

**UNIVERSITY OF MALAWI**

**KNOWLEDGE AND PRACTICES TOWARDS  
HIV/AIDS PREVENTION AMONG WOMEN  
OF LOW SOCIO ECONOMIC STATUS IN  
FEMALE HEADED HOUSEHOLDS**

**BY**

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**A DISSERTATION SUBMITTED IN PARTIAL  
FULFILLMENT OF THE REQUIREMENTS FOR  
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**TO**

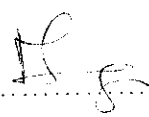
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**APRIL 2001**

(i)

**Declaration**

Except where indicated, this research study is completely the result of my own work and originality and is not currently being submitted in candidature for any other degree.

Signature ..... 

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Signature .....

Mrs D. Jere

**SUPERVISOR**

Date .....



(ii)

### **Dedication**

This work is dedicated to:-

- Francis my husband, through bright and dark you were there, thank you again!
- Tionge and Onenji my children, for their silent support and patience, you made this study a reality.
- Pattern and Rose my parents, for their love and encouragement, you inspired me.

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### **Abstract**

The purpose of this descriptive study was to assess the knowledge and examine the practices towards HIV/Aids prevention of women of low socio-economic status in female-headed households, in order to identify the barriers and potential strategies to influence safer sex among women.

The specific objectives of the study were to determine the women's knowledge on HIV/AIDS transmission and prevention. To identify their practices towards achieving safer sex, to explore the barriers towards safer sex practices and to make recommendations to policy makers, which would benefit the majority of women, with particular attention to low income women.

The study was conducted in the townships of Limbe, Bangwe, Mpemba, Lunzu, Ndirande, Chilomoni and Zingwangwa in Blantyre City and consisted of a convenient sample of 35 women of low socio-economic status in female-headed households.

The data collection methods used consisted of, structured interview schedules to obtain quantitative information on knowledge and practices and semi structured interviews for collection of some qualitative data on practices. Data was analysed and coded using the data master sheet and the EPI (Version 6.04) statistical programme. Coding for open-

*ended questions was done by sampling of questions where the most frequently occurring responses, were coded by grouping similar types of responses into single categories.*

The findings of the study indicated that, despite the women's high knowledge levels of HIV/AIDS and awareness of the seriousness of AIDS, most of the women in the study were not practicing safer sex. Lack of perceived susceptibility, powerlessness to negotiate condom use, negative attitudes about the use of condoms, unavailability of condoms and economical status, interfered with safer sex practices. This study thus reveals an area that needs attention i.e. that apart from emphasising the level of awareness, there should be a focus on how to effect behavioural change among a knowledgeable population.

Findings of the study have implications for nursing education, research, practice and for policy makers, who have to enact and ensure that strategies aimed at stemming the rampage of HIV/AIDS should benefit women of low socio-economic status. Findings of the study will help increase the body of nursing knowledge, so that nurses can competently impart in women accurate and appropriate information to influence behavioral change in them.

### **Definition of Terms**

#### **Acquired Immunodeficiency Syndrome (AIDS)**

It is a complicated disorder of the defense system of the body caused by the Human Immune Virus (HIV), characterized by increased susceptibility of the individual to even opportunistic affections which were previously harmless (SAF Aids, 1995).

#### **Male Condom**

A rubber device placed on the erect penis during intercourse to prevent pregnancy and transmission of STDs and HIV/Aids, (Southern Africa Aids Action, 2000).

#### **Female Condom**

The female condom, a thin plastic sheath is like a male condom. It has a small (inner) ring at one end and a large (outer) ring at the other end. It can be used with water based or oil based lubricants, (Southern Africa Aids Action, 2000).

#### **Female Headed Households**

A group of related and unrelated persons who live together in the same dwelling unit and acknowledge an adult female as head of a household, (World Bank 1990).

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## Abbreviations

AIDS	-	Acquired Immuno deficiency Syndrome
AIDS CAP	-	aids Control and Prevention
HIV	-	Human Immuno deficiency Virus
MKAP	-	Malawi Knowledge and Practices
NACP	-	National Aids Control Programme
STDs	-	Sexually Transmitted Diseases
STIs	-	Sexually Transmitted Infections
SAF Aids	-	Southern Africa Aids
UN Aids	-	United Nations Aids
UNICEF	-	United Nations Children's Educational Fund
CCAP	-	Church of Central African Presbyterian
NGO	-	Non-Governmental Organisations

## CHAPTER ONE

### Introduction

World-wide studies have revealed that the Human Immuno-deficiency Virus (HIV) that infects both men and women is increasingly affecting women in a disproportionate manner. WHO (1995) states that the social and economic subordination of women, fuels the HIV/AIDS pandemic. SAF Aids (1995) concurs with this, stating that the epidemic hits hardest among the world's poor 70% of whom are women. In Malawi among the most vulnerable groups and those in a state of continuous deprivation are female-headed households who constitute thirty percent of Malawian households and belong to the poorest rural and urban households (Government of Malawi/UNICEF, 1993).

Malawi Demographic and Health Survey (MDHS, 1997) defines a female headed household as a group of related and unrelated persons who live together in the same dwelling unit and acknowledge an adult female as head of the household. Sahn et al (1990) distinguishes between three categories of female headed households, those divorced and or widowed, those whose husbands are working elsewhere in Malawi, and those whose husbands are working as migrant labourers e.g. in South Africa. Sahn et al (1990) further states that the first two groups are among the poorest households in rural areas receiving significantly lower per capita incomes, than male headed households while the third category had incomes 40% higher than male headed households and double that of other female headed households. In this study, female headed households will imply those divorced, widowed and those whose



husbands are working elsewhere in Malawi but with an income of less than \$40 capita per annum.

### **Background**

The HIV/AIDS pandemic is a global threat with long-term social and economic problems. HIV/AIDS is currently one of Malawi's major health concerns. National AIDS Control Programme, (NACP, 1998) states that there is strong evidence that HIV transmission affects women at a higher rate than men, and women tend to be infected at younger ages than men.

Women's vulnerability to HIV/AIDS is partly determined by physiological factors i.e. researchers estimate that women's risk of HIV infection from unprotected sex is at least twice that of men (SAF Aids, 1995). Women are more exposed through the extensive surface area of mucous membrane in the vagina, and the cervix through which the virus may pass and semen, which has a high concentration of the virus remains in the vaginal canal a relatively long time. Young women are even at a greater risk as their vaginas are not well lined with protective cells and their cervix are most easily eroded potentially enhancing their risk to HIV infection (S.A.F Aids, 1995).

WHO (1995) further states that the social and economic subordination of women fuels the HIV/AIDS pandemic as women are unable to make informed choices and to improve their quality of lives which may greatly influence growing numbers of HIV/AIDS cases among women. SAF Aids (1995) also concurs with the above indicating that women's vulnerability to HIV/AIDS further reflects on social and economic factors with inequity being the central issue. Economic needs, lack of job

opportunities, poor access to education and training, cultural expectations of female submissiveness and male dominance, all combine to prevent women from actively making choices and decisions about their lives, particularly with regard to limiting sexual risks and protecting their families' health. This then implies that women who are badly in-need of social and economic support may accept subsistence in exchange for sexual favours, which may place them in a position to lack the social power to set the terms of their sexual relations (a fairer and less dangerous relationship with men through practising safer sex).

Studies on HIV/AIDS conducted in Malawi i.e. Kornfield & Namate (1997) indicate that, despite the increased awareness of HIV/AIDS, unprotected vaginal sex is common. Studies further indicate that, condom use (in prevention of HIV/AIDS) mainly depends on the attitudes of men, as although women are more motivated than men to accept HIV prevention behaviour, they may have little bargaining power.

Chirwa (1993) states that while more than 90% of sexually active Malawians are aware of AIDS and its dangers, they have not started practising low-risk sexual behaviour. Mc Auliffe (1994) further states that, people feel more motivated to make behavioural changes when they believe that their personal and cultural views are understood while Bandura (1991) in Centre for Human Rights and Rehabilitation (1999) argues that interpersonal influences within the immediate social network of a person have strong effects on behaviour than general normative sanctions, he believes that risk reduction behaviours for HIV are often not adopted because socio-cultural, religious, and economic factors operate as constraints on self-protective behaviour. This then implies that for women struggling with daily survival, concern about a

disease that may kill in the future is a luxury, they can ill afford, hence low income women in female headed households may indulge in unsafe sex for subsistence because of the priority they give to their immediate anticipated socio-economic gains, rather than to use condoms consistently to prevent further away HIV/AIDS. Bassett et al (1991) in Van den Borne (1998) concurs with the above and states that for “women faced with divorce or dire poverty on one hand and the risk of HIV infection on the other, the choice becomes one of social death or biological death”.

It is important therefore that low income women in female headed households, who face a high risk of contracting HIV, be studied to unveil the socio-economic, cultural and personal dynamics that influence them with a view to come up with appropriate interventions specifically for their group.

### **Statement of problem**

Studies have shown that in virtually every society women face discrimination in education, employment and social status, resulting in economic vulnerability to HIV/AIDS. Significant power differences that exist between men and women, supported by social and cultural systems that posit the control by males, also equally increase vulnerability of women to HIV/AIDS (WHO, 1995). It is this view that has prompted the researcher to consider exploring the knowledge and practices of low-income women towards HIV/AIDS prevention, who due to their socio-economic status may indulge in unsafe sex as they may have limited options in negotiating safer sex, hence increasing their exposure to HIV infection.

### **Significance of the Study**

The findings of this study will help policy and programme makers in designing and implementing more effective interventions so that women in particular are protected from acquiring and transmitting the HIV virus through appropriate policy support and resource allocation.

### **Objectives of the study**

- 1 The overall objective of the study is to assess the knowledge and practices towards HIV/AIDS prevention among women of low socio-economic status in female-headed households.

### **Specific Objectives**

- 2 The specific objectives are: -
  - (a) To determine women's knowledge on HIV/AIDS transmission and prevention.
  - (b) To identify practices towards the prevention of HIV/AIDS in low-income women in female headed households.
  - (c) To identify factors that influences the practices of safer sex other than socio-economic factors.
  - (d) To make recommendations to National AIDS Control Programme, Ministry of Health and Health workers on how to improve interventions i.e. information education and

communication to help promote behavioural change among women of low socio-economic status.

## CHAPTER TWO

### Literature Review

#### Introduction

A review of literature showed that many studies have been conducted looking at different aspects of HIV/AIDS.

#### Knowledge About HIV/Aids Transmission And Prevention

Many studies have indicated high awareness of HIV/AIDS transmission and prevention. In Rwanda, Bingingo et al (1993) conducted a survey to assess knowledge, attitudes and practices of women at high risk for HIV/AIDS. The study consisted of a total of 45 unmarried women ranging from 18-44 years with no income of any kind. A detailed questionnaire including various aspects of HIV/AIDS such as its ecology, modes of transmission, clinical features and prevention strategies was administered to each participant. Voluntary HIV testing was done, to which 38% volunteered to undergo an HIV test after a session of pre-test counselling.

The results of the study indicated that, most women had good to excellent knowledge of HIV/AIDS and STIs, transmission and prevention. However, few women practiced safer sex practices, which is indicative in the evidence that, 77% used condoms on an irregular basis and that all 38 women who volunteered for HIV testing were HIV positive.

In Malawi, a study by Kishindo (1994) whose purpose was to find out the Knowledge, Attitudes and Beliefs on Aids in eight districts in Malawi, found that there was a high level of awareness of AIDS in the country. 93% of the sample had heard about the

disease and eighty four percent recognised that there is so far no cure for the disease. Sexual intercourse was identified as the major mode of transmission for HIV/AIDS and although sixty-one percent of the sample thought they could catch AIDS, there was a high level of awareness that the disease could be avoided by adopting certain changes in behaviour. In another study in Zomba, where he targeted bar-girls Kishindo (1995) found that all the bar-girls interviewed were aware of the modes of transmission of HIV and most knew someone who had died of AIDS or presented symptoms of the disease but, persisted in the high risk occupation because it was potentially more attractive, than any occupation they could get with their low academic qualifications.

Similarly, in a study by Wynendaal et al (1991), 98% of the participants knew that AIDS is a sexually transmitted disease, 78% knew about the condom as a protective device against HIV infection however, only 46% had ever used the condom.

From the studies above there is an indication that, the vast majority of people have knowledge of HIV/AIDS, transmission and prevention but utilization of the protective device (the condom is low). Muller et al (1992) concurs with this, stating that reports from Sub Saharan Africa suggest that although, there is a high level of knowledge about appropriate sexual risk reduction practices among populations, few individuals engage in safer sex practices.

Contrary to the above Hobfoll et al (1993), conducted a study where he studied a sample of 289 single African-American inner city women in Ohio. The results of the study indicated that, women had poor knowledge of HIV/AIDS, hence did not

practice safer sex, which puts them at risk for HIV infection. These women however, did not put themselves at risk of HIV as they based their lack of risk as being, because they had a single partner though disregarding their partners' current or past behaviour, which might place them at risk.

### **Socio Economic Status**

In virtually every society, women face discrimination in education, employment and social status resulting in economic vulnerability to HIV/AIDS, (WHO, 1995). In Malawi, although poverty is wide spread and deep, it is most prevalent and austere in rural areas and has strong intra rural, inequalities within the Southern Region, which has the highest concentration of poor households, (World Bank, 1990). WHO (1995) further states that poverty affects female headed households hardest where these households are likely to be more financially poor, than those headed by males. Women's economic dependence on male partners to avoid poverty for themselves and their children makes it difficult for women to negotiate safer sex practices to protect themselves from infections. Concurring with this, Evian (1992) observed that women in poor circumstances and in migrant situations regard sex as a commodity they can sell or a means to obtain desperately needed money to satisfy hunger and other needs.

In Brazil, Lurie et al (1995) conducted a cross sectional study of 600 female sex workers in three cities, (100 of a higher socio-economic status and 100 of a lower socio-economic status). Risk behaviors were assessed by questionnaire and serological tests were administered to assess prior exposure to HIV-1, Syphilis and Hepatitis. On completion of the study, it was found that sex workers with a lower socio-economic status worked longer hours each day. (9.6 versus 7.9) had more



clients per day (5.4 versus 2.6) and had fewer episodes of intercourse per client per encounter (1.1 versus 1.4). 23% feared violence if they insisted their clients use condoms. 74% voiced similar fears regarding their non-clients sexual partners. An overall of 11% tested positive to HIV-1, 45% for Syphilis and 39% for Hepatitis B. Those with lower socio-economic status were more likely, than those with high socio-economic status to be infected with HIV-1, (17% versus 4%) Syphilis (66% versus 24%) and Hepatitis B (52% versus 26%). This was because of the low status and economic dependence of these women, which enabled them not to negotiate safer sex. Concurring with this, Alexander (1990) observed that in USA affected women and their partners, were more likely to be poor from an ethnic minority and from a drug using community. In Ethiopia, a study by Zewdic et al (1990) found that, women's economic and social situations in themselves may increase their vulnerability and therefore risk of infection, for example, the risk of HIV infection and Syphilis in Ethiopian women, was three times higher in women earning less than US\$25 per month than in women earning more than US\$200. Infection was 6.5 times higher in single women, 9 times higher in divorced sex workers than in married women.

Contrary to the above, in Ruanda, Chao et al (1994) conducted a survey, whereby risk factors associated with prevalent HIV-1 infection were assessed among pregnant women in a semi rural but densely populated area. The findings indicated that high social economic status was a risk factor for HIV-1 infection. Similarly in Malawi, Dallabeta Miotti et al (1994) studied 5376 women presenting for prenatal care at a large urban hospital. Interviews and HIV serological tests were done. The findings indicated that 22% (1220) of the women were HIV - 1 seropositive. Multiple sex

partners and husbands reported partners were positively associated with HIV – 1 infection and current STDs. The strongest predictors of HIV–1 infection were those of A high socio economic status (husbands of over eight years of education) and any current STDs. Regression analysis of risk factors for HIV–1 infection and current STD indicated that, high socio economic status is a strong risk factor for HIV–1 infection but protective for STDs.

The above reviewed studies give contradicting results, the first three indicate that individuals with low socio economic status are likely to be infected with HIV–1 while the last studies indicate that high socio economic status is a high risk factor for HIV–1 than low socio economic status. This may be because, women who barter sex for subsistence will go for prosperous men who can be able to financially support them. These men in turn will go back to their wives transmitting the virus further on. A report by the Aids Secretariat of the Ministry of Health and Population states that younger women are motivated to engage in casual intercourse in exchange for material needs. In such circumstances these women (who are breadwinners of their families) start going out with elder men who will provide their basic essentials. These elder men believe that these young women who look healthy are Aids free yet these women may have multiple partners and are therefore at high risk of contracting HIV/Aids, (NACP, 2000).

### **Practices**

In Trinidad and Tobago cultural and socio economic difficulties were found to affect women's ability to adopt risk reduction behaviours as part of their life style. These difficulties were rooted in perceptions of gender roles and the extent of viable

economic opportunities for self reliance (Kambon, 1993). Concurring to the above, Lundgren et al (1992) explored factors identified in the health belief model, which influence behavioural change in order to reach women through prenatal services. The findings suggested that, the power dimensions of sexual decision-making and cultural definitions of gender roles are major determinants of AIDS prevention behaviour (i.e. men had decision – making authority in the sexual sphere).

In Malawi, Chaima & Zimba (1998) also found that males play a dominant role in decision making in as far as sexual matters are concerned. 47% of male respondents and 36% of female respondents ever talked to their partners on issues related to sex and condom use. The findings also indicated that culture accepts males to have extra marital relationships with a girlfriend against 4% of females with an extra boyfriend. In addition to this, Mc Auliffe (1994) states that those who are most affiliated by poverty are most infected and affected by HIV/AIDS, such that a higher percentage of females engage in sex because of financial needs and are less likely to insist on condom use in such relationships, which mainly depends on the attitudes of men as women have little bargaining power. Concurring with this, a study by Hickey (1998) on factors explaining observed patterns of sexual behaviour among individuals found that safer sex practices were rarely practiced in such that, only in 5 out of 2,047 encounters was the condom used and in only single and divorced males. This indicates that the use of safer sex practices in married individuals is very limited. This is also evident in a study by Kornfield and Namate (1997) who found that, the promotion of condom use in general and in marriage in particular is a formidable task. While a study in Zambia by UN Aids (2000) revealed that low condom use in marriage are common, even when either or both partners also have unprotected sex

outside marriage. This is because of the women's inferior status and lack of power, which makes them unable to discuss the subject with their husbands.

### **Summary Of Literature Review**

The studies reviewed thus, reveal that several individual and social factors influence risk-taking. These prevent risk-reduction behaviour in individuals hence preventing them from practicing safer sex. These studies did not though, specifically look at HIV/AIDS knowledge on transmission, prevention and practices among women of low socio-economic status in female-headed households in a Malawian setting. The gap of information created by these studies has urged the researcher to carry out a study on women of low socio economic status in female-headed households to assess their knowledge on prevention of HIV/AIDS.

## **CHAPTER THREE**

### **Conceptual Framework**

The model that helps to guide this study is the Health Belief Model by Hochbaum, 1958, Kegeles, 1965 and Rosenstock 1974, which provides a framework for exploring why some people take specific actions to avoid illness while others fail to protect themselves (Lancaster, 1996).

The model provides a tool for identifying clients perceptions of disease and the decision making process the person uses, in seeking health care services i.e. it predicts how individuals' readiness to take action on a health problem depends on the perception of the health threat and on health motivation (Creasia & Parker, 1991).

### **Health Belief Model**

The major components of the Health Belief Model include perceived susceptibility, which is an individual's estimated probability that they will encounter a specific health problem, perceived seriousness, which is the perceived severity of a given health problem, which can be judged either by the degree of emotional arousal created by the thought of the diseases or the difficulty that individuals believe a condition would create for them. While the perceived threat, is the combination of perceived susceptibility and perceived seriousness which represents the negative valence of illness and predisposition to avoidance (Pender, 1987). Modifying factors in the model which affect predisposition to take preventive action, include a variety of demographical socio-psychological and structural factors. Demographic factors such as sex, age, income and education correlate to the use of health services. Socio-

survival and a lack of power in sexual decision making, they will not practice safer sex. On the other hand low income women will consistently practice safer sex regardless of their poverty stricken situation if they perceive the susceptibility and seriousness of contracting HIV/AIDS and its threat to their life, which then suggests that the decision to comply or the likelihood of taking recommended preventive health action will depend on weighing the perceived benefits of preventive care against the perceived barriers to preventive care.

However, when the virus that infects both men and women is increasingly affecting women in a disproportionate manner the cue to action is to review the knowledge and practices whereby ignorance may not be the main reason for failing to protect themselves against the virus, but the priority given to anticipated immediate social-economic gains and the limited options in negotiating consistent safe sex. Therefore actions which will enable women to improve their quality of lives and to make informed choices will be undertaken i.e. motivation of women to practice consistent safe sex, empowering of women and improvement of women's' access to health, education, legal and economic prospects.

psychological variables i.e. social pressure or social influence, play a role in stimulating appropriate health actions, even when low levels of individual motivation exist. While structural variables presumed by the model to influence preventive behaviour, include knowledge about the target disease and prior contact with it (Pender, 1987).

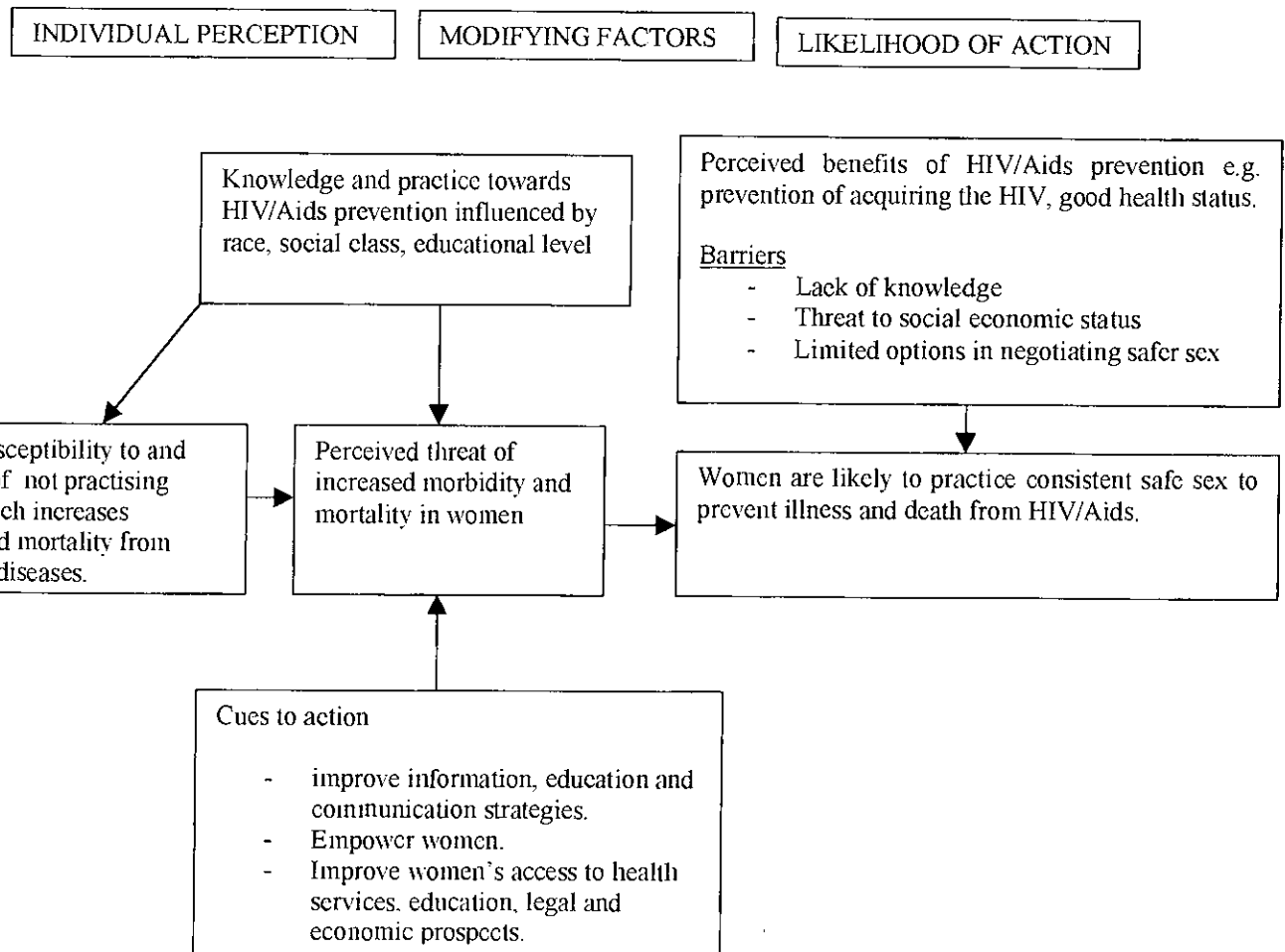
Cues to action affect the incidence of health behaviour by triggering appropriate overt actions. These cues can be internal or external, internal cues include uncomfortable symptoms, feelings of fatigue or recall of the condition of affected individuals to whom the individual is close, while external cues include mass media, advice from others, posters etc (Pender, 1987). The likelihood of action (or the decision to comply) depends on two factors, which are perceived benefits and perceived barriers. Perceived benefits are beliefs about the effectiveness of recommended prevention actions while perceived barriers, are the barriers to obtaining preventive care i.e. anticipated costs or fear of pain or discomfort from procedures.

#### **Application of the Health Belief Model**

In this study the relevant concepts that have been selected and used are perceived susceptibility, perceived severity, perceived threat, perceived benefits and perceived barriers, motivation and modifying factors.

Women are viewed as individuals who perceive the benefits of practicing consistent safer sex, a key to preventing HIV/AIDS (the perceived threat). However, if the women have no knowledge of HIV/AIDS prevention or take health risks though they know the risks involved i.e. because of perceived threats to their social and economic

# APPLICATION OF THE HEALTH BELIEF MODEL TO THE STUDY





## CHAPTER FOUR

### Methodology

#### Research Design

For the purposes of this study, a descriptive research design was used to provide detailed information about the interrelationship of certain variables concerning the phenomena in question, i.e. the knowledge and practices towards HIV/AIDS prevention among women of low socio-economic status in female headed households. In order to come up with this, both qualitative and quantitative methods were used simultaneously to address the same problem. Qualitative methods were used to describe the affective aspects of the domain while quantitative methods were used to measure other variables i.e. knowledge of HIV/AIDS transmission and prevention (Polit & Hungler, 1991)..

#### Setting

The study was conducted in the townships of Limbe, Bangwe, Mpemba, Lunzu, Ndirande, Chilomoni and Zingwangwa in Blantyre City. These were selected because of their location in low-income areas, which are socially active and densely populated.

#### Sampling

A convenience sampling method entails the use of the most readily available persons or objects in a study (Polit & Hungler, 1991). In this study, a convenient sample of 35 women of low socio-economic status in female-headed households was extracted with 5 women from each area. A convenient sampling method was selected because of time constraints on the part of the researcher, otherwise a quota sampling method

would have been used. Polit & Hungler (1991) states that a quota sample entails the non-random selection of subjects in which the researcher pre specifies characteristics of the sample. In this study this method would have been ideal to broadly represent the experiences of the population in the city as a whole.

### **Instrumentation**

An interview schedule with open ended and close-ended questions was used to collect data on knowledge and practices towards HIV/AIDS prevention of low socio economic women in female headed households (see Appendix F). Structured interviews were selected by the researcher because they yield a higher response rate, are suitable for a wider variety of individuals and provide richer data than questionnaires (Polit & Hungler, 1989). The interview schedule was developed basing on the literature that was reviewed and the conceptual framework. The schedule contained 46 closed and open ended questions designed in English and were during the time of discussions simultaneously translated in vernacular Chichewa. The use of vernacular language was to make participants at ease when verbalising their views and experiences. The instrument had four sections. The first section consisted of demographic data, the second on knowledge of HIV/AIDS transmission and prevention, the third section on practices while, the last section contained questions on the socio economic status of respondents. To ensure validity and reliability of the tool used a pilot study was done in Kawale (Lilongwe City), using 5 subjects to test the tool.

### **Data Collection & Storage**

Data was collected in 7 days using the interview schedule on a face to face basis by the researcher herself as the response rate tends to be high in face to face interviews. Interviews are also less prone to misinterpretation by the respondents because the interviewer is present (Polit & Hungler, 1989). In this case the researcher was present to clear misinterpretations and to determine whether the questions were understood or not. The interviews took 30 minutes each and during the interviews, the researcher wrote down the respondents' responses for transcription later on. Observations that were made during the interview were also recorded. This helped the researcher to draw conclusions about what constituted the truth about the subjects in the study (Polit & Hungler, 1991).

### **Data Analysis**

Analysis of data was done both manually and with the aid of a computer using the data master sheet and the EPI (Version 6.04). Close ended questions were coded while content analysis was first done to analyse open ended questions before coding. Data was then analysed to arrive at descriptive statistical measures which were used to make tables, bar charts, pie charts and correlation tables.

### **Confirmability of Qualitative & Quantitative Data**

To ensure fittingness of the study, only women of low socio-economic status in female-headed households were interviewed. Credibility of the researcher's interpretation of the data was enhanced by participant validation, where by an independent researcher was engaged to read and provide opinions on the analyzed data to ensure validity. Audibility was obtained by evaluating the consistency of the

findings. Here an independent researcher read and analyzed two randomly selected transcripts. Her findings were compared to those of the researcher where validity was ensured.

### **Limitations**

This researcher has recognized the fact that there were some limitations on the study, which may have an impact on the results.

- There was limited time as the study was conducted for academic purposes and had a time frame attached to it.
- The results of the study cannot be generalizable, because the sample size was small and hence not a good representative of the population therefore other studies considering a bigger sample need to be conducted for the study findings to be generalized.
- Other variables like attitudes and beliefs should have been included if it had not been for the time frame of the study where in-depth interviews would have been conducted to provide rich information.
- The interviews were conducted in Chichewa language then translated into English. The language differences may have caused limitations of data coding and analysis and some valuable information may have been lost.

### Ethical Consideration

Permission was sought from the Ministry of Health and Population. A clearance letter was sent to the Health Research Officer for national clearance to conduct a study in the country (see Appendix A). Permission was also sought from the Chief Executive of Blantyre District (see Appendix B) and the District Health Officer for the district, (see Appendix C). Informed consent was also obtained from the women who participated in the study where confidentiality and anonymity were also ensured Appendix D & E).

## **CHAPTER FIVE**

### **Findings**

#### **Introduction**

This section presents the results of the study, whose purpose was to explore the knowledge and practices of women of low socioeconomic status in female headed households as regard to HIV/AIDS prevention. The results focus on demographic data, HIV/AIDS awareness, practices and socioeconomic status. Tables, bar charts, pie charts and description of facts are used to present the findings.

#### **Demographic data**

Demographic information collected in this section dealt with basic indicators such as age, location, tribal group, religious affiliation, educational attainment and marital status. The results are presented below:-

##### **Location**

Information was gathered from 5 women from each location in the townships of Bangwe, Lunzu, Zingwangwa, Chilomoni, Ndirande, Mpemba and Limbe.

##### **Status of respondents within the household**

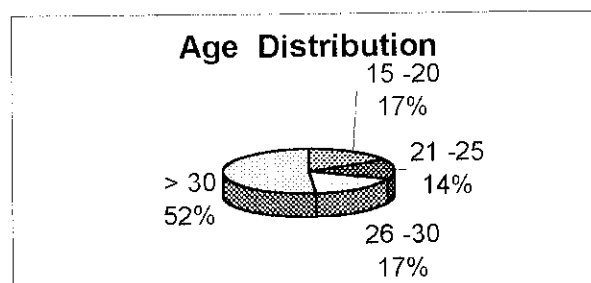
All the respondents interviewed were heads of households with 40% , (n=14) being single, (Table 1 below).

Item	Number	Percentage *
Married	6	17.1%
Divorced	5	14.3%
Separated	2	5.7%
Husband migrated away Elsewhere in Malawi	2	5.7%
Widowed	6	17.1%
Single	14	40.0%
Total	35	100.0%

### Age Distribution

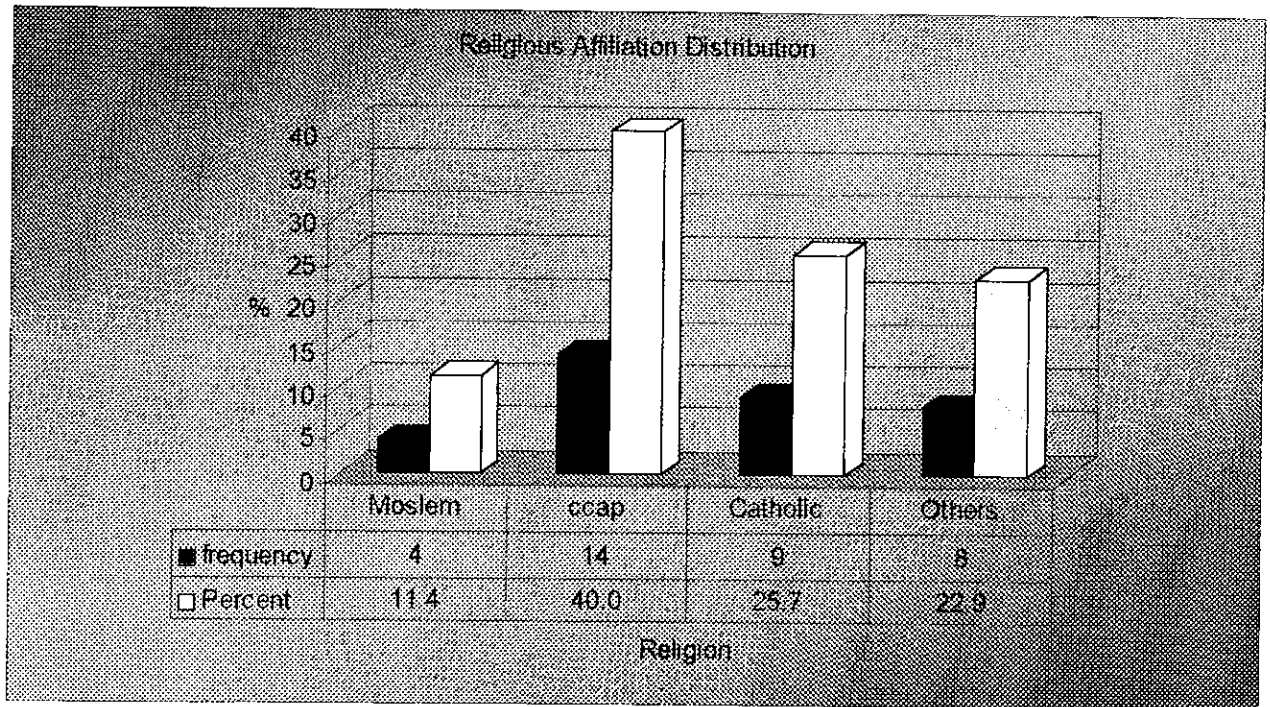
The majority of the respondents, 52% (n=18) fell in the age group greater than 30 years of age, with the lowest number, 14% (n=5) falling in the 21 – 25 age group (see figure 1 below). The standard deviation for age was 1 with a mean of 28.

*Figure 1*



- **Religious Affiliation**

Figure 2

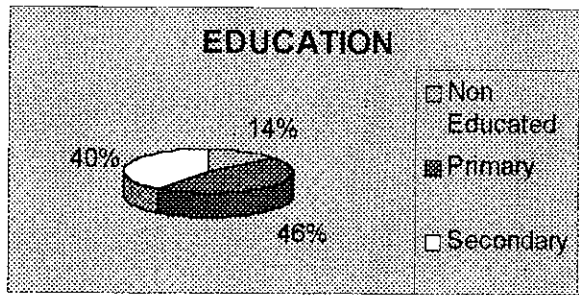


The religious affiliation of the respondents was of particular interest to the investigator, because of the possible influence of religion on sexual behaviour. The findings indicated that the majority of the respondents were Christians with the Presbyterian faith accounting for 40% (n=14) of the respondents. The Catholic faith came second with 25.7% (n=9) of the respondents closely followed by the others category which referred to those respondents who claimed to belong to churches like Assemblies of God, Blackman Church or African International Church. A few respondents, 11.4% (n=4) rather, claimed to be Moslems.



## Education

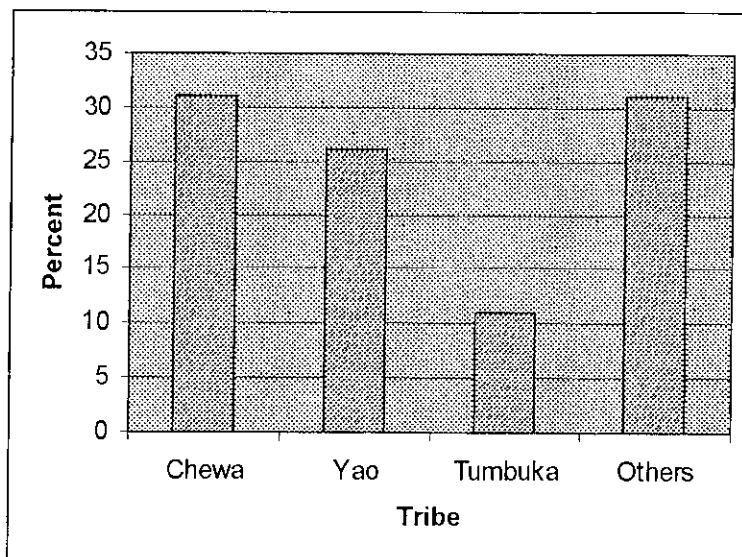
Figure 3



Generally, the levels of education among the respondents as shown in figure 3 above are relatively on the lower side with 45.4% (n=16) of the respondents having attained primary education. Only 40% (n=14) had attained secondary education with none going as far as tertiary education, while 14.3% (n=5) had not even had any education at all.

## • Ethnic Distribution

Figure 4



According to the above figure the dominant ethnic groups were Chewa recording a 31% (n=11). The others in the diagram with a similar percentage of 31% (n=11) represented groups like the Ngonis, Tongas and Mang'anjas, while the least group which recorded a percentage of 11% (n=4) were the Tumbukas.

### HIV/Aids Knowledge And Awareness

All the respondents had heard of HIV Aids and were aware that Aids is a serious health problem. Of the 35 respondents, the majority 60% (n=21) did not however, perceive themselves to be at risk of HIV Aids (Figure 5 below).

Figure 5

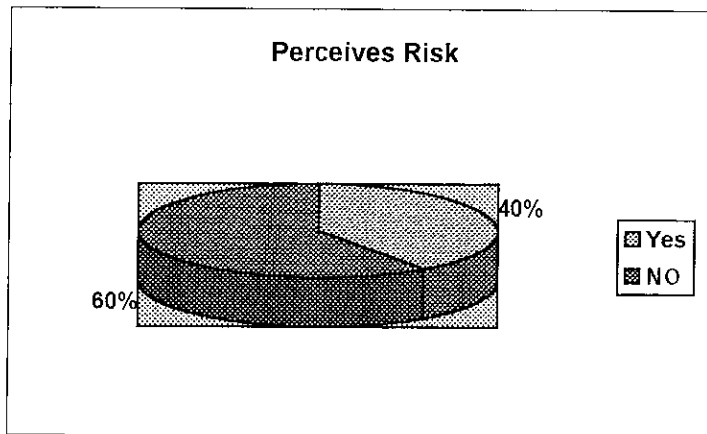


Table 2

### Body Fluids containing the HIV Virus

Body Fluid	Number	Percentage(%)
Semen	13	27
Blood	22	45
Breast Milk	3	6
All Of The Above	11	22
Total	48	100%

n = 48

45% (n=22) of the responses indicated that the virus was found in blood, 27% (n=13) indicated of the presence of the virus in semen while 6% (n=3) of the responses indicated of its presence in breast milk. 22% n=11 of the responses also indicated that the virus could be found in all three of the body fluids stated namely blood, breast milk and semen.

- **Sources Of Information About HIV/Aids**

From the responses the hospital was found to be the most popular source of information accounting for 36.2%,(n=34) of the responses, followed by the media which represented 33%,(n=31). Relatives also play a role in dissemination of information on HIV/Aids and this accounted for 30.8%,(n=28) of the responses. The least was others, 1%,(n=1) which represented the church.

#### **Most Helpful Source**

According to the responses, the hospital was the most reliable and helpful source accounting for 54.5%,(n=24) seconded by the media with 34%,(n=15). Relatives accounted for 9.1%,(n=4) and the church 2.3%,(n=10).

## Transmission of HIV/Aids

Table 3

ITEM	NUMBER	PERCENTAGE
Unprotected sex	34	48%
Blood Transfusion	3	4%
Tooth Brush	10	14%
Razor Blade	15	21%
Unsterilised Needles	9	13%
TOTAL	71	100%

n = 71

All the respondents knew that HIV/AIDS could be transmitted through unprotected sex. Other methods cited included needles, blades and skin punctures, use of same toothbrush and blood transfusions (Table 3 above). All respondents also agreed that an HIV infected mother can pass on HIV to her baby during pregnancy but refuted that the virus can be transmitted through the use of the same toilet seat with an infected person. All respondents were also able to indicate that HIV/AIDS could be prevented.

## No Risk Of HIV/Aids

Table 4

ITEM	COUNT	PERCENTAGE
Abstinence	33	27%
No premarital sex	31	25%
Sex with only one uninfected faithful partner	22	18%
Hugging, kissing, masturbation	12	10%
Having unprotected sex	0	
Deep kissing	1	1%
Using the same plate and cup	2	2%
Using a condom	21	17%
<b>Total</b>	<b>122</b>	<b>100%</b>

n = 122

The table above indicates that the majority 27%, (n=33) of the responses referred to abstinence as what has no risk followed by no premarital sexual relationships and testing of blood before marriage 25% (n=31) while 17% (n=21) of the responses cited use of a condom as that which has no risk of getting infected with the HIV/AIDS virus.

### Knowledge Of Condom And Source Of Information

All respondents were aware of the condom and its use in the prevention of HIV/AIDS. All respondents knew about the male condom which was commonly

referred to as the Chishango condom. Only a few, however, 17% (n=6) were able to state that there is a female condom. The sources of information varied from individual to individual with the main source of information on knowledge of condoms being the hospital. See Table 5 below:-

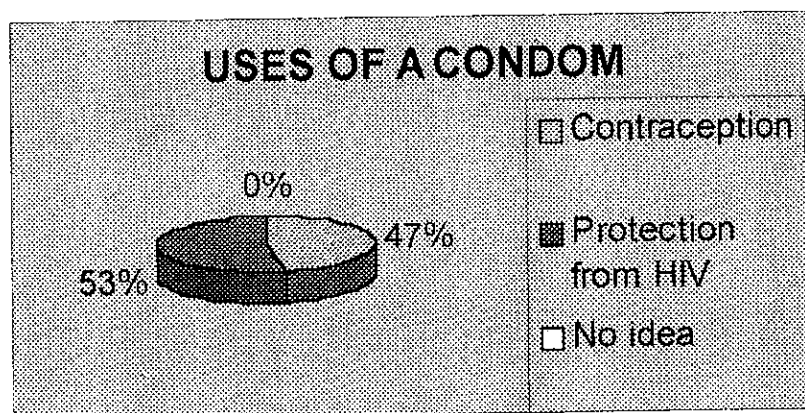
*Table 5*

SOURCES	NUMBER	PERCENTAGE
Hospital	24	38
Radio	27	42
Relatives	3	4
Schools	4	8
Health personnel	5	8
<b>Total</b>	<b>63</b>	<b>100%</b>

n = 63

#### Condom Use

*Figure 6*

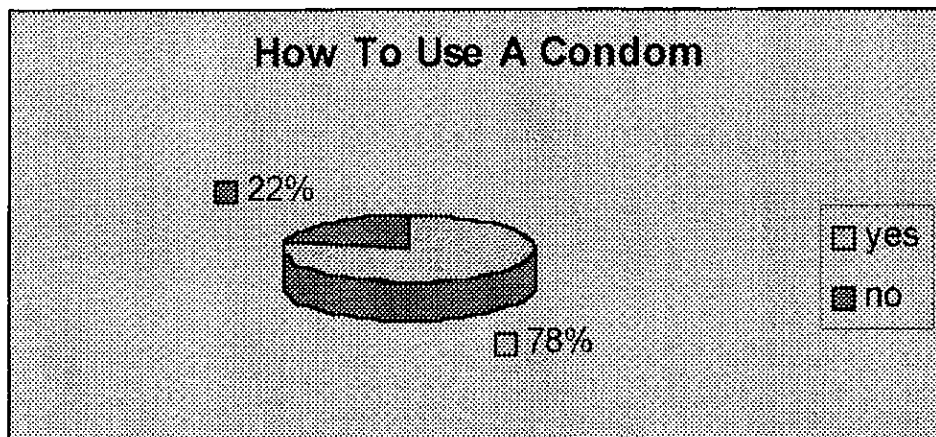


From the above figure (Figure 6) the majority of the responses, 53% indicated that the condom was used to protect individuals from getting sexually transmitted

infections including HIV/AIDS. The condom was also indicated as being used for contraception purposes.

- The findings also indicated that 78% (n=25) knew how to use a condom properly while 22% (n=7) indicated they had no idea. See Figure 7 below.
- 97.1% were also aware that a condom was used once and discarded while 2.9% had no idea.

*Figure 7*



#### **Recommendation Of Condom Use To Friends And Family.**

- All respondents indicated they would recommend condoms to their friends and families suggesting prevention of STIs including HIV/AIDS prevention, family planning and lack of trust for sexual partner as the main reasons for recommending condom use.

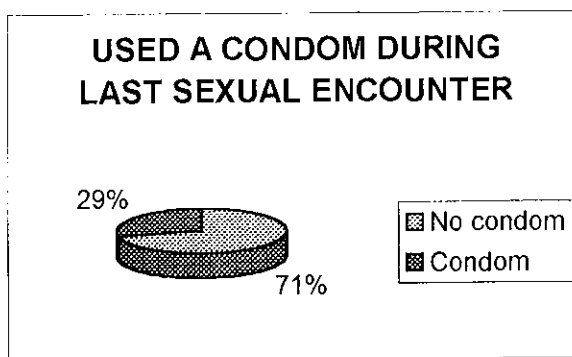
#### **Practices**

Practices of the respondents as pertaining to sexual activity for 3 months were recorded where respondents reported their sexual activity, condom discussion and use between partners.

### Frequency of Sexual Intercourse

The majority of the respondents had, had sex in the last 3 months with 11.4% (n=4) having had more than 5 encounters in the last two weeks. However,, of the 35 respondents only 10 representing 29% had used a condom the last time they had sexual intercourse (see figure 8 below):-

Figure8



### Why A Condom Was Used

Table6

ITEM	NUMBER	PERCENTAGE
For contraception	6	16
Prevention from STIs including HIV/AIDS	7	19
N/A	24	65
<b>TOTAL</b>	<b>37</b>	<b>100</b>

n = 37

The responses from the 29% (n=10) majority of the respondents who used a condom, indicated that they used condoms to prevent themselves from getting HIV/AIDS



while the rest showed that they used it to prevent them from getting pregnant (see Table 6 above).

*Table 7*

**Reasons for not using Condoms**

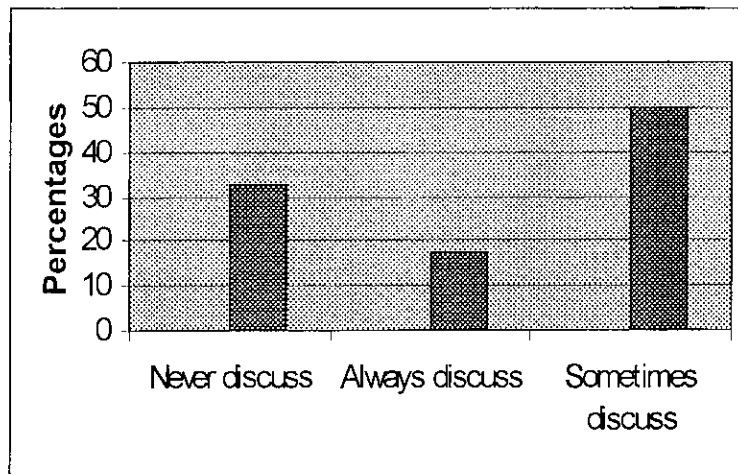
ITEM	NO	PERCENTAGE
Sex with husband	12	32%
Wanted a child	1	3%
Did not have any condoms	2	5%
He is my regular partner	3	8%
My partner insisted not to use a condom	2	5%
Would indicate that one of us was unfaithful	4	11%
I don't like condoms	1	3%
Condoms are for commercial sex workers	1	3%
We trust each other	1	3%
N/A	10	27%
<b>TOTAL</b>	<b>37</b>	<b>100</b>

n=37

Table 7 above shows that 32% (n=12) of the responses showed that the condom was not used because respondents felt no need of using a condom with a partner who was a husband.

### Discussion on Condom Use

*Figure 9*



The figure above shows that 17% (n=6) of the respondents always discuss condom use with their partners, 50% (n=17) sometimes discuss condom use while 32%, (n=11) never discuss the use of condoms.

### What is discussed as regard to Condom Use

*Table 8*

ITEM	NUMBER	PERCENTAGE
Use of Condoms to prevent STIs including HIV/AIDS	10	22%
Use of condoms in extra	5	11%

marital affairs		
Importance of condoms in family planning	17	37%
Effectiveness of condoms	3	6%
N/A	11	24
<b>TOTAL</b>	<b>46</b>	<b>100</b>

n=46

From the responses, the importance of condom use as a method of contraception was popularly discussed among couples, followed by its use as a means of preventing STIs including HIV/AIDS. Other responses also indicated that couples discussed the use of condoms in extra marital affairs as well as the effectiveness of condoms.

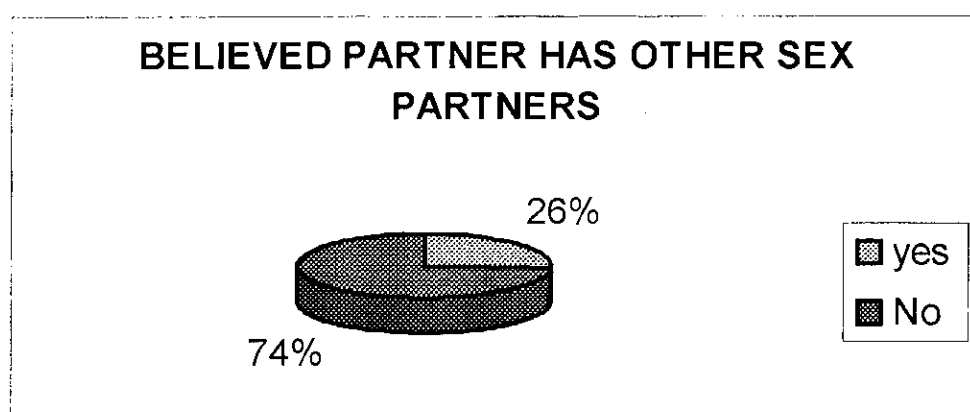
### **The Female Condom**

More than half of the respondents 60% (n=21) were willing to use a female condom if their partner insists not to use one. However, the responses among those who indicated they would use a female condom showed that they would do so if their partners did not realise they had one on (accounting for 24% (n=10) of the responses) apart from wearing the condom to prevent getting STIs including HIV/AIDS or getting pregnant.(which had 17.1% of the responses). Some of the respondents indicated that they would rather seek consent from their partners first (accounting for 24.4% (n=10) of the responses ) before wearing a condom and felt that it showed you did not trust your partner, see Table 9 below

Table 9

ITEM	NUMBER	PERCENTAGE
To prevent getting pregnant	7	17.1
If my partner doesn't realise I have one on	10	24.4
To prevent getting STIs including HIV/AIDS	7	17.0
Would not without my partner's consent	10	24.4
It would show lack of trust	7	17.1
Never used a condom before	0	0
Don't like condoms	0	0
<b>TOTAL</b>	<b>41</b>	<b>100</b>

n=41

**Extra Partners***Figure10*

More than half of the respondents 74% (n=25) indicated that they believed that their partner had other sex partners beside them (Figure 10 above) indicating the following (as in Table 10 below) as reasons for believing so.

*Table 10*

ITEM	NUMBER	PERCENTAGE
He is a womanizer	7	21
Comes late at night	2	6
Has been married before	1	3
I don't trust him	13	40
He is married	4	12
He has been away for months	1	3
N/A	5	15
<b>TOTAL</b>	<b>33</b>	<b>100</b>

n =33

### **Sex With An Irregular Partner**

All the respondents suggested the use of a condom when having sex, with an irregular partner and cited the following reasons as why they would use a condom, see Table:11 below-

Table 11

ITEM	NUMBER	PERCENTAGE
To avoid STIs including HIV/AIDS	30	57
You cant trust an irregular partner	14	26
To prevent pregnancy	9	17
<b>TOTAL</b>	<b>53</b>	<b>100</b>

n=33

### Socio-Economic Status

#### **Occupations Of Respondents**

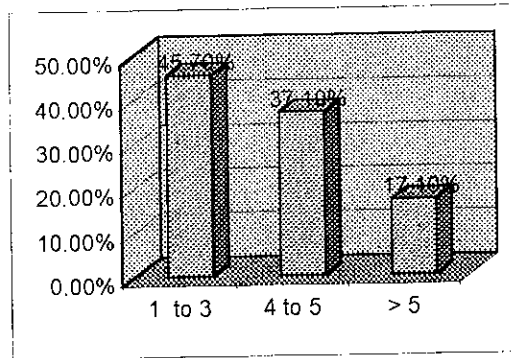
The majority of the respondents, 71% (n=25) indulged in small businesses/trade with only 29% (n=10) working. Those who worked were categorised as unskilled, labourers. Work in this case ranged from being a cleaner to sorting out cereals like groundnuts and maize at a factory while businesses ranged from selling local beer to selling second hand clothes.

#### **Earnings and number of Children**

Incomes for women in the study ranged from K800 per month to K3000.00 per month and with these earnings all women who were the heads of their households had to provide for almost all necessities in the households. The majority of the women had 1 to 3 children accounting for 46% (n=16) of the respondents, 37.1% (n=13) of the women had 4 to 5 children while 17% (n=6) had more than 5 children, see Figure 11 below. The mean number of children was 4.

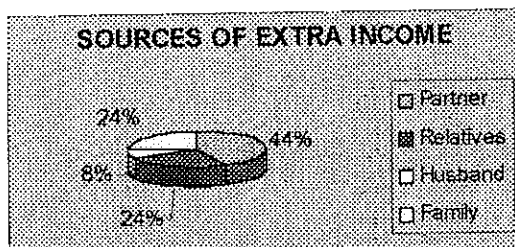
## Number Of Children

Figure 11



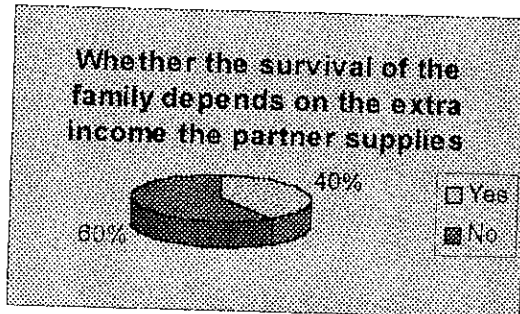
Only 15.7% (n=2) of the respondents indicated that they were able to comfortably fend for their families with their incomes while 94.3% (n=33) said they could not. Those who indicated that they could not, had other means of earning extra cash to fend for their children as in Figure 12 below:

Figure 12



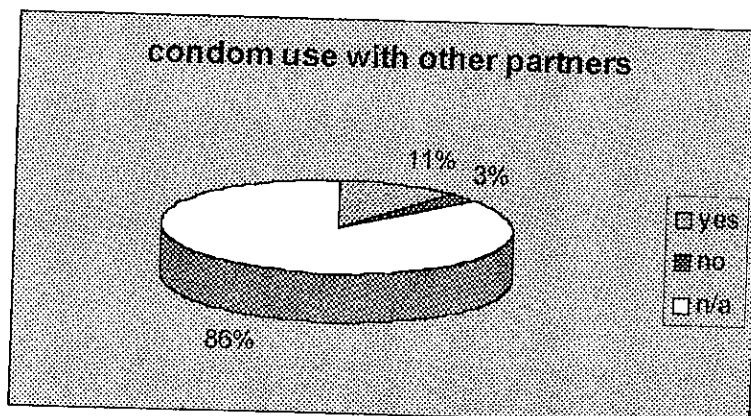
## Whether Survival Of Family Depends On The Extra Income The Partner Provides

Figure 13



The above figure (Figure 13) indicates that 60% (n=21) of the respondents were dependent on the partners who provided extra income for the survival of their families. Only 15.2% (n=5) however indicated that they have other partners to supplement their income when the regular partners are unable to give and out of these, only 11% (n=4) use condoms with these partners. (see figure14 below).

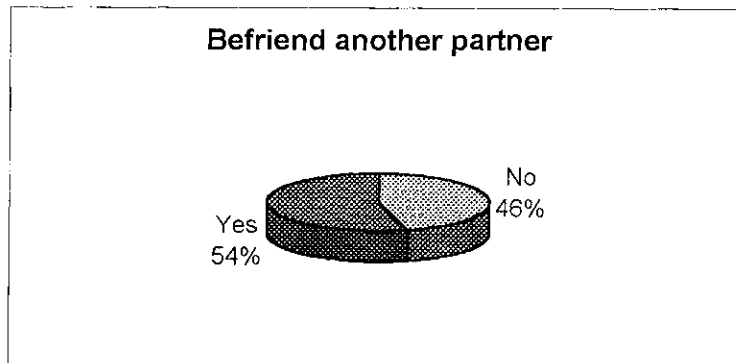
Figure 14





## Befriending Of Another Man In Cases Where Present Relationships Is Terminated

Figure 15



The figure above (Figure 15) indicates that just over half (54%) of the respondents indicated that they would befriend another man in cases where the present relationship was terminated while 46% indicated that they would not do so. Those who indicated they would do so, cited the main for doing so as being for their partner to provide financial assistance (see Figure 16 below).

Figure 16

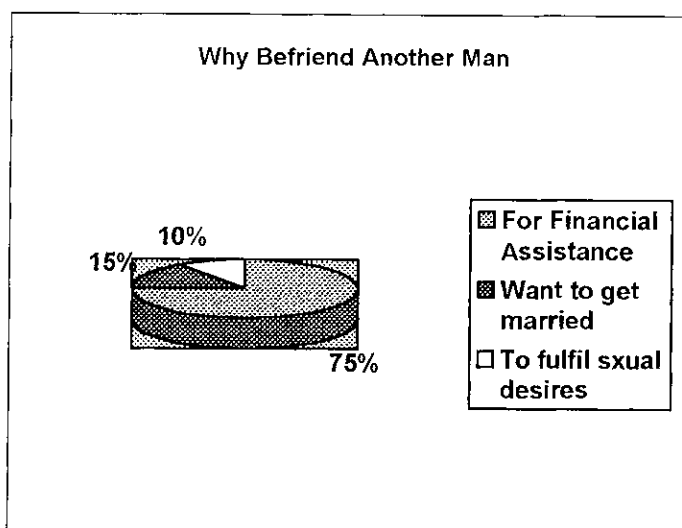


Table 12

**Marital Status Vs Condom Use**

<b>Maritals</b>	<b>Married</b>	<b>Divorced</b>	<b>Separated</b>	<b>Husband Migrated Elsewhere</b>	<b>Widowed</b>	<b>Single</b>	<b>Totals</b>
<b>Condoms Use</b>							
No (0)	24% (6)	12% (3)	8% (2)	8% (6)	24% (6)	24% (25)	71.4% (48)
Yes (1)	0% (0)	20% (2)	0% (0)	0% (0)	0% (0)	80% (10)	28.6% (10)
Totals	17.1% (6)	14.3% (5)	5.7% (2)	5.7% (2)	17.1% (14)	40.0% (35)	

Table 12 above shows the relationship between marital status and condom use. According to the table of those who used condoms, 80% were single and 20% were divorced, none of those who were married, separated or husband migrated elsewhere used a condom.

Table 13

**Education Vs Condom Use**

<b>Education</b>	<b>No Education</b>	<b>Primary</b>	<b>Secondary Tertiary</b>	<b>Totals</b>
<b>Condom Use</b>				
No	20% (5)	52% (13)	20% (7)	71.4% (25)
Yes	0% (0)	30% (3)	70% (7)	28.6% (10)
Total	14.3% (5)	45.7% (10)	40.0% (14)	35

Table 13 above shows that only those who had primary education 30% (N=3) and those with secondary education 70% (n=3) education used a condom during their last sexual encounter.

Table 14

**Age Vs Condom Use**

Age Condom Use	15-20	21-25	26-30	>30	Total
No = 0(5)	(1)	(4)	(4)	(16)	25
Yes = 1	(5)	(1)	(2)	(2)	10
	50%	10%	20%	20%	28.6%
Total	6	5	6	18	35
	17.1%	14.3%	17.1%	51.4%	100%

Table 14 above shows the relationship between condom use and age, which indicates that the majority 50% who used a condom were in the age group 15-20.

Table 15

**Religion Vs Condom Use**

Religion Condom Use	Moslem	CCAP	Catholic	Others	Total
No – 0	(2)	(9)	(7)	(7)	25
				28%	71.4%
Yes – 1	(2)	(5)	(2)	(1)	10
	20%	50%	20%	10%	28.6%
Total	4	14	9	8	35
	11.4%	40%	25.7%	22.9%	100%

Table 15 above shows the relationship between religion and condom use where those respondents who belonged to the CCAP denomination used the condom most accounting for 50%.

Table 16

**Discuss Vs Condom Use**

<b>Discuss Condom Use</b>	<b>Never Discuss</b>	<b>Always Discuss</b>	<b>Sometimes Discuss</b>	<b>Totals</b>
No (0)	44% (11)	0% (0)	56% (14)	73.5% (25)
Yes (1)	0% (0)	66.7% (6)	33.3% (3)	26.5% (9)
Totals	32.4% (11)	17.6% (6)	50% (17)	(34)

The above table shows the relationship between condom use and discussion where those who never discussed condom use never used condoms while those who adiscussed condom use used condoms.

Table 17

**Earnings Vs Condom Use**

<b>Earnings Condoms Use</b>	<b>K100-K800</b>	<b>K900-K1600</b>	<b>K1700-K2300</b>	<b>K2400-K3200</b>	<b>Total</b>
No	20% (3)	40% (10)	32.0% (2)	80% (25)	71.4 %
Yes	10.0 (1)	50% (5)	10.0 (3)	30% (10)	28.6 %
Total	17.1% (6)	42.9% (15)	25.7% (9)	14,3% (5)	35

Table 17 above shows the relationship between earnings and condom use. The results showed that the amount earned did not specifically determine individuals ability to practise safer sex where an increase in amount of earnings did not influence safer sex.

## CHAPTER SIX

### Discussion

#### Introduction

This chapter presents the discussion of significant findings from the analysed data, which emanated from the knowledge and practices towards HIV/Aids prevention of low-income women in female-headed households. The relationship between the health belief model which focuses on the motivational determinants that direct health actions and the study findings will be drawn. Supporting literature will also be included and the implications of the study on nursing practice, education and research will be stated. Finally, the study's conclusions and recommendations will be presented.

#### **Relationship Between the Health Belief Model and the Study Findings**

The results of the study support the usefulness of the Health Belief Model in explaining and predicting who would, or would not use preventive measures and to suggest interventions that might increase predisposition of resistant individuals to engage in preventive or health protective behaviours.

The study findings indicated that, the majority of the women in the study are armed with basic knowledge of HIV transmission routes (Table 3), relative risks of sexual acts, and how to prevent these risks (Table 4). The findings also showed that all the women were able to perceive the severity of HIV/AIDS, that it has no cure and is fatal. However, some of the individuals (60%) did not perceive themselves as being susceptible to contracting the virus (see Figure 5). Other respondents rather, who perceived the benefits of practising safer sex practices (See Table 6), where they

could prevent contracting HIV/AIDS, at the same time prevent unwanted, pregnancies used condoms (see Figure 6). However, they were others, who perceived the barriers to safer sex, which included indications of mistrust if condoms were suggested in relationships, lack of decision-making power for women in relationships, inavailability and accessibility of the female condom, (the only female controlled physical barrier method) or dire poverty (Table 7). These, together with the cues to action which according to the model, create a force leading to action, included discussion of HIV/AIDS and safer sex, with health personnel, relations, spousal communication or mass media campaigns on HIV/AIDS. These determine an individuals choice whether to practice safer sex or not. Ignorance therefore, is not the main reason for the women failing to protect themselves against HIV/AIDS. These women take these health risks because of perceived threats to their social and economic survival (Figure 16) and a lack of power in decision making as they have limited options in negotiating consistent safer sex. They weigh the benefits of taking preventive action against those of not. The findings, therefore, highlight the urgent need for the development of strategies, which will enable women to negotiate and practice safer sex like women's educational and economic empowerment, the availability and accessibility of female controlled methods like the female condom or microbicides.

### **Knowledge and Awareness of HIV/AIDS**

The study findings demonstrated high knowledge and awareness of HIV/AIDS transmission and prevention among respondents (see Tables 3 & 4), who were aware that AIDS is a serious health problem, has no cure and is fatal. Many studies have also indicated high awareness of HIV/AIDS transmission and prevention for example,

a study by Bingingo et al (1993) revealed that most women who participated in the study had good to excellent knowledge of HIV/AIDS transmission and prevention. Similarly analysed studies by UN Aids (2000) also indicated that remarkably high proportions of people of all ages, in most continents know about HIV/AIDS, its seriousness and most can repeat the basic facts about its transmission and prevention. This is a positive fact and confirms that, public awareness campaigns have succeeded in communicating messages on AIDS to most women in Malawi. Despite high knowledge levels, more detailed knowledge of HIV/AIDS and its transmission may be important for full understanding and internalization of AIDS education messages. This is evidenced from the results, which indicated that, only 6% of the responses had breast milk as a body fluid that would contain the virus (see Table 2). Only a few individuals also accounting for 4% of the responses cited blood transfusions as a means of transmitting the HIV virus (Table 3). This implies that other respondents had superficial knowledge, which may be due to the source of information i.e. radio which may not provide in-depth information.

The findings further revealed that the hospital was the most popular source of information, followed by the media and relatives (see Table 5). The hospital was also reported to be the most preferred source of information on HIV/AIDS. Similarly, McAuliffe & Ntata (1994) also found that the radio and the hospital were the best channels for educating youth on HIV/AIDS. This implies that health personnel and the media have a significant role to play towards HIV/AIDS prevention where they have to ensure that, they provide accurate and appropriate information that is user friendly.

The results of the study also showed that, most women could cite the common measures to prevent HIV transmission, (Table 4). However, most of the responses cited abstinence, no pre-marital sex and sex with only one uninfected faithful partner than condom use (see Table 4). Similarly Mc Auliffe & Ntata (1994) found that more youth mentioned other methods than condom use as methods of prevention of HIV. This may be an indication that the message of condom use as a primary preventive measure has not been effective with women as other preventive methods or else, it may imply that, most women due to their culture, may feel it embarrassing to talk about sensitive issues like the condom.

Contrary to the above however, UN Aids (2000) states that by far the commonest method of prevention mentioned spontaneously by people in many studies is condom use. For example, a study among miners in South Africa in 1997 revealed that, three quarters of them mentioned condom use while only two fifths mentioned monogamy. It is interesting though, to note that, here again differences in cultures customs and religion may have influence on condom use or even its discussion among users. However, despite opposition from many quarters condoms have and still are been actually and successfully promoted as part of HIV prevention strategies in many countries (SAF Aids 1995).

The findings further indicated that, although all respondents were aware of the male condom, only 17% knew of the existence of a female condom. This signifies that the female condom, the only woman initiated protective method is not readily available and accessible. All the respondents who indicated they knew what a condom was, referred to the male "Chishango Condom" distributed by a social marketing company



– Population Services International (PSI) which only distributes male condoms. This product is widely and conveniently accessible to all individuals countrywide in Malawi as the social marketing company applies commercial marketing techniques where it involves market research, message testing, mass media, advertising, consumer education, effective use of news media and public relations, product promotion at the point of purchase, increased access to products and affordable pricing. The media in this case plays a great role in dissemination of information on condom use. It was therefore not surprising to find that the results showed that the radio was the main source of information on condoms.

Respondents who showed knowledge of the female condom indicated that they had heard about it from the hospital, relatives or friends. The results therefore confirm that awareness of another physical barrier methods apart from the male condom is low, with 83% not knowing of the female condom. However, in countries like Zambia and Zimbabwe analysed studies by UNAids (2000) showed that where mass marketing of the female condom has been done, research has revealed that awareness of the female condom is high though use remains extremely low, (UNAids 2000).

The results further showed that only 78% knew how to correctly use a condom (Figure 7). However, some of the respondents 22% denied knowledge of proper use of condoms. This would suggest that either these women were unreached with condom promotional campaigns i.e. especially that commercial marketing does not show how to use a condom or that cultural modesty has presented a significant barrier to their access to information on condom use or other safer sex information.

condom to prevent getting STIs including HIV/Aids (see Table 6) which was a positive fact and showed that, to some extent safer sex practices aimed at HIV/Aids prevention are being practiced. Concurring with this Hickey (1998) also found that respondents cited the use of condoms and complete abstention as methods of ensuring safer sex. However, just like in this study, safer sex practices were rarely practiced in the study where only in 5 out of 2,047 encounters was the condom used and only by single and divorced males. It is interesting though to note that in both studies, respondents did not indicate that they are aware of safer sex practices like non-penetrative sexual activities such as masturbation, thigh sex (where the penis does not enter the vagina or rectum), stroking, massaging or kissing which could be used even when one of the partner is HIV positive. Southern Africa Aids Action (2000) also states that, safer sex should not just be couples trusting each other but should include couple screening of STIs including HIV/AIDS before having unprotected sex. This is, provided they do not engage in sex with other people and are safe from infection, through infected blood, from injecting drugs or unsafe blood transfusions. However in the study, some respondents indicated they did not need to use condoms because they trusted each other, they were married or because they had sex with a regular partner, (were in monogamous relationships), (see Table 7). These individuals did not perceive themselves as being at risk of getting HIV/AIDS, despite that neither one of them had ever been tested and there is no evidence that to both of them they are each other's first and only partner. This perception may influence a woman's motivation to protect herself, especially by negotiating condom use. Commenting on this, (UNAids 2000) reports that in Uganda, where striking successes in prevention exist an increasing number of people are choosing to be tested for HIV before getting married

or getting into a new relationship which is an important option to include when ensuring safer sex.

### **Barriers Against Safer Sex**

Culture, religion and society itself can impose barriers that work against efficient practice of safer sex. In this study, several barriers to safer sex were revealed which had an influence on use of safer sex measures for example, despite high knowledge of safer sex practices i.e. condom use, safer sex practices among spouses was very low. The study results showed that marital status has an influence on adoption of safer sex practices were no respondent who was married used a condom (Table 12). Out of those who used a condom during the last sexual encounter, 80% were single and 20% percent were divorced (Table 12). These results agree with those by Hickey (1998), who found that, the condom was used only by single and divorced individuals. This implies that, use of safer sex practices in married individuals is very limited. This is also evidenced in a study by Kornfield & Namate (1997), which indicates that, the promotion of condom use in general and in marriage in particular is a formidable task. Similarly, a study by UNAids in Zambia indicates that low condom use rates in marriage are common even when either or both partners also have unprotected sex outside marriage, (UNAids) 2000).

The results also show that education can also be a barrier to adopting safer sex practices among women especially to adopting condom use (See Table 13). It was observed from the findings that none of those who had no education at all had used a condom during the last sexual encounter, rather of those who had used a condom 70% had secondary education and 30% had primary education. Similarly, attempts to draw

correlations between sexual behaviour and education among studies conducted by UNAids have also showed that, as the level of education increases people are far more likely to protect themselves by using condoms for casual sex, (UNAids 2000). This implies that more educated women are better informed, better able to gather information from newspapers and other media and usually more articulate, hence will act on the information they accrue. This concurs with the understanding of the health belief model which states that, people cannot be considered to consider seriously practicing correct and consistent safer sex if they do not understand that (in this case) practicing safer sex is beneficial to their personal survival.

The study results also found that age is a determining factor in the use of safer sex practices in HIV/AIDS prevention (Table 14). It was observed that of those who used condoms the majority fell in the age group 15 – 20 years of age. These results correspond to analyzed studies by UNAids which indicate that young people are most likely than elders to use condoms to protect themselves and their partners against HIV infection. For example in Uganda the percentage of teenage girls who had ever used a condom tripled between 1994 and 1997 and teenage girls reported more condom use than any other age group, (UNAids 2000). Concurring to these findings a study by Bisika & Ntata (1996) found that, more youth in the age group 16 – 20 years in all three cities of Malawi had used condoms than their counterparts in the age group 10 – 15 years. This is a positive fact indicating that young people in all cultures and corners of the globe have proved themselves ready and willing to adopt behaviours and attitudes that promise to stem the rampage of HIV/AIDS.

Religion according to the health belief model is a modifying factor that has an influence on behaviour (Pender, 1987), in this case an individual's sexual behaviour. The study findings revealed that, among the CCAP members, the proportion of condom use is approximately one in every 3 members while the proportion of condom use among the Roman Catholic members was 1 in every 5 members despite the fact that the church preaches against condoms, rather emphasizing on abstinence, (Table 15). This implies that, individuals who used the condom had personal feelings against the risk of contracting HIV/AIDS hence used it despite their churches doctrine, which discourages condoms as they are thought to promote promiscuity and casual sex.

Availability and Accessibility of the female condom, which, despite its popularity in other countries is not only more expensive than the male condom but is not readily available is also a barrier to safer sex practices (Southern Africa Aids Action, 2000). The results of the study found that, knowledge of its existence was very low among respondents where only 17% were aware of the physical barrier method that is meant to, not only increase the options available to fight HIV and other sexually transmitted infections, but to provide women with a method they can control. This implies that the female condom has not received the mass marketing awarded to the male condom, which is evident in countries like Zambia or Zimbabwe where mass marketing of the product has brought awareness of the female condom to extremely high levels though user levels are still low (UNAids 2000). Through the interviews, the researcher explained about the female condom, however, it was interesting to note that the majority of the respondents indicated they would use the device, only if their partners did not realise they had one on and with full consent of their partners (Table 9). This then confirms the inability of most women not to have the capacity to negotiate safer

sex, indicating lack of assertiveness among the respondents as they want a method that is not visible so that negotiation is limited. This also concurs with findings by McAuliffe & Ntata (1997) who found that, since the majority of the males were considered as heads of relationships, who possessed the ultimate power, the females were reluctant to suggest safer sex practices i.e. condom use.

Knowledge of effective use of safer sex practices may also influence the ability for individuals to practice safer sex measures. In the study, it was observed that 22% of the respondents showed ignorance of proper and appropriate use of condoms (see figure 7) which according to Spryt & Finger (1998) may result in failure of the condom i.e. if a condom was not correctly opened by the user, who used a sharp instrument to open the device which later led to it being porous hence ineffective. It was also noted that, women who showed ignorance of a condom did not use one and did not discuss condom use with their partners (Table 16). This implies that, since sex is an act where partners are learning all the time they may not be willing to learn the new skill of using the condom.

The study also assessed spousal communication as regard to safer sex practices where it was revealed that only 17% always discussed condom use with their partners, with 50% sometimes discussing condom use and 11% never discussing its use at all (See Figure 9). The results further revealed that, the respondents, who never discussed condom use, never used condoms while those who always discussed condom use used condoms and were either single or divorced (see Table 16). Many obstacles, however, prevent men and women from talking about sexual and reproductive issues where a complex web of social and cultural factors impede such discussions,

(SAFAids, 1995). The study revealed that women's inferior status and lack of power, limited couple communication where most women were controlled by traditional gender roles, which meant they had little say in sexual matters and lacked the status to influence their partner's behaviour. Hickey (1998) agrees with these results indicating that though communication between partners is essential for healthy sexual relationships and for respecting the wishes and desires of other partners, there is little discussion between sexual partners unlike that which exists within gender groups. Lack of communication between partners may thus, lead to couples frequently misperceiving each other's views and then turning to informal networks, which then spread disinformation. These informal networks (which exists within gender groups) are usually poorly informed and spread unsubstantiated rumours and allegations (Hickey, 1998). For example, they may indicate that the condom may stick in your vagina and that it actually spreads HIV/Aids rather than protect against it. These misconceptions may thus only be corrected if men and women are encouraged to discuss sexual matters with their partners.

The study also assessed what is discussed as regard to condom use between partners. The results showed that, most respondents who always discussed condom use (those who were single or divorced) focused the discussion on the use of the device to prevent contracting STIs including HIV/Aids. While the rest of the respondents focussed the discussion on its use as a method of contraception though they had HIV/Aids prevention in mind (Table 8). Most of those who were married separated or husband migrated elsewhere in Malawi, seldom discussed condom use. They indicated that, bringing up the subject of condoms in the home might send the wrong messages where it may be interpreted as either a confession or an accusation, bringing

in an element of mistrust in the relationship (Table 7). The women said that they were afraid of contracting HIV from their husbands but found it hard to discuss the subject with them even though they were sure that, their partner had extra marital affairs. The results even showed that 74% of the women believed that their partners had other sex partners with only 26% thinking their partners were faithful (see figure 10). Those who doubted their partners still did not refuse to have sex with them for fear they would turn even more to other women. These results agree with the findings by Hickey (1998) who found that despite that, a woman discovers that her husband has been unfaithful to her, it is unlikely for her to suggest consistent condom use within and outside the marriage. The woman would rather suspend the sexual aspect of the marital relationship for a short period of time, to be resumed later with the marriage still remaining intact. This implies that women are at risk of getting STIs including HIV/Aids, which are brought into the relationship by their male counterparts.

Traditional culture also has a great influence on the practicing of safer sex practices as traditionally, most men have sexual relationships with more than one woman. The majority of women are brought up in a polygamous environment and share general statements about men, such as a man cannot stay in marriage without fooling around sometimes or a man is never sexually satisfied, (Van den Borne, 1998). The study results showed that, the majority of the respondents (74%) believed their partners had other sexual partners besides them (see Figure 10). They indicated they did not trust their partners as culturally men were expected to have more than one sexual partner. Some of the respondents indicated that "*men are never satisfied they are attracted to every woman they see*" and they expected that. Other women in the study especially those who were single, widowed or divorced had partners who were married and were



sure that their partner had another sex partner apart from them, however, they did not care, provided he could take good care of them. These results concur with those of Hickey (1998) who found that it was considered masculine and macho for men to have a second lover as it indicated to some extent, their standing and wealth within a community. This implies that, experiences like these hamper realistic approaches to keep HIV infection outside relationships, as it prevents taking effective measures to enhance risk reducing sexual practices like consistent condom use within and outside the marriage. This happens especially when the man contracts diseases outside the marriage and women though, they know that their men were unfaithful due to they being powerless, are unable to change their husbands sexual behaviour for fear of their husbands or partners turning to even more prostitutes or other women. This is even evident in a study in Zambia by UNAids (2000) which indicates that, less than a quarter of the women interviewed in the study believed that a married woman could not refuse to have sex with her husband even if he has been demonstrably unfaithful and was infected, and only 11% of the women thought a woman could not ask her husband to use a condom in these circumstances (UN Aids 2000).

Women's perceptions on the uses of safer sex practices may also affect utilization of HIV/Aids prevention practices. The findings indicated that the majority of the respondents considered using a condom when with an irregular partner and not with someone who was their regular partner or husband (Table 7). They indicated the condom would be used with the irregular partner because they did not trust him but trusted their regular partners or husbands. This implied that women did not perceive themselves at risk of HIV/Aids which they could contract from those their trusted especially that none had showed they had ever been tested before nor knew enough

about their partners to be sure. This concurs with a study in Brazil which states that, those who are married or in consensual unions do not perceive themselves to be at risk of contracting STIs or HIV/Aids (UNAids, 2000). This implies that these individuals are less likely to practice safer sex practices, as they do not put themselves at risk of contracting HIV/Aids. The study findings further showed that a considerable number of the respondents had the impression that condoms are mostly used for the prevention of unwanted pregnancy only (see Table 6). Nyanda and Mmanga (1992) also found that condom use within a relationship is only considered appropriate for pregnancy prevention while a study in Uganda by Lule (1992) found that, 58% of the subjects in his study doubted the effectiveness of the condom, in the prevention of HIV/Aids. This lack of perceived benefits of safer sex practices, may affect the use of condoms in the prevention of HIV transmission. This implies that women will tend to only use condoms when they perceive that they would get pregnant as in the health belief model where health seeking behaviours will be sought only when individuals perceive they are at risk of getting pregnant. This, however, is likely to have an impact on safer sex practices to prevent HIV/Aids as modern health facilities now provide the use of emergency obstetric pills to prevent unwanted pregnancy, which could be used by individuals.

The study results also revealed that, several misconceptions and beliefs discouraged the women from using safer sex practices, where it was believed that condoms were for commercial sex workers as well as for use in extra marital affairs (see Table 7), Hickey (1998) also found that the condom was discouraged as it was thought to promote promiscuity and casual sex. The results of the study further indicate that some respondents were not sure of the effectiveness of condoms, which were also

believed to spread HIV/AIDS, and their use indicated unfaithfulness by either partner (Table 7). Kornfield and Namate (1997) in a study on condom use in marriage, found that those respondents who did not use condoms indicated that condom use encouraged infidelity. To further support the findings, a study by UNAids (2000) in Central Africa found that over half of the parents and guardians of the young people in the study thought that HIV could pass through a condom and only 48% said condoms were effective prevention against HIV. This implies that women may be less likely to suggest condom use for safer sex because of fear of being misinterpreted as accusing the partner of being infected whilst still risking contracting HIV/Aids.

Power and decision-making were also considered to influence safe sex practices in respondents. The study revealed that the majority of the women in the study had little power in terms of controlling their own sexuality. The majority of the respondents accepted the idea that men control and initiate sex which resulted in women not even having the confidence to initiate discussion towards safer sex (Figure 9). These findings are similar to those in a study by Hickey (1998) which also revealed that in both formal (i.e. marriages), and informal relationships men tend to be the dominant ones where women appear to have very little power either in the decision making process or in negotiating the parameters of the relationship. This is a disadvantage as if a woman shares decision-making power with her partner she is better able to bring up and discuss sexual relations with her partner and can therefore negotiate safer sex.

### **The Impact of Socio Economic Status on HIV/AIDS Prevention**

The study further revealed that, to some extent an individuals socio economic status may influence her ability to practice or not to practice safer sex. The results of the

study showed that, the majority of the women who were low-income women could barely fend for the families they headed (94.3% indicated they could not). The majority of the respondents could not make ends meet and depended elsewhere for financial assistance (see Figure 12). These findings correlate with those by World Bank (1996), as cited in Borne (1998) which indicate that, poverty affects female-headed households hardest, and is most rampant with in the Southern Region, which has the hardest concentration of poor households, the highest poverty prevalence and the deepest poverty. The study findings further revealed that 60% of the respondents depended on the partners to provide extra income for the survival of their families (see Figure 13). 15.2% indicated that they have other partners to supplement their incomes and out of these, only 11% use condoms with these partners (see Figure 14). The findings further revealed that the majority of the women indicated that they maintained these partners because of the immediate benefits they acquired from the relationships, which were to do with fulfilling their economic needs. The results also indicated that inspite of all the risks involved which included contracting HIV/AIDS through unprotected sex, some of the women disclosed that they could not resist the money temptation when the condition is to provide sexual services without a condom where partners would give them more money despite that most of them did not offer chargers. These results concur with a study by Orubuloye et al (1991) in Borne (1998) which indicates that, bartering sex for subsistence has become a necessity for many women who must secure food and essential commodities for themselves and their children. This indicates that, a significant percentage of women become dependant on income derived from having sex with men, which enables them to survive hence the long term concern of a disease that will come in the future remains out of focus.

It was also observed from the findings that, the amount of income earned by the women did not significantly affect condom use among respondents which suggested that there was no correlation between condom use and amount of income where individuals with a higher income did not necessarily register a high condom use rate and vice versa (see Table 17). The results also indicated that the majority 54% insisted they would befriend another man in cases where the present relationship was terminated and the majority cited the reason for doing so as being, in order for the partners to provide them with financial assistance (see Figure 16). These findings correlate with results from a study by the Centre for Human Rights and Rehabilitation (CHRR 1999) which indicated that most commercial sex workers despite the risks continue their businesses because they are trapped in a vicious circle of having to fulfill their daily needs. Studies by NACP (1995) also indicate that, exchanging gifts for sex also takes place even among those not considered to be prostitutes. This is also supported by Plummer et al in Van de Borne (1998) who states that some women in Nairobi, sell sex during day time from their homes and live a regular family life in the evenings with husband and children. This indicates that for some low-income women, economic networking implies sexual networking. However, it is interesting to note that all these women had basic knowledge of HIV/AIDS awareness and prevention though condom use was low which registered only 29% of the respondents (see Figure 8). This, therefore, indicates that individuals tend to take health risks though they know the risks involved and know how to prevent these risks as stated in the Health Belief Model (Pender, 1974).

Here ignorance is not the main reason for failing to protect themselves against sexually transmitted infections including HIV/AIDS. These women rather engage in unsafe sex practices i.e. do not seriously consider practicing correct and consistent safe sex mainly because of perceived threats to their social and economic survival and since they lack the power to make decisions concerning their sexuality, they are unable to negotiate consistent safe sex.

### **Conclusion**

The study has generally established high knowledge and awareness levels of HIV/AIDS transmission, prevention and its severity. However, just like in the Health Belief Model, (Pender 1987) some women after perceiving their risks take necessary steps to prevent contracting HIV/AIDS. While others who are not aware of their risk, because they feel they are married or in monogamous relationships do not. Some, however, do perceive their risk but are obstructed by obstacles to behavioural change such as inability to negotiate safer sexual practices because of lack of social or economic freedom. The positive association between level of education and condom use, indicates the importance of improving both women's access to education and their social status as part of long-term strategies to prevent HIV/AIDS. The association also suggests, the need for designing educational strategies that should also target women with little education. However, since knowledge alone is a necessary precondition for, but not a guarantor of behavioural change, strategies to counteract cultural, religion and societal obstacles should be carefully enacted and implemented.

## **CHAPTER SEVEN**

### **Implications**

The findings of this study have implications for nursing education research practice and to health policy makers.

#### **Nursing Education**

The study findings revealed that they were a lot of misconceptions myths and beliefs which prevented women from practicing safer sex practices i.e. condom use. This is a challenge to nurse education as it implies that training institutions are not adequately equipping students with the knowledge and skills to competently impart in individuals accurate and appropriate information to influence behavioral change in a knowledgeable population especially that the main source of information about HIV/AIDS (according to the study findings) is the hospital.

#### **Nursing Practice**

The study findings found that almost all the respondents lacked knowledge of other safer sex practices like non penetrative sexual activities which include masturbation, thigh sex (where the penis does not enter the vagina or rectum), stroking, massaging or kissing. These could be used even when one of the partners is HIV positive. Only a few individuals (17%) were also aware of the female condom. This implies that such information is not made available to the women during health education by health personnel or through intensive community outreach.

### **Policy Makers**

The study findings also revealed that some individuals have *superficial knowledge* of HIV/AIDS transmission and prevention which implies that national public awareness campaigns do not provide in depth knowledge on HIV/AIDS to reach individuals of all cadres.

The findings further indicated that apart from culture, social and economic threats, impair women's ability to negotiate safer sex. This implies that there is lack of top level commitment to reduce the social vulnerability of women to HIV infection through better health, education, legal and economic prospects. This also confirms the presence of inadequate policies and programmes which target women.

### **Nursing Research**

The study findings suggest that there is need for further research to explore interventions that would promote positive attitudes towards safer sex, increase perceived susceptibility to HIV infection and develop skills in negotiation of safer sex practices and the use of reduced risk behaviours. The findings also suggest for the need for further research to explore why men are reluctant to adopt safer sex practices and interventions that would encourage men to adopt safer sex practices.



### **Recommendations**

- There is need for the mass media to disseminate useful information about HIV/AIDS transmission and prevention in order to prevent HIV through consistent condom use and address common fears and misconceptions about condoms.
- There is need for the dissemination of information on other safer sex practices like thigh sex or masturbation to give women an alternative method from the condom, which can also be practiced in cases where one partner may be HIV positive.
- Community level interventions should be initiated where community peer educators should be promoted, especially where literacy levels are low and where there is mass media irregularities or even inavailable theatre groups performing in communities. This should enable change in attitudes towards condom use and modeling skills such as condom acquisition and negotiation between couples prior to sexual intercourse.
- There is need to sensitize health personnel so that they are knowledgeable and provide a welcoming environment to attract more men to reproductive health services even when offered along with services for women where couple communication in relationships can be discussed especially since communication is a key to accurate perceptions.

- There is need to promote women assertiveness so that they have the ability to negotiate safer sex practices through providing women opportunities to meet regularly in women's groups away from homes to give them much needed support from their peers.
- There is need to lobby for the availability and accessibility of female controlled barrier methods to give women an alternative to male condoms i.e. the female condom or vaginal microbicides.
- Empowering women to protect themselves, to speak up and to access technologies which frees men from the stereotypical role of oppressor and exploiter by incorporating gender sensitive topics in schools so that girls and boys grow up regarding themselves as equals.
- There is need to intensify sexual assertiveness and negotiating skills in girls' curriculum at school so that girls grow up to be assertive enough to be able to negotiate for safer sex.
- There is need to improve women's socio-economic status by linking HIV/AIDS programs with existing economic intervention's, such as credit programs, agricultural extension services for women farmers, women cooperatives or saving schemes. This will uplift women's economic status so that they can negotiate safer sex without fearing for its threat on their social or economic status.

- There is need to advocate for improvements in women's access to education and productive resources as more educated women are better informed, better able to gather information from newspapers and other media and usually more articulate which puts them at a better position to practice safer sex practices.
- There is need for training schools to adequately equip students with the knowledge and skills to competently influence behavioural change in a knowledgeable population.

### **Dissemination of the Findings**

The findings of this study indicated some implications in areas of nursing education practice, research and for policy makers. To make the concerns and recommendation of this study known, and be discussed for possible implementation of the study's recommendations. The results will be communicated to the Ministry of Health and Population, several non governmental organisations, dealing with health activities especially, those targeting HIV/Aids and women's groups in the country. The findings will also be disposed in the libraries of Kamuzu College of Nursing, College of Health Sciences and the College of Medicine. A one-day seminar including representative of nurses, doctors, policy makers, politicians and all concerned parties will be conducted so that the results are discussed at length.

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**Appendix A**

University of Malawi  
Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

26<sup>th</sup> September 2000

The Secretary for Health  
P O Box 30377

Lilongwe

Attention: Health Research Officer

Dear Sir/Madam

**APPLICATION FOR NATIONAL CLEARANCE TO CONDUCT A  
RESEARCH STUDY**

I write to apply for national clearance to conduct a research study whose title is knowledge and practices of women of low socio-economic status in female-headed households towards HIV/AIDS prevention in Blantyre city. Enclosed is my research proposal.

I am a second year mature entry Bachelor of Science in Nursing student at the above-mentioned college and as partial fulfillment for the Bachelor of Science in Nursing I am expected to conduct a Research Project.

Your favorable consideration will be greatly appreciated as I await your response.

Yours faithfully

**MARIA MUKWALA (Nee Kaonga)**

**Appendix B**

University of Malawi  
Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

The Chief Executive Officer  
P O Box  
Blantyre

Dear Sir/Madam

**APPLICATION FOR PERMISSION TO CONDUCT A  
RESEARCH STUDY IN YOUR AREA**

I am a second year mature entry Bachelor of Science in Nursing student at the above-mentioned college and as partial fulfillment for the award of the Bachelor Science in Nursing. I am required to conduct a research study.

I therefore write to apply for permission to conduct a study in your area in the townships of Zingwangwa, Bangwe, Mpemba, Lunzu, Ndirande, Chilomoni and Limbe. The title of my study is **Knowledge and Practices of Women of Low Socio Economic Status in Female Headed Households towards HIV/AIDS Prevention.**

Your favorable consideration will be greatly appreciated.

Yours faithfully

**MARIA MUKWALA (MRS)**

**Appendix C**

University of Malawi  
Kamuzu College of Nursing  
Private Bag 1  
**Lilongwe**

The District Health Officer  
P O Box 3  
**Blantyre**

Dear Sir/Madam

**NOTIFICATION OF INTENTION TO CONDUCT A RESEARCH  
STUDY IN YOUR CATCHMENT AREA**

I am a second year mature entry Bachelor of Science in Nursing student at the above-mentioned college and as partial fulfilment for the award of the Bachelor Science in Nursing. I am required to conduct a research study.

I therefore write to notify you that I intend to conduct a study in your catchment area in the townships of Zingwangwa, Bangwe, Mpemba, Lunzu, Ndirande, Chilomoni and Limbe. The title of my study is **Knowledge and Practices of Women of Low Socio Economic Status in Female Headed Households towards HIV/AIDS Prevention.**

Your favourable consideration will be greatly appreciated.

Yours faithfully

**MARIA MUKWALA (MRS)**

## Appendix D

University of Malawi  
Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

Dear Participants

I am a second year mature entry student at the above-mentioned college. As part of the programme requirement, I am required to conduct a research study. The title of my study is **Knowledge and Practices of Women of Low Socio Economic Status in Female Headed Households in Blantyre City towards the Prevention of HIV/AIDS.**

The results of the study will help N.A.C.P and policy makers in designing new interventions in order to promote the fight against the HIV/AIDS epidemic. The purpose of this letter is to seek permission to take part in the study. To collect information, interviews will be conducted and each interview will take a maximum of 30 minutes. An interview schedule will be used and the information collected will be confidential. The information will be used for educational purposes only. Your identity will remain anonymous hence I will not write your name on the questionnaire, instead identification numbers will be used.

Participation in this study is on voluntary basis and you are free to withdraw anytime you feel like doing so. Be assured that you are not obliged to participate.

### CONSENT

I have been told the details of the study and I am willing to participate. My signature/thump print is endorsed below: -

Name of Participant \_\_\_\_\_ Code No \_\_\_\_\_

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

Name of Investigator \_\_\_\_\_ Date \_\_\_\_\_

Signature of Investigator \_\_\_\_\_ Date \_\_\_\_\_



## Appendix E

University of Malawi  
Kamuzu College of Nursing  
Private Bag 1  
Lilongwe

Kwa Otenga Mbali

Ine ndine mayi Mukwala ndikutenga maphunziro a ukachenjede ku koleji ya anamwino. Pofuna kukwaniritsa za maphunziro anga ndikupanga kafukufuku wofuna kumva zamaganizo anu ndi machitidwe anu poziteteza ku matenda a AIDS.

Cholinga cha kalatayi ndi chokupemphani ngati mungatenge nawo mbali mukafukufuku ameneyu. Kuti ndithe kupeza maganizo anu muzafunsidwa mafunso mchichewa. Pokutetezani inu dzina lanu sililembedwa koma m'malo mwake muzapatsidwa nambala. Muli ndi ufulu kutenga nawo mbali kapena ayi.

### CHILOLEZO

Dzina la otenga mbali \_\_\_\_\_ Nambala \_\_\_\_\_

Saini Yanu \_\_\_\_\_ Tsiku \_\_\_\_\_

Dzina La Wofunsa \_\_\_\_\_ Tsiku \_\_\_\_\_

Saini \_\_\_\_\_ Tsiku \_\_\_\_\_

## Appendix F

### Questionnaire

Knowledge and Practices of HIV/Aids Prevention among low socio-economic women in female headed households in Blantyre City

My name is Maria Mukwala, I am coming from the University of Malawi (KCN). I would like to take a few minutes of your time to ask you a few questions on HIV/Aids Prevention. The information you provide will help to improve interventions on the prevention of HIV/Aids.

Please feel free to answer and ask any questions whenever necessary. Stop me if you want to say something. The interview is confidential. No one will identify who answered which questionnaire because your name will not be written on the questionnaire. Instead a code number will appear on it.

Interview Code: \_\_\_\_\_

Date of Interview: \_\_\_\_\_

### SECTION A

#### Demographic Data

1. Age:
  - a) 15 – 20 ( )
  - b) 21 – 25 ( )
  - b) 26 – 30 ( )
  - c) >30 ( )
2. Religion
  - a) Moslem ( )
  - b) CCAP ( )
  - c) Catholic ( )
  - d) Others ( )

3. Level of Education    a) No Education    ( )  
                                  b) Primary    ( )  
                                  c) Secondary    ( )  
                                  d) Tertiary    ( )
4. Tribe    a) Chewa    ( )  
                  b) Yao    ( )  
                  c) Tumbuka    ( )  
                  d) Other(specify) \_\_\_\_\_
5. Location \_\_\_\_\_
6. Marital Status    a) Married  
                                  b) Divorced  
                                  c) Separated  
                                  d) Widowed  
                                  e) Single  
                                  f) Migrated elsewhere in Malawi

## **SECTION B**

### **Awareness**

7. Have you heard of the disease called HIV/AIDS? Yes ( )    No ( )
8. From where did you get information about HIV/AIDS (can choose more than one)  
     a) Friends    ( )  
     b) Relatives    ( )  
     c) Media    ( )  
     d) Others (specify) \_\_\_\_\_
9. Which source of information did you find most helpful? (can choose more than one)  
     a) Friends    ( )  
     b) Relatives    ( )  
     c) Media    ( )  
     d) Others (specify) \_\_\_\_\_
10. Do you know how HIV/AIDS can be transmitted? YES ( )    NO ( )
11. If yes, how? \_\_\_\_\_  
     \_\_\_\_\_
12. What body fluids contain the HIV virus? (can choose more than one)

- a) Semen ( )
  - b) Blood ( )
  - c) Breast milk ( )
  - d) All of the above ( )
13. The most common way in which people get the HIV virus is through unprotected sexual relationships. YES/NO
14. AIDS can be transmitted through the use of the same toilet seat with an infected person. YES/NO
15. An HIV infected mother can pass on HIV to her baby during pregnancy. YES/NO
16. Can HIV/AIDS be prevented? YES/NO

**CIRCLE CORRECT ANSWER**

17. Which of the following has no risk of getting infection with the HIV/AIDS virus? (can choose more than one)
- a) Abstinence
  - b) No premarital sexual relationships and testing of blood before marriage.
  - c) Sex with only one uninfected completely faithful partner who has no previous partner.
  - d) Hugging, kissing, masturbation.
  - e) Having unprotected
  - f) Deep kissing.
  - g) Using the same plate and cup.
  - h) Using a condom.
18. Have you heard of a condom? YES/NO
- If yes, where? \_\_\_\_\_
19. What type of condoms have you heard of?
- \_\_\_\_\_
20. What are the uses of a condom (can choose more than one)
- a) Contraception
  - b) Protection from HIV.
  - c) No idea.

21. A condom can prevent the spread of HIV. YES/NO

22. Do you know how to use a condom? YES/NO

If yes, explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. How many times do you use each condom?

- a) 0 times
- b) 1 time
- c) 2 times
- d) 3 times

24. Would you recommend condoms to your friends and family?  
YES/NO

25. Why would you recommend condoms?

- a) AIDS prevention.
- b) Sexually transmitted infections prevention.
- c) Family planning
- d) Lack of trust for sex partner
- e) Others, specify
- f) Not/applicable
- g) Want to have children.
- h) Partner is sterile
- i) Never considered to use condoms with this partner.

26. Do you perceive yourself at risk of contracting HIV/Aids?

### SECTION C

27. Have you had sex in the last three months? YES/NO

28. During the last two weeks, how many times did you have sexual intercourse (estimate where necessary number of times).

\_\_\_\_\_

29. The last time you had sexual intercourse with your partner, did you use a condom? YES/NO

30. Why did you use a condom?

\_\_\_\_\_

31. Why did you not use a condom?

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32. Do You discuss condom use with your partner?

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33. What is it, that you discuss on condom use with your partner?

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34. Would you be willing to use a female condom if your partner insists not to use one? YES/NO

Explain 

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Yes/no

35. Do you believe that your partner has other sex partners beside you? YES/NO

If yes, why? 

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36. Could you suggest the use of a condom when you are having sex with an irregular partner? YES/NO

Explain?

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37. Do you work? YES/NO

38. If no, how do you earn your living?

- a) Small business/trade
- b) Small crafts
- c) Others, specify \_\_\_\_\_

39. What is your average weekly/monthly earnings? \_\_\_\_\_

40. How many children do you have?

- a) None ( )
- b) 1 – 3 ( )
- c) 4 – 5 ( )
- d) > 5 ( )

41. From your income, are you able to comfortably feed your family? YES/NO

42. If no, how are you able to earn extra cash? \_\_\_\_\_

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43. Does the survival of your family depend on the extra income your partner supplies?

- a) Yes ( )
- b) No ( )
- c) Not applicable( )

44. If yes, do you have other partners to supplement your income when your regular partner is unable to give?

- a) Yes ( )
- b) No ( )
- c) Not applicable( )

45. If yes, do you use condoms with these other partners?

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46. Assuming your manfriend decides to terminate the relationship, will you befriend another man to help with your financial problems? YES/NO

**Explain?**

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