

Men, women and the trouble with condoms: problems associated with condom use by migrant workers in rural Zambia*



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Abstract

Understanding cultural attitudes to condoms is of the utmost importance in promoting their use as a means of protection against HIV transmission. This article examines condom use in relation to what people see as the purpose of sex, what good sex entails and how this relates to ideas of being a proper woman or man. It seems that the underlying and pervasive ideal is that sex is essentially a procreative act, since an emphasis on male potency and male and female fertility often overrides anxieties about contracting HIV and other sexually transmitted diseases. Hence condom use is usually only negotiated within some short-term relationships and then not consistently. Whilst both men and women have negative attitudes to condoms, women because of their economic and ideological dependence on men are in a much weaker position to negotiate condom use.

The use of condoms is one of the major strategies for combating sexually transmitted diseases, including HIV. In Africa, condom use has been hotly debated. Public health specialists in their attempts to promote condom use have faced opposition from Christian and Muslim religious viewpoints, as well as traditional moralists. The argument that condoms curtail fertility and save lives has been pitted against condoms as a symbol of immorality and women's uncontrolled sexuality (Lyons 1993; Preston-Whyte 1993). This discourse reflects genuine conflicts faced by individuals when considering whether to negotiate condom use in each sexual encounter. Religious objections to condoms appear to play less on people's minds in our field site than objections that rise out of ideas about the purpose of sex and what good sex entails. The latter lies at the core of the dilemma regarding condom use in a modern African context.

* This research has been funded throughout by the Swedish Agency for Research Cooperation with Developing Countries (SAREC). Three institutions are involved in the research project 'Community Capacity to Prevent, Manage and Survive HIV/AIDS' (1991 to date): the Department for International Health Care Research (IHCAR), Karolinska Institutet, Sweden; the University of Hull, Britain; and the Institute for African Studies (IAS), University of Zambia.

In cultures where fertility is paramount and sexually transmitted diseases (STDs) shameful, condoms are often viewed negatively because they prevent conception and represent disease. The consequent association, embodied in the dual purpose of condoms, between conception and disease is a 'source of ambiguity at the level of meaning' (Ulin

1992:67). Indeed condoms have become symbols for a range of negative attributes in Africa including infidelity in men and women (Worth 1989), unsuccessful sex (Musingeh, Chama and Mulikelela 1991:100) and political efforts to control reproduction in the African population (Bledsoe 1991:7; Preston-Whyte 1991:1393).

We are not arguing that condoms are totally inappropriate in Africa. During a recent training program held for peer educators in Zambia, apart from negative associations, participants associated condoms with caring for oneself and one's family and recognized the role of condoms in family planning and protection from STDs. However our research further demonstrates that the use of condoms as a means of preventing the spread of HIV and other STDs is checkered with problems of cultural acceptability and availability. Hence, whilst people are aware of the necessity of using condoms and have anxieties about contracting HIV, they are tending to use condoms, if at all, only within certain sexual relationships. Other research in Africa corroborates this finding demonstrating low reported condom use in most relationships (Ahmed et al. 1991; Neequaye, Neequaye and Bigger 1991; Preston-Whyte 1991, 1993; Rind 1991; Vos 1993; Romero-Daza 1994). The highest reported condom use in Africa is amongst prostitutes and their clients but even then use is not consistent or without problems (Wilson et al. 1990). Condom use is therefore highly inconsistent (Fuglesang 1995:70), even though people may recognize the need to use condoms and ask for them. This seriously undermines the effectiveness of this method in preventing HIV and other STDs.

A major element which inhibits the use of condoms in the population we have studied, is the focus that people have on sex as basically a procreative act. Male potency, and male and female fertility, are formative concepts imbued through upbringing. Full adulthood is only really achieved through the production of children and large families are still an ideal. Indeed in local religious custom, only the spirits of people who have reproduced are recalled to the family compound. The profound concentration on procreation results in an uneasy interface between customary ideas and modern lifestyles and needs. This creates anomalies between people's knowledge and their sexual practice. In a study in South Africa, Preston-Whyte (1993:6) acknowledges the paramount importance of fertility amongst Kwazulu in South Africa and asks 'How does the emphasis on fertility play itself out in the modern context?'. In our experience the underlying belief in procreation as an intricate part of 'good' sex is not necessarily acknowledged in modern life, although it remains both persuasive and pervasive, often prohibiting the use of condoms. A Zambian researcher, Mushaba (1993), says that condoms are shunned by most people in Zambia because of the desire to have children. Yet our research demonstrates that people report that they often do not use condoms, despite stated wishes to avoid pregnancy, as well as STDs and HIV.

The research site and population

In the last five years the number of migrant workers coming to Chiawa, a rural chieftaincy in Lusaka Rural Province, has dramatically increased. A large commercial farm, owned by a multinational company, is the largest employer, recruiting on an annual basis roughly 2,500 seasonal migrant workers. Tour operators, a European Union tsetse project and National Parks also recruit smaller numbers of migrants. This migrant population is mostly composed of young men, employed on a temporary basis, living without their spouses in camps. Hence, as with earlier urban migration in Zambia, there is in Chiawa a seasonal disparity between men and women, with many more migrant men than women and relatively few women residing in the camp compounds¹. Many of the married migrants find it difficult not to strike up other

¹Although, as indicated by the title, the focus of this paper is on the migrant population in Chiawa, it is impossible to discuss the issue of condoms without drawing on material from the resident population, a

sexual relationships whilst in Chiawa, and are also concerned about their wives' faithfulness in their absence. Women in Chiawa, outnumbered by men and struggling to survive in a harsh economic climate, are under exceptional pressure to have sexual relations. Throughout Southern Africa, migrant labour, since the beginning of the century, has been a major reason for both husbands and wives to seek sex outside marriage and has been a leading factor in the spread of STDs (Kark 1949; Hunt 1989; Romero-Daza 1994; Webb 1994).

The perceived significance of the migrant population in the spread of STDs and HIV in Chiawa is partly confirmed by medical statistics available from a nearby mission hospital and by our own research. According to medical statistics, the commercial farm has the highest number of known cases of TB, STDs and HIV in Chiawa (Bond and Ndubani 1992; Bond, Macwang'i and Ndubani 1992). In a random survey, conducted amongst 10 per cent of the farm workers in 1994, 17 per cent reported having ever suffered from an STD and 13 per cent having suffered in the past year. The farm records reflect that the most common reasons for casual workers going to the hospital are STDs and dysentery. Researchers and research assistants are constantly approached to give advice on STDs and asked for treatment. There is an acute concern amongst some migrant farm workers that they may already be infected with HIV.

Since the project started to distribute condoms in 1991, these migrant men have been the main clients, constantly approaching us and our research assistants as we go about our work, requesting condoms. Requests are often indirect, masked by euphemisms such as 'socks' or 'wellingtons' or statements like 'I want to play with a woman' and 'It is cold now. We need condoms'. We were happy to oblige by supplying condoms, having secured a source of free condoms from Medical Stores, under Overseas Development Agency (ODA) and WHO sponsorship. The demand for condoms has continued and increased since 1991. Yet STDs and unwanted pregnancies apparently remain common in and around the camps.

In 1993 at a series of meetings, it became obvious that the condom distribution was causing conflicts between married couples who lived together in the farm camps. In 1994² we did more explicit research into male and female sexual activity amongst both farm workers, many of whom are migrants, and villagers. This inquiry revealed that condoms were not popular. This paper looks in detail at the trouble these men and women in Chiawa have with

Shona-speaking group called the Goba. Chiawa was a secluded community for many years because of poor access and the Zimbabwe war (mid-1970s to 1980). Suddenly, since the late 1980s, the resident population has been exposed to tourism, large-scale commercial agriculture and other development projects. The belief systems of the Goba have met head-on with other ethnic groups, flooding into Chiawa to work or settle, and other changes. It is hard to present the migrant workers as an isolated group since sexual contact takes place between migrant workers and villagers. On the issue of condoms their ideas intermix. Therefore both the resident and migrant population are represented in this paper, in relation to the sexual contact in and around the migrant workers' camps.

²The material for this paper is based on research with the migrant camp population and in the Chiawa villages since 1991; specifically, the following studies: 1991 socio-economic survey of individual camp workers (Bond, Macwang'i and Ndubani); 1993 feedback meetings in all camps (Bond); 1994 random survey of individuals on the commercial farm (Bond); 1994 focus-group interviews with farm workers (men and women, different age-groups) (Bond, Dover); and 1994 in-depth interviews with individual camp workers (Bond). We have also drawn extensively from our fieldwork in Chiawa villages when it relates directly to the camps. The quotations in the text are either derived from taped interviews (focus groups and individual interviews) or fieldwork notes.

condoms and tries to explain the anomaly that although there are many problems with condom use, there is still a demand for condoms³.

Ideals of male potency

‘A women cannot propose [to] a man’

‘Only a man can impregnate a woman’

Statements of this kind are often made by men and women in Chiawa when discussing sex and gender relations. Men are seen as instigators of the sexual act, as seems to be the case in other areas of central and southern Africa. Preston-Whyte (1993:3), for example, reports that in Kwazulu, South Africa, men take the lead in sex and women’s preferences are not discussed. However, Vos (1993:13) says that amongst the Ndebele a wife can discuss sexual preferences although if she initiated a new style she would be accused of infidelity since it would be evidence of experience with other men. Lyons (1993:6) asserts that in South-West Uganda ‘men make decisions concerning sexual practice’. Hence, it is often difficult for women to instigate condom use and it is men who largely control condom use in sexual encounters. A single migrant woman on the farm explained: ‘Condoms are good but although some men agree to use condoms, if a man refuses to use one, there is nothing you can do’. It is clear that a woman could ask a man to use a condom but rarely can she force him to, and even asking could expose her to violence or verbal abuse, whereas a man can insist on condom use. Some men said that if a women is unwilling you can slip one on in the dark anyway.

In Chiawa, semen is seen as the catalyst of reproduction; men are ‘productive’, women the recipients. Potency and quality of semen are strong symbolic elements of male identity. Men take regular doses of potency medicines to improve performance and semen quality. When a boy is deemed old enough, his grandfather (i.e. a male relative of that generation), will start giving him potency medicine. These men of the grandparent’s generation are also responsible for the boy’s sex education. The potency medicines are usually locally made herbal mixtures, but there are commercial brands available, sold in urban areas.

Quality of semen is seen as extremely important by both sexes in Chiawa. In consistency it should be thick, cream coloured and sticky. If a woman is concerned about the quality of her husband’s semen because she is failing to conceive, she takes a specimen of it in the sexual cleaning cloth (with which she cleans her husband after sexual intercourse) for examination by an older woman. If it is considered too ‘watery’ the older woman can advocate that her husband take medicine to make him strong. Local people also report that if a young couple fail to conceive a first child after a reasonable period, examination of the husband’s sperm is made. Boudillon (1982:44), in a work based mainly on the Korekore Shona — closely related to the Goba — reports on semen tests for youths before marriage. The semen is dropped in water, if heavy it is deemed potent, if it floats the young man is given potency medicines.

Quality of semen is seen as having an inverse relation to the number of ejaculations. The first ejaculation is thus the most important, when a man’s ‘bullets’ should penetrate deep inside the woman. Ideally ejaculation should thus take place for the purpose of reproduction. Consequently oral sex is seen as a perversion and masturbation is a waste of semen in that it ‘drains your batteries’ which makes men, women say, ‘mentally confused’. Masturbation is

³Research amongst farm workers in Zimbabwe has similar findings. Despite condom distribution increasing, condom use remained reportedly low, with only five per cent of men claiming they had used condoms the last time they had intercourse (Laver 1995).

also seen as the action of a young boy, not befitting a man⁴. Male decisiveness, strength and potency are thus interlinked, and male sexual tension can only find proper release in a woman. Viewpoints from some Christian groups on masturbation and condoms may have reinforced these ideas. A number of Christian denominations stress that sex should only be for procreation, and the Bible likens masturbation to 'seed....spilled on the ground' (*Genesis* 38:9). In the 1994 random survey on the commercial farm, 65 per cent said that they were Christian, and during peer education training in 1995, some men and women referred to a Christian view of masturbation and condoms.

Condom use in Chiawa is likened to masturbation⁵. 'It's like fucking yourself'. '....you have to use your imagination, it's not real...'. These comments at a recent focus-group discussion illustrate well the general negative attitudes to condoms. Men appear to have psychological anxieties about performance when using condoms. They also say that prolonged use of condoms leads to impotence. Given semen's high symbolic value, one can see that condoms trap this vital male fluid, turning it into unpleasant rubbish to be thrown away. There are rumours in Chiawa and other parts of Zambia that men are now cutting holes in the ends of condoms, thereby protecting themselves whilst releasing their semen.

A man is expected to perform well sexually. Both women and men say that 'one round' (ejaculation) is not sufficient for a man in the prime of life. An older woman explained that more than two rounds 'shows love; that a woman is good and a man is strong'. Sexual satisfaction appears to be more related to achieved ejaculations, than to prolonged bouts of lovemaking. Men, for instance, say that condoms lessen sensitivity making the achievement of ejaculation longer and the number of rounds reduced. Both men and women complain about the latter.

The words used to explain male potency such as 'productive' and 'batteries', implicitly contain ideas on men's need for release. Men are seen as prolific by nature and not able to control their sexual appetites for long periods. Mudenda (1992), in a study of school children's attitudes, says that from an early age Zambian schoolgirls explain that boys, unlike girls, are not able to control themselves. A woman in Chiawa gives her own explanation:

A man cannot go without sex for a long time unless he is impotent. A woman is able to. A man is productive and if your husband is away from home working elsewhere then you suspect he has a girlfriend.

Male infidelity should be conducted surreptitiously, however. If the wife has proof it may lead to recriminations, and if the wife tires of her husband's behaviour, possibly divorce.

Many peoples in Zambia have customarily practised postpartum abstinence until the child is weaned. This is a period in which husbands are thought likely to look for alternative partners, though our research does point to some couples using condoms specifically during this period. There is a local illness called *masoto*, which a father can inflict on his unweaned child by having sexual relations with a woman other than his wife. *Masoto* can be prevented or cured by a man confessing directly to the child and using certain herbs until the child is weaned. Thus while condoms are recognized as inhibiting infection from certain sexually transmitted diseases, there are some local illness categories connected to sex which condoms

⁴Similar attitudes appear in Zimbabwe; Vos (1993:4), for example, reports the Ndebele as regarding masturbation as deviant, though Runganga says that Zimbabwean boys at boarding school admit that masturbation is a common solution to cope with sexual desire (Runganga 1992:15).

⁵Runganga (1992:17) makes the same observation amongst Shona in Zimbabwe.

do not prevent. These are illnesses connected to sexual intercourse and moral digression, of which *masoto* is one example⁶.

In Lesotho, Romero-Daza (1994:202) recommends promoting condom use through sexual taboos, such as postpartum abstinence. It might be worth trying this as a condom promotion strategy, and some people do appear to be using condoms as an alternative to abstinence. But this is only within a specific situation in which local beliefs fit in with condom use, in that semen should not enter the women's body and mingle with breastmilk, nor should the women become pregnant until the child is weaned. As outlined above, there are local illnesses connected to sexuality which are caused by infractions of traditional norms and beliefs, in which condoms have no significance.

Certain sexual practices and needs

Good, proper sex in Chiawa is vaginal penetrative sex without condoms. This would appear to apply to other areas in Zambia (Mushaba 1993)⁷. Musingeh, Chama and Mulikelela (1991:100), in a study of women fish traders in Northern Zambia, conclude that these women would rather catch HIV than use condoms since successful sex is both 'discharging sperm into the vagina and conception'. Indeed in Chiawa the release of semen into a woman not only fulfils a man's productive role, it is also seen as important in satisfying the woman. Both sexes say it makes her feel 'sweeter and warmer' after coitus. Condoms 'deny this last warmth because the penis is in a sack' as a young migrant man put it. Men say that because of the need of women to feel the ejaculation, women are more unwilling to use condoms than men. Women certainly admit that sex is more satisfying without a condom: 'Sex with a condom feels worse', said a young woman working at the farm. One research assistant records a local woman in a bar on payday telling her companion that he should 'fire, fire' and comments in his diary 'This means you should not use condoms if you wish to sleep with her'. Older women in particular resist the use of condoms and they are in part responsible for teaching younger women about sex, marriage and childbirth. Hence, as Kline et al. comment with reference to minority women in New Jersey, low level of condom use is not only due to men's negative attitude but also to women's own needs and concerns, as well as neither sex wanting reduced sexual pleasure (Kline, Kline and Oken 1992:455). Fuglesang cites young men in Tanzania explaining that if they wish to maximize sexual pleasure with a 'pretty and fit girl' then they have *kavu kavu*: sex without any additions, even though they realize that unprotected sex is a risk (Fuglesang 1995:68).

Another element in good sex is the use of different agents by women to reduce lubrication and 'tighten' it by inserting the agents, by douching or through drinking herbal medicine. This practice, common in Zambia, Zimbabwe and South Africa, has become known in recent literature as 'dry sex' (Nyirenda 1991). Women in Chiawa believe it is shameful to be 'watery' and relate how men can insult them by telling them that they are too wet saying, 'You are useless! You are wet and cold!'. Preston-Whyte (1993:11) relates that in Kwazulu wet sex further implies infidelity and a wish to prevent conception. Both men and women in

⁶A paper by Bond and Ndubani (forthcoming) attempts to develop a glossary which correlates biomedical terms for STDs with local terms for disease associated with sexual intercourse. Local terms fall into three broad categories; generic terms, symptomological terms and folk terms connected to moral digression. In all categories, but especially the latter, it is difficult to establish definite connections between local names and biomedical STDs. What is established is the importance of cultural perceptions of diseases and local disease terminology.

⁷The condom being marketed currently in Zambia has the brand name 'Maximum'. A joke circulating in urban centres is that 'Maximum' condoms give you minimum pleasure.

Chiawa state that a woman should be dry and warm: 'warm, not like a snail', one man explains. Some women say it makes you 'feel sex' more. Some say it is painful. Katele Kalumba, a previous senior Zambian researcher on the project, proposes that the practice 'makes a man feel big and a woman feel small' (Bond 1992:3). Lubrication provided by condoms is the opposite of this ideal. Dry sex and condoms are not compatible (Meade 1995:26). Some women also mention that condoms cause pain. This may be the pain associated with the friction created by dry sex or by lack of stimulus. Runganga (1992:1041), from a Zimbabwean study, points out that for Shona women the use of agents gives the perception of controlling intercourse and fidelity. Preston-Whyte (1993:11) wryly reflects that the necessity for good sex and for satisfying men justifies these sexual practices for women. Runganga, Pitts and McMaster (1992:32) conclude that '...pleasing a man could take primacy over asking him to use a condom or challenging him about his "risky" sexual habits'.

Oral and anal sex are widely regarded as perversions by people in Chiawa. Two Zimbabwean studies describe similar attitudes. Vos (1993:4) reports oral and anal sex regarded as unnatural in rural Matebeleland. Wilson et al. (1989:269) in a study of prostitution in Harare says it is rare for even prostitutes to engage in this type of sex. Homosexuality is an extremely sensitive issue and men in Chiawa generally deny any knowledge of the subject; professing 'It's not the African way', 'We Africans do not do such things'. Gay rights does appear to be an emerging issue in larger urban centres in Southern Africa, but in rural areas such as Chiawa it is a closeted domain and taboo subject.

Other options than penetrative sex with or without a condom are limited in Chiawa, as indicated by the above and the discussion on procreativity and male potency. Young women say it is possible to 'kiss, touch and just play without having sex' in teenage encounters. On the commercial farm many women said they did not wish to become pregnant, mainly because it prevented them from 'loving a man'. It would be difficult to have a succession of boyfriends or start up new relationships during pregnancy and for a period afterwards. To prevent pregnancy condoms are one option but other methods are preferred. Certain herbs, strung around the woman's waist with her other beads, are believed to prevent pregnancies, as is having sex only on 'safe days', sometimes biomedically inaccurate. Withdrawal before ejaculation is advocated by the Catholic church as a family planning method although women say when it comes to the point, men often 'do it inside'. Another measure is to induce abortion. There have been a number of cases of abortion at the farm and some have resulted in the death of the woman as well as the foetus.

At a certain stage in a woman's life, she needs a child. Women in Chiawa openly state it is more important to have a child than a husband. Using condoms obstructs fertility and the lateral links that give women access to more resource networks (Bledsoe 1991:2). For young women in Chiawa a desire to be impregnated (as opposed to getting pregnant through force, ignorance or by mistake) is either a strategy for marriage and support or just a decision to become a proper woman and have a child. A girl will try to become pregnant by a man with whom she would not mind having a long-term commitment.

Both men and women cite poverty as one of the major reasons that women accept 'proposals' from men. Any sexual relationship outside of marriage involves 'presents', which are expressive of a man's commitment and a woman's worth. They can also be linked to traditional contractual gifts within courtship and marriage. The widespread use of presents partly conceals the utility of many sexual relationships. Presents are found along a continuum of relationships from more-or-less stable attachments to commercial sex, and women can often be given money in lieu to purchase something. Naturally, not only money, but food, clothes and other luxury goods are conducive to accepting proposals. Falling in love, finding a husband, desire for children and peer pressure are other important elements for women. Nevertheless money and other necessities are sometimes more important motives than self-

protection. Lyons (1993:6) sees women in South-West Uganda as 'trapped between powerful concepts of morality and the harsh realities of survival', thus having '...limited opportunity to control their own bodies and live without the patronage of a man'.

Some Chiawa girls in sexual contact with migrant workers are very young and may well be too inexperienced to consider or negotiate condom use. Some parents are said to turn a blind eye to the sexual activities of their daughters unless they are 'damaged' or impregnated. This may be because damages fines and marriage payments are among the major injections of capital into the life-cycle of a household (Keller 1979)⁸.

The negative connotations of condoms

As can be seen from the above in Chiawa and elsewhere in Africa there are a number of negative connotations and attitudes to condoms. They trap the semen. They lessen sensitivity and thus it takes longer to ejaculate, reducing the number of 'rounds'. In Preston-Whyte's study (1993:15) young men in Kwazulu complained that it was embarrassing to put them on and take them off for each round. The lubrication required by condoms lessens the effects of dry sex. Men in Chiawa complain that the condoms supplied are not strong enough and are too small. They often talk of condoms breaking — this is sometimes related to male pride in sexual vigour — or say that they come off and can even be lost inside the women. Men say that women are afraid of condoms getting stuck inside them. This fear is echoed in studies from Zaire, Lesotho and Kenya (Rind 1991:79; Romero-Daza 1994:197; Welbourne 1995:78). Condoms take away the pleasure of sex (Vos 1993:15-16). 'When you are using condoms', one young man in Chiawa commented 'you may as well abstain from sex'. A migrant woman asserts that 'condoms make a woman not feel anything so it is better not to use them'.

There are also a number of misunderstandings and scare stories about condoms: for example, the stories that men cut holes in the end of condoms. Some people believe that regular use will lead to impotence. Others say that the lubrication enters the penis and makes one sick, and it may be the case that some people are allergic to certain brands of lubrication. A common fear is that they do not protect against HIV because they are permeable. People say that if you fill up a condom with water, tie it up, and leave it for four days, the water will have vanished. If water gets through the rubber, then HIV must also be able to. Radio programs and films, broadcast by certain Christian religious groups, claim that the HIV virus is so small it passes through condoms. Elsewhere in Africa other scare stories abound. In Tanzania, Fuglesang (1995:70) reports a rumour that condoms are infected with the HIV virus and therefore spread AIDS. In Uganda and South Africa political motives make people mistrust condoms, believing them to be a strategy to control the reproduction of black Africans (Bledsoe 1991:7; Preston-Whyte 1991:1373).

Condoms in Chiawa are also connected to 'movious' people⁹, prostitutes and diseases. A woman may be insulted by a man wanting to use a condom. For example an older woman proclaimed: 'I have never seen a condom. Why should I use a condom? Condoms are only used by prostitutes'. Indeed a man may consider a woman who wants to use a condom as promiscuous or perhaps a prostitute. Bledsoe (1991:8) and Fuglesang (1995:68) observe that ironically some condom promotion material targets prostitutes and reinforces this idea. People reason that the motivation for someone wanting to use a condom may be that they are already diseased. Condoms are after all associated with treatment for STDs and, now, with preventing

⁸Personal communication from Thayer Scudder about the longitudinal Gwembe study of four villages whilst in the field, Chiawa, July 1995.

⁹'Movious' is a colloquial term for promiscuous.

the transmission of HIV (Bledsoe 1991:8; Preston-Whyte 1993:9). Yamba (1989:169-170) relates how a West African Islamic pilgrim in Southern Sudan was thrown out by a prostitute for attempting to use a condom. The prostitute thought he must have considered her diseased or that he must have been carrying a disease himself. In either case he had no business coming to her.

There are also strong Christian religious sanctions against condom use. Religious groups, such as Catholics and some evangelists, moralize against condom use, saying that they encourage promiscuity and that people should learn to resist temptation. A discussion amongst wives of migrant game guards in Chiawa reflects their belief that condoms enable their husbands to engage in extramarital sex. 'Give men condoms and they go straight [to other women]. They don't go home to use them for child spacing!', the wives exclaimed. Another researcher in Zimbabwe encountered the same objection amongst wives of farm workers who will actually throw away condoms being publicly distributed, proclaiming 'We don't want them here', and complaining that children and youth get hold of them (Laver 1995).

Thus condoms cause mistrust in relationships and are associated with infidelity. At two meetings we held in 1993 with some migrant workers and their wives, the women were outspoken and adamant that condoms are not good because of the way men use them. A suggestion that women as well as men should be given condoms was greeted with outrage by the men. One husband commented: 'Then a wife would behave like a husband and there would be no home'. Women in this discussion were frustrated with the men implying that men could control their use whereas women could not. At length they argued over husbands and wives being given condoms. One possibility raised would be to count the number of condoms in their possession to ensure that the condoms were only used within the marriage. Men admitted that they have to hide condoms from their wives to avoid suspicion. Women said it was difficult for them to be given condoms openly in public and to use them in private, fearing accusations of infidelity in both areas. Obviously, within marriage or steady relationships, condom use or possession engenders lack of trust. The wife of a game guard once asked in all sincerity whether there were two types of condoms; one for leisure and one for family planning. Condoms have therefore become symbols of unfaithfulness (Runganga 1992:13) and 'seem to challenge the very basis of human relationships — trust and willingness to put one's life into another's hands' (Preston-Whyte 1993:15).

What type of partner to use condoms with

There are relationship categories in which people in Chiawa are more or less likely to use condoms. Men and women are less likely to use condoms with their spouses as reflected in the following:

My husband is too movious with a woman at the pontoon. This woman has many other men at the farm. I can give him condoms to use with this woman. But why should I use a condom with him? It is better that I divorce him before he brings a disease to me (the wife of a local Chiawa man who is working on the farm).

I cannot use condoms with my wife. Why should my wife have condoms? (a migrant game-guard).

For migrants the difficulties of using condoms with their wives causes anxiety. One tsetse worker remarked 'I use condoms with my girlfriend but what if my wife is misbehaving at home?'. Another migrant worker at a safari camp said

You cannot trust either a girlfriend or your wife one hundred per cent especially when you are away from your wife for most of the year. You can catch AIDS from your wife. Yet with wives you want skin to skin.

If condoms were used consistently with partners other than spouses, then they could effectively reduce STD and HIV transmission. A Zaire study shows that condoms are more likely to be used with extramarital partners: three per cent of men report using condoms in marriage and 24 per cent outside marriage (Rind 1991). However in Chiawa the use of condoms outside marriage is by no means consistent, since people also are less likely to use condoms with 'steady' or 'decent' girlfriends or boyfriends who are less likely to be diseased and whom they can trust. People define 'steady' as not being seen with too many other men or women. There is a preference for having married women or men as girlfriends or boyfriends because they are more likely to have fewer sexual partners and, it is believed, less likely to have an STD. Men also say that if you are married it is safer to have a married woman as a lover, in that there is less chance that she will tell her friends. A relationship can become steady in a short time, and condom use suspended correspondingly. Bledsoe (1991:7) remarks that stopping using a condom signifies a transition from a loose attachment to one that a woman wishes to sustain. There are more reasons for not using a condom in Chiawa than wishing to sustain a relationship but certainly it is ironic that some of the relationships within which condoms are less likely to be used are those in which a future is more likely.

On the commercial farm, as mentioned before, women are sometimes tempted or coerced into sex in exchange for employment, favourable tasks or extra wages. Although we cannot be sure, it appears in such compromised circumstances condoms are rarely used.

It is acknowledged, especially by women, that it is important to be discerning about sexual partners. This is not an ideal attitude but a realistic one, particularly in relation to migrant workers. A young migrant woman explains, 'You wait first before having sex. You never know maybe he is diseased or is not a humble person'. Both men and women complain about the type of partners available in Chiawa, criticizing those who are too 'movious'. For women the option of using condoms with such characters is not usually brought up; but men advocate condom use with 'hit and run' or 'loose' girlfriends, with 'outsiders' and with prostitutes. Prostitutes at a nearby border post do actually carry condoms with them. In Zambia prostitutes charge less for sex with a condom (Tacintha, personal communication 1995). Although the highest use of condoms appears to be between prostitutes and their clients, prostitutes face refusals from clients to use condoms. Wilson (1990:616) says that prostitutes in Zimbabwe are also less likely to use condoms with regular clients, boyfriends and non-paying partners. A study in Ghana reports 66 per cent of clients refused to use one after a direct request (Neequaye et al. 1991:917). Again the effectiveness of the method is undermined by the failure to use condoms consistently.

Men in Chiawa also believe that they can decide to use condoms in casual encounters on the basis of physical appearance or age. Frequently men remark that condoms should be used in 'an emergency' when out drinking, although, they admit, it is easy to forget under the influence of alcohol.

Obtaining, using, disposing of condoms

Where then do people obtain condoms? They can be obtained from the clinic at the main village, from the project which distributes them through the farm management and peer educators, from a Catholic Mission Hospital, from community health workers and from some bars and shops. In a 1994 survey amongst the farm workers, 60 per cent knew where to get condoms and the most common source mentioned was the hospital. Obtaining condoms is complicated by religion at the hospital, and women and girls in particular are often too shy

and ashamed to request condoms at any source. The project has thus made provision for anonymous distribution to women through the female peer educators, though they are no longer available free of charge.

Nationally an American social marketing program has taken over condom distribution and supply outside formal health facilities in Zambia and it has become extremely difficult to secure a source of free condoms for the project in Chiawa. Therefore this year a condom manufacturer has taken over the distribution on the farm through the project peer educators. These condoms are sold in strips of four (approximately US five cents) and sales, which had only just started in September 1995, are low, partly because workers are used to being provided with free condoms. Previously we used to give eight condoms free of charge to each person who asked us. Money is a problem for people in Chiawa who are mostly poor.

A further problem is availability of condoms at specific moments. Respondents in the 1994 survey gave the most common reason for not using a condom the last time they had sex as unavailability. An evening drinking party in one of the villages is a good example: these are the occasions when casual sex is likely to occur. Carrying condoms on one's person can be problematic, for example if a partner discovers them, and condoms are not supplied by any of the women selling beer or the strong local wine in the villages. Alcohol is anyway not conducive to the use of condoms according to our research and research amongst prostitutes and their clients in other parts of Africa (Neequaye et al. 1991; Wilson 1990:616).

The peer educators and health workers are supposed to demonstrate correct use of condoms. Before they were trained leaflets were occasionally handed out to explain how condoms should be used correctly. From what people say they are not used more than once, though several might be used simultaneously. Some men are said to wear up to three condoms for maximum protection. Fuglesang (1995:69) reports the same practice among young Tanzanian men. Breakage is reported, and mainly accounted for by the 'roughness of men'. Condoms are disposed of in latrines, though as a lot of illicit sex takes place at night-time in the bush, people say that condoms get left there as well. There have been a few stories of children using them as balloons. Storage, in the intense heat of the Zambezi river valley, is a problem.

Respondents in the 1994 survey reported a surprisingly high rate of use of condoms with 35 per cent claiming they used a condom the last time they had sex. This could be partly a reflection of a high frequency of casual sex (in this type of sexual contact condoms are more likely to be negotiated) and may have also been partly because they knew that the project wanted them to have used a condom. Worth (1989:305) experienced a drop in reported condom use during her study in New York and participants admitted that they had exaggerated at the beginning to please the researchers. Actual use is not equivalent to reported or correct use. There are nevertheless consistencies in reported condom use from various studies in Africa which are indications of actual use. Rates of regular use between spouses are reportedly extremely low, mostly around two per cent (Rind 1991:78). Women, other than prostitutes, report very limited use of condoms, with around four per cent of women claiming to have ever used condoms (Neequaye et al. 1991:918; Romero-Daza 1994:197). Although most prostitutes may have used condoms, Wilson reports from Zimbabwe that on average not more than 40 per cent of clients will consent to use them (Wilson 1990:609).

Promoting condoms

We think that condom promotion in Zambia should be sensitive to local concepts and practicalities. In a recent intervention in Chiawa, 18 people, mostly farm workers, were trained to be peer educators and condom promotion was an important component. We incorporated the troubles men and women had with condoms by first holding group discussions, with men and women in separate groups. The discussions revolved around the

themes of good sex and condoms, associations with condoms, negotiating condom use, the reliability of condoms and how to obtain condoms. The discussions raised many of the local issues covered in this paper and structured the session with the condom manufacturers, present to demonstrate correct use and disposal and to discuss supply. We asked the manufacturers to address the issues raised. They did this, explaining for example how condoms do indeed reduce feelings because they do not move easily. However, they argued, this loss of feeling outweighed exposing oneself to HIV infection. Although their explanations were specific, and the demonstration of use clear, the rehearsed talk they then gave was not very appropriate, more akin to an American concept of good sex and overlooking many of the local concepts previously deliberated.

Bledsoe (1991:6) notices that 'international agencies... are scrambling to subsidise and distribute condoms in Africa', and 'condoms, once placed in the African context, have taken on meanings that their advocates in other parts of the world do not fully appreciate' (Bledsoe 1991:9). One suggestion is that local manufacture and sale of condoms should be promoted, rather than securing an external supply, since this would build on profit motives and cultural sensitivity as well as creating jobs (Barton 1991:13).

There is evidence that condom promotion can modify sexual practices although only in certain types of relationship or through reinterpreting cultural beliefs. Hence information, counselling and support can lead to increased use amongst prostitutes (Neequaye et al. 1991:917; Wilson 1995). Increased use may also be possible in one geographical location with people engaging in 'high-risk sex' with very many partners, a situation analogous to prostitutes and their clients. The commercial farm in Chiawa may fall into the latter category. Otherwise condom promotion needs to tackle cultural barriers to condom use. Schoepf claims that a workshop held in Zaire with traditional healers succeeded in re-interpreting the meaning of semen from a vital force of health to a dangerous force. She said that the healers bowed to family and cultural survival (Schoepf 1991:21). Yamba's (1989) work in Southern Sudan with West African migrants supports her view of the overriding importance of cultural survival. The leaders of the West African community decided to promote an earlier marriage age for young men when they feared STD prevalence amongst their young men was causing infertility and threatening the future of their group. It is significant that they however chose to promote earlier marriage over promoting condom use with a small cohort of prostitutes with whom the younger unmarried men had sexual contact.

One strong barrier to successful condom promotion is the fact that we may be 'asking women to do something that in many cases they do not have the power to do' (Worth 1989:306). If condoms are contrary to 'traditional values and attitudes, survival strategies, personal goals or actual behaviour' (Worth 1989:306) held by men and women, it is excessively hard to try to use a condom in certain types of sexual relationships. This implies that it is necessary to have more than one strategy for promoting safe sex (Preston-Whyte 1993:14).

Wilson makes an interesting observation in his research with prostitutes in Zimbabwe. Among a cohort in Bulawayo, condom use was associated with higher charges, absence of client violence and having another job (Wilson et al. 1990:612). This reiterates Worth's conviction that the power dimensions of sexual decision making and sexual exchanges have to be examined (Worth 1989:297). Recent research in Zambia suggests that reciprocity between men and women was the most significant determinant of condom use, above all other variables including education, profession and socio-economic status¹⁰. Thus it is vital to promote more open discussion of sexual decisions between men and women.

¹⁰Personal communication from Chirwa 1995, based on her dissertation on condom use in Zambia.

Conclusion

Some of the problems associated with condoms by migrant workers in Chiawa are not exclusive to Africa. Women in many cultures face relative sexual inequality and strive for their identity through motherhood (Worth 1989:97). Many cultures also find that negotiating condoms in some relationships can jeopardize the relationship: introducing mistrust, undermining intimacy, acknowledging the possibility of other sexual partners, reducing pleasure and denying conception. Correct and consistent use is also universally a problem.

Other problems are more specific to Chiawa and often to other parts of Africa: the preoccupation with sex as a procreative act and the resulting notion of what constitutes successful sex; the acceptance of men's lack of control over their sexual drive; the practice of dry sex in Southern Africa; limited access to effective or popular contraceptive methods other than condoms; the fact that alternatives to penetrative sex appear, at least these days, not be used. The negative associations with condoms, failure to discuss sexual decisions between men and women, migrant labour patterns, alcohol and poverty: these are all factors associated with problems in using condoms in Chiawa and other parts of Africa.

In Chiawa it is evident that HIV infection and change in modern life are forcing the migrant workers we have studied to reassess their sexual activity. They are anxious about being infected with STDs including HIV. To deal with this anxiety some will demand and use condoms for certain types of sexual relationships. Yet use itself is limited and complex, and always has to be renegotiated. There is an inherent conflict between what it is to have good sex, to be a proper man and a proper woman, and daily reality in which they may wish to avoid pregnancy and they do obviously wish to avoid STDs and HIV infection. Condoms are yet another complication in the decisions they now have to make about sexual relationships.

Condoms are an unpopular option. But other than abstinence and faithfulness within marriage, which appear unlikely options for migrant workers, ideally condoms are an effective means of inhibiting the spread of STDs including AIDS. Therefore intervention strategies to promote their use are of the utmost importance and strategies need to be devised which tackle problems of their cultural acceptability. Promotion might be more successful if managed and designed locally. Perhaps the new attitudes to sexual activity, brought about by socio-economic changes in Chiawa, create an ideal opportunity to promote more widespread acceptance and use of condoms.

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