

The effectiveness of the government's HIV/AIDS  
programme and condom use among educators

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On the 06 November 2010, as I am seated in the front row, close enough not to miss any glance of the unfolding events, thoughts go through my mind.

A colleague, a friend, an educator, a father to his daughter is indeed lying in that wooden box.

Did I even think he will be gone before he turned forty?

Did I even think our department will be one educator less?

Did I even think our school's disciplinarian will be gone?

Did I even think his masters' degree will be of no use?

Did I even think a daughter will have no one to take her shopping?

Yes.

It is happening before me.

It is real. Once again, it has struck.

I can only vent my frustration and say, "It has to stop! one way or the other. It is enough."

In memory of a friend, a dear colleague, a civilian, above all, AN EDUCATOR, I pledge to be part of those who will continue to seek answers.

# DECLARATION

I declare that “The effectiveness of the Government’s HIV/AIDS programme and condom use among educators is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete reference.

Full name: Mahadi Mansfield

Date:

Signed:

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Others

The author wishes to thank the almighty God for providing her with the courage and determination to pursue her dream.

My husband, Colin, for his tolerance especially when I got emotionally fragile.

My sons, Keaobaka and Peter for their understanding and support when they had to do without their motherly care and love.

# **SUMMARY**

The effectiveness of the government's HIV/AIDS programme and condom use as a prevention strategy amongst educators

By

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As South Africa is one of the countries with the highest HIV/Aids prevalence in the world, many South Africans are affected by the pandemic. The education system is one of the structures that cannot escape the effects of the pandemic. Educators are especially affected by the pandemic due to the fact that they not only have to cope with the infected colleagues who are often absent, but are also burdened with numerous orphans and vulnerable children at their schools because of the pandemic. Sometimes educators are infected themselves and still have to deal with the reality of witnessing the loved ones suffer or die of HIV related disease. The effects can be overwhelming and result in personal stress, such as depression and suicidal ideation, plus professional impairment such as through increased workload and staff negativity. Increased pressure also arises from societal expectations that educators are perceived as role models by their

communities and by virtue of their profession, are expected to practise safer sex and behave responsibly.

Current literature reveals that new infections are continuing to occur among educators hence the aims of this research were to determine knowledge, perceptions and attitudes of educators towards condoms.

Condoms have been identified as the government's integral part of STI and HIV/Aids prevention which necessitates consistent use thereof. This study focuses on determining the factors hampering consistent use by female educators since literature attests to high vulnerability rate in women.

A quantitative research design where female educators in the Dr J.C. Motaung circuit which is in Dr Kenneth Kaunda District (North-West) responded to the questionnaire was conducted. The investigation of the extent of attitudes towards condoms revealed that a high percentage of female educators do consider the consistent use of condoms very important and necessary. They display willingness and determination to adhere to its use, however there are defaults and factors causing such irresponsible behaviour are cited.

The results of the empirical results led to the researcher making some recommendations which the government can adopt in order to increase condom use and consequently curb problems affecting effective teaching and learning to take place.

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# CHAPTER ONE

## ORIENTATION TO THE STUDY

### 1.1 INTRODUCTION

Previous research has observed that safer sexual practices such as consistent and correct condom use are highly effective in disease and pregnancy prevention. Despite recent reports that there is increasing condom use, however, resistance to condom use remains high. The determinants to barriers preventing condom use will thus remain of crucial importance. This study focuses on factors inhibiting condom use among female educators and explores issues related to safe sex practices to prevent HIV infection in women, particularly because they are more vulnerable.

The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (Aids) have caused immense human suffering in the world (UNAIDS, 2009), with effects felt at various levels. HIV attacks and destroys the immune system, the most visible effect being illness and death. However, the impact of the epidemic not only affects an individual human body, nor has it been confined to the health sector, households, schools and workplaces. It also weakens society, organisations and countries, both socially and economically. Aids damages businesses by squeezing productivity, adding costs, diverting productive resources, and depleting skills (AVERT 2010). The normal functionality of many structures is disrupted and left weakened (non-functional).

One such structure that is being endangered by the HIV/AIDS pandemic is education (Louw *et al.*, 2006: 206), with consequences that are far reaching since the education sector is a leading employer in all countries. Education determines the future economy and is critical for long-term development. According to Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, 2005: 126), HIV/AIDS is having a devastating effect on the demand for education, the already inadequate supply of teachers, and the quality and management of education.

Educators form an important part of the successful functioning of an education system; however they are facing a number of problems. Jansen stated in an article "Give teachers their dignity" (*The Times*, 21 October, 2010) that often educators express feelings of frustration due to low pay salaries and their devalued standing in the community. The HIV/AIDS epidemic can only add to educators' discontent and suffering, and further rob them of their dignity. According to Hall *et al.* (2005), South African educators fall in a high risk group regarding HIV/AIDS, since the education sector is faced with training new teachers to replace the AIDS victims, and that training alone involves great expense that has to be met largely by the provinces. For instance, in the North-West, in the Dr Kenneth Kaunda district in particular, the employee assistance programmes designed to address teachers' personal problems reveal that the mortality and absenteeism rate of teachers from schools is high. The education district is facing a problem of replacing the personnel who have died of HIV/AIDS, thus hindering the performance of the whole district.

Since education is generally occupied by Blacks, females and youths, and the average person living with HIV/AIDS is a female African between the ages of 15-35 years (Vaas, 2003:195), it is logical for the emphasis of prevention and intervention strategies to be directed at the youth and females. UNAIDS (2004) and other subsequent reports, reveal that women are more vulnerable to HIV and the infection occurs earlier amongst that group. Factors ranging from gender violence to unequal power relations are cited as contributory factors.

South Africa has come a long way in responding to its HIV epidemic, with a decrease in the new infection rates among young people resulting from awareness campaigns run by the government (National Communication Survey, 2009). However, far more needs to be done if the country is to achieve its goal of halving the 2007 infection rate by 2011. The challenge is to redirect the effort to other age groups, especially married couples as they prove to be at high risk.

Promotion and provision of male condoms, together with demonstration of their correct use is an essential part of prevention of sexually transmitted infections (STIs), including HIV. It should also be an integral part of any encounter in antenatal and family planning services designed to increase options for dual

protection against unintended and unwanted pregnancies and sexually transmitted diseases (STDs). In addition, condoms should be easily accessible for all clients at every health facility during and beyond service hours.

Both male and female condoms are manufactured, the latter having been introduced recently, with South Africa cited as one of the few countries in the world where a national planning programme has played a central role in introducing female condoms. Condoms are widely recommended and they have shown to be effective in reducing infection rate by 99% in both men and women.

The male condom supplied by the public sector is made out of latex (rubber) imported from Malaysia, and procured from the supplier by the national Department of Health (DoH). Other types of male condoms can be accessed from different outlets, but quality assurance forms an integral part of the manufacturing process, before and after packaging by South African Bureau of Standards, during storage at primary and secondary delivery sites, until it reaches the end consumer. The female condom, meanwhile, is a polyurethane sheath with two flexible rings at each end, one of which is inserted into the upper vagina and the other to cover the vulva. The female condom is less likely than a male condom to leak or break during sexual activity, but intrusion of the outer ring into the vagina is reported in 2% of coital episodes. The cumulative probability of vaginal exposure to semen with female condom use has been estimated at 3% compared to 11.6% with the male condom.

- Despite the publicized effectiveness of condoms in preventing the abovementioned problems, continuous and new infection rates suggest that condoms are not consistently used. Statistics relating to STI's and HIV prevalence amongst women attending antenatal clinics in the province stood at 31% for 2009. Several factors leading to consistent use of condoms have been cited. According to Mitchell (2004:168), in the cohort study in which the HIV status of sexual partners is not known, 60% of women with HIV infection used condoms consistently. Consistent use was associated with having one partner, greater income and literacy level, abstention from illicit drug use and use of condoms as the only contraceptive method.



On the other hand, inconsistent condom use has been attributed to certain factors, namely that women who use effective or long term methods of contraception are less likely to report consistent condom use. Condom use is also related to whether the woman has informed her partner of her HIV status, and less consistent use being reported by concordant couples. Even within discordant partnerships, consistent condom use is reported by 50% of couples.

It is also notable that obstacles to greater use of male condoms include lack of availability, fear of being perceived as having multiple partners and being unfaithful to a regular partner, opposition on religious grounds and male dominance in decision-making (Albarracin, Kumkale, Johnson, 2004: 702). Women living with HIV infection may feel unable to disclose their HIV status or negotiate condom use with new sexual partners for fear of abandonment, domestic violence, loss of economic support, and social isolation.

## **1.2. STATEMENT OF THE PROBLEM**

While sexual activity is a normal and a natural process for most human beings it is often characterized by a desire for instant gratification, which has the potential for placing an individual at risk of unprotected sexual activity, unplanned pregnancy and STIs, including HIV. Literature on studies of sexual behaviour indicates that a high degree of protection is provided by consistent and correct condom use, while inconsistent or incorrect use is not protective. Most STIs and HIV infections occur because condoms are not used at all during sexual intercourse. Condom use has been advocated to reduce the risk of unplanned pregnancy, horizontal transmission of HIV to an uninfected partner, transmission of resistant virus to a partner with HIV infection, and the risk of acquisition of other STIs, including high risk human papillomavirus (HPV) types which predispose women to cancer of the cervix ( DoH, 2010).

The impact of HIV and AIDS is felt at every level of society, in families, communities and workplaces, and so threatening the effectiveness and functioning of the public sector system (Shisana, *et al*, 2005: 120). Although all sectors of society have been affected, one sector in particular that has also been

hit hard is education. In spite of all the intervention strategies implemented by the national Department of Education (DoE, 2004), teacher supply and teacher performance are declining because of the prevalence of HIV/AIDS. Specifically, the rate of STI and HIV incidents among educators in the North-West province has increased largely as a result of inconsistent and incorrect usage of condoms. Such an increase is a dependant variable, whereas condom usage is an independent variable. Individuals who believe in the use of condoms will be more likely to survive than those who do not.

### **1.3. OBJECTIVES**

The primary goal of this research is to:

- obtain an understanding of the factors leading to inconsistent use of condoms among female educators
- obtain an understanding of the knowledge, attitudes and practices of condom usage among female educators
- assess the effectiveness of the government's HIV/AIDS prevention programme.

The risk of contracting STIs and preventing unwanted pregnancies will be reduced through the use of condoms when barriers have been identified and the DoE are informed of the current affairs, such that the intervention programmes can be aligned to the need.

In view of the problem posed, and within the frame of reference defined above, this research proposes to reach the following secondary objectives:

- to establish what consistent condom use entails
- to assess the extent to which female educators use condoms
- to identify the underlying factors leading to inconsistency in condom use and
- to determine the extent to which condom use can be enhanced utilising the current information and intervention programmes available.

#### **1.4. SIGNIFICANCE OF THE STUDY**

The significance of this study is intended to lie in making a contribution to policymakers concerned with educator mortality and attrition in South Africa. The behaviour of educators may be changed if there are corresponding changes in the attitudes and thinking of the policymakers and top officials in the DoE. Added significance lies in possible changes to the morals and values among educators and within the society at large. Since education has the potential to influence these factors, the study may help regenerate value for life and thus improve human life sustainability for all economic sectors. Specifically, however, it is aimed at significantly improving wellness of educators and so sustaining them in their work of educating future generations.

#### **1.5. METHODOLOGY**

A literature review and empirical research methods were used in this study.

##### **1.5.1. Literature review**

The aim of a literature review is to show that the researcher has read and grasped the main published work concerning a particular topic or question in the field (Leedy and Omrod, 2005: 32). This includes the latest relevant journal articles, internet sources and books on the topic. A literature study on condom use and its effectiveness was conducted with the aim of understanding its use and the risks associated with lack of use. The extent to which female educators in the J.C. Motaung circuit in the North-West province are affected will be assessed in relation to other areas in South Africa and countries nationally and internationally. The literature study will seek to reveal the underlying causes and variables influencing risky sexual behavior.

### **1.5.2. Empirical study**

Surveys are appropriate for research questions about self-reported beliefs and behaviours, and are strongest when the answers people give measure variables (Neuman, 1997:228). The second advantage of a survey is that it is used to gather data from a large population through questionnaires. For the purpose of this study, which was to rely mainly on self-reported responses from the respondents, the survey was considered appropriate.

A survey design study was conducted over a two-month period with questionnaires administered to sexually active African female educators between ages 20 and 59 in the Matlosana area in the North-West province. Variables used in this research were gender (females) and age (between 20 and 59), because their values were measurable.

#### **1.5.2.1. Sampling procedures**

Large samples enable researchers to draw more accurate conclusions and make more accurate predictions (Leedy and Omrod, 2005: 319). As it is not possible to study the whole population, the sample may provide more accurate data than might have been obtained if one had studied the entire population. The findings of the study have not been generalised over the whole population of educators because the researcher used a small sample. The sampling base was selected from the Dr Kenneth Kaunda Region (North- West)., with the focus on female educators in J.C. Motaung circuit secondary schools of Matlosana Project Area Office. All female educators between the ages of 20 and 59 were eligible to participate, since this was the purposive sample relevant to answering the research question.

### **1.5.2.2. Data collection**

Following networking with the Provincial Department of Education, to obtain support for the study, data was<sup>1</sup> collected through self-administered questionnaires, which contained sections on the following:

- Personal information
- Knowledge and attitude towards condom usage
- Condom usage
- Relationship factors
- Barriers to condom usage

### **1.5.3. Analysis techniques**

Statistical analysis using the SAS (2003), SPSS (2009) statistical packages was done through the Statistical Consultation Services of the North-West University.

## **1.6. OPERATIONALISATION OF MAJOR CONCEPTS**

It is important to clarify the key concepts used in this study.

### **1.6.1. HIV**

Human immunodeficiency virus (HIV) is a specific virus that attacks the immune system and decreases its ability to defend against opportunistic infections (Fisher, 1991).

### **1.6.2. AIDS**

Acquired Immunodeficiency syndrome (AIDS) is the medical designation for a set of symptoms and opportunistic infections (Irwin, Miller & Fallows, 2003). “Acquired” refers to the transmission of disease from one person to another, while “Immunodeficiency” is a disease that weakens and destroys the body’s ability to

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<sup>1</sup> Although ‘data’ is a Latin plural of datum, it may also be used grammatically as an uncountable singular, as is the case in this paper.

fight off infectious organisms. “Syndrome” refers to a particular pattern of illness associated with this disease.

### 1.6.3. STIs

Sexually transmitted infections (STIs), previously termed STDs (sexually transmitted diseases), are conditions that have a significant probability of transmission between human or animals by means of human sexual behaviour, including vaginal intercourse, oral sex and anal sex. The transmission of STIs is through exchange of semen, blood, and other body fluids.

### 1.6.4. HIV prevention

Strategies exist to protect people from the risk of HIV. HIV prevention should be comprehensive and include methods that will provide information, build skills and provide access to essential commodities such as condoms or, in the case of intravenous drug users, sterile injecting equipment. HIV prevention needs to reach both people who are at risk of infection and those who are already infected.

### 1.6.5. Sexual behaviour

Sexual behaviour is a form of physical intimacy that may be directed to reproduction and/or to the enjoyment of activity involving sexual gratification (*The International Encyclopaedia of Sexuality*, 2001).

### 1.6.6. Mortality

Mortality, in the sense in which it is used in this study, refers to the large number and various categories of deaths caused by a disease.

### 1.6.7. HSRC

The core business of the Human Science Research Council (HSRC) is to conduct large-scale, policy-relevant, social-scientific projects for public sector users, non-governmental organisations (NGOs) and international development agencies. This is a partnership with researchers globally, but specifically Africa (HSRC, online).

#### 1.6.8. UNAIDS

The Joint United Nation Programme on HIV/AIDS (UNAIDS) regards itself as an innovative partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support (UNAIDS, 2009).

#### 1.6.9. HCT

The HIV Counselling and Testing (HCT) campaign has replaced VCT (Voluntary Counselling and Testing), since its launch in April 2010. It is a more direct campaign, actively encouraging people to test and aims to test 15 million people by June 2011. The launch of a new campaign is aimed at mobilising all South Africans to be tested for HIV and to ensure that every citizen and occupant knows his or her status.

#### 1.6.10. AVERT

It is an international HIV and AIDS charity based in the UK, working to avert HIV and AIDS worldwide, through education, treatment and care.

### **1.7. ETHICAL CONSIDERATIONS**

Ethical measures were adhered to and included aspects such as the quality of the research, ensuring confidentiality and anonymity, privacy, and prevention of harm, the right to withdraw from the research without consequence, if respondents felt otherwise uncomfortable.

### **1.8. LIMITATIONS OF THE STUDY**

The study was limited to a small area and a small group of the population, therefore the results may not be representative. The study concentrated only on one area, the Matlosana area of the North-West Province, so generalisation of findings should be made with caution.

## **1.9. CHAPTER DIVISION**

For this study, data has been carefully analysed and selected, divided into different aspects of the study. These aspects are discussed fully in five separate chapters.

**CHAPTER 1** is the introduction to the study, including the background, problem statement and methods employed in data collection and analysis.

**CHAPTER 2** reviews the latest literature on condom use, and develops a theoretical framework in which to conduct the research.

**CHAPTER 3** presents the steps used to determine the study objectives.

**CHAPTER 4** analyses the results of the research.

**CHAPTER 5** presents a summary and draws conclusions from both literature and the empirical study. Recommendations are made for further study.



## CHAPTER 2

### CONDOM USE AS A GOVERNMENT'S PREVENTATIVE STRATEGY

#### 2.1. INTRODUCTION.

South Africa's HIV epidemic is defined by the Joint United Nations Programme on HIV/AIDS (UNAIDS) as being a hyper-endemic epidemic, due to the country having more than 15% of the population aged between 15-49 living with the condition (UNAIDS,2008:1).

**Table 2.1:** HIV prevalence by province, 25+ age group, South Africa: 2002, 2005, and 2008

	2002			2005			2008		
	n	%	95% CI	n	%	95% CI	n	%	95% CI
Western Cape	579	11.2	6.6–18.3	1 072	2.7	1.6–4.6	1017	5.4	3.7–7.9
Eastern Cape	562	8.1	5.5–11.9	1 128	13.8	10.9–17.4	986	15.6	12.0–20.1
Northern Cape	347	10.6	7.0–15.6	588	8.0	5.6–11.4	636	8.6	6.2–11.9
Free State	368	22.0	14.3–32.2	534	19.7	13.2–28.4	505	20.4	17.0–24.3
KwaZulu-Natal	720	14.9	10.1–21.5	1 449	20.5	16.8–24.6	1 338	23.5	19.7–27.8
North West	307	17.8	13.4–23.3	528	18.9	14.3–24.5	600	17.7	13.9–22.2
Gauteng	658	18.1	13.8–28.8	1 317	14.9	11.9–18.4	1 057	14.4	11.4–18.0
Mpumalanga	241	21.0	14.8–28.8	584	24.4	19.6–30.0	475	24.5	18.4–31.9
Limpopo	299	14.0	8.8–21.8	712	11.4	8.7–14.9	577	16.7	12.2–22.4
National	3 981	15.5	13.6–17.6	7 912	15.6	14.2–17.1	7 191	16.8	15.3–18.4

Source: National Communication Survey, 2008

Table 2.1 shows HIV prevalence among the sample size of adults over time. Some of the provinces have had substantial increases in prevalence (KwaZulu-Natal is the highest), while others declined (Western Cape is the lowest), and in some there was no change. This empirical study was conducted in the North-West

province hence it is of interest to note the HIV prevalence there, which shows a slight decrease when comparing 2002, 2005 and 2008. According to the National Antenatal Sentinel HIV and Syphilis Prevalence survey in South Africa, 2009 (DoH, 2010), the HIV prevalence in this province has declined slightly by one percentage point from 31% in 2008 to 30% in 2009. Of the four health districts in the North-West province, HIV trends among antenatal women were reported to be the highest in the Bojanala district (34.9%), followed by Dr Kenneth Kaunda (29.2%). Dr R.S. Mompoti was at 25.7% and Ngaka Modiri Molema at 25.1% (DoH, 2010).

Various studies confirmed heterosexual transmissions between couples to be the predominant mode of HIV spread in Sub-Saharan Africa, of which South Africa is part. According to the department of health, condom use has been proven to be more effective in preventing HIV and still requires its promotion to be intensified. This chapter will clarify the role played by condom use as a preventative measure in relation to the HIV/AIDS epidemic through previous literature.

#### **2.1.1. Condom use**

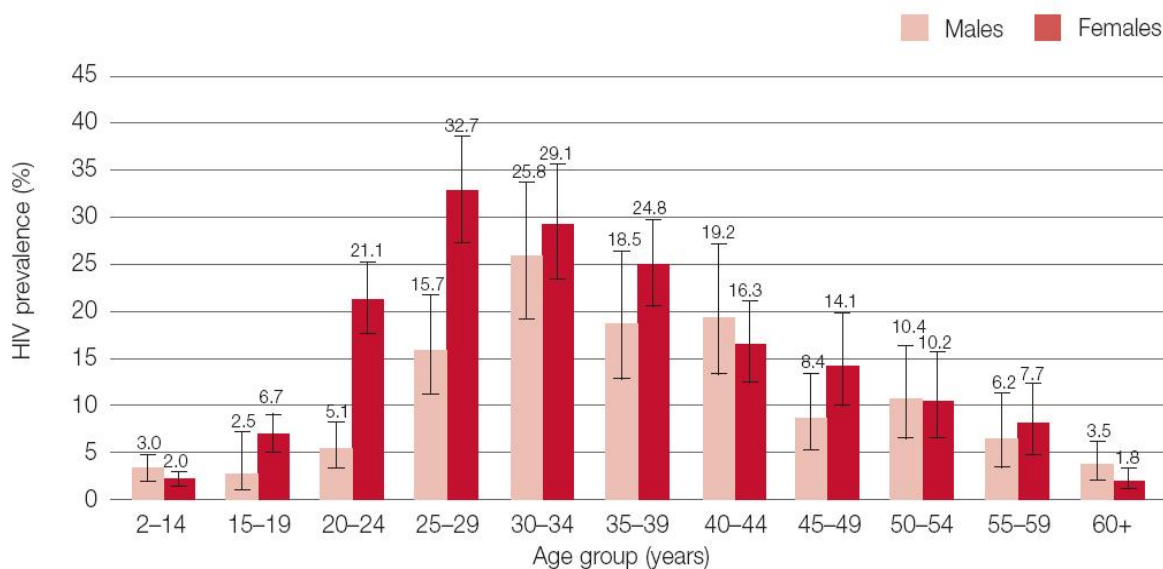
Condoms are an integral part of STD and HIV/AIDS prevention and their use has increased significantly over the past decade (Peltzer, 2004). The National Communication Survey (2009) revealed that condom use in South Africa is increasing, with the percentage of those using a condom during their last encounter increasing from 27% in 2002, and 35% in 2005 to 62% in 2008. According to Peltzer (2000:48), correct use reduces the risk of HIV transmission by almost 100 percent. In support of Peltzer, the World Health Organisation (WHO, 1995:5-10) submits that condom promotion should continue to receive considerable attention in the fight against the AIDS pandemic.

Considering that HIV transmission is mainly through sexual contact, condom use should be strictly adhered to, yet the slow decrease in the HIV infection rates and the prevalence of new infection bears testimony to non-conformance of correct and consistent use of condoms. The number of people newly infected in 2008 was 2.7 million (UNAIDS, 2008:4). Orrington, Bradshaw, Johnson and Budlender (in (Shisana and Rehle, 2005) argue that South Africa has been affected greatly by

HIV AIDS, with over 5 million people infected with HIV by mid 2004. The global statistics issued in 2005 by WHO confirmed an increase in numbers living with HIV, newly infected children and adults and deaths. The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million [31.1 million- 35.8 million], more than 20% higher than in 2000, and the prevalence was roughly threefold that of 1990 (WHO, 2008:3). However, according to UNAIDS OUTLOOK (2008), of greater concern is that measurable progress on access to treatment has yet to be made.

### 2.1.2. Women’s vulnerability to HIV

UNAIDS (2004) revealed the infection rates among women occur early. According to Shisana, *et al.* (2005), the situation has continued to worsen, with infection of women peaking at 10 percentages higher than that of men. UNAIDS (2006:2) attested to figures escalating to 50.8% or 17.3 million of 34 million people living with HIV being women. 2008 figures show the similar results, indicating minimal change in the women’s and girls’ vulnerability (UNAIDS, 2008).



**Figure 2.1:** HIV-prevalence according to sex and age group, South Africa 2009  
Source: National Communication Survey, 2008

Of great concern from the findings in Figure 2.1 (above) on women's vulnerability are the sustained high levels of HIV infection among young females. HIV prevalence among females increases even more dramatically in subsequent age cohorts, reaching 21% among the 20-24- year-olds, and 32.7% among 25-29-year-olds. By age 30-34 the disproportionate levels of HIV prevalence are much smaller, although with females still having a higher HIV prevalence than males. The figures of high HIV prevalence in females can be attributed to a number of factors, in particular violence against women, including sexual violence, which is widespread in South Africa. According to the National Communication Survey (2009), more than 40 percent of South African men admitted having been physically violent to an intimate partner. Furthermore, the survey reported that over 25 percent of men admitted having raped a woman, and five percent within the previous year. Based on the above figures, the generally high HIV prevalence among all men surveyed suggests there is a good chance that a man who commits rape has HIV. The survey confirms previous studies that the disempowerment of South African women revealed by such high levels of rape and domestic abuse is a factor in the country's HIV epidemic. According to Shisana, *et al.* (2005: 130), it is commonly asserted that women who are unable to negotiate safer sex and condom use will inevitably be at a higher risk of HIV.

HIV prevalence among women aged between 25 and 29 was 33% in comparison to men between the ages 34 and 39 at 23% globally. This proportion has remained unchanged, and was at the same level in all three (2002, 2005 and 2008) HSRC surveys. Considering the results of the South African National survey (2008:30), condom promotion efforts should specifically address women, especially since women and girls account for almost 57% of adults living with HIV in Sub-Saharan Africa.

It is against this background that this study will pursue the enquiry into gender inequalities that predispose women to HIV vulnerability, as recommended by The Global Coalition on Women and AIDS (an UNAID initiative). The Global Coalition on Women and AIDS is therefore advocating the empowerment of women and the promotion of girls' rights as one of the ways that could reverse the dramatic upward trend of HIV infection.

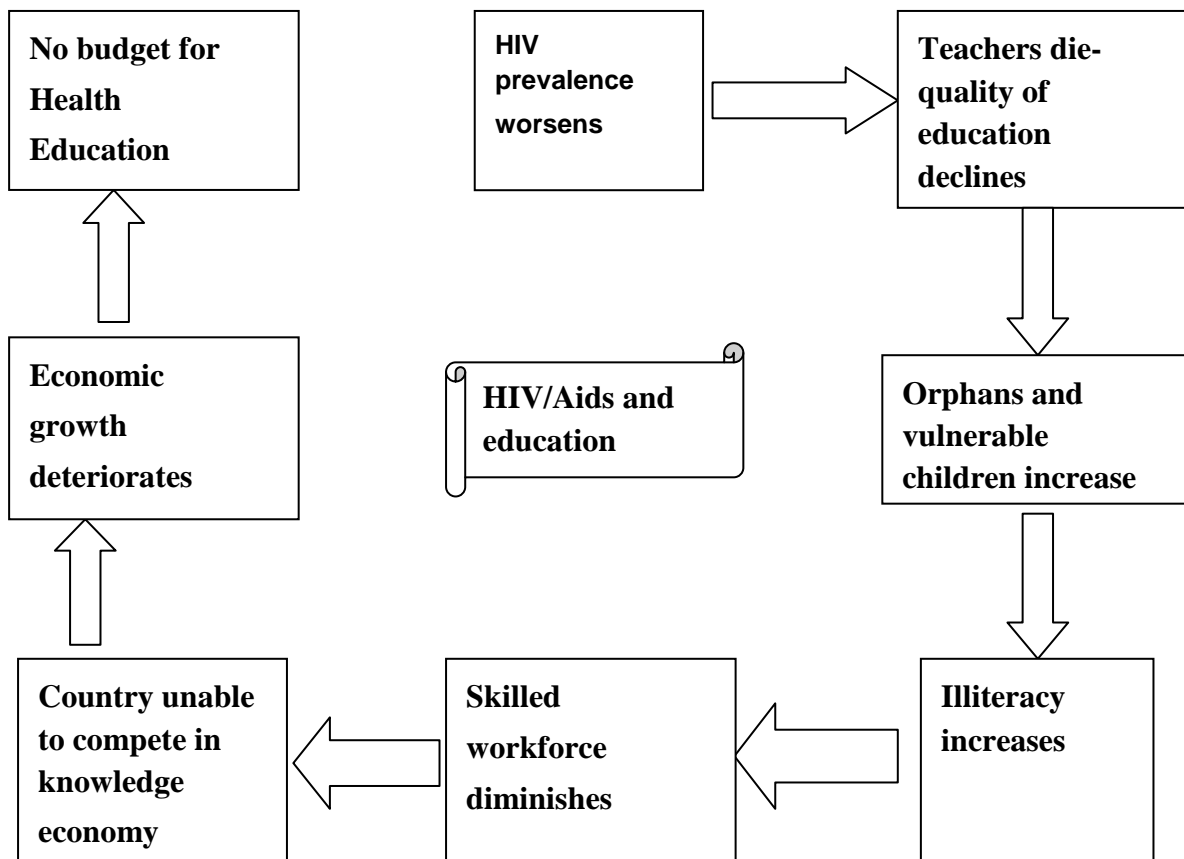
### **2.1.3. The effects on education.**

Within the context of the challenges presented worldwide by HIV/AIDS, Coombe (2000:6) reported that the DoE was struggling to deal with the problem. A claim substantiated by Bennel (2005:440), who asserted that they anticipated HIV/AIDS threatening impact to the efficient, functioning of the education sector and found it necessary to commission risk assessment of HIV impact on the education sector to be undertaken. However the results of the report in 2000 were not released due to very high estimates, later proven inaccurate by HSRC research conducted in 2004. It is apparent that the DoE's concerns were justifiable, considering the submission made by Coombe (2000:7) that the education service is the largest occupational group in the country. Therefore, educators form part of the global statistics and workforce and are proportionately affected by the prevailing AIDS epidemic. The HIV prevalence curve for South African public sector educators indicated a 12.7% rate (Louw;*et al*, 2009:205).

According to *Good Practice Notes* developed by the Environment and Social Development Department (2002), impacts of HIV on the workforce included an increase in sick leave and other absenteeism, a decline in work performance due to employee illness, voluntary resignation, and death, all of which have led to loss of skilled and experienced employees. Similar results were found to be present by Shisana, *et al* (2005), including:

- ❖ Performance decline as co-workers are demoralized by loss of a colleague.
- ❖ Morale, discipline, and concentration of other educators are disrupted by frequent deaths of colleagues.
- ❖ Performance is further affected by stigmatisation and discrimination.
- ❖ Learners, as an essential part of the success of teaching and learning, are also traumatised as they witness their perceived role models die before them, with a further impact on performance.

Coombe (2000:7) reports that HIV positive educators' lifespan will be reduced without access to antiretroviral drugs which help prolong their lives. Many others will be ill and therefore absent from work, and become preoccupied with HIV-related family crises. As a result, school effectiveness is bound to decline.



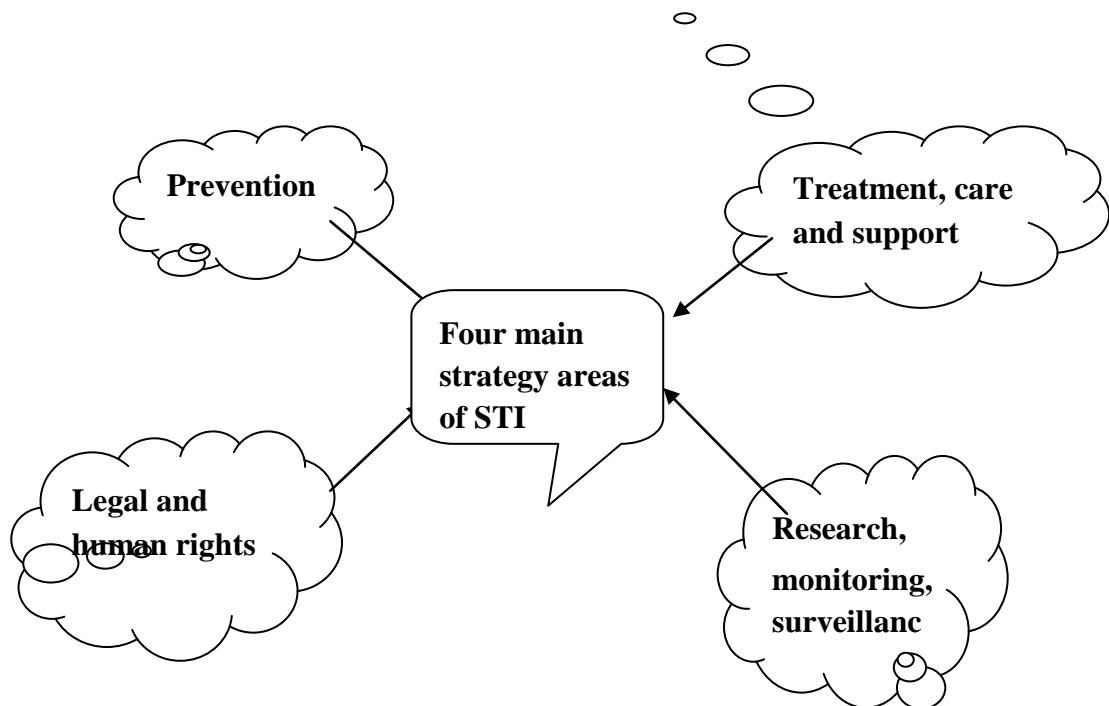
**Figure 2.2:** HIV/AIDS and Education (Anon., 2006)

Figure 2.2 (above) depicts the negative effects that HIV/AIDS have on education. According to Hall *et al.* (2005), the effects of the sickness have been presenting serious challenges to the DoE, as increasing numbers of teachers are absenting themselves from school, leaving the educational system or dying unnoticed. As skilled and highly educated personnel become infected, the concern increases.

Based on the various authors' literature, one may reason that there is a considerable scope for improving the rates of heterosexual condom use in addressing devastating HIV/AIDS pandemic. WHO (2008) endorsed the finding that AIDS-related illnesses remain one of the leading causes of death globally and are projected to continue as a significant global cause of premature mortality in the coming decades.

## 2.2. THE GOVERNMENT'S FIGHT AGAINST HIV

The government is also affected by the AIDS pandemic (Lewis, 2004), most directly as it takes much responsibility for the cost of additional AIDS-related spending aimed at combating the spread of the disease (e.g. public awareness and educational campaigns, condom distribution initiatives), as well as the cost of care for those population groups who are already infected and are dependent on public health care system. Realising, somewhat belatedly, the seriousness and the magnitude of the pandemic, it created the STI Strategic Plan for South Africa in 2000-2005. Since then, improvements and modifications were made, culminating in the new revised Strategic Plans (2007-2011). According to Jordaan (2006:23), failure to discover a medical cure has resulted in a number of prevention strategies being implemented in an attempt to combat the spread. The four main areas of focus in the Strategic Plans are indicated in Figure 2.3:



**Figure 2.3:** The four main areas in the Strategic Plans

It was realised that a real commitment to halting the spread of the epidemic required that health education be improved in terms of effectiveness and resources, with teaching on HIV/AIDS in educational institutions being vital. It had to be included in discussions on sexuality in the broadest sense, and, as part of

wider curriculum reform, 'Life Orientation' as a 'Learning Area' was introduced in schools.

According to the South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (2008), numerous research studies conducted to determine the impact and the spread of HIV/AIDS has continued to indicate that the fight against it continues to be a challenge in many countries. According to Coombe (2000:5), in South Africa the government and its partners had demonstrated their commitment to combat the pandemic since the first South African HIV/AIDS strategy and implementation plan (DoH, 1994). Despite high levels of STDs, the low status of women, social norms which accept or encourage high numbers of sexual partners, and resistance to the use of condoms, the National Communication Survey of 2008 reported that the government's battle continues, as proven by its engagement in a number of activities such as:

- Mother-to-child transmission prevention programme
- Voluntary counselling and testing (VCT) programmes
- HIV/AIDS education programmes, all of which are aimed at addressing the pandemic by achieving behavioural change.
- AIDS awareness campaigns
- Condom use and distribution
- Sex education in schools
- The launch of a major counselling and HIV testing campaign (HCT) in 2010. The National Strategic Plan is aiming for one quarter of all people to take a test every year by 2011.
- Reviewing the evidence on male circumcision and HIV reduction so as to give further guidance on the practice.

All of the above-mentioned comprehensive measures and prevention programmes are put into place in an attempt to continue the fight against the spread of HIV/AIDS and to reduce the mortality rate associated with AIDS.



**Table 2.2: History of SA governments' prevention strategies**

1985	An AIDS Advisory Group was established
1991	First official AIDS Programme was established
1992	The National AIDS Co-ordinating Committee of South Africa was established
1994	Consolidation of National AIDS Strategy and National AIDS Plan
1997	The South African National STD/HIV/AIDS Review which resulted in STD/HIV/AIDS Strategic Plan for South Africa, 2000-2005
Jan 2000	Final draft of STD/HIV/AIDS Strategic Plan for South Africa, 2000-2005 and is the policy framework
Dec 2006	Release of Broad Framework for HIV/AIDS/STI Strategic Plan for South Africa 2007-2011
March 2007	The final National Strategic Plan for South Africa 2007-2011

### **2.2.1. Prevention strategies of the South African government**

Since there is no cure for HIV, prevention strategies are extremely important (ECA, 2000), with most focussing on the common modes of HIV-infection, such as sexual transmission, conditions, norms, practices and intravenous drug use. The government's understanding of the causes of the epidemic will shape their prevention strategies, and according to the DoH these are socio-economic conditions such as poverty, commercial sex work, migrant labour, the low status of women, illiteracy, stigma and discrimination.

The national response to HIV is managed at different levels. At national and provincial level there are a various structures with responsibilities and roles in relation to the prevention of HIV/AIDS. The most important body is the National AIDS council that advises the government on STD/HIV/AIDS policy and advocates the involvement of all relevant sectors in programmes and strategies.

The Strategic Plan for the prevention, care and treatment of HIV/AIDS has the following elements:

- A strategy that is effective with culturally appropriate information
- An increase in the access as well as acceptability of voluntary HIV testing and counselling
- A strategy to improve both care and treatment of People Living With HIV and AIDS.

The focus of this research will be on the prevention strategies since they have proven to be of gradually benefit. According to the key facts of the National Communication Survey (2009), knowledge of HIV prevention is high, condom use being the most commonly known preventative method at an average of 87% across age groups. The same sentiments are shared in the government's Strategic Plan, which states that if prevention strategies are implemented properly they can work. There follows a discussion of the specific goals.

#### **2.2.1.1. AIDS awareness campaigns**

The government has engaged in strategies aimed at increasing and scaling up the awareness of HIV. In April 2010, a principle of the HIV counselling and testing was launched in order to create a general discussion of HIV throughout the country. The strategies included the use of the media to publicise availability of free testing and counselling in health clinics. Khomanani was such a government initiative, using the media to broadcast its messages, including radio announcements and the use of situational sketches of television. There was also door-to door-campaigning, billboard messages and vox pops to highlight personal experiences and expel the myths and stigma of HIV (AVERT 2010). The findings of the National Communication Survey (2009) reveal that 90% of South Africans were reached by at least one of the eleven HIV/AIDS communication programmes examined in the study.

#### **2.2.1.2. Condom use and distribution**

The department of health asserts that it is evident that condom distribution is very important in the behavioural change strategies of the prevention programme. The DoH therefore targets all areas, especially those of high transmission, such as borders, mines, truck-stops and brothels (DoH, 2010). The distribution of condoms in all government buildings is also advised as an attempt to broaden the

responsibility of HIV prevention. The DoH procures and distributes male condoms to all provinces, and a limited supply of female condoms is available at selected clinics.

#### **2.2.1.3. Sex education in schools**

The first objective of the National Strategic Plan (2008) was to promote improved health seeking behaviour, as well as the adoption of safer sex practices by individuals. This was to be achieved by education, and the distribution of information, communication material and messages to different stakeholders. Life skills education at primary and secondary school level would ensure that these messages reached the main target group, the youth. The life skills education programme was a combined effort by the Department of Health, Department Welfare and Department of Education to ensure that school children receive information regarding HIV/AIDS. This part of the programme was to be funded by the government (DoH, 2001).

#### **2.2.1.4. HIV Counselling and Testing (HCT)**

HIV counselling and testing programmes are designed to provide easy access to HIV testing for persons who wish to know their serostatus, through an approach that emphasizes the informed consent (Marum, *et al*, 2002). These programmes enable individuals and couples to learn their test result in a setting in which confidentiality is strictly maintained, and they strive to empower persons to use their test results to make informed decisions about important life events such as partner selection, marriage, pregnancy and family finances, and to help individuals reduce risk of HIV transmission (Ibid.). Government is insistent that people should know their HIV status, as the most appropriate way to ensure that those with opportunistic infections receive the treatment they need. Since 2000 until the introduction of HCT in 2010, VCT stations have been opened in all provinces. As the government seeks to increase the number of HIV testing and counselling sites, so the number of people seeking VCT services should also increase. The National Communications Survey (2009) indicated a positive development in the effectiveness of programmes and the general perception towards testing, following the optimistic results from surveys conducted in 2002 and 2005 that showed VCT

in the form of HIV testing had increased from 18.9% to 30.3% (Shisana et.al., 2005). There has been an increase of 36 percent since 2006.

#### **2.2.1.5. Male circumcision**

The government has included voluntary medical male circumcision as an integral part of its HCT campaign. According to AVERT (2010), several large studies of male circumcision and HIV have produced evidence supporting a claim that the procedure reduces by 60 percent the risk of sexual transmission from women to men. However, the National Communication Survey (2009) revealed that such evidence is problematic, with only 7.5% and 12-22% of men, and 12-17% of women across age groups believing that circumcised men do not need to use condoms. A belief amongst poorly educated citizens that circumcision is an alternative to condoms is therefore a dangerous one.

#### **2.2.2 Problems with government's prevention strategies**

A number of problems have arisen from the government's prevention strategies.

*i. ABC strategy fails to address issues of masculinity*

The Abstain Be Faithful Condomise approach is the core of the prevention campaign as it aims at ensuring that people take responsibility for their own lifestyle. According to Jordaan (2006:143), it is questionable whether the model is applicable to a South African situation, as he strongly contends that a limited ABC approach does not take into account the realities that many women live in. Findings from her research revealed that men cannot abstain from sex and that it is perceived by young boys as their first step to manhood. Abstinence, meanwhile, is seen as a harmful practice in certain cultures, and frequent intercourse forms part of a healthy lifestyle. Men use sex to establish their power over women while married couples want to have children, especially a son in the case of men.

*ii. Condom use*

Use of condoms is not a totally secure method of prevention. They should be correctly and consistently used to ensure that they are effective. As discussed in 2.4, several factors have been seen to lead to inconsistent condom use, for example, men's reluctance to use a condom, beliefs, issue of trust, power relations between men and women, and condom use negotiation skill.

*iii Awareness campaigns*

Despite all efforts to disseminate information regarding HIV transmission, and to make people aware of safe sex practises, accurate knowledge about HIV and AIDS is poor among all age groups.

*iv Khomanani*

Khomani is also an organisation from the Gauteng Provincial Government, with a motto: "*Caring together for life*" (Soul city, 2003:1). The government has used it to distribute knowledge (through media, pamphlets) and workshops to enable people to be more informed about HIV/AIDS, however, it appears to have been downgraded following the allegations of financial discrepancies and termination of government funding in March 2010.

*v HIV and sex education*

The quality of education provided through Life Orientation as a learning area is questionable, due to lack of training of teachers and an unwillingness on the part of the schools to provide such education. In one survey, some teachers reported feeling uncomfortable about teaching a curriculum that contradicted their own values and beliefs.

*vi HCT*

Certain problems noted as impediments to an individual's willingness to access VCT were reported in the National Communication Survey (2008) as follows:

- A fear of being seen at a healthcare facility for VCT (Kalichman & Simbayi, 2003)

- The type of testing (Kassier *et al.*, 1998)
- Transport difficulties (Matovu & Makumbu, 2007)
- Concerns about confidentiality, as well as delays associated with reporting HIV test results (Greek *et al.*, 2007).

These factors will result in the lack of knowledge about one's HIV status. However, it is worth noting that continuous efforts are made by the government to eliminate these problems, hence updates pertaining to HIV/AIDS are made from time to time about new milestones reached.

Obstacles hindering the success of HIV prevention have been identified in other countries, with submissions made by various delegates at a discussion held in the UN Information Service (2006). For instance, reasons considered to exacerbate the problem of feminisation of AIDS in the USA, among others, were:

- Insufficient public policy that guaranteed women's rights.
- The persistent view of women's health that focused merely on its reproductive aspects.
- Lack of access to education and services that promoted women's sexual rights.
- Persistence of cultural and religious standards that interfered negatively in the adoption of preventive measures, such as the use of both male and female condoms, had only made matters worse.

Dr Peter Piot, the founding executive director of UNAIDS noted that the reasons identified above are indicative of different countries having different concerns and so having to design strategies targeting specifically those areas (UNAIDS OUTLOOK, 2008). For example, in Southern Africa, programmes should look more closely at issues such as young women's sexual debut, biological vulnerability, multiple sexual partnerships, the role of gender-based violence and cross-generational sex.

Louw, *et al* (2009:205) affirm that further investigations to determine factors contributing to negative attitudes towards condom use, as submitted by many other authors, will thus remain critically important, as well as supporting educators

both infected and affected by HIV. However, on a positive note, the recent trends indicate a possible turning point in the epidemic. HIV incidence in multiple countries demonstrates the possible reduction in HIV sexual transmission. For instance, in 2008, the estimated number of new infections was approximately 30% lower than at the epidemic's peak 12 years earlier (UNAIDS, 2009). There is evidence of success in HIV prevention as proven by the decline in the annual number of new infections and the prevalence among young people has fallen in many countries (UNAIDS, 2008).

South Africa has also reported a notable achievement in decreasing new infections among youth (AVERT, 2010), with prevalence having decreased among youths aged 15 -24 from 10.3% in 2005 to 8.6% in 2008 (HSRC, 2008). Recent trends also indicate an increase in condom use throughout the decade across all age groups. However, HIV prevalence remains high and the National Strategic Plan (HSRC, 2008) recommends the country to re-double its efforts if it is to reverse the trends among other age groups by 2011.

### **2.3. THE IMPACT OF HIV & AIDS IN THE EDUCATION SECTOR**

According to Bennel (2005a:440), the HIV/AIDS pandemic will continue to have a significant impact on the growth of the labour force and will create labour shortages in several sectors, including education. Even if facilities continue to be available, there may be lack of educators and other personnel to provide a teaching service. Although Bennel qualifies the impact of the pandemic, he concludes that because education is person-intensive it is extremely vulnerable and could be negatively affected where prevalence is high. Meanwhile Kinghorn and Kelly (2005:491) emphasise the need for condom use as an effective HIV prevention measure, and to secure the functionality of the education sector.

#### **2.3.1. Absenteeism and mortality**

Costs to the economy of absenteeism and reduced productivity may be higher than the costs of eventual deaths. According to Hall *et al.* (2005:36), HIV infected educators will experience ill-health as their physical well-being begins to

deteriorate and they are periodically ill. A high rate of absenteeism is then inevitable and will impact on the smooth running of the teaching and learning activities. Bennel (2005a:450) declares that when teachers are absent due to illness or medical treatment, the children are often left without schooling and can lose up to six months of teaching time. Such conditions are bound to have long-term effects as children lose the benefits of continual schooling.

Educators who are ill due to AIDS-related illnesses and not on medication have a relatively short lifespan, with a consequent reduction in the experienced and skilled workforce (Louw. *et al.* 2009:209). The statistics revealed that approximately 4,000 educators had died of AIDS-related illnesses in 2004 (Shisana, *et al.* 2005:120). In addition, Coombe (2003:3) points out that when a teacher dies from AIDS, he or she is seldom replaced immediately, due to cumbersome administrative structures and general teacher shortages. The school efficacy is expected to decline as new employees cannot make up for the loss of experienced senior educators, managers, educators, professors and science and mathematics specialists (Combe, 2003:3).

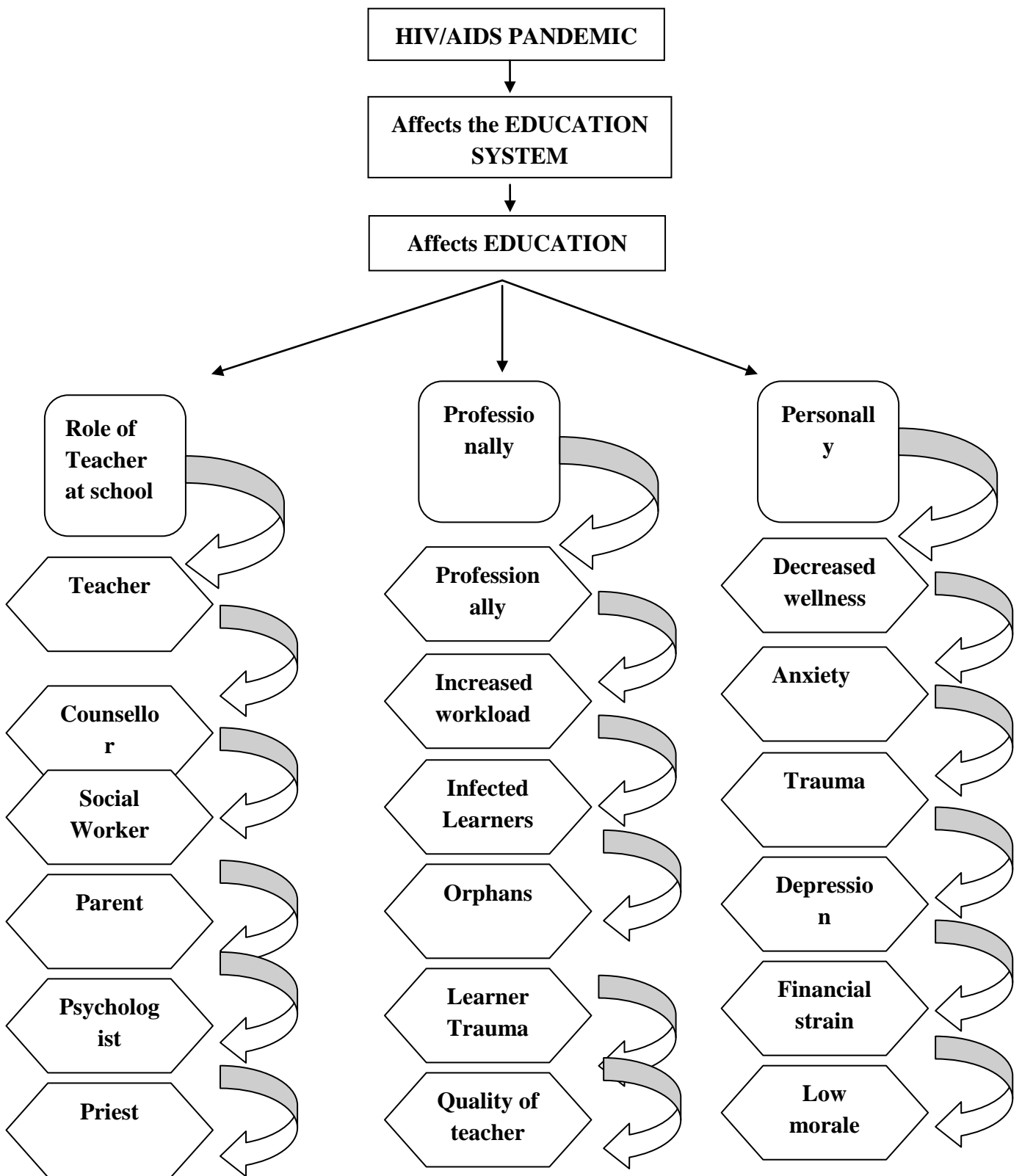
The long-term effects of ill-health and teachers' mortality will thus negatively impact on the quality of the education system in several ways. Parents' willingness to enrol their children will be reduced as they prefer to keep them at home and engage them in other activities that may add to the household income. Substitute educators will have to be sourced, who might not be readily available and have no requisite experience or subject matter knowledge. With the loss of experienced educators, poorer quality can be expected with regard to creating, presenting and explaining learning material to learners.

Louw, *et al* (2009: 206) maintains that the absence of ill educators will also add more workload to their stand-ins, leading to an undesirable learner-educator ratio. According to the World Bank (2002) absenteeism will eventually have financial implications as hiring more educators, training them and paying absent educators full salaries is costly.



### **2.3.2. Poor performance and poor education quality.**

The quality of education is also at risk through low morale of colleagues, and of learners who witness their perceived role models sickening and dying. An individual functions optimally when all spheres of life are taken care of, hence depressed learners and educators' emotional state will have an impact on the quality of education, through factors ranging from personal, interpersonal and social issues (Cohen, 2002:1). Ill educators cannot model good health or devote themselves to their profession (Theron, 2005:57). HIV/AIDS affects education at all levels by negatively impacting on education management, as the whole system becomes disorganised and weakened by fear (Cohen, 2002:1).



**Figure 2.4:** The impact of HIV/AIDS on the affected educator (Cohen, 2002)

Figure 2.4 (above) indicates the potential effect the pandemic may have on educators.

The HIV/AIDS epidemic has the potential to undermine the ability of the education sector to deliver a quality service and to support economic growth and human development (Schierhout, 2004).

## **2.4. LIMITATIONS TO CONDOM USE**

According to Zungu-Dirwayi, Shisana, Louw, Dana (2007:1296), factors contributing to lack of condom use, among others, vary from country to country, different age groups, gender, social background and sexuality. Factors affecting condom use are a range of situational, interpersonal and structural factors, such as knowledge about AIDS, behavioural intention, perceived susceptibility, perceived barriers, self-efficacy, and demography. This study will focus on social restraints, which the individual finds it more difficult to shake off and hence may experience conflict when trying to deviate from expected norms of behaviour (Sarkar, 2008:114). There is an urgent need for HIV prevention interventions in South Africa, and the most effective interventions will be informed by careful analysis of social and behavioural factors associated with increased risks of HIV infection.

### **2.4.1. Gender**

Gender inequality in society, gender-based human rights abuses, poverty among women, violence, and lack of legal protection increase the incidence of HIV infection among females. The spread of the infection can be curtailed by tackling the factors that compel girls and women to engage in risky behaviour. Toraya Obaid, the executive director of UNFPA, reiterated in her presentation during the AIDS discussion in the USA (2006) that it is only by addressing the needs and human rights of women, and ensuring their full participation in decision-making, that the course of the HIV pandemic can be changed.

Women have been exposed to varying forms of inequalities in different cultures and situations. Their general status in society is low and they are often discriminated against, hence it is no surprise that vulnerability to HIV infection is considerably higher among females, in spite of prevention programmes addressing both genders. Lack of condom use by women may be attributed to factors stemming from stereotypical gender roles that deprive women of involvement in decision-making, including risky sexual matters that endanger their lives.

Ironically, as Campbell (1997) argues, ideologies of male superiority surrounding gender roles also increases the vulnerability for males, in that women may want to take measures to protect themselves from HIV infection but having received no cooperation from men could go on to spread the infection to them. Nevertheless, HIV prevalence among women in South Africa continues to be higher than for males, despite the availability of a comprehensive plan for the control of HIV and a plethora of prevention programmes (Zungu-Dirwayi, *et al* (2007: 1296). It is against that background that this study seeks to further explore underlying causes leading to inconsistent condom use among female educators, as an effective HIV prevention measure.

Zungu-Dirwayi, *et al* (2007: 1296) maintains that there is much known about the relationship between HIV and gender, whereas little is known about this relationship among educators. Educators are perceived to be in a better position to practise less risky sexual behaviours as they are responsible for imparting life skills designed to prevent HIV infection and should behave in accordance with their teaching. The question remains, however, as to why they have some of the highest rates of infection. First it is necessary to qualify the statistics, as there are other variables with which gender interacts, including age, race, religion, class, social and economic status and wealth.

#### **2.4.2. Age**

The prevalence of HIV was highest among educators aged 25 to 35, and low for older educators. Women had a much higher prevalence than males, but only for

educators aged 25-35 years. For educators older than 50 years of age, men had higher prevalence than men (Zungu *et al.*, 2007:1296).

### **2.4.3. Intergenerational sex**

Muula (2009: 426) refers to intergenerational sex as a form of sex where younger females are having sex with older males, usually with five years of difference. The difference in age implies insufficient knowledge about HIV transmission and inexperience in decision-making skills, as well as lack of self-efficacy amongst the younger females in communicating their desires and wishes. The significance of such relationships for this study are a lack of skills and power to negotiate the use of a condom, as the younger female is at elevated risk of exposed to HIV, particularly as the older men, by virtue of being older, have had more time to acquire sexual experience and develop potential power which they can use to manipulate the situation in their favour.

Further, older partners of young women and girls frequently sustain multiple and concurrent partnerships, not only with other casual partners but also with a main long-term partner. Such individuals may act as a bridging population, encouraging the opportunist HIV to spread indirectly from older to younger age groups. Shisana *et al.* (2005:130) confirmed the status quo, reporting higher prevalence among teenage males and females who reported having sexual partners who were five or more years older than themselves. Termed by Hope (2007:1-3) as “sugar daddies”, she aligned herself with the associated risks of intergenerational sex, including complications or death from unsafe abortions.

Younger women’s vulnerability is perpetuated by factors such as poverty, which then leads to transactional sex.

### **2.4.4. Educational status**

Analysis showed that those with higher education, regardless of whether they are male or female, had a lower HIV prevalence compared to those with less education (Zungu *et al.*, 2007:1297). The study conducted by Maharaj and Cleland (2005:25) in Kwa-Zulu Natal also revealed that, in general, younger,

better educated couples were more likely to use condoms than older, less educated couples.

#### **2.4.5. Women's position in society**

Ackermann and de Klerk (2002:163) referred to the position of women in society as the very factor that predisposes them to poverty, malnutrition and uncontrolled fertility, which increases their risk of acquiring HIV. In South Africa, as in many other parts of the country, women are born into inequity, which has the effect of restricting their ability to protect themselves from STIs and thus HIV infection (Ackermann & de Klerk, 2002:163).

#### **2.4.6. Power relations**

The relationship may be characterised by male dominance, where the female partner is rendered powerless and has minimum or no say in decision-making (Pullum, Cleland and Shah, 2005:5). Various factors are attributed to that situation, such as the nature of the relationship, income inequalities, societal stereotypes, and gender roles depicted in different cultures that subsequently put a woman in a disadvantaged position of negotiating, whether they are used or not. Women have reported that the relationship with their partners had been difficult because of the absence of dialogue about sexual matters, but with men always having the last say (Sarkar, 2008:116). Women may need motivation and skills that will enhance behaviour, such as negotiation, assertive communication, and refusal of sex unless a condom is used.

#### **2.4.7. Marital factors**

Despite early announcements that HIV was exclusively transmitted by homosexuals, HIV is also transmitted in heterosexual activity. Since both partners are capable of spreading it, a certain level of mutual communication, decision-making and agreement should be attempted. However, as Sarkar (2008:115) argues, mutual agreement pertaining to sexual matters is not always forthcoming.

The suggestion to use condom may create uncomfortable suspicions of lack of trust, infidelity, especially in an abusive relationship. Marriage is characterised by trust and love, but in various studies conducted at Tanzania, Uganda, Zimbabwe married men had an unprotected sex as they did not feel the need to use a condom with their regular sexual partners (Pillum, *et al.* 2005:10). In Tanzania, men felt it appropriate to use a condom at the beginning of a sexual relationship, before they knew how much to trust a person, but that there was much distrust, suspicion and even paranoia surrounding the use of condoms within marriage or between partners in a stable relationship.

Hadden (1997, in Kalichman, *et al.* 2005: 299) confirmed the suspicions associated with requesting the use of a condom. According to a study conducted by the International Centre for Research on Women, it was found that South African women do not initiate discussions about safer sex or tell their partners to use a condom because their husbands may be suspicious that they are cheating.

#### **2.4.8. Gender-based violence**

It is essential to note that women need control over their own bodies and lives, and mutual consent in sexual relations thus becomes significant hence the investigation of factors that make women unable to practise “safe sex” becomes inevitable.

Women cannot be expected to negotiate safe sex in a culture of gender violence (Ackermann and de Klerk, 2002:166). Any reference to a condom implies mistrust and often results in dissension, even violence and therefore refusal to engage in sexual activity with husband is out of the question in those settings (Pillum *et al.*, 2005:5). The unfortunate part is women sometimes stay in those abusive relationships because of fear and economic dependence.

Studies conducted in the USA show that women in violent and abusive relationships are less likely to use condoms, more likely to incur abuse as a result of requesting condoms, and more likely to contract an STI than women who have not been in violent relationships (Kalichman, *et al.*, 2005:300).

Associations between violence, particularly sexual assault, and risks for HIV/STI have also been observed in Southern Africa, where girls' and women's rights to choose when to have sex are reported not to be respected. For example, 30 percent of women said their first intercourse had been forced and 71 percent had experienced sex against their will (Maharaj & Cleland, 2005: 25). Married couples and those in steady relationships will therefore become reluctant to negotiate condom use and rely on uncertain assumptions that their partners are faithful. The South African National HIV Prevalence, Incidence, Behaviour and Communication Survey conducted in 2008 confirmed low use of condoms with primary partners, either spouses or steady partners. Overall levels of condom use decrease as the degree of intimacy or regularity of the partner increases. Even amongst those who do use condoms, few users achieve 100% consistent use.

#### **2.4.9. Multiple sexual partners**

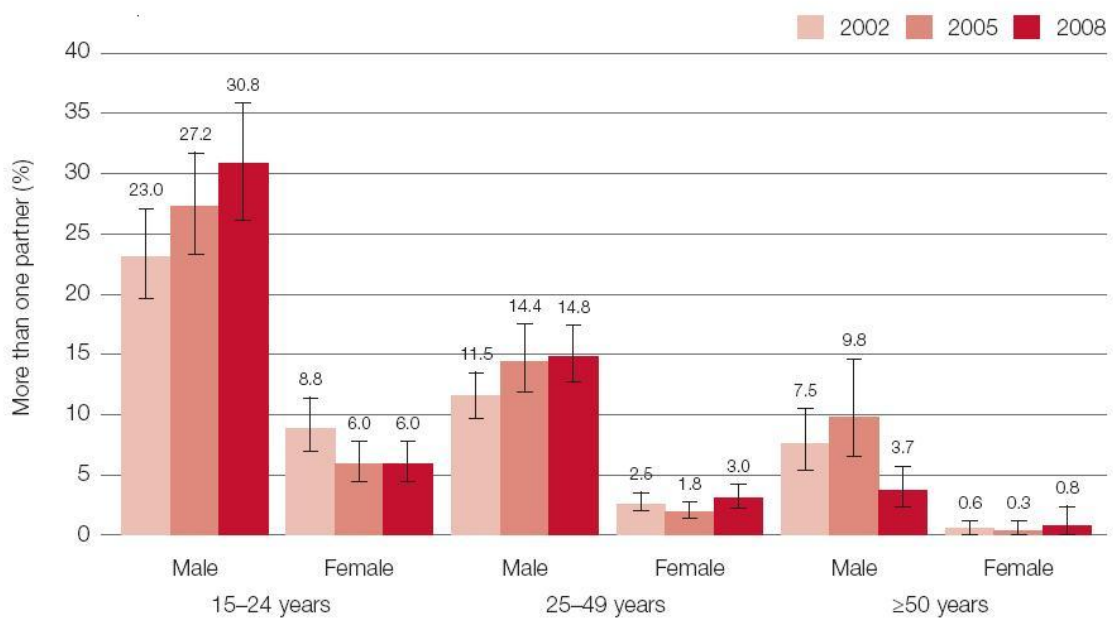
Concurrent sexual partners, where sexual relationships overlap in time, are noted to be a major factor contributing to the rapid growth of HIV infections, as they create multiple pathways for HIV transmission to occur. Zungu *et al.* (2007:1299) reported cases of women admitting to knowing that their partners were involved in extra-marital affairs, and for many women the threat of HIV infection begins with such a lack of control over the sexual lives of their partners. For many wives, the danger lies in their husband's sexual relationships outside marriage. Pullum, *et al.* (2005:6) argue that women could advise the husband to use a condom, irrespective of his extra-marital; behaviour, thus placing their own well-being above concerns for their husband's infidelity.

Despite awareness of the partner's engagement in multiple relationships, women have still had unprotected sex due to lack of power in the relationship, especially if the male partner has personal attitude towards a condom (Kalichman *et al.*, 2005:302). This means that many more women are at risk as many new infections in women are from their long-term male partners. It is for this reason that further investment in condom use has continued to be of significance, since even with increased supply and promotion many people were still not using condoms, especially with their main partners.



UNAIDS (2008) reflected a positive change in condom use among people in multiple relationships, especially in areas most affected by the epidemic. There has been an increase in the number of males (33%) and females (27%) using condoms in the last year (2008).

Figure 2.5 (below) shows the data on multiple sexual partners among adults in the past 12 months by age group.



**Figure 2.5:** Percentage of adults who reported having more than one sexual partner in the past 12 months by age group, South Africa 2002, 2005, and 2008

Source: National Communication Survey, 2008

The results presented in figure 2.5 attest to the gender differences on multiple sexual partners among adults. In all three surveys, statistical gender differences were found between percentages of male and females who reported having had multiple sexual partners in the past 12 months. Such partners were 4 to 7 times more common in males than in females.

#### **2.4.10. Cultural beliefs**

Cultural practices, values, norms and traditions impact on people's control over their sexual lives and create unequal power relations between men and women. Kalichman, *et al* (2005:299) believes that culturally-sanctioned gender roles foster power imbalances and facilitate women's risks for both sexual assault and STI/HIV. When gender power imbalances place women in subordinate roles, they have few options for exercising personal control in their sexual relationship.

In some cultures, the belief that the man is the head of the family has perpetuated the notion that sexual intercourse is about his own personal sexual pleasure. Condoms are sometimes perceived as reducing men's emotional fulfilment with attainment of satisfaction through direct penile-vaginal contact and ejaculation during natural intercourse (Sarkar, 2008: 120). The willingness to use a condom as a HIV prevention strategy is therefore overshadowed by sexual pleasure.

Glick *et al.* (2000, as quoted by Kalichman, *et al*, 2005:299), suggest that South African women are faced with a serious challenge in their effort to reduce their risks for HIV infection. The cross-cultural research reflected that South African men often hold strong traditional gender beliefs which consequently expose women to multiple barriers linked to increased HIV infection.

#### **2.4.12. Contraception**

Intention to have or not to have children may be a determining factor for a need to use condoms as a contraception method. A study conducted by Pullum, *et al* (2005:6) among six eastern African countries revealed that negotiating condom use was possible if cited as a contraceptive method rather than disease prevention strategy. Condoms can be accepted if family planning is stressed. Married women are not expected to refuse to have sex with their husbands, even if they fear contracting diseases. Rural women in South Africa, in particular, stated that it is inconceivable for a woman to refuse to engage in sexual activity with her husband (Pullum, *et al*, 2005: 5).

Cultures and religions that promote childbearing forbid the use of condoms. Being married creates expectations of a woman bearing children and increases non

condom use. Roman Catholicism could be cited as an example whereby the Church's hard-line stance over contraception has led to the Vatican being heavily criticised for its position in the context of the Aids crisis. Previously in 2009, on a visit to Cameroon, the Pope said the use of condoms could endanger public health and increase the problem of HIV/Aids, rather than help to contain the virus. This drew criticism from several EU states. However, the Pope seems to be gradually changing his stance in favour of condom use in some circumstances. According to the responses given by Pope Benedict XVI to the German journalist, if the intention [of condom use] is to prevent transmission of HIV, rather than prevent contraception, moral theologians would say that was of a different moral order. Pope Benedict XVI has said the use of condoms is acceptable in exceptional circumstances, according to a new book (*Light of the World: The Pope, the Church and the Signs of the Times* - is based on a series of interview the Pope gave the German Catholic journalist, Peter Seewald). He said condoms could reduce the risk of HIV infection, such as for a male prostitute, in a series of interviews given to a German journalist. But he said a more humane attitude to sexuality, and not condom use, was the proper way to combat HIV infection. The comments were made in a new book. The United Nations programme on HIV/Aids (UNAIDS) welcomed the Pope's comments and sees it as a significant and positive step forward taken by the Vatican. This move recognizes that responsible sexual behaviour and the use of condoms have important roles in HIV prevention.

#### **2.4.13. Socioeconomic status and transactional sex**

Income inequality is also linked to women's submissiveness to "safe sex" negotiations, through financial dependency and not being self sufficient. According to Zungu-Dirwayi, *et al* (2007:1296), women's economic status may increase the risk of acquiring HIV as they may have multiple sexual partners willing to pay for sex. The greater the need for money, the more likely the woman will have casual and concurrent sexual partnerships (Louw *et al.*, 2009: 209). The relationship between marital status and HIV is complex and depends on various demographic factors and sex behaviour practises (Shisana *et al.*, 2004).

Single, young educators were found to show a higher HIV prevalence (23.3%) than married educators, suggesting that they are at more risk of HIV infection because they engage in unsafe sexual practises (Zungu *et al.*, 2007:1296). Thus, being young and single has its own contributory factors that lead to vulnerability.

Using sex to make money, especially if jobless and with less schooling, increases risky behaviour in both single and married women. An individual is less likely to insist on “safer sex” if she were to benefit materially or financially from the sexual transaction (Sarkar, 2008:118). The reasons behind sex exchange for money vary, from individual to societal cultural norms. For instance, economic factors for some of the younger girls might not necessarily be as strong as peer pressure and experimentation. While economic needs for buying basics such as food may be relevant for some girls (Hope, 2007), in one of the studies conducted in 12 Sub-Saharan countries by Chatterji, Murray, London, Anglewics (2004), it was found that peer pressure to obtain luxury items such as expensive clothing, jewellery, fashionable hairstyles, accessories and makeup motivates young women to engage in transactional sex.

The expectation that the male should provide material and financial resources to the female partner in African countries such as Tanzania and Malawi, suggest that exchange of money and material resources will surge amongst youth (Muula, 2008: 425). Notably, the justification for engaging in transactional sex does not eliminate the risks. Transactional sex has consistently been associated with a high risk of sexually transmitted infections and HIV.

Divorced, widowed single parents may also find it compelling to use sex as a strategy for survival. With increasing pressure on them, women are forced to find some means of supplementing their economic situation to attain some measure of autonomy and self-reliance (Ackermann & de Klerk, 2002:166). Muula (2008:425) cited apartheid as a cause of poverty and poor economic conditions for Blacks in South Africa, the legacy of which provided limited educational opportunities for many, with minimal chances of employment in the job market. Women also suffered the effects of apartheid and transactional sex became an alternative source of income (Muula, 2008:425).

#### **2.4.14. Mobility**

Coombe (2000:5) traced the high levels of mobility in South Africa as related to the impacts of the apartheid legacy, the regime which for decades disrupted family and community life. A migrant labour system contributed the rapid spread of HIV into new communities. Although educators are not usually regarded as mobile or migratory workers, they share some of the infection risks of a migratory labour force. For instance, the risk is increased by their distance from homes and families, due to lack of suitable housing. Family members who are reluctant to move to rural locations could cause educators to have more sexual partners and frequent transfers from school to school are also contributory factors to the spread of the disease.

In a study conducted in five African countries, it was found that in Burkina Faso temporary separation from spouses was prevalent (Tamokong & Joseph, 2004). Because of the large numbers of the educator component in the DoE it is not easy to gain employment where one's family is living. Educators, both male and female, find themselves compelled to leave their spouses behind when they are sent to work in remote areas, and young and unmarried teachers engage with multiple partners in unsafe sex.

#### **2.5. CONCLUSION**

In this chapter, it is evident that there are some factors that will ensure the success of HIV prevention while others will inhibit it. The HIV/AIDS pandemic requires the involvement of all parties, especially the change in behaviour of perpetrators. Although the AIDS is making the future of teachers gloomy, the government should not turn a blind eye to the problem while teachers are facing the harsh realities of the pandemic. Peter Piot (AVERT, Sept 2008) maintains that "With AIDS out of control education will be out of reach".

Chapter 3 will explain in detail the methodology used to reach objectives of this study.

## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1. INTRODUCTION**

In the previous chapter, a broad literature study was undertaken with regard to the use of condoms as an effective preventative measure of both pregnancy and sexual infections. The emphasis was placed on soliciting factors inhibiting condom use. The methodology chapter presented here describes the steps taken to achieve the study objectives.

#### **3.2. AIMS OF THE STUDY**

The primary goal of this research is to assess usage of condoms among female educators by studying the factors leading to inconsistent use of condoms, and to determine knowledge, perceptions and attitudes of educators towards condoms. This study seeks to gauge what female educators believe regarding the effectiveness of condom use, and to establish whether their sexual behaviour is consistent with those stated beliefs.

Failure to use condoms consistently would then justify a need to seek explanations for irresponsible behaviour, given the evidence supported by research that condoms form an important part of infection prevention and add ultimately to a broader concept of quality life.

In order to achieve this objective, the following sub-aims are proposed:

- ✓ To establish what consistent condom use entails
- ✓ To assess the extent to which female educators use condoms
- ✓ To identify the underlying factors leading to inconsistency in condom use.
- ✓ To determine the extent to which condom use can be enhanced utilising the current government's information and prevention programmes available.

### **3.3. METHOD OF RESEARCH**

#### **3.3.1. Study population**

The target population included all female educators between ages 20 and 59 in the North-West province, however, this study was localised due to logistics. Therefore the population comprised all African female educators in the Matlosana Area Project Office secondary schools, which consists of four circuits, namely Meepong, D, J.C. Motaung, and Refentse. Schools were situated in the Matlosana area of the North West province, and the geographical areas of participants ranged from Khuma, Stilfontein, Alabama, Hartebeesfontein, Jouberton, Klerksdorp, Orkney and Dominionville (See appendix C for the list of all public schools in the Matlosana APO). In particular, sexually active African female educators, aged 20-59, in the J. C. Motaung circuit made up the study population.

Employee tenure within the cluster is newly appointed, temporary, or permanent, with zero to over 35 years of experience. Educators' qualifications vary from diploma to master's level, with the age range of between 20-59 years, since educators retire at the age of 55. The positions held from management to teaching staff are categorised in terms of levels:

- PL1: Educator
- PL2: Head of department
- PL3: Deputy Principal
- PL4: Principal

#### **3.3.2. Sampling**

Only the J.C. Motaung cluster was used for the purpose of this study, consisting of 11 public secondary schools from Kanana Township, Jouberton township, Klerksdorp and Orkney. The total number of African female educators in all 11 secondary schools was 144. The total number of female educators in each school varied and the number correlated with the size of the school. Exact numbers are

provided in Appendix C. Questionnaires were distributed to all 144 educators, of whom 101 responded and form the availability sample.

No prior information was gathered with regard to the educators' active sexual engagement, however, considering their age, an assumption was made that most of them would be sexually active. As a measure to prevent any skew in results analysis, questionnaires provided options room for those who might not be sexually active.

### **3.3.3. Data collection**

A number of methods were used in the process of data collection.

#### **3.3.3.1. Questionnaire as an instrument**

Questions used in the questionnaire were personally formulated based on the literature study conducted in the previous chapter. The questionnaire was intended to achieve the aims of the study and the information solicited would be treated confidentially. It consists of five sections, namely:

##### **Section A:**

Six questions were asked based on personal information pertaining to age, marital status, number of working years, employment type, highest academic qualifications and length of stay at that particular town.

##### **Section B**

A pool of ten questions was generated to address the objective intended to determine the knowledge and attitudes about condom use as outlined in the literature review (chapter 2). The rating scale of 1 to 4 was used, where 1 is "Totally disagree" and 4 is "Totally agree".

##### **Section C:**

Consistent condom section use consisted of seven questions. The questions were administered to a sample of female educators who, for the first group of questions (C1-C4), indicated by means of "Yes" or "No" if they agreed or disagreed with the



statements. The second group of questions (C5-C7) required respondents to indicate with the following options: never, sometimes, always or not applicable

#### Section D:

This section focuses on relationship factors and barriers. It also included open-ended questions to assist with the analysis as participants were allowed to briefly explain their choice.

The instruction pertaining to the completion of each section was to make a cross in the applicable block from the correct answers, ranging from three to five possible answers.

#### 3.3.3.2. Procedure

On 15 August 2010, permission to continue with the topic within the J.C. Motaung district was requested and granted on the 9<sup>th</sup> September 2010 by the District manager, Dr M.A. Motaung. (A letter in support of the research is reproduced in Appendix A).

A total of 144 questionnaires were distributed personally to all secondary schools in J.C. Motaung district of Matlosana Area Project Office. The forms were handed to the principal who was then asked to distribute them to all female educators, irrespective of qualifications, age or marital status. The only exclusion of female educators was in Vaal Reefs Technical High school and Milner High School, which had White and Indian female educators, the study calling only for "African" female participants.

Since data collection took place just after the end of a public strike (Cosatu, 2010), it was anticipated that educators might be reluctant to complete questionnaires, therefore a special request was made to the principal with regard to the presentation of the questionnaire. The identity of the researcher was not to be made known to the participants. Participants could perhaps feel uncomfortable since the nature of the topic was personal and may have been viewed as sensitive, especially since most were personally known as colleagues and accomplices to the researcher. As expected, in some schools questionnaires were returned un-attempted. There were no incentives offered to encourage

participation, since the study was not sponsored and considered to be of academic importance, not commercial profit.

#### **3.3.4. Data analysis and management**

In essence, statistical analysis entails the analyst breaking down data into constituent parts to obtain answers from the various research questions, thus testing research hypothesis (Leedy & Omrod, 2005:319). For the purpose of this study, statistical computer analyses were done by the Statistical Consulting Services of the North-west University using the SAS (2003), SPSS (2009) and Statistica (2009) statistical packages. An item analysis was performed and the results presented in the form of frequency distributions. Descriptive statistics were also calculated and included the computation of means and standard deviations for total knowledge scores.

#### **3.4. ETHICS**

Participants in a research project must clearly understand the nature of the study and be willing to participate (Leedy & Omrod, 2005:144). A number of ethical issues should be adhered to when human beings are the objects of a research study, because data should never be acquired at the expense of the participants (Strydom: 2002a:62).

No activities in which participants had to take part exposed them to stress or embarrassment. The questionnaire clearly stated the aims of the study, and since the nature of the topic was sensitive, confidentiality was assured to participants. At no point were they manipulated by the researcher.

According to Leedy and Omrod (2005:101) and Strydom (2002a: 65), participants should clearly be informed about the aim and process of the research and possible risks and benefits to which they could be exposed. They should give consent to the research and be aware that they may withdraw from the investigation at any time.

At no stage was any educator forced by the researcher to participate in the study and they were aware that they could withdraw if they wished to. Consent was obtained from educators who agreed to participate as well as from the principal of the school and the district manager (cf. Annexure C). All the aforementioned were completely informed about the aim, the process, as well as the benefits or risks of the study. Benefits of taking part in the study included reducing educators' mortality due to HIV/AIDS, and ensuring quality education and sustenance of skilled educators. On the other hand, some of the risks involved could be emotional and psychological harm especially to those infected and affected.

Every individual has the right to decide when and to whom her beliefs, circumstances, and behaviour may be revealed (Strydom, 2002a:67). In this research, all participants' responses were kept strictly confidential by reporting them in an anonymous manner.

Strydom (2002a:66) defines deception of participants as "deliberately misinterpreting facts in order to make another person believe what is not true, violating the respect to which every person is entitled". The researcher endeavoured to maintain the highest standards of honesty at all times. Also according to Strydom (2002a:69), the researcher should constantly be aware of ethical responsibility, and to this end, throughout the duration of this research, no value judgements were made on cultural aspects of the communities or participants involved.

When findings of a research project are released, researchers should understand the importance of documenting them accurately, objectively, completely and with certainty Strydom (2002a:71). In this research, findings were documented completely with accuracy, objectivity and without any bias. The researcher took great care to avoid and duplication which could be seen as plagiarism.

### **3.5. STUDY LIMITATIONS**

The study is analysing data on self-reported sexual and condom behaviour, which may result in social desirability bias. As they are expected to be role models to

learners and are better informed about the pandemic, respondents may have provided inaccurate information so as to appear responsible. They may have underreported the number of sexual partners in order to appear less at risk of HIV infection.

Condom use information could have been distorted in order to compensate for negative attitudes towards condoms. Reported condom use practise may be inaccurate as they are self-reported behaviour and cannot be verified on their own.

Finally, the sample is an availability sample which may not be representative of the population and therefore generalization of the results should be handled with caution.

## CHAPTER 4

### ANALYSIS AND INTERPRETATION OF RESULTS

#### 4.1. INTRODUCTION

The aim of the empirical study of this research was primarily to determine by means of a questionnaire the factors leading to inconsistent use of condoms. The results of the questionnaire were used together with the findings of literature to make an assessment as to whether the government's intervention programmes are effective. Interpretations and suggestions on matters to be addressed will be discussed in the next chapter.

This chapter presents the results from the analysis in the following sections:

- Personal information
- Knowledge and attitudes about condom use
- Consistent condom use
- Relationship factors
- Barriers

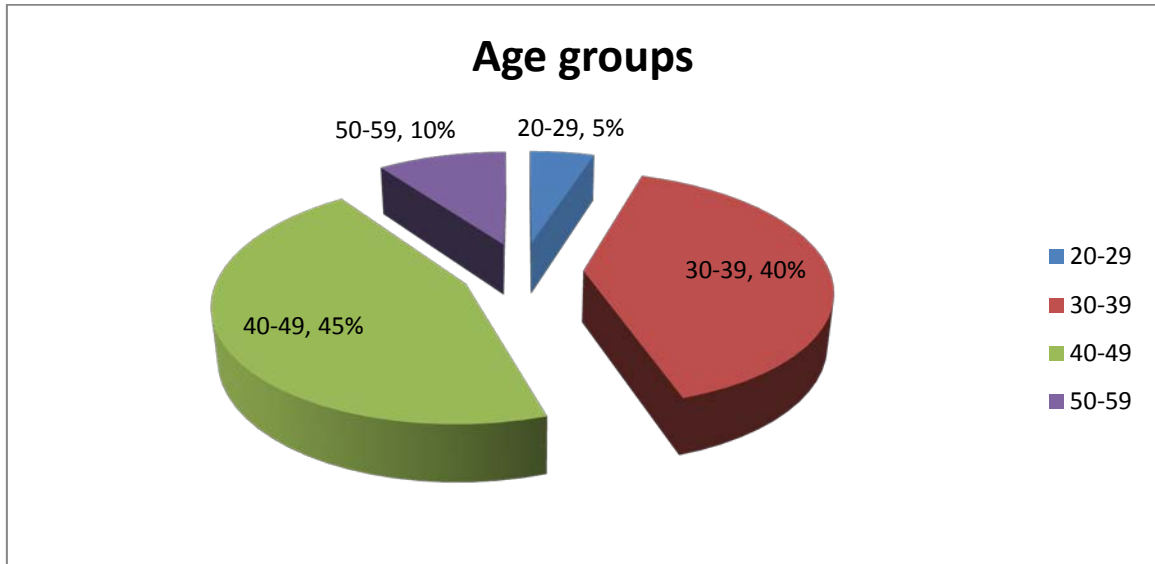
The summary of the data collected during the empirical research is analysed and interpreted in this chapter.

At each section, the results will be presented in tables and figures. In case of missing values (i.e. no responses to the particular question) the number of missing values is reported, and percentages, means and standard deviation in the tables are calculated after removal of the missing value. Below are the results.

#### 4.2. Analysis of section A: Personal Information

Analyses and interpretations of the data concerning the demographic information provided by the respondents are presented in figure 4.1 to 4.6.

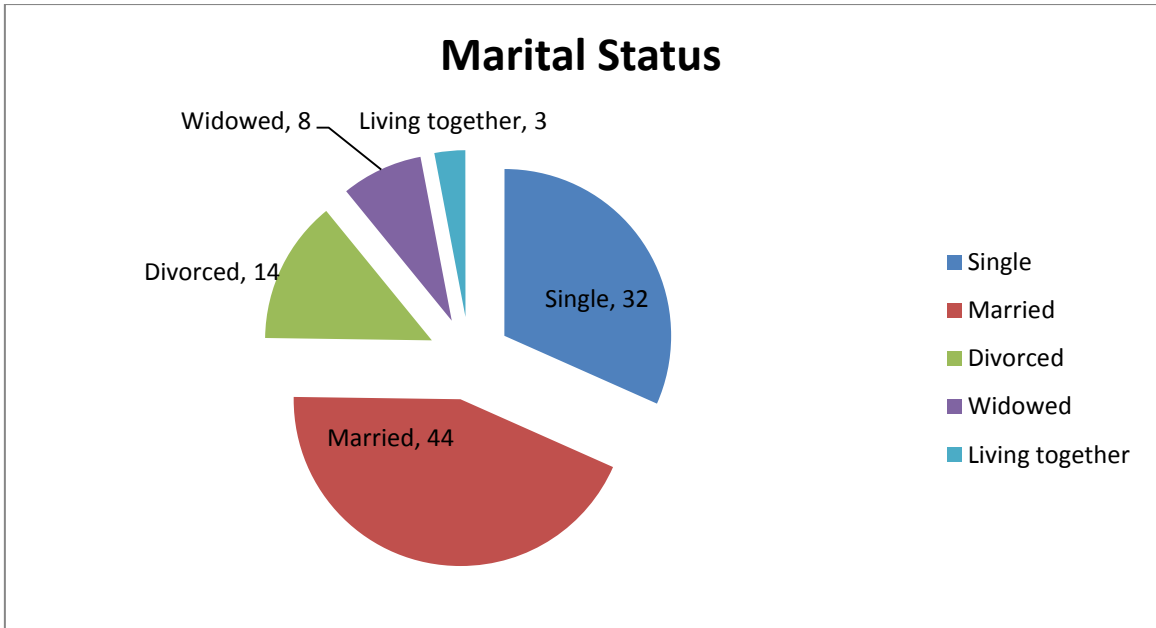
The first question was included to establish the age group distribution of female educators who took part in the survey.



**Figure 4.1:** The demographic distribution of the number of respondents who participated in this research according to age. Source: Own compilation

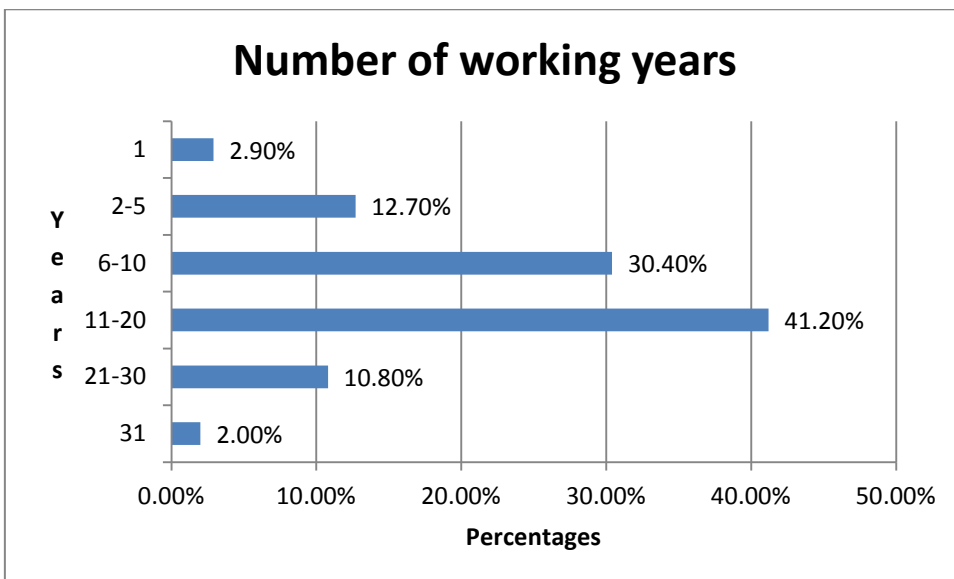
Educators were grouped in four group ranges. The first age group was between 20 and 29, with only 4.9 percent in this category. The second group ranged from 30 to 39, accounting for 40.2 percent of the total sample. The third group ranged from 40 to 49, or 45.1 percent of the sample, and was the largest,. The last group ranging from 50 to 59 accounted for 9.8 percent of the sample. It was considered the last because educators are eligible for pension at the age of 55. Since the majority of female educators fall in a middle aged category, they had a reasonable level of maturity and decisions made with regard to safe sexual practices could be expected to be sound.

The second question was included to establish the marital status distribution of female educators that took part in the survey.

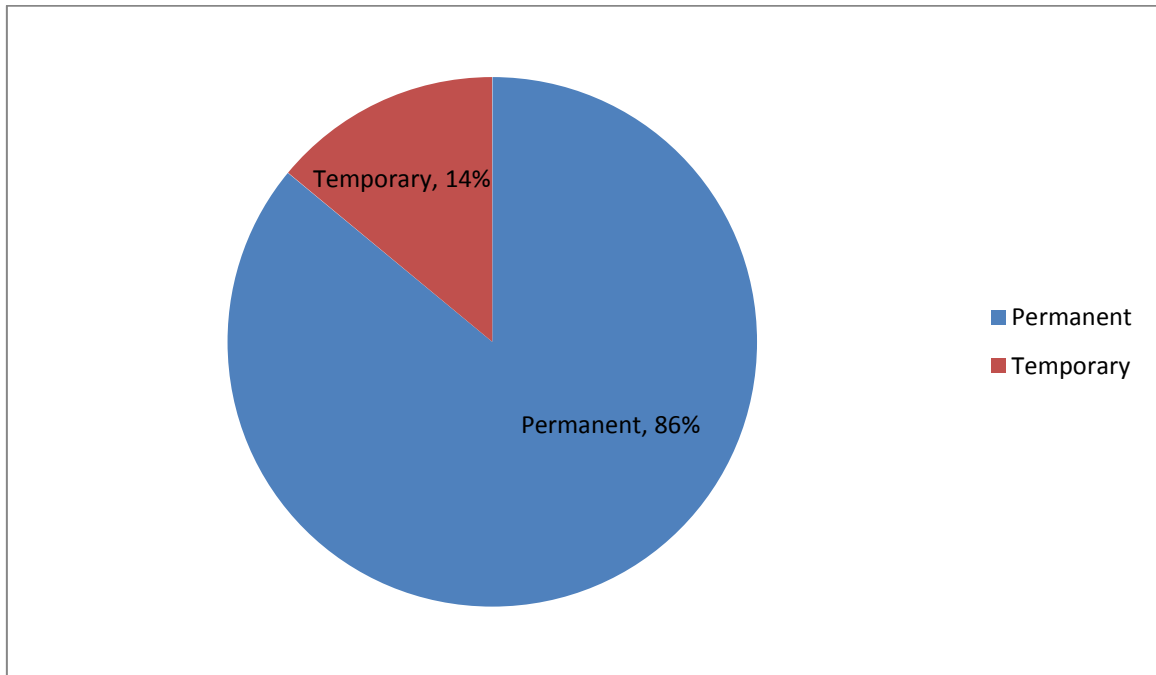


**Figure 4.2:** Demographic distribution of the number of respondents who participated in this research according to marital status

Figure 4.2 (above) shows that the majority of participants were married (43.6%). The next group of 31.7 percent were single and only 3.0 percent living together. Another 13.9 percent represent divorced female educators and the remaining 7.9 percent were widowed.



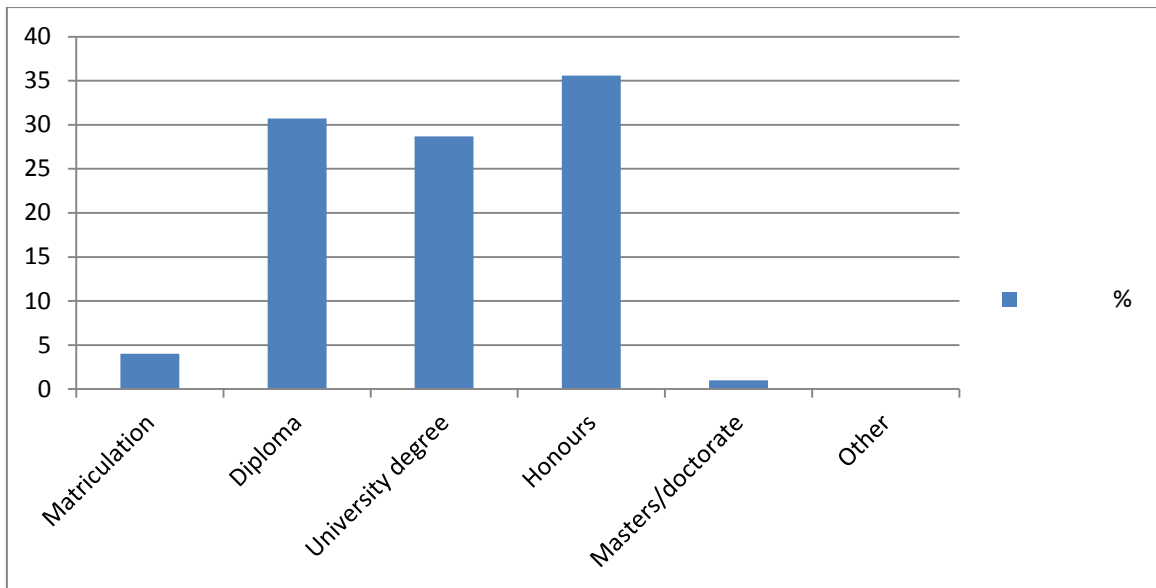
Based on the results in Figure 4.3 (above), it can be concluded that the educators who participated in this survey have a substantial number of years of experience. Comparatively speaking, educators who have experience of 20 years and more, and those below 6 years of experience, constitute a smaller percentage. 10.8% have been working for between 21 and 30 years and 2% have been working for more than 31 years.



**Figure 4.4** Employment type

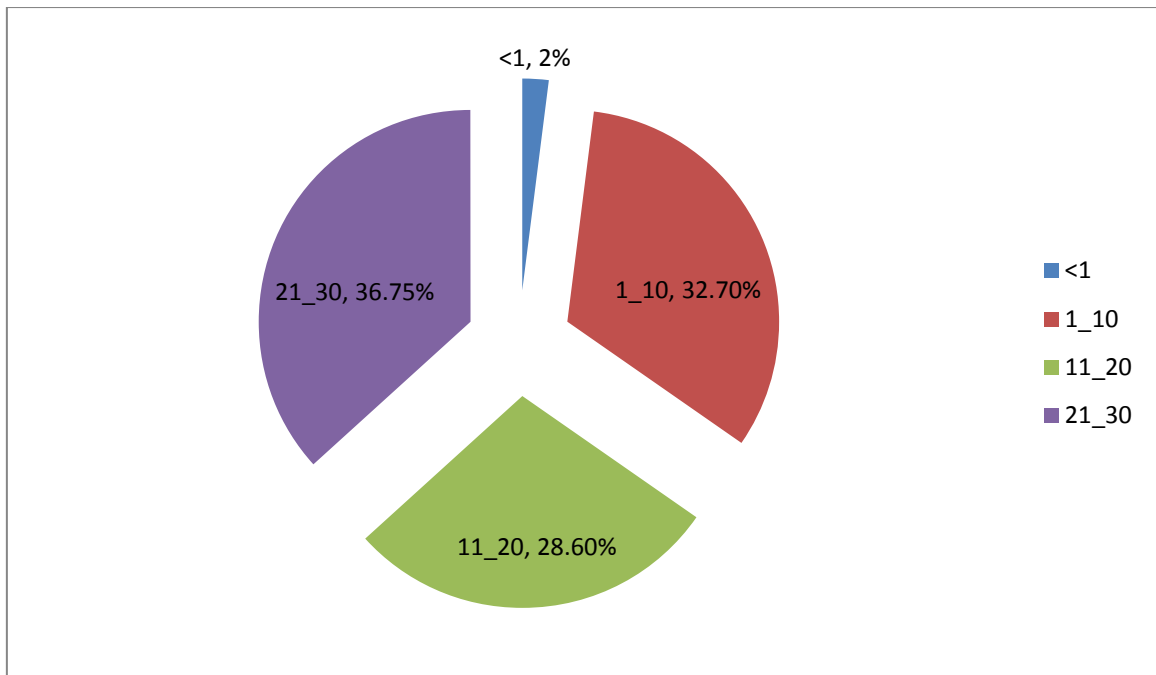
In terms of the type of employment, the figure of 86% on a permanent basis is largely due to the DoE having undertaken to absorb temporary educators in their main system. It can be argued that the very few temporary educators may experience some instability and mobility which in return exposes them to higher HIV risk.





**Figure 4.5:** Qualifications

The demographic composition suggests that female educators are generally well-educated, the majority having an honours degree (35%) and a few (2%) a master’s and/or doctorate. Since these are postgraduate degrees it indicates the highest level of education and experience. Long years of experience coupled with the highest qualifications would suggest educators are better informed about safe sex.



**Figure 4.6:** Length of stay at your place

Figure 4.6 (above) depicts the duration of the educator’s stay at the current geographical area. The majority at 36.7% have been residing in their places of residence for longer periods, followed by those who have lived fewer years. This indicates that most of the educators may not be seen as targets for new relationships and thus make them vulnerable and susceptible to HIV.

### 4.3. Analysis of Section B: Knowledge and attitude about condom use

The specific aim for this section was to describe the level of knowledge and attitude regarding the use of condoms.

Table 4.1 (below) summarizes the responses by presenting percentages and descriptive statistics.

**Table 4.1.** Responses to individual statements made by the whole sample of 101 educators who participated in the survey to knowledge and attitudes about condom use. (cf appendix B for questionnaire questions).

Question number	Totally Disagree (01)	Disagree (02)	Agree (03)	Totally agree (04)	Number missing	Mean	Standard deviation
B1	63.6	24.2	7.1	5.1	0	1.54	0.837
B2	41.2	35.3	11.8	11.8	0	1.94	1.003
B3	75.2	19.8	1.0	4.0	0	1.34	0.679
B4	53.5	35.6	7.6	3.0	0	1.60	0.763
B5	48.5	26.7	19.5	5.0	0	1.81	0.924
B6	68.6	23.5	5.9	2.0	0	1.41	0.694
B7	55.9	21.6	15.7	6.9	0	1.74	0.964
B8	52.5	29.7	14.9	3.0	0	1.68	0.836
B9	62.4	23.8	10.9	3.0	0	1.54	0.807
B10	22.8	18.8	28.7	29.7	0	2.65	1.135

The results in Table 4.2 (below) represent the combined percentage of female respondents who totally disagreed and disagreed with specific statements about condoms (knowledge and attitudes), as well as the combined agree and 'totally agree' responses.

**Table 4.2: Combined percentages of knowledge and attitude about condom use**

Statement	Disagree (%)	Agree (%)
B1: I would not use a condom because I want flesh to flesh.	87.8	12.2
B2: If a man and a woman trust each other there is no need to use a condom.	76.5	23.5
B3: If someone wants to use a condom, you know they have HIV.	95	5
B4: If my partner asked me to use a condom, I would think they are having sex with other people.	89.1	10.9
B5: If you forgot to use a condom once or twice, there is no need to use a condom with the person you were having sex with.	75.3	24.7

B6: Using condoms seems like an insult to my partner.	92.1	7.9
B7: I do not enjoy (or think I might not enjoy) sex when using condom.	77.5	22.5
B8: It is embarrassing (to me) to buy condoms.	82.2	17.8
B9: I perceive condoms to be effective for STI/HIV prevention.	86.2	13.8
B10: I perceive condoms to be effective for contraception.	41.6	58.4

## Interpretation

From these figures it is evident that most of the respondents were well informed in terms of HIV and AIDS, aware of the myths and stigma surrounding the disease and able to demystify and de-stigmatise the conditions. However, a few still needed to learn more and equip themselves with more information regarding them.

For further interpretation of table 4.1 and 4.2 the researcher decided to group questions addressing a specific issue, for example physical gratification, emotional concerns and misconceptions, all of which will either enhance condom use or hamper the use thereof.

## Physical gratification

B1 and B8 focus on sexual pleasure derived from physical contact. Responses to both questions revealed that most respondents did not perceive sexual pleasure as more important than their health safety.

63.6% strongly disagreed with the statement that they would use a condom because they wanted flesh to flesh and 24.2% disagreed, leaving only the total of 12.2% agreeing to flesh to flesh. 52% strongly disagreed while 29.7% disagreed to not enjoying sex without a condom.

It can be deduced from the analyses of these results that the majority of the respondents did not put physical gratification above health safety. However, a percentage of 12% for question B1 and 18% for question B8 pursued sexual pleasure through physical contact.

## **Emotional concerns**

Some of the reasons leading to inconsistent condom use relate to not wanting to hurt the other party's feelings. As indicated in the literature review, one prerequisite for a normal relationship is mutual trust, which a suggestion, such as the use of a condom, may jeopardise. In such an instance, if the use of a condom is perceived as showing no trust of the partner, the suggestion may be abandoned. The analyses of statements in B2 and B7 are used as examples of typical emotional concerns that may arise when condom use is suggested.

41.2% of the respondents strongly disagreed and 35.3 disagreed that if a man and a woman trust each other, there is no need to use a condom. 62.4% of the respondents strongly disagreed and 23.8% also disagreed that it was embarrassing for them to buy condoms. Perhaps the feelings of infidelity may be associated with being fear of being observed purchasing a condom.

The above results illustrate that respondents in this study seemed to separate issues. The use of a condom should be seen as both a preventative measure against disease and contraception, nothing else.

## **Misconceptions**

It sometimes happens that individuals have misconceptions regarding HIV, which are indicated in the statements made in B3, B4 and B5. They seem to contradict the literature review's finding that condoms are an integral part of STI prevention, and in some instances they are used for contraception. It therefore becomes a misconception to assume anything that is not in line with that.

75.2% strongly disagreed and 19.8 disagreed that if someone wants to use a condom, you know they have HIV. 53.5% strongly disagreed and 35.6% disagreed that if their partners asked them to use a condom, they would think that they are having sex with other people. 48.5% strongly disagreed and 26.7% disagreed that if one forgot to use a condom once or twice, there was no need to use a condom with the person one was having sex with.

The findings of these analyses confirm the truth about HIV. The respondents rejected the statements as true and thus supported the opposite view.

#### 4.4. Analysis of Section C: Consistent condom use

Table 4.3 (below) gives the results of how consistently the respondents used condoms.

**Table 4.3:** Consistent condom use of female educators

	Yes (01)	No (02)	Number missing
C1	99.0	1.0	1
C2	96.1	3.9	0
C3	55.9	44.1	0
C4	51.5	48.5	0

#### Interpretation

The majority of the respondents claimed to be sexually active and aware of condoms, having previously used them. However, they did not use them consistently, though about half used them consistently.

The last questions (C5-C7) of Section C required respondents to choose from 'never', 'sometimes', 'always' and 'not applicable'. The 'not applicable' column was removed before calculating the mean and standard deviation.

Table 4.4 (below) reflects the answers given expressed as percentages regarding the consistency of condom use by female educators.

	Never (01)	Sometimes (02)	Always (03)	Not Applicable (04)	Missing	Mean	Standard deviation
C 5	23.5 %	30.4%	37.3%	8.8%	?	?	?

C 6	5.0%	4.0%	31.0%	60%	?	?	?
C 7	5.0%	23.8%	71.3%	0	0	2.66	0.57

**Table 4.4:** Items determining consistent condom use

An interesting point to take note of is that 60% of the respondents indicated that they did not have a casual partner. One may therefore conclude that for this sample the majority of female educators did not engage in multiple sexual relationships. The results pertaining to sexual behaviour with main partners show that 24% never used and 30% used condoms sometimes. On the other hand, only 37% always used condoms consistently.

#### 4.2.3.1. Further analyses of Section C based on age and marital status

Of the above items analysed in tables 4.3 and 4.4, an assessment of the relationships between consistent condom use and selected characteristics were made.

Table 4.5 (below) reflects the answers given expressed as percentages regarding the consistency of condom use by female educators at their last sexual encounter (C3).

**Table 4.5:** Consistency of the use of a condom at last sex (C3) with age (A1)

AGE	Total number of respondents	YES		NO	
		n	%	n	%
20-29	5	2	40	3	60
30-39	41	25	61	16	39
40-49	44	27	58.7	17	41.3
50-59	11	3	30	8	70

The respondents within the age groups of 20 and 29, as well as 50 to 59 reported a lower percentage of condom use during the last act of sex. It could therefore be said that the HIV risk is high in these age groups. If people at risk of HIV infection do not perceive their risk, it is difficult for them to take precautions. However, it is notable that the number of respondents in the 20-29 and 50-59 age groups were very small, therefore the results may not be representative and should be considered with caution.

Some of the responses solicited from open-ended questions asked in the questionnaire give an explanation to why they did not use condoms consistently. Both groups hinted the desire to keep the partner as the motivating factor. At a young age (20-29 in this case), respondents said that they aspired to being married and were desperately looking for a stable and main partner. Conversely, in the case of the older respondents (50-59), there was a subtle belief that both partners were mature enough to know what was right and what was wrong. They believed that they had outgrown the stage of philandering or “fooling around”, therefore suggesting condom use may seriously offend the partner.

Participants in the age groups 30-39 and 40-49 displayed a more responsible sexual behaviour, with an average of 60% agreeing to have used a condom during their last sexual encounter. It is clear that, for example, married people and the young and old are using condoms consistently, which can be a risk. However, before deducing that they are more at risk, one has to consider other factors as well. For instance, it might be that married people do not use a condom very often, but they have had only one partner all their life. Even though not using a condom is a risk factor, they may have a very low risk on other factors. It is therefore crucial to mention that this is a very complex area and should not be oversimplified. This study did not go into deeper analyses and results could not be understood simply by looking at a few cross-tabulations, hence results are presented in the manner in which they did.

Table 4.6 reflects the answers given, expressed as percentages regarding the consistency of condom use by female educators at their last sexual encounter, with specific reference to usage of a condom in all rounds (C4).



**Table 4.6:** Consistency of the use of a condom in all rounds of last sex (C4) with age (A1)

AGE	Total number of respondents	Yes		No	
		n	%	n	%
20-29	5	2	40	3	60
30-39	41	22	53.7	19	46.3
40-49	44	25	55.6	16	44.4
50-59	11	3	30	9	70

### Interpretation

There is a correspondence between these and the previous results. A similar pattern was observed where the participants in the age group ranging from 30-39 were the highest for using a condom in all rounds at 53.7%. As compared to the previous results, there was a decline in consistency in the 40-49 age groups, from 58.7% of participants who used a condom at last sex to 55.6% who agreed to having used it in all rounds. It is notable that although they may have shown a willingness to use a condom, they failed to remain consistent throughout the sexual intercourse. It is again notable that the number of respondents in the 20-29 and 50-59 age groups was very small, therefore the results may not be representative and should be considered with caution.

A number of reasons may be cited, such as sexual pleasure, whereby participants may claim that a condom reduces sexual satisfaction.

Table 4.7 (below) reflects the answers given expressed as percentages regarding the consistency of condom use by female educators (C7) according to age groups (A1).

**Table 4.7:** The use of a condom if the respondent decided to have a sexual intercourse with a partner (C7) according to different age groups (A1)

AGE	Total number of respondents	Never		Sometimes		Always	
		n	%	n	%	n	%
20-29	5	0	0	2	40	3	60
30-39	41	2	4.9	9	21.9	30	73.1
40-49	44	3	6.7	10	23	31	70
50-59	10	0	0	3	30	7	70

Table 4.7 (above) indicates the highest percentage (73.1%) of respondents who maintained that they would always use a condom if they decided to have sexual intercourse with a partner was of those who ranged between 30-39 years. In addition, the other age groups results were relatively high, 20-29 (60%), 40-49 (70%), and 50-59 (70%).

A substantial percentage of respondents in all age groups demonstrated a high level of inconsistency when they responded to a question of only having considered using a condom sometimes if they decided to have sexual intercourse with a partner. The age groups that are at high risk of contracting HIV with their attitude of never intending to use a condom if they decided to have sexual intercourse with a partner were 30-39 and 40-49. That it is a low percentage does not justify this finding as of less significance. It is notable that the small sample sizes of the 20-29 and 50-59 age groups may be limiting.

Table 4.8 (below) reflects the answers given expressed as percentages regarding the consistency of condom use by female educators (C3) according to their marital status (A2).

**Table 4.8:** Consistency of the use of a condom at last sex (C3) with marital status (A2)

MARITAL STATUS	Total number of respondents	Yes		No	
		n	%	n	%

Single	32	24	75	8	25
Married	44	14	31.8	30	68.2
Divorced	14	8	57.1	6	42.9
Widowed	8	8	100	0	0
Living together	3	2	66.7	1	33.3

### Interpretation

The results show the highest percentages of participants who used a condom at last sex according to marital status seems to be the widowed at 100%. The second highest group is those who were single, at 72%, followed by the divorced at 57%. The lowest percentage of participants who used a condom at last sex was those who were married. Only 32% agreed to have used a condom at last sex, which disposes them as a group at highest risk. This finding concurs with previous literature that maintains that married females are at high risk. It is notable that the results for the widowed and living together groups should be considered with caution, as the sample sizes are very small.

Table 4.9 (below) reflects the answers given expressed as percentages regarding the consistency of condom use by female educators according to their marital status (A2) at their last sexual encounter (C4).

**Table 4.9:** Consistency of the use of a condom in all rounds of last sex (C4) with marital status (A2)

MARITAL STATUS	Total number of respondents	Yes		No		Number missing
		n	%	n	%	
Single	31	22	68.8	10	31.2	0
Married	43	12	27.9	31	72.1	1
Divorced	14	8	57.1	6	42.9	0

Widowed	8	8	100	0	0	0
Living together	3	1	33.3	2	66.7	0

### Interpretation

Results in table 4.9 (above) show a similar pattern of married females being at the greatest risk. Only 27.9% agreed to use a condom in all rounds of last sex as compared to 31.8% who used it at last sex. It is interesting to observe that the widowed are still maintaining the highest percentage of 100%. It is also evident that single respondents, at 68% comparatively show a higher level of consistency followed by those who are divorced at 57%. It must however be mentioned that a percentage of between 32 and 47 is dangerously high. It is notable that the results for the widowed and living together groups should be considered with caution, as the sample sizes of these groups are very small.

Table 4.10 (below) reflects the answers given expressed as percentages regarding the consistency of condom use by female educators according to the marital status at their last sexual encounter.

**Table 4.10:** The use of a condom if the respondent decided to have a sexual intercourse with a partner (C7) with marital status (A2)

MARITAL STATUS	Total number of respondents	Never		Sometimes		Always		Number missing
		n	%	n	%	n	%	
Single	31	0	0	6	19	25	81	0
Married	43	4	9.3	16	37.2	23	53.4	1
Divorced	14	0	0	2	14	12	86	0
Widowed	8	0	0	0	0	8	100	0
Living together	3	1	33.3	0	0	2	66.7	0

Clearly, the results in table 4.10 (above) reveal that matters are getting worse with regard to married women's risk levels. It is a shocking discovery that there are 9% who state that they would never use a condom if they decided to have sexual intercourse with a partner. The next worrying group is those who live together, with 33% asserting that they would never use a condom if they decided to have sexual intercourse with a partner. It is however a consolation to realise that, on the contrary, 81% of those who are single do agree that it is important to always use a condom when considering sexual activity. Lastly, a good example is set by the widowed on maintaining their 100% record. It is notable that the results for the widowed and living together groups should be considered with caution, as the sample sizes of these groups are very small.

#### **4.5. Analysis of Section D: Relationship factors**

The following section reflects the answers given to express beliefs and opinions held by female educators about factors that affect a relationship.

Previous studies have shown in the literature review that a relationship is a play of interchangeable factors that may either affect it negatively or positively. Table 4.11 sheds a light on how relationship factors promote or impede on condom use.

**Table 4.11: Analysis of items on relationship factors**

	Totally Disagree (01)	Disagree (02)	Agree (03)	Totally agree (04)	Number missing	Mean	Standard deviation
D1	2.0	5.9	41.1	51.0	0	3.41	.694
D2	10.8	16.7	39.2	33.3	0	2.95	.969
D3	5.9	13.7	32.4	48.0	0	3.23	.900
D4	6.9	9.8	40.2	43.1	0	3.20	.879
D7	66.0	19.0	9.0	6.0	0	1.55	.892

The responses to the above items are positive in the sense that they reflect a high percentage of commitment to practising safe sex.

The statement “who decides to use a condom” was included in this section to establish if equal decision-making existed in relationships of the female educators who took part in the survey.

**Table 4.12: Analysis on who decides to use a condom**

<b>D5</b>	<b>I do (01)</b>	<b>He does (02)</b>	<b>We both do (03)</b>
%	29%	4%	67%

### **Analysis**

Previous studies have shown that in the heterosexual driven sector of the epidemic, it is males who typically determine whether or not condoms are used and there is a varying degree of male dominance in all societies. Along with women’s social and economic disempowerment in many South African communities, these factors render many women unlikely to be able to negotiate condom use with their partners and many men are unlikely to want to use condoms.

In table 4.13 (below), an inclusion of D4 to be coupled with D7 in the analysis was deemed necessary as statements intended to assess the level of equal power relations present in relationships. This reveal results obtained after an analysis.

**Table 4.13: Unequal power relations**

		<b>Totally disagree and disagree</b>	<b>Totally agree And agree</b>
<b>D4</b>	Very confident to refuse sex Without condom.	17%	83%
<b>D7</b>	Women should not talk about sex with men.	85%	15%

Respondents endorsed gender attitudes that encourage women to have a say in a relationship and to be involved in decision making process, especially with matters that personally affect them.

**Table 4.14:** Relationship factors relating to violence

	<b>Never 01</b>	<b>Some- times 02</b>	<b>Always 03</b>	<b>Not Applicable 04</b>	<b>Missing</b>	<b>Mean</b>	<b>Standard deviation</b>
D 6	60.8%	36.3%	2.9%	0	0	1.42	.553
D 8	72.5%	22.5%	4.9%	0	0	1.32	.566

According to Table 4.14 (above), 60.8% of the respondents indicated that they had never been pressured to have sex, 36.3% sometimes and 2.9% always. This means that the highest percentage of the respondents had consented to sex, which puts them in a better position to make informed decisions of either using protection or not. It is followed by those that are sometimes forced, which puts them in a risky position. The least are always forced, and so more at risk of contracting STIs, including HIV, as they may not be in a position to negotiate condom usage.

72.5% of the respondents were never afraid that their partners may hurt them, indicating that their relationships were based on trust. 22.5% said they were sometimes afraid, suggesting a little trust may be lacking in their sexual relationship. 4.9% said they were always afraid that their partners might hurt them, indicating that they lived in constant fear and were exposed to more risk than the rest.

Sexual violence was reported as having been encountered ( section D), with 36.3% of female educators indicating that they had sometimes been pressured to have sex, as shown in table 4.11 ( )below), and 22.9% were afraid their partners would hurt them.

Statements that focus on communication as an important factor necessary if condom use is to be promoted, has been grouped together in table 4.15.

**Table 4.15:** Selected items focusing on communication

		Totally disagree and disagree	Totally agree and agree
		%	%
D1	Very comfortable talking about sex	7.9	92.1
D2	Very confident could convince regular partner to use a condom	27.5	72.5
D3	Very confident could convince a new partner to use a condom	19.6	80.4

This table illustrates the degree of agreement and disagreement combined with reference to specifically issues pertaining to the level of communication present in a relationship. Communication is vital in any type of a relationship as it allows parties to exchange views on matters at hand. Lack thereof may result in another party being subjected to decisions imposed on him or her. However, the analyses of table 4.12 show those respondents are able to communicate since they are able to talk and even convince their partners on sexual matters.

#### **4.6. Analysis of Section E: Barriers**

The occurrence of new infections suggests that condoms are not being used consistently or correctly. It was for that reason that statements that sought to expose varying factors, encompassing different point of views that might be held, were included in this section.



**Table 4.16: Barriers to condom use**

	Did Not inhibit condom use at all 01	Inhibited condom use to some extent 02	Inhibited condom use to a great extent 03	Number missing	Mean	Standard deviation
E1	50.1	15.7	34.3	0	1.84	.909
E2	68.6	3.9	27.5	0	1.59	.894
E3	46.5	26.7	26.7	0	1.80	.837
E4	45.1	33.3	21.6	0	1.76	.786
E5	52.0	31.0	17.0	0	1.65	.757
E6	65.7	17.2	17.2	0	1.42	.757
E7	73.7	10.1	16.2	0	1.64	.826
E8	58.6	19.2	22.2	0	1.58	.809
E9	62.6	17.2	20.2	0	1.45	.760
E10	70.7	13.1	16.2	0	1.52	.774

Table 14.6 (above) indicates that 50.1% the high risk at which partners find themselves in once they consider their relationship to be steady.

Previous studies have shown that transactional sex may place women at increased risk for HIV, and is associated with gender-based violence, substance use and socio-economic disadvantage. For the purpose of this study, the statement “had sex in order to get money” has been included to reflect on the effects on transactional sex.

**Table 4.17:** Financial abuse

		Missing	Did no inhibit condom use at all.	Inhibited condom use to some extent	Inhibited condom use to a great extent
E8	Had sex in order to get money.	3	60%	21%	19%

The results in table 4.17 (above) do not suggest that respondents engage in sex motivated by material or financial gains. The majority of respondents at 60% indicated that money as a factor did not inhibit condom use at all. The smallest number of respondents gave a negative response when indicating that having sex for money inhibited condom use to a great extent.

#### **4.7. CONCLUSION**

The results presented in chapter four gave generally positive responses with regard to knowledge about HIV and the use of condoms as an effective measure to prevent the spread of HIV. The last chapter will thus summarise, conclude and offer recommendations based on the findings of this chapter.

## **CHAPTER 5**

### **SUMMARY, FINDINGS AND RECOMMENDATIONS**

#### **5.1. INTRODUCTION**

This chapter presents a summary and draws conclusions from findings of the literature review and the empirical study. This summary will enable the researcher to make recommendations on the basis of the problem statement posed in Chapter One. The empirical study findings to be discussed here are the products of the responses derived from the respondents.

#### **5.2. SUMMARY AND CONCLUSIONS**

##### **5.2.1. Finding and conclusions from the literature study**

In the literature study it was found that correct and consistent condom use forms an essential part of HIV/STI prevention. Both male and female condoms may contribute to addressing the HIV/AIDS pandemic which has ravaged countries worldwide. UNAIDS/WHO gives alarming statistics of increasing numbers of people living with HIV, newly infected children as well as mortality rates.

South Africa is reported to be no exception and is one of the countries with the highest HIV/AIDS rates in the world. According to the National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey (2009), condom use is acknowledged as a prevention strategy and the percentage of those who used a condom during their last encounter has increased from 27% in 2002, 35% in 2005 to 62% in 2008. However, the literature also emphasises that its effectiveness can only be ensured through correct use and consistency. The increasing numbers of newly infected people suggest improved and better strategies should continue to be of main priority to the government in its endeavour to strengthen prevention measures.

The focus of this research was on female educators, which prompted closer examination of how women in particular are affected. Forty percent of South African men were reported in the National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey (2009) to have been physically violent to an intimate partner, which renders women vulnerable.<sup>2</sup>

The impact of HIV on education has also received widespread attention as it has proven to be one structure which is being endangered by the HIV/AIDS pandemic. According to Bennel (2005:440), the impact is threatening efficient functioning of the education sector, as not only educators are infected, but also student educators, learners and education administrative staff (Shisana *et al.*, 2005). From the literature study it is evident that HIV/AIDS impacts negatively on the quality of education due to an increase in sick leave and absenteeism, demoralised educators and stigmatisation associated with being diagnosed HIV positive.

HIV/AIDS policy has been in place since 1994, and the government's Strategy Plan focuses on four main areas:

- Prevention
- Treatment, care and support
- Human and legal rights
- Monitoring, research and surveillance.

In this research, the focus was on the first area, namely the prevention of HIV/AIDS/STI's by means of correct and consistent condom use.

The literature review identified the government's prevention strategies to include:

- Media campaigns to increase awareness
- ABC approach
- Distribution of condoms
- The Life-Skills education programme
- HIV counselling and testing
- Male circumcision

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<sup>2</sup> It must however be noted that the current government prevention strategies are steered towards addressing gender-based issues in general.

However, Jordaan (2006) and Reid (2001:1) are of the opinion that most prevention strategies are inadequate for the needs of women. The assumption is made that women have the power to change the behaviour of men, which is not necessarily the case at all times. The same views are held by Lewis (2006), when he criticises government's insensitive and inattentiveness regarding the provision of treatment.

From the literature study it is clear that the HIV/AIDS pandemic impacts negatively on many people's lives including educators. Currently the government's commitment to continue the fight against HIV/AIDS is evident though it needs to be strengthened.

### **5.2.2. Conclusions made from the empirical study**

Practical recommendations to support the successful implementation of the HIV/AIDS prevention strategy as envisaged by the government are shared after taking into account consideration both the results findings of the responses to statements and open-ended questions. The achievement of the study's objectives is ascertained after the discussion in this section.

According to the literature review in chapter two, knowledge of what constitutes risk is an essential prerequisite for promoting healthy behaviour change. Knowledge about AIDS has been seen to play a role in motivating initial behaviour change, particularly in persons who see themselves as being at risk. If people at risk of HIV infection do not perceive their risk, it is difficult for them to take precautions.

Results of this study indicate that the level of knowledge regarding AIDS and its transmission were generally high. It was a positive sign that most of the sample was displaying precautionary behaviour. The statements that assessed the value attached to physical gratification showed that the majority of respondents understood the danger associated with putting sexual pleasure above their own life. Similar observations were made where respondents neither considered emotional blackmailing and misconceptions that may be held to deter them from practising safer sex. Certain basic knowledge was lacking, however, as few subjects indicated that they do not use condoms consistently. It is apparent from

the findings that information regarding AIDS and HIV still needs to be imparted to many educators.

Previous condom use by subjects of the sample was generally high, with 96% having used a condom. The disturbing revelation however was that the results reflected that almost half did not use condoms regularly. Thus, many sexually active participants (as confirmed by the results of C1 in the questionnaire, 99% having agreed to ever having sex), although cognitively aware of the ability of condoms to reduce the possibility of HIV infection, do not put such knowledge into constructive action. Such a finding again implies that subjects did not perceive themselves to be personally vulnerable to HIV infection, and this would be consistent with previous research findings.

Concerning the influence of age on certain behaviours, it seemed to have an influence on sexual behaviour. Findings were similar to those found in the study by Zungu *et al.*, (2007:1296). The prevalence of HIV was highest among educators aged 25-35 and low for older educators. The findings of this study concur with previous findings of NCS that younger females (20-29) showed low percentage of condom use at last sex. On the other hand, the low percentage of condom use at last sex among 50-59 age groups does not support the notion that HIV prevalence in older educators is low. However, the explanation for low percentage of condom use at last sex in the 50-59 age range may be argued as a result of their minimal sexual activity in comparison to middle-aged group participants.

Some of the reasons solicited from their responses are the following:

- It was not necessary to use a condom since *they are no longer sexually active.*
- They have been in a relationship with their partners *long enough to trust them.*

Marital status has been seen as a contributory factor in inconsistent condom use in the previous literature (Sarkar, 2008:115). It is commonly asserted that women who are unable to negotiate safe sex and condom use will be at a higher risk of HIV.

The findings of this research reveal an unwelcoming trend. The female educators falling in the married status category are continuing to show the same attitude and behaviour to which most researchers in previous studies have alluded. They are at the highest risk, as evident in findings both on condom use at last sex and on condom use in all rounds of last sex. In comparison to other groups, they were the lowest at 31.8% for condom use at last sex and 27.9% agreeing to condom use in all rounds. One may thus conclude that though the new HCT policy emphasises the importance of couples counselling and testing, minimal progress is being made in encouraging married couples to change their sexual behaviours. It seems there is still a long way to go in winning the struggle against HIV/AIDS. The government's HIV/AIDS prevention strategy will not be able to achieve its objectives because there is no alignment in their vision and the sexual behaviour of sexually active individuals.

Another serious concern derived from the study relates to power relations in love relationships. Previous studies have shown that in the heterosexually driven sector of the epidemic, it is males who typically determine whether or not condoms are used, and there is a varying degree of male dominance in all societies (Sarkar, 2008:116). Along with women's social and economic disempowerment in many South African communities, these factors render many women unlikely to be able to negotiate condom use with their partners, and many men are unlikely to want to use condoms. In the study the statements that sought to establish the presence of unequal power relations in a relationship were based on the female's counterpart ability to be involved in decision-making. The ability to refuse or talk about sex to one's partner would in this case imply mutual consent is the norm in sexual matters. In all four questions linked to unequal power relations and violence, impressive results were sought. Of the respondents, 83% indicated that they were confident to refuse sex without a condom, while 85% agreed they should be able to talk to their partners about sex. Violence was identified in the literature review as a factor impeding condom use, however 60.8% respondents reported that they were not pressured to have sex and 72.5% revealed that they were not afraid that their partners would hurt them.

The last section (E) of the questionnaire was a summary of all barriers and factors that have been identified in other sections and in literature review. The inclusion of this section was specifically to gauge alignment and consistency in responses. In this study, emphasis was placed on indicators such as perceptions, physical pleasure, mutual understanding, pregnancy, power relations, violence, decision-making, and financial reasons.

The same pattern of response was observed as in previous sections where participants gave mostly positive responses expected if condom use is to bear effective results. One of the limitations was the possibility that respondents may say what they know to be true about HIV/AIDS and not what they practise in reality, due to the sensitive nature of this topic. Several distressing observations were made that necessitate further action and intervention.

### 5.3. IMPLICATIONS

As mentioned in the discussion, the present study was found to have many similarities to findings reported in many previous studies. It presents a wealth of HIV prevalence and the effects of the HIV pandemic at international, national and provincial level. As envisaged by the DoH (South Africa, 2010), it is hoped that government departments, non-governmental organisations, the private sector, community-based organisations and international development partners will use current emerging information as part of a collective response to stop new infections and provide care and support to those living with the HI virus, and to ensure access to treatment for all South Africans in need.

The South African government efforts should therefore keep abreast of international programmes. The support that HIV infected people need from the wider community is crucial. More emphasis will have to be placed on how everyone is susceptible to the disease and how it is therefore the responsibility of all to prevent its spread.



## 5.4. RESEARCH EVALUATION

The measurement of success of this study is based upon the achievement of the primary and secondary objectives as indicated in chapter 1, section 1.4 of this study.

### **The primary objective**

The primary objective of the study was to assess the effectiveness of the government's HIV/AIDS programme. The achievement of the primary objective would be informed by the identification of perceptions, attitude and knowledge held by female educators, as well as identifying the underlying factors that lead to inconsistent condom use.

The primary objective was achieved because perceptions, attitude and knowledge of female educators were analysed and the factors that lead to inconsistent condom use were assessed. As such, a number of issues were identified and subsequently the effectiveness of the government's HIV/AIDS programme was reflected upon. Recommendations to address these issues were made in this chapter.

### **Secondary objectives**

Secondary objectives are to:

- establish what consistent condom use entails
- assess the extent to which female educators use condoms
- identify the underlying factors leading to inconsistency in condom use
- determine the extent to which condom use can be enhanced utilising the current information and intervention programs available.

The first objective was achieved by reviewing what the previous studies have found and relating it to the findings of this study. The empirical study also raised questions on perceptions, attitude and knowledge included in section B of the questionnaire. It was thus determined through the responses that female educators hold correct perceptions, attitude and knowledge that will enhance condom use. The high number (percentage) of female educators indicated their

commitment to sustaining and practising safe sexual behaviour. A sizeable number did give reasons for concern and the need to strengthen the government's HIV/AIDS programme was evident, and proven to be inevitable.

The second objective was by realised by covering the issue of consistent condom use in section C of the questionnaire.

The third objective was by realised by highlighting relationship factors known to inhibit condom use.

Lastly, the government's HIV prevention strategies (with special emphasis on condom use) were stipulated in chapter two (section 2.2), together with their barrier. It was therefore possible to gauge female educators' degree of adherence to those strategies which in return informs future action to be taken.

The conclusion can be drawn that all objectives were met. Based on realising these objectives, recommendations are made below.

## **5.5. RECOMMENDATIONS**

There need to be platforms for more dialogues and round-table discussions targeting women, where they would be free to relate with others and share experiences. Different departments and institutions, both public and private, can take the lead in this activity.

Women should be empowered to be free to 'get out of the closet' and talk about abusive relationships. This will put them in a better position of awareness of self and avoid being victimised.

More accessible women's clinics should be established, where women are attended to by women and are empowered to discuss gender-sensitive issues affecting them freely.

More awareness needs to be created on the importance of couples counselling and testing as emphasises in the new HCT strategy. This will encourage partners to also visit health outlets for counselling and testing in order to know their status.

Conduct-specialised training of counsellors by different departments is needed to sharpen their counselling skills. This will ensure good quality counselling which will lead to more acceptance and disclosure.

Female condoms should be made more accessible for women to make independent informed decisions regarding their sexual preference.

More crisis centres need to be built to offer safety and security to these women. They should be made aware of their existence.

## **5.6 CONCLUSION**

Although much had been done to fight HIV/AIDS it is evident that the pandemic still negatively influences the department of education's success in promoting quality education. Therefore it is necessary to support and reach out to educators affected and infected with HIV/AIDS.

This research investigated the factors hindering the correct and inconsistent condom use, which in return will inform the future strategic plans of the government. It is hoped that this research will make a contribution in the understanding of the pandemic and its effects on the education department.

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# ANNEXURE A: THE QUESTIONNAIRE

## QUESTIONNAIRE

**PLEASE NOTE:**

The questionnaire is aimed at analysing the factors affecting condom use among African female educators in J.C. Motaung Circuit of Matlosana District in Dr Kenneth Kaunda Region (North-West). The research is undertaken as partial fulfilment of successful completion of the study undertaken for a Masters in Business Administration. Recommendations will be made available to the North West Department of Education.

All information will be treated as **STRICTLY CONFIDENTIAL**.

**Instructions for completion:**

1. Please answer the questions as objectively and honestly as possible.
2. Please answer all the questions, as this will provide more information to the researcher, so that an accurate analysis and interpretation of data can be made.

Mark the applicable block with a cross (X). Complete the applicable information.

### SECTION A: PERSONAL INFORMATION

A1	In which age group do you fall?	20-29	30 -39	40 - 49	50 - 59
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(01)

(02)

(03)

A2	What is your marital status?	Single	Married	Divorced	Widowed	Living together
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(01)

(02)

(03)

(04)

A3	Indicate number of working years as an educator.	< 01	01 - 05	06 - 10	11 -20	21 - 30	+31
----	--------------------------------------------------	------	---------	---------	--------	---------	-----

(01)

(02)

(03)

(04)

(05)

A 4	Employment Type	
	Permanent employee	(01)
	Temporary employee	(02)

<b>A 5</b>	<b>Indicate your highest academic qualification.</b>			
	<b>Matriculation</b>			<b>(01)</b>
	<b>Diploma</b>			<b>(02)</b>
	<b>University Degree</b>			<b>(03)</b>
	<b>Honours/Post Graduate Diploma/BTech</b>			<b>(04)</b>
	<b>Masters/Doctorate</b>			<b>(05)</b>
	<b>Other (Please specify)</b>			<b>(06)</b>

<b>A6</b>	<b>How long have you lived in the town you are living in now</b>	<b>&lt;1</b>	<b>1 – 10</b>	<b>11 – 20</b>	<b>21 - 30</b>
		<b>(01)</b>	<b>(02)</b>	<b>(03)</b>	<b>(04)</b>

**SECTION B: KNOWLEDGE AND ATTITUDES ABOUT CONDOM USE**

**To what extent do you agree with the following statements?**

Please rate the following on a scale 1 to 4. 1 is **TOTALLY DISAGREE** and 4 is **TOTALLY AGREE**.  
 Mark the applicable block with a cross (X). Complete the applicable information.

		Totally Disagree	Disagree	Agree	Totally agree
B1	I would not use a condom because I want flesh to flesh sex.	01	02	03	04
B2	If a man and a woman trust each other, there is no need to use a condom.	01	02	03	04
B3	If someone wants to use a condom, you know they have HIV.	01	02	03	04
B4	If my partner asked me to use a condom, I would think they are having sex with other people.	01	02	03	04
B5	If I asked my partner to use a condom, they would think I am having sex with other people.	01	02	03	04
B6	If you forgot to use a condom once or twice with a particular partner, there is no need to use it in future when having sex with the same person.	01	02	03	04
B7	Using a condom seems like an insult to my partner.	01	02	03	04
B8	I do not enjoy (or think I might not enjoy) sex when using a condom.	01	02	03	04
B9	It is embarrassing for me to buy condoms.	01	02	03	04
B10	I perceive condoms to be effective for contraception.	01	02	03	04

**SECTION C: CONSISTENT CONDOM USE**

Mark the applicable block with a cross (X). Complete the applicable information.

		Yes	No
C1	Have you ever had sex?	01	02
C2	Have you ever used a condom?	01	02
C3	Did you use a condom at last sex?	01	02
C4	Was the condom used in all rounds of last sex?	01	02

		Never	Sometimes	Always	Not applicable
<b>C5</b>	<b>How often did you use a condom with your main partner in the past year?</b>	<b>01</b>	<b>02</b>	<b>03</b>	<b>04</b>
<b>C6</b>	<b>How often did you use a condom with your casual partner?</b>	<b>01</b>	<b>02</b>	<b>03</b>	<b>04</b>
<b>C7</b>	<b>If you decided to have sexual intercourse with a partner you would use a condom.</b>	<b>01</b>	<b>02</b>	<b>03</b>	

**SECTION D: RELATIONSHIP FACTORS**

Mark the applicable block with a cross (X). Complete the applicable information.

<b>D1</b>	<b>I am very comfortable talking about sex to my partner.</b>		
	Totally disagree		(01)
	Disagree		(02)
	Agree		(03)
	Totally agree		(04)

If totally disagree or disagree, please explain

---



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<b>D2</b>	<b>I am very confident that I could convince my regular partner to use a condom.</b>		
	Totally disagree		(01)
	Disagree		(02)
	Agree		(03)
	Totally agree		(04)

If agree or totally agree, please explain shortly.

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<b>D3</b>	<b>Very confident could convince a new partner to use a condom.</b>		
	Totally disagree		(01)
	Disagree		(02)
	Agree		(03)
	Totally agree		(04)

If “agree” or “totally agree”, please explain shortly

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<b>D4</b>	<b>I am very confident that I could refuse sex without a condom.</b>		
	Totally disagree		(01)
	Disagree		(02)
	Agree		(03)
	Totally agree		(04)

If “totally disagree” or “disagree”, please explain

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<b>D5</b>	<b>Who decides to use a condom?</b>		
	<b>I do</b>		<b>(01)</b>
	<b>He does</b>		<b>(02)</b>
	<b>We both do</b>		<b>(03)</b>

<b>D6</b>	<b>How often are you pressured to have sex?</b>		
	<b>Never</b>		<b>(01)</b>
	<b>Sometimes</b>		<b>(02)</b>
	<b>Always</b>		<b>(03)</b>

**Please motivate your answer.**

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<b>D7</b>	<b>Women should not talk about sex with men.</b>		
	<b>Totally disagree</b>		<b>(01)</b>
	<b>Disagree</b>		<b>(02)</b>
	<b>Agree</b>		<b>(03)</b>
	<b>Totally agree</b>		<b>(04)</b>

<b>D8</b>	<b>How often are you afraid that your partner will hurt you?</b>		
	<b>Never</b>		<b>(01)</b>
	<b>Sometimes</b>		<b>(02)</b>
	<b>Always</b>		<b>(03)</b>

**If “sometimes” or “always”, please explain**

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## SECTION E: BARRIERS

Mark the applicable block with a cross (X). Complete the applicable information.

E	To what extent do the following factors (challenges) inhibit effective condom use.	Did Not inhibit condom use at all	Inhibited condom use to some extent	Inhibited condom use to a great extent
<b>E1</b>	<b>I was with my steady sex partner.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E2</b>	<b>I do not have the AIDS virus.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E3</b>	<b>The sex was so exciting.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E4</b>	<b>My partner did not want to use a condom.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E5</b>	<b>I did not want to use a condom.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E6</b>	<b>Could not talk about it.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E7</b>	<b>My partner got angry for suggesting using one.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E8</b>	<b>I needed money.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E9</b>	<b>Wanted pregnancy.</b>	<b>01</b>	<b>02</b>	<b>03</b>
<b>E10</b>	<b>I was forced to have sex against my will.</b>	<b>01</b>	<b>02</b>	<b>03</b>

**THANK YOU FOR YOUR TIME.**



ANNEXURE: C



**education**  
Lefapha la Thuto  
Onderwys Departement  
Department of Education  
**NORTH WEST PROVINCE**

Alabama Secondary School Hostel  
1 Neuwannout Street,  
Alabama 2577  
Klerksdorp  
Private Bag A28, Klerksdorp  
Tel. No.: (018) 467-9300  
Fax No.: (018) 467-9309  
e.mail: mot@landc.net

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**DR KENNETH KAUNDA DISTRICT**

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**MATLOSANA AREA OFFICE**

**TO: THE PRINCIPALS  
J. C. MOTAUNG CIRCUIT**

**FROM: THE AREA MANAGER**

**DATE: 09 SEPTEMBER 2010**


**SUBJECT: PERMISSION TO CONDUCT RESEARCH**

This memo serves to confirm that **MRS M. A. MANSFIELD** has been granted permission to conduct research in the *J.C. Motaung Secondary Schools*. Her research title is: *"Condom use among female educators"*.

**MRS M.A. MANSFIELD** is currently studying for a *Master of Education Degree in Management* at the North West University. She is given permission on the following conditions:

1. Teaching and learning must not be compromised.
2. All research ethics must be observed.
3. The results of this research must be shared with the DoE on completion.

I take this opportunity to wish her well in her self-improvement efforts.

  
.....  
**DR. MA MOTAUNG**  
**THE AREA MANAGER**

## ANNEXURE: D

Circuits	PUBLIC SECONDARY SCHOOL	LOCATION	NUMBER OF EDUCATORS	NUMBER OF FEMALE EDUCATORS
MEEPONG	Borakanelo	Khuma	43	
	Dirang ka Natla	Khuma	26	
	Stilfontein	Stilfontein	13	
	Thutho-Thebe	Khuma	32	
	Vuyanimawetu	Khuma	35	
D	Alabama	Alabama	39	
	Alabama Comb.	Alabama	12	
	Gaenthone	Haarstebeesfontein	38	
	Gaenthone	Haarstebeesfontein	17	
	Chris Hani	Jouberton	19	
	Cocekani	Jouberton	30	
	Letlhasedi	Klerksdorp	13	
J.C MOTAUNG	Are-Fadimeheng	Jouberton	33	15
	Milner	Klerksdorp	25	13
	Mofathosi	Jouberton	22	12
	Tshedimoseetso	Jouberton	27	12
	Thuto-Tshebo	Kanana	24	12
	Vaal Reefs Tech	Orkney	63	30
	Orkney H.S	Orkney	16	7
	Kanana	Kanana	28	10
	Tshebedisamo	Kanana	22	10
	Matlhaleng	Kanana	21	10
	Mmonkeng	Kanana	28	12
	REFENTSE	Klerksdorp Comb	Manzilpark	20
Klerksdorp HTS		Klerksdorp	32	
Schoonspruit		Klerksdorp	23	
New Vision		Klerksdorp	15	
Nkang-Mahlale		Jouberton	28	
Tsamma		Jouberton	28	
Wesvalia		Klerksdorp	30	
Matlosana		Jouberton	32	
Dominion Reefs		Dominioville	18	
Phakela Comb.		Haartebeesfontein	11	
Klerksdorp H.S.		Klerksdorp	36	

Source: Matlosana Area Project Office