	Condoms are an effective method of preventing pregnancy.	1	2	3
28.	It is impossible for women in this area to suggest the use of condoms to her husband.	1	2	3
29.	Most women are willing to take an HIV test if recommended to do so by a nurse or doctor.	1	2	3
30.	It is easy to talk to female clients about sexual matters.	1	2	3
31.	Clients are willing to receive information on HIV/AIDS	1	2	3
32.	It is possible for women to refuse sex with their husbands if they fear that he is infected	1	2	3
33.	It is easy to get male partners to come for treatment for STIs.	1	2	3

34. In view of the high levels of STIs/HIV do you think that all new FP clients should (read 1-4)?	Yes	No	Don't Know
1. undergo routine pelvic examination as part of their family planning consultation	1	2	3
2. undergone routine behavioural screening of themselves and their partners to identify high risk cases	1	2	3
3. be encouraged to use a condom as the primary method of contraception	1	2	3
4. be encouraged to use a condom together with another method of family planning	1	2	3

35. In view of the high levels of STIs/HIV do you think that all re-visit FP clients should (read 1-4)?	Yes	No	Don't Know
1. undergo routine pelvic examination as part of their family planning consultation	1	2	3
2. undergone routine behavioural screening of themselves and their partners to identify high risk cases	1	2	3
3. be encouraged to use a condom as the primary method of contraception	1	2	3
4. be encouraged to use a condom together with another method of family planning	1	2	3

36. Are pregnant women screened for syphilis?
 Yes 1
 No 2
 Don't Know 3

37. Is breastfeeding recommended for HIV positive mothers?
 Yes 1
 No 2
 Don't Know 3

38. Is there compulsory HIV testing of pregnant women

- Yes 1
- No 2
- Don't Know 3

39. Do you think there is a need to improve STI management in this clinic?

- Yes 1
- No 2 → Go to Q41
- Don't Know 3

40. If you could suggest one improvement to the STI services provided, what would it be?

41. Do you think that there is a need for additional training for staff in this clinic?

- Yes 1
- No 2 → Go to Q43
- Don't Know 3

42. What should the training cover? (Probe: What else?)

	Mentioned
1. Family Planning	01
2. Antenatal Care	02
3. Maternity Care /Delivery Services	03
4. HIV/AIDS counselling	04
5. HIV/AIDS testing	05
6. Other STI counselling	06
7. Other STI diagnosis	07
8. Other STI treatment	08
9. Child Immunisation	09
10. Child Growth Monitoring	10
11. Other (Specify)	11

43. In this facility, which would you prefer (READ OUT)

All staff able to promote FP, MCH, STI/HIV services	1
Specialist staff to promote these services separately	2
Other (Specify)	3

44. How integrated are existing services?

- Not integrated 1
- Partially integrated 2
- Fully integrated 3

45. Do you think that there should be further integration?

- Yes 1
- No 2 → Go to Q47
- Don't Know 3

46.

47. If yes, what should be integrated?

48. Are there any aspects of STI/HIV management that you personally would not want to do?

- Yes 1
- No 2 → Go to Q49
- Don't Know 3

49. Which aspects? Probe: what else?

- STI diagnosis 1
- STI treatment 2
- STI counselling 3
- HIV/AIDS counselling 4
- HIV testing 5
- Other (Specify) 6

Service Provider Profile

To end with, I would like to ask you a few questions about yourself.

50. Gender

- Male 1
- Female 2

51. What was your age at your last birthday?

Age in completed years

Don't Know99

52. What is your current marital status?

- Married 1
- Cohabiting 2
- Never married, not living together 3
- Divorced/Separated 4
- Widowed 5

53. How many living children of your own do you have?

Number of Children

If none enter 00 → Go to Q54

54. What is the age of your youngest child?

Age in completed years

55. Would you like to have a/another child in the future?

- Yes 1
- No 2 → Go to Q56
- DNK/undecided 3

56. Would you like the (next) child within the next 12 months?

- Yes 1
- No 2
- Don't Know 3

57. What method of family planning have you ever used?

- Pill 1
- IUD 2
- Injections 3
- Implants 4
- Diaphragm\Foam\Jelly 5
- Condom 6
- Female Sterilisation 7
- Male Sterilisation 8
- Rhythm 9
- Withdrawal 10
- Sporadic Abstinence 11
- Other (specify) 12

58. Are you and your partner currently using any method?

- Yes 1 → Go to Q59
- No 2

59. Which method are you currently using?

- | | |
|----------------------|----|
| Pill | 1 |
| IUD | 2 |
| Injections | 3 |
| Implants | 4 |
| Diaphragm\Foam\Jelly | 5 |
| Condom | 6 |
| Female Sterilisation | 7 |
| Male Sterilisation | 8 |
| Rhythm | 9 |
| Withdrawal | 10 |
| Sporadic Abstinence | 11 |
| Other (specify) | 12 |

60. What is your religion?

- | | |
|---------------------|---|
| Protestant | 1 |
| Catholic | 2 |
| African Independent | 3 |
| Moslem | 4 |
| Hindu | 5 |
| None | 6 |
| Other (Specify) | 7 |

Appendix 8 Guide for Exit Interviews

<p>1. SDP visited (Name): _____</p> <p>2. District (Name): _____</p> <p>3. Date of Interview: _____</p> <p>4. Name of Interviewer: _____</p> <p>5. Type of SDP</p> <table style="width: 100%;"> <tr><td>Hospital</td><td style="text-align: right;">1</td></tr> <tr><td>Health Centre</td><td style="text-align: right;">2</td></tr> <tr><td>Clinic</td><td style="text-align: right;">3</td></tr> <tr><td>Other (Specify)</td><td style="text-align: right;">4</td></tr> </table>	Hospital	1	Health Centre	2	Clinic	3	Other (Specify)	4	<p>6. Locality of Facility</p> <table style="width: 100%;"> <tr><td>Rural</td><td style="text-align: right;">1</td></tr> <tr><td>Urban</td><td style="text-align: right;">2</td></tr> </table> <p>7. Time of Interview</p> <p>Beginning of the Interview: _____</p> <p>End of the Interview: _____</p>	Rural	1	Urban	2
Hospital	1												
Health Centre	2												
Clinic	3												
Other (Specify)	4												
Rural	1												
Urban	2												

Section 1: Background Questions

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|------|---|--------|---|---------|---|------------|---|-----------------------|---|----------------------------|---|-------------------|---|-----|---|----|---|------------|---|---|-----|---|----|---|---------------|---|-----|---|----|---|------------|---|-----|---|----|---|------|---|-----|---|------------|---|----------|---|----------------------|---|--------|---|----------------------|---|--------------------|---|--------|---|------------|----|---------------------|----|-----------------|----|
| <p>8. Sex</p> <table style="width: 100%;"> <tr><td>Male</td><td style="text-align: right;">1</td></tr> <tr><td>Female</td><td style="text-align: right;">2</td></tr> </table> <p>9. What was your age at your last birthday?
Age in completed Years <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p> <p>10. What is your current marital status?</p> <table style="width: 100%;"> <tr><td>Married</td><td style="text-align: right;">1</td></tr> <tr><td>Cohabiting</td><td style="text-align: right;">2</td></tr> <tr><td>Single, never married</td><td style="text-align: right;">3</td></tr> <tr><td>Divorced/separated/widowed</td><td style="text-align: right;">4</td></tr> <tr><td>Refused to answer</td><td style="text-align: right;">5</td></tr> </table> <p>11. How many living children of your own do you have?
Number of Children <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
If none enter 00 → Go to Q13</p> <p>12. What is the age of your youngest child?
Age in completed years <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/></p> <p>13. Are you currently pregnant?</p> <table style="width: 100%;"> <tr><td>Yes</td><td style="text-align: right;">1</td></tr> <tr><td>No</td><td style="text-align: right;">2</td></tr> <tr><td>Don't Know</td><td style="text-align: right;">3</td></tr> </table> | Male | 1 | Female | 2 | Married | 1 | Cohabiting | 2 | Single, never married | 3 | Divorced/separated/widowed | 4 | Refused to answer | 5 | Yes | 1 | No | 2 | Don't Know | 3 | <p>14. Would you like to have a/another child in the future?</p> <table style="width: 100%;"> <tr><td>Yes</td><td style="text-align: right;">1</td></tr> <tr><td>No</td><td style="text-align: right;">2</td></tr> <tr><td>DNK/undecided</td><td style="text-align: right;">3</td></tr> </table> <p style="text-align: right;">} → Go to Q16</p> <p>15. Would you like the (next) child within the next 12 months?</p> <table style="width: 100%;"> <tr><td>Yes</td><td style="text-align: right;">1</td></tr> <tr><td>No</td><td style="text-align: right;">2</td></tr> <tr><td>Don't Know</td><td style="text-align: right;">3</td></tr> </table> <p>16. Are you or your partner currently using any method of contraception?</p> <table style="width: 100%;"> <tr><td>Yes</td><td style="text-align: right;">1</td></tr> <tr><td>No</td><td style="text-align: right;">2</td></tr> </table> <p style="text-align: right;">} → Go to Q18</p> <p>17. Which method are you using? (Probe: What else?)</p> <table style="width: 100%;"> <tr><td>Pill</td><td style="text-align: right;">1</td></tr> <tr><td>IUD</td><td style="text-align: right;">2</td></tr> <tr><td>Injections</td><td style="text-align: right;">3</td></tr> <tr><td>Implants</td><td style="text-align: right;">4</td></tr> <tr><td>Diaphragm\Foam\Jelly</td><td style="text-align: right;">5</td></tr> <tr><td>Condom</td><td style="text-align: right;">6</td></tr> <tr><td>Female Sterilisation</td><td style="text-align: right;">7</td></tr> <tr><td>Male Sterilisation</td><td style="text-align: right;">8</td></tr> <tr><td>Rhythm</td><td style="text-align: right;">9</td></tr> <tr><td>Withdrawal</td><td style="text-align: right;">10</td></tr> <tr><td>Sporadic Abstinence</td><td style="text-align: right;">11</td></tr> <tr><td>Other (specify)</td><td style="text-align: right;">12</td></tr> </table> | Yes | 1 | No | 2 | DNK/undecided | 3 | Yes | 1 | No | 2 | Don't Know | 3 | Yes | 1 | No | 2 | Pill | 1 | IUD | 2 | Injections | 3 | Implants | 4 | Diaphragm\Foam\Jelly | 5 | Condom | 6 | Female Sterilisation | 7 | Male Sterilisation | 8 | Rhythm | 9 | Withdrawal | 10 | Sporadic Abstinence | 11 | Other (specify) | 12 |
| Male | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Married | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cohabiting | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Single, never married | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Divorced/separated/widowed | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Refused to answer | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Don't Know | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DNK/undecided | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Don't Know | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pill | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IUD | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injections | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Implants | 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diaphragm\Foam\Jelly | 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Condom | 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female Sterilisation | 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male Sterilisation | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rhythm | 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Withdrawal | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sporadic Abstinence | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other (specify) | 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Section 2: Information, Education and Counselling

18. Did you see any of the following today?
(Read through 1-7)

	Yes	No	DK
1.FP Poster	1	2	3
2.STI Poster	1	2	3
3.HIV/AIDS Poster	1	2	3
4. FP Pamphlet/ Brochure/ Information Sheet	1	2	3
5. STI Pamphlet/ Brochure/ Information Sheet	1	2	3
6. HIV/AIDS Pamphlet/ Brochure/ Information Sheet	1	2	3
7. Sample of Condoms	1	2	3

19. Did you receive any written material to take home during this visit?

Yes 1
No 2 → Go to Q21

20. If yes, what was the subject of the written information? Circle all that apply (Probe: What else)

Family Planning 1
Antenatal Care 2
Post-Natal Care 3
STIs 4
HIV/AIDS 5
Child Nutrition 6
Other (Specify) 7

21. Did you attend a group health talk at the facility today?

Yes 1
No 2 → Go to Q23

22. What was the subject of the group talk?

Circle all that apply (Probe: What else?)

Family Planning 1
Antenatal Care 2
Post-Natal Care 3
STIs 4
HIV/AIDS 5
Child Nutrition 6
Other (Specify) 7

Section 3: Quality of Care

I am going to read some statements with regard to your visit to the clinic today. I would like you to say whether you agree, disagree or have no opinion about the following statements.

	Statements	Agree	Disagree	Mixed / No opinion
23.	Staff were friendly	1	2	3
24.	Staff were difficult to understand	1	2	3
25.	Staff were helpful in providing information.	1	2	3
26.	I was provided with all the information I wanted during today's consultation	1	2	3
27.	I felt that there was insufficient time to ask questions	1	2	3
28.	Staff answered all my questions to my satisfaction	1	2	3
29.	Staff gave me the opportunity to ask questions about health issues that I thought were important	1	2	3
30.	There was insufficient privacy during the consultation	1	2	3
31.	The waiting time for the consultation was reasonable	1	2	3
32.	I came away from the clinic feeling that I had received good quality care	1	2	3

Section 3: Quality of Care (continued)

I am going to ask you about your general experiences at this health centre. I would like you to say whether you agree, disagree or have no opinion about the following statements.

	Statement	Agree	Disagree	Mixed/No Opinion
33.	The Staff are helpful	1	2	3
34.	The staff treat me with respect	1	2	3
35.	I find it difficult talking to staff about my sexual life	1	2	3
36.	Staff are usually too busy to answer my questions	1	2	3
37.	If I thought I had an STI, I would first go to the traditional healer	1	2	3

Section 4: Knowledge and Ever Use of Services Available at Facility

Services	38. I am going to read out a list, tell me whether this type of service is provided at the clinic?			39. (If yes to Q38) Have you ever used this service?	
	Yes	No	DK	Yes	No
1. Family planning	1	2	3	1	2
2. Antenatal care	1	2	3	1	2
3. Postnatal care	1	2	3	1	2
4. Delivery	1	2	3	1	2
5. Child health	1	2	3	1	2
6. Child growth monitoring	1	2	3	1	2
7. STI diagnosis	1	2	3	1	2
8. STI treatment	1	2	3	1	2
9. HIV/AIDS testing	1	2	3	1	2
10. HIV/AIDS counseling	1	2	3	1	2
11. Other (specify	1	2	3	1	2

Section 5: Main Reason for Visit

40. What was the main reason for visiting the clinic today?
- | | | |
|----------------------|----|-------------|
| Family Planning | 1 | → Go to Q47 |
| Personal Illness | 2 | |
| Child/Baby Illness | 3 | |
| Child Immunisation | 4 | |
| Antenatal Care | 5 | |
| Postnatal Care | 6 | |
| STI management | 7 | |
| HIV/AIDS testing | 8 | |
| HIV/AIDS counselling | 9 | |
| Other (Specify) | 10 | |

Section 6: Non-Family Planning Clients

41. During your visit to the clinic today, did the service provider mention anything about family planning?

- Yes 1
- No 2
- Don't Know 3

42. Were the following issues mentioned to you during your consultation today? (Read 1 through 7).

	Yes	No	DK
1. Whether you wanted a/another child	1	2	3
2. Whether you wanted to rest or space before having a/another child.	1	2	3
3. Whether you are interested in using family planning	1	2	3
4. If you have ever used any method	1	2	3
5. If you have any concerns about using any method	1	2	3
6. If you had discussed family planning with your husband/partner.	1	2	3

43. Did the provider mention any specific methods of contraception during your visit today?

- Yes 1
- No 2 → Go to Q45
- Don't Know 3

44. Which methods did the provider mention? (Probe by asking: "Anything else?")

Circle all that apply

- Pill 1
- IUD 2
- Injections 3
- Implants 4
- Diaphragm\Foam\Jelly 5
- Condom 6
- Female Sterilisation 7
- Male Sterilisation 8

45. Do you need any (more) information or advice about family planning?

- Yes 1
- No 2
- Don't Know 3

46. Would you have welcomed (more) information/advice on family planning on today's visit?

- Yes 1
- No 2
- Don't Know 3

Section 7: Non-STI/HIV/AIDS clients

[NB: Answer only if response to Q40 was 1-6]

47. During your visit to the clinic today, did the service provider mention anything about:

(Read 1-2)

	Yes	No	DK
1. STIs	1	2	3
2. HIV/AIDS	1	2	3

48. During your visit to the clinic today, did the service provider: (Read out 1-8)

	Yes	No	DK
1. Ask about vaginal discharge	1	2	3
2. Perform a pelvic examination	1	2	3
3. Ask whether you have more than one partners	1	2	3
4. Ask whether your partner is likely to have more than one partner	1	2	3
5. Ask if you have any concerns about getting an STI	1	2	3
6. Ask if you had discussed STIs with your husband/partner.	1	2	3
7. Ask if your partner would be willing to receive treatment.	1	2	3
8. Advise you to have a laboratory test/ has test done	1	2	3

49. Do you need any (more) information or advice about STIs/HIV/AIDS?

- Yes 1
- No 2
- Don't Know 3

50. Would you have welcomed (more) information or advice on STIs/HIV/AIDS on today's visit?

- Yes 1
- No 2
- Don't Know 3

Section 8: Family Planning Clients

[NB: Answer only if response to Q40 was 1]

51. I understand that your main purpose for coming to this health facility today was family planning. What was the reason for visiting the family planning provider?

- Adoption of a new method 1
- Re-supply 2
- Method Change 3
- Problem with Method 4
- Other (Specify) 5

52. Did you receive any contraceptive supplies during this visit?

- Yes 1
- No 2 → Go to Q54

53. Which method(s) did you accept today? (Probe: What else?)

- Pill 1
- IUD 2
- Injections 3
- Implants 4
- Diaphragm\Foam\Jelly 5
- Condom 6
- Female Sterilisation 7
- Male Sterilisation 8

54. During your visit did the provider mention any other methods?

- Yes 1
- No 2 → Go to Q56
- Don't Know 3

Section 8: Family Planning Clients [continued]

55. Which other methods did the provider mention? (Probe by asking: "Anything else?") Circle all that apply.

- Pill 1
- IUD 2
- Injections 3
- Implants 4
- Diaphragm\Foam\Jelly 5
- Condom 6
- Female Sterilisation 7
- Male Sterilisation 8

56. Did the provider discuss condoms with you?

- Yes 1
- No 2
- Don't Know 3

57. Did the provider mention that condoms can be used in combination with other methods?

- Yes 1
- No 2
- Don't Know 3

58. Did you have a pelvic examination during your visit today?

- Yes 1
- No 2 → Go to Q61
- Don't Know 3

59. Did the provider explain the purpose of the examination?

- Yes 1
- No 2
- Don't Know 3

60. Did the provider explain the results of this examination?

- Yes 1
- No 2
- Don't Know 3

61. Were you told when to return for a follow up visit?

- Yes 1
- No 2
- Don't Know 3

Section 9: STI/HIV clients [NB: Answer only if response to Q40 was between 7-9]

62. I understand that your main purpose for coming to this health facility today was STI/HIV. What was the main reason for visiting the provider? (Read out list) Circle only one answer

- Confirmed HIV Positive 1
- Possibly HIV Positive 2
- Awaiting HIV test 3
- Confirmed STI 4
- Possible STI 5
- Awaiting Diagnosis 6
- Cured STI 7
- Other (Specify) 8

63. Did you have a pelvic examination during your visit today?

- Yes 1
- No 2 → Go to Q66
- Don't Know 3

64. Did the provider explain the purpose of the examination?

- Yes 1
- No 2
- Don't Know 3

65. Did the provider explain the results of this examination?

- Yes 1
- No 2
- Don't Know 3

66. Did the provider advise you to have a laboratory test?

- Yes 1
- No 2
- Don't Know 3

Section 9: STI/HIV clients [continued]

67. Did the provider take any specimen (such as blood, urine or swab) for testing in a laboratory?

Yes	1
No	2
Don't Know	3

68. Did the provider ask about vaginal discharge?

Yes	1
No	2
Don't Know	3

69. Did the provider talk to you about multiple sexual partners?

Yes	1
No	2
Don't Know	3

70. Did the provider advise you to bring your partner for treatment?

Yes	1
No	2
Don't Know	3

71. Would your partner be willing to receive treatment for a STI at this clinic?

Yes	1
No	2
Don't Know	3

72. Did the provider tell you to refrain from sexual intercourse?

Yes	1
No	2
Don't Know	3

73. Did the provider discuss condoms with you?

Yes	1
No	2
Don't Know	3

74. Did the provider mention that condoms protect against STIs/HIV?

Yes	1
No	2
Don't Know	3

75. Were you told when to return for a follow up visit?

Yes	1
No	2
Don't Know	3

Section 10: Perceived Risk of HIV/AIDS

To end up with I would like to ask you some questions about yourself. I would like to remind you that the information that you provide will remain strictly confidential.

76. How many sexual partners have you had in the past 12 months?
 Number of Partners
 Don't Remember.....99

79. Before today, have you ever thought about your own chance of contracting HIV/AIDS?
 Yes 1
 No 2

77. Did you have sex with any new partner(s) in the past 12 months?
 Yes 1
 No 2
 DNK/ can't remember 3

80. Considering all things, do you consider your chance of getting HIV to be high, medium, low or no chance at all?
 High 1
 Medium 2
 Low 3
 No chance 4

78. Did you use a condom the first time you had sex with your most recent new partner?
 Yes 1
 No 2
 DNK/ Can't remember 3

81. If a doctor or nurse advised you to use a condom, would it be possible for you to do so with your spouse or main partner?
 Yes 1
 No 2
 Don't Know 3

Thank you very much for answering these questions

Appendix 9

Background characteristics of sexually active men and women: Unweighted

Age:		
Less than 35	310	429
35 or more	201	153
Marital Status:		
Married	153	161
Cohabiting	105	124
Neither	253	297
Place of Residence:		
Urban	234	315
Rural	277	267
Level of Education:		
Less than Secondary	119	145
Secondary or More	392	437

Background characteristics of married and cohabiting men and women: Unweighted

	Men	Women
Age		
Less than 35	83	160
35 or more	175	125
Marital Status		
Married	153	161
Cohabiting	105	124
Place of Residence		
Urban	133	150
Rural	125	135
Level of Education		
Less than Secondary	75	102
Secondary or More	183	183
Desire for more children		
Yes	120	117
No	95	138
Unsure	41	30
Number of living children		
0-1	101	120
2-4	131	138
5 or more	25	30

Cohabiting and married men and women by psychosocial factors: Unweighted

	Men	Women
Perceived Severity of AIDS:		
Low	219	3
High	36	47
Perceived Prevalence of AIDS:		
Low	94	89
Medium	104	128
High	58	62
Perceived Self-Efficacy:		
Low	115	138
Medium	52	66
High	88	79
Belief in condom efficacy:		
Low	228	238
High	27	47

Wife's background characteristics, unmet need and condom use : Unweighted

Age:	
Less than 35	134
35 or more	104
Marital Status:	
Married	137
Cohabiting	101
Place of Residence:	
Urban	122
Rural	116
Level of Education:	
Less than Secondary	85
Secondary or More	153
Number of living children:	
0-1	97
2-3	92
4 or more	42
Unmet Need	
Yes	17
No	221
Condom Use	
Yes	51
No	187

In-depth Interviews

Interview Number	Sex	Place of Residence	Exposure to HIV Infection	Exposure to Pregnancy
1	Male	Rural	High	High
2	Male	Urban	High	High
3	Female	Rural	High	High
4	Female	Rural	High	High
5	Female	Urban	High	High
6	Male	Rural	Low	High
7	Male	Urban	Low	High
8	Male	Urban	Low	High
9	Male	Urban	Low	High
10	Female	Rural	Low	High
11	Female	Rural	Low	High
12	Female	Urban	Low	High
13	Male	Rural	High	Medium
14	Male	Urban	High	Medium
15	Male	Urban	High	Medium
16	Female	Rural	High	Medium
17	Female	Rural	High	Medium
18	Female	Urban	High	Medium
19	Male	Rural	Low	Medium
20	Male	Rural	Low	Medium
21	Male	Rural	Low	Medium
22	Male	Urban	Low	Medium
23	Male	Urban	Low	Medium
24	Female	Rural	Low	Medium
25	Female	Rural	Low	Medium
26	Female	Rural	Low	Medium
27	Female	Urban	Low	Medium
28	Female	Urban	Low	Medium
29	Male	Rural	High	Low
30	Male	Rural	High	Low
31	Male	Rural	High	Low
32	Male	Urban	High	Low
33	Female	Rural	High	Low
34	Female	Rural	High	Low
35	Female	Urban	High	Low
36	Female	Rural	High	Low
37	Female	Urban	High	High
38	Male	Urban	High	Medium
39	Female	Rural	Low	Medium
40	Female	Rural	Low	Low

In-depth Interviews: Senior Staff	
1	Urban
2	Urban
3	Urban
4	Urban
5	Rural
6	Rural
7	Rural

Focus Group Discussions: Providers	
1	Urban
2	Urban
3	Rural
4	Rural

