An Exploratory Study of the Behaviors and Practices that may Increase HIV Risk among Pregnant and Lactating Women in Communities in Swaziland

The Elizabeth Glaser Pediatric AIDS Foundation

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BACKGROUND

HIV in Swaziland
Swaziland has the highest HIV prevalence rate in the world, with an estimated HIV adult prevalence of 26%.1 The Swaziland HIV and AIDS epidemic appears to have plateaued at a high rate; in the last decade, national prevalence rates were virtually unchanged, at 23.6% in 2001 and 25.9% in 2009. Women and young girls bear a disproportionate burden of the HIV and AIDS epidemic in Swaziland. An estimated 31% of Swazi women are HIV-positive, compared to an HIV prevalence rate of 26% for men.2 Pregnancy is recognized as a period of increased risk of HIV acquisition for women. HIV prevalence is estimated at 40% among Swazi pregnant women, ranging from 38% in Shiselweni to 40% in Lubombo.3

While strong national HIV counseling and testing and prevention of mother-to-child HIV transmission (PMTCT) programs exist, Swaziland’s primary HIV prevention efforts have historically focused on increasing knowledge, attitudes, and beliefs, mainly through interpersonal communication, mass media, social marketing, and commodity distribution.4 More recently, interventions aimed at social and behavioral change, and newer biomedical approaches (such as medical male circumcision) are being scaled-up.5 Programs addressing key risk factors such as sexual networking, multiple and concurrent sexual partners, alcohol consumption, migration, and discordance in couples are inadequately addressed in the national context.

There are contextual factors that affect pregnant and postpartum women’s risk of MTCT of HIV, including, socioeconomic factors, cultural practices, and perceptions of risk during pregnancy. If women are not aware of an increased risk of HIV transmission during pregnancy, they may engage in more risky behaviors.

Seroconversion risks during pregnancy and lactation

Increased HIV transmission during acute HIV infection
In the weeks after HIV acquisition, the concentration of HIV in the blood and in genital secretions is exceptionally high, resulting in increased infectiousness.6 In a prospective cohort of Ugandan and Zimbabwean women experiencing acute HIV infection, cervical HIV-1 viral loads were elevated during acute infection.7 These findings suggest an elevated risk of transmission of HIV to newborns during pregnancy, labor and delivery, and breastfeeding for women newly infected with HIV during pregnancy.

High HIV incidence during pregnancy
A study conducted by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and the Swaziland Ministry of Health and Social Welfareshowed that 4% of women who tested HIV-negative early in pregnancy became infected with HIV before their child was delivered, (incidence rate of 16.8 per 100 person-years).8 Seroconversion, and the resulting viral surge, elevate risks of mother-to-child HIV transmission making the importance of PMTCT program access and uptake even more urgent.
These findings are supported by growing literature in this field. HIV incidence rates of two to three per 100 person-years during pregnancy and one to three per 100 person-years during lactation were observed in a study population of Ugandan women. While the authors attributed the increased risk to hormonal changes affecting the genital mucosa or immune system in pregnancy, another study suggested that the elevated risk of HIV acquisition could be attributable to sexual behavior.

Sexual activity during pregnancy and lactation
A few studies suggest that sexual desire and intercourse may increase during pregnancy. In one study, almost half of women considered sex during pregnancy as important to keeping their husbands from having sexual relations with other people; sex during pregnancy within a cohort of African women was described as “positive” and “purposeful”. However, pregnancy and post-partum sexual abstinence have been reported, related both to cultural taboos and HIV prevention. A Ugandan study reporting on sexual practices of pregnant or lactating women’s marital partners indicated that husbands of 36% of pregnant women and 40% of lactating women had a current external sexual partner, increasing risks of HIV acquisition and perinatal transmission of HIV if the women seroconverts during pregnancy and lactation. Women are particularly vulnerable to HIV infection during pregnancy and lactation. The vulnerability is related to sex practices and risky vaginal hygiene as well as social and economic factors.

Social and economic factors influencing sexual practices
The literature extensively documents the psychological and health effects of women’s lack of decision-making power, economic dependence, and physical vulnerability in the Southern African context. In Soweto, South Africa, 21% of women attending antenatal care (ANC) reported transactional sex (in exchange for food, clothing, cosmetics, cash, a place to sleep, etc.) in the last year, although no attempts were made to disaggregate sex during pregnancy.

Risky vaginal hygiene and sexual practices.
Risky vaginal practices related to gender expectations have shown to increase women’s vulnerability to HIV infection. Qualitative studies conducted in several countries in Eastern, Southern, and Central Africa have described men’s preference for ‘dry sex’ and ‘vaginal tightness’ as important attributes for sexual arousal. According to one study, the prevalence of dry sex among a cohort of women in Zambia was 86% and 93% in a female cohort in Zimbabwe. Drying practices may include vaginal insertion of a range of substances such as leaves, stones, and powders prior to sexual activity, for the purpose of vaginal drying and/or restoring the vaginal environment to a virginal state. Dry sex is also documented across other countries in East, Central, and Southern African region, including: Kenya, Mozambique, South Africa, and the Democratic Republic of Congo. Dry sex has been associated with lower overall frequency of condom use during intercourse with sex workers.

Drying practices can produce inflammatory reactions and epithelial damage in the vagina, resulting in ulceration, sloughing of the vaginal wall, and necrosis. It is known that genital lesions caused by sexually transmitted infections (STIs) increase the risk of HIV transmission, and it is possible that the
lesions arising from dry sex pose a similar risk. However, to date, no studies have shown increased HIV risk from this practice.

Perception of HIV risk during pregnancy
Evidence suggests that while non-specific HIV and AIDS knowledge is high, while risk perception and nuanced comprehension of specific HIV risks is remarkably low. According to the most recent Swaziland Demographic and Health Survey (2006-2007), only 58% of women and 59% of men demonstrated accurate knowledge about the modes of HIV transmission. In addition, individuals often have mismatched perceptions about partner sexual risk-taking. For instance, in one study conducted among people with gonorrhea or chlamydia infection, patients’ perceptions of partner risk behaviors did not agree with the partners’ self-reports of risk-taking.

Study rationale
High rates of maternal and infant antiretroviral drug (ARV) coverage notwithstanding, pediatric HIV in Swaziland is unlikely to be sustainably eliminated without attention to new HIV infections during pregnancy and lactation. Few quantitative or qualitative studies describe sexual practices in pregnancy and lactation, and none conducted in Swaziland. While high levels of new HIV infections during pregnancy and lactation have been documented in Swaziland, it is not clear how much is due to biological factors, and how much of this risk is related to behavioral factors. In addition, the lack of knowledge about sexual norms and practices during pregnancy and lactation prevents design of effective program interventions. Studying the norms, perceptions, and practices that place Swazi women at risk of HIV during pregnancy and lactation is a critical first step towards designing evidence-based prevention interventions.

METHODOLOGY

Objective
The broad objective of the study is to explore sexual behaviors and practices that may increase HIV risk during pregnancy and lactation among women in Swaziland.

Study aims
The study explored four aims related to sexual behaviors and practices during pregnancy and lactation:

- **Aim 1**: To describe beliefs, communication, and behaviors regarding sex and sexuality in Swaziland.
- **Aim 2**: To understand how sexual practices change during pregnancy and lactation.
- **Aim 3**: To examine knowledge and perceived risk of HIV acquisition during pregnancy and lactation among women and men.
- **Aim 4**: To explore HIV prevention practices during pregnancy and lactation.

Study design
The study used a qualitative exploratory study design. Data were collected from three study populations through focus group discussions and in-depth interviews. Focus group discussions with...
the study population (see below) were used to gather more general information about cultural and traditional sexual norms and practices. Individual interviews with study participants provided an opportunity to explore participants’ sexual experiences during pregnancy and lactation. Focus group discussions were conducted with health care workers to gather an additional perspective and triangulate findings between the study populations.

**Site selection**

Swaziland is comprised of rural, urban, and semi-rural areas. In order to ensure that the study was representative of the country’s regions, the study included one urban, one rural and one semi-urban site. For the purposes of this study, a site was defined as the catchment area surrounding a selected health facility. Data were collected from three EGPAF-supported sites. The urban site, Mbabane PHU, was selected because it is located in a town where the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL)* is implementing work place programs that make it easy to recruit men. The rural site, Ka-Mfishane, was selected because it is remote and the views of the people in that community tend to be traditional. The local clinic staff is all male, which facilitated the process of recruitment at the dip tanks (where men take their cattle to be dipped in chemicals to rid them of ticks and disease). The HCWs (male nurses) accompanied the research assistants into the community to make the appropriate introductions and assist with recruitment at the dip tanks. The dip tanks proved an effective location for recruitment of men because there are many men present and they have to wait for their cattle to finish dipping. This allowed them to allocate extra time to participate in the study. The semi-rural site, Lamvelase, was selected because even though it is in a rural setting, it is close enough to the city, Manzini, and is thus representative of a significant segment of the Swazi population who live in semi-rural locations.

**Study population**

The study gathered data from three populations: pregnant and lactating women ages 16-45 years; men who were 16 years or older; and health care workers from the selected sites. The study team decided that collecting data from these three study populations would provide the most insight into sexual practices during pregnancy and lactation. Gathering data from the three populations allowed the study team to triangulate the findings.

To be eligible for the study, women had to be between 16-45 years, carried a child to full term, and had resided within the selected community for the past six months before the study. The men had to be 16 years or older and have resided within the selected community for at least six months before the study.

Health care workers were recruited from the three selected sites. To be eligible to participate in the study, health workers had to be employed in the maternal and child health unit within the three selected regions for at least six months before the study.

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* AMICALL comprises active members from 12 urban local authorities across Swaziland. Established in 2001, the Swaziland programme aims to build healthy and productive urban communities in the era of HIV/AIDS. Initially focused on advocacy, programme development and technical capacity development of municipalities and urban communities to mount local responses, more recent activities have targeted service development in all 12 municipalities including: prevention, home-based care and other support, voluntary counseling and testing (VCT), feeding centers, and support to orphans and vulnerable youth, including vocational training.
Study procedures (recruitment)

Study participants were recruited from different locations. The women were recruited from both the child welfare clinic and the ANC. Facility nurses were trained on study inclusion and exclusion criteria and were able to identify eligible women who presented for care at the clinic for the study. The nurse recruiters briefly informed each eligible woman about the presence of the study and then referred all interested clients to a study research assistant stationed at the site. The research assistants provided additional information about the study to the women. Women who were interested in the study were asked to provide written informed consent. Those who consented to participate were invited to join the study. Those who participated in the in-depth interviews (IDIs) were interviewed that same day at the site and were given two bars of washing soap to thank them for their participation.

Those who were eligible and agreed to participate in the focus group discussions (FGDs) were recruited over three to five days (length of recruitment was dependent on client volume at the sites). Their contact information was collected and when enough participants were recruited to meet the 6-12 person range for a FGD, the EGPAF study team telephoned the women and set up a day and time for each FGD. Participants who returned for the FGD were reimbursed for their transport costs and provided with refreshments during the discussion. To gain further understanding of different practices among different age groups, and to increase participant’s level of comfort in FGDs, the women study population was also divided into two age groups (ages 16-25 and 26-45). About 10-12 women in each age group were recruited for each FGD. The study team recommended this age range, as women 16-25 may engage in more casual relationships but starting in the mid-twenties women begin to get married and start families and therefore may have a different perspective.

The male group was recruited based on location. In the rural and semi-rural sites, men were recruited from the dipping tanks, which are predominantly visited by men in these areas. A clinic staff accompanied trained research assistants to the dipping tanks to make initial contact with the men and provide an appropriate introduction to them and the study as they are well known and trusted within the community. Recruitment of the male groups from the rural and semi-rural communities was assisted by village heads known in the local language as “Bucupho”. The Bucuphos were oriented on inclusion and exclusion criteria of the study. Recruitment for FGDs was done over one to two weeks depending on the availability of the Bucupho. The IDIs were conducted by EGPAF study staff at a location agreed upon by participants in the community. Some interviews took place near the dipping tanks under trees, while others chose their homes which were near the dipping tanks. FGD participant contact information was collected on study forms and when six to 12 participants were recruited, EGPAF worked with the village head to locate an appropriate venue, day, and time agreed upon by the group for the discussion in the community. The FGDs were led by trained EGPAF study staff and conducted in the community.

In the urban location, AMICAALL had ready access to men in the male dominated industries and community settings and was able to recruit men from job sites within male-dominated industries such as the armed forces, uniformed non-military services, security companies, transportation employment, and factory employment for FGDs and IDIs. Once the men agreed to participate in
data collection, the interviews and FGDs were led by EGPAF trained research assists at AMICAALL’s headquarters. Male participants who met the inclusion criteria were selected on a first come-first served basis. Male IDI participants were given caps or t-shirts to thank them for their participation. Participants who returned for the FGD were reimbursed for their transport costs and provided with light refreshments after the discussion. For both men and women, FGDs took place on weekends, so as not to interfere with work schedules.

The third study population, health care workers, was recruited to participate in FGDs by regional PMTCT coordinators in the selected regions. The regional PMTCT coordinator called the eligible HCWs or informed them via word of mouth while doing supervisory visits. FGDs were organized for this group as the study team wanted multiple perspectives generated in an interactive group discussion. The FGD provided an opportunity to discuss the differing opinions and the rationale behind them. FGDs for health workers were held on weekends at EGPAF offices in Mbabane to avoid disrupting services provided at clinics. Before the FGD began, health workers were individually informed about the study and given the option to consent to participate or decline to participate by study staff. These participants were reimbursed for their transport costs and provided with light refreshments during the discussion.

The data collection instruments focused on understanding the different sexual practices and behaviors men and women engage in during pregnancy and lactation. The FGD and IDI guides used open-ended questions to guide the conversation.

Data collection
Between December 2012 and January 2013, a total of 60 IDIs and 24 FGDs were conducted: 30 with women (15 each from rural and urban) and 30 with men (15 each from rural and urban). Between February and April 2013, 24 FGDs were conducted: six were conducted with health workers (two each from Hhohho, Manzini and Shiselweni), nine with women (three groups of 16-25 year olds, six with 26-45 year olds) and nine with men (three groups with 16-30 year olds, nine with 31+ year olds).

Data analysis and interpretation
The recorded IDIs and FGDs were transcribed and translated into English. A study team of researchers who were in-country and familiar with the culture and clinical practices, and others, based in the Washington, D.C. office conducted the data analysis. After reading through seven transcripts several times, a coding scheme was suggested and circulated among the study team for comments and feedback. Suggestions were made and the coding scheme was revised. The coding scheme followed the main aims of the study protocol; subthemes were also identified and definitions written for each. The codes were entered in the software data analysis program MAXqda. The data were coded by the study team and then compared to ensure intercoder reliability, and adjustments were made as needed.
Ethical review
The study received ethical approval from the Swaziland Scientific and Ethics Committee at the Ministry of Health and from Chesapeake Research Review Inc., a U.S.-based institutional review board.

Study limitations
The primary limitation of the study was that only women accessing health care facilities were interviewed, which accounts for about 84% of pregnant and lactating women in Swaziland. Therefore, the remaining 16%, who may be of different socioeconomic or religious backgrounds, are not represented in this study.

Findings & discussion by aim
The following section includes both the study results and discussion. This section is organized by the study aims.

AIM 1: Describe beliefs, communication, and behaviors regarding sex in Swaziland

Sexual norms and practices in Swaziland
Attitudes towards sex have evolved over time in Swaziland. Traditionally a polygamous culture, modernization has led to a different set of sexual norms. It is interesting to note that nearly all the participants said sex should happen within marriage and that it wasn’t acceptable to have multiple partners, however nearly all described that what was commonly practiced was quite different.

Sexual relationships are very easily initiated with little ongoing commitment required. Of note, none of the discussions touched on how to begin a relationship or when a couple begins a sexual relationship. The ease with which sex is entered into between strangers or acquaintances with no expectation of an emotional connection was perhaps the most telling aspect of this study. The data illustrated that sexual relations were by no means reserved for relationships and people entered freely into sexual engagements with minimal expectations of a relationship to develop.

Sexual practices today in Swaziland are reported to be very tied to the benefit that will accrue to each person. Transactional sex is about more than just money – there are also benefits of having sex with someone that the community has deemed desirable, including improved status. Sexual relationships were overwhelmingly transient and most were based on what benefit the relationship provides – financial support, status, and revenge were all mentioned by participants.

Tradition of polygamy
Swaziland has a strong tradition of polygamy. Social structures and norms have changed dramatically over the last few generations, with polygamy still accepted among the older population. The youngest groups have a very low rate of any kind of marriage. In addition, Swaziland entered the 21st century with the world’s highest prevalence of HIV, which has led, in many cases, to fatalism among some young people about the inevitability of HIV infection.
In this study, participants discussed how marriages have changed over the last generation. Traditionally, men with multiple wives treated each wife equitably and the wives got along. Male heads of households were also able to provide for their children financially and were more apt to marry a partner who they impregnated. Participants frequently stated that men in polygamous marital relationships were faithful to their wives. Participants had differing perspectives on polygamy, with some equating it with having multiple partners. In this study, however, we use the term multiple partners to refer to non-marital partners, not the partners within a polygamous marriage.

In Swaziland, Christianity is the prevailing religion. Christianity promotes abstinence until marriage and faithfulness to your partner, however many Swazis will use the Swazi culture of polygamy to justify having multiple partners, even if they are Christian. Currently, men in polygamous marriages may show favoritism towards one wife, leading to jealousy among other wives, however, this may have also been the case in the past. Furthermore, a man may now also take another wife without introducing her to the other wives. Some participants claimed that polygamy was traditionally practiced in secret; others asserted that polygamy was socially acceptable and practiced openly.

The interviews highlighted that multiple partners were not seen as a problem in the past, as polygamy was a socially accepted practice, but now, women are not as comfortable with the practice. Several participants claimed polygamy was traditionally practiced at the exclusive will of Swazi men. Currently, it is common for women to take multiple partners as well.

A few participants expressed financial concerns about having additional children to take care of should they marry all partners whom they impregnated. Among younger generations, poverty is an important factor when considering whether to have multiple wives.

Interestingly, several participants correlated the practice of polygamy with HIV transmission and stigmatized the practice. In contrast, some participants claimed their forefathers did not have multiple partners external to the polygamous marriage; this claim was often used to support the lack of HIV prevalence among older generations.

“I think polygamy didn’t expose people to HIV. Because with polygamy, the man has three wives and he is faithful to his three wives and the three wives are faithful to the man... polygamy is not a problem but multiple partners is the problem.” - health worker in FGD

Overall, it is clear that polygamous marriages continue to exist in Swaziland, whether formally or informally. However, the character of marriage seems to have changed into one where multiple partners is an accepted practice even if a man is married.

**Attitudes towards sex, relationships, and marriage**

In Swaziland, sex is encouraged as an important part of married life. Churches and family members, particularly mother-in-laws, promote and reinforce the importance of sex. These groups believe that a woman should not withhold sex from her husband. When one member of the relationship is unhappy with the sexual practices in the marriage, the family becomes involved. All participants stated that the main purpose of sex is to produce children and “build your home,” and that if a wife
does not get pregnant, it is acceptable for the man to seek sexual relationships elsewhere in order to produce children. Men also mentioned that sex is acceptable in a serious relationship or when people are in love and necessarily strictly in marriage. However, among older age groups, pre-marital sex was not considered appropriate, and having sex for fun was thought to be more common among the younger age groups.

All groups agreed that they see a lot of short term relationships or casual relationships. Often the youth were cited as the ones engaging in these types of relationships. People will sleep together for fun or because the man “lusts after the woman,” not because they are in love and want to get married. As one participant stated,

“In my community, engaging in sexual intercourse is like the fashion” – male FGD participant

Some participants mentioned sleeping with someone for a particular reason (e.g., financial gain, ability to brag to friends) then leaving the person once they got what they were looking for. Some of these short term relationships are also seasonal, such as during “marula season,” when drinking is common among all demographic age groups. Marula season is a traditional festival or celebration where members of the community gather together and harvest rip fruits, brew and drink the alcohol that is made through the fermentation of the marula fruits. One-night stands are also common. Alcohol was cited as a common influencer in both short-term relationships and one-night stands.

Long term relationships are less common, but do exist. Getting tested for HIV is seen as a sign that a couple is in a steady relationship. Some couples also live together like a married couple without getting married. This scenario appears to be most common when a man impregnates his partner. The traditional practice of getting “taken” (marrying a couple after the woman stays the night at the man’s homestead) was mentioned as still occurring although less common than with older generations. Divorce rates appear to be increasing; however it is still not a common practice. Homosexual relationships were mentioned but were described as rare, lasting a very short time, or not occurring in the participant’s community.

Participants also commonly reported older people becoming sexually involved with younger people. Usually this involved older men and younger women, but sometimes older women become sexually-involved with younger men. Usually this scenario involves financial gain for the younger partner.

Additionally, participants mentioned that rape (men raping women) occurs, but is not considered acceptable behavior. Men fighting, or even killing, each other over a woman was also mentioned, and was often linked to alcohol use.

Several participants talked about grade school youngsters engaging in sex frequently, both with teachers and with their peers, and that this was dangerous for them and for their communities. Participants said that there was no socially acceptable way for younger people to get to know potential partners.
“So I won’t bring different girls at home because I know my father will kill me if I do that not that she is a wife, another thing that is killing us is our culture it does not promote this.” - man in 16-30 FGD

Traditionally, family members instilled their children with information regarding sex, how children are conceived, and the importance of maintaining one’s virginal status until marriage. Currently, this custom is no longer widely practiced. Discussions regarding sex were traditionally conducted in secrecy; nearly all participants agreed that sex is more widely discussed in the open today. Young people receive information about sex from their peers, television, and health clinics. Television was seen as a major influence in sexual practices. Some participants reported that they got most of their information from “blue movies” (pornographic movies), and after watching these “blue movies”, they wanted to try the practices they saw.

Sexual decision-making
Participants reported major changes in decision-making about sex. Traditionally, marriages were arranged by family members and Swazis regularly practiced cultural traditions that promoted virginity/abstinence until marriage. These customs have faded with time and are not widely practiced today. Several participants confirmed that traditionally, men and women did not sleep in the same bed or even the same house; additionally, men often initiated sex by using a stick or a probe to signify that he is ready to have sex. Teenage pregnancies outside of marriage and premarital sex were not common among older generations. Many participants reported both
practices are widespread today and regarded the shift in social acceptance of these practices with disdain.

Culturally, the decisions about sex (e.g., who has the right to initiate sex, when to initiate, and condom use) lies with the man. He is considered the head of the family, supported by the Bible, and makes all decisions, including about sex. If a woman does not satisfy her man, then he will often seek other women to make him satisfied sexually. Some participants discussed that the decision should be with both partners, although in reality it is usually the man in control. If a man is paying dowry, then he automatically gains certain rights over the woman. Sexual power was also linked to the person with most money or education, but not necessarily always the man. Because the wife is unable to leave, she may have less power than her husband’s secret lover.

The idea that the man has the power in more traditional families, while more modern families share the power, was also mentioned. It is becoming more common for women to be allowed to initiate sex and make some decisions about it. Some men cited that lack of decision making puts women at higher risk for HIV. In addition, women often get wrongfully blamed for bringing diseases into the household. Overall, the men seemed divided about the idea of allowing women more control when it came to sexual issues. It is increasingly common for decisions regarding how, when, and where to have sex to be reached jointly by men and women. In addition, modern women often initiate sex and discuss with their partners which sexual positions they would like to try to be more fully sexually satisfied. Men and women are more likely to discuss sex as it relates to family planning as compared to previous generations. Young people of today’s generation were reported to not take the time to court and romance a potential partner, but instead network briefly before engaging in sex.

Discussing sex between partners is a difficult practice for couples. The men were usually cited as having a harder time discussing sex with women. The male participants felt that husband and wife should communicate about their sexual preferences, which would lead to happier relationships, and that men should teach their wives what they like from the beginning. One male participant suggested that men need more empowerment and education; too much focus has been on the women, who are not as effective as men in making decisions.

The men expressed that men must have sex with women to give some sort of claim over her, and that men always need to have a girlfriend. They also stated that men are more likely to have sex for fun, while women want love. Therefore, men would lie about being in love, just to convince a woman to have sex. Also, the male groups mentioned that if a man does not satisfy his girlfriend, it is thought that she is sleeping with other men.

Men are seen as the one that are looking for sex; all participants discussed men always being “horny”, while women are more in control and more likely to not want sex. One women’s focus group (ages 26-45), brought up the idea that women can be “lucky” if a man gets sick with a disease like diabetes or tuberculosis, because then he will want sex less. Some men believed that if women wore tight clothes or short skirts, the women are tempting them and that the women want to have sex. This then also leads them to believe that she is looking for sex with any man.
Both male groups also discussed common sexual practices. Most felt that oral sex has become common, while there were mixed responses about the commonality of anal sex. Anal sex was considered a more taboo practice that either homosexuals or people in jail engaged in. Some felt that women liked it more than men. Foreplay was also discussed in the male groups; participants mentioned that men needed to know more about foreplay, and that it is really only practiced by committed couples that do not have to be secret about their relationship. Common methods of birth control mentioned by the men were withdrawal, condoms, and family planning methods at the clinic.

**Multiple partners**

The discussions on multiple partners brought out many of the complexities that exist within the social norms in Swaziland. Against the background of a polygamous culture, where sex is valued and is seen as the prerogative of the man, social structures have evolved so that many participants felt there is little regard for monogamous relationships. While this was reported among all age groups, the difference in attitude between the genders was most striking in the younger groups. Most participants across the demographic groups mentioned that multiple partner practices are very common in the communities among both men and women, regardless of relationship status or type of relationship (short or long term) -- many participants had concurrent partners. In long term relationships, multiple partners became more commonplace once the couple were not particularly satisfied by their relationship anymore (e.g., not being sexually satisfied by the other, woman unable to get pregnant). The groups often referred to multiple partners as “secret lovers.”

Most of the older group participants agreed that both men and women should only have one partner. A commonly cited reason for this was because of diseases like HIV. Sources such as the church, community health workers, and radio promote being faithful to your partner; however, few families discourage both men and women from taking multiple partners.

Among older groups, the attitudes about multiple partners were related to reasons why a man might go outside marriage. If a wife is unable to have sex with her husband due to sickness, then the man will seek sex with another woman. If a woman is unable to bear children, then it is encouraged, often by his family, to find another sexual partner that will give him children. This is also acceptable behavior if the wife does not bear him male children. Sometimes the wife herself will encourage the husband to find another sexual partner if she is unable to have sex or bear children. This way she will know the other woman and feels she could share the man more easily.

Several participants across all groups commented that Swazi culture makes it acceptable for men to have multiple partners and is even considered as a point of pride for men. A man may even receive praise for having more than one partner while a woman will be called names such as prostitute and thrown out of her home.

“A woman is not supposed to do that because men are doing it as it is normal for them to do and they are called ladies’ men. As a woman you are called a prostitute when you have other partners, men are free and they brag about it saying it does not mean that if they are committed to you they are not supposed to go out with another woman you see. -- I wanted to add that Swazis by nature
like to have more than one girlfriend at a given point in time ... This is coupled by the idea that a true Swazi man will be seen by having a couple of lovers so that we can recommend him as a great and true Swazi.” - man in 16-30 FGD

Restrictions on sexual relations were clearly stronger when discussing women’s behavior. A woman is expected to be faithful to her husband and submit to sex with her husband even if she knows he is sleeping with other women. Even though many participants believed that “under no circumstances is a woman allowed to have more than one sexual partner”, they reported the practice to be quite common.

The attitudes of the young men and women about sexual behavior tended to be much more casual, and centered on having sex for fun and status.

“I want to add on that, its fashion that like cool to have more than one sexual partner across on each both males and females” – health worker in FGD

Among younger participants, the frequency and number of sexual partners has led to a social shift towards concurrent or sharing partners.

“There is nothing serious anymore, we are sharing.” - Man in 16-30 FGD

The ease at which sexual relationships are entered into was a lively topic of discussion, especially among the younger groups. The list of places where one might meet a new sexual partner were extensive and included house, plaza, clinic, kombi, bar, church, bathroom, car, in shrubs, and friend’s house.

“Maybe I will have sex with someone at seven and then at nine I will have it with someone else, same thing at six I will be with a different person. I feel like I am playing my tricks.” - man in 16-30 FGD

Younger groups often discussed sexual partners amongst themselves, and recommend good partners to others. In addition, being known as a good sexual partner contributes to social status. The men mentioned that if they know a friend is having sex with a woman, then all the men in the community will want to have sex with her. However, contrary to this, another male participant mentioned that virginity is valued and a man would desire to take the girl’s virginity.

“We do it for status, so that you can act big with your friends, but... things have changed because even the woman wants to brag about it: to say ‘I had sex with this and also that one’. They are tired of men having sex with them now they want to be the one in control when it comes to sexual issues.” - man in 31+FGD

“Let me make this clear, girls don’t get to a relationship with you when they know that you don’t have a girlfriend. Others get in a relationship after knowing that you had different affairs. So as we know you as young men, when you want a girl, I will go and have sex with different people. She will get to know that I had sex with different people, she will say “eish, what excites those people” you see. So in that way she will get closer and I will have sex with her.” - man in 16-30 FGD
Transactional sex

Both men and women were said to engage in multiple relationships because some relationships will give them a financial benefit, such as money, food, clothing, tuition, or rent.

“One thing you can [use to] get a woman easily is food. When there is food, no matter what, she will go.” – man in 31+ FGD

The most common perception voiced across all groups was that transactional sex happens often in Swaziland. A few participants disagreed with this, and said that it is not common, and they do not see it occurring in their communities, but know it exists elsewhere. Transactional sex is seen as a major contributor to multiple partner practices, as women will take a sexual partner to provide for each financial need in her life. For example, she will sleep with one man that pays her rent, another who buys her food, and another to provide her with transportation money. However, some participants said that this wasn’t always the case, and that some women simply do not want to pay for those needs. Participants stated that when a man runs out of money or tires of the woman, the woman could just find another man to replace him. For the most part, transactional sexual relationships are kept secret and are short term.

Both male and female participants acknowledged that when men are paying for sex, they have full control as women are generally unable to negotiate condom usage and are more vulnerable to abuse in this situation. One man explained that you just needed to offer more money to the woman in order to not use a condom.

Female participants often used the term “love” when discussing the man providing her with money. In order to earn a woman’s “love”, a man must give her something --multiple men used the analogy of needing to bait their hook for fish (“tibanjwa ngaletikudlako”). The health care workers and both male groups discussed that women were attracted to any man that appears financially wealthy, and that is all that women care about in a relationship. If a man obviously has money then he will attract lots of women, including those who are married as they believe he will be able to provide her with additional financial resources. The men discussed that to engage in one-night stands, they needed to give women some sort of incentive. Some men mentioned they were able to pick up women at bars easily by buying them drinks.

The health care workers and male group identified transactional sex as a strong risk factor for HIV; it increases the number of sexual partners, and people may not use condoms as men can pay more for not using one. Alcohol is often used during these transactions, which may impair judgment around safe sex.

Commercial sex

Mahhala (in Matsapha along the Manzini highway), was frequently mentioned as a common place for commercial sex. One participant mentioned that, in addition to Mahhala, commercial sex workers were in other communities too. South Africa and Logoba were also cited as places with many prostitutes. Commercial sex is also considered to be common in professions where people live away from home, including: nurses, teachers, and police officers. Women are perceived to be at higher risk for HIV because women can be sex workers, while men are generally not sex workers, and therefore have a lower perceived HIV risk.
The male groups gave a mixed response regarding whether they prefer commercial sex or not. Some said it was better because prostitutes are more sexually satisfying, or because commercial sex is less stressful since you can easily send the woman away if needed. A handful of men felt that paying for sex was not ideal, but that it was better than not having sex, while other men were very against the idea of paying for sex. These men tended to want a relationship with a woman who cared about them, not just their money. In addition, not engaging in commercial sex was mentioned as a sign of maturity by one male in the younger age group.

Cheating

There was extensive discussion of cheating, especially among the older age groups, who tended to be in long-term relationships. The topic resulted in mixed and varying discussions. The health care workers felt that women are good at keeping cheating a secret. Cell phones were often used, as they conceal cheating activities well.

Some participants believed that men are aware their wives/committed partners have additional sexual partners but choose to deny it, as they want to believe their woman is perfect and faithful. The spouse often eventually finds out about the additional partners and may react violently. Women mentioned that they check their husband’s/partner’s cell phone to find out if he has been talking to other women. Another woman also mentioned that she sees evidence of another woman (e.g., hair, belongings) at their man’s residence when visiting. In addition, wives are often unaware of the other children their husbands may have with other women in different locations.

Men will become suspicious of their partner for a lot of reasons. If a woman initiates sex, she may make her partner suspicious about her activities when he is not around. However, if she seems uninterested, then he will think that is because she is having sex with someone else. To prevent their wives from cheating on them, men may leave their wives at their family’s homestead so that the family members can keep an eye on her.

“At times it can happen that a man who works far away from home can leave home and eventually decide to go back home if transport is scarce and can find you with his wife inside the house. In that case you are in danger because the man can actually kill you for stealing his wife. You may find that you can get injured for no good reasons.” - man in 16-30 FGD

Even though the consequences of getting caught are often severe, such as violence or divorce, all groups mentioned that cheating would often result in the partner cheating themselves (revenge cheating).

“Maybe we have said we will meet at the park with my man, and when I go to the park I find him there he is with someone else and I also get someone. When we go back to the house he will beat me for that guy I was with, and the guy I was with will also beat me for not telling him that I have a partner. He will beat me and then we will break up after that” - woman in 16-25 FGD

“[Cheating] happens for many [reasons] and it can destroy your relationship. It happens that your partner ends up leaving you. There are so many women we have
seen leaving their marital homes and their husbands having new partners” - man in 31+

FGD

Involvement of community in sexual practice
There were disagreements among participants about the role of elders/community leaders in giving advice about sexual practices. These disagreements were mixed across the demographic groups. Some said community elders appear to give some advice about sex and pregnancy, while others said that is taboo to discuss sex at all. Community members, particularly the older women, were mentioned as often gossiping about other people’s sexual relationships within communities. Whether or not youths felt they should listen to elders in the community differed by community.

Church leaders were also cited as potentially having influence on sexual practices, and promoting abstinence and faithfulness. Country leaders, however, are seen as being hypocrites that promote abstinence and faithfulness, but do not practice it themselves.

AIM 2: To explore sexual behaviors and practices that may increase HIV risk during pregnancy and lactation among women in Swaziland

Using insertion of items to prepare for sex
The data suggests that many people are aware of methods that make the vagina appear and feel more “virginal”, but these methods are not that common in practice. Some participants believed the drying methods were more frequently used among sex workers. The most common agents used to achieve this appearance included insertion of snuff (tobacco), but also items such as ice cubes, tiger burn, limestone, unknown chemical agents, and weeds were also mentioned.

Additionally, a couple of women mentioned inserting fingers to cleanse the vagina. Items used for cleansing included cold water, Dettol, and limestone. However, the idea of “cleansing the vagina” appeared to be much less common. Some women believed that cleansing the vagina was not good as it takes away pleasure from the man during sex and because the vagina already cleans itself naturally.

Sex during pregnancy
All participants agreed that sexual relations change during pregnancy, but there were different opinions about how sex changes. Some thought that women’s sexual desire increased during pregnancy, while others thought it decreased. Health care workers and men felt that women are very sexually active during the early stages of pregnancy, especially before the pregnancy is visible. The men often described a woman’s blood to be “hot” at this point and that they needed to have sex with her or she would find someone else to take as a sexual partner.

Some men discussed really enjoying sex while their partner is pregnant. Men frequently stated that sex was “nicer” when a woman was pregnant and some said women’s sexual performance was best during their pregnancy. However, a few men mentioned that they would be less interested in sex with their pregnant partner, and would only engage in sex to please her. In addition, some of the women participants also mentioned only engaging in sex with men to please them and to ensure that they didn’t find another sexual partner. Some women said that men sometimes preferred sex during pregnancy as they did not have to use family planning methods. However, this was also
mentioned as a challenge related to HIV prevention, because men may contract diseases from other partners and then infect their pregnant partner.

Health workers reported that pregnant women often need to be treated for STIs, indicating that they are sexually active during pregnancy. Health care workers felt that it is common for a woman to be infected with HIV while pregnant, especially during the first and second trimesters, when she is more sexually active. They also stated that if a woman tests negative she often believes she is “safe” and will not decrease risky sexual behaviors.

Both men and women discussed the need to “grow” the baby by having sex while the partner is pregnant (“kukhulisa umnftwana”). This belief could lead to women having sex with other men if her partner is not around to “grow” the baby. However, other conflicting cultural beliefs state that if a pregnant woman sleeps with a man other than her husband she will have a miscarriage or the child will take on features of the other man.

All participants agreed that later in a woman’s pregnancy (after six months), the woman’s sexual interest and activity decreases, especially in the month before birth. There are also cultural beliefs surrounding late-term sex. One belief is that if a woman has sex too late in her pregnancy the baby will come out “dirty.” Another common belief is that having sex too close to delivery will result with the baby being born with sperm on it or that sperm will fill the delivery canal and make delivery difficult.

The women participants and health workers generally felt that a pregnant woman would only have multiple partners in certain circumstances, such as when she is unsure of which man impregnated her, or when she breaks up with the father and is looking for another man to take responsibility of the child. Due to high rates of poverty, pregnant women often attempt to find partners that could provide them with money and food or supplies for the baby. The men felt it was more common in this situation for a woman to have multiple partners.

The need to find a financially stable man can result in the woman not telling her partner she is pregnant with another man’s child. If there are paternity concerns, community elders are brought in to decide if the baby is part of the family. Men also discussed how they may leave their primary partner if she becomes pregnant if finances are already constrained. In addition, some men stated that if a man’s casual partner becomes pregnant, he would prefer to send the baby away so his primary partner does not find out.

Men and women generally believed men sought additional partners during pregnancy. One common traditional practice involves sending a pregnant woman away to her family during the later stages of her pregnancy, which could lead to men seeking additional partners during pregnancy. While men may seek additional sexual partners during their primary partner’s pregnancy, it is rare that a man will intentionally seek out another pregnant woman to be intimate with.

**Sex during lactation**

Overall, participants generally agreed that sex was less frequent during lactation; this was often attributed to the baby taking up so much of the woman’s time and energy. Many participants
commented on men’s lack of interest in having sex with their lactating partner. The most common response was that women “smell like milk and are dirty”.

“...he left me in the morning wearing the same clothes and when he comes back in the evening he will find me still the same. I have not even taken a bath yet I am breastfeeding (laughing) no man will be happy with that although he won’t say it” – woman in 16-30 FGD

The participants frequently mentioned that men take additional partners while their partner is lactating.

“It happens that some men are traditional Swazis. They will tell you that ‘since the baby is still very young, I will visit you after two or four months’ so he might go and get additional women’ - Woman in the 30+ IDI

Health care workers start educating couples about family planning around six weeks, since that is when most couples start engaging in sex again post-birth. Some health care workers commented that women might take additional partners while breastfeeding, primarily if she had an additional lover before the pregnancy or if the husband is taking on additional partners and is uninterested in sex.

Cultural practices discourage sex for some time after child birth – known as “Uyatinta”. Traditionally, the time recommended to wait before resuming sex after birth was six months, but now couples typically wait six weeks. Another traditional belief is for women to wear a wooden necklace (“Ematinta”), which will fall off if the woman engages in sex too soon. It is believed that if the parents engage in sexual activity too soon, the baby may become sick and stunted.

Multiple concurrent partners during both pregnancy and lactation
One of the main drivers of HIV in Swaziland and several other countries is multiple concurrent partners. This is an issue especially during pregnancy and lactation. Some men were less attracted to their pregnant/lactating partners and would look for sex elsewhere, while for others, the women themselves were pushing men away from sex during pregnancy. The smell of breast milk was cited as a deterrent of having sex with their partners while some mentioned that when their partner delivers, they will look for sex elsewhere until about three months post-delivery.

“I have had three partners during my partner’s pregnancy” - man in 30+ FGD

“....What I can say is that it is the milk when she is breastfeeding I don’t know maybe it happens to her but she had smell that was not familiar she smelled different, I was not sure if it was the smell from the baby or her because we had the baby around but it wasn’t that much” - man in 16-30 FGD

However, some men mentioned that pregnant women are attractive for sex and therefore see no reason of getting other partners.

Practices in early childhood
The woman has traditional medicines to put on her breasts when travelling to avoid infecting the baby during breastfeeding. Women may also use traditional medicine to protect the baby from swallowing the poisonous water in the mother’s womb. Older people may also encourage the
mother to use traditional practices on the child such as using medicine to clean the colon (“umutsi wenyoni”), sending the child to Holy Spirit Church (“enyonini”) or being sent for incision (“kugata”).

Once the child is born, there is a traditional belief that the baby must be protected from evil spirits (“kuhabula”) that the child could inhale during its first month, so the mother does not go outside. Herbs may be burnt (“kubhunyiselwa”) to prevent the inhalation of evil spirits, and each homestead would have their own unique herbs (“tinyoni”) and burning herbs (“tinyamatane”) for African magic (“muti”). These practices are said to protect the infant from witches (“tinyanga mthakathi”). Women may also embark on a long journey with “botuhba”, a traditional herb smeared over the newborn’s forehead. Participants felt these practices are becoming rare. Some participants claimed that if a child is born at the clinic, the nurses will use modern medicine first, but if the child is born at home, herbs will be used before taking the child to the clinic.

AIM 3 – To examine knowledge and perceived risk of HIV acquisition during pregnancy and lactation

Knowledge and understanding risk of HIV acquisition during pregnancy
Risk perception and nuanced comprehension of specific HIV risks are inadequate. According to the most recent Swaziland Demographic and Health Survey 2006-07, only 58% of women and 59% of men demonstrated accurate knowledge about the modes of HIV transmission.1

A positive observation in this study was that most people expressed that women are at higher risk of acquiring HIV during pregnancy and lactation. Interestingly both young and older women perceived that women are at a higher risk of acquiring HIV during pregnancy and breastfeeding, while men of both young and older age groups felt that men and women are at equal risk of acquiring HIV during pregnancy and breastfeeding. Another positive observation was that some young men understood that infection can happen during the window period.

The understanding of the risk for HIV transmission seem to be similar for both women and men participants in both FGDs and IDIs. Lack of consistent use of condoms by men, concurrent STI’s, having multiple sexual partners during pregnancy and breastfeeding, and sexual violence are among the risky practices for HIV transmission mentioned by both women and men participants. Almost all health care workers mentioned that women are more receptive to health education and messages HIV transmission risk and HIV prevention than men. Moreover, health workers mentioned that men believe that condoms are not intended for trusting relationships with primary partners.

As in many African societies, in Swaziland, the power imbalance between men and women puts the women in a difficult position to protect themselves from HIV. In this study, most female participants mentioned that their partners refused to use condoms, which puts them at risk of acquiring HIV and STIs.

“Like when you say let’s use a condom during pregnancy... He will say ‘you are pregnant because we didn’t use a condom, so let’s continue’” - woman in 16-25 FGD
Knowledge and understanding of risk of HIV transmission to the unborn child

Both men and women in all age groups had an understanding of the risk and mode of HIV transmission to an unborn baby. Most study participants indicated that HIV can be transmitted to the baby during pregnancy, labor, and delivery through exchange of blood and body fluids and through breastfeeding. Few women over the age of 30 worried about infecting their fetus. Despite the knowledge on the risk of transmission, some women are afraid of finding out their status and thus seek out ANC clinics that do not require HIV testing.

Health workers seemed to inform pregnant women and breastfeeding women on risk of HIV transmission to an unborn baby and infants post-delivery. Although women are largely receptive to the messages, they do not implement or share what they heard to their spouses, and do not take the necessary precautions (because their male partners are not receptive). Some women stated that their male partners felt that HIV cannot be transmitted to children.

Knowledge and understanding about HIV risk reduction during pregnancy

Participants reported that a pregnant woman generally wants to do all that it takes to protect her baby. Once the baby is born, however, the baby belongs to the family, and thus the baby’s health needs are dictated by paternal family norms. Grandmothers and mother-in-laws have the upper hand in decision making of both mother’s and baby’s health care issues.

Interestingly, most women and men of both age brackets identified use of condoms, faithfulness, abstinence, use of ARVs, and exclusive breastfeeding as practices that reduce HIV transmission during pregnancy and breastfeeding for both women and their babies. In addition, a few older women had adequate knowledge of CD4 counts and the importance of medication adherence to reduce HIV transmission. Adequate knowledge of HIV treatment and adherence by some women may not be translated into practice as their partners may not support these practices. Some women mentioned that knowing one’s HIV status early and delivering in health facilities are good practices that would help prevent HIV transmission during pregnancy, delivery, and breastfeeding.

Most health workers mentioned that they educate both women and men on the methods of reducing and preventing HIV transmission during pregnancy, delivery, and breastfeeding. They observed that while women are generally receptive of their preventive messages, men are generally not. Health workers also mentioned that men are not as accessible and thus are not aware of the preventive services.

Moreover, some health workers emphasize that pregnant and breastfeeding women present late to health facilities for care and thus compromise the benefits for early intervention which would maximize efforts to reduce HIV transmission.

“A long time ago there used to be community nurses. They would take a car and go to the communities [to provide HIV education] but those projects have since died... maybe it’s because our numbers as health workers have gone down or the strategies for accessing communities are no longer functional. But sitting in the health facilities, we are not winning the battle, be it tuberculosis, be it HIV, we are not winning it.” – health care worker in FGD
Aim 4: To explore HIV prevention strategies during pregnancy and lactation

Condom use
In this study, all participants discussed lack of condom use as one of the issues that puts pregnant and lactating women at risk of HIV acquisition. Most men interviewed seemed to understand the importance of condom use during pregnancy and lactation. However, it was evident from health care workers’ and women’s interviews that actual condom use during sex is not being practiced by most couples.

Several reasons were cited for poor condom use during pregnancy and lactation. Some men saw no reason for using a condom when the woman is already pregnant, as they felt condoms are mostly important in preventing unwanted pregnancies. Women also felt that men are the only ones who have the final say regarding condom use, and most of the time they do not want to use them. Using condoms was also seen as inducing a feeling of mistrust within the relationship and seen as negatively affecting sexual satisfaction.

“I didn’t like using condoms. The problem with condoms is that it is not a natural thing and so the mind doesn’t really trust that the condoms will make you satisfy her in bed which is why you then feel it should be put aside so that you can really show her how much you love her, which then results in the inconsistent use of condoms...condoms are not a natural thing.” - man in 31+ FGD

There were also myths associated with use of condoms during pregnancy - some thought that using a condom would affect proper development of the baby.

“When I was pregnant we were not using condoms because the baby must be developed and I don’t know how this happens but that made it a challenge for me to avoid HIV.” - woman in 16-25 IDI

This study suggests that condom use during pregnancy and lactation is still a challenge for most couples. Most of the reasons described are not particular to pregnancy and lactation but are general issues and myths that need to be addressed in a general context. Some participants suggested the need to ensure communities are educated and empowered, so that they understand the need for condom use.

Testing for HIV
HIV testing and counseling has been identified as one of the key strategies for HIV prevention, care, and treatment. Chances of HIV transmission and acquisition are high if one does not know their HIV status. Testing and counseling uptake among pregnant and lactating women has always been high in Swaziland. However, very few partners of pregnant or lactating women receive testing and counseling, hampering HIV prevention strategies. In this study, participants consistently mentioned unwillingness of men to get tested for HIV.

“......even if the couples have come you will find the man would just say the woman should test; he will want to know the status of the woman and not him.” - health worker in FGD
Several barriers that affect uptake of HIV testing and counseling among men were discussed by most participants. Some of these included: fear among men around knowing their own HIV status; men’s unwillingness to go to a health facility; and men assuming their HIV status is the same as that of their partner.

“Clinic encourages [partner testing] but our partners say “as you are clean, it means I am also clean. They don’t usually come.” - woman in 16-25 FGD

Lack of testing among men predisposes their partners to HIV acquisition. In this study, men agreed that they use the woman’s status as theirs and so if the woman is negative, the man also assumes he is negative.

“Men use their wives as a yardstick when it comes to HIV testing” - man in 31+ FGD

Disclosing one’s HIV status was discussed as another issue affecting HIV prevention. Several men and women in this study mentioned HIV status disclosure was not an easy thing especially for women testing HIV-positive.

Some recommendations made by the participants to improve male partner testing included: provision of more education and information to men through cultural forums like “kudliwa inhloko majaha”, community outreach to reach men for HIV testing, and counseling, establishment of laws that force men to know their HIV status in order to get married/have children.

Circumcision

Male circumcision is another proven HIV prevention strategy. Though male circumcision does not directly reduce HIV transmission from men to women, men who are circumcised are less likely to contract HIV, which will indirectly benefit their HIV-negative partners. In this study, participants mentioned that men generally do not want to be circumcised. Participants also felt that circumcision encourages non-condom use among men.

“I think what has come out as a problem here is that, there’s this circumcision thing which people has made people to think they are now walking condoms...and it is very rare for them to get infected with the virus.” - man in 16-30 FGD

Though the issue of circumcision is not particular to pregnancy and lactation, the study results highlighted a lack of understanding around circumcision and HIV transmission, therefore more needs to be done to educate and mobilize men on circumcision in Swaziland.

Practices at health facilities

Another interesting finding of this study was the belief that pregnant women are at risk of HIV acquisition due to “unhygienic practices” at the health facilities. Women believe that because of staff and supply shortages, nurses will cross-infected them with HIV during labor and delivery

“If three women are delivering at the same time with one nurse helping them, when is she going to change the gloves? I am just making an example on things that usually happen. We don’t think about them. We think about it when you see that she is still not changing the gloves. She is moving up and down with the same gloves...”- woman in 26-45 FGD
RECOMMENDATIONS

Health education targeting men

One of the results of the study was the need for strengthened health education targeted towards men. The study findings and current literature highlight that the majority of health information shared with women at the facility does not reach the men. The study also found that many men refuse to receive HIV testing and are therefore not receiving the necessary health information to protect their own health, their partner’s health and their baby’s health. Health education campaigns which target men in the community and provide HIV services could help address this lack of knowledge and facility service utilization. Participants in the study commented that previous health education campaigns targeting men have been successful in their goal of encouraging men to get tested for HIV.

A variety of health education messages were suggested for men. Some participants recommended that men need to be encouraged to take responsibility for their own health, in addition to that of their partner and family. Men need to receive more information about the benefit of knowing their HIV status and taking control of it. Both men and women stated that many men believe that their partner’s HIV status directly determines their own HIV status and therefore believe that they do not need to go to the clinic and test, that they will be able to learn their HIV status from their partner’s
HIV status. In addition to the messages about the benefits of getting tested, men also need to understand the benefits of starting treatment early.

Messages that focus on the benefits of using condoms during transactional and commercial sex should also be shared. All groups discussed the frequency of transactional sex; however condom usage within these relationships was not frequently mentioned. Messages about the benefits of using protection need to be focused towards men. Often it is the men who have control of if and when a condom is used, and need to understand that using a condom benefits them. The data illustrated that some men do not know how to use a condom and some men understand that circumcision can prevent HIV acquisition. Therefore, more information needs to be shared on how to properly use a condom and the risk of HIV transmission even when circumcised.

A finding in this study noted negative Swazi cultural associations of what it is to be a “real man.” Men stated that current beliefs around what it means to be a real man include having unprotected sex with many partners. Therefore, one recommendation is to strengthen dissemination of messages that promote ideas that “real men” use condoms and protect their health and partners’ health. Messages about being a “real man” could also be used to decrease the number of sexual partners.

Intensified campaigns need to target men and provide more information about sex and pregnancy. Findings highlighted that both men and women lack understanding that women are more susceptible to HIV acquisition while pregnant. Therefore, messages need to explain how additional partners during pregnancy and breastfeeding put both women and babies at a higher risk of HIV acquisition. Participants discussed the need for these health education messages and information to target men directly in the community, workplace and through media campaigns.

**Health education targeting women**

In general, women were much more knowledgeable about health care matters than men; however, there were certain topic areas that need reinforced messaging

One of the main areas in need of reinforced messaging is the importance of receiving repeated HIV tests during pregnancy and lactation. There needs to be a greater understanding that HIV infection can occur at any time throughout the pregnancy and lactation among women. Women also need more education on the importance of starting treatment right away.

Most women were not aware that they are at increased risk of HIV transmission during pregnancy. Messages on the importance of using condoms while pregnant also need to be shared, as most women did not understand why they would need to use condoms, if they were already pregnant. Myths that condoms are only needed for family planning should be dispelled.

There is also a need for improved messaging on when it is safe to resume sexual activity post-delivery. Traditional practices encourage a longer waiting period (three to six months), which can result in male partners taking on additional sexual partners, and putting the mother and infant at
risk once sexual activity is resumed. Women should receive counseling at the facility around when it is safe to resume sexual activity.

Additional messages need to be shared at the facility about the dangers of some of the traditional practices on a newborn. Participants reported practices such as cleaning the baby’s colon, incisions or tying cow dung to the umbilical cord. These practices are dangerous to the child and new mothers need to be warned about the potential consequences of these actions.

**Health education targeting youth**

Health education targeting youth and providing them with basic sexual health information is needed. Study participants reported youths being sexually active as early as age nine. Elders and parents discussed challenges providing sex education to youth as they feel that most youths are better educated than they are and that they show less respect towards elders than previous generations. Youth are also uninterested in listening to their elders, as they feel that they do not understand new generation functions (e.g. social media).

If youth are uninterested in learning about sex from their elders, then sexual health education needs to target youth through a forum they will respect such as youth clubs, improved sex education at school (at a younger age), or adding sexual youth health programs to existing community day activities. It is important that these messages are provided in a manner that the youth will be receptive to and be comfortable with.

**Recommendations for messages at the community level**

Education is also needed at the community level to improve common HIV knowledge. This increase in community-level knowledge should focus on the importance of testing both partners as polygamy and multiple partner relationships are quite common, dispelling myths around sperm helping to “grow” the baby as this only encourages unprotected sex and potentially higher risks of HIV transmission. There is still confusion in the community about that a person who looks healthy cannot be HIV-positive. Such misconceptions can encourage dangerous behavior.

**Limitations**

The study recruited female participants directly from the clinic and therefore did not sample women who do not seek health care services at the clinics in Swaziland, who may hold other views. This study is based solely on verbal information provided by study participants. Considering the lack of data surrounding this topic, there is limited opportunity to cross check participant responses to see whether participant perceptions are in line with practice. This was also a small qualitative study, therefore the results are not generalizable.

**CONCLUSION**

This study sought to understand sexual behaviors and practices that may increase HIV risk during pregnancy and lactation among women in Swaziland. The study identified that sexual relationships
in Swaziland are very transient and often based on what benefit the relationship provides (financial support, status, revenge, etc.). Multiple partners have become a norm in the Swazi culture and pregnancy does not limit the numbers of partners, in some cases it may increase the number of partners. In Swazi culture it is acceptable for men to have multiple partners and it may even be a source of pride. The desire to gain financial support may encourage women to take additional partners in the hopes of securing a “father figure” to support the child. Women may also accept additional partners while pregnant in order to “grow” the baby. And men might choose to take additional partners while the wife is pregnant or breastfeeding if the wife is uninterested or unable to be sexually active.

Although both men and women of the younger and older age groups have an understanding of the risk and ability to transmit HIV to the unborn baby, men often still do not use condoms with their primary partners. Men frequently refuse to get tested for HIV, which can make it more challenging to encourage condom usage. The study identified the need for more health education targeting men, specifically the benefits of knowing one’s HIV status and starting treatment early.

In addition there needs to be more information shared about sex, pregnancy, and HIV transmission to the unborn child. Women also need to receive reinforced messaging about the importance of repeated HIV testing during pregnancy and lactation. Both men and women need to understand that women are at increased risk of HIV transmission during pregnancy. This information can be translated into social campaigns and enhanced messaging at the facility level.

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2. Ibid.

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