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COMMUNICATING AIDS NEEDS PROJECT • CAN

Breaking the Barriers: An Analysis of Condom-related Calls to the National AIDS Helpline

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Over the past decade considerable efforts have been made to promote the availability, acceptability and use of condoms worldwide as part of attempts to stem the spread of HIV infection. Condoms have been promoted intensively in South Africa since 1995 and increases in condom use among all age groups have been found in behavioural surveys over the past five years. Condoms are, however, only effective in preventing HIV transmission if they are used consistently and correctly. Among obstacles to the use of condoms in South Africa are lack of knowledge about the correct use of condoms, myths and misunderstandings about their importance in preventing the spread of HIV, and general reluctance or difficulty to introduce condoms into sexual relationships. This report draws upon qualitative findings from focus group sessions with counsellors at the South African national AIDS Helpline to highlight contextual problems and informational needs about condoms as reflected in calls to the Helpline. On the basis of these findings, the paper makes recommendations for enhancing condom-related communications.

Since the earliest days of the HIV/AIDS epidemic, male condoms have been promoted as a fundamental strategy for preventing the spread of HIV. The correct and consistent use of latex condoms has been found to prevent HIV infection in both men and women; its secondary benefits include prevention of some types of sexually transmitted infections (STIs), as well as pregnancy (NIAID 2001; WHO 2000).

As the HIV/AIDS epidemic has advanced, international health bodies, many national governments, and other organisations working in the health field have heavily promoted the availability, acceptability and use of barrier methods – particularly male condoms – to curb the spread of the epidemic. Female condoms have also been distributed and promoted – although on a more limited basis, given cost constraints – since the mid-1990s.

National-level condom distribution systems are considered to be most effective if they are multi-sectoral, involving government agencies and ministries, non-governmental organisations, community groups, and the private sector (WHO 2004). Barriers to accessing condoms can be reduced by distributing condoms free of charge through a wide network of primary and secondary distribution points, including clinics, hospitals, bars, transport hubs and workplaces. In some countries, free (public sector) condoms are complemented by the availability of branded condoms developed and marketed as part of social marketing systems, as well as commercial brands.

The emphasis of early condom promotion campaigns was on the use of condoms in non-marital situations – e.g. commercial sex or sex with non-regular partners (Ali et al 2004). While this strategy was seen as appropriate in countries with limited or concentrated HIV epidemics, the growing number of countries with generalised epidemics (55 in 2000) has led to a focus on condom use at the general population level.

Condoms and Condom Policy in South Africa

South Africa's overall HIV prevalence rate was found to be 11.4% in 2002 (Shisana et al 2002). Condoms have

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formed the cornerstone of HIV prevention efforts in South Africa and have been widely promoted for HIV prevention. Since the early 1990s, condoms have been distributed free of charge through the public sector.

Currently, the Department of Health procures condoms via a tender system. Suppliers have to meet criteria for quality control, and be able to deliver condoms in sufficient quantities in a timely manner. All condoms distributed through the public sector must conform to quality standards set by the South African Bureau of Standards.

Public sector condoms are distributed to 166 primary delivery sites (government stores, hospitals, clinics, NGOs and private sector organisations), which in turn distribute condoms to thousands of secondary points (clinics, smaller hospitals, and community service points such as workplaces, taverns, shebeens, and spaza shops[1]). In 2002, 350 million public sector condoms were distributed by the Department of Health, up from 267 million in 2001 (personal communication, John Wilson, DOH; Cabinet 2002). The Society for Family Health promotes and distributes two social marketing brands – Lovers Plus and Trust. In 2003 11.9 million were sold; up from 6.7 million in 2001 (Personal communication, Katie Schwarm, Society for Family Health).

Condoms are promoted through both formal advertising and promotional campaigns linked to provincial governments, NGOs and community-based organisations. These initiatives have drawn upon community media (such as local radio), local events, peer communication schemes and day-to-day interactions. Emphasis has been placed on promoting condom use in all 11 official South African languages.

Condom use has increased significantly in South Africa – from 8% at last intercourse amongst sexually active females aged 15-49 in 1998, to 28.6% in 2002. Amongst females aged 15-19, the increase was from 19.5% to 48.9% (DHS 1998; Shisana et al 2002). In 2002, condom use at last intercourse amongst 15-24 year olds was 57.1% for males and 46.1% for females (Shisana et al 2002). Similar levels were found in a study of 15-24 year old youth in 2003 – 57% for males and 48% for females (Pettifor et al 2004).

Perception of ready access to condoms is high – in 2002 95.1% of sexually active respondents aged 15-24 agreed that they could obtain a condom if they needed one. Public sector clinics and hospitals were the most likely source of condoms. Messages about condom use also had the highest level of recall of all HIV/AIDS slogans or messages in South Africa in 2002, and were mentioned by 90.8% of 15-24 year olds (Shisana et al 2002).

Findings from the AIDS Helpline

Methods

The Communicating AIDS Needs Project (CAN) focuses on individual and community-level responses to HIV/AIDS with a view to understanding communication and resource needs at both levels. The project includes a number of in-depth research activities in selected South African communities, as well as reviews of service provision and communications systems. One component of the project is research and analysis of calls to the national AIDS Helpline.

The AIDS Helpline was established by the South African Department of Health in 1992, in partnership with Life Line. The Helpline service was consolidated into a centralised call centre in Johannesburg in 2000. It is staffed by full-time, trained counsellors and can handle up to 24 incoming calls at a time. Calls are monitored through data capture forms, and also through automated electronic call counting. It provides callers with basic information, counselling, and referral to services in all 11 South African languages and is available 24 hours a day, seven days a week.

The Helpline has received close to seven million calls since May 2001; approximately seven percent of these are 'genuine calls' (currently defined as calls that are more than one minute in duration where information, referral and counselling is provided). A quantitative analysis of calls to the Helpline between July 2000 and December 2003 found that slightly more than half of genuine calls to the Helpline are for information, although the proportion of counselling calls has been rising over time. Seventy-five percent of callers are under 30. A growing proportion of callers to the Helpline are disclosing their HIV status (Katz 2004).

Awareness of the Helpline extends throughout the country, and calls are recorded from both urban and rural areas from all provinces. Telephone access in South Africa is high – 42% of all South African households have either a landline or cellphone, and only 9.4% of households have no access to a telephone nearby (Statistics South Africa 2003). The table on the following page illustrates call volumes, by subject, between October 2002 and September 2003.

During the latter half of 2003, a series of focus group discussions was conducted with AIDS Helpline counsellors with a view to assessing call trends and exploring key issues raised by callers. The focus groups were conducted with five to six counsellors at a time and followed standardised protocols. Most counsellors had worked at the AIDS Helpline for two or more years, and were thus able to reflect on a large body of calls to the line. All counsellors had completed relevant counselling training courses and received ongoing supervision, training and debriefing.

The focus groups demonstrated that a specific value of the Helpline service is the capacity to respond in detail to individual situations and contexts. Counsellors were well-informed on matters related to condom use and had developed clear strategies for discussing condom-related enquiries that emerged from callers. Responses included careful explanation of facts and use of logical arguments in response to enquiries.

It was clear from the focus group discussions that the

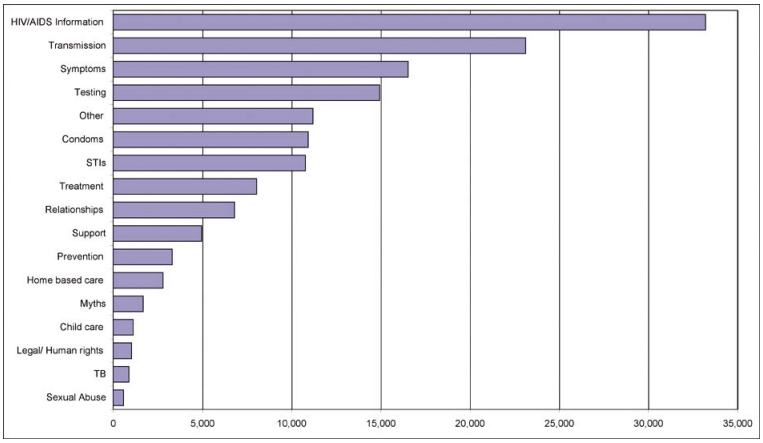

Figure 1: Calls to the AIDS Helpline by primary reason for calling. 1 October 2002 to 30 September 2003

Helpline provided the opportunity for deep explanatory dialogue, and counsellors generally felt that callers had understood and were positively oriented towards the information they were given. There was also the sense that the Helpline played an important role in verifying information that was encountered through other sources, and counsellors were seen as a credible and trustworthy source of information. In instances where callers indicated that misconceptions or questions existed in their peer group, callers were encouraged to pass the information on to their peers.

It was noted that some callers raised issues that could not readily be solved through information provision or counselling – for example, the introduction of condoms between married couples, as well as in contexts of coercion and violence.

The duration of the focus group sessions ranged from one and a half to two hours. Sessions were mostly conducted in English, although allowance was made for the use of other languages as the need arose. Facilitators prepared discussion guides prior to each session and discussions were tape-recorded, translated where applicable, and transcribed. All transcriptions were checked for accuracy.

Focus group transcripts were read a number of times by a senior researcher to allow for an understanding of the material and to develop a strategy for coding. The data was then coded and categorised electronically by two researchers using HyperRESEARCH OSX 2.6.

Strengths and limitations

The focus group discussions with Helpline counsellors were conducted as a counterpart to a quantitative analysis of data on calls to the Helpline, the results of which have been published separately (Katz 2004). The qualitative research was intended to highlight key issues and gaps in understanding about HIV/AIDS on the basis of actual cases and examples recounted by Helpline counsellors.

It is important to underscore that the findings of this research are not uniformly generalisable. Whilst calls to the AIDS Helpline are made by callers countrywide, callers are primarily individuals inclined towards information seeking. The issues raised in this report emerged from the subjective recall of participating counsellors.

The strength of the approach is that it provides a relatively simple means through which to assess concerns and misunderstandings in relation to HIV/AIDS, drawing on national-level perspectives. The calls allow for analysis of gaps in understanding, which in turn provide useful reflection on potentials for communication campaigns and local and/or service-level communication support. Novel perspectives also emerge through the capacity to develop an understanding of the experience of HIV/AIDS within individual contexts. It is also acknowledged that the AIDS Helpline service plays a valuable role in reducing misunderstanding, and also providing a mechanism to address individual-level concerns and contexts – communication processes that are only matched by face-to-face counselling.

Findings

Analysis of the focus group data revealed that condom-related calls generally related to one of seven themes, with related sub-themes:

- ❑ Condom efficacy and quality
  - Safety and reliability
  - Smell
  - Condom breakage
  - Myths
- ❑ Correct and safe use
  - Use in multiple ‘rounds’ of sex
  - Using more than one condom at once
  - When to put a condom on
  - Loss of erection
  - Condom comes off during sex
  - Latex allergy
  - Oral sex
  - Anal sex
  - Condom size
  - Storage and disposal
  - Female condoms
- ❑ Condom negotiation
  - Non-use: coercion, violence
  - Condom use between sex workers and clients
  - Discordant couples
  - Concordant couples
- ❑ Condom use in marriage
  - Mistrust and fidelity
  - ‘Cultural factors’
  - Knowledge of HIV status
  - Child-bearing
- ❑ Perceptions of condom types
  - Public sector condoms
  - Social marketing brands

- Condom access
  - Attitudes of nurses
  - Access in rural areas
  - Issues in parent-child relationships
- Communication messages
  - Religious perceptions
  - Contradictory messages

Condom efficacy and quality

Safety and reliability

According to counsellors, callers often ask whether condoms are safe and effective and frame the question in terms of '100 percent safety.' When responding, counsellors are cautious about condom efficacy:

> *They always want to know if it is '100 percent safe' – that '100 percent' is the one thing that the person is really interested in. What I usually say is that you can never say something is '100 percent safe' because, like any other thing, there is a user who lessens the efficacy of that product. The circumstance under which it is being used also lessens [efficacy] – during sex a lot of things can happen.*[2]

In response to this type of question, counsellors noted that they focus on the correct and consistent use of condoms as critical to their reliability.

Smell

A number of callers were concerned about the smell of condoms, and tended to single out public sector condoms as having an unpleasant smell.

> *'These ones that you get for free from the clinic and the hospital – they've got this bad smell. The ones that you buy – the lubricant is the same, but at least they smell better that those ones.' Which means these [free ones] are maybe old and such. Maybe it would help if they could improve the smell, because people are complaining about them. Somebody says, for example, 'If I don't have the money to buy Lovers Plus [a socially marketed condom], I'd rather have sex without a condom because these ones smell bad.'* [3]

Condom breakage

According to counsellors, calls about condom breakage were regularly received. Frequency of such calls may be related to the fact that the AIDS Helpline number is printed on condom packaging. Counselling in relation to breakage offers an opportunity to address a number of issues, including correct use, storage, the need to address possible pregnancy, STIs and HIV exposure.

> *They always phone about the condom having burst, and they will phone late. They will say, 'It has burst now.'* [4]

Counsellors reported calls about breakages due to lack of lubrication. This was evidenced both in relation to condom breakages, but also in relation to complaints of painful sex during intercourse with condoms.

> *…What happens is the condom itself – it's so painful, you know?… Another guy was cross with me – I had to tell him [that]… maybe we don't know sex or foreplay, because what happens is that if my boyfriend is going to enter me when I'm already wet, he is going to say I've been sleeping around… So each and every time we hold ourselves or maybe we don't do foreplay before a man will want to enter and that's the problem. If the man is going to penetrate me with a condom whilst I'm dry… A woman will say, 'I don't want this guy [to use a condom] because it's painful.' Then you try to explain … to a guy that when you enter a woman, it is better when she is already wet.*[5]

Breakages were also connected to poor storage techniques. For example:

> *[When] a person complains about condom breakage, you ask, 'Where do you place your condoms?' And they are almost always placed on the windows, [or] in wallets. Then you explain, the wallet is in your back pocket, you sit on it…* [6]

For some callers, the fact that condoms occasionally break was linked to a generally fatalistic attitude about the merit of using condoms at all:

> *Their concern is that, even if they use a condom, the condom breaks – so what is the use? Because most of the condoms that they get from the government or the condoms they get from the public sector – they break, sometimes they are expired, so why should they use them? At the end of the day, you are not protected when a condom breaks.*
>
> *Facilitator: Can you give an example of a caller?*
>
> *It was a man. He said he was having sex, he used the condom. The condom broke, so what are the chances of him getting HIV? Then we would explain that, and then he said, 'So, but what is the use of using a condom if the condom is going to break?'* [7]

Myths

Myths are concepts and ideas that become validated through repetition and apparent common-sense appeal. Some myths are also built upon an apparent kernel of truth that gets woven into a common-sense understanding. Condom myths include the following:

- Condoms have holes: "Condoms have holes. They have holes that can make the virus pass from one person to another". [8]
- Some condoms are unsafe: "[Callers ask], 'How true it is that there are some condoms which are not specifically manufactured to prevent this virus?' You know, there are different types of condoms." [9]
- Condoms contain HIV: "They say that it has the virus. Ever since there are condoms [distributed widely], there's a lot of people who are infected with HIV." [10]

- Condoms have worms: "You know, if you place a condom into hot water, you see worms."[11]

Correct and safe use

Use in multiple 'rounds' of sex

A number of callers were unclear how to approach condom use during multiple acts of sexual intercourse within the same encounter. There were reports of condoms being used during the first act of intercourse, but not for subsequent acts. Counsellors noted:

> *They believe that the first round is where you get the virus.* [12]

> *Others would put on a condom for the first round and then for subsequent rounds they don't put on a condom. Because they say that… the initial ejaculate [is] gonna be infected.*[13]

Such calls point to a lack of knowledge around modes of transmission for both HIV and other STIs, and the role of condoms in preventing such infections.

Using more than one condom

Counsellors reported receiving questions from callers about whether it is possible to use two condoms simultaneously to be extra cautious about preventing HIV infection. Counsellors respond to such calls by explaining the greater risks of the condom tearing or coming off. They explain that it is better to use one condom correctly.

> *We receive calls like, 'Can I use two or more condoms, because I'm afraid my partner is HIV positive. How can I put those two condoms on?'*
>
> *Facilitator: How do you respond to those calls?*
>
> *I usually say that one is enough, because as long as you use it correctly, you will be safe from being infected with the virus. If you use more than one, I don't see it fitting very well, because of the rubber – you have to insert another plastic on top of the other plastic. So long as you use it properly, it is okay to use one.*
>
> *The other thing that I'm concerned about…using double – it's the friction. It's going to be easier for both condoms to tear. That's where it goes to education – getting more information from this person. Why is he so concerned about using [two]?*[14]

When to put a condom on

Counsellors noted that some callers said they had acquired STIs, even after using a condom. When this was discussed at length, however, it was found that there were misunderstandings about when a condom should be put on. Potential infection was related to rubbing the vaginal area with the penis prior to putting a condom on or having vaginal fluids on the fingers.[15]

> *We get calls, for example, 'I've been using condoms always and now I have an STD. But I am using a condom.' [I would say], 'Look at your behaviour before you put on a condom. What do you do? Do you touch the vagina? Or do you have contact with your penis first and put a condom on after?' That's what we explore first, then sometimes you find out: 'Yes, I touch the female and then I put on a condom.' Or 'Before I use a condom, I use my fingers first.' I said, 'Ya, that's where you get STDs.'*[16]

Loss of erection

Counsellors described calls about loss of erection during condom use. Counselling was provided to address this problem. [17]

Condom comes off during sex

Counsellors noted that callers were unclear what to do when a condom comes off during sex, and how to extract it if it was 'stuck' in the vagina. It was also necessary to provide callers with information about possible risks for pregnancy and HIV infection in such cases.

Latex allergy

Allergic reactions can occur in relation to condom use, and some callers raise the issue of rashes occurring when they use condoms. However, there were no reports of severe reactions, and in some instances, counsellors felt reference to reactions to condoms might be related to rationalising non-use.

> *Sometimes you think that maybe this person is allergic to latex, but when you go deeper, you discover that maybe the person doesn't even want to use a condom. But sometimes you find that what they are saying is true – they do have a rash…* [18]

Oral sex

The risks of HIV and STI infection during oral sex were not clearly understood by some callers. There was also a concern about the safety of oral contact with condom lubricant if a condom was used during oral sex.[19]

> *[Callers will ask] if it is safe to put a condom on [during oral sex]. For example, 'If a man has a condom on, can you perform oral sex with it on?'…And the safety thereof, especially as far as the lubrication is concerned…. Is it going to cause harm?*[20]

Anal sex

It was recognised that condoms were necessary for protection during anal sex. One of the scenarios in which this was raised was the desire to maintain female virginity. As one counsellor noted:

> *Usually teenagers avoid this … [vaginal] penetration – because they want to save themselves for virginity… So they would rather make use of the anus to have sex.*[21]

Calls also related to safety of condoms for anal sex, and

the tendency for condoms to break during anal sex. Counsellors reported questions from gay callers about the safety of various types of condoms for anal sex:

> *Most such comments come from gays…[for example], 'Can I use this condom for anal sex? What are the procedures? Where can I get them?' Those kinds of things.*
>
> *And usually they talk about safety, because they say that if they are using condoms they usually burst, because of the dryness of the anus. So we talk about things like using KY jelly…to make it more wet.*[22]

Counsellors provided information on the need to use additional lubricant to prevent breakage. It was however also noted that the recommended lubricant – KY jelly – was not widely available and was expensive.

Condom size

Calls relating to condom size were noted amongst younger callers.[23]

Storage and disposal

According to counsellors some callers, particularly younger callers, were unclear on safe storage techniques, and poor storage was sometimes identified when callers probed reasons for condom breakages. They found that condoms were potentially exposed to heat and sunlight as a result of being hidden from parents or others. For example:

> *Behind the TV there is heat being generated… [The caller] has to hide it [the condom] and that is the problem: putting it behind the curtain [exposed to heat and sunlight] before the mother comes in.* [24]

There was a lack of clarity on safe disposal of condoms – particularly whether they should be flushed down toilets. Pit toilets were noted to be a safe place for disposal.

Female condoms

Female condoms were not explored in detail in the focus group sessions. However, counsellors noted that they were not generally available to women who wanted them. Some callers who had used the female condom reported that it was noisy. According to counsellors, common concerns expressed about the female condom included its safety and fears about it disappearing inside the woman's body:

> *[They say] that the female condom is too big. And its safety – there is a fear that it can just disappear. What would you do in order to pull it out? What will happen?*[25]

Condom negotiation

Counsellors were in a position to provide detailed support to callers in relation to specific relationship contexts.

Non-use: coercion, violence

Some calls to the Helpline underscore the connection between effective condom negotiation and power relations within relationships. Counsellors reported calls in which coercion, threats of violence, or actual violence were factors in unprotected sex. For example:

> *We have had young callers on the issue of 'I was forced to have sex,' or 'The reason we didn't use a condom is because I love my partner,' or 'I was scared to lose my partner' and so forth… [Others say] 'I was forced to have sex with this person without using a condom,' or 'We did use a condom and when he was about to ejaculate he pulled off the condom.' They want to know whether it is a crime… I had a caller asking me if she can take the boyfriend to court for that.* [26]

Coercive aspects are related to the issue of trust, and callers are concerned about possible exposure to pregnancy, STIs and HIV:

> *A caller will say, 'My boyfriend said I don't trust him and I told him I trust him. He said, "Why should we use a condom? It means you don't trust me. Do you think I'm HIV positive?"' And then, 'Because I love him too much, I don't want to lose him. I end up sleeping with him without a condom.' What they'll want to know is pregnancy first – they want to know whether they can go for the morning-after pill. Then, can they go to the clinic to check for STDs and all sorts of things. When you go deeper and [talk] about HIV, that's where the problem really is. She'll start saying, 'I don't like to be pregnant, but wow – HIV? Do you think I am positive?' They start getting worried, and frustrated too. The caller will want to know right away whether he or she is HIV positive or not – whether she can go to the government clinic immediately to do an HIV test…* [27]

In some instances coercion is attributed to cultural factors:

> *Others phone because they've got a problem that their partners don't want to use a condom. But that one is more to do with the culture. Maybe he's from a certain tribe – he is refusing or he does not even believe in using a condom. So what must they do? What can I tell this person?* [28]

In cases of coercion or violence, or in other instances where a condom has not been used, counsellors provide information on pregnancy, STIs and post-exposure prophylaxis.

Sex workers

Counsellors described calls from sex workers regarding condom use with clients. Sex workers told counsellors that some clients insist on not using condoms and that they find themselves in situations where insisting on a condom will possibly result in losing the client. Some sex workers are therefore forced into having sex without a condom because of their precarious economic circumstances.

> *I had [a call from] a sex worker. Seemingly she knew about HIV and AIDS and as she is busy working, she wants to always use condoms. The problem she's encountered is*

from the clients – they don't want to use condoms because they pop out their money and don't believe that there is HIV and AIDS. She wanted to know how to go about telling clients about HIV, that HIV is here and it is killing. We talked about it and how to go about dealing with it and I told her she's got every right to use a condom if she wants to use a condom. But because that's how she works, sometimes it's a problem because she ends up not having clients because they insist on not wearing condoms. If she wants to use a condom she will end up not having money. So she's forced to have it without a condom.[29]

There is also an economic incentive for sex workers not to use condoms, as they explain that they are paid more if they do not insist on using a condom.

The [sex workers] will go for a higher price if they don't use a condom. They'll say, 'Okay, it's R50 with a condom, but R250 without a condom.' And [the clients] say, 'Okay, fine, no problem.' And some of the prostitutes know about HIV, but they choose not to use condoms. They'll tell you, 'The person gave me R500 an hour – for an hour who will give me R500? I have a family in KwaZulu-Natal – 1, 2, 3, 4, 5 – and anyway, I'm going to die. Why should I?' [30]

Counsellors noted that the lure of more money and the imagined assistance the money will bring to them and their families outweighs the physical health consequences of becoming infected with HIV.

Discordant couples

Couples who find that they are sero-discordant have typically undergone one or more face-to-face counselling sessions as part of VCT, but questions may still exist. For example:

The person will say, 'I am HIV negative, she's positive and we have been having unprotected sex. We didn't know that she was positive and I am negative, and we've been in this relationship for years. Now here it is. I still want to have children… and we have already had children. We have a child and she discovered when she was pregnant that she is positive. I have tested three times and I've tested negative. So now where do we go from here? Do we use a condom? After all, we haven't been using condoms, and I still remain negative and we had a baby that is well, so now why do we have to use a condom? Because we have managed so far, without a condom and it's okay.' [31]

Concordant couples

Counsellors agreed that there was very little information available in relation to HIV reinfection, and concordant couples were not clear about the benefits of condom use:

It seems as if people are not aware of the issue of reinfection. They will just tell you, 'Since me and my partner tested, I'm now faithful to my woman. I am no longer sleeping around.' And if you ask, 'Are you using a condom?' they say, 'Oh, is it necessary?' Because some people think that reinfection occurs if you sleep with other partners, but if it's both of you, it doesn't happen. [32]

Others noted:

Ja, they are saying the viruses get used to each other. [33]

Condom use in marriage

Mistrust and fidelity

It was noted that condom use within marriage is a difficult concept to convey and explain:

The person wanted to know if he must still wear a condom when he is having sex with his wife. I don't know – I think we all say 'Condomise, condomise,' but we don't talk about why to condomise. We are not talking about what happens if they think that there is mistrust or something like that.[34]

Condom use might also be covert, and require reconciliation of the possibility that a partner is having sex outside marriage with the fact that he/she is using condoms:

There was this woman who called. She was very cross… She found condoms in her husband's car. I said to her… 'You know, you are fortunate because that means your husband is protecting himself.' [35]

It is, however, also difficult to address condom use in the case of suspected infidelity:

Especially ladies of 40 to 50. Maybe they are married, they don't know anything about the husband, but apparently they suspect. They [just] don't have evidence that the husband is sleeping around… So if they are just suspecting, how can they convince him to use a condom? [36]

You find that there is a couple, and the woman is aware that her partner is cheating on her. So the woman will initiate use of a condom, but the problem lies with the husband. He denies that he is cheating. He thinks that because the woman wants to use a condom that it means she is the one who is cheating.[37]

Economic dependence

Counsellors described contextual factors raised by callers – particularly women – when explaining why it is difficult for them to suggest using condoms with their spouse.

The other thing…that makes it difficult to negotiate is when the other party is not working. If you say to a caller, 'You must tell your husband to use a condom,' and he says to her, 'No, I'm going to divorce you,' and he is the only bread winner. The caller asks, 'What should I do?' It's not only HIV that is a problem – it's also kids, sharing a house, having food. It is difficult. If you have a partner you cannot say that. There are some very important things besides HIV. [38]

Such calls suggest that complex gender-power relations underpin some negotiations around condom use. In this case, economic dependence of women on male partners,

and fear of abandonment or destitution, are obstacles to women negotiating for safer sex.

'Cultural factors'

Mistrust was also related to a variety of factors, including the separation of couples due to labour migration, 'cultural factors', and issues of respect within a relationship.

> *This condom thing – the prevention – clashes with culture. You say to a person in the rural area – the husband is working here [in Johannesburg] – 'Well, if you don't trust him when he's here, when he comes home, maybe condomise.' She'll say, 'Well I can't, you know? My culture doesn't allow me to condomise. It will be disrespect for my husband.' So then it becomes a problem. What do you do?* [39]

'Culture' was also referred to in relation to authority of the husband:

> *Culturally you find … that there are people, especially from the rural areas, who can never talk openly about sexual topics with their partner. If he says, 'I want to have sex with you' it means 'I want to have sex with you and you don't have to question me about what to use.' At the same time, if you bring up the issue of condoms, maybe he will start beating [his wife].* [40]

Knowledge of HIV status

Learning one's HIV status at some point during the marriage also poses problems in relation to condom use, especially in the case of migrant couples:

> *[For example] the woman is staying somewhere and the husband is working, and the woman [in KwaZulu-Natal] tests positive and then has to use a condom. How does she tell her husband who is in Johannesburg that now they are going to use a condom? I always find it very difficult to put myself in that position – the position of being a woman. [I] probe around [about] who takes decisions in the household: 'Is there a grandmother? Is there your mother's husband? Your mother-in-law – is she there? Do you discuss these things with her?' We look for a person who might [be able to] introduce condom use and why it is necessary now. In that case I've always found them to say, `Ya, I do talk to my mother-in-law and she is the one, really, who can talk to her son rather than me'.*[41]

> *It's the introduction of that condom – from both sides. Because even if a man phones, he will say, 'What is my wife going to say when I suddenly say, "Let's use a condom."' Maybe he has recently been diagnosed and he is not yet ready to disclose, so now what is he going to say to his wife? I mean, they have been married for ten years and suddenly he says 'Let's use a condom!'* [42]

Child-bearing

A further problem, in the case of one or both partners knowing their HIV-positive status, is the issue of child bearing, especially as this relates to expectations of in-laws and relatives:

> *If I'm using condoms in marriage and then don't have children, what are my in-laws going to say? That I am barren and whatever: 'You don't have babies!' It will be like an insult within the family, you know? So I can't go on using condoms.* [43]

> *I think [in respect to married couples] that the in-laws put pressure on the whole [situation]. I was speaking to this married couple – they are not that old – still in their 30s. And they did not want to have a child, they were not ready for a child. But the in-laws wanted them to have a child; they wanted grandkids. So we looked at the options – for example, had they thought of going for testing before they have children and all that? The in-laws don't want them to go. It's like the in-laws were running their lives for them. I wonder how many couples are experiencing the same thing, because in-laws don't encourage condom usage. They instil the fear that, no, this is not going to happen, and they just don't concentrate on using the condom.*[44]

Perception of condom brands

Public sector condoms

The Helpline receives enquiries that are related to a lack of clear understanding about the relationship between free public sector condoms and commercial brands. This contributes to the perception that free condoms are of low quality. It also frames a number of condom-related myths.

> *They call them government condoms and [say they] are the main ones that spread HIV. The main question is why they are not for sale and the others are for sale. That's the part they don't understand.* [45]

> *People [talk about] the difference between condoms which they buy from the chemist and the ones that are given for free. They say, 'This one which is given for free – it has the virus.' Or maybe, 'It's just cheap, you know? It's not okay like the one you buy from the chemist.'* [46]

> *Callers say, 'Why are they giving away free condoms? How safe are they?' They don't trust the fact that the condom is given free. They say that the government is using the condom in order to spread HIV, because since these free condoms were introduced, the virus came.* [47]

The perceived lower quality of public sector condoms is also expressed in relation to 'strength,' as well as having 'excess lubricant.'

> *The difference around the condom is that the ones you buy are stronger than the ones you get for free. The latex is not the same and the other one has got too much fat. The other one – the one that you buy – it's lighter.* [48]

Counsellor responses to such calls include exploration of the person's context. This allows for the construction of understanding in relation to public sector condom

supply. For example:

> *For instance, I start questioning a person about why he says the condoms are free – then he says because he collects them at the clinic. Sometimes I will ask the person whether he is employed or not. Then he says 'No, I am not employed'. That's when we start to explain about the subsidies – how the condoms are subsidised and why are they are subsidised: so that each and everybody can have access.*[49]

The packaging and look of public sector condoms appears to affect people's perceptions of their quality:

> *The problem is that many people are saying that Lovers Plus [social marketing condom] is packaged nicely and they take out money for it. The government one – they don't take out anything. Even though we try to educate them that it doesn't mean the government is spending nothing on it, or that it [works with] a company that makes them for free or [that they] are buying them from the very same companies [as the social marketing or commercial condoms]. As a business person you can buy something and decide on your own packaging – which becomes the brand. Then they give the very same condom as the branded ones. I think [different] packaging would have a very positive impact.*

> *And the naming – it's very important to have something catchy. You know, the package now – silver, with the AIDS Helpline number – really! That's why [people] say, 'This thing is for AIDS.' Whereas if you have something catchy…*[50]

Social marketing brands

It appeared that there was little understanding of the differences between public sector, condom social marketing and commercial brands. Counsellors did, however, mention that Lovers Plus was perceived to be a high-quality condom. Some callers also mentioned that if they wanted to impress their partners, they would use a branded condom (including a socially marketed one).

Condom access

Attitudes of nurses

Attitudes of some nurses appeared to be a barrier to condom use, especially amongst youth.

> *The young people [sometimes] say that nurses at the clinics deny them the opportunity to use condoms. When I go deeper, I find that there is reality [to this]. Nurses say, 'What they are gonna do with the condoms? They should be focusing on their studies.' They don't know that they've got the right to get those condoms freely.* [51]

> *If you to a clinic, the nurses are kind of scolding them: 'What are you doing here?' And because they know each other, 'I'm gonna tell your mum this is what you are doing.'* [52]

When counsellors probed the situation of some of the younger callers, it appeared that access might also be constrained by fear of being discovered accessing condoms:

> *When I probe a person who comes with this, I find that it's just that they know the nurse – they think the nurse might tell the parents. [The counsellor responds] 'Did the nurse say that she's going to tell your parents?'… 'No, but you know we attend the same church – this is a mother figure, this is my mother. How can I go and actually ask for condoms?' 'Okay, but usually in clinics, there are condocans outside with the condoms… You don't even have to ask for them.' The response is 'No, but they will see me.' You know, the fear is more of what might happen than of the nurse, because now most of the condocans are outside – you don't even have to talk to the nurse. They no longer stay in the drawers as it was previously. So I think it's fear that it is the local clinic.* [53]

Access in rural areas

Access to condoms in rural areas was noted to be inconsistent – both in terms of stock replenishment and in terms of convenient location.

> *Most people, especially people in the rural areas, will say that initially there will be a lot of condoms, but replenishing the stock is a problem. It will take a long time before it is done. They will also say, 'Can't you get them nearer? They're at one central place. We only get them when we go to town. Can't you make it possible for the condoms to be placed, say, at a shop or at an induna's house or whatever? Because then it is accessible.' So accessibility, especially in the rural areas, and the replenishment of the stock is a problem.* [54]

Issues in parent-child relationships

Parents were concerned about the risks of HIV, and wish to ensure that their children can access condoms. Direct communication, however, was perceived as being difficult. Some parents describe trying other strategies. For example:

> *It was the mother who was suspecting that her children might need condoms. She tried to talk to them and [it was unsuccessful]… So she got condoms, she would place them, for example, in the bathroom – anywhere – and they would disappear. …She did that because she thought they would understand that this was her way to open lines of communication. But the condoms were disappearing and she didn't know who [was taking them], because she has three, four sons. And she also has daughters, but she never suspected. She said, 'No I don't think it's my girls. I'm sure it's the boys. But now I would like to know what to do, because I was doing this so that whoever is using condoms would come to me so that we can talk.' And I said, 'Why don't you call a family meeting? Sit down with them and talk'… She said, 'But I tried that, and they are still not talking.' I said, 'Then don't make a mass meeting – make it an individual meeting. Maybe one to one they will open up.' So she said she would try that. The other*

thing I suggested was to introduce them – because she was involved in these community things – and to get them to also be involved in youth clubs or whatever, since they will get information there. Maybe they will talk more there, and then they might open up. I don't think it was easy for them to open up to the mother. [55]

Communication messages

In general there were few explicit references to communication campaigns, although it was clear that some slogans used by callers in conversation with counsellors were derived from campaigns – for example, the concept of 'condomising' or the slogan 'one round, one condom.'

Religious perceptions

In some instances, slogans were reconfigured – and to some extent, subverted. For example, some churches were promoting the concept of 'kingdomising' over 'condomising':

The church says don't use a condom – just kingdomise… They are saying kingdomise, don't condomise. It is a problem for us, because if a youth member phones, it becomes so confusing what now to tell this person, because the church elder said that [they should kingdomise]. [56]

Religious attitudes were also noted to conflict with explicit promotion of condoms. Counsellors noted that some callers perceived them to be sinners and would want to pray for them on the line. In other instances, they were perceived as being directly involved in promoting immorality.

That loveLife billboard – a guy with a condom behind his back. I had a caller from Cape Town – that lady was so angry with the line. She said, 'You are the people who are giving our children condoms - stop doing that, you stop doing that!' She could not even listen to me. I just listened, stayed on the line and listened to the lady as she preached and preached, including things from the Bible. [57]

A person will say, for example, 'Is this the AIDS Helpline? What are you telling people? You are telling people to use condoms. You know that God doesn't want that.' And the person will go on and on and on.[58]

The same loveLife billboard was also seen as presenting problems in relation to promotion of abstinence.

That billboard was quite something, you know? I mean, it depended on how a person looked at it. Because younger people, the ones that were phoning in, maybe had discussed it somewhere and would come and ask, 'So now we can use a condom?' This was after that strong campaign by other NGOs on abstinence. And suddenly for youth there was this condom thing, and they were like, 'Oh – so now it's changing. We can condomise… It's not that [abstinence] is the only option. [59]

Discussion and Recommendations

Condom-related calls to the Helpline provide insight into a wide range of perceptions and experiences. The calls clustered around several main themes:

- Condom efficiency and quality;
- Correct and safe use of condoms;
- Condom negotiation;
- Condom use in marriage;
- Perceptions of condom types;
- Access to condoms; and
- Communication messages.

It appears from the focus group discussions that some information gaps exist amongst callers in relation to condoms, technical aspects of their use, their role in preventing the spread of HIV, and how to introduce them into relationships. In many instances, these have direct implications for communication campaigns – both at the level of 'key messages' and at the level of information provision through small media and dialogue-oriented approaches.

- *Condom efficacy and quality:* There is a perception that public sector condoms are of inferior quality. This is partly reinforced by a general lack of communication around the rationale for public sector distribution systems. It is recommended that communication programmes promote an understanding of both public sector condom distribution strategies, as well as quality aspects to public sector condoms. The introduction of a branded public sector condom should emphasise quality, but also promote understanding of public sector condom distribution approaches – specifically, that a large investment of public resources has been made to support HIV prevention.
- *Smell:* It may be possible to introduce a specification to address the smell of public sector condoms. It is unclear, however, whether the perceptions of smell are related to the process of rationalising non-use of condoms.
- *Condom breakage, 'condom comes off during sex,' and use of condoms during anal sex:* Condom breakages do occur and condoms may also come off during sex. This may relate to incorrect use, lack of sufficient lubricant on condoms, and lack of lubrication during sex. There is very little explicit information for users regarding what to do in the event of a condom breaking or coming off during sex. Information could be provided via small media, including information on post-exposure risk reduction for pregnancy, STIs and HIV. Provision of Post Exposure Prophylaxis (PEP) for HIV (as well as pregnancy and STIs) beyond the standardised provision for rape is something to be considered – given that this would further support

prevention efforts of unintended exposure. Lubricant – specifically KY jelly – is not widely available and is costly. Thicker latex condoms are also safer in the case of anal sex. There may be a role for provision of line extensions via social marketing to reduce risk of breakage.

- *Myths:* Myths feed into processes of denial and are an obvious barrier to condom use. Myths can be addressed via communication campaigns.
- *Multiple rounds:* It is unclear how this misconception might have emerged. However, the slogan 'one round, one condom' is useful as a component of interpersonal communication activities, and perhaps also delivery via small media.
- *Use of multiple condoms at once:* It is unclear how frequently this particular question arises. However, emphasising correct and consistent condom use as an effective – and sufficient – way to guard against transmission of HIV and other STIs should help to dispel concern about the need to use more than one condom at once.
- *When to put a condom on:* There is very little information on how widespread incorrect condom use might be. However, there are benefits to the provision of explicit information on correct use, including when a condom should be put on, how to remove a condom and so on.
- *Latex allergy:* Whilst the prevalence of latex allergy is unclear, communication in small media and interpersonal communication would assist in identifying latex allergy. Consideration might also be given to provision of alternative, non-latex products.
- *Oral sex:* It appears that use of condoms in oral sex has not been explicitly promoted and information gaps appear to exist about the safety aspects of oral sex with condoms. Flavoured condom line extensions might be considered for social marketing.
- *Storage and disposal:* It appears that safe storage of condoms hasn't been sufficiently promoted, and breakages may be occurring as a result of incorrect storage. Clear guidelines should also be provided for disposal.
- *Female condoms:* Calls to the Helpline suggest that some of the same misconceptions and concerns about male condoms apply to female condoms. Aspects of safe and correct female condom use should be included in contexts where female condoms are distributed.
- *Coercion and violence:* Explicit communication on the right to insist on condom use would provide clarity on an individual's right not to be exposed to HIV infection, and obligations to prevent potential infection. Such communication could beneficially be linked to campaigns against coercion and violence, and point to the need to foreground gender-power relations in relation to HIV prevention.
- *Discordancy/concordancy:* Understanding of the use of condoms in cases of discordancy and concordancy would be beneficial to promote. There appears to have been very little communication with regard to reinfection among concordant couples.
- *Condom use in marriage:* Mistrust in relation to fidelity and/or HIV disclosure is not readily addressed between married couples, and counselling support is required. There are also higher risks to couples where one or both partners seek work in other locales. Expectations of child-bearing also mitigate against condom use.
- *Condom access:* Whilst studies such as the Nelson Mandela/HSRC survey indicate that perceptions of condom access are high, it is clear that in some instances, distribution systems at clinics may be barriers to condom use for young people. This can be addressed through dissemination of condom distribution guidelines, as well as promotion of the right to access condoms without discrimination. The point raised in relation to lack of convenient access and poor restocking practices in rural areas should also be reviewed.

Helpline counsellors noted that they were seldom informed of new strategic developments, particularly in relation to national-level interventions. Briefing of counsellors would assist in ensuring that the aims and objectives of interventions are clearly communicated to callers. It would also allow for appropriate standardised responses to be developed. For example, in the case of the introduction of a public sector branded condoms, a briefing of counsellors and Helpline managerial staff would allow for clearer understanding and improved information provision to callers. Similarly, review of Helpline calls in relation to particular interventions could provide important insights into popular perceptions of those interventions.

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Footnotes

1 Shebeens are small informal or semi-formal bars; spazas are informal or semi-formal shops, typically run from a home. Such sites are predominantly found in African residential areas.
2 2213 General FGD 5 Sept.txt
3 22369 General FGD 5 Sept.txt
4 19852 General FGD 5 Sept.txt
5 21606 General FGD 2 Sept.txt
6 24243 General FGD 5 Sept.txt
7 3034 General FGD 31 Oct.txt
8 22031 General FGD 5 Sept.txt
9 22031 General FGD 5 Sept.txt
10 3079 General FGD 2 Sept.txt
11 2933 CAN HL FGD16 Sept. txt
12 3650 General FGD 2 Sept.txt
13 28683 General FGD 5 Sept.txt
14 12462 CAN FGD 16 Sept.txt
15 27894 General FGD 5 Sept.txt
16 27947 General FGD 19 Sept.txt
17 6765 Condom FGD 16 Sept.txt
18 22172 General FGD 5 Sept.txt
19 11194 Condom FGD 16 Sept.txt
20 11172 FGD 16 Sept.txt
21 9982 General FGD 2 Sept.txt
22 11721 CAN FGD 16 Sept.txt
23 23296 General FGD 5 Sept.txt
24 24599 General FGD 5 Sept.txt
25 10104 FGD 16 Sept.txt
26 13363 General FGD 2 Sept.txt
27 14151 General FGD 2 Sept.txt
28 14000 General FGD 5 Sept.txt
29 19064 FGD 30 Sept.txt
30 61619 General FGD 2 Sept.txt
31 26136 General FGD 5 Sept.txt
32 31587 General FGD 5 Sept.txt
33 31993 General FGD 5 Sept.txt
34 5509 General FGD 2 Sept.txt
35 8710 General FGD 2 Sept.txt
36 14381 General FGD 5 Sept.txt
37 10527 FGD 31 Oct.txt
38 42468 FGD 16 Sept.txt
39 5509 General FGD 2 Sept.txt
40 16369 General FGD 2 Sept.txt
41 10876 General FGD 5 Sept.txt
42 24888 General FGD 5 Sept.txt
43 25850 General FGD 5 Sept.txt
44 45623 FGD 16 Sept.txt
45 3539 Condom FGD 16 Sept.txt
46 22899 General FGD 2 Sept.txt
47 17336 General FGD 5 Sept.txt
48 7905 General FGD 5 Sept.txt
49 3808 Condom FGD 16 Sept.txt
50 30152 FGD 3 Oct.txt
51 6071 General FGD 5 Sept.txt
52 6646 General FGD 5 Sept.txt
53 7207 General FGD 5 Sept.txt
54 4965 General FGD 5 Sept.txt
55 14512 General FGD 5 Sept.txt
56 1634 Condom FGD 19 Sept.txt
57 491 Condom FGD 19 Sept.txt
58 45475 FGD 3 Oct.txt
59 751 Condom FGD 19 Sept.txt