

**EXPLORING FACTORS THAT INFLUENCE SAFER SEX
PRACTICES IN MALAWI**

by

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DECLARATION

I declare that **EXPLORING FACTORS INFLUENCING SAFER SEX PRACTICES IN MALAWI** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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ABSTRACT

The purpose of the study was to explore factors that influenced safer sex practices in Malawi. A quantitative, explorative, descriptive study was conducted to determine why the prevalence of new HIV infections was still high in Malawi despite. Questionnaires were used to collect data. Sexually active men, women, boys and girls that participated in the Centre for Human Rights and Rehabilitation community awareness activities participated in this study. The study found that demographic, socio-economic and knowledge-related factors influence safer sex practices in Malawi. Various modifying factors played a role in influencing the individuals' perception of susceptibility, severity, barriers and benefits of practising safer sex. The findings indicated that individuals generally had a broad knowledge of the spread and prevention of HIV. The Health Belief Model was used as theoretical framework for the study.

KEY CONCEPTS

Safer sex; Health Belief Model; HIV/Aids; Malawi.

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Dedication

To my children, Jimmy (Jnr), Michelle and the triplets, Kevin,
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Your unending love and support kept me going. I am sure that you have learnt that it is possible to study at all odds if one is determined to. If studying could be classified as a hobby, I would encourage you to take it seriously as it keeps you busy and adds meaning to life.

Your loving mother (Ma),
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List of abbreviations

Aids	Acquired Immunodeficiency Syndrome
BCI	Behaviour Change Interventions
CDC	Centers for Disease Control and Prevention
CHRR	Center for Human Rights and Rehabilitation
DC	District Coordinators
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
MDHS	Malawi Demographic Health Survey
MDoS	Malawi Department of Statistics
NAC	National Aids Commission
PSI	Population Services International
STIs	Sexually Transmitted Infections
SRH	Sexual Reproductive Health
SPSS	Statistical Package for Social Sciences
T/As	Traditional Authorities
USA	United States of America
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

List of annexures

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- Annexure B Application for clearance to carry out the study from the National Health Sciences Research Committee
- Annexure C Approval of application to conduct the study from the National Health Sciences Research Committee
- Annexure D Permission to conduct a research study from the District Commission
- Annexure E Consent form for respondents
- Annexure F Questionnaire

ANNEXURE A

Map of Malawi

ANNEXURE B

**Application for clearance to carry out the study from
the National Health Sciences Research Committee**

ANNEXURE C

**Approval of application to conduct the study from the
National Health Sciences Research Committee**

ANNEXURE D

**Permission to conduct a research study from the
District Commission**

ANNEXURE E

Consent form for respondents

ANNEXURE F

Questionnaire

CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

Since Acquired Immune Deficiency Syndrome (Aids) was first diagnosed in 1981, over 20 million people have died and almost 38 million people have been and are living with Human Immunodeficiency Virus (HIV) worldwide (UNAIDS 2004:3). In Malawi, the first Aids case was diagnosed in 1985 and by 2003, the national adult (15-49 years) HIV prevalence was estimated at 14.4% of the 12 million population. Even though 90% of the Malawian population were aware of the mode of transmission of HIV/Aids in 2003, the prevalence of new infections was as high as 110 000 people annually. The HIV epidemic in Malawi has increased the deaths of members of the most productive age group (15-49 years) of the population. Further effects of HIV/Aids include ever-growing numbers of orphans; increasing shortages of drugs, cost of caring for the sick and congestion in hospitals; reduced economic productivity, and a reduced life span from 49 to 39 years (NAC 2003c:1).

According to UNAIDS (2002:25), sexual behaviour is the principal factor influencing the spread of sexually transmitted infections (STIs), HIV and subsequently Aids in Africa. Sexual behaviour varies greatly across cultures, age groups, socio-economic class and gender. The adverse socio-economic impact of HIV/Aids is a key concern for the Malawi government, hence exploring factors that influence safer sex practices is yet another integral area for research in striving to promote behavioural change in Malawi.

1.2 BACKGROUND TO THE PROBLEM

In an effort to control HIV/Aids, NAC (2003b:17) developed national guidelines for planning behaviour change interventions (BCI) and HIV/Aids and sexual reproductive health (SRH) for 2001-2004. The aim of the BCI strategy was to empower the Malawian nation to develop or maintain safer SRH practices in a stigma and gender transformative environment. While the majority (85.6%) of Malawians are HIV/Aids

negative, the profile of HIV infection still presents a challenge to keep all these people free from HIV infection, hence the need to find out how people could remain HIV negative in Malawi.

UNAIDS (2000:5) attributes the spread of HIV/Aids in Africa to sexual behaviour and environmental factors such as gender, inequality and poverty. For example, in Nsanje, a rural district in Malawi, a widow is culturally expected to undergo a sexual cleansing ritual by having sexual intercourse with her deceased husband's brother or close relative regardless of the deceased's cause of death. This is believed to remove bad spirits that would eliminate the whole clan if the ritual were not performed (Jana 2003:25). According to NAC (2003c:1), women were more vulnerable to HIV/Aids than men because 58% of the estimated 14.4% national adult (15-49 years) HIV prevalence were women. This imbalance in the sex ratio could be attributed to the vulnerability of women to HIV infection. According to Cichocki (2008:2), women have a larger mucosal surface exposed during sexual intercourse than men and semen has a fairly higher concentration of HIV than vaginal fluid. The vaginal mucosa, in comparison to the penis, is more susceptible to small tears and irritation during sexual intercourse. Women, thus, run a bigger risk of HIV entering their bodies, especially if intercourse takes place before adulthood when the mucosal surface is still tender and easily bruised. According to UNAIDS (2002:25), there is substantial evidence that STIs enhance the risk of sexual transmission of HIV particularly in women when the STIs are symptomatic in men but asymptomatic in women. The asymptomatic STIs remain untreated while creating a favourable port of entry for HIV when unprotected sexual intercourse takes place.

According to the Malawi Demographic Health Survey (Malawi Department of Statistics [MDoS] 2005:201-212), of the respondents between 15 and 19 years of age who had sex for the 12 months preceding the study, 8% of the women compared with 27% of the men engaged in higher risk sex (i.e., sex with a partner other than a husband or cohabiting partner); 30% of the women used condoms for higher risk sex compared to 47% of the men. Finally, 77% of the women and 88% of the men between 15 and 24 years old knew places where they could get male condoms if there was a need (MDoS 2005:201-212). This data indicated that a high percentage of pre- or extra-marital sex was unprotected in Malawi. The findings of the survey and her work as a nurse

motivated the researcher to explore strategies to promote safer sex practices that would complement the existing HIV/Aids behavioural change programmes in Malawi.

1.3 STATEMENT OF THE PROBLEM

In Malawi, more than 110 000 new HIV infections occur every year even though 90% of the population are aware of HIV/Aids and its mode of transmission (NAC 2003c:1). The challenge for health personnel is therefore to safeguard the members of the community from infection. The rates could be lowered if sexually active people in Malawi practised safer sex.

1.4 RATIONALE FOR THE STUDY

The only way members of the community could be protected against HIV/Aids infection is to change their sexual behaviour by promoting safer sex practices. There could be cultural and other factors that influence sexual practices. These factors need to be explored and described to enable policy makers and health care providers to implement strategies to complement the existing HIV/Aids behavioural change programmes in Malawi.

The researcher therefore considered it important to investigate which factors influenced safer sex practices in Malawi.

1.5 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the factors associated with safer sex practices in Malawi.

1.5.1 Objectives of the research

The following objectives have been derived from the purpose of the research:

- to determine perceived susceptibility of HIV/Aids of literate, sexually active men, women, boys and girls living in the Centre for Human Rights and Rehabilitation

(CHRR) operational sites in Malawi.

- to determine seriousness of HIV/Aids of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.
- to identify factors that influenced modifying self-protection in literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.
- to identify perceived benefits of practising safer sex of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.
- to identify perceived barriers to risk reduction behaviour of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.

1.5.2 Research questions

In view of the problem statement and purpose, the study wished to answer the following research questions:

- How did the respondents perceive their susceptibility to HIV/Aids?
- How did the respondents perceive the seriousness of HIV/Aids?
- What influenced the respondents' modifying factors for self-protection?
- How did the respondents perceive the benefits of practising safe sex?
- How did the respondents perceive the barriers to risk reduction behaviour?

1.5.3 Delimitation of the study

This study was conducted in eight districts in the Northern, Central and Southern regions in Malawi. The *Compact Oxford English Dictionary* (2005:288) defines a district as "an area or a town or region regarded as a unit for administrative purposes". Malawi has twenty-eight districts. Each district is further broken down into areas that are under the governance of traditional authorities (paramount chiefs) that oversee and rule villages under chiefs and headmen. The traditional authorities (T/As) report to the District Commissioners who are the head of administration at the district headquarters or District Assembly. The study focused on respondents living in the villages under the jurisdiction of two T/As, in each of the selected eight districts.

1.5.4 Geographical area

Of the eight districts chosen for the study, Chitipa and Karonga are in the North, Salima and Dedza are in the West, Mchinji and Lilongwe are Central, and Mangochi and Zomba are in the South. The map provided in annexure A indicates only 27 of the 28 official districts.

1.6 SIGNIFICANCE OF THE STUDY

The findings of this study should increase the body of knowledge of HIV/Aids in Malawi and assist policy makers and health care providers in preventing the spread of HIV/Aids by promoting safer sex practices in communities.

1.7 THEORETICAL FRAMEWORK

A theoretical or conceptual framework is “the abstract, logical structure of meaning that guides the development of the study and enables the researcher to link the findings to the existing body of knowledge” (Burns & Grove 2005:37). Brink, Van der Walt, Van Rensburg (2006:24) state that a framework helps the researcher to organise the study and provides a context in which the researcher examines a problem and gathers and analyses data. The researcher used the Health Belief Model (HBM) as a theoretical framework for the study. Stanhope and Lancaster (2000:271) identify three major components of the model, namely individual perceptions, modifying factors and variables affecting the likelihood of action (see chapter 2).

1.8 ASSUMPTIONS

An assumption is something that is taken for granted or assumed without proof (*Collins English Dictionary* 1991:92). In this study it was assumed that the respondents were practising heterosexual relationships only and that they would answer the questions truthfully and honestly.

1.9 RESEARCH DESIGN AND METHODOLOGY

A research design is the “overall plan for obtaining answers to the questions being studied and for handling some of the difficulties encountered during the research process” (Polit & Beck 2004:49). Burns and Grove (2003:195) describe a research design as “a blueprint for conducting a study that gives maximum control over factors that could interfere with the validity of the research findings”.

In this study, the researcher selected a quantitative, explorative and descriptive design to explore factors that influence safer sex practices in Malawi. Quantitative research is “a formal, objective, systematic process in which numerical data are used to obtain information about the world” (Burns & Grove 2003:18). Explorative research “investigates the full nature of the phenomenon, the manner in which it is manifested and the other factors to which it is related” (Polit & Beck 2008:20). Descriptive research “provides a picture of the situation as it naturally happens and is designed to gain more information about characteristics within a particular field of study” (Burns & Grove 2003:200).

1.10 POPULATION AND SAMPLE

Polit and Beck (2004:289) define a population as “the entire aggregation of cases in which the researcher is interested”. In this study, the population consisted of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi. According to Benson, Kaphuka, Kanyanda and Chinula (2002:3-5), in 1998 the population in the CHRR catchment area was 1 075 616 and comprised of 231 407 households, and formed 8.82% of the 9.9 million people in Malawi (see chapter 3 for full discussion).

Burns and Grove (2003:56) describe a sample as “a subset of the population that is selected for a particular study”. In this study, the researcher used a stratified random sampling method to select a sample of 108 subjects comprising 1.07% of the total research population of sexually active men, women, boys and girls that participated in the CHRR community awareness activities.

1.11 DATA COLLECTION

Data collection is a precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypotheses of a study (Burns & Grove 2003:56). In this study, data was collected using a questionnaire as an instrument. The questionnaire was based on the components of the HBM.

A questionnaire is “a printed self-report form designed to elicit information through written or verbal responses of the subject” (Burns & Grove 2003:289). The questionnaire contained closed-ended and open-ended questions (see annexure E). The fixed alternative questions (closed-ended questions) were used to ensure comparability of responses and facilitate analysis while the open-ended questions obtained the respondents’ own perceptions. The responses to the items in the questionnaire were measured at the nominal or ordinal levels.

Questionnaires have advantages and disadvantages (Burns & Grove 2003:289). Questions are presented consistently and gather a broad spectrum of information from the respondents. However, responses cannot be probed in depth, and respondents are not permitted to elaborate on the responses or to have the questions clarified (Burns & Grove 2003:289).

1.12 DATA ANALYSIS

Collected data should be analysed to elicit meaning. Data analysis reduces, organises and gives meaning to the data (Burns & Grove 2003:56). In this study, a statistician analysed the data, using the Statistical Package for Social Sciences (SPSS) version 15 computer program (see chapter 3).

1.13 VALIDITY AND RELIABILITY

Polit and Beck (2004:35) emphasise that validity and reliability are two of the most important criteria to measure the quality of a study. Validity is “the degree to which an instrument measures what it is supposed to measure” (Polit & Beck 2004:243). Reliability refers to how consistently a particular instrument measures the concept of

interest. The measure is reliable if the same results are achieved each time the same situation is measured (Burns & Grove 2003:45).

In this study the researcher developed a draft questionnaire based on the HBM. The questionnaire was discussed with the study supervisors, a statistician and colleagues with knowledge of HIV/Aids and research in order to elicit their views before pre-testing the instrument. The relevance and wording of the questions were examined. The feedback assisted the researcher to make alterations to meet the intended purpose of the study.

Polit and Beck (2004:361) point out that a “pre-test should be administered to individuals who are similar to actual participants”. The questionnaire was pre-tested with ten respondents who did not participate in the main study. Pre-testing the instrument helped to measure its content validity and reliability. The identified shortfalls in order to make the questions clearer and get the intended responses were considered and incorporated to improve the reliability of the questionnaire.

1.14 ETHICAL CONSIDERATIONS

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual”. In this study, the researcher adhered to the ethical principles of respect for persons, beneficence and justice (see chapter 3).

1.15 DEFINITIONS OF KEY CONCEPTS

For the purpose of this study, the following terms are used as defined below:

➤ Explore

The *Compact Oxford English Dictionary* (2005:350) defines explore as “to inquire into or examine in detail”.

This study inquired into and examined factors likely to influence safer sex practices in Malawi.

➤ **Factor**

A factor is an element, cause, circumstance, or fact that contributes to a result (*Compact Oxford English Dictionary* 2005:356).

This study wished to determine factors that influence the spread of HIV among sexually active Malawians.

➤ **Influence**

Collins English Dictionary (1991:794) defines influence as “(n) an effect of one person or thing on another; the power of a person or thing to have such an effect; (v) to persuade or induce; to have an effect upon (actions, events, etc); affect”.

In this study, influence refers to the circumstances and factors that determine whether the respondents practise safer sex or not.

➤ **Safe sex practices**

Safe sex is “sexual intercourse using physical protection, such as a condom, or non-penetrative methods to prevent the spread of such diseases as AIDS” (*Collins English Dictionary* 1991:1362).

In this study, safe sex implies abstinence from sex or having sex with one faithful and consistent partner whose HIV sero status is negative.

➤ **Safer sex**

Safer sex means “avoiding sexual contact where semen, blood or vaginal secretions of one person can enter the body or bloodstream of another person”, which is most effectively done by condoms used properly (*Sexually Transmitted Diseases Services* 2008c:1).

In this study, safer sex implies consistent and correct condom use.

➤ **Acquired Immune Deficiency Syndrome (Aids)**

Aids is “a disease caused by infection with the Human Immunodeficiency Virus (HIV)” (*Compact Oxford English Dictionary* 2005:18).

Mosby’s Medical and Nursing Dictionary (2002:13) describes Aids as “acquired immune deficiency syndrome (AIDS), a disease involving a defect in cell-mediated immunity that has a long incubation period, follows a protracted and debilitating course, is manifested by various opportunistic infections, and has a poor prognosis. The disorder is found primarily in homosexual men and intravenous drug users and to a lesser degree in female sex partners of bisexual men and children of those with the disease. The causative agent is believed to be a retrovirus, identified as HTLV-3 (Human T-cell Lymphotropic Virus) transmitted through sexual contact or exposure to contaminated blood.”

Aids is “a disease caused by HIV, which kills or impairs cells of the immune system and progressively destroys the body’s ability to fight infections and certain cancers. HIV is most commonly spread by sexual contact with an infected partner” (NIAID 2006:1).

➤ **Human Immunodeficiency Virus (HIV)**

HIV is “a retrovirus that causes AIDS” (*Compact Oxford English Dictionary* 2005:480) (see definition of Aids).

1.16 OUTLINE OF THE STUDY

Chapter 1 outlines the problem, purpose and significance of the study, research design and methodology, data collection and analysis, and ethical considerations, and defines key terms.

Chapter 2 discusses the literature review undertaken for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 discusses the data analysis and interpretation and the findings.

Chapter 5 concludes and summarises the study, briefly describes its limitations, and makes recommendations for practice and further research.

1.17 CONCLUSION

Research in HIV/Aids is required to address gaps in existing knowledge on HIV/Aids and to inform policy, practice and HIV/Aids-related interventions (NAC 2003c:40). Malawi has a high incidence of HIV/Aids irrespective of the majority of the population knowing how HIV is spread. In an effort to strengthen behavioural change interventions to reduce the sexual transmission of HIV, the current study wished to establish factors that influence safer sex practices in Malawi. This chapter outlined the research problem, the purpose and objectives, theoretical framework, underlying assumptions, research design and methodology of the study, and defined key concepts.

Chapter 2 discusses the literature review conducted for the study.

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter discusses the literature review conducted for the study. A literature review assists researchers to comprehend and extend their knowledge of the phenomenon under study (Polit & Beck 2008:105). In this study, then, the literature review covered the Health Belief Model (HBM), HIV/Aids prevention, and factors that influence safer sex practices.

2.2 PURPOSE AND SCOPE OF THE LITERATURE REVIEW

The purpose of a literature review is “to determine the extent to which the topic under study is covered in the existing body of knowledge” (Babbie & Mouton 2001:565). Burns and Grove (2003:110) point out that a literature review assists researchers to direct the development and implementation of a study. The literature review familiarised the researcher with the HBM; research design and methodology, and what was known and unknown about safer sex practices. The researcher was motivated to conduct the study to identify the knowledge gap on safer sex practices in order to make a contribution to HIV prevention through sexual contact.

2.3 HEALTH BELIEF MODEL (HBM)

The researcher selected the HBM as the theoretical framework for this study (Stanhope & Lancaster 2000:271). The HBM explains and predicts health behaviour that helps individuals perceive vulnerability to disease and the benefits of adopting the desired behaviour. It also assumes that people take recommended health-related actions if they expect to avoid a negative health condition and if they believe they can successfully undertake the recommended health action (Stanhope & Lancaster 2000:271).

Regarding the use of preventive health services, Clemen-Stone, McGuire and Eigsti (2002:386) describe the HBM as “a single model with components that interact to explain health behaviour”. The researcher considered it appropriate to adopt the HBM as a framework to study factors influencing safer sex practices because it could help the development of effective behaviour change and persuasive health messages to prevent HIV/Aids.

2.3.1 Components of the HBM

According to Stanhope and Lancaster (2000:271), the three main components of the HBM are “individual perceptions, modifying factors, and variables affecting the likelihood of action”. Figure 2.1 illustrates the HBM conceptual model. The figure shows that individuals’ perceptions (beliefs about susceptibility and seriousness of disease) influence the perceived threat of illness and the importance of health to them. In this study, the researcher used the HBM to explain why literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi took action to prevent the transmission of HIV/Aids. This would indicate factors that influenced safer sex practices in Malawi in order to enable policy makers and health care providers to implement strategies to complement the existing HIV/Aids behavioural change programmes in Malawi.

Modifying factors such as demographic variables (age, gender, marital status, religion, education), socio-psychological variables (personality, culture, peer pressure), structural variables (knowledge about the disease, availability of Voluntary Counselling and Testing services [VCT], prior contact with the disease), and cues to action (education, symptoms, media information) may also influence the perceived threat of the disease as well as the likelihood of behavioural change. Variables that could affect the likelihood of practising safer sex are perceived benefits of the action, such as good health. Resistance to change could manifest if there were dominant barriers to behavioural change, such as men’s cultural dominance in sexual matters, and gender-based violence (Stanhope & Lancaster 2000:271).

Cues to action and self-efficacy are additional factors that respectively activate the “readiness to act” in order to stimulate the overt behaviour and assist people to successfully avoid HIV/Aids infection (Stanhope & Lancaster 2000:271). According to

Clemen-Stone et al (2002:386), cues to action “provide suggestions on how to trigger health action” and therefore might help to motivate individuals to take preventive health measures. Sources of such cues include public and media information, health education, environmental events, and bodily changes associated with HIV/Aids. In this study, self-efficacy was demonstrated when individuals successfully practised safer sex, which was the required behaviour in order to prevent new HIV infection or spreading the infection.

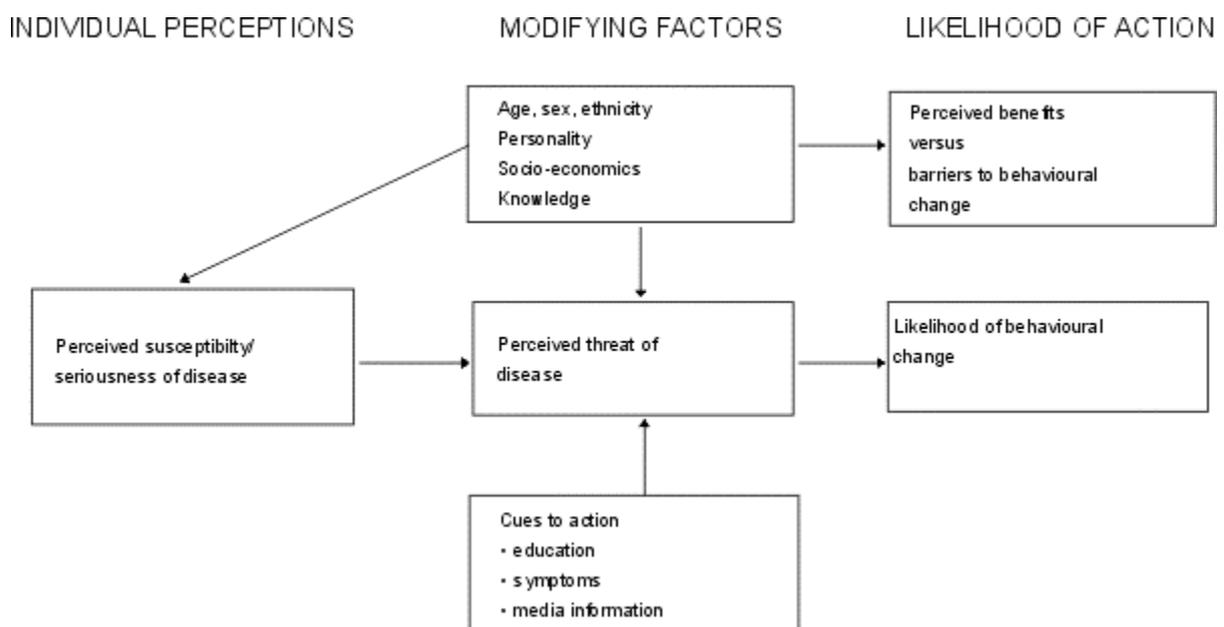


Figure 2.1 Health Belief Model
(Glanz, Reimer & Lewis 2002:52)

In this study the use of the model “helped to identify important factors that influence behavioural change” (Clemen-Stone et al 2002:387). The factors involved were perceived susceptibility, perceived severity, benefits and barriers, cues to action, and self-efficacy. The study assumed that individuals would be motivated to protect themselves against HIV and Aids by opting to practise safer sex depending on several factors guided by the HBM. Depending on the perceived susceptibility and seriousness of HIV/Aids, individuals were likely to be motivated to practise safer sex or even abstain from unprotected sex by weighing the benefits against the risk of acquiring HIV and subsequently developing Aids. Individuals would only reach readiness to practise safer sex after overcoming the barriers that would otherwise hinder them from making the

desired decision. At the same time, however, individuals' demographic variables, personality, social class, peer and reference-group pressure, knowledge and prior contact with the disease, attitude towards use of condoms, could modify such a decision. Modifying factors are likely to play a role in influencing individuals' perception of susceptibility, severity, barriers and benefits of adopting the desired action to prevent HIV/Aids.

Clemen-Stone et al (2002:386) emphasise that "cues to action provide suggestions on how to trigger health action". The cues to action could be internal, such as perception of Aids as a health problem, or external reminders, such as the sight of an AIDS-afflicted individual as well as messages from the media (electronic and print). Individuals' self-efficacy focuses on their ability to carry out safer sex practices. Furthermore, the "most promising application of the HBM is for helping develop messages that are likely to persuade individuals to make healthy decisions" (Clemen-Stone et al 2002:387).

2.3.2 Factors influencing safer sex practices

The chief factors influencing safer sex practices in Malawi and elsewhere were perceived susceptibility to HIV/Aids; perceived seriousness of HIV/Aids; perceived barriers to engaging in safer sex practices; cues to promote safer sex practices, and self-efficacy in safer sex practices.

2.3.2.1 *Perceived susceptibility to HIV/Aids*

According to UNAIDS (2002:25), the principal factor influencing the spread of STIs, HIV and subsequently Aids in Africa is sexual behaviour (over 90%), which varies greatly across cultures, age groups, socio-economic class and gender. The sexual transmission of HIV occurs between spouses, casual or secondary relationships, sex workers and clients, and homosexuals. UNAIDS (2000:5) attributes the spread of HIV/Aids in Africa to environmental, economic and social factors including gender inequality and poverty. For example, women are generally not empowered to negotiate for safer sex, and their vulnerability is compounded by lack of accessibility to reproductive health services and control over their reproductive health.

In the United States of America (USA), Black and Hispanic women accounted for 81% of the women living with HIV/Aids who had acquired it through high-risk heterosexual contact. Inadequate HIV knowledge; lower perception of risk; drug or alcohol abuse, and different interpretations of safer sex exacerbated the situation. Women were significantly more likely than men to acquire HIV during vaginal intercourse and the presence of STIs greatly increased their susceptibility (CDC 2008:3-4.)

According to the MDoS (2005:200-201) a high rate of high-risk sex between partners other than spouse or cohabitating partner have been found. Fewer women (30%) than men (47%) reported condom use. Regarding where to obtain condoms, 77% of women and 88% of men aged 15 to 24 knew where they could get male condoms (MDoS 2005:212). This indicated that men were more empowered than women to opt for safer sex and an enormous percentage of pre- or extra-marital sex was unprotected in Malawi. UNAIDS (2002:25) points out that STIs enhance the risk of sexual transmission of HIV. The vulnerability of women to other STIs that are symptomatic in men but asymptomatic in women further enhances the risk of HIV infection. The asymptomatic STIs remain untreated while creating a favourable port of entry for HIV when unprotected sexual intercourse takes place (UNAIDS 2002:25).

In South Africa, Cullinan (2003:72) found a significant increase between 1998 and 2003 in people practising safer sex, women who had no current sexual partner, and condom use. For women aged 15 to 49, condom use at last intercourse had tripled from 8% in 1998 to 29% in 2003 and increased from 14% to 47% among women aged 20 to 24. Of those who were sexually active, 85% had had only one partner in the past year. The behaviour changes because of HIV/Aids included staying faithful to one partner; condom use; sexual abstinence; and reducing the number of sexual partners. Females accounted for 12.8% and males for 9.5% of the HIV-positive respondents. Among those aged 15 to 24, 12% of females and 6% of males had tested positive. This clearly indicated that it was possible to practise safer sex if people perceived HIV/Aids to be a threat to their life (Cullinan 2003:72).

In 2001, Smith and Watkins (2004:649-660) conducted a study in rural Malawi on changes in perceived risk of contracting HIV/Aids. The study found that Malawians worried less about contracting HIV/Aids in 2001 than in 1998, and married Malawians frequently discussed HIV/Aids and strategies to prevent it. Furthermore, women

worried most about their husbands as possible sources of infection, discussed the importance of avoiding infection with them, and increasingly used divorce to reduce their risk. Men worried most about their extra-marital partners and adopted strategies such as fewer partners and more careful partner selection. The perceived risk was significantly associated with a decline in the behaviours that Malawians worried most about and perceptions of risk in individuals' social networks. These findings indicated that Malawians were changing their behaviour in ways that might reduce the spread of HIV/Aids (Smith & Watkins 2004:660).

2.3.2.2 Perceived seriousness of HIV/Aids

In 2001, Aids was seen as a disaster for human life and expected to continue as a challenge to health and development. Between 2001 and 2003, the global HIV prevalence increased from 35 million to 38 million with about 25 million in Sub-Saharan Africa (UNAIDS 2004:3). Malawi, situated in this region, is also severely affected by the epidemic with a prevalence rate of 14.4% in a population of about 12 million people (NAC 2003c:1).

In a study on Malawians' cultural practices that promote positive living among people living with HIV/Aids, Jana (2003:14) found that people in the Chewa, Yao, Tumbuka, Sena and Lomwe tribes in the respective districts of Dowa, Machinga, Mzimba, Chikwawa and Thyolo in Malawi admitted that HIV/Aids was a serious problem largely because it has no cure. The main effects of HIV were increasing *orphanhood* and *development going down* (Jana 2003:14):

We know that AIDS is dangerous mainly because it has no cure. It kills; when you contract it, you die. We therefore spread this word to everybody in this village reminding each other of the danger of AIDS.

AIDS is troubling so much. When you contract it, you suffer from a lot of disease, and you just notice your body wearing out, and there is no cure. It is troubling so much.

To add on to that, I should make one comment, hmm, when a person contracts AIDS in a community, developmental activities are slowed

because instead of going to gardens, they go to attend to the sick person. When he dies, he might leave behind children and this also is increasing the number of orphans.

2.3.2.3 Perceived benefits of engaging in safer sex practices

In Cape Town, South Africa, Mathews, Aaron, Flisher, Mukoma, Wubs and Schaalma (2008:1-10) investigated the effect of a school-based HIV prevention programme among Grade 8 students. At baseline, 1 440 students were virgins but 15 months later, 1 144 remained virgins while 296 (20.6%) reported having had their first sexual intercourse. The study found that “transition to first sexual intercourse was more likely among males than females, among the older students and among students with lower socio-economic status” (Mathews et al 2008:9). Factors significantly associated with the transition to first sexual intercourse were intention to have sexual intercourse, poor self-efficacy to negotiate delayed sex, and intimate partner violence. Mathews et al (2008:1-10) emphasise that to be effective, interventions need to address the factors that influenced young adolescents’ transition to first intercourse.

The researcher is of the opinion that Malawi with its high HIV and STI rates could learn from these studies.

2.3.2.4 Perceived barriers to engaging in safer sex practices

In the USA, Graham, Crosby, Yarber, Sanders, McBride, Millhausen and Arno (2006:255-260) assessed the prevalence of condom-associated erection loss and identified correlates of erection loss among 278 men attending an STI clinic. The study collected data on erection loss only from men who had used condoms during penile-vaginal sex at least three times in the three months prior to the study. The mean age of the respondents was 23.7 years (s.d.=4.1). Condom-associated erection loss not associated with age and race/ethnicity was reported by 37.1% of the men on at least one occasion. More frequent unprotected vaginal sex ($P=0.04$) was reported among the men who had reported condom-associated erection loss and used condoms less consistently ($P=0.014$) than those who had had no erection loss. The men with erection loss also removed the condoms before sex was over ($P=0.001$) than those who did not lose erection. Three significant statistical predictors were identified, namely low self-

efficacy to use condoms ($P=0.001$); problems with 'fit or feel' of condoms ($P=0.005$), and having more than three sex partners during the previous 3 months ($P=0.02$). The findings indicated that men at risk for STIs commonly had condom-associated erection loss that could lead to incomplete or inconsistent condom use. Graham et al (2006:260) found that more men who lacked confidence in correct condom use, had problems with the fit or feel of condoms, and had sex with multiple partners, experienced condom-associated erection loss.

Women's power to negotiate the use of condoms, discuss fidelity with partners or leave risky relationships is limited due to their low economic and social status (UNAIDS 2002:65). Such disempowerment increases women's vulnerability to HIV/Aids. In a study conducted in 2000 in Kenya the reasons why women and men enter into cross-generational relationships; their perceived risks of such relationships; and relationship dynamics have been studied (Longfield, Glick, Waithaka and Berman 2002:4). Financial gain was the biggest incentive for young women to have relationships with older men. The young women actively sought partners willing to spend on them and often initiated relationships with older men. Peer pressure to "fit in" and family pressure to obtain financial support compelled women to engage in these relationships. The older men perceived sexual gratification as the major incentive for pursuing younger partners.

Longfield et al (2002:1-20) found that most of the participants under-estimated the risk of STIs and HIV. The women assessed the risk of STI and HIV as minimal, assuming that older men were non-promiscuous and remained faithful to younger partners and their wives. The men gave STI and HIV the lowest priority, perceiving young women to be less risky partners because they were innocent and sexually inexperienced. General obstacles to condom use were females' embarrassment to buy and carry condoms and doubts about the effectiveness of condoms. It was also noted that the young women were often unable to negotiate for condom use with their older, more dominant partners who insisted on not wearing them. The men accused the women of not trusting them and threatened to abandon the relationship if they insisted on condom use. Most of the participants concurred that men disliked condoms and believed they reduced sexual pleasure. The participants attributed low condom use to couples' misconception that cross-generational partners were not risky (Longfield et al 2002:1-20).

A primary school survey on the knowledge, attitudes and practices of primary school youth related to sexual and reproductive health in Malawi (PSI Malawi 2003:1) found that:

- The mean age at first sex was 14 years and 6% of the pupils were sexually active.
- Many of the pupils had used a condom during sex at some time and several had used a condom during their last sexual intercourse.
- The majority knew that abstinence was related to not having sex but were confused as to whether abstinence meant not or never having sex.
- Many of the female pupils had received gifts or money in exchange for sex.
- The most common reasons for not using a condom during sex were that they did not know how to use one and inability to get a condom.

The findings indicated clearly that the youth did not have adequate knowledge of safer sex practices and were not empowered to avoid possible HIV infection from casual sex (PSI Malawi 2003:1).

Chirwa, Gondwe and Ngwata (2002:1-41) investigated factors contributing to the prevalence of HIV/Aids in the Malawi Defence Force (MDF) and its impact on the organisation. The study established that 99% of the service members, their spouses and civilian employees were aware of HIV/Aids through the radio and friends. The main mode of HIV transmission was believed to be through sexual contact. The majority (85%) of the respondents were aware that HIV/Aids had no cure but only 58% mentioned that soldiers and their spouses talked about safer sex and HIV prevention. Although the majority of the MDF servicemen knew how to avoid contracting HIV/Aids, their sexual behaviour did not portray the same. Chirwa et al (2002:39-41) found that some soldiers knowingly indulged in sexual relationships with widows or widowers whose spouses might have died of HIV/Aids-related diseases. A belief that soldiers are expendables, encouraged casual sex during peace time and promoted fear of bullets during war rather than HIV/Aids. Nevertheless, the respondents indicated that abstinence, faithfulness and condom use were methods to prevent HIV/Aids. Most of the respondents felt that condom use encouraged promiscuity and possession of condoms created the impression that an individual already had plans to have sex at any time.

2.3.2.5 Cues promoting safer sex practices

In 2001, Zacchariah, Spielmann, Harries, Behendwa and Chingi (2003:88-91) explored the motives, sexual behaviour, and risk factors associated with HIV in individuals seeking Voluntary Counselling and Testing (VCT) for HIV in Thyolo, a rural district in Southern Malawi. The study found that the individuals had sought VCT for the following reasons: recent knowledge of HIV/Aids and a desire to know their HIV status; repeated illness and suspicion of Aids; a suspicion that their partners had practised unprotected sex outside their relationship, and encouragement to undergo VCT by others who already knew their sero-status. The majority indicated that they regularly had sex and many engaged in unprotected sex. The HIV prevalence was 31% and most of the respondents were females and over the age of 25 years (Zacchariah et al 2001:88-91). UNAIDS (2000:5) stresses that the spread of HIV/Aids in Africa is due mainly to factors like gender inequality and poverty. Women are generally not empowered to negotiate for safe sex, lack access to reproductive health services and control over their reproductive health rights. VCT could be an entry point for the prevention of HIV and care for those already infected. HIV-negative individuals could take measures to remain uninfected, such as safer sex practices, and HIV-positive individuals could protect their partners from becoming infected too.

2.3.2.6 Self-efficacy in safer sex practices

In rural Malawi, Smith and Watkins (2004:649-660) investigated changes in the perceived risk of contracting HIV/Aids and established that the respondents' social networks promoted discussion of HIV/Aids and provided a mechanism for identifying sources of HIV risk. Rural Malawians were perceived to identify and evaluate potential ways of contracting HIV, sources of personal risk, and acceptable strategies for avoiding infection. The social networks also served as a context for collectively formulating strategies to avoid infection (Smith & Watkins 2004:654).

To further control HIV/Aids, the National AIDS Commission (NAC) (2003b:17) developed a BCI strategy intended to empower the Malawian nation to develop or maintain safer SRH practices in an environment that is stigma free and gender transformative. The BCI strategy emphasised delay of first sexual intercourse until

adulthood; reduction of multiple sexual partners; correct and consistent use of condoms for cohabitating and non-cohabitating partners, and other safer sex practices.

2.4 CONCLUSION

This chapter discussed the literature undertaken for the study. The literature emphasised that HIV/Aids is a global problem and Sub-Saharan Africa, including Malawi, is the worst hit region. The review covered the HBM, HIV/Aids prevention, and factors that influence safer sex practices.

Chapter 3 describes the research design of the study.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

The literature review for this study covered HIV/Aids as a global problem, factors influencing safer sex practices, and the Health Belief Model (HBM) (see chapter 2).

This chapter describes the research design and methodology, including the population, sampling and sample, data collection and analysis, validity and reliability, and ethical considerations.

3.2 RESEARCH DESIGN

A research design is an overall plan for obtaining answers to research questions (Polit & Beck 2008:66). It is a blueprint or plan to direct the conduct of a study in order to maximize control over factors that would interfere with the study's desired outcome. The purpose of the design is to maximise the possibility of obtaining valid answers to research questions or hypotheses. "A good design provides the subjects, setting, and the protocol, within which these comparisons can be clearly examined" (Burns & Grove 2005:228).

Burns and Grove (2005:211) point out that by "using the problem statement, framework, research questions, and clearly defined variables, the researcher can map out the design to achieve a detailed research plan for data collection and analysis". In this study, a quantitative, explorative, descriptive study was conducted to identify, analyse and describe factors that influenced safer sex practices in Malawi.

3.2.1 Quantitative

Cormack (2000:19) describes quantitative research as "a formal, objective, systematic process for obtaining quantifiable information about the world, presented in numerical form and analysed through the use of statistics". This study quantified the factors

identified to influence safer sex practices in Malawi using the HBM as a framework for collecting data. According to Polit, Beck and Hungler (2001:19), quantitative description involves the prevalence, incidence, size and measurable attributes of a phenomenon. A statistician collated and analysed the data using the Statistical Package for Social Sciences (SPSS) program, version 15. The results were presented in frequencies, percentages, graphs and tables.

A quantitative approach was suitable for this study for the following reasons (Neil 2007:1):

- The researcher knew clearly in advance what the study was investigating, namely factors influencing safer sex practices.
- All aspects of the study were carefully designed before data was collected.
- The researcher collected data in the form of numbers and statistics using a questionnaire.
- The researcher classified features and counted them utilising SPSS, in an attempt to explain the results from a formally structured questionnaire.
- Quantitative research seeks precise measurement and analysis of target concepts.
- The researcher remained objectively separated from the subject matter. In this study, objectivity was maintained as all the data was collected using a copy of the same questionnaire per individual respondent.

3.2.2 Explorative

According to Polit and Beck (2008:20), exploratory research begins with a phenomenon of interest and investigates the full nature of the phenomenon, the manner in which it is manifested and other factors to which it is related. Exploratory studies are designed to increase the knowledge of a field of study of which not much is known and are not intended for generalisation to a large population (Burns & Grove 2005:357). This study explored factors that promoted or hindered safer sex practices in Malawi, as well as different aspects of safer sex practices and related factors. The results were not meant for generalisation to a large population, but to increase the knowledge and provide a better understanding of the factors influencing safer sex practices in a selected population in Malawi.

3.2.3 Descriptive

According to Burns and Grove (2005:232), descriptive research provides a picture of a situation as it naturally happens. The design “may be used for the purpose of identifying problems with current practice, justifying current practice, making judgments, or determining what others in similar situations are doing” (Burns & Grove 2005:232 citing Waltz & Buell 1981).

Polit and Beck (2008:274) point out that descriptive studies observe, describe, and document aspects of situations as they naturally occur and sometimes are starting points for hypothesis generation or theory development. The study therefore investigated what other countries with similar situations were doing to control HIV/Aids. In a descriptive study, Kuntolbutra and Khamboonruang (1998:F29-F36) examined and found a decreasing incidence of HIV and STD among young men in military service in Northern Thailand, which indicated the success of the HIV/Aids control and prevention programme.

In this study, a descriptive approach was used to document the natural occurrence of the situations influencing safer sex practices, and identify a problem with the current practice, namely why Malawians still practised unsafe sex although NAC (2003c:1) found that the majority knew how to prevent HIV infection. Factors influencing safer sex practices were also investigated to create evidence-based knowledge in nursing. Descriptive statistics were used to summarise the demographic characteristics of data in the form of frequency distributions and percentages.

3.3 PURPOSE AND OBJECTIVES

The purpose of the study was to identify the factors associated with safer sex practices in Malawi. The researcher used the HBM as the theoretical framework for the study. The study was conducted in nine districts in the Northern, Central and Southern regions of Malawi, which were operational sites for CHRR, the researcher’s employer. The respondents were identified from the villages under the jurisdiction of two T/As in each of the CHRR’s operational districts. The research objectives and questions guided data collection. In order to achieve the purpose, the study sought to explore and describe:

- The perceived susceptibility and the seriousness of HIV/Aids in the community.
- Factors that influenced modifying factors for self-protection.
- The perceived benefits of practising safer sex by the community.
- The perceived barriers to risk reduction behaviour in the community.

3.4 RESEARCH POPULATION AND SAMPLE

Burns and Grove (2003:43) define a population as “all elements that meet certain criteria for inclusion in a study”. A research population is the entire aggregation of cases in which a researcher is interested. It is all the elements (individuals, objects, events, or substances) that meet the sample criteria for inclusion in a study (Polit & Beck 2008:274).

3.4.1 Population

The population considered in this study consisted of sexually active men, women, boys and girls who participated in the CHRR community awareness activities in the following districts in Malawi: Chitipa, Karonga, Salima, Dedza, Mchinji, Lilongwe, Mangochi and Zomba. The eight districts selected were the CHRR’s operational area. The people living in the villages under the following T/As were included: Mwenemlambiya and Mwenemisuku in Chitipa, Kachere and Kasumbu in Dedza, Kyungu and Wasambo in Karonga, Chiseka and Kalolo in Lilongwe rural, Chitukula and Tsabango in Lilongwe urban, Mpondas and Nankumba in Mangochi, Mavwere and Mlonjeni in Mchinji, Kalonga and Khombedza in Salima and those from Chikowi and Mwambo in Zomba. Table 3.1 indicates the population and household consistency of these T/As. According to the Malawi 1998 census, the population in the CHRR catchment area was 1 075 616 which consisted of 231 407 households and formed 8.82% of the total population of Malawi that stood at 9.9 million people (Benson et al 2002:3-5).

Table 3.1 Population and household consistency

District	Traditional Authority	Population	Households
Chitipa	Mwenemlambiya	49 443	1 000
	Mwenemisuku	22 970	4 810
Dedza	Kachere	51 711	12 179
	Kasumbu	56 115	12 841
Karonga	Kyungu	46 063	2 554
	Wasambo	37 725	6 970
Lilongwe Rural	Chiseka	173 468	40 371
	Kalolo	104 939	23 451
Lilongwe Urban	Chitukula	21 900	4 824
	Tsabango	19 027	4 885
Mangochi	Mpondas	87 426	20 754
	Nankumba	79 419	19 248
Mchinji	Mawwere	68 202	16 000
	Mlonyeni	27 181	5 059
Salima	Kalonga	42 496	9 484
	Khombedza	45 765	11 269
Zomba	Chikowi	45 660	11 329
	Mwambo	96 106	24 379
Total		1 075 616	231 407

Adapted from Benson et al (2002:3-5).

3.4.2 Sampling

Sampling is “the process of selecting a portion of the population to represent the entire population” so that inferences can be made about the population (Polit & Beck 2008:339). The purpose of sampling is to increase the efficiency of a study by concentrating on a smaller number of subjects rather than the entire population.

A sample consists of “a subset of the units that comprise the population; it is the proportion of subjects selected from the accessible population from whom information for the study is obtained. A sample should be representative of the population from which it is selected to enable generalisation of findings to be made about that population” (Babbie & Mouton 2001:124).

Probability sampling increases the representativeness of a sample. In this study, a stratified random sample was selected since the researcher knew variables in the population that were critical for achieving representativeness of the sample (Burns & Grove 2003:242). Sampling or eligibility criteria are the characteristics essential for inclusion in the sample. The researcher therefore decides what attributes members of the sample should have to be considered for inclusion in the sample (Burns & Grove 2003:246). Accordingly, to participate in this study, the respondents had to be

- literate
- sexually active men, women, boys and girls
- from the CHRR operational sites
- willing to take part in the research

The sample consisted of six (6) people from each of the eighteen (18) T/As, giving a total of 108 respondents. The sample comprised 1.07% of the total research population. The respondents were selected at each site, by deliberately including men, women, boys and girls that were able to read and write, at least with Standard 5 education, since there was need for self-administration of the questionnaire. The sample was selected among the community members that had converged for HIV/Aids and Human Rights community awareness activities that CHRR conducted in its operational areas. The DCs, with the help of the volunteers in each T/A helped to identify the respondents that they knew had the required inclusion criteria, namely, literate and sexually active men, women, boys and girls between 15 and 49 years of age who were resident in CHRR operational sites. Only those willing to participate in the study were included. Where the participants exceeded the required number to participate, the males and females were picked up by secretly picking a folded piece of paper indicating “yes” or “no”. the “yes” were finally chosen to participate in the study.

3.5 DATA COLLECTION

Data collection is “the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study” (Burns & Grove 2005:42). Data was collected in Chitipa, Dedza, Karonga, Lilongwe Rural, Lilongwe urban, Mangochi, Mchinji, Salima and Zomba using a structured approach.

The researcher used District Coordinators (DCs) who coordinate district activities for the CHRR, the researcher's employer, as research assistants. Their role included mobilising community members in their respective districts with the help of the CHRR community coordinators and traditional leaders. Before data collection, the researcher trained all nine DCs to administer the questionnaire (see annexure E) in places where the researcher was not available to supervise the data collection. Twenty questionnaires were distributed to each DC for data collection in their respective districts.

All nine districts were visited over a period of three weeks. At each site, community coordinators and traditional leaders facilitated community awareness activities while the researcher or the district coordinator purposefully identified men, women, boys and girls to complete the questionnaires. The nature and purpose of the study was explained to the respondents and they were assured of anonymity and confidentiality. After clarifying the instructions for completing the questionnaire, the respondents were allowed to complete the self-administered questionnaire. The researcher or assistant researcher gathered the completed questionnaires.

3.6 DATA-COLLECTION INSTRUMENT

A structured data-collection approach was adopted, using a questionnaire (see annexure F). The structured approach was chosen because it "yields data that is easy to analyse and does not require much effort from the respondents" (Polit & Hungler 1997:202). The respondents had to complete the questionnaires themselves in a paper-and-pencil format and were asked the same questions in exactly the same order with the same set of options for their responses (Polit et al 2001:267).

The researcher developed the questionnaire based on the HBM tenets. The questionnaire contained both closed-ended and open-ended questions that served as a guide to ensure uniformity and easy flow of questions for all the respondents. Open-ended questions allowed the respondents to respond to questions in their own way while closed-ended questions provided specified response options (Polit et al 2001:267).

The questionnaire was divided into seven (7) sections. Section 1 covered the respondents' demographic data likely to influence sexual behaviour, including age, gender, area of residence, marital status, religion and age at menarche.

Section 2 explored the respondents' knowledge of the perceived susceptibility to HIV infection that influenced decision for self-protection. This section investigated the respondents' age at sexual debut, external influences for the sexual debut, influence of STIs on acquisition of HIV infection, perception of their own susceptibility to Aids, and knowledge of spread of HIV.

Section 3 explored the respondents' knowledge of HIV/Aids that determined perceived seriousness of Aids and influenced decision for self-protection. This section covered the respondents' knowledge of someone with Aids, the spread of HIV and the adverse effects of Aids on development, perception of the seriousness of Aids, and personal sexual practices.

Section 4 determined how the respondents perceived benefits of engaging in safer sex practices (see annexure F). This section explored condom use with sexual partners, number of sexual partners, situations warranting safer sex, perceived benefits of condom use, and attitudes towards their own and other people's health.

Section 5 explored the respondents' perceived barriers to safer sex practices, including beliefs about condom use, problems associated with condom use, limiting factors for practising safer sex, gender issues in safer sex practice, and socio-cultural issues influencing sexual practices.

Section 6 determined cues to action for safer sex practices, including sources of HIV prevention messages, community support in HIV prevention, and institutional support in HIV prevention.

Section 7 determined self-efficacy in safer sex practice and considered safer sex practices, how HIV is known in absence of symptoms, and self-confidence in condom use.

3.6.1 Advantages of questionnaires

Burns and Grove (2003:289) list the following advantages of questionnaires:

- Complete anonymity is permitted.
- They require less time to administer and are less costly.
- There is less chance of bias than in an interview.

3.6.2 Disadvantages of questionnaires

At the same time, Polit and Beck (2004:356) refer to the following disadvantages of questionnaires:

- Misinterpretation of questions by respondents could lead to false conclusions.
- There is a lower response rate than other forms of data collection.
- Respondents might fail to answer all the questions if the questionnaire is too long, thus compromising the validity of the instrument.

3.7 PRE-TEST

A pre-test is a trial run to determine whether the instrument is clearly worded and free from major biases and whether it solicits the desired information (Brink et al 2006:94). It provides an opportunity to try out the technique or instructions that will be used with an instrument, especially if the instrument has not been used with a specific population, as in the case of this study. The research instrument was pre-tested to assess the content validity. Polit and Beck (2004:361) point out that a “pre-test should be administered to individuals who are similar to actual participants”. In this study, ten respondents from T/A Kalonga in Salima district who were not included in the main study participated in the pre-test.

The researcher pre-tested the instrument to

- check the content validity and reliability of the instrument
- identify any questions that respondents found objectionable or offensive

- determine the time required to administer the questionnaire
- identify questions they might find difficult to read or understand, or might misinterpret

After pre-testing the questionnaire, the researcher made the necessary amendments. The questionnaire took an average of one hour to complete and the respondents did not find the questions offensive. The final amended questionnaire was better organised and easier to complete.

3.8 VALIDITY AND RELIABILITY

The quality of research is determined by its validity and reliability. In this study, the researcher adhered to the principles of reliability and validity. According to Burns and Grove (2005:214) “study validity is a measure of the truth or accuracy of a claim”.

Validity and reliability were maintained by utilising the same research instrument and questionnaire, to collect data in all the research sites and comparing the consistency of the responses obtained from the pre-test to those from the main study.

3.8.1 Validity

Burns and Grove (2003:45) describe validity as “the extent to which the instrument actually reflects or measures what it is supposed to measure.” This study intended to explore factors influencing safer sex practices. Polit et al (2001:308) describe validity as “the degree to which the instrument measures what it is supposed to be measuring.” The study ensured content and external validity.

3.8.1.1 Content validity

Content validity refers to “the extent to which the method of measurement includes all the major elements relevant to the concept being measured” (Burns & Grove 2003:274). In order to check for content validity, the researcher constructed the questionnaire utilising items from the literature review and based on the HBM theoretical framework. In addition, the researcher had a rich firsthand knowledge of the

domain. The items included factors that influenced safer sex practices and contentious issues identified in the literature review.

The researcher submitted the questionnaire to the study supervisors and colleagues with expertise in research for comment. The questionnaire was subsequently altered according to their feedback and ambiguity eliminated. A statistician was consulted to ascertain whether the questionnaire was appropriately structured and sufficiently comprehensive to determine factors that influence safer sex practices in Malawi. Where necessary, questions more specific were added to ensure adequate exploration of the research problem.

3.8.1.2 External validity

Polit et al (2001:194) refer to external validity as the generalisability of the research findings to other settings or samples. In this study, the researcher ensured external validity as follows:

- All the respondents used the same questionnaire.
- The selected sample included men, women, boys and girls in the reproductive age group.
- Data collection was conducted in similar settings where all the respondents had converged to attend the CHRR's community awareness activities.
- All eight operational districts within the researcher's employment catchment area were included in the study.
- The sample included six people from each of the eighteen T/As and a total of 108 respondents were selected from the districts under study.

3.8.2 Reliability

Reliability is "the degree of consistency or dependability with which the instrument measures the attribute it is designed to measure. If the instrument is reliable, the results will be the same each time the test is repeated" (Polit & Hungler 1997:308).

Reliability of a measure denotes how consistently the use of a particular instrument measures the concept of interest. The measure is reliable if the same results are given

each time the same situation is measured (Burns & Grove 2005:215). In this study the researcher ensured reliability by pre-testing the questionnaire and exposing all the respondents to the same questions (Burns & Grove 2005:374).

3.9 DATA ANALYSIS

A statistician collated and analysed the data using the Statistical Package for Social Sciences (SPSS) program, version 15. A wide range of analysis and statistical tests including frequency distribution and central tendency were conducted and the results represented in tables, pie graphs and diagrams to visualise and summarise the empirical information. Polit et al (2001:331) point out that statistical procedures enable researchers “to summarise, organise, interpret and communicate numerical information”.

3.10 ETHICAL CONSIDERATIONS

The goal of ethics in research is to ensure that no one is harmed or suffers adverse consequences from research activities. Accordingly, the researcher obtained permission to conduct the study, observed scientific honesty, and respected the respondents’ right to self-determination, anonymity and confidentiality (Burns & Grove 2005:196).

3.10.1 Permission

To ensure that the rights of the participating institutions were protected, permission to conduct the study in Malawi was sought and obtained from the National Health Sciences Research Committee (see annexure B and C). Permission to conduct the study in each of the eight districts under study was also sought from the District Commissioners (see annexure D) as a courtesy gesture to officially inform them that such a study was underway. The permission from the National Health Sciences Research Committee to conduct the research was at a higher level than at district level. The DCs verbally consented telephonically just to acknowledge that they were aware of the study in their area of jurisdiction.

3.10.2 Scientific honesty

Researchers are responsible for monitoring the integrity of their research protocols, results and publication (Burns & Grove 2005:218). The researcher maintained scientific honesty and integrity by discussing all findings honestly and correctly and keeping all the data on the personal computer to be monitored at any time. Moreover, the researcher undertook not to deviate from the original findings when writing an article on the research for publication.

3.10.3 Self-determination

The respondents' right to self-determination was ensured by explaining the purpose of the study and its contribution to public health to them; obtaining their informed consent, and emphasising that participation was free and voluntary, and that they had the right to withdraw from the study at any time without penalty (Burns & Grove 2005:186). The respondents then signed a consent form to participate in the study (see annexure E).

3.10.4 Anonymity and confidentiality

Anonymity means that the researcher cannot trace the data to specific subjects (Brink et al 2006:51). The respondents were instructed not to write their names on the questionnaires to protect their anonymity. Only protected code numbers were entered onto each questionnaire to facilitate proper analysis (Burns & Grove 2005:188).

Confidentiality entails that information provided by respondents will not be divulged or made available to any other person. The completed questionnaires were kept safely locked in a cabinet to which only the researcher had access. The researcher kept the computer database in a personal computer with a confidential password.

3.11 CONCLUSION

This chapter described the research design and methodology, including the population, sample, data collection, data-collection instrument, validity and reliability, and ethical considerations.

Chapter 4 discusses the data analysis and interpretation.

CHAPTER 4

Data analysis and interpretation

4.1 INTRODUCTION

This chapter discusses the data analysis and interpretation. The purpose of the study was to explore and describe the factors associated with safer sex practices in Malawi. The study also identified factors that promoted unsafe sexual practices. Consequently, the study needed to answer the following questions:

- How did the respondents perceive their susceptibility to HIV/Aids?
- How did the respondents perceive the seriousness of HIV/Aids?
- What influenced the respondents' modifying factors for self-protection?
- How did the respondents perceive the benefits of practising safe sex?
- How did the respondents perceive the barriers to risk reduction behaviour?

The researcher selected a stratified random sample of six (6) people from each of the eighteen (18) T/As from the nine selected districts in the Northern, Central and Southern regions of Malawi, which were operational sites for the CHRR. A total of 108 respondents representing 1.07% of the total research population participated in the study, but only 106 questionnaires were completed.

4.2 DISCUSSION OF ANALYSED DATA

The data were analysed using the SPSS program, version 15. Data were collected by means of a questionnaire consisting of seven sections. The data analysis is discussed according to the sections of the questionnaire.

4.2.1 Respondents' demographic data (Section 1)

The respondents' demographic data included district of residence (see annexure F), T/A, age, gender, marital status, religion, qualifications and age at menarche. The analysis used frequencies, percentages and mean scores. The missing values were excluded from the calculation of valid percentages, but included for statistical purposes. The results were presented in tables, graphs and pie diagrams.

4.2.1.1 Respondents' district of residence (N=106) (Item 1.1)

Of the respondents, 12 each came from Dedza, Mangochi, Mchinji, Salima and Zomba (56.6%; n=60); n=11 each came from Chitipa and Karonga (20.8%; n=22), while the remaining 22.6% (n=24) came from Lilongwe as the district was divided into rural and urban areas for administrative purposes.

Table 4.1 Respondents' district of residence (N=106)

District	N	Percentage
Chitipa	11	10.4
Dedza	12	11.3
Karonga	11	10.4
Lilongwe	24	22.6
Mangochi	12	11.3
Mchiji	12	11.3
Salima	12	11.3
Zomba	12	11.3
Total	106	100.0

4.2.1.2 Respondents' traditional authority's location (N=106) (Item 1.2)

Malawi is divided into twenty-eight (28) districts for administrative purposes. Each district is further broken down into areas under the governance of T/As (paramount chiefs) that oversee and rule villages under chiefs and headmen. The T/As report to the DCs who are the head of administration at the district headquarters or District Assembly. The T/As fall under the jurisdiction of a district. In this study, 5.7% (n=6)

respondents were included from each of the following T/As: Mwenemlambiya in Chitipa; Kachere and Kasumbu in Dedza; Wasambo in Karonga; Chiseka, Kalolo, Chitukula and Tsabango in Lilongwe; Mpondas and Nankumba in Mangochi; Mawwere and Mlonyeni in Mchinji; Kalonga and Khombedza in Salima; Chikowi and Mwambo in Zomba, as well as 4.7% (n=5) respondents from Mwenemisuku in Chitipa and Kyungu in Karonga.

4.2.1.3 Respondents' ages (N=106) (Item 1.3)

The respondents were aged from 15 to over 51 years (see table 4.2).

Table 4.2 Respondents' age (N=106)

Age	Gender		N	Percentage
	M	F		
15-17	9	17	26	24.5
18-24	15	19	34	32.0
25-35	15	9	23	21.7
36-45	3	5	8	7.5
46-50	3	3	6	5.7
Above 51	2	0	2	1.9
Missing			7	6.6
Total	47	53	106	100.0

Of the respondents, 24.5% (n=26) were between 15 and 17 years old; 32.1% (n=34) between 18 and 24; 21.7% (n=23) between 25 and 35; 7.5% (n=8) between 36 and 45; 5.7% (n=6) between 46 and 50, and only 1.9% (n=2) were older than 51. In addition, 6.6% (n=7) did not indicate their age. Of the respondents, 43.4 % (n=46) had primary education (see table 4.3). The study deliberately targeted a sample of sexually active youth and adults whose HIV prevalence is the highest in Malawi with 12% of the population aged 15 to 49 living with HIV/Aids (MDoS 2005:230).

4.2.1.4 Respondents' gender (N=106) (Item 1.4)

Of the respondents, 44.3% (n=47) were males, 50.0% (n=53) were females, and 5.7% (n=6) did not specify their gender.

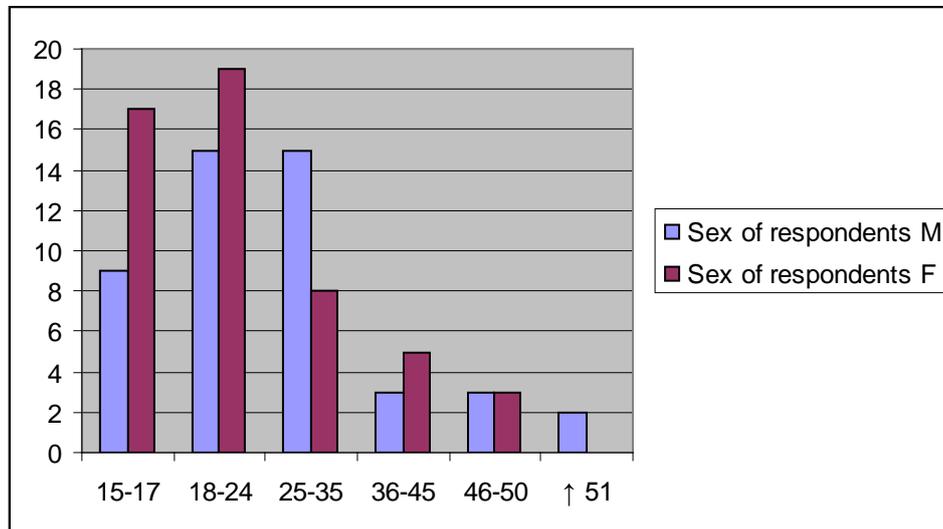


Figure 4.1 Respondents' age and gender (N=106)

Figure 4.1 presents the respondents' gender and age. More females were deliberately included in the study, but at the same time more females than males were available. The respondents included men, women, boys and girls to capture their views in recognition of the sensitivity of the sexual issue under study. The women were infected with HIV at an earlier age than the men, with an HIV prevalence of 4% of women aged 15-19 in comparison to less than 1% for men in the same age group. The HIV prevalence was 13% in women compared to 10% in men (MDoS 2005:230).

4.2.1.5 Respondents' marital status (N=106) (Item 1.5)

Of the respondents, 58.5% (n=62) were single; 26.4 % (n=28) were married; 6.6% (n=7) were divorced; 1.9% (n=2) were widowed, and 0.9% (n=1) was separated from his spouse (see figure 4.3). Six respondents (5.7%) did not answer the question.

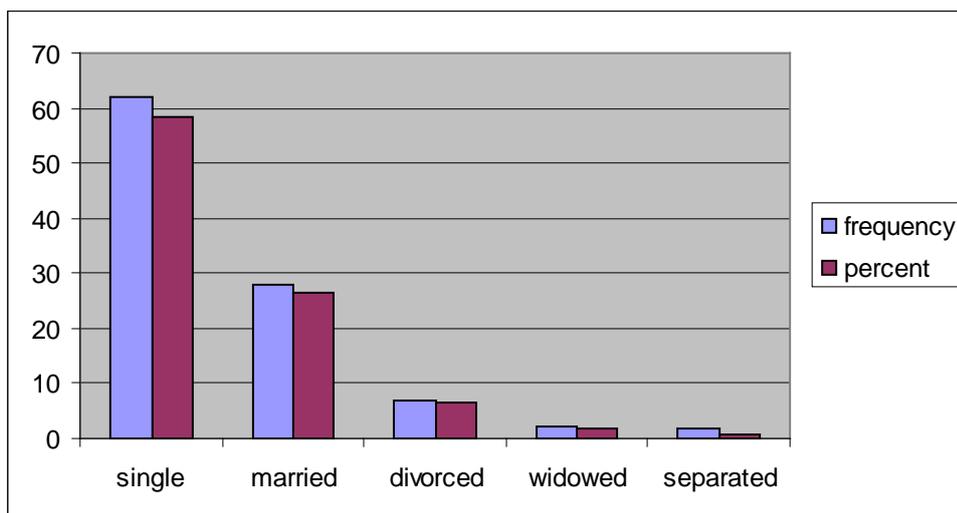


Figure 4.2 Respondents' marital status (N=106)

The divorced or separated men had higher infection rates than the married men. Those who had never been in a marital union had a lower prevalence rate of 2%. Of the respondents, 56.6% (n=60) were youths who were able to read and write and were also sexually active.

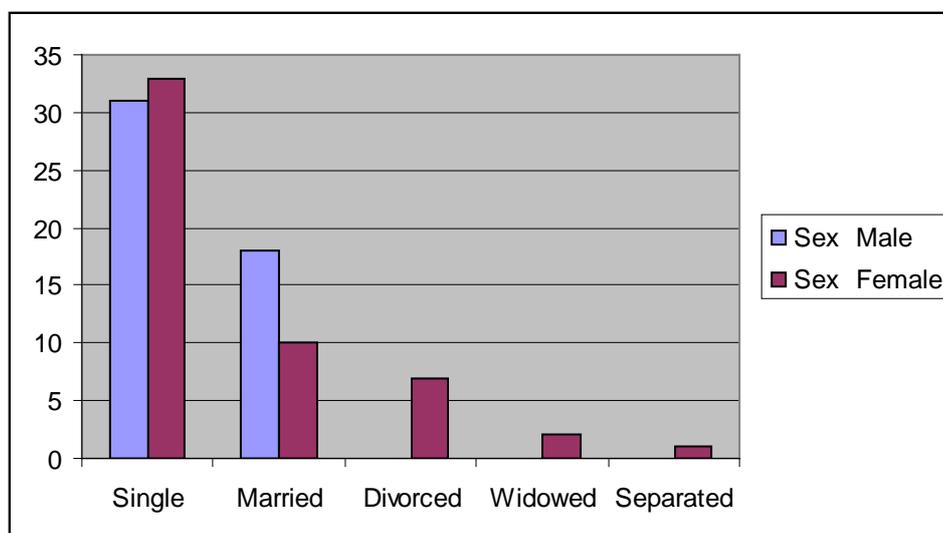


Figure 4.3 Respondents' gender versus marital status (N=106)

Of the respondents, 31.1% (n=33) females versus 27.3% (n=29) males were single; 9.4% (n=10) females versus 17% (n=18) males were married; 6.6% (n=7) females versus 0% (n=0) males were divorced; 1.9% (n=2) females versus 0% (n=0) males were widowed, and 0.9% (n=1) females versus 0% (n=0) males were separated (see figure 4.3). The MDoS (2005:234) found marital status related to HIV infection. Women who were no longer in a marital union (widowed, divorced or separated) had

significantly higher rates of HIV infection (37% and 26%, respectively) while women who had never been in a marital union had the lowest prevalence (5%).

4.2.1.6 Respondents' religious affiliation (N=106) (Item 1.6)

The majority of the respondents were Christians while the minority were Muslims (see figure 4.4). Of the respondents who were Christians, 38.7% (n=41) were Roman Catholics.

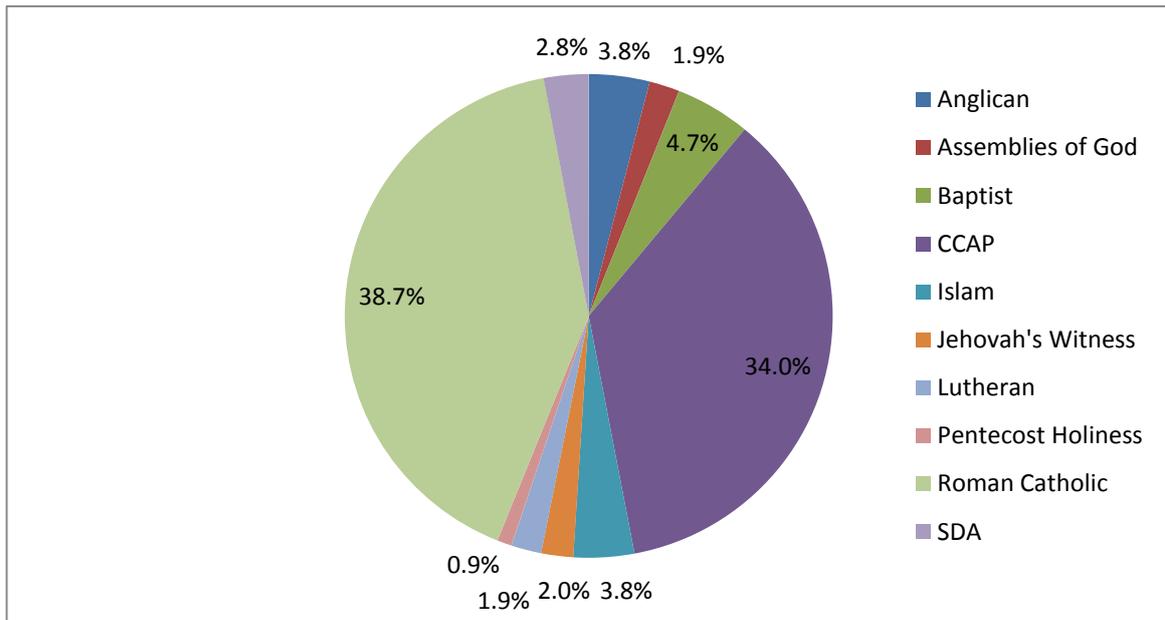


Figure 4.4 Respondents' religion (N=106)

In this study, the respondents had the following religious backgrounds: Roman Catholics 38.7 % (n=41), CCAP 34.0% (n=36), Baptist 4.7% (n=5), Anglican 3.8 % (n=4), Islam 3.8% (n=4), Seventh Day Adventist (SDA) 2.8% (n=3), Assemblies of God 1.9% (n=2), Jehovah's Witnesses 1.9% (n=2), Lutheran 1.9% (n=2), and Pentecost Holiness 0.9% (n=1). Six respondents 5.7% did not state their religious affiliation. Some religious leaders in Chitipa, Malawi, reportedly promoted unsafe sex through their opposition to condom use (Liwanda 2006:3). The researcher considered it important to know the respondents' religious affiliation in order to explore their vulnerability to unsafe sexual practices on religious grounds. According to MDoS (2004:233), HIV prevalence varies by gender across the religions with Anglican and Muslim women having the highest infection rate (18 and 17%, respectively). The SDA men had the highest HIV prevalence rate of 17%.

4.2.1.7 Respondents' educational levels (N=106) (Item 1.7)

The respondents were asked to indicate their educational level (see table 4.3).

Table 4.3 Respondents' educational levels (N=106)

Education level	Frequency	Percentage
Primary	46	43.4
Secondary	45	42.5
College	8	7.5
Missing	7	6.6
Total	106	100.0

Table 4.3 indicates that of the respondents, 43.4% (n=46) had primary education; 42.5% (n=45) had secondary education, and 7.5% (n=8) had tertiary education. The MDoS (2005:188) found “a strong association between the respondents' educational level and knowledge of AIDS prevention” with respondents with no education having less knowledge than those with secondary or higher levels.

4.2.1.8 Female respondents' age at menarche (n=53) (Item 1.8)

The age at which the female respondents started having their menstrual periods (menarche) varied. Of the respondents, 13.2% (n=7) started between 10 and 12 years old; 32.1% (n=17) started at 13 to 14; 50.9% (n=27) started at 15 to 16, and 3.8% (n=2) started at 17 to 19 (see table 4.4).

Table 4.4 Female respondents' age at menarche (N=53)

Age	Frequency	Percentage
10-12	7	13.2
13-14	17	32.1
15-16	27	50.9
17-19	2	3.8
Total	53	100.0

From table 4.4 it is clear that most of the female respondents started menstruation from 15 to 16 years of age. In Malawi, the Sena tribe, for example, attributes the start of menstruation to sexual maturity when the first sexual encounters are likely to take place as the girls experiment with sex. The MDoS (2005:230) found that women aged 15 to 19 years were HIV infected at a younger age than men. Knowledge of the estimated time for starting menstruation in girls would help in educating the youth, especially girls, with facts about human sexuality to help them abstain from sex or practise safer sex if they cannot abstain.

To summarise: The analysis indicated that all the respondents came from the CHRR's eight administrative districts out of the twenty-eight districts in Malawi and were spread across all three regions of the country. The majority of the respondents came from Lilongwe where respondents from four (4) T/As participated in the study while the remaining seven (7) districts had two (2) T/As authorities represented. The respondents' ages ranged from 15 to 51 years with the majority aged 18 to 24. There were more females than males in the sample. Most of the respondents were single, with more single females than males and more married males than females. The majority of the respondents were Christians and the minority were Muslims. Most of the respondents had primary or secondary school education while the minority had tertiary education. It was also clear from the findings that most of the females had their first menstrual period at 15 to 16 years of age.

4.2.2 Respondents' knowledge of perceived susceptibility to HIV infection that influenced decision for self-protection (Section 2)

This section examined the respondents' knowledge of perceived susceptibility to HIV/Aids, including sexual debut and the surrounding influences, association of STIs to Aids, sexual practices, causes of Aids and mode of spread.

4.2.2.1 Respondents' sexual debut (N=106) (Item 2.1)

Of the respondents who answered the question:

- 4.7% (n=5) of the respondents which represented 8.5% (n=4) of the males (3.8% respondents of the total sample), and 1.8% (n=1) of the females (0.9% respondents of the total sample) had their sexual debut at 13 to 14 years old.
- 32.1% (n=34) of the respondents which represented 23.4% (n=11) males (10.4% respondents of the total sample), and 43.4% (n=23) females (21.7% respondents of the total sample) had their first sexual encounter at 15 to 16.
- 37.7% (n=40) which represented 40.4% (n=19) males (17.9% respondents of the total sample), and 36.6% (n=21) females (19.8% respondents of the total sample) had theirs at 17 to 19.
- 17.9% (n=19) of the respondents which represented 25.5% (n=12) males (11.3% respondents of the total sample), and 13.2% (n=7) females (6.7% respondents of the total sample) had theirs when they were older than 20.

Table 4.5 Respondents' gender and age at first sexual intercourse (N=106)

Age at first sexual intercourse	Sex	N	Percentage
10-12	Male	0	0.0
	Female	0	0.0
13-14	Male	4	3.8
	Female	1	1.8
15-16	Male	11	23.4
	Female	23	43.4
17-19	Male	19	40.4
	Female	21	36.6
Above 20	Male	12	25.5
	Female	7	13.2
Missing	-	8	7.6
Total		106	100.0

From table 4.6 it is clear that most of the females (43.4%; n=23) had their first sexual encounter at 15 to 16 years of age. This concurred with the results in item 1.8, which indicated most of the females (13.7%; n=7) had their first menstrual period at 15 to 16. Moreover, most of the respondents (40.4%; n=19 males, and 43.4%; n=23 females) had their first sexual intercourse from 17 to 19 years of age. In this context, the findings indicated that most of the female respondents' first sexual intercourse was related to their first menstrual period. This was higher than the PSI Malawi's (2003:1) finding that the mean age at first sex of both females and males was 14 years. According to MDoS (2005:235), earlier sexual debut (before 15) for women shows a clear pattern of higher HIV prevalence than those with a later sexual debut. The present results suggested that the respondents were at high risk for HIV infection. Cichocki (2008:2) found that women who had sexual intercourse before adulthood ran a bigger risk of HIV infection because the genital mucosal surface was still tender and easily bruised. Cichocki (2008:2) is of the opinion that women are especially susceptible to heterosexual transmission physically because the mucosal lining of the vagina offers a large surface area to be exposed to HIV- infected seminal fluid. Plus, the vagina is more susceptible to small tears and irritation during intercourse than the penis.

4.2.2.2 Respondents' factors influencing first sexual intercourse (N=106) (Item 2.2)

Figure 4.5 illustrates the respondents' reasons for sexual debut. The respondents' main reasons were sexual desire (54.7%; n=58); curiosity (17.9%; n=19); peer pressure (6.6%; n=7); poverty (5.6%; n=7); poverty (5.6%; n=6); cultural practices (4.7%; n=5); influence of a boy/girlfriend (1.9%; n=2), and other (1.9%; n=2). Seven (6.6%) respondents did not answer this question.

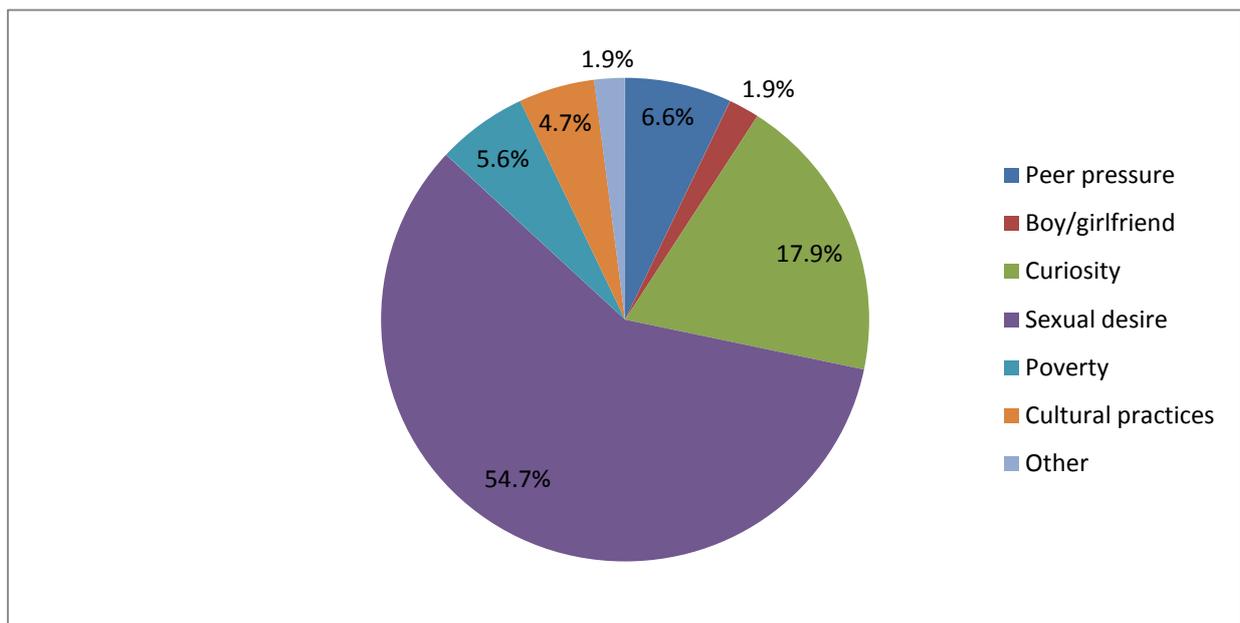


Figure 4.5 Respondents' reasons for first sexual intercourse (N=106)

The study further examined the respondents' gender and their reasons for first sexual intercourse (see table 4.6). The findings indicated that 5.1% (n=5) of the females and 2% (n=2) of the males were influenced to have sex by their peers; 2% (n=2) of the females were influenced by their boyfriends to have sex, and 6.1% (n=6) of the females were influenced by poverty to have their first sexual intercourse. In addition, more males (12.1%; n=12) than females (7.1%; n=7) had their first sexual intercourse due to curiosity; more males (30.3%; n=30) than females (28.3%; n=28) due to their own sexual desires, and more males (3%; n=3) than females (2%; n=2) due to cultural practices. Of the respondents, 72.6% (n=77) had their first sexual intercourse through sexual desire, and 17.9% (n=19) through curiosity. Mathews et al (2008:6) found that adolescents who expected negative social consequences of delayed transition had stronger intentions to have their first sexual intercourse. The perceived benefit of having the first sexual intercourse could have been sexual gratification.

Table 4.6 Respondents' gender and reasons for first sexual intercourse (N=106)

Reasons for first sexual intercourse	Gender	N	Percentage
Peer pressure	Male	2	1.9
	Female	5	4.7
Boy/girlfriends	Male	0	0
	Female	2	1.8
Curiosity	Male	12	11.3
	Female	7	6.6
Sexual desire	Male	30	28.3
	Female	28	26.5
Poverty	Male	0	0
	Female	6	5.7
Cultural practice	Male	3	2.8
	Female	2	1.9
Other	-	2	1.9
Missing	-	7	6.6
Total		106	100.0

Seven respondents (6.6%) did not answer the question and two respondents (1.9%) indicated that reasons other than those reasons provided made them have intercourse at a young age. Unfortunately they did not indicate what the “other” reasons were.

4.2.2.3 STIs increase the chances of acquiring AIDS (N=106) (Item 2.3)

Of the respondents, 91.5% (n=97) agreed that STIs could increase the chances of acquiring HIV/Aids; 0.9% (n=1) did not agree, and 7.5% (n=8) did not know. It was clear from the findings that the majority of the respondents were aware that STIs had an influence on HIV infection.

4.2.2.4 Respondents' practice of extra-marital relationships (N=106) (Item 2.4)

Of the respondents, 68.9% (n=73) denied engagement in extra-marital relationships; 25.5% (n=27) acknowledged infidelity, and 5.6% (n=6) did not respond. Having "a higher-risk sexual partner (non-marital, non-cohabitating partner) increased the risk of HIV infection" (MDoS 2005:235). The study found that some of the respondents had a high risk for new HIV infection or spreading the infection unless self-efficacy of consistently practising safer sex was ensured to prevent contracting HIV infection.

4.2.2.5 Respondents' sexual intercourse at first meeting and later not seeing each other again (N=106) (Item 2.5)

The study found that it was fairly common for people to have sex with a person they met for the first time but then did not see each other again. All the respondents (100%; N=106) agreed that this had either happened to them or someone they knew, which correlated with the evidence of the practice of higher-risk sex.

4.2.2.6 Condoms assistance to prevent HIV (N=106) (Item 2.6)

To the question whether condoms assisted the prevention of HIV, 68.8% (n=73) of the respondents agreed that condoms could assist in preventing HIV, while 31.2% (n=33) did not agree. Cullinan (2003:72) emphasises that people would practise safer sex if HIV/Aids were perceived to be a threat to their life. The results also concur with the HBM that individuals' perceived susceptibility to disease is determined by their perception of the chances of getting a condition (Stanhope & Lancaster 2000:271).

4.2.2.7 Respondents' knowledge of the cause of Aids (N=106) (Item 2.7)

Of the respondents, 91.5% (n=97) knew that Aids is caused by HIV; 1.9% (n=2) thought bacteria caused it, and 6.6% (n=7) did not know. The results concurred with NAC's (2003c:1) finding that 90% of the population was aware of HIV/Aids and its mode of transmission.

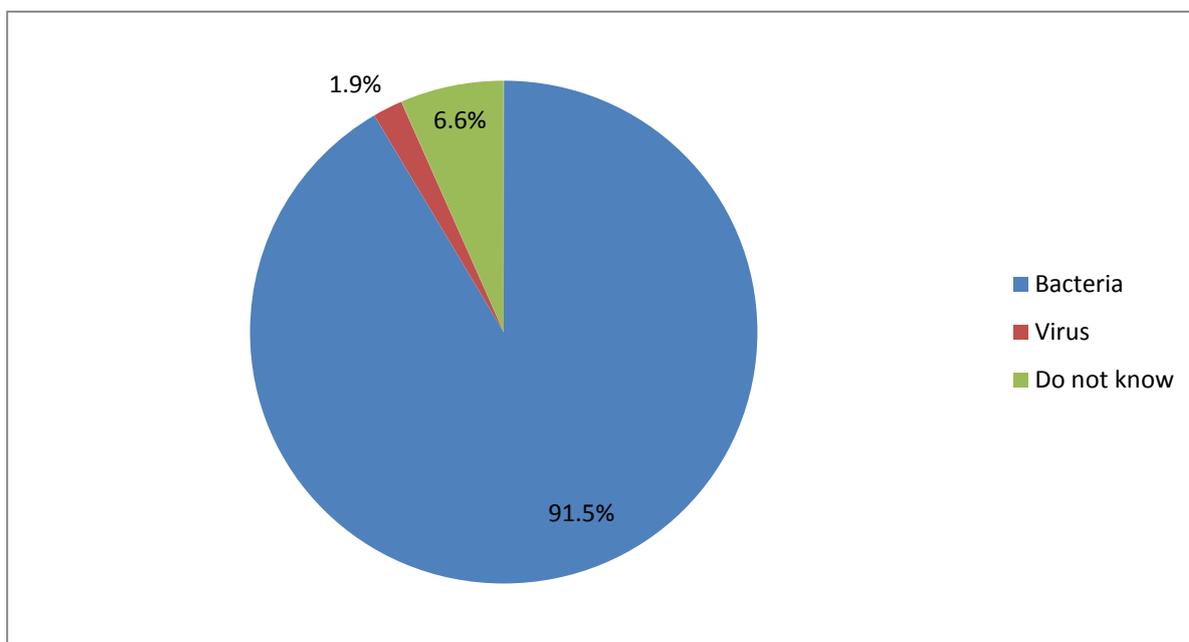


Figure 4.6 Respondents' knowledge of the cause of Aids (N=106)

4.2.2.8 Respondents' knowledge of spread of HIV (N=106) (Item 2.8)

Of the respondents, 53.8% (n=57) believed that promiscuity was the major cause of the spread of HIV; 38.7% (n=41) indicated unprotected sexual intercourse; 5.7% (n=6) indicated mother-to-child transmission, and 1.9% (n=2) indicated unscreened blood transfusions (see table 4.7).

Table 4.7 Respondents' ranking on spread of HIV (N=106)

How HIV is spread	Rank	Frequency	Percent
Promiscuity	1	57	53.8
Unprotected sex	2	41	38.7
Mother to child	3	2	1.9
Unscreened blood	4	6	5.7

To summarise: The results indicated that most of the females had their first sexual encounter at 15 to 16 years of age and it was related to their first menstrual period. The principal factors that influenced the respondents' first sexual encounters were sexual desire, curiosity, peer pressure, boy/girlfriends, cultural practices, and poverty. The majority of the respondents agreed that STIs could increase the chances of acquiring HIV. All the respondents denied having sexual intercourse with people of the same

sex. The respondents agreed that sometimes people had sex with a person that they had met for the first time but did not see each other again, and that this had either happened to them or someone they knew. The majority of the respondents knew that HIV causes Aids. According to the respondents, the main causes of the spread of HIV were promiscuity; unprotected sexual intercourse; mother-to-child transmission, and unscreened blood transfusions.

4.2.3 Respondents' knowledge of HIV/Aids that determined perceived seriousness of Aids and influenced decision for self-protection (Section 3)

In this section the respondents were asked about their knowledge of HIV and Aids to determine the perceived seriousness of Aids.

Table 4.8 Respondents' knowledge of HIV/Aids and perceived seriousness of Aids (N=106)

Item	Issue	Responses			
		Yes		No	
		N	%	N	%
3.1	Knowledge of someone suffering from Aids	106	100	0	0
3.2	Ability to tell HIV infected person by sight	100	94.3	6	5.7
3.3	Sexual intercourse as most common mode of spread of HIV	80	75.5	26	24.5
3.4	Can a person with HIV/Aids be cured?	0	0.0	106	100
3.5	Can Aids reduce your life span?	106	100.0	0	0
3.6	Can Aids reduce developmental activities?	106	100.0	0	0

4.2.3.1 Respondents' knowledge of someone living with Aids (N=106) (Item 3.1)

All the respondents (100%; N=106) knew someone living with Aids. In Malawi, 90% of the population are aware of HIV/Aids (NAC 2003c:1).

4.2.3.2 Respondents' identification of someone with Aids by sight (N=106) (Item 3.2)

As to whether they could identify somebody with Aids by sight, 94.3% (n=100) of the respondents agreed that they could not tell that someone had HIV infection just by seeing them, while 5.7% (n=6) thought they could tell. There is often confusion when people do not differentiate between the terms HIV and Aids, as the HIV virus cannot be seen by the naked eye while a person with Aids can be identified by seeing the signs.

4.2.3.3 Most common mode of spreading Aids (N=106) (Item 3.3)

Of the respondents, 75.5% (n=80) agreed that Aids is most commonly spread through sexual intercourse while 24.5% (n=26) answered "no" to the question.

4.2.3.4 HIV/Aids is curable (N=106) (Item 3.4)

Of the respondents, 100% (N=106) disagreed that a person with Aids could be cured. According to Jana (2003:14), people perceived the seriousness of HIV/Aids as Aids was dangerous mainly because it had no cure and once contracted, it killed: "We therefore spread this word to everybody in this village reminding each other of the danger of Aids." The findings in this study concurred with Jana's (2003) finding that people perceived HIV/Aids as deadly.

4.2.3.5 Reduction of life span due to Aids (N=106) (Item 3.5)

All the respondents (100%; N=106) agreed that Aids could reduce a person's life span, a perception related to the perceived seriousness of Aids.

4.2.3.6 Influence of Aids on activities for the development of people (N=106) (Item 3.6)

Malawi is a poor developing country where subsistence farming is a major source of livelihood. The respondents' views related to knowledge of HIV/Aids that determined perceived seriousness of Aids. All the respondents (100%; N=106) agreed that

developmental activities would decline when people developed Aids (see table 4.8). The results concurred with Jana's (2003:14) finding that when a person contracts Aids in a community, "developmental activities are slowed because instead of going to gardens, they go to attend to the sick person".

To summarise: All the respondents knew someone suffering from Aids. The majority agreed that they could not tell that people had HIV infection just by seeing them. Most of the respondents agreed that Aids is most commonly spread through sexual intercourse. All the respondents disagreed that a person with Aids could be cured and they all agreed that Aids could reduce individuals' life span. All the respondents agreed that developmental activities would decline when someone developed Aids. The results generally reflected the perceived seriousness of HIV and Aids.

4.2.4 Respondents' perceived benefits of engaging in safer sex practices (Section 4)

In this section the respondents were asked to indicate the perceived benefits of engaging in safer sex.

4.2.4.1 Respondents' condom use (N=106) (Item 4.1)

Of the respondents, 67.9% (n=72) had not used condoms before; 26.4% (n=28) had used condoms, and 5.7% (n=6) did not respond. It was of concern that most of the respondents had not used condoms. MDoS (2005:212) found that an enormous percentage of pre- or extra-marital sex was unprotected in Malawi since only 77% of the women and 88% of the men between 15 and 24 years old knew where they could get male condoms. This could have indicated that they did not find it beneficial to use condoms when indulging in sexual intercourse or that the individuals had consistent, faithful partners therefore they did not see the need for condom use. In this study, the results from item 2.4: practice of extra-marital relationships indicated that 25.5% (n=27) of the respondents engaged in extra-marital relationships, which is a higher-risk sexual practice that increased the risk of HIV infection if no safer sex was practised (see table 4.10).

4.2.4.2 Respondents' frequency of condom use in the two months prior to study (N=106) (Item 4.2)

In the two months preceding the study, 51.9% (n=55) of the respondents denied having used condoms; 42.5% (n=45) had used them once or more times, and 5.7% (n=6) did not respond. These results contradicted the fact that only 26.4% (n=28) of the respondents had agreed to having used condoms before in the previous question. Nevertheless, the results of 42.5% (n=45) still indicated low condom use and high likelihood of the respondents' practising higher-risk sex.

4.2.4.3 Respondents' reasons for using a condom (N=106) (Item 4.3)

Among the reasons given for condom use, 8.5% (n=9) of the respondents knew their partners had STIs; 28.3% (n=30) had evidence that their partners had other sexual partners; 13.2% (n=14) were unknown persons to the respondents, and 50.0% (n=53) gave other (unspecified) reasons (see table 4.9). Smith and Watkins (2004:649-660) found that Malawian men worried most about their extra-marital partners and adopted ways such as fewer partners and more careful partner selection. The use of condoms could be perceived as protecting their partners against HIV/Aids. According to Sexually Transmitted Diseases Services (2008b:1) "use of a condom greatly reduces the risk of passing on infection to either partner and also protects the female from pregnancy".

Some of the respondents did not indicate why they used condoms. Although the respondents had consented to participate in the study by accepting to complete the questionnaire, they still had the right to answer or refrain from answering some of the questions. In Malawi, the subject of sex and sexuality is a sensitive one and usually not freely discussed. Some of the respondents could have felt uncomfortable about giving information on condoms.

Table 4.9 Respondents' reasons for condom use (N=106)

Reason for condom use	N	Percentage
Partner had STIs	9	8.5
Evidence of other sexual partners	30	28.3
Unknown person to me	14	13.2
Other reasons	53	50.0

4.2.4.4 Respondents' decisions about condom use (N= 106) (Item 4.4)

Regarding the decision about condom use, of the respondents, 20.7% (n=22) representing 11 men and 11 women, made the decision to use condoms; 22.5% (n=24) representing 10 males and 14 females indicated that their partners decided, and 16.0% (n=17) representing 11 males and 6 females involved their partners in making the decision about condom use. However, 40.8% (n=43) abstained from answering the question. The findings indicated that more males made decisions on condom use than females although the sample was too small to make a generalisation about Malawi. Cichocki (2008:2) found gender inequities in developing countries like Malawi where women are generally culturally not free to refuse sex or to insist on safer sex using condoms.

4.2.4.5 Respondents' ways of protection from unsafe sex (HIV/Aids) (N=106) (Item 4.5)

Of the respondents, 62.5% (n=66) indicated being faithful to one uninfected partner; 29.0% (n=31) indicated avoiding excessive use of drugs and alcohol; 5.7% (n=6) indicated abstaining from sex, and 2.8% (n=3) indicated not knowing how to protect oneself (see table 4.10). This perception concurs with Sexually Transmitted Diseases Services (2008a:1) that "some of the STDs can be easily treated but unfortunately there is no cure for many of them, and these incurable STDs tend to be the most common and longest lasting. Some, for example HIV and hepatitis B, can have serious health consequences".

4.2.4.6 Respondents' care about their own health (N=106) (Item 4.6)

The respondents were asked if they cared about their own health. Of the respondents, 91.6% (n=97) cared about their own health; 0.9% (n=1) did not, and 7.5% (n=8) were not sure. The results in item 2.4 showed evidence that the majority (68.9%; n=73) of the respondents cared for their own health as they denied having extra-marital relationships, which pose a higher-risk factor in HIV/Aids (see table 4.10).

Table 4.10 Respondents' perceived benefits of engaging in safer sex (N=106)

Item	Issues	YES	
		N	%
4.1	Used a condom before	28	26.4
4.2	Use of condoms in the past 2 months:		
	None	55	51.9
	Once or more times	45	42.5
4.3	Reasons for condom use:		
	Partner had STIs	9	8.5
	Evidence of other sexual partners	30	28.3
	Unknown person	14	13.2
	Others	53	50.0
4.4	Who decided on condom use:		
	Myself	22	20.8
	My partner	24	22.6
	Me and my partner	17	16.0
4.5	Other ways of protecting self apart from condom use:		
	Being faithful to one uninfected partner	66	62.3
	Avoiding excessive use of drugs and alcohol	31	29.2
	Abstinence	6	5.7
	Do not know	3	2.8
4.6	Care about own health	97	91.5
4.7	Care about partner's health	89	84.0
4.8	HIV/Aids prevention better than cure	92	86.8
4.9	Knowledge of HIV/Aids stigmatized and Discriminated	10	9.4
4.10	Receipt of money or favours for sex using condoms	43	40.6
4.11	Benefits of engaging in safer sex practices:		
	Prevention of STIs	64	60.4
	Prevention of pregnancy	35	33.0
	I do not know	7	6.6

Item 2.4 showed that 25.5% (n=27) of the respondents had extra-marital relationships, which increased the risk of HIV infection (MDoS 2005:235). Cullinan (2003:72) emphasises that it is possible to practise safer sex if HIV/Aids is perceived to be a threat to life. Behavioural changes such as staying faithful to one partner, condom use, sexual abstinence and reducing the number of sexual partners occurred because of a perception of HIV/Aids as a serious health problem.

4.2.4.7 Care about partner's health (N= 106) (Item 4.7)

Of the respondents, 83.9% (n=89) representing 42 males and 47 females indicated that they cared about their partners' health; 3.8% (n=4) representing 2 males and 2 females did not care, and 12.3% (n=13) were not sure. Items 4.6 to 4.8 showed that the majority of the respondents cared about their own and their partners' health. This indicated further that the respondents had a positive attitude towards health and wellness. This is a good basis for health promotion because individuals' perceptions (beliefs about susceptibility and seriousness of disease) influence the perceived threat of illness and the importance of health to them (Stanhope & Lancaster 2000:271) (see table 4.10).

4.2.4.8 HIV/Aids prevention better than attempt to cure it (N=106) (Item 4.8)

All the respondents (100%; N=106) agreed that HIV prevention was better than attempting to cure it. The results indicated that the respondents had a perceived benefit of preventing HIV/Aids. The perceived benefit was also likely to have an indirect social and economic impact on the country as a whole. NAC (2003a:1) points out that most homes' economic viability has deteriorated due to the death of the breadwinners in households with the orphaned children supported by the elderly and older siblings (see table 4.10).

4.2.4.9 Respondents' knowledge of people who have been stigmatised due to their HIV/Aids status (N=106) (Item 4.9)

The study found that 16.1% (n=16) of the respondents knew of people that had been stigmatised due to their HIV/Aids status while 83.9% (n=90) did not. These results showed that the communities under study generally had an environment that enabled living positively with Aids. With regard to Malawian cultural practices that promoted positive living among people with HIV/Aids, Jana (2003:8) found an absence of stigma and discrimination: "We stay with them (the people with HIV/Aids) very well. We care for the person very well; we bathe them, feed them, and provide them with whatever they need. We should not be scared of them because they have Aids. They are also human beings." (see table 4.10).

4.2.4.10 Receipt of money and favours for using condoms (N=106) (Item 4.10)

Of the respondents, 40.6% (n=43) received money/favours for using condoms during sex; 50% (n=53) did not, and 9.4% (n=10) did not answer the question. These results indicated that there is transactional sex in Malawi. In a survey on the knowledge, attitudes and practices of primary school youth in relation to sexual and reproductive health in Malawi, PSI Malawi (2003:1) found that 56% of female pupils who had sex, received gifts or money in exchange for sex. Moreover, condoms were not used during sex because 20% of the youth did not know how to use them and 18% were unable to get condoms. There is a need to empower people, including the youth, to consistently practise safer sex including the “delay of first sexual intercourse until adulthood, reduction of multiple sexual partners, and correct and consistent use of condoms for cohabitating and non-cohabitating partners” (NAC 2003b:17) (see table 4.10).

4.2.4.11 Benefits of engaging in safer sex practices (N=106) (Item 4.11)

The respondents were required to indicate what they regarded as the benefits of engaging in safer sexual practices. Of the respondents, 60.4% (n=64) comprising 32 males and 32 females indicated prevention of STIs including HIV; 33% (n=35) comprising 15 males and 20 females indicated prevention of pregnancy, and 6.6% (n=7) did not know (see figure 4.7). The respondents who did not know that the abovementioned might be the benefits of safe sex were of major concern. In the USA, 81% of the women living with HIV/Aids were Black and Hispanic women who had acquired HIV through high-risk heterosexual contact (CDC 2008:3-4). Women were more likely than men to acquire HIV during vaginal intercourse and the presence of STIs greatly increased their susceptibility. In relation to HIV/Aids, the study indicated that most of the respondents (60.4%; n=64) perceived prevention of STIs and Aids as a benefit of engaging in safer sex practices (see table 4.10).

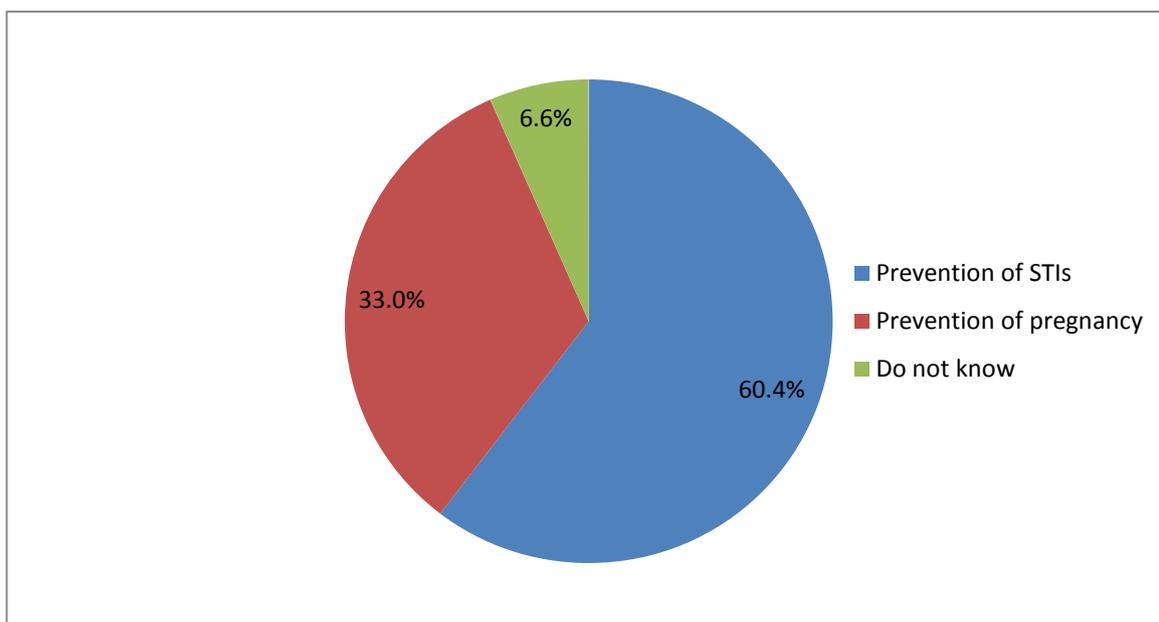


Figure 4.7 Benefits of engaging in safer sex practices (N=106)

To summarise: The study found that the majority of the respondents had not used condoms before. In the two months preceding the study, the majority of the respondents denied having used condoms before while a few respondents had used them once or more times. An open question was asked to determine the reasons for condom use. Most of the respondents mentioned they had evidence that their partners had other sexual partners; some knew their partners had STIs, and some had sex with persons unknown to them. Regarding deciding to use condoms, some of the respondents indicated that the decision was theirs; some indicated that their partners decided, and some indicated that they and their partners mutually decided on the use. It was noteworthy that the majority of the respondents were involved in decision-making for condom use. Apart from condom use, most of the respondents indicated that being faithful to one uninfected partner could protect them from unsafe sex and avoiding excessive use of drugs and alcohol. The majority of the respondents cared about their own and their partners' health. All the respondents agreed that HIV prevention was better than attempting to cure it. Most of the respondents did not know of people that had been stigmatised and discriminated due to HIV and Aids. Some respondents agreed that they had received money or favours for using a condom while others did not. Most of the respondents indicated the prevention of STIs and of pregnancy as the benefits of engaging in safer sexual practices.

4.2.5 Respondents' perceived barriers to safer sex practices/risk reduction behaviour (Section 5)

This section examined the perceived barriers to risk reduction behaviour/safer sex practice.

Table 4.11 Respondents' perceived barriers to risk reduction behaviour (N=106)

Item	Barriers	Responses				Do not know	
		Yes		No		N	%
		N	%	N	%		
5.1	Use of drugs before having sexual intercourse	6	5.7	94	89	6	6
5.2	Drinking alcohol before having sexual intercourse	14	13.0	86	81	6	6
5.3	Belief that condoms DO NOT help to prevent the spread of Aids	56	53.0	42	40	8	8
5.4	Condoms encourage people to engage in sexual activity outside of marriage	72	68.0	27	26	7	7
5.5	Condoms make it seem like you were planning to have sex any time	65	61.0	35	33	6	6
5.6	Any difficulties using condoms	39	37.0	55	52	12	11
5.7	Less sexual pleasure from using condoms	32	30.0	64	60	10	9
5.8	Condom causes man to lose erection	21	20.0	76	72	9	9
5.9	Condom too tight when used	13	12.3	83	78	10	9
5.10	Condom too loose when used	10	9.4	86	81	10	9
5.11	Got rash or itching when used condoms	17	16.0	79	75	10	9
5.12	Condom remained inside the woman at withdrawal	14	13.0	81	76	11	10
5.13	Condom broke inside the woman during use	32	30.0	64	60	10	9
5.14	Feeling embarrassed getting condoms	36	34.0	61	58	9	9
5.15	Not having money to buy condoms	39	37.0	57	54	10	9
5.16	Religion allows use of condoms	37	35.0	61	58	8	8
5.17	Culture accords men a superior status in sexual matters including condom use	68	64.0	27	26	11	10
5.18	Indulging in unsafe sex due to peer pressure	61	58.0	37	35	8	8
5.19	Indulging in unsafe sex due to family pressure	21	20.0	76	72	9	9

4.2.5.1 Use of drugs and alcohol before having sexual intercourse (N=106) (Items 5.1 and 5.2)

Table 4.11 lists the respondents' perceived barriers to risk reduction behaviour. In item 5.1, 88.8% (n=94) of the respondents denied using drugs before having sexual intercourse while only 5.7% (n=6) consisting of 5 males and 1 female admitted using drugs. Six (5.6%) respondents did not answer this question.

With regard to item 5.2, 81.2% (n=86) of the respondents denied drinking alcohol before having sexual intercourse while 13.2% (n=14) comprising 7 males and 7 females admitted drinking alcohol. Six (5.6%) respondents did not answer this question. In the USA, 1 in 5 Black and Hispanic women newly diagnosed with HIV used injection drugs and others were at risk of sexually transmitted HIV from selling or trading sex for drugs (CDC 2008:4). Higher risk behaviours such as unprotected sex are common when both casual and chronic substance users are under the influence of drugs or alcohol. This study found that the minority of the respondents were at risk of acquiring or spreading HIV if they continue abusing drugs or alcohol and do not practise safer sex (see table 4.11).

4.2.5.2 Belief whether condoms helped stop the spread of HIV/Aids (N=106) (Item 5.3)

Of the respondents, 52.8% (n=56) believed that condoms did not help to prevent the spread of HIV/Aids. The NIAID (2007:7) stresses that the use of "male latex condoms or female polyurethane condoms may offer partial protection during oral, anal or vaginal sex." In Nairobi, Mombasa, Kisumu and Meru (Kenya), Longfield et al (2002:1-20) found that participants' doubts about condom effectiveness were an obstacle to condom use. Moreover, a misconception that cross-generational partners were not risky attributed to low condom use. In this study, the respondents' belief that condoms did not help to prevent HIV/Aids prevented condom use. This emphasised that it is imperative to impart correct information about HIV/Aids and condoms if consistent and correct condom use is to be adopted (refer to table 4.11).

4.2.5.3 Condom use an encouragement of sexual activity outside marriage (N=106) (Item 5.4)

Of the respondents, 67.9% (n=72) indicated that condoms encouraged people to engage in sexual intercourse outside of marriage. The respondents' perception that condom use encouraged extra-marital sex was a barrier to practising safer sex and using condoms to prevent HIV/Aids (refer to table 4.11).

4.2.5.4 Possession of condoms makes it seem like the respondents were planning to have sex (N=106) (Item 5.5)

Of the respondents, 61.3% (n=65) indicated that having condoms made it seem like one was planning to have sex. The results are similar to item 5.4 where the respondents' morals and values about possessing condoms influenced the likelihood of not using condoms to prevent higher-risk sex. With regard to the HIV/Aids prevalence in the Malawi Defence Force, Chirwa et al (2002:1-41) found that condom use was perceived to encourage promiscuity with possession of condoms giving the impression that individuals already had plans to have sex any time (refer to table 4.11).

4.2.5.5 Difficulties using condoms (N=106) (Item 5.6)

More than half of the respondents, 51.9% (n=55) indicated that they experienced no difficulty in using condoms. A primary school survey on the knowledge, attitudes and practices of primary school youth related to sexual and reproductive health established that 20% of the participants did not use condoms during sex because they did not know how to use them (PSI Malawi 2003:1). Furthermore, the youth needed more knowledge on safer sex practices. Similarly, in this study, the respondents could benefit from knowledge and skills on how to use condoms by support from family planning service providers and community-based distributors in the villages where the respondents reside (refer to table 4.11).

4.2.5.6 Less sexual pleasure out of using condoms (N=106) (Item 5.7)

As to the question about sexual pleasure related to condom use, 60.4% (n=64) of the respondents denied having less sexual pleasure out of using condoms while 30.2% (n=32) admitted having less sexual pleasure. Longfield et al (2002:1-20) found that men disliked condoms and believed that they reduced sexual pleasure. The results are worrisome where casual sex is practised because the perception of having less sexual pleasure would be an obstacle to practising safer sex to prevent HIV/Aids (see table 4.11).

4.2.5.7 Condoms cause men to lose erection (N=106) (Item 5.8)

Of the respondents, 71.1% (n=76) had no perception of condoms causing men to lose erection while 19.8% (n=21) perceived that condoms caused men to lose erection. The remaining respondents did not answer this question. According to Graham et al (2006:255-260), a study on condom-associated erection loss among 278 young men attending a public STI clinic in the USA found that 37.1% of the men reported condom-associated erection loss on at least one occasion. In addition, the men were likely to have more unprotected sexual intercourse with women and were less likely to use condoms consistently in comparison to men without condom-associated erection loss. Having sex with multiple partners and nervous excitement of sex with a new partner, lack of confidence to use condoms correctly and problems related to the feeling or fitting of condoms might have influenced the men to experience condom-associated erection (see table 4.11).

4.2.5.8 Condom too tight or too loose when used (N=106) (Items 5.9 and 5.10)

Of the respondents, 12.3% (n=13) agreed that condoms were too tight, and 9.4% (n=10) agreed that condoms were too loose when used. Most of the respondents were therefore satisfied with the way in which the condoms fitted. There is a relationship between these findings and a perception that condoms cause loss of erection. According to Graham et al (2006:255-260), penile erection might be directly related to the sensations associated with ill-fitting condoms that are too tight or too loose. Anxiety caused by slippage or breakage of condoms could result in less concentration on the sexual pleasure and cause loss of erection with a resultant condom failure. In order to

overcome the perceived barriers to consistent and correct condom use, people need to be empowered with correct knowledge, skills and positive attitudes to effectively use condoms for protection against STIs and HIV (see table 4.11).

4.2.5.9 *Rash or itching when using condoms (N=106) (Item 5.11)*

Of the respondents, only 16% (n=17) developed a rash or itchiness. GenneX Healthcare Technologies (1999:1) found that very few people are actually allergic to latex, which would be characterized by anaphylactic shock. Many people have a sensitivity to it that gets worse with repeated or prolonged exposure. The symptoms of sensitivity present as itching, dryness, rash, welts, eczema and shortness of breath. The rash or itching expressed by the respondents could be associated to latex allergy or sensitivity as also seen in latex gloves and latex condoms and could only be ascertained by further analysis (see table 4.11).

4.2.5.10 *Condom remained inside the woman at withdrawal (N=106) (Item 5.12)*

Of the respondents, only 13.2% (n=14) reported that the condom remained inside the woman. This could be attributed to poor withdrawal techniques such as leaving the penis inside the woman long after ejaculation or after the erection is gone. This indicated the necessity of proper instruction in technique in condom use (see table 4.11).

4.2.5.11 *Condom broke inside the woman during use (N=106) (Item 5.13)*

Of the respondents who used condoms, 30.25% (n=32) indicated that the condom broke inside the woman during sexual intercourse. Ferguson (2005:2) attributes condom breakage to deterioration and brittleness due to several factors such as exposure to severe temperature, rough handling, or age (beyond life span). The researcher is of the opinion that there may be a need to explore the factors surrounding condom breakage to establish the possible causes and plan appropriate education and counselling to improve self-efficacy in condom use (refer to table 4.11).

4.2.5.12 Embarrassment over acquiring condoms (N=106) (Item 5.14)

Of the respondents, 34.0% (n=36) felt embarrassed to obtain condoms. In Kenya, Longfield et al (2002:1-20) observed that one of the obstacles to condom use was females' embarrassment to buy and carry condoms. In the UK, Bell (2008:1-13) found that fear of embarrassment inhibited the extent to which young people sought sexual health advice, accessed and used condoms. The young people feared being publicly exposed, humiliated and alienated, and highly valued privacy and anonymity when accessing condoms, particularly in rural areas. Embarrassment to get condoms is a perceived barrier to practising safer sex and increases the risk of acquiring STIs and HIV if higher-risk sex takes place when individuals are not able to abstain from having sexual intercourse (refer to table 4.11).

4.2.5.13 Availability of money to buy condoms (N=106) (Item 5.15)

The respondents were asked if they had money to buy condoms. Of the respondents, 53.8% (n=57) had no money to buy condoms. Poverty in Malawi prevents many people from buying condoms. UNAIDS (2000:5) stress that gender inequality and poverty play a role in promoting HIV/Aids because people are prohibited from practising safer sex due to lack of money to purchase condoms (refer to table 4.11).

4.2.5.14 Religion does not allow use of condoms (N=106) (Item 5.16)

The respondents were asked if their religion allowed them to use condoms. Of the respondents, 57.5% (n=61) indicated that their religion did not allow them to use condoms. Liwanda (2006:3) reported that religious leaders in Chitipa, one of the districts under study, were in effect promoting promiscuity among people by forbidding condom use. Ferguson (2005:1) maintains that leading fundamentalist Christian organizations have been a major source of misinformation regarding safer sex practises. According to Ferguson (2005:1), the trouble is that "those who put ideology before science have led a new movement across the country to gag schools with abstinence only curriculum, which fails to present fact-based information about pregnancy and disease control. The religiously affiliated believe that the young ones will feel encouraged to become sexually active if they are taught how to avoid STDs and pregnancy." The results of item 5.4 and item 5.5 indicated that some of the

respondents' moral beliefs influenced their negative perception of condom use, which hindered the practice of safer sex (see table 4.11).

4.2.5.15 Cultural status of men also with condom use (N=106) (Item 5.17)

Of the respondents, 64.2% (n=68) indicated that their culture accorded men a superior status in sexual matters including condom use (see table 4.11).

4.2.5.16 Influence of sexual practices by peer pressure (N=106) (Item 5.18)

Of the respondents, 57.5% (n=61) agreed that they would indulge in unsafe sex due to peer pressure while 34.9% (n=37) disagreed. This finding does not correspond with item 2.2 where only 6.6% (n=7) of the respondents indicated that they were influenced by peers (refer to table 4.11).

4.2.5.17 Influence of sexual practices by family pressure (N=106) (Item 5.19)

Furthermore, 19.8% (n=21) of the respondents indicated that they would indulge in unsafe sexual practices due to family pressure. In Nairobi, Mombasa, Kisumu and Meru in Kenya, Longfield et al (2002:1-20) found that girls were involved in cross-generational relationships due to peer pressure to "fit in" and family pressure to obtain financial support. According to Stanhope and Lancaster (2000:271), resistance to adopt the desired behaviour of practising safer sex would manifest if there were a dominance of psycho-social variables such as personality, cultural dominance of men in sexual matters, gender-based violence, peer pressure and family pressure. In this study, the few respondents who were still influenced by their culture, and peer and family pressure to indulge in risky sexual practices were a source of grave concern because of their susceptibility to new HIV infection or spreading the existing infection (refer to table 4.11).

To summarise: Regarding the perceived barriers to HIV/Aids risk reduction behaviour, the study found that the majority of the respondents did not use drugs or alcohol before having sexual intercourse although a few did. Some of the respondents believed that condoms did not help to prevent the spread of HIV/Aids while others believed that condoms could help. The majority of the respondents did not doubt the effectiveness of

condoms although the majority had a perception that condoms encouraged people to engage in extra-marital sexual intercourse. The majority of the respondents had a perception that having a condom made it seem that individuals were planning to have sex any time. Among the respondents, the majority had no difficulty in using condoms while a few had difficulty. The majority denied having less sexual pleasure out of using condoms while the minority admitted having less sexual pleasure. Most of the respondents did not perceive that condoms caused men to lose erection although a few perceived that condoms did. Although the majority did not find condoms too tight or too loose when used or have a rash or itching after using condoms, a few did. A few of the respondents reported that the condom had remained inside the woman at withdrawal.

Of the respondents, only 30.18% (n=32) [Item 5.13] experienced that the condom broke inside the woman during sexual intercourse. The majority did not feel embarrassed at obtaining condoms but some did. The study found that the majority of the respondents had no money to buy condoms. Religion was also noted as a barrier to risk reduction behaviour with the majority of the respondents agreeing that their religion did not allow them to use condoms. Most of the respondents indicated that their culture accorded men a superior status in sexual matters. The majority of the respondents indicated that they would indulge in unsafe sex due to peer pressure, and the minority indicated they would do so due to family pressure.

Condoms were perceived to provide a window of hope in prevention of HIV/Aids for the respondents who practised safer sex, though some respondents' socio-cultural values remained a barrier to condom use. The findings indicated that religion, culture, peer pressure, lack of money, and perceptions about condoms play a role in promoting and hindering the practice of safer sex.

4.2.6 Cues to action for safer sex practices (Section 6)

The respondents were required to indicate sources of information that assisted them to follow or adopt safer sex practices (see table 4.12).

4.2.6.1 Best source of information about HIV/Aids (N=106) (Item 6.1)

The respondents came mainly from rural areas in Malawi where radios are the most accessible electronic mass media, which utilise batteries, not electricity like television sets. Printed media such as newspapers and magazines, if available, are usually outdated and too expensive to be bought on a regular basis.

The respondents ranked the source where they found the best information about HIV/Aids prevention as follows: radio (54.7%; n=58); hospital (19.8%; n=21); television (5.7%; n=6); magazines and others (4.7%; n=5), and newspapers (4.7%; n=5). Of the respondents 9.4 (n=10) did not answer the question.

4.2.6.2 HIV/Aids prevention radio programmes (N=106) (Item 6.2)

The respondents indicated the following radio programmes that reminded them to avoid HIV/Aids: *Pakachere* (44.3%; n=47); *Youth magazine* (27.4%; n=29); *Sewero la Sabata ino* (8.5%; n=9), others (7.5%; n=8) and 12.3% (n=13) did not respond. The radio programmes mentioned were very popular when the study was conducted. Many households had radios and were able to listen to the programmes that were aired mostly over weekends and at night when most families were at home. *Pakachere* and *Youth Magazine* were interactively presented through phone-in requests or by responding to letters from listeners and occasionally having selected the youth involved in reading letters from the listeners on air among the youth-friendly programmes presented. *Sewero la Sabata ino* was a weekly radio drama, which featured family scenarios based on social issues high on the national agenda such as HIV/Aids.

Bertrand, O'Reilly, Denison, Anhang and Sweat (2006:567-597) conducted a systematic review of the effectiveness of mass communication programmes to change HIV/Aids-related behaviours in developing countries. On the seven outcomes reviewed, half of the studies indicated a positive impact of the mass media in knowledge of HIV transmission and reduction in high-risk sexual behaviour. Nevertheless, there is need for further evaluation on comprehensive programmes to provide a more definitive answer of media effects on HIV/Aids-related behaviour in developing countries.

4.2.6.3 HIV/Aids prevention television programmes (N=106) (Item 6.3)

The respondents were asked to indicate television programmes that reminded them about safer sex practices. The respondents who answered this question indicated the following: *Tikuferanji* (41.5%; n=44); *Youth Magazine* (22%; n=17); others (12.2%; n=10), and *Pakachere* (8.5%; n=9). In Malawi television is limited to urban and semi-urban areas due to infrastructure networks and limitations imposed by developmental issues and the electricity supply. Consequently, even though some of the respondents mentioned the programmes, they might not have viewed them frequently.

Table 4.12 Sources of information about HIV/Aids prevention (N=106)

Item	Sources of information about HIV/AIDS prevention	Responses	
		N	Percentage
6.1	Radio	58	54.7
	Television	6	5.7
	Hospital	21	19.8
	Magazines	5	4.7
	Newspapers	1	0.9
	Others	5	4.7
	Did not answer question	10	9.4
6.2	Radio programmes that remind respondents to avoid HIV/AIDS		
	<i>Pakachere</i>	47	44.3
	Youth magazine	29	27.4
	<i>Sewero la sabata ino</i>	9	8.5
	Others	8	7.5
	Did not answer question	13	12.3
6.3	Television programmes that remind respondents to avoid HIV/AIDS		
	<i>Pakachere</i>	9	8.5
	Youth magazine	17	22.0
	<i>Tikuferanji</i>	44	41.5
	Others	10	12.2
	Did not answer question	25	23.5
6.4	Reading materials that remind respondents to avoid HIV infection		
	Newspapers	6	5.7
	Magazines	5	4.7
	HIV/AIDS leaflets	20	18.9
	School books	50	47.2
	Others	7	6.6
	Did not answer question	18	17.0

4.2.6.4 HIV/Aids prevention reading matter (N=106) (Item 6.4)

Regarding reading matter that reminded them to avoid HIV infection, 47.2% (n=50) of the respondents indicated school books; 18.9% (n=20) indicated HIV/Aids leaflets; 5.7% (n=6) reported newspapers; 4.7% (n=5) indicated magazines and 6.6% (n=7) indicated others. The respondents came mainly from rural areas in Malawi, therefore the printed media were not a feasible option for mass communication for socio-economic reasons such as poverty, illiteracy, and the logistics of making reading matter available (see item 6.1).

4.2.6.5 Community help to avoid HIV infection (N=106) (Item 6.5)

Of the respondents, 76.4% (n=81) indicated that their communities helped to prevent HIV/Aids, but 23.6% (n=25) did not respond.

4.2.6.6 Government and non-governmental organisations' involvement in HIV/Aids prevention (N=106) (Item 6.6)

All the respondents (100%; N=106) agreed that government and non-governmental organisations were involved in HIV/Aids prevention in their areas. The results indicate mechanisms in place to control HIV/Aids at local and national levels in Malawi. All sectors of Malawian society have been affected by the impact of Aids and require national response matched with multi-sectoral strategies and interventions (NAC 2003b:9).

To summarise: According to the findings, the majority of the respondents identified the hospital as the source of information about HIV/Aids prevention followed by television, magazines, newspapers and other sources. The radio programmes that reminded the respondents to avoid HIV/AIDS were mainly *Pakachere*, *Youth Magazine*, and *Sewero la Sabata ino*. The primary television programmes that reminded them about safer sex practices were *Tikuferanji*, *Youth Magazine*, and *Pakachere*. The chief reading matter that reminded the respondents to avoid HIV infection was school books, HIV/Aids leaflets, newspapers, and magazines. The majority of the respondents agreed that their communities helped to prevent HIV/Aids. All the respondents agreed that

government and non-governmental organisations were involved in HIV/Aids prevention in their areas.

4.2.7 Self-efficacy in safer sex practices (Section 7)

In this section questions pertaining cues to action for safer sex practices were probed.

4.2.7.1 *Abstinence from sex when regular partner is away (N=106) (Item 7.1)*

The respondents were asked if they always abstained from sex when their regular partners were away (see table 4.14). Of the respondents, 76.4% (n=81) indicated that they abstained from sexual intercourse when their regular partners were away, and 23.6% (n=25) did not. Chirwa et al (2002:1-41) found abstinence, faithfulness, and condom use as methods for HIV/Aids prevention. PSI Malawi (2003:1) established that many primary school pupils (77%) knew that abstinence was related to not having sex but were confused whether abstinence meant *not* or *never* having sex. This indicated clearly that there is knowledge of abstinence from sex to prevent the spread of HIV. Self-efficacy, if successfully implemented, could help lower the incidence of new HIV infection and prevent re-infection.

4.2.7.2 *Sex during menstruation (N=106) (Item 7.2)*

The respondents were asked if they indulged in sexual intercourse during menstruation. Of the respondents, 59.4% (n=63) indicated having sexual intercourse during menstruation while 33% (n=35) did not. Henry (2006:2) refers to unprotected sex during menstruation increasing the likelihood of contracting HIV and other STIs, as well as pelvic inflammatory disease. Having sex during menstruation is risky, as the bleeding uterine cavity creates a favourable environment for exchange of body fluids. The findings in this study indicated that the respondents who indicated having sexual intercourse during menstruation needed information and motivation to take preventive health measures such as condom use or abstinence to protect themselves against HIV and other STIs.

Table 4.13 contains the findings of the closed questions:

Table 4.13 Issues of self-efficacy in safer sex practices (N=106)

Item	Issues	Responses					
		Yes		No		Missing	
		N	%	N	%	N	%
7.1	Abstinence from sex when regular partner is away	81	76.4	25	23.6	0	0.0
7.2	Sexual intercourse during menstruation	63	59.4	35	33.0	8	7.5
7.3	Effective negotiations for condom use with sexual partners	63	59.4	29	27.4	14	13.2
7.4	Acceptance of having sex in a cultural cleansing ritual without condom use	12	11.3	88	83.0	6	5.7

4.2.7.3 Negotiation on condom use with sexual partners (N=106) (Item 7.3)

To explore efficacy of safer sex practices, the respondents were asked if negotiation on condom use always worked with their sexual partners. Of the respondents, 59.4% (n=63) comprising 35 males and 28 females indicated effective negotiation for condom use with sexual partners as a practical way to have safe sex while 40.6% (n=43) respondents abstained from answering the question. The results correlate with items 4.4 and 5.17 on decision-making in relation to condom use, where more males (n=36) made decisions on condom use than females (n=27). Though the sample was too small to make a generalisation about males and females in Malawi, the results concur with Cichocki's (2008:2) finding on gender inequities influenced by culture in developing countries where men are more empowered than women to make decisions on safer sex practices.

4.2.7.4 Acceptance of cultural sexual cleansing ritual without using condoms (N=106) (Item 7.4)

The respondents were asked if they would accept to have sex with a man or woman in a cultural sexual cleansing ritual (initiation ceremonies, wife inheritance) without using a condom. Of the respondents, 83.0% (n=88) would not accept to have sex in a cultural cleansing ritual without using condoms while 11.3% (n=12) said they would accept.

The results concur with item 5.17 that some of the respondents were still influenced by their culture to indulge in risky sexual practices that spread HIV.

Table 4.14 Beliefs and self-efficacy in safer sex practices (N=106)

Item	Issue	Strongly agree		Agree		Do not agree		Missing	
		N	%	N	%	N	%	N	%
7.5	Need to go for VCT to know HIV sero status	32	30.2	61	57.5	6	5.7	7	6.6
7.6	Necessity to use condoms with regular partner if HIV sero positive	29	27.4	34	32.1	33	31.1	10	9.4
7.7	Used female condom before	8	7.5	23	21.7	67	63.2	8	7.5
7.8	Like the female condoms	5	4.7	14	13.2	80	75.5	7	6.6
7.9	Female condoms are easy to use	5	4.7	15	14.2	79	74.5	7	6.6

4.2.7.5 Need to go for VCT to know HIV sero status (N=106) (Item 7.5)

Table 4.14 lists the respondents' views on issues on self-efficacy in safer sex practices. Regarding whether they needed to go for VCT to know their HIV sero status, 30.2% (n=32) of the respondents strongly agreed; 57.5% (n=61) agreed; 5.7% (N=6) did not agree, and 6.6% (n=7) abstained from answering the question. Regarding the reasons for seeking VCT, Zacchariah et al (2003:88-91) found that people went for VCT because of recent knowledge of HIV/Aids and a desire to know their HIV status; repeated illness and suspicion of Aids, and suspicions that their partners had practised unprotected sex outside current relationship. In this study, self-efficacy was indicated as the majority of the respondents agreed or strongly agreed that they needed to go for VCT to know their HIV sero status. However, the respondents were not asked to give their reasons for doing so.

4.2.7.6 Necessity to use condoms with regular partner if HIV sero positive (N=106) (Item 7.6)

The respondents were asked whether it was necessary to use condoms even with regular partners if they tested positive for HIV. Of the respondents who answered the question, 27.4% (n=29) strongly agreed; 32.1% (n=34) agreed; 31.1% (n=33) did not agree, and 9.4% (n=10) abstained from answering the question. In Malawi, Jana

(2003:9) found that some communities encouraged the HIV-positive members to avoid spreading HIV and re-infecting themselves and increase their viral load because “when one is HIV positive, we advise him to use condoms because he is just like anyone of us in terms of sexual desires. If we stop him from doing that then we are breaking his rights. We therefore advise him to use condoms whether inside marriage or outside marriage to avoid spreading the disease or getting infected further.”

4.2.7.7 Availability of female condoms (N=106) (Item 7.7)

The respondents were asked whether they had used female condoms before. Of the respondents, 63.3% (n=67) had not used a female condom before; 21.7% (n=23) agreed that they had; 7.5% (n=8) strongly agreed that they had, and 7.5% (N=8) abstained from answering. Female condoms are not as commonly used in Malawi as male condoms due to socio-economic factors such as cost effectiveness (more expensive than male condoms) and lesser demand.

4.2.7.8 Choice of use of female condoms (N=106) (Item 7.8)

The respondents were asked whether they liked the female condom. Of the respondents, only 4.7% (n=5) females strongly agreed; 13.2% (n=14) comprising 3 males and 11 females agreed; 75.5% (n=80) comprising 44 males and 36 females did not agree, and 6.6% (n=7) abstained. The results indicated clearly that the most of the men and women were not in favour of the female condoms. According to UNAIDS (2000:5) negotiation for safer sex in women is hampered by gender inequality and poverty, and made worse by lack of access to reproductive health services and control over their reproductive health rights. Item 7.7 indicated that female condoms were not as widely available as male condoms in Malawi. The option for possible condom users, then, was the male condom, which gives men the dominance in practising safer sex.

4.2.7.9 Female condoms are easy to use (N=106) (Item 7.9)

Of the respondents, 4.7% (N= 5) strongly agreed that female condoms were easy to use; 14.2% (N= 15) agreed; 74.5% (N= 79) did not agree, and 6.6% (N= 7) abstained. Most of the respondents did not agree that female condoms were easy to use. These results could be misleading if most of the respondents had not used female condoms

because female condoms were expensive and not as widely available as male condoms besides gender inequality factors (see item 7.7 and item 7.8).

To summarise: The findings in this section indicated that the majority of the respondents indicated that they abstained from sexual intercourse when their regular partners were away, but accepted having sexual intercourse during menstruation. Most of the respondents indicated effective negotiation for condom use with sexual partners as one of the practical ways to have safe sex. The majority of the respondents would not accept having sex in a cultural cleansing ritual without using condoms. Regarding self-efficacy in safer sex practices, the majority needed to go for VCT to know their HIV status and indicated the necessity to use condoms with regular partners if they were HIV positive. In addition, the findings indicated that the majority of the respondents had not used a female condom before and most were not in favour of the female condoms. The minority of the respondents agreed that female condoms were easy to use while most disagreed.

4.3 CONCLUSION

This chapter discussed the data analysis and interpretation. Several factors that influenced safer sex practices in Malawi were identified, including gender issues, knowledge of HIV/Aids, religion, and perceptions about condom use. Beliefs, cultural values, poverty and religion were found to promote unsafe sexual practices. The respondents, nevertheless, had a broad knowledge and awareness of HIV/Aids, how it is spread and prevented, and its effects on health and development.

Chapter 5 discusses the findings and makes recommendations for practice and further research.

CHAPTER 5

Findings, conclusions and recommendations

5.1 INTRODUCTION

This chapter discusses the findings, conclusions and limitations of the study, and makes recommendations for practice and further study.

5.2 SUMMARY OF THE STUDY

The purpose of the study was to explore and describe the factors associated with safer sex practices in Malawi, including:

- The perceived susceptibility to HIV/Aids of literate, sexually active men, women, boys and girls living in the Centre for Human Rights and Rehabilitation (CHRR) operational sites in Malawi.
- The perceived seriousness of HIV/Aids of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.
- Factors that influenced modifying self-protection in literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.
- The perceived benefits of practising safer sex of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.
- The perceived barriers to risk reduction behaviour of literate, sexually active men, women, boys and girls living in the CHRR operational sites in Malawi.

The researcher conducted a literature review to gain insight into the HBM, which was used as the theoretical framework for the study; research design and methodology; HIV/Aids prevention, and factors that influence safer sex practices. A quantitative, explorative, descriptive study was conducted to identify, analyse and describe factors that influenced safer sex practices in Malawi.

The research population consisted of sexually active men, women, boys and girls that participated in CHRR community awareness activities and resided in the following districts in Malawi: Chitipa, Karonga, Salima, Dedza, Mchinji, Lilongwe, Mangochi and Zomba. Data were collected by means of a structured questionnaire and analysed using the SPSS version 15. The results were presented in tables, graphs, and diagrams.

The findings showed that the respondents' ages ranged from 15 to 51 years and the majority were between 18 and 24. Most of the respondents were single and there were more female respondents than males. The majority of the respondents were Christians and the minority were Muslims. Most of the respondents had primary or secondary school education and some had tertiary education. The majority of the females had their first menstrual period at 15 to 16 years of age.

5.3 FINDINGS

The findings are discussed according to the objectives of the study.

- **Respondents' perceived susceptibility to and the seriousness of HIV/Aids**

The findings indicated that the most of the respondents are susceptible to contracting HIV/Aids as shown by demographic variables such as age and gender in relation to their first sexual encounters. The majority of the respondents (74.5%; n=79) had their first sexual encounters from 13 to 19 years of age, while only a minority had their first sexual encounters after 20 years of age (see table 4.5). The primary factor influencing the spread of STIs, HIV and subsequently Aids in Africa is sexual behaviour (UNAIDS 2002:25). Commencing menarche determined most of the female respondents' initiation of sexual encounters at 15 to 16 years of age, giving the impression that girls' sexual activity is related to menarche.

Cichocki (2008:2) emphasises that women are more susceptible to HIV than men by nature of their bodily structure, as a larger surface of women's vaginal mucosa is exposed during sexual intercourse than men's penis. Women can easily suffer vaginal trauma, which further makes them more vulnerable to HIV infection especially before adulthood. In this study, the factors that influenced the respondents' first sexual

encounters, namely sexual desires, curiosity, peer pressure, boy/girl friends, cultural practices and poverty, could also influence their susceptibility to HIV.

The MDoS (2005:234) found marital status related to HIV infection and those “no longer in union (widowed and divorced or separated) have significantly higher rates”. This study found the females more susceptible to HIV than the males because more females than males were widowed, divorced or separated. Most of the respondents (68.9%; n=73) perceived casual sex with a person met for the first time but not seen again as a catalyst to HIV infection. Moreover, promiscuity, unprotected sexual intercourse, mother-to-child transmission, and unscreened blood transfusions were also viewed as increasing susceptibility to HIV infection. The majority of the respondents (94.3%; n=100) agreed that they could not tell that people had HIV infection just by seeing them, which implied that people could easily spread HIV infection if they looked healthy at sight. More than half of the respondents (53.8%; n=57) perceived Aids to be most commonly spread through promiscuity. All the respondents’ perceived the seriousness of HIV/Aids, as all disagreed that a person with Aids could be cured. All the respondents had a perception that Aids could reduce one’s life span and lead to decline of developmental activities.

- **Respondents’ factors that influenced modifying self-protection**

The findings indicated that the respondents had different sources of information that assisted them to modify their behaviour and promote self-protection against HIV and Aids. Of the respondents, 54.7% (n=58) identified the radio and 19.8% (n=21) identified hospitals as major sources of information about HIV/Aids prevention, followed by television, magazines, newspapers and other sources. The main radio programmes that reminded the respondents to avoid HIV/Aids were *Pakachere*, *Youth Magazine*, and *Sewero la Sabata ino*. Safer sex practices were also promoted through television programmes such as *Tikuferanji*, *Youth Magazine*, *Pakachere*, and others. School books, HIV/Aids leaflets, newspapers and magazines were reading matter that reminded the respondents to avoid HIV infection. The communities where the respondents lived also helped to prevent HIV/Aids as well as government and non-governmental organisations that were involved in HIV/Aids prevention in their areas.

Some modifying factors such as abstaining from sexual intercourse when regular partners were away and effective negotiation for condom use with sexual partners influenced safer sex practices. The majority of the respondents (83%; n=88) indicated that they would not accept to have sex in a cultural cleaning ritual without using condoms. The majority of the respondents (87.7%; n=93) went for VCT to know their HIV sero status, and 59.5% (n=63) indicated the necessity to use condoms if the regular partners were HIV sero positive.

- **Respondents' perceived benefits of practising safer sex**

According to the findings, most of the respondents (67.9%; n=72) had not used condoms before while 26.4% (n=28) accepted condom use, which implied low condom use. The reasons given for condom use included having evidence that their partners had other sexual partners; knowing their partners had STIs, and having sex with persons they did not know (casual sexual partners). The respondents themselves and their partners or either parties made decisions regarding condom use and it was noteworthy that most of the respondents (59.4%; n=63) indicated that they had participated in decision-making for condom use.

Of the respondents, 62.5% (n=66) indicated that apart from condom use, being faithful to one uninfected partner could protect them from unsafe sex as well as avoiding excessive use of drugs and alcohol. The majority of the respondents (91.5%; n=97) had a positive attitude towards health and wellness, as they indicated that they cared about their own and their partners' health. All the respondents further agreed that HIV prevention was better than attempting to cure it. The respondents indicated living in an environment that allowed living positively with HIV and Aids, since the majority (84.9%; n=90) did not know of people that had been stigmatised and discriminated against due to HIV and Aids. Receipt of money or favours for using condoms was perceived as a benefit of practising safer sex. Of the respondents, 60.4% (n=64) indicated prevention of STIs as a benefit of engaging in safer sexual practices, and 33.0% (n=35) indicated prevention of pregnancy.

- **Respondents' perceived barriers to risk reduction behaviour**

The findings also indicated the respondents' perceived barriers to risk reduction behaviour. Of the respondents, 53.0% (n=56) believed that condoms did not help to prevent the spread of HIV/Aids while some believed that condoms could help. Most of the respondents (68%; n=72) maintained that condoms encouraged people to engage in extra-marital sexual intercourse, which would be a barrier to practising safer sex. Most of the respondents (61%; n=65) negatively perceived having a condom as an indication of intending to have sex at any time. The majority of the respondents (54%; n=57) had no money to buy the condoms, which was an obstacle to those seeking to use condoms. Religion was also perceived as a barrier as 58% (n=61) of the respondents indicated that their religion did not allow them to use condoms. Culture was also perceived as a barrier to risk reduction behaviour because of the respondents 64.2% (n=68) agreed that it accorded men a superior status in sexual matters. It was of concern that of the respondents, 57.5% (n=61) agreed that they would indulge in unsafe sex due to peer pressure, and 19.8% (n=21) indicated that they would indulge in unsafe sexual practices due to family pressure.

A few barriers to risk reduction associated with self-efficacy were noted. Of the respondents, 36.8% (n=39) had difficulty in using condoms and 30.2% (n=32) admitted having less sexual pleasure. Problems associated with condom use were as follows: condoms caused men to lose erection (19.8%; n=21); condoms were either too tight (12.3%; n=13) or too loose (9.4%; n=10) when used; the male or female partner developed a rash or itchiness after condom use (16%; n=17); condoms remained inside the woman at withdrawal (13.2%; n=14); condoms broke inside the woman during sexual intercourse (30.2%; n=32), and embarrassment about getting condoms (34%; n=36). The respondents with problems associated with condom use were a source of concern as they were unlikely to perform safer sex when required.

Other perceived barriers to risk reduction behaviour were associated with the use of female condoms. Of the respondents, 63.2% (n=67) had not used female condoms before; 75.5% (n=80) did not like the female condoms, and 74.5% (n=79) indicated that female condoms were not easy to use. The results suggested that female condoms were not commonly used. Not using female condoms would be a barrier to practising

safer sex, as the respondents were not empowered to protect themselves by using the female condoms.

5.4 CONCLUSIONS

According to the respondents, there are many factors that influence safer sex practices in Malawi. A variety of modifying factors played a role in influencing the individuals' perception of susceptibility, severity, barriers and benefits of practising safer sex.

Demographic variables such as age at first sexual intercourse, gender, marital status, and educational level influenced susceptibility to unsafe sexual practices.

Socio-cultural and economic factors such as poverty, religion and culture were perceived barriers to practising safer sex in terms of affordability, accessibility and acceptability of condoms. Poor condom use techniques indicated by breakage, remaining inside the woman at withdrawal and being the wrong size, played a role in unsafe sexual practices.

The respondents had different sources of information that assisted them to modify their behaviour and promote self-protection against HIV and Aids such as reading matter, and radio and television programmes. The study found that individuals had widespread knowledge on the spread and prevention of HIV/Aids. The respondents perceived the seriousness of HIV/Aids, its effects on health and development, which also influenced decisions to practise safer sex.

5.5 LIMITATIONS OF THE STUDY

The researcher identified the following limitations in the study:

- It was not possible to capture the whole population in the CHRRs operational sites in the eight districts due to the geographical vastness of the area in which the study sample was selected as well as the limitation of resources (human, material, finances and time).
- The study was restricted to the CHRR operational sites in the eight districts and a small sample hence the findings cannot be generalised to the whole Malawi

population.

- There was a language barrier during data collection since English was not the respondents' mother tongue.
- There was a possibility of obtaining biased information from the respondents since they were giving information about themselves on a culturally sensitive topic.

5.6 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for practice and further research.

5.6.1 Practice

The researcher recommends that

- The government strengthen the existing behavioural change interventions awareness campaigns through a multi-sectoral approach including schools, media and churches to help boys and girls delay their first sexual encounters targeting factors that influenced the respondents' first sexual encounters, namely sexual desires, curiosity, peer pressure, boy/girl friends, cultural practices and poverty. The campaigns should target pre-menstrual groups before the age of 15 years, as they are a greater risk.
- HIV/Aids programmes integrate gender issues in sectoral response to HIV and Aids in order to empower females who are more vulnerable than men in taking responsibility for their sexual health. The programmes should also target peer pressure and family pressure.
- CHRR and other stakeholders develop and implement more community advocacy strategies in existing HIV/Aids and human rights programmes to empower individuals, families and communities to negotiate for safer sex.
- The government and donors provide more accessible resources for female-controlled HIV prevention methods such as female condoms. Women should be empowered to use female condoms.
- The government introduce and roll out community-based distribution of free condoms with demonstration of correct condom use techniques by Health

Surveillance Assistants (HSAs) and trained volunteers to more communities to cater for the masses who cannot afford to buy condoms and whose condom use techniques are faulty.

- Government and NGOs providing VCT services introduce and roll out accessible services to the rural communities to empower the population make informed choices on sexual protection if sero status is known.
- The government and NGOs emulate the CHRR to provide information cost effectively to assist communities to modify their behaviour and promote self-protection against HIV and Aids, such as conducting community awareness activities through drama, peer education, songs and traditional dances.
- The government and NGOs mobilise communities to take action against unsafe sexual practices in the same way as action on other developmental issues. For example, traditional leaders as custodians of culture should be ordered to modify and, where necessary, eradicate cultural practices that promote unsafe sexual practices that predispose men, women, boys and girls to HIV/Aids.
- Faith-based organisations incorporate HIV/Aids in the clergy's curricula to provide acceptable strategies for safer sex practices for their followers. This should help reinforce and sustain moral behaviour and discourage extra-marital sex. Abstinence should be encouraged if not in a steady relationship.
- The government involve its stakeholders to economically empower men, women, boys and girls to reduce poverty and promote equality and self-sustainability to discourage unsafe sexual practices influenced by poverty.
- The Ministry of Health disseminate the findings of this study to stakeholders for their information and motivation to promote safer sex practices.

5.6.2 Further research

Further research should be conducted on the following topics:

- Factors influencing safer sex practices in Malawi on a wider scale to compare the results with the findings of this study and possibly generalise the results to the Malawian population
- An investigation into the user-friendliness of condoms on the market in Malawi
- An exploration of alternative strategies to abolish risky cultural practices that

promote unsafe sexual practices

- An assessment of the perceived barriers to risk reduction behaviour
- An investigation into heterosexual transmission of HIV/Aids across cultures, age groups, socio-economic class and gender
- A similar study on a larger scale in order to increase the credibility of the results and find strategies to reduce HIV incidence and re-infection
- The social demographic factors that determine sexual behaviour
- The relationship between knowledge of Aids and the decision for self-protection
- Factors contributing to condom use
- Strategies used for self-protection when sexual intercourse is inevitable.

5.7 CONCLUSION

The study explored demographic, socio-economic and knowledge-related factors that influence safer sex practices in Malawi. This chapter summarised the study, briefly discussed its limitations, and made recommendations for practice and further research. The study concurs with UNAIDS (2000:5) that the spread of HIV/Aids in Africa is due to sexual behaviour and factors such as gender, inequality and poverty. Furthermore, in Malawi, HIV/Aids research “is required to address gaps in existing knowledge about HIV/Aids and to inform policy, practice and HIV/Aids-related interventions” (NAC 2003a:40).

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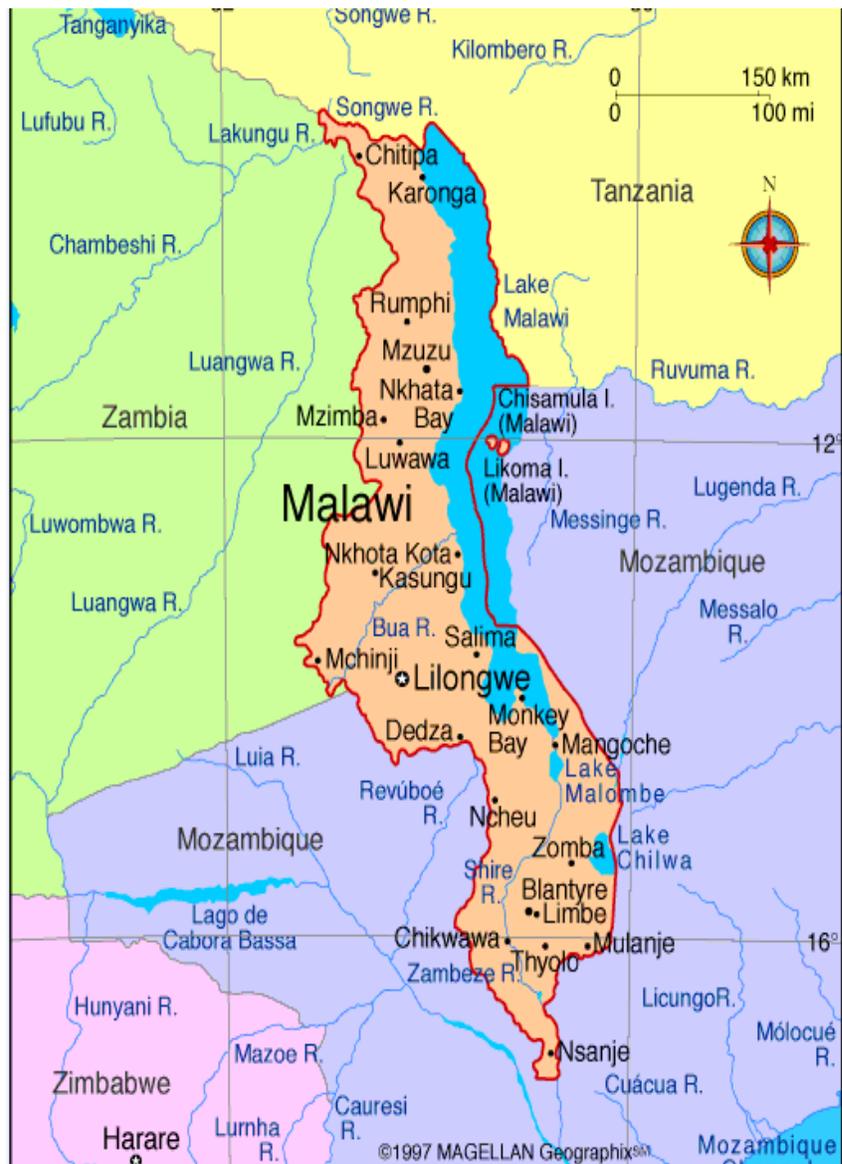
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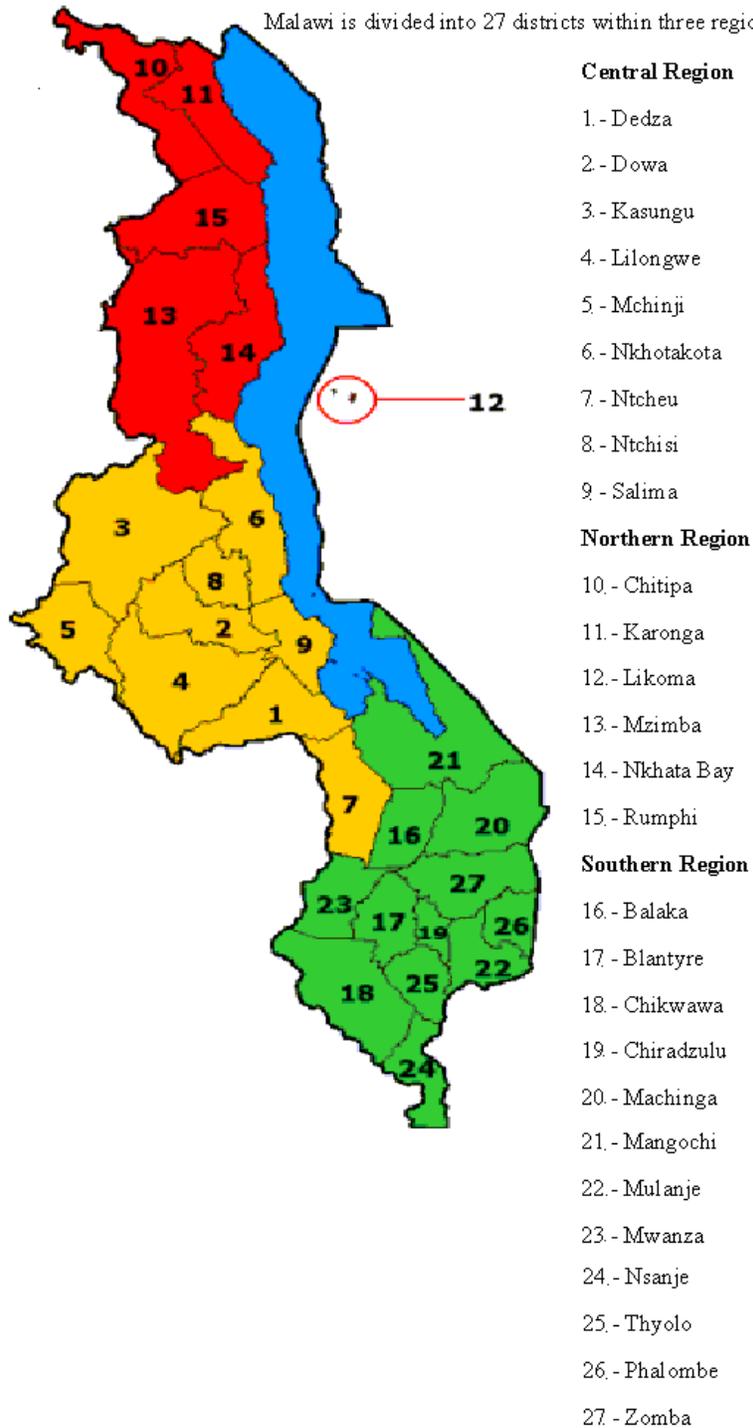
ANNEXURE A



Map of Malawi

Source: Adapted from <http://www.infoplease.com/atlas/country/malawi.html>

Malawi is divided into 27 districts within three regions:



Adapted from "http://en.wikipedia.org/wiki/Districts_of_Malawi"

ANNEXURE B

Centre for Human Rights and Rehabilitation

PO Box 2340

Lilongwe 3

Malawi

8 August 2006

The Health Sciences Research Committee

PO Box 30377

Lilongwe 3

Malawi

Attention: The Chairperson

Dear Sir,

APPLICATION FOR CLEARANCE TO CARRY OUT A STUDY TO EXPLORE FACTORS INFLUENCING SAFER SEX PRACTICES IN MALAWI

I am a post basic student studying for a Master of Arts Degree in Public Health with the University of South Africa (UNISA) through open learning. In partial fulfillment for the academic award, I am required to conduct a research on a topic of choice. The title of my proposed study is "Exploring factors influencing safer sex practices in Malawi". I propose to conduct the study from 1st September 2006.

The purpose of this letter is to seek permission to proceed with the study.

Looking forward to hearing from you soon.

Yours truly

Ellen Charity Nkhata (Mrs).

Telephone: + 265 789 400
Facsimile: + 265 789 431
e mail doccentre@malawi.net
All Communications should be addressed to:
The Secretary for Health and Population



In reply please quote No. MED/4/266

MINISTRY OF HEALTH
P.O. BOX 30377
LLONGWE 3
MALAWI

6 September 2006

Mrs. E. Nkhata
Centre for Human Rights
P.O. Box 2340
Lilongwe

Dear Madam

RE: Exploring factors that influence safer sex practices in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has reviewed and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER** : NHSRC/7g/405
The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 26/08/2006
- **EXPIRATION DATE** : This approval expires on: 25/08/2007
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat, should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** : All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789314, 08588957 or by e-mail on doccentre@malawi.net
- **Others**:
Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: Dr. C. Mwanambwa (Chairman), Prof. E. Molyneux (Vice Chairman)
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00013905 PWA00005976)

ANNEXURE D

Centre for Human Rights and Rehabilitation

PO Box 2340

Lilongwe 3

Malawi

10 September 2006

The District Commissioners

Chitipa, Karonga, Dedza, Lilongwe, Mchinji, Salima, Mangochi and Zomba Districts

Dear Sir/Madam

PERMISSION TO CONDUCT A RESEARCH STUDY

I am a post basic student studying for a Master of Arts degree in Public Health with the University of South Africa (UNISA). In partial fulfillment for the academic award, I am required to conduct a research on a topic of choice. The title of my proposed study is "Exploring factors that influence safer sex practices in Malawi".

I propose to conduct the study from 30 September 2006 to 30 October 2006 in eight (8) districts namely, Chitipa, Karonga, Dedza, Lilongwe, Mchinji, Salima, Mangochi and Zomba. Two Traditional Authorities (T/As) were conveniently identified as sites for data collection in these districts since they are operation sites for CHRR the researcher's employer. The study aims to identify factors that would promote safer sex practices to prevent new HIV infections and re-infections. The purpose of this letter is to seek for permission to proceed with the study in your district.

Looking forward to hearing from you soon.

Yours truly

Ellen Charity Nkhata (Mrs)

ANNEXURE E

I, the undersigned, have understood the explanation of the purpose of the study and its contribution to public health. I have the right to withdraw from the study at any time without penalty if I wish. I give consent for participation in the study.

SIGNATURE:
Participant

SIGNATURE:
Witness

Date:

Date:

ANNEXURE F

QUESTIONNAIRE

ID CODE.....

Purpose of the questionnaire:

To collect data that enables the researcher identify factors influencing safer sex practices in Malawi.

Note:

Some of the questions may be sensitive to the respondents hence; a self-administered questionnaire is designed to ensure privacy. The respondents are advised not to write their names on the questionnaires and answer the questions below openly and truthfully without fear of being identified by the responses made. The data will be held in strict privacy and confidentiality in accordance with ethical research standards.

Instructions:

Please indicate the most appropriate response in the provided spaces.

1.0 RESPONDENT'S PERSONAL DEMOGRAPHIC DATA

Please circle your personal data as appropriate

1.1 District where you are resident:

- A Chitipa
- B Dedza
- C Karonga
- D Lilongwe Rural
- E Lilongwe Urban
- F Mangochi
- G Mchinji
- H Salima
- I Zomba

1.2 Traditional Authority:

- A Mwenemlambiya
- B Mwenemisuku
- C Kachere
- D Kasumbu
- E Kyungu
- F Wasambo
- G Chiseka
- H Kalolo
- I Chitukula
- J Tsabango
- K Mpondas
- L Nankumba
- M Mavwere
- N Mlonyeni
- O Kalonga
- P Khombedza
- Q Chikowi
- R Mwambo

1.3 Age Bracket:

A (15-17) year

B (18-24) years

C (25-35) years

D (36-45) years

E (46-50)years

F (above 51)years

1.4 Gender:

A Male

B Female

1.5 Marital Status:

A Single

B Married

C Divorced

D Widow

E Widower

F Other

1.6 Religion:

A CCAP

B Roman Catholic

C Seventh Day Adventist

D Anglican

E Others

1.7 Educational level:

A Primary

B Secondary

C College (Tertiary education)

1.8 Age at menarche (when did you come of age?)

- A (10-12) year
- B (13-14) years
- C (15-16) years
- D (17-19) years
- E Others

2.0 KNOWLEDGE ON HIV/AIDS THAT DETERMINES PERCEIVED SUSCEPTIBILITY

Please complete the most appropriate response

2.1 Sexual debut (At what age did you start having sexual intercourse with the opposite sex?)

- A (10-12) year
- B (13-14) years
- C (15-16) years
- D (17-19) years
- E Others

2.2 What made you start having sexual intercourse that time?

- A Peer pressure
- B my boy/girl friend
- C Curiosity
- D Sexual desire
- E Poverty
- F Cultural practices (initiation ceremonies)
- G Other

Do sexually transmitted infections increase the chances of acquiring Aids?

- A Yes
- B No
- C Do not know

2.3 Do you engage in extramarital sexual relations?

A Yes

B No

2.4 Sometimes people have sex with a person they have met for the first time but later do not see each other again. Has this ever happened to you or someone you know?

A Yes

B No

2.6 Would condoms have assisted this person who had sex with a person he /she had met for the first time to prevent HIV?

A Yes

B No

2.7 What is the cause of AIDS?

A Bacteria

B Human immunodeficiency virus (HIV)

C Don't know

2.8 How is HIV spread?

A Promiscuity

B Unprotected sexual intercourse

C Unscreened blood transfusions

D Mother to child

E Others

3.0 KNOWLEDGE OF HIV/AIDS THAT DETERMINES PERCEIVED SERIOUSNESS OF AIDS

Please indicate the most appropriate response

3.1 Do you know someone suffering from Aids?

A Yes

B No

3.2 Can you tell that someone has HIV infection by just seeing him/her?

A Yes

B No

3.3 Is Aids most commonly spread through sexual intercourse?

A Yes

B No

3.4 Can a person who has HIV/AIDS be cured?

A Yes

B No

3.5 Can Aids reduce your life span?

A Yes

B No

3.6 Can developmental activities be promoted when some one has developed Aids?

A Yes

B No

4.0 PERCEIVED BENEFITS OF ENGAGING IN SAFER SEX PRACTICES.

Please indicate the most appropriate response.

4.1 Have you ever used condoms before?

A Yes

B No

4.2 In the past two months, how many times did you use a condom?

A None

B Once or more times

4.3 If you used a condom what were the reasons?

A Partner had sexually transmitted infections (STIs)

B Evidence of other sexual partners

C Unknown person to me

D Others

4.4 Who decided that you should use a condom?

A Myself

B My partner

C Me and my partner

4.5 Apart from using condoms, how can you protect yourself from unsafe sex?

A Being faithful to one uninfected partner

B Abstinence

C Avoiding excessive use of drugs and alcohol

D I do not know

4.6 Do you care about your own health?

A Yes

B No

4.7 Do you care about your partner's health?

A Yes

B No

4.8 Is HIV/Aids prevention better than attempting to cure it?

A Yes

B No

4.9 Do you know people that have been stigmatized and discriminated due to HIV and Aids?

A Yes

B No

4.10 Have you ever received money or favours for sex using a condom?

A Yes

B No

4.11 What are the benefits for engaging in safer sex practices that you know?

A Prevention of sexually transmitted infections

B Prevention of pregnancy

C I do not know

5.0 PERCEIVED BARRIERS TO RISK REDUCTION BEHAVIOUR

Please indicate the most appropriate response.

5.1 Do you use any drugs such as chamba (hashish) before having sexual intercourse?

A Yes

B No

5.2 Do you drink alcohol when you want to have sexual intercourse?

A Yes

B No

5.3 Do you believe that condoms DO NOT help to prevent the spread of HIV/Aids?

A Yes

B No

5.4 Do condoms encourage people to engage in sexual activity outside marriage?

A Yes

B No

5.5 Do condoms make it seem like I was planning to have sex anytime?

A Yes

B No

5.6 Do you have difficulties using condoms?

A Yes

B No

5.7 Would you get less sexual pleasure out of using a condom?

A Yes

B No

5.8 Does a condom cause a man to lose his erection?

A Yes

B No

5.9 Was a condom too tight when you used it?

A Yes

B No

5.10 Was a condom too loose when you used it?

A Yes

B No

5.11 Did you get a rash or itching when you used a condom?

A Yes

B No

5.12 Did the condom remain inside the woman at withdrawal?

A Yes

B No

5.13 Did a condom break inside the woman during use?

A Yes

B No

5.14 Do you feel embarrassed getting condoms?

A Yes

B No

5.15 Do you have no money to buy the condoms?

A Yes

B No

5.16 Does your religion allow you to use condoms?

A Yes

B No

5.17 In your culture, are men accorded a superior status in sexual matters including condom use?

A Yes

B No

5.18 Would you indulge in unsafe sex because of peer pressure?

A Yes

B No

5.19 Would you indulge in unsafe sex because of family pressure?

A Yes

B No

6.0 CUES TO ACTION FOR SAFER SEX PRACTICES

Please indicate the most appropriate response.

6.1 Where did you get information about HIV/AIDS prevention?

A Radio

B Television

C Hospital

D Magazines

E Newspapers

F Other

6.2 Which are the radio programmes that remind you to avoid HIV/Aids?

A Pakachere

B Youth magazine

C Sewero la sabata ino

D Other

6.3 Which are the television programmes that remind you to avoid HIV infection?

A Pakachere

B Youth magazine

C Tikuferanji

D Others

6.4 Which reading materials remind you to avoid HIV infection?

- A Newspapers
- B Magazines
- C HIV/Aids leaflets
- D School books
- E Others

6.5 Does your community help you to prevent HIV/Aids?

- A Yes
- B No

6.6 Are government and non governmental institutions involved in HIV/Aids prevention in your area?

- A Yes
- B No

7.0 SELF-EFFICACY IN SAFER SEX PRACTICES

7.1 Do you always abstain from sex when your regular partner is away?

- A Yes
- B No

7.2 Do you have sex with your partner during menstruation?

- A Yes
- B No

7.3 Does negotiation always work when you need to use condoms with your sexual partners?

- A Yes
- B No

7.4 Would you accept to have sex with a man or woman in cultural sexual cleansing rituals (initiation ceremonies, wife inheritance) without using a condom?

A Yes

B No

Please tick the most appropriate response in the following questions:

Item	Questions	Responses		
		Strongly agree	Agree	Do not agree
7.5	I need to go for voluntary counselling and testing to know whether I have HIV or not			
7.6	It is necessary to use condoms even with a regular partner if he/she tests sero positive of HIV			
7.7	I like the female condoms			
7.8	The female condoms are readily available			
7.9	The female condoms are easy to use			

Thank you for your participation!