WOMEN SEXUAL EMPOWERMENT: ADOPTION OF FEMALE-CONTROLLED PREVENTIVE MEASURES AGAINST TRANSMISSION OF HIV INFECTION

A Case Study

PERCEPTION OF THE FEMALE CONDOM AS A MEANS FOR SEXUAL EMPOWERMENT FOR PROTECTION AGAINST HIV INFECTION AMONG BARMAIDS, KINONDONI MUNICIPALITY DAR ES SALAAM REGION TANZANIA

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the University of Dar Es Salaam a dissertation entitled:

Women Sexual Empowerment: Adoption of Female-controlled Preventive Measures against Transmission of HIV infection;

in partial fulfillment of the requirements for the degree of Master of Public Health.

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I declare that this dissertation is my original work and it has not been submitted for a similar degree in any other University.

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Dr Florence Sipora Temu Mbaga

DEDICATION

I DEDICATE THIS STUDY TO MY SONS

NEKILANGWA-HUMPHREY VINCENT

LUTTU-JULIUS SIMON

AND MY HUSBAND

GEORGE-RODERICK OMARY

ABSTRACT

A cross-sectional study among 356 barmaids in Kinondoni Municipality Dar Es Salaam, was undertaken during June and July 2000. It sought to establish their perception of the female condom and its role in the struggle for women sexual empowerment. Ability to negotiate safer sex was considered as a proxy for women sexual empowerment. Only 7% of them were most able to negotiate.

The salary of barmaids ranged from Tanzanian Shillings 4,000 to 50,000 per month, and most barmaids had dependants. Low income and increasing number of dependants among barmaids whom are of low level of education, were associated with involvement in multiple sexual relations and became unable to negotiate safer sex. Having multiple sexual relationships was a survival strategy among barmaids. In effect their employment did not improve their economic status but rather it exposed them to risks of HIV infection, STDs and unwanted pregnancies.

Though the barmaids realized the possibility for their self-protection, male dominance in the sexual relationships stood as an obstacle for barmaids' efforts against HIV infection STDs and unwanted pregnancies, as most of their sexual partners were not in favour of using condoms. Not many barmaids could forego the monetary gains as a result of insisting on condom use.

Barmaids perceived the female condom as device meant to empower them sexually but were concerned with its price and the fact that it was not widely available.

Multiple approaches for addressing the economic and social deprivation of barmaids and hence their vulnerability in order to empower them for self protection against HIV infection are recommended.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS: Acquired Immune Deficiency Syndrome

AIDSCAP: AIDS Control and Prevention Project

FHI: Family Health International

HIV: Human Immunodeficiency Virus

MoH: Ministry of Health

NACP: National AIDS Control Programme

STDs: Sexually Transmitted Diseases

UNAIDS: Joint United Nations Programme on AIDS

WHO: World Health Organization

USAID: United States Agency for International Development

INTRODUCTION

Barmaids in Tanzania form a social group of women who are most likely to engage themselves in high-risk sexual behavior. Studies in several countries show high prevalence of HIV infection among this group (Briggs 1999; NACP 1998). It has also been found that barmaids have a considerable range of sexual relationships. They often have regular sexual partners, casual partners and sometimes they operate as professional commercial sex workers (Mgalla and Pool 1996). Barmaids therefore are prone to acquire STDs including HIV infection from, or to transmit these infections to their partners. Most of their partners are either married or have other relations elsewhere (Mgalla and Pool 1996; Mhalu *et al* 1991). This means transmission is far beyond the barmaids' immediate relations. Barmaids can also be considered as a sub-group among prostitutes serving as core transmitters of HIV infection. These facts make barmaids one of the groups which deserve particular public health attention in the context of concerted efforts to curb the rate of HIV transmission.

Efforts to provide preventive measures among high-risk groups have been one of the strategies in the initial response in the intervention to prevent HIV transmission (UNAIDS 1997). The male condom has been all along the only device that has dual protection against unwanted pregnancies and STDs/HIV transmission. However some studies had shown lower level of condom use despite high level of awareness and availability of the male condom. Among the reasons that make women either not to use or to stop using the male condom are those, which have, to do with economic,

social and gender inequalities. That is to say women are ill-placed to get their partners to use male condom (WHO 1997; Ankrah 1995; Mgalla and Pool 1996). As a result women often yield their control over sexual relations out of economic necessity or fear of violence.

The female condom is now another device that can serve as a contraceptive as well as a protection against STDs including HIV transmission. Apart from having other contraceptive benefits such as being free from hormonal side effects, being immediately reversible and does not rely on physicians assistance, the female condom is a protective method whose use a woman can initiate and probably exercise control over its use, therefore making her sexually empowered. Once they are sensitized about the use female condom women with high-risk behaviors can expand their choices of barrier methods in situation where the male condom is not preferred. Studies suggest that expanding choices increase the percentage of sexual acts which are protected against STDs including HIV infection and unwanted pregnancies (WHO 1997). In addition the laboratory evidence that female condom is impermeable to organisms responsible for STDs including HIV (Deniaud 1997) means that a woman can confidently guarantee her protection if the device is used effectively. Therefore effective use of female condom by women such as barmaids who are exposed to high risk behavior, can make a substantial contribution towards prevention of HIV transmission.

BACKGROUND

REASONS FOR SEX DISCRIMINATION IN SOCIETIES

Many of the women serving in bars fall into prostitution because of various underlying factors. Prostitution generally represents a means of survival. It is in fact an extreme case of vulnerability, despair and reflects inadequacy of the social support system for women. In most societies women are sub-ordinate and marginalized as regards to income, assets, education, information, political influence, sexual life and so on. From her early days of life, a female child is being given less weight as compared to a male child. Son preference appears to exist in many regions of the world. In some areas where there is high degree of daughter neglect, girls are less educated, neglected, abused or even killed (Population Reports 1994). Reasons underlying this sex discrimination within societies are mainly based on economic and socio-cultural factors. Other factors can be political and environmental.

Economic factors

Economic inequality is a prevailing problem among most African societies (Ulin 1992). In many developing countries there is cultural preference for sons and there is also preferential allocation of family resources to them. Parents consider their sons as their source of security in their old age. They invest in the child most likely to yield highest return. They would like to invest their scarce resources more in male children (Matos Ala 1998; Population Reports 1994; Freemmann and Maine 1993). Investing it in female children is regarded as wastage because they will marry and leave their

families. Boys are seen to have the potential for wage employment while girls are expected to be housewives or domestic workers in subsistence farming with little or no earning. There is vivid gender discrimination even in feeding practice since childhood (Population Reports 1994).

In these societies women are not supposed to own property (Ulin 1992). It is only until recently that some states including Tanzanian have enacted legislation to protect women's right to inherit property (UNAIDS 1997; Outwater 1997). Most African women had been economically dependent on men. Women in Africa, who constitute 52% of the total population, contribute about 80% of the agriculture work and produce 60-80% of food. However they are excluded as factors to consider when formulating and implementing development strategies. In capitalism unpaid work is devalued and regarded as invisible. Workers are only those who earn while those who receive little remuneration for their subsistence farming or nothing for their domestic work are not workers. The western planners do elevate the men's work and marginalize the women's work (Matos Ala 1998). Between 1965 and 1986 development planners excluded women from any substantial involvement in development process as planners or specific targets of development programme.

Having low economical position, most women are driven into relationships in order to sustain lives. This makes them to yield control over sexual relations to men. Some may be employed in jobs whose nature exposes them into risk behaviors either because of the working environment or due to underpayment. Such jobs include working in bars, guesthouses or other public houses as maids, waitresses and the like

(Mhalu *et al* 1991). Poverty, lack of employment and underpayments make women be economically vulnerable and they lose power in negotiating for safer sexual practices. Barmaids for instance at times fall into unprotected sex because the man (who has to give her money in return) refuses to put on the male condom. If she insists there will be no sex -hence no money (Mgalla and Pool 1996; Mhalu *et al* 1991). Therefore for women "lacking economic resources of their own, and fearful of abandonment or violence on the part of their male partners, they have little or no control over how and when they have sex and hence becoming infected with HIV"(UNAIDS 1997). But it should be stressed that even for a woman who is not economically vulnerable can still be socially vulnerable because the husband may have multiple sexual partners thereby increasing her risks of infection.

Despite being marginalized women in developing countries bear the responsibility for meeting health needs, nutritional needs and social needs of their families. A woman in a household is the one upon whom the welfare of many people depend despite her economic and social subordination. Economists contend that women use most of their scarce income to meet family needs compared to men (Narda 1998). Women need economic freedom and self-driven income generating activities to earn enough income meet their needs.

Socio-cultural factors

In many societies, tradition and religion put more value on males than females. Societies do give men and women different activities, responsibilities, authorities, power and value in the context of gender relations. This leads to gendered division of

labor, gendered access to resources (land, credit, education, labor), powerful control of men over decision-making process and also discourse on tradition or ideology which legitimatize and justifies this male control (Mbughuni 1994). Cultural inequalities pre-dominate in most, if not all, of African societies (Ulin 1992). Traditionally the position of a woman in decision-making in most of African cultures is sub-ordinate to that of men. For an African woman it is against cultural norms to suggest how to go about sex. Girls are taught to leave sex initiatives and decision - making to males. It is the man who dominates and decides how and when to perform the sexual act (Blogg *et al* 1994; Ray *et al* 1995; Jenkins *et al* 1995). For most women it is almost impossible to bring up the issue of safer sex in their sexual relationships. In some parts of Africa including Tanzania, Kenya, and Uganda married women are culturally not expected to say no to sex with their husbands. A study by Kabatesi and Asiimwe-Okikor found that the majority of women in this region had little or no control over either abstinence or condom use with their husbands. Neither can they suggest condom use to their husbands' extramarital sexual activities (Kabatesi and Asiimwe-Okikor 1998). Condom use in some societies has been associated with promiscuity. As a result a woman would have unprotected sex as an expression of confidence and love (UNAIDS 1998).

Wife inheritance is another cultural factor which puts an African woman at a risk of acquiring HIV when inherited with a man whose HIV status is unknown. In some communities in Zambia widows are forced to have sex with a brother in-law in the belief that the act will cleanse them of their husbands' spirit. This does not necessarily lead to marriage (Kiragu 1995). An African woman is expected to be

faithful to the man whereas a African man is free to have sexual relationships with other partners (Outwater 1996; UNAIDS1997; Ankrah 1995).

There are also some religious beliefs among Catholics, Muslims, (Blogg and Blogg, 1994; UNAIDS 1998) that constitute a barrier to condom use.

Peer pressure is one of the societal factors which can lead one to engage in risk behaviors. For instance a woman who leads a "better" life because of "multiple sources of income" (i.e. multiple sexual partners) will recommend this to others as an easily available alternative strategy to solve life's hardships.

It is clear that through a triad of division of labor, differential access to resources and decision-making process [as in the conceptual framework for gender analysis created by feminists in Tanzania- (Mbughuni 1994)-] women are faced with overwork, poor health, low income and disenfranchisement.

Political factors

As regards HIV pandemic; until recently most of the African political platforms were not addressing the AIDS/HIV catastrophe as a major issue affecting every sector in human life. As Muhondwa commented during the 3rd USAID HIV/AIDS prevention conference in 1995, it took years before there was a political response to HIV/AIDS in most of African countries (Muhondwa 1995). There have been no formal rules and regulations against risk behaviors. In other places governments have instituted a 'condom-only' rule (UNAIDS 1997). In Tanzania the year 2000 has been designated

to be a year for fighting against HIV/AIDS. This move has provided impetus to most actors to lay down orders against behaviors leading to the increasing transmission of HIV infection. in Dar Es Salaam City for instance , the Regional Commissioner has announced deliberate measures against the roadside commercial sex activities.

Environmental factors

Many educational and preventive services for HIV infection are inaccessible for most women at high risk for HIV infection. These services are mostly made available in family planning clinics and in some pharmacies where condoms can be bought. For most women would not access them for various reasons. Location and distance where the services are made available can be some of those reasons.

Working environment for some women like those working in public houses as maids and waitresses expose them to high risk of acquiring HIV infection (Mhalu et al 1991).

GENDER BIASES

Matos Ala categorized the gender biases into two major aspects; one as external gender biases and the other as internal gender biases (Matos Ala 1998).

EXTERNAL GENDER BIASES

The macroeconomic trends and policies have a conceptual bias against women and are usually presented in gender-neutral language in that there is no mention of division of labor that exists in Africa societies (Elson 1989). The economy is defined

in terms of marketed goods and services. The domestic arena which involves such activities as nurturing children, processing food, preparing meals, collecting water, housekeeping, nursing the sick; which are mainly done by women, is excluded. These are among the women's unpaid labor which are regarded as elastic, that is are able to stretch to make any shortfall in other resources (Matos Ala 1998). The planners fail to view that the success of macro-economic policies in achieving the objectives will be through the cost of longer and harder working days for women, that women work 13 hours more per week than men and continue to work after 60 years of age.

The traditional gender division of labor, which perpetuates subordination and marginalization of women, put women responsible for the roles of reproduction, production, and community work. However in production roles, women are rather secondary earners. Gender division of labor is based on traditional gender stereotypes within a particular community, and it is rigid and resistant to change. Woman's work appears invisible and perceived as natural work. As the gender roles become more rigid, the sharper the division of labor and therefore lower the status of women (WHO 1997).

INTERNAL GENDER BIASES

Here the focus is mainly on the household. It is believed that the source of gender bias within a society, is the household. This type is most resistant to change. In patriarchal society males will not surrender their power so that women might live better lives. In the developing world, men are always regarded as heads of

households. This has influenced the development planners to target the husbands when aiming at households. For instance in agricultural adjustments, land is registered in the name of the head of the households.

The states would affect the lives of women through the legal, labor, economic, social and political policies but still would not intervene the household domain (Matos Ala 1998). A state can either reinforce patriarchal values embodied in the household or it can challenge them. States do benefit from women during revolutionary times when women are used to mobilize families and communities. Tetreault has observed that few revolutionary movements once they have triumphed, have substantially altered the position of women in society as they initially promised. Policies regarding marriage, rape, abortion and population control, effect the lives of women but not their households (Tetreault 1992). Women are as only means to an end and remain marginalized despite their contribution to revolution.

In Kenya for instance, the law interprets wife beating as a domestic, and therefore a private matter and the law enforcement agents avoid interfering in a family conflict (Kiragu 1995). Among the Luhya society, in Kenya women are expected to accept being beaten by their husbands and to see it as a sign of love.

TRADITIONAL LEGAL STATUS OF WOMEN

Another major contributing factor in women subordination and marginalization is the women's traditional legal status. In sub-Saharan Africa women are considered to be legal minors. Matos Ala commented that, traditional laws perceive women not as

individuals but as extensions of their husbands' or fathers' personalities (Matos Ala 1998). Land rights are usually linked to inheritance, which is customary from father to son, to grandson, great grand son and so on, in the hierarchy of male dominance. Women are given 'rights' to work on their husbands' land so that they fulfil their obligation to the family, for food production and for the husband by cultivating the cash crops.

In Tanzania, even in a female-headed household, where there is a room for the female's decision-making, the access to land is still limited. In Tanzania it has been recently legalized for married even those in non-formalized marriages, to retain half of the possession acquired during the marriage. Despite these legal rights, Tanzanian women do not seem to liberate themselves from the traditional roles and norms of wife, mother, and caregiver (Outwater 1996).

REPRODUCTIVE DECISIONS

In many cultures it is the men who make decisions on when to have sex, whether to use any contraception and the size of the family they would need (Hollerbach 1982). In many instances when there is disagreement on whether to use contraception it is the man's preference that dominates (Lloyd 1992). In some situations men are willing to practice withdrawal only as a way to re-enforce their sexual control (Rogow and Horowitz 1995).

In many African societies, a man needs a bigger number of children than he is able to provide for. On the other hand the woman is denied freedom to discuss, to initiate or

to decide on the use of contraceptives (Freemann and Maine 1993). In African societies, women are not expected to raise any sex-related issue(s) with their male partners (Blogg *et al* 1994; Jenkins. *et al* 1995).

When faced with such circumstances, a woman is forced to take her initiatives to use contraceptives methods that will not be easily recognized by the partner, such as oral contraceptives, injectables or spermicides. However in cultures where dry sex is highly preferred, the spermicides are not very appealing.

Other contraceptive methods, which involve minor surgical procedures, the Norplant and the permanent method, bilateral tubular ligation may go unnoticed if the partner does not recognize the scars.

The female condom is a contraceptive device, which is more of female-controlled in its application but needs male co-operation to be effective.

In Tanzania, research shows that different people have different reasons for not discussing contraception with their partners (Population Reports 1994). Among the reasons given is religious faith especially among older women. They believe that it is God who determines the number of children. Some women do not discuss reproductive issues with their husbands for fear of disapproval. Younger people perceive discussions on contraceptives as indicative of promiscuity.

In marriages, men assume that they can have sexual access to their wives whenever and however they want. They can even apply coercion to fulfil their sexual needs. As many societies do accept forced sex within marriages (Lori *et al* 1995), a wife is denied power to negotiate about sex.

WOMEN AND HEALTH SERVICES

Women are the major consumers of health services both directly in terms their own health needs and indirectly as care givers of children, husbands or a relatives. However women are faced with economic constraints and poverty that limit their ability to seek health care and ability to pay for health care in health facilities (Narda 1998). Accessibility to health services can be limited by economic factors of not being able to afford the costs. Physical accessibility, that is, place and distance can be a limiting factor in the utilization of health services. Failure for most women to access various health services does deprive them of knowledge on various health-related issues, like safer sex, family planning, safe motherhood, nutrition and others. Lack of preventive knowledge on various health hazards is one of the factors which predispose women to ill health. This disadvantage is further compounded by the fact that men who are the main decision-makers in households' affairs are not targeted by programmes which seek to promote the health of women. (Becker 1996).

WOMAN AND HIV/AIDS

AIDS is continuing to be a leading threat for morbidity and mortality throughout the world. The recent report by UNAIDS and WHO on global HIV/AIDS epidemic indicate that by the end of the year 1999, indicates that over 33.6 million people

(adults and children) were infected with HIV (UNAIDS 1999). Among these 23.3 million are in sub-Saharan Africa where 55% of them are women. Women account for 46% of all people living with HIV worldwide.

The mode of spread of HIV in sub-Saharan Africa is mostly heterosexual accounting for more than 4/5 of the transmission routes. The remaining fraction can either be due to blood transfusion or, drug injection or use of contaminated sharp objects.

UNAIDS documented that the risk of HIV infection for women is rising worldwide (UNAIDS 1997). A total of 13.8 million women aged above 15 were living with HIV/AIDS by the year 1998. Since the beginning of the epidemic in the late 70's and 80's a total of 4.7 million women have died from AIDS (Women with AIDS: Global fact sheet 1999). Everyday more than 5000 women become infected with HIV and 500 die of AIDS or related illness. In every five women living with HIV, four of them live in Africa (UNAIDS 1999; Reid *et al* 1993). This shows that the burden in Africa is very heavy. In Africa women to men ratio of HIV infection is 6:5. The younger women aged between 15-24 constitute the greater part (UNAIDS 1999).

At the beginning of the epidemic, in industrialized countries, the infection used to occur more in men. In United States, women accounted for only 8% of the infections but in the year 1996 the rate raised to 21% (Osmond 1998). In France, 1985, women comprised around 12% of the AIDS cases but rose to 20% in 1995. In Spain it doubled in the period of ten years from 7% to 19% .In Brazil the women: men ratio

increased from 1:99 in 1984, to 1:4 after a decade. In Asia the situation is the same, with women account for 25% of cases of HIV/AIDS.

The following is a summarized data from Women with AIDS: A Global Fact Sheet by Briggs (1999):

Table 1 **Summarized data showing percentage of women living with HIV/AIDS worldwide.**

REGION	No of People Living with HIV/AIDS (in millions)	Percentage of women
sub-Saharan Africa :	23.3	55
South and S.E Asia :	6.0	30
Latin America :	1.3	20
North America :	0.92	20
Caribbean :	0.36	35
Eastern Europe and Central Asia :	0.36	20
Western Europe :	0.52	20
East Asia and Pacific :	0.53	15
North-Africa and Middle East :	0.22	20
Australia and New Zealand :	0.12	1

Some countries in Africa have identified groups of women which have alarming levels of HIV prevalence. In South Africa on average 22.8% of all women attending antenatal clinics were infected with HIV; in some areas the figure was up to 32.5%. In Botswana, 43% of pregnant women tested HIV positive in Francistown; In Zimbabwe in 1997 up to 40% of the pregnant women were infected. In Uganda, which was the first country in Africa to experience a massive HIV/AIDS burden, the HIV prevalence among young women aged 15-19 is up to 20 times higher than in young men of the same age. Also 67% of the bar workers in Uganda were once reported as being infected with HIV (Briggs 1999).

Situation in Tanzania

For Tanzania the situation is worsening with time. According to MoH and NACP the impact of HIV/AIDS on her people's lives is very devastating. By 1997 about 1.5 million Tanzanians were estimated to be infected with HIV (MoH/NACP 1998). There were 103,000 reported cases of HIV. But since many cases go unreported the extent was estimated to be well over 520,000 cases of AIDS in Tanzania by year 1997. According to UNAIDS 1997, Tanzania was among the countries with the highest prevalence level of HIV infection. Adults living with HIV were approximately 1.4 million which is 8.2% of the total adult (aged 15 and above) population. Women in particular are more infected with HIV than men. Roughly about 7% of all adult women are infected compared with 5.4% of all adult men. Relatively high prevalence of HIV/AIDS has been found in different groups of women studied in Tanzania. Though not mutually exclusive, studies have shown that:

-Antenatal clinics in Tanzania report up to 13% of HIV positive pregnant mothers. (Briggs 1999)

-Among the sex workers 49.5 up to 60% were found to be HIV positive (NACP 1997)

-12.2% of the female patients attending STD clinics were HIV positive (Mhalu *et al* 1987)

-50% of female bar workers in Dar Es Salaam city were HIV positive (NACP 1997).

-52% of the female bar workers in Mbeya municipality were HIV positive

-32% of the female bar workers in Moshi municipality were HIV positive (NACP 1997).

-11.8% among female blood donors between 1992-1998 were HIV positive (MoH/NACP 1998).

It is therefore right to say that the plight of barmaids is not unique to them. It is rather shared by many women, especially African women. However prevalence of HIV among them is at a rate that can not be neglected.

EFFORTS AGAINST WOMEN SUBORDINATION AND MARGINALIZATION IN HEALTH

For many years the health of women apart from their reproductive and nurturing roles received little notice at national and international conferences or in scientific journals (Ulin 1992). However the health priorities are now expanding. Currently the development programmes with an overall goal of poverty alleviation and

improvement of health and nutrition of families view women as more efficient targets of their policies (Mayoux 1995). A general recommendation by a committee on elimination of discrimination against women seeks to remove all barriers to women's access to health services and reproductive health, and calls for allocation of resources targeting the prevention and treatment of STDs and HIV/AIDS (Press Release WOM/1097 1999). Programmes to empower women are now of high interest and they seek to enhance women's ability to take an active role in getting access to and utilization of services. As for the fight against HIV/AIDS, UNAIDS have stated six paths to empowerment of women (UNAIDS 1997). These are:

to combat ignorance;

-education to girls and women about AIDS and STDs and skills to prevent unwanted and unsafe sex.

provision of women-friendly services

-increase accessibility for girls and women to HIV and STD services

-expand voluntary testing and counseling services

-increase availability of condoms for women

build safer norms

-questioning some behavioral traditions such as tolerance of child abuse, rape and sexual coercion

-educating males to respect females

-men to share responsibility for protecting women and children

reinforce women's economic independence

-increasing and strengthening existing training opportunities and the income generating activities

reduce vulnerability through policy change

-increasing political voice for women to protect human rights and to improve their economic independence

develop female-controlled prevention methods

-to complement to the available male condom by having a method for women to use through their own initiative, preferably without male's awareness, a method that can be inserted earlier before sex.

Microbicides that can kill the virus but not the sperm are still being researched.

Female condom is a device that can serve both as a contraceptive and a protection against HIV and other STDs. This device is meant to empower women in that they can initiate and probably control its use. This device however needs to be in use simultaneously with other measures to liberate women from economic and social marginalization. However it should be the female condom still requires the participation of the male partner for its effective use. Studies have shown women stop using it because of male partners' disapproval of the device.

Even for prostitutes who have commercial influence in the sexual activities may not be able to use it if the partner refuses. Those who are poor would still accept unprotected sex for money.

STATEMENT OF THE RESEARCH PROBLEM

Barmaids represent one group among women who have become victims of women economic and social deprivation. Most of them engage themselves into multiple sexual relationships as a survival strategy. This behavior puts them at high risk for acquiring STDs, HIV and unwanted pregnancies. Because of their subservience most of them cannot negotiate safer sex.

Many of them fail to persuade a male partner to put on a condom during sex. Female condom is meant to be a female-controlled device that is effective in preventing STDs, HIV and unwanted pregnancies. A barmaid can insert it earlier before sexual encounter. Although for it to be effective the male partner's cooperation is necessary, the barmaid is empowered in initiating and to negotiate its use. There is therefore need to explore the potential of the female condom for empowering women generally and vulner4able groups such as barmaids in particular for negotiating safer sex.

The main questions in this study was:

Do barmaids, as a category of women who engage in high-risk behavior for both STDs, HIV infection and unwanted pregnancies perceive use of the female condom as a means for their sexual empowerment?

If barmaids can succeed to initiate and to control its use, the female condom would be a welcome means for sexual empowerment generally and a means for preventing HIV infection.

JUSTIFICATION OF THE STUDY

Barmaids being exposed to high-risk behavior are one group of women who could benefit from a female-controlled method. One of the major strategies to make the female condom popular among this risk group is to create awareness about the female condom.

Barmaids need to perceive the female condom as a means for their women sexual empowerment. This is especially necessary in situations where barmaids are faced with clients who use either their economic or physical powers to demand unprotected sex and refuse to use the male condom. If the female condom is made available in places where high-risk behavior takes place, it will serve as an easily accessible solution for these women who might be the core transmitters of HIV infection. Acceptors of the female condom may be peer educators to enlighten others on the issues of sexual empowerment.

Experiences with the promotion of the use of the female condom among barmaids may prove useful for similar efforts among other marginalized groups of women, if not women in general.

STUDY OBJECTIVES

BROAD OBJECTIVES

TO STUDY BARMAIDS PERCEPTION OF THE FEMALE CONDOM AS A MEANS FOR SEXUAL EMPOWERMENT IN PROTECTION AGAINST HIV INFECTION

SPECIFIC OBJECTIVES

1. **To assess respondents' realization of the possibility for women's self protection against HIV infection**
2. **To assess respondents' ability to negotiate safer sex in order to protect themselves against HIV infection.**
3. **To assess respondents' awareness of the unique attributes of the female condoms for women's self-protection against HIV infection.**
4. **To assess respondents awareness of the effectiveness of the female condom over other female methods of contraception for protection against HIV infection.**
5. **To explore how respondents' perception of sexual empowerment varies with their socio-demographic characteristics.**

LITERATURE REVIEW

Barmaids and their plight

Among the high risk groups of women are the female bar workers commonly known as bar maids (NACP 1998). By definition, a bar is a place, room or a counter where alcohol or refreshments are served. Studies show that most of women who are employed as bar maids or waitresses, took the job as the only available alternative form of employment (Mgalla and Pool 1996; Mhalu *et al* 1991). According to Outwater (Outwater 1996), the majority of barmaids have either a primary or lower education level and do not qualify for most of the other jobs. However the monthly earning of these workers usually does not suffice or meet their financial needs. As a result they are sometimes forced to look for extra earnings from other available sources. Because of their working environment they are bound to accept customers' sex demands and receive money in exchange. Mhalu *et al* noticed that bar maids and waitresses are often engaged in prostitution. Mgalla and Pool found that most of these women are single. They have never been married while others are either divorced, or widowed. Almost all barmaids interviewed had at least a dependent child. Being single, divorced or widowed increases the risks of the woman to acquire HIV infection (Rutenberg *et al* 1993). This group of women perceive themselves as being economically vulnerable and hence seeks out relationship(s) to make end meet. Mgalla and Pool report two types of employment terms among the barmaids they studied. The first type comprises those who are employed on a monthly payment basis and the other is that of those who buy alcohol from the owner of the bar and sell it to the customers within the same bar. Barmaids in both situations face

economic problems. Barmaids in the former category face the problem of underpayment while those in the latter lack enough money to purchase large stocks.

One characteristic observed among barmaids is the tendency of shifting from one bar to another in search for better payment.

Barmaids; a high risk group for HIV/AIDS

Risk in the context of HIV/AIDS is referred to as the probability that someone may acquire HIV infection (UNAIDS 1998).

High risk behaviors include the following:

-frequent change of sexual partners

-unprotected sex with a partner whose HIV status is unknown

-multiple unprotected sexual partnerships

-unprotected sex with a partner who has multiple sexual partners

Biologically a woman is more vulnerable with risk of becoming infected with HIV during unprotected sex up to four times higher than men. This is because of the large female (vaginal) mucosal area exposed to male sexual secretions which, if infected, do contain a considerable concentration of the HIV (Kabatesi and Asiimwe-Okikor 1998; UNAIDS 1997). Also untreated sexually transmitted disease in females, which in most cases go unnoticed, increase the risk of HIV transmission by ten folds. For this reason the male-to-female transmission becomes more efficient than female-to-male transmission.

However there are some factors which impel woman to engage risk behaviors, and find it difficult to desist from doing so. These factors include lack of knowledge, awareness and skills for self-protection and inability to negotiate for a safer sex.

The study by Mgalla and Pool, revealed a number of types sexual relationships among barmaids. These include having a regular partner or partners, casual partners as well as commercial sex work. The amount of financial 'support' the woman receives from a sexual partner varies with the type of sexual relationship they have.

A regular partner tends to provide regular financial support and not necessarily in direct exchange with sex, as opposed to casual partners who 'pay' for each sexual contact.

Tips from customers are a major trap which customers use to seduce to barmaids. In most cases the tips and offers of alcoholic drinks are meant for exchange with sex (Ulin 1992; Mgalla and Pool 1996; Mhalu *et al* 1991). Most barmaids do know the risks of unprotected sex and of having multiple sexual partners, but for economic reasons or for fear of violence, they accept unprotected sex (Kabatesi and Asiimwe-Okikor 1998; Ankrah 1995; Mgalla and Pool 1996).

With regard to condom use by their sexual partners, a drunkard man may put on the condom wrongly which does not serve the purpose. It was also found that barmaids do use condom mostly with their casual partners but rarely or never with their regular

partners. These regular partners are in most cases married men and therefore are unfaithful to their barmaid partners who claim to trust them.

Female condom

I) Uses and effectiveness

The female condom is made of polyurethane plastic. It is 17 cm long, tubular, with an outer and inner ring .The outer end is open and the inner is closed. The inner ring in the inner end anchors the condom at the tip of the vaginal canal around the cervix, while the outer ring covers the vulva and prevents the condom from slipping up the vagina. The female condom is pre-lubricated. However any type of additional lubricant whether oil-based or water-based, spermicidal cream or foam can be used (WHO 1997). Female condoms are sturdier, 40% stronger than the latex male condom. It potentially offers greater protection, is less likely to break or to leak. They provide an improved comfort and have longer shelf life, even under unfavorable storage conditions. Less allergic reactions have so far been reported among the users as compared to latex condom where up to 8% of users are allergic (UNAIDS 1997). They cover much of the external female genitalia up to the base of the penis hence they offer a more extensive barrier and somewhat greater protection, against genital ulcer disease such as herpes and chancroid, which also serve as port of entry for HIV infection. Their contraceptive effectiveness is similar to that of other barrier methods for women (Trusell *et al.* 1994). Though laboratory tests show that female condom is an effective barrier against HIV and other STDs, that is, it is

impermeable to various STD organisms including HIV, there is only limited evidence of its efficacy in vivo (Deniaud 1997; Drew *et al* 1990; Network 1995; Rosenberg *et al* 1992). In a trial conducted by Family Health International (FHI) and the Contraceptive Research and Development Programme (CONRAD) among women who had been previously diagnosed and treated for recurrent vaginal trichomoniasis, there was no re-infection among the 20 participants who reported perfect use of the female condom. Re- infection occurred (within the 45 days of follow up) among the controls (those who did not use) and non-perfect users (Deniaud 1997). The female condom has been marketed in more than 13 countries since 1996 and most of these are industrialized countries with the selling price too high for developing countries. However the female condom is now being mass-marketed in the developing world, where the highest HIV rates are found.

Apart from being a device that women have more involvement in initiating its use, the female condom has other advantages over other means a couple could use aiming at the prevention of sexually transmitted diseases and HIV, as well as for contraception. It gives a woman a better way to communicate her wishes to have a safer sex. Other important advantage is that it is more convenient to use because it can be inserted before the intercourse and as such does not need a male partner to maintain erection to fit it. It does not fit tightly on the penis instead it fits loosely along the vaginal wall. When using a female condom a man would not have to withdraw immediately after ejaculation as it is for the case of a male condom which would otherwise slip off and remain in the vaginal canal once the penis loosens.

II) Limitations

The female condom on the other hand has some limitations. Its tubular appearance and the fact that it hangs outside the external female genitalia render it unattractive to some.

To some, especially for the inexperienced users, it can be difficult to manipulate and insert, however studies report that this problem becomes less with practice (Blogg and Blogg 1994; Jenkins *et al* 1995; Ray *et al* 1995).

Some report that it can be displaced during intercourse but this seems to be due to poor insertion techniques (Jenkins *et al* 1995).

Price of the female condom is another anticipated barrier to the use of the female condom as it is relatively more expensive than the latex male condom.

The female condom has also been reported by some users to be noisy during sexual intercourse (Population Reports 1999).

The pre-lubrication might not be favorable in circumstances where a dry sex is preferred.

III) Acceptability of the female condom among users

Most of the trials have generally found the female condom to be acceptable (Deniaud 1997; Blogg and Blogg, 1994;Ray *et al* 1995; Jenkins *et al* 1995; WHO 1997). The

acceptability was established more quickly among prostitutes. They were interested in this new method because it gave them an additional method of safer protection during sex.

Some women were likely to drop out of the studies because of the attitude of their male partners about the female condom.

With specific reference to a study carried out in Zimbabwe reported a figure of 77% prostitutes whose clients liked it. Reasons given by these male partners in Zimbabwe for liking the female condom over the male condom included the fact that, it is the woman who inserts it hence making the man less responsible for the protection, that there is no need to interrupt sex to insert it; and that there is no need to withdraw immediately after ejaculation as it is for the case of male condom.

STUDY METHODOLOGY

STUDY AREA:

This study was conducted in Kinondoni municipality, in Dar Es Salaam City.

STUDY DESIGN

This was a sample survey of cross-sectional descriptive design. The instrument used had both closed and open-ended questions. Closed-ended questions sought to elicit socio-demographic information. It is open-ended questions that delved into the substance of the study. These allowed probing which enabled to obtain the information required. The questionnaire were had five sections:

I. Socio-demographic characteristics of the respondent
II. Realization of the possibility for women's self protection against HIV infection
III. Ability to negotiate safer sex in order to protect themselves against HIV infection.
IV. Awareness of the unique attributes of the female condoms for women's self-protection against HIV infection.
V. Awareness of the effectiveness of the female condom over other female methods of contraception for protection against HIV infection.

STUDY POPULATION

The population targeted in this study was all barmaids working or employed in the bars within Kinondoni municipality. There were 550 bars situated in Kinondoni Municipality with estimated number of barmaids of 4787(CRE Feb.2000).

SAMPLING METHODS AND THE SAMPLE SIZE

Multistage sampling technique was applied to obtain the study sample. A list of wards within Kinondoni municipality was compiled and ten wards were picked at random. A table of random numbers was used to select a sample of bars within the selected wards. 62 bars were selected. All barmaids working in the selected bars were included in this study. A total of 356 barmaids were interviewed.

The sample size **n** of 356 barmaids, was determined by applying the single proportion formular by Kish & Leslie, (Survey Sampling, John Wiley & Sons, NY, 1965); used in the statcalculator programme of EPI-info version 6, such that

$$\mathbf{n} = \frac{z^2 p(1-p)}{d^2}$$

where z= z value= 1.96 (corresponding to the confidence level at 95%)

d= absolute precision will be taken at 5%

p= expected proportion in the barmaids who would perceive the female condom as a means for empowerment is not known; so a proportion of 50% was considered in this calculation, given the population of barmaids in Kinondoni municipality is 4787, according to the Central Register of Establishments (CRE), by February 2000.

OPERATIONAL DEFINITION OF TERMS USED IN THE STUDY

1) ***Women sexual empowerment***: - ability for women to negotiate for safer sex, to decline unwanted sexual advances and ability to convince a man to practice safer sex

2) ***Bar***: -was regarded as any commercial place, room, or a counter where alcohol is sold among, all other drinks (if any).

3) ***Barmaid:*** - any female attendant in a bar whose main task is to serve the customers.

4) ***Safer sex:*** - consensual sex, with no mixing of genital fluids, aiming at prevention of sexually transmitted infections.

ETHICAL CLEARANCE AND OTHER ETHICAL ISSUES

Before embarking to the field exercise ethical clearance was obtained from the Ethical Board of Muhimbili University College of Health Sciences (MUCHS. Permission to do the study in Kinondoni was obtained from the Kinondoni Municipal Executive Director's Office. Bar owners/managers were contacted for permission to interview their staff. Permission to conduct interviews was also obtained from the barmaids themselves. In order to assure privacy, the respondents were allowed to choose place and time for holding the interviews. Informed consent was expressed by signing a consent form before the interview started. Anonymity was maintained, as the respondents were not asked their names. Only re-embursement of transport costs and supply of a packet of female condom free of charge were made to the respondents.

RANKING OF THE ABILITY TO NEGOTIATE SAFER SEX

Scoring system has been used to rank the respondents according to their ability to negotiate for safer sex. Criteria set for these scores were based on the open-ended questions in section III of the questionnaire. Responses for each question were used to score the respondents.

A respondent would score '1' to each question if the responses reflected

- knowledge on safer sex,
- knowledge about condoms,
- attempts against conception,
- attempts against sexually transmitted diseases and HIV infection,
- ability to openly decline unwanted sexual advances,
- consistent attempts to negotiate safer sex and
- having no unprotected sex.

A score of '0' was given to responses having meanings judged differently from these.

A total score for each respondent was used to rank her as 'most able', 'more able', 'just able' or 'unable' to negotiate safer sex as listed:

I. Any knowledge on safer sex

Yes =1

No = 0

II. Any knowledge about condoms

Yes = 1

No = 0

III. Any attempts against conception

Yes = 1

No = 0

IV. Any attempts against Sexually transmitted Diseases & HIV

Yes = 1

No = 0

V. Can directly say 'no' to sex

Yes = 1

No = 0

VI. Always attempt negotiation for safer sex

Yes = 1

No = 0

VII. Has no unprotected sex

Yes = 1

No = 0

Total score	**Rank**
7	Most able
6	More able
5	Just able
4 or less	Unable

TRAINING OF RESEARCH ASSISTANTS AND PILOT TESTING

Four research assistants underwent a two-day training by the principal investigator. During the first day the aim of the study, ethical issues, introduction of the questionnaire and mode of interviews, were addressed. During the second day, emphasis was on appropriate interview technique using a structured questionnaire.

The training was followed by another two days of questionnaire pre-testing. The pre-testing exercise involved four bars in which a total of 22 barmaids were interviewed. Each researcher interviewed at least four barmaids.

Some of the immediate outcomes of the pre-testing exercise included the need to rephrase some of the questions so as to minimize inter-observer variations.

It was found that the most appropriate time for data collection was between 1500 to 1900 hours when the bars were less busy.

DATA COLLECTION

Data collection was done on each day of the week. In each bar, the owner or manager was approached with the letter of permission from the Municipality.

Each research assistant was assigned an area to conduct the interviews. The principal investigator assumed the overall supervision of the data collection in all the areas covered by the research assistants. Further to that the principal investigator checked

all the filled questionnaires from the previous days' work. Any errors were corrected and clarifications made before the interviewers embarked on that day's work. This procedure which minimized the inter-observer variation to a greater extent was done on a daily basis.

DATA PROCESSING

The written information was then re-checked for completeness each day after the fieldwork, and was then coded for computer entering. All the coded data was entered in the computer using EPI-INFO version 6 programme ready for analysis.

DATA ANALYSIS

EPI-INFO version-6 computer programme has been used for analysis. The Chi-square test has also been used in analyzing some of the quantitative data where a P value of less than 0.05 has been considered as significant.

DATA PRESENTATION

Tables have been used to summarize the information.

Frequency distribution tables and cross tabulations have been used to present most of the quantitative data. Quotations are used to substantiate the qualitative results.

RESULTS

1. Socio-demographic characteristics of the respondents

A total of 356 barmaids were interviewed. Barmaids in the study area were of diverse origins. They belonged to almost 45 different Tanzanian tribes hailing from all parts of the country.

42.7% were Muslims and the rest were Christians composed more of Roman Catholics (121), 59.3%; 55 Lutherans (27.0%), 20 Anglicans (9.8%) and other denominations (3.9%).

Most of the respondents (72.1%) were aged between 20 and 29 years with a range between 14 and 42 years

It was also found that most of the respondents were of 'single' status; the unmarried were 59.8%; 18.3% were separated from their husbands and 14.3% were divorced. Those who were married or cohabiting comprised 2.5%.

Most of the respondents (88.8%) were primary school leavers with few dropouts. There were 26 (7.3%) respondents with secondary school education.

69.6% of all respondents had at least a child to look after. Also 56.5% of them had at least a dependant to take care of.

Multiple sexual relationships was noted among barmaids. Three categories of sexual relationships were noted among these barmaids. These could be described as:

1. Regular sexual partner: this was described as one who comes on and off but in most cases has a committed sexual relation elsewhere. Respondents explained that their contact with partners in this category was purely for sex, which was not always paid for in cash. It was found that the highest number of regular sexual partners respondents had was 3, with a mean of one partner.

2. Casual sexual partners: these were described as those who were basically new or strangers to them and the sexual contacts were purely for cash payment.

3. Boyfriends: these belong to a special category. Boyfriends are regarded as potential husbands. Respondents expressed commitment to and respect for boyfriends. The maximum number of boyfriends reported was 2.

Only one barmaid mentioned she had had up to 10 casual sexual partners in a week. However the mean number of casual sexual partners was found to one.

Most of the barmaids had monthly salaries of between 10000/= and 14000/= Tanzanian shillings. The lowest salary was found to be 4000/= per month while the highest was 50000/=. There were two respondents who were selling and serving local

brew they prepared themselves. These two earned more than 90000/= a month. Another two respondents could not tell what their salaries were because they were newly employed and they had no salary agreement yet.

Only 22.8% (80) of the respondents had extra income generating activities. Among them 67.1% (55) had petty businesses such as selling groundnuts, cashew nuts and doughnuts; others 25,6% (21) were selling dress materials, khanga and few 4.8% (4) had mini groceries.

The assessment of income which barmaids earn take into account their salaries only. Barmaids make money from casual sex and they receive tips from patrons. But this kind of income could not be easily tracked and therefore is exclusive from the analysis. Incidentally some barmaids confided as making between 1500/= and 10000/= shillings per sexual encounter with casual partners.

Tables 2-6 represent the number and percentages of barmaids in terms of some of their socio-demographic characteristics as related to their monthly salaries.

Table 2 Respondents' levels of monthly salary in relation to their levels of education

*Level of education	Salary (T. Shs.)				N
	< 10000	10000-19000	20000-29000	30000+	
No educ. Ad. educ. Pr. Drop	5 (35.7)	8 (57.1)	1(7.1)		**14**
Pr. Compl.	18 (5.8)	226(72.2)	52 (16.6)	17 (5.1)	**313**
Sec.		14 (56.0)	6 (24.0)	5 (20)	**25**
Total	**23 (6.5)**	**248(70.5)**	**59 (16.8)**	**22 (6.2)**	**352**

Table 2 shows that 92.8% of barmaids with no primary or secondary education had salaries less than 20,000/= Tanzanian shillings and none of them had monthly salary of 30000/= or more. None of the barmaids with secondary education had salaries of less than 10,000/=. Only 6.2% of the respondents had monthly salaries of 30000/- shillings or more.

* No educ = no formal education; Ad. Educ= Adult education; Pr. Drop= dropout from primary school education; Pr. Compl.= completed primary education; Sec= secondary education

Table 3 **Respondents' levels of monthly salary in relation to number of their children**

Number of children	Salary (T. Shs.)				N
	< 10000	10000-19000	20000-29000	30000+	
None	5 (4.6)	69 (63.9)	23 (21.3)	11 (10.2)	**108**
One	12 (8.3)	107(73.8)	21 (14.5)	5 (3.4)	**145**
Two	5 (7.1)	53 (75.7)	8 (11.4)	4 (5.7)	**70**
Three or more	1 (3.4)	19 (65.5)	7 (24.1)	2 (6.9)	**29**
Total	**23 (6.5)**	**248(70.5)**	**59 (16.8)**	**22 (6.2)**	**352**

Table 3 shows that only 4.5% of those with at least one child did get a monthly salary of 30000/- or above. More than half of those with salaries of less than 10000/= had children to take care of.

Table 4 **Respondents' levels of monthly salary in relation to number of other dependants**

Number of other dependants	Salary (T. Shs.)				Total
	< 10000	10000-19000	20000-29000	30000+	
None	16 (69.6)	148(59.7)	20 (33.9)	11 (50.0)	**195(55.4)**
One	4 (17.4)	33 (13.3)	13 (22.0)	4 (18.2)	**54 (15.3)**
Two	1 (4.3)	36 (14.5)	15(25.4)	5 (22.7)	**57 (16.2)**
Three or more	2 (8.7)	31 (12.5)	11 (18.6)	2 (9.1)	**46 (13.1)**
N	**23**	**248**	**59**	**22**	**352**

In table 4 many of barmaids with salaries less than 20000/= did not have other dependants. This is different from those with salaries of 20000/= and above, where more than 50% of then had at least a dependant.

Table 5 Type of sexual relationships among barmaids in relation to their salary levels

Salary levels	Types of sexual partner			
	Casual	Regular	Boyfriend	N
< 10000	19 (82.6)	17 (73.9)	17 (73.9)	**23**
10000-19000	155 (62.5)	151 (60.9)	111 (44.8)	**248**
20000-29000	14 (23.7)	27 (45.8)	47 (79.7)	**59**
30000+	4 (18.2)	6 (27.3)	17 (77.3)	**22**

Chi square = 63.47 d.f. = 6 P value = 0.00001

Many of the respondents with relatively higher salaries of 20000/= or above had boyfriends. This is different from what was seen among respondents whose salaries were less than 20000/= whom many had casual sex partnerships. They also presented with high percentages of regular partners too. The Chi square test of P value < 0.001 was observed. This indicates there is evidence that better salary makes it unnecessary for the barmaid to look for a paying partner, but would rather have boyfriends.

Table 6 Respondents' levels of monthly income from other sources in relation to their monthly income

Salary (T.Shs.)	Earnings from other sources of income (T.Shs.)					
	< 10000	10000-19000	20000-29000	30000+	None	Total
< 10000			1 (4.3)		22 (95.7)	**23**
10000-19000	21(8.4)	9 (3.6)	8 (3.2)	19 (63.3)	191(77.0)	**248**
20000-29000		4 (6.8)	5 (8.5)	8 (26.7)	42 (71.2)	**59**
30000 +	1 (4.5)	3 (13.6)		3 (10.0)	15 (68.2)	**22**
N	**22**	**16**	**14**	**30**	**270**	**352**

Table 6 shows the number (and proportions in brackets) of the respondents who had extra earning in relation to their level of salaries. It can be seen that most of the respondents did not have additional sources of income. Most of the respondents who earned a minimum of 30000/= from other sources had monthly salary ranging between 10000/= and 19000/=. However they are the same group of respondents who form the majority of those earning less than 10000/= from the additional sources. It can also be seen that only one barmaid among those with monthly salary of less than 10000/= did have an additional source of income making her income to be closer to that of the respondents with higher salaries. It can also be seen that the proportion of barmaids who had an extra earning activity was increased with increased level of salary.

2. Assessing respondents' realization of the possibility for women's self protection against HIV infection.

Respondents gave responses as to whether they perceive self-protection against HIV infection was possible or not. They elaborated on their responses and suggested whom they perceived as responsible for their protection and why. They also gave reasons as to why most women were at risk of acquiring HIV infection.

Tables 7-10 give frequency distribution of the common responses for each inquiry.

Table 7 Frequency distribution of barmaids' responses to the question: Is women's self protection against HIV infection possible?

Response	Number of barmaids	Percentage
Possible	290	81.5
Not possible	50	14.0
Don't know	16	4.5
TOTAL	**356**	**100**

Different means which women could protect themselves against HIV infection were mentioned. Some respondents mentioned only one method while others mentioned multiple methods.

on the condom as one reason. 5.9% expressed the opinion that the female condoms, which could be ideal, were not readily available.

Unwillingness of men and women to change behaviour which was mentioned by slightly over quarter of the respondents referred to the tendency for men to have multiple sexual partners and women being lured by money.

Table 10 gives the groups of people perceived by respondents to be responsible for women protection against HIV infection.

Table 10 Respondents' views as to who is responsible for women protection against HIV infection.

Responsible	Number of Respondents	%
1. Both men & women	192	53.9
2. Women themselves	81	22.8
3. Men	36	10.1
4. Society as a whole	35	9.8
5 The Government	10	2.8
6 DON'T KNOW	2	0.5
TOTAL	**356**	**100**

Views given as to why women are prone to HIV infection can easily be grouped into five categories as shown in table 11.

Table 11 Categories of reasons as to why women are prone to HIV infection as expressed by the corresponding number of barmaids

Reasons	Number of Respondents	%
Economic	286	80.3
Behavioral	273	76.7
Biological/Anatomical	70	19.7
Socio-cultural	53	14.9
Don't know	4	1.1

N= 356

Some respondents gave multiple reasons. The majority gave reasons which fell into the economic and behavioral categories.

Generally, most respondents were of the opinion that women self-protection against HIV infection was possible though use of the male condom.

3. Assessing respondents' ability to negotiate safer sex in order to protect themselves against HIV infection.

Open-ended questions were used to elicit information about respondents' ability to negotiate safer sex. The questions sought to establish whether the respondents:

I. knew about safer sex;

II. knew about condom;

III. made efforts to prevent unwanted conception

IV. made efforts to prevent getting infected with STDs and HIV infection;

V. were able to decline unwanted sexual advances

VI. made consistent attempts to negotiate safer sex

VII. were consistently able to avoid having unprotected sex

318 (89.3%) respondents were found to have correct ideas about the concept of safer sex. Statements considered to reflect knowledge of safer sex included; -prevention against sexually transmitted diseases; prevention of sexually transmitted diseases and conception; use of condoms during sex; being faithful with one sexual partner; abstinence.

All 356 respondents knew about condoms. 86.5% mentioned two types of condoms: the male and female condoms, whereas 13.5% knew about the male condom only.

As whether respondents made any attempts to prevent conception it appeared that only 3.4% of the 356 respondents did not bother to take any action. Most of the

respondents said they used male condoms, female condoms, took oral contraceptives, had the Depo-Provera injection or Norplant implants. Others used the calendar method (Safe days) or asked the male partner to withdraw.

As for attempts to prevent HIV infection, the respondents mentioned use of male condom, or female condom. 88.8% of the respondents reported to attempt prevention against HIV infection.

More than 95% reported that they were able to decline unwanted sexual advances. But when asked to explain exactly how they did it, only 66.3% said they could directly say 'no'. The other admitted that they would not say 'no' directly.

When asked whether they were able always to negotiate protected sex, only 28.9% insisted that they were able to do so although they were not always successful.

Thus 72.7% said they sometimes ended up having unprotected sex. Only 33.4 % claimed that they always had protected sex, either following negotiation or even without it.

If the items used to assess respondents' ability to negotiate safer sex are treated as constituting an Ability Test, the following observation becomes apparent:

- Only 25 or 7 percent of the respondents scored all the seven items correctly, and can be considered as 'most able' negotiators of safer sex.

- 85 or 23.9 per cent of the respondents scored six items correctly. These can be considered to be 'more able' to negotiate safer sex.

- 148 or 41.6 per cent of the respondents scored five test items correctly. These can be regarded as 'just able' to negotiate safer sex

- 98 or 27.5 percent of the respondents scored only four or less test items correctly. It can be assumed that these are unable to negotiate s safer sex.

Table 12 shows total scores and the frequencies of the respondents according to how they were judged for each question.

Table 12 Scores and number of respondents found following the criteria set to assess their ability in negotiating safer sex

CRITERIA	I	II	III	IV	V	VI	VII	TOTAL SCORES				No of respondents
								7	6	5	≤4	
All barmaids 356	Y	Y	Y	Y	Y	Y	Y	✔				25
	Y	Y	Y	Y	Y	Y	N		✔			17
	Y	Y	Y	Y	Y	N	Y		✔			43
	Y	Y	Y	Y	Y	N	N			✔		103
	Y	Y	Y	Y	N	Y	Y		✔			14
	Y	Y	Y	Y	N	Y	N			✔		13
	Y	Y	Y	Y	N	N	Y			✔		9
	Y	Y	Y	Y	N	N	N				✔	56
	Y	Y	Y	N	Y	Y	Y		✔			5
	Y	Y	Y	N	Y	Y	N			✔		3
	Y	Y	Y	N	Y	N	Y			✔		3
	Y	Y	Y	N	Y	N	N				✔	11
	Y	Y	Y	N	N	N	Y				✔	2
	Y	Y	Y	N	N	N	N				✔	4
	Y	Y	N	Y	Y	N	N				✔	2
	Y	Y	N	N	Y	Y	Y			✔		1
	Y	Y	N	N	Y	N	N				✔	4
	Y	Y	N	N	N	N	N				✔	3
	N	Y	Y	Y	Y	Y	Y		✔			6
	N	Y	Y	Y	Y	Y	N			✔		6
	N	Y	Y	Y	Y	N	N				✔	5
	N	Y	Y	Y	N	Y	Y			✔		10
	N	Y	Y	Y	N	Y	N				✔	2
	N	Y	Y	Y	N	N	N				✔	5
	N	Y	Y	N	N	N	N				✔	2
	N	Y	N	N	Y	N	Y				✔	2
TOTAL	Y(318) N(38	Y (356)	Y (344) N(12)	Y(316) N(40)	Y (236) N(120)	Y (103) N(253)	Y(119) N(237)	**25**	**85**	**148**	**98**	**356***

* Numbers in brackets in the total row give frequency for either 'Y' or 'N' responses.

Table 13 **Respondents ability to negotiate safer sex in relation to their responses to the question: Is women's self-protection against HIV infection possible?**

Response	Able	Just able	Unable	N
Possible	94(32.3)	125(42.9)	72(24.7)	**291**
Not Possible	12(24.0)	16(32.0)	22(44.0)	**50**
Don't know	4(26.7)	7(46.7)	4(26.7)	**15**
TOTAL	**110 (31.3)**	**148 (42.0)**	**98 (27.5)**	**356**

Chi Square = 9.16 d.f. = 4 P value = 0.057

In each rank, many of the respondents perceived women's self-protection against HIV infection as possible. However a relatively higher percentage of those who expressed self-protection as not possible were 'unable' to negotiate safer sex. But this difference in perception was not significant with the p-value >0.05. This shows that respondents' perception of possibility for self-protection was not associated with their ability to negotiate safer sex.

Table 14 **Respondents' perceived ability to negotiate safer sex in relation to their perception of who should be responsible for women protection**

Who's responsible	Able	Just able	Unable	N
Women themselves	28 (34.6)	32 (39.5)	21 (25.9)	81
Men only	3 (8.6)	16 (45.7)	16 (45.7)	35
Both men &women	74(39.4)	75 (39.9)	39 (20.7)	188
Society	4 (11.1)	22 (61.1)	10 (27.8)	36
Govt only	1 (10.0)	2 (20.0)	7 (70.0)	10
TOTAL	110 (31.3)	148 (42.0)	94 (26.7)	352

Chi Square = 35.10 d.f = 8 P value = 0.000

Only a few (8.6%) of the barmaids who perceived men as responsible for women's protection were ranked as 'able' to negotiate. Most of those who perceived it as Government's responsibility were 'unable' to negotiate safer sex. With the statistical P-value <0.05, it suggests for respondents to perceive themselves as not responsible their own protection made them unable to negotiate safer sex.

4. Assessing respondents' awareness of the unique attributes of the female condoms for women's self –protection against HIV infection

Awareness of the female condom was first established basing on whether they had ever heard about, seen and used the female condom. Table 15 summarizes the findings by giving proportion for each aspect.

Table 15. Number and proportion of the barmaids who had heard and accessed the female condom

Aspects	Number of the respondents	Percentage
HEARD	308	86.5
SEEN	121	33.9
ACQUIRED	49	13.8
USED	36	10.1
		N= 356

Most (86.5%) of the barmaids had heard of the female condom but only a few (10.1%) had used it. This means only 11.7% of those who had heard had tried to use it.

Those who had never seen the female condom were shown one, and then all respondents were then asked what they thought about it and what they liked about it. Table 16 summarizes attributes of the female condom which the respondents highlighted.

Table 16 Perceived unique attributes of the female condom as viewed by the corresponding proportion of the barmaids

Attributes	Number of Respondents	Percentage
It is worn exclusively by women	297	83.4
It can be worn earlier before sex	161	45.2
It gives women opportunity to talk about safer sex and sex in general	91	25.6
Women can use it during sex without partner's awareness	25	7.0

N=356

The fact that the female condom is worn by women was the key attribute mentioned by most respondents. Slightly less than a half of the respondents expressed their appreciation of the fact that it can be worn quite earlier before sex.

5. Respondents awareness of the effectiveness of the female condom over other female methods of contraception for protection against HIV infection

Table 17 summarizes their responses with the corresponding percentage of respondents as to how they perceived the female condom as compared to other contraceptive methods used by women. The focus was on prevention of STDs and HIV infection.

Table 17. Proportion of the barmaids according to their awareness of the effectiveness of the female condom over other female methods of contraception for protection against STIs and HIV infection

Contraceptive Method	Percentages of barmaids who mentioned it as a contraceptive	Percentages of barmaids who mentioned it as providing dual protection
Nonoxyl-9 spermicides	7.3	
Diaphragm	1.4	1.1
Cervical cap	5.9	
Pills	93.5	
IUCD	82.9	
Depo-Provera	92.7	
Norplant	73.9	
Female condom	80.3	96.3
Tubal ligation	42.7	
		N=356

Although more respondents mentioned pills, Depo-Provera and intrauterine contraceptive device (IUCD) than those who mentioned the female condom as a contraceptive, most of the respondents mentioned the female condom as the contraceptive method which can also prevent STDs and HIV infection.

6. Respondents' ability to negotiate safer sex in relation to their socio-demographic characteristics.

This section explores how respondents' ability to negotiate safer sex varies with their socio-demographic characteristics. The socio-demographic characteristics in question are those of age, marital status, level of education, number of children and other dependants, monthly income and income from other sources, as well as the number of sexual partners they may have. The variable which is considered in this exercise is the ability for negotiating safer sex and this is taken as proxy for sexual empowerment.

The most able and more able respondents have been grouped together.

Table 18 Respondents' perceived ability to negotiate safer sex in relation to age

Age group	Able	Just able	Unable	N
≤19	7(41.2)	4 (23.5)	6(35.3)	**17**
20-29	80(31.1)	111 (43.2)	66 (25.7)	**257**
≥ 30	23(28.0)	33(40.2)	26(31.7)	**82**
Total	110 (31.3)	148(42.0)	98(27.5)	**356**

Chi square = 2.8 d.f. = 4 P-value= 0.592

In each level of ability to negotiate safer sex the most prevalent age group was between 20 and 29 years of age. With exception of the few who were under 19, in each age group most respondents were 'just able' to negotiate safer sex. However the

P-value for this table is not statistically significant (P>0.05). That is the difference in age seen does not account for the difference seen in the negotiation ability in this study sample.

Table 19 Respondents' perceived ability to negotiate safer sex in relation to their level of education

Level of education	Able	Just able	Unable	N
No educ Ad. Educ Pr. (drop)	3 (21.4)	5 (35.7)	6(42.8)	**14**
Pr.(compl)	95 (29.9)	134(42.3)	88(27.8)	**317**
S	12 (48.0)	9 (36.0)	4(16.0)	**25**
Total	110 (30.9)	148(41.6)	98(27.5)	**356**

Chi Square = 4.67 d.f= 4 P value= 0.323

Most of the respondents with secondary education (48%) were 'able' to negotiate safer sex; whereas higher proportions of others with either primary or lower education were 'just able'. From statistical Chi-square testing, this difference was not significant (P-value>0.05). This suggests that there was no association between level of education and ability to negotiate safer sex among these respondents.

Table 20. Respondents' perceived ability to negotiate safer sex in relation to to their monthly salary.

Salary in Tshs	Able	Just able	Unable	N
< 10000	5 (21.7)	10 (43.5)	8 (34.8)	**23**
10000-19000	57 (22.9)	112 (45.2)	79 (31.9)	**248**
20000-29000	35 (59.3)	19 (32.2)	5 (8.5)	**59**
30000+	12 (54.5)	7 (31.8)	3(4.5)	**22**
Total	109(30.9)	148(42.0)	95(25.9)	**352**

Chi Square= 41.80 d.f=6 P-value=0.000

Most of the respondents who had salaries of less than 20000/= were in the 'just able' group while the majority of others with higher salaries were in the 'able' group.

There were two respondents who were selling their own locally made liquor (not included in the table) who were both ranked as 'unable' in negotiating safer sex. Also the two respondents who did not know their salaries (not in the table) one was found to be 'able' and the other 'unable'.

The statistical testing shows P value<0.05. This suggests that the level of salaries of the respondents was associated with their ability to negotiate safer sex.

Table 21 **Respondents' perceived ability to negotiate safer sex in relation to number of their children**

Number of children	Able	Just able	Unable	N
None	45 (41.3)	35 (32.1)	29 (26.6)	**109**
One	38 (26.4)	73 (50.0)	33 (22.9)	**144**
Two	19 (26.8)	29 (40.8)	23(32.4)	**71**
≥Three	8 (26.7)	11(36.7)	13 (40.6)	**32**
Total	110 (30.9)	148 (41.6)	98(27.5)	**356**

Chi Square= 13.08 d.f=6 P value= 0.04

Many of the respondents with no child were in the 'able' category as compared to others that had at least a child, whom the majority was in the 'just able'. The statistical Chi-square gives a P-value <0.05. This suggests that having children was associated with inability to negotiate safer sex among the respondents.

Table 22 **Respondents' different types of sexual relationships in relation to their perceived ability to negotiate safer sex**

Ability to negotiate	Types of sexual partners			N
	Casual	Regular	Boyfriend	
Unable	65 (66.3)	59 (60.2)	49 (50.0)	**98**
Just able	92 (62.2)	86 (58.1)	68 (45.9)	**148**
Able	36 (32.7)	56 (50.9)	71 (64.5)	**110**

Chi square = 42.34 P-value = 0.00001

Though respondents could have more than one type of sexual partner, high proportions of respondents who are unable to negotiate safer sex are found to engage

into casual sexual relationships. Many of those ranked as able had boyfriends. With a P-value< 0.05 it shows that being engaged more into casual partnership contributed to their inability to negotiate safer sex.

QUALITATIVE INFORMATION

The following section gives the qualitative information given by the respondents under the stated themes. This information supplements the quantitative data presented in the previous section. The presentation corresponds to the themes under which the quantitative results are organized.

1. Assessing respondents' realization of the possibility for women's self protection against HIV infection.

Respondents had different answers as to whom they thought was responsible for women's protection against HIV infection (Table 10).

Respondents who expressed the opinion that it was up to ***women*** to protect themselves argued that;

"It is women who decide to have sex or not. It is their duty to make sure that the man puts on the condom. If the man cannot put it on himself then she has to put it on him".

"There's CARE nowadays we can easily put it on especially when a man is drunk he can hardly notice anything and that way you protect yourself"*

"Women are the ones who are highly affected as well as their children so they have the responsibility to look after themselves"

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* CARE is a trade name for female condoms sold in Tanzania.

Those who gave an opinion that it is ***the men*** who are responsible for women's protection made the following statements;

"Men are the ones who wear condom"

"Some men who put on condoms do punch holes in them" (wanapiga ukucha)

" Men are the ones who always deceive young ladies by offering them some material goods, money or sometimes just sweet words, for sex".

"Men are more powerful. If they refuse to put on condoms you can not do anything"

The majority of respondents (53.9%) saw that **both men and women** need to cooperate in the struggle against HIV infection. The common argument was that,

"it needs more than one partner to accomplish women's protection".

For those who thought that it was the ***Government*** which was responsible, commented that it is the Government's responsibility to see to it that her people change behavior.

"The government has to use the media and the leaders to condemn behaviors which expose women to HIV infection"

"Government leaders should intervene our employment and salary schemes"

Some mentioned that the ***society as a whole*** should be responsible for women protection against HIV had the following views;

"When a woman is infected many people who depend on her are affected too (jamii inayomtegemea itaathirika)"

"Community elders, parents and guardians need to alert their people"

" Religious people need to be involved fully in this because they can easily convince their believers to change behavior".

"Employers should raise our salaries so that we are able to meet our own needs"

Then the respondents gave a number of reasons as to why women are prone to HIV infection (Table 11). These included economic, behavioral, biological/anatomical and socio-cultural reasons.

Economic reasons

Economic reasons given included the fact that most women had a meagre or no income and they could not meet their end needs. As one respondent said,

"At least those who have husbands at home have some support but others like me are prone to accept offers... and that way we end up giving our bodies in exchange."

Others blame their job which pays poorly as contributing to their economic vulnerability. They commented that,

"Our job is low paying and risky, sometimes we get loose because we don't

have enough in the pocket. It is not that we like to behave that way."

"It is just because of life difficulties ... no one would like to have so many sexual encounters."

Working long working hours in the bars was also mentioned as a factor hindering barmaids from doing other income generating activities.

"We work long hours. We don't have time do other income generating activities. The few hours we get off duty go into housekeeping activities, then oops! It's time for duty again. And that's the trend unless you quit the job".

Others indicated that they were aware of the risk which having multiple sexual encounters poses but could not help it:

"After all there is this killing disease AIDS... you are tempted when a man shows you a bundle of money and you know that sure you need it, then you just have to accept it."

"When you need money badly you are unable to insist on condom use"

"Sometimes I make sure I get his money then I look for a way to escape, but sometimes I fail."

Behavioral reasons

One respondent who had only one long-term boyfriend said the following:

"This is just someone's behavior because when you agree to work in bars you are told right away what is going to be your salary; so this promiscuity has got nothing to do with poverty, it is just someone's behavior "

Others said,

"We women tend to have so many unnecessary and excessive demands which we can hardly afford"

"Many women are not satisfied with the little they have"

Biological/Anatomical reasons

Some of respondents pointed out reasons reflecting the unique female anatomy. That the structure of female reproductive organ is such that it can immediately receive than it can provide, anything poured in and that is why women can easily end up with unwanted pregnancies and sexually transmitted diseases.

One respondent stressed her opinion that,

"Menstrual periods exposes women more to such infections".

Others said,

"Our bodies are structured just to receive"

Socio-cultural reasons

Some other respondents saw that the socio-cultural environment had a role in exposing women to HIV infection. Opinions given were that the society treats men as superior and most of them feel they hold the decisions on how to go about sex.

"Even the condoms which are available are meant for men"

"Most of the male partners do not give room for discussion about condom"

"Men are very stubborn ... it is so hard to convince one to put on a condom if he doesn't want"

2. Assessing respondents' ability to negotiate safer sex in order to protect themselves against HIV infection.

Respondents had different opinions which were used to judge their ability to negotiate safer sex (Table 12,13 and 14).

Knowledge on Safer sex

As stated earlier most of the respondents had correct ideas about safer sex.

Explanations they gave include the following:

"Safer sex deals with condoms"

"Those are condom issues"

"It deals with preventing sexually acquired infections".

" Practicing safer sex is preventing sexually acquired infections, pregnancy and being faithful to one sexual partner."

Attempts against conception

Most of the respondents made attempts to prevent conception:

"I do not see why I should bother to tell someone to consider avoiding impregnating me... I simply take my pills earlier each day before I go for duty, ...at least if I fail to make him put on condom I am safe against pregnancy"

Another one said she tells the man,

"Hey, we are not here to reproduce... we are just having good time so please put on your condom I don't want to conceive."

Others said,

"When I am on unsafe days I keep reminding him, 'make sure you do not pour in me'... and if does, oh it is a great quarrel that day!"

Another one said,

> *"You know pills are not good for me so I always count my days. When it is not safe I don't have sex because most men are very stubborn,... they refuse to use the condom. When you conceive they are not there for you... I have had an abortion and I don't want to repeat."*

Attempts against sexually acquired infections including HIV

Many respondents appeared to depend on the male condom for their protection against infections. They said they always make sure to have male condoms in their pockets for their partners to put on. One of them said,

> *"Some partners say they want unprotected sex because they have no condoms with them. So we make sure we have at least a few all the time"*

Sometimes they have to put the condom on the man;

> *"When a man is and you want to be safe then you just make sure to put the condom on him... There are many ways to do that, you may caress his manhood while you fit it on... It is difficult but we do it... Otherwise I would be dead by now!"*

One respondent who said she uses the female condom had this to say:

> *"I do not have much to talk especially when a man is drunk... I just insert my CARE earlier on... and many of them will go without noticing it."*

Declining unwanted sexual advances

Although many respondents said they could turn down unwanted sexual advances, only a few said they could express their objection directly. They would say:

"I do not want"

"I do not love you" *"look for others"*

"I have my own partner/husband... so stop disturbing me"

"I tell him I don't want and if the problem is the offer to 'keep change' I simply return it to him."

Consistency in negotiating for safer sex

Many respondents reported that once in a while they try to negotiate safer sex.

The few who claimed to be consistent in their attempts at negotiating safer sex said:

"I don't want to conceive"

"Please put on your condom there is virus nowadays"

"You know we barmaids meet many men like you, so let us don't trust each other"

"I have a female condom we can use it if you do not want us to use yours."

Protection as an outcome

The goal is for the barmaids to avoid having unprotected sex. Most of the respondents admitted to have had unprotected sex several times even if they attempted to negotiate. The few who claimed to be successful in avoiding unprotected sex maintained that;

"I would rather stay awake the whole night than having sex without a condom"

"If he refuses to use condom then that is the end of the contract".

3. Assessing respondents' awareness of the unique attributes of the female condoms for women's self-protection against HIV infection

Respondents explained in different ways how they view the female condom (Tables 15 and 16). They said:

"This now is ours"

"This is different from the condom that we are used to, this is worn by a woman"

"You see, this is specially for us...because as we finish our duty at night most of us are already drunk and we may not remember to tell a man to put on his condom, as he might also be drunk"

Another woman who saw the female condom for the first time said,

"I am delighted because this one can be worn quite earlier before going to bed, and it minimizes embarrassments when it comes to ascertaining whether your partner has the condom on or not."

Some saw a need of having the female condom despite the existence of the popular male condom. One of them said,

"Yeah it is okay let us women have our condoms too ...that is equality and freedom in love affairs"

" It seems that this one will not bursts easily and will be more effective in providing protection"

"This is good, because it appears you do not have to stop what you are doing and start putting it on"

Among those who had used the female condom five respondents said their partners had commented that the female condom does not tight them. However two of these reported that their partners said they did not notice any difference when compared to the male condom. Only three respondents who used the female condom reported that their partners expressed concern about reduced pleasure during sex.

Female condom users also reported some problems with its use.

"It seems difficult to use".

Most respondents were concerned about the high price charged for female condom. They complained that the female condom did not have a fixed price. Despite the fact that it is supposed to be sold at 300 shillings it's price goes up to 1500 shillings. Some of these respondents then said,

"The female condom it is meant for the financially able people."

Regarding the availability of female condom, many of the respondents were concerned that it was not easily available.

One of them said,

"This female condom does not have any contribution in the fight against HIV because it is not available"

Another one made the following observation,

> *" We see it just as an item for advertisements an not a real thing, it is not known, not seen, we just hear about it... but if it is real I think it will be an ideal choice"*

Those who knew where to get it said,

> *"It has been made available in pharmacies, and other business places but not in the bars or guest houses where most of us go"*

> *"This device is for commercial purposes (hii kitu ni ya biashara tu). It is advertised in towns, it is very expensive, and it is only made available in towns. Most of us who would need it are not well informed about it and have to rely on male condom which are available for free"*

The advent of the female condom seems in the mind of these respondents to have negated the need for behavioral change.

This qualitative information has supplemented the quantitative results, which gave the magnitude of the stated issues. The qualitative information therefore has reflected in reality what the barmaids experienced regarding those issues.

DISCUSSION

Implementing women sexual empowerment aiming at prevention of HIV infection is not a simple action. It needs multifaceted approaches to be well accomplished. These approaches should focus on the economic, social and sexual needs of the marginalized groups of women. This, as expressed by barmaids in this study, involves more than one group of people to empower them sexually.

The efforts directed at fighting against HIV infection among women have to find ways of empowering them for negotiating safer sex. One of the paths laid down by UNAIDS in this move is to re-enforce women's economic independence (UNAIDS 1997). As it was reported in many other studies most women are vulnerable to HIV infection because of economic inequality and their dependency (Ulin 1992).

The results of this study show that over 90% of the barmaids had salaries well below 40,000 Tanzanian Shillings (T.Shs). On average these salaries are lower than the Tanzanian minimum wage of 45,000 shillings. Some barmaids received salaries which were below the Tanzanian poverty line of $ 0.65 a day (IMF 2000). Even for those few barmaids who had some extra earnings many of them did not meet these levels. The findings suggest that there is no uniform system for deciding on barmaids' salaries among bar employers. Furthermore the finding that some barmaids started working without knowing their payment levels suggests that there are no regulations on employment in this sector.

Although increasing political voice for women and to protect human rights is recommended for improving women's economic dependency (UNAIDS 1997), barmaids do not seem to be recognized in the workers associations or political platforms that would protect their welfare.

Girls in African culture do not have any share in the inheritance, and therefore these barmaids were not expected to have valuable property such as farms or other wealth from their families. Many barmaids had dependants to look after even though they were unmarried, separated or divorced. They had to maintain their own lives as well as that of their dependants on very meagre salaries. This rendered them vulnerable to involvement in risk sexual behaviors to supplement their income. Hence barmaids become victims of their gendered social roles of nurturing children (Matos Ala 1998).

Denying an African girl child the opportunity for better education seems to have happened to most of these barmaids. Low level of education among barmaids as seen in this study did not qualify them even for low waged jobs. In most cases through traditional division of labor, women are expected to earn little or none (Ulin 1992). This concept is perpetuated in jobs done by women who have low or no qualifications. Bar owners consider barmaids as cheap labor because of their low qualifications.

Barmaids' employment, which takes most of their time, does not make them meet most of their basic economic and social needs. Several programmes need women to adopt alternative income generating activities, which do not expose them into risk

behaviors (NACP 1998; UNAIDS 1997). But prolonged working hours and lack of proper skills make barmaids unable to engage themselves into extra income generating activities. Instead most barmaids engage themselves into multiple sexual relationships as their survival strategy.

This survival strategy make barmaids more vulnerable to HIV infection, STDs and unwanted pregnancies, as most of them were concerned about their working environment, which constituted high-risk situations. These are situations of constant seduction into sexual relations as well as sexual harassment. Just as seen in other studies many of them succumbed into having sexual relationships in exchange for money (Mgalla and Pool 1997, Mhalu F. *et al* 1991).

Barmaids lack social support in their efforts to sustain life. Their employment subject them into more risks, and like many other Tanzanian women, barmaids do not seem to seek for their legal rights (Outwater 1996). This can be explained by the traditional differential access to information and gendered access to resources (Mbughuni 1994).

Even when women make efforts to liberate themselves from male dependency, male dominance in most African cultures continues to prevail. Men continue to decide on how the money earned by their spouses is to be spent. Thus some barmaids in this study reported as having no control over how the money they earn is spent.

Though Tanzanian NACP consider barmaids in the group of prostitutes, these are women who have been employed for defined purposes and not for prostitution. They

are not targeted as a special group deserving particular attention, though they may serve as core transmitters of HIV infection.

Many barmaids make unfruitful efforts in protecting themselves against HIV infection. Being economically deprived with the prevailing male dominance in the patriarchal society, barmaids' initiatives fail to win their partners support for implementing safer sex.

Most barmaids perceived men as not recognizing the risks of acquiring HIV infection through unprotected sex. As it had also been found in other studies, male partners were seen as obstacle in condom use (Blogg *et al* 1994; Ray *et al* 1995; Jenkins *et al* 1995).

Despite the fact that barmaids reported that they try to get their casual sexual partners to use condoms, findings of this study show clearly that they have no negotiation power. Women have to take the initiative to avoid unprotected sex but the findings indicate that barmaids perceived women's protection to be the responsibility of the male partner. This was particularly the case among the categories of barmaids found to be less able to negotiate safer sex.

For a woman to be able to negotiate she has to have some skills. Negotiating safer sex involves communication between the partners about sex as well as what is needed to make it safer. Successful negotiation needs support and practice. For a woman to be able to communicate about safer sex and to avoid having unprotected sex or being

able to decline unwanted sexual advances are indicators for women sexual empowerment (UNAIDS 1997).

Barmaids identified the means to achieve self-protection which are expressed by the concept of 'fleet of hope'. This concept emphasizes three options for healthy behavior (Joinet and Nkini 1996). These are abstinence, fidelity and condom use. Though adoption of these options needs consistency, one can shift between options in order to achieve self-protection against HIV infection and STDs.

The male condom was considered by the majority as the main means for barmaids' self-protection. As only a few realized that the female condom was meant for their self-protection, it poses a question concerning familiarity of the device and hence how quickly this can become a reality for their self-protection.

Despite the increasing recognition of the importance of equal gender relations, many programmes continue to work solely with women in an attempt to help empower them in sexual relationships (Becker 1996). But men have to share the responsibility for protecting women.

The female condom is an intervention that focuses on women sexuality by enabling them to practice safer sex (Ray *et al* 1995, Blogg and Blogg 1994, Janneke 1999). It is meant to increase the options that women can deploy for negotiating safer sex. But because of the patriarchal nature of society, the barmaids' experienced difficulties in convincing men to practice safer sex may continue even with use of the female

condom. As such men's support remains to be a crucial resource for a successful negotiation process.

This study found that the barmaids who used the female condom used it stealthily. This suggests that despite being able to use the female condom these barmaids did not communicate with their partners about it. Obviously this appears to have worked for them because many of the men they had sex with tended to have been under influence of alcohol. Consistent use of the female condom requires that one has to be able to win the cooperation of the male partners.

Studies revealed that barmaids and other women who practice prostitution can communicate more openly about sexual issues as compared to other women who are in 'non-commercial' sexual relations (UNAIDS 1999;Mgalla and Pool 1997). But the major problem among barmaids was how to communicate successfully about safer sex. The underlying factor that led most barmaids to fail in their negotiation process was their economic status. Those barmaids who had better income appeared to be more able to negotiate than the others.

Though detailed risk assessment was not done in this study it can therefore be said that most women were conscious of the fact that they were at risk of HIV infection and that they were victims of their means of survival.

Negotiating safer sex as expressed by barmaids appears as a process that most barmaids would like to succeed through. Carter and others also found that women and

men have unique roles in the negotiating process but women have to play a more active role in negotiating condom use while men play a more reactive role (Carter *et al* 1999).

The findings in this study suggested that although the majority of barmaids interviewed had heard of the female condom only a few had made efforts to access it. Nevertheless most of the barmaids recognized the importance of female condom within the context of their risky working environment. In particular they appreciated the fact that it can be worn long before the sexual encounter and that its use is not purely a man's affair. Other studies have also found that the female condom is quickly accepted among women at higher risk of acquiring HIV infection because of these attributes (Deniaud 1997; Blogg and Blogg 1994; Ray *et al* 1995; Jenkins *et al* 1995; WHO 1997).

Barmaids perceived positively the effectiveness of the female condom, but 90% of them had never tried to use it. They also recognized the dual protection which the female condom provides as compared to other female-controlled contraceptives. But in practical terms, the effectiveness of the female condom in preventing HIV infection, STDs and unwanted pregnancies is when it is used correctly and consistently in every act of sexual intercourse. This means that condom use needs consistent efforts in negotiating its use.

If still faced with their current economic and social situation, the introduction of the female condom to barmaids may not be the ultimate solution to their sexual disempowerment.

The popular male condom worn by men seems to make the barmaids to project their failure to achieve protected sex on men's sexual behaviors. The issue appears to be that if only men would cooperate and agree to put on the condom they would not be at risk of infection. Through women sexual empowerment women have to use their capacity to influence their individual situation by bringing about social changes (Zorrilla and Santiago 1998). But this empowerment aiming to protect them against HIV infection through use of female condom is not meant to threaten the balance of power in sexual relationships, but to add to the existing efforts.

An unpublished study was conducted by PSI-Tanzania in 1997 to establish the acceptability of female condom among middle-class women in Dar Es Salaam. It found that women found difficult to convince their male partners to use the female condom. Also some partners expressed that they took no responsibility when the female condom was used. This may suggest that men consider the device as meant to shift the responsibility rather than to share it.

As many other studies have found, the barmaids in this study lacked self-esteem largely because of their economic and social deprivation (UNAIDS 1997). Although there were some barmaids who reported to had never had unprotected sex, their pattern of negotiation and attempts to decline unwanted sex were not consistent. This

suggests that even the protected sex they reported to always practice may have been by default. Also a contradictory finding that some barmaids who perceived self-protection as possible did not make any effort to negotiate safer sex suggests that some barmaids who were judged to be able to negotiate could not do so when faced with a real situation.

Despite their sub-ordination women still recognize the importance of their social roles. In this study barmaids expressed their concern that the people who depend on them, especially their children would be affected if they got infected.

Prevention for unwanted pregnancies was well understood than that for HIV infection. Some did demand use of male condoms purely as a method for contraception. Other studies have also shown that women are more conscious about conception than infections (Ray *et al* 1995).

Though many barmaids expressed self-criticism as regards their tendency to demand more than they can afford, other studies found that most men especially the older ones do take advantage of this weakness by providing them with material goods or money (Ankrah 1995). In this study offers from their customers found to be one of the methods used to lure barmaids into sexual relationships.

Need for other behavior change such as abstinence and fidelity was hardly advocated for by many barmaids. They perceive sexual relationships with men as solutions to their immediate problems. The fact that barmaids thought that married women were

better off because the man will always provide further indicates how most of them had a notion that men would always have enough to provide.

UNAIDS path to empowerment recommend that women-friendly services should be accessible and affordable to them (UNAIDS 1997). But this does not appear to be the case with for the female condom. Barmaids were concerned about the price of the female condom, and the fact that it was not easily available in areas where high-risk behavior is highly practiced.

The concern expressed by these barmaids to the effect that this device which is meant to empower women in the fight against STDs and unwanted pregnancies was unaffordable to those really in need. It should be emphasized that most women are at risk of acquiring HIV infection but these are the same people who may not be able to afford the female condom.

It appears from this study that if the female condom is to successfully empower marginalized women its accessibility and affordability has to become a reality to them. To make use of female condom among barmaids, prostitutes and other women at risk a sustainable proposition their purchasing power which currently constitute an obstacle has to be addressed. This is a challenge for the social marketing system through which the female condom is marketed in Tanzania.

Some barmaids had wrong ideas about their bodies. They thought that menstruation cycles expose then to HIV infection. Such an idea may make them think that there is nothing they can do to prevent HIV infection.

Therefore the mixed feelings among the barmaids on viewing their economic potentials suggest that the women working in bars are not uniform. Most do lack skills to enable them earn from extra sources. Many expressed that their job was *"risky and low paying"* but still they had to continue working. This was seen even in a study done by Mgalla and Pool (Mgalla and Pool 1997) who found that most of the barmaids interviewed did not like the job only that it was the readily available alternative.

To empower barmaids sexually is therefore not a one-dimensional move. It needs to provide them simultaneously with multiple skills to meet their basic economic needs, to meet their social demands and to successfully practice safer sex.

Barmaids are therefore one of the groups of women who deserve public health attention. Many women with low earnings irrespective of the nature of their economic activities do experience the same risks (UNAIDS 1998). Therefore the findings of this study have relevance to what other women with the same economic status who face the risk of HIV infection.

CONCLUSIONS

i. Most barmaids realized the possibility for women self-protection.

ii. Most barmaids fail in their efforts to protect themselves against STDs and HIV infection as well as unwanted pregnancies.

iii. Multiple factors seem to underlie the barmaids' vulnerability to STDs and HIV infection as well as unwanted pregnancies.

iv. Poor economic status among many barmaids continues to be a leading factor exposing them to practice high-risk behaviors. Lack of capital and skills for alternative income earning activities exist among barmaids.

v. Barmaids' employment does not improve their financial status but exposes them to the risks of acquiring HIV and other STDs as well as unwanted pregnancies.

vi. Low income and having dependants are the predisposing factors for barmaids to acquire casual sex partners and contribute to their inability to negotiate safer sex.

vii. Lack of negotiation skills is a major drawback in barmaids' efforts to protect themselves.

viii. Men still stand as the main obstacle and contributors to barmaids' vulnerability, be it economic, cultural or biological.

ix. The long time male condom appeared to have done no better as far as prevention of HIV infection among barmaids is concerned.

x. Many barmaids perceived the attributes and effectiveness of the female condom more positively. Barmaids showed need for adopting its use in future though their concern about the price, availability and consistent use remained the same.

xi. Many barmaids did perceive the female condom as a means to empower them sexually.

xii. Many barmaids did not seem to focus on behavior change

xiii. Lack of proper knowledge about their own bodies among women may contribute to the fact that some women do not sense that they more likely to be infected than men.

RECOMMENDATIONS

1. Barmaids need to be recognized in the efforts to empower women against HIV infection and unwanted pregnancies. Many other women with low wage-jobs or jobless, or non-salaried jobs like housewives who share barmaids' economic, social and biological vulnerability need to be focused too. The governmental and non-governmental organizations can organize programmes in their agenda to incorporate them.

2. Health education and promotion strategies have to address the negotiation skills of women in order to build a sense of self-esteem among them. Women have to have skills to negotiate safer sex and to decline unwanted sexual advances. Men should also be targeted so that they learn to respect women and take the "No" from them. They have to take more active roles in preventing HIV infection and unwanted pregnancies.

3. Women exposed to high-risk behaviors need to be equipped with income generating skills so that they can earn from other activities. Barmaids need to be educated on how to join women groups or formulate their own, where they can meet and learn from different experiences.

4. Policies and regulations meant to improve women welfare and their rights to reproductive health and economic wealth have to be put in place. All women need to know their respective rights and be motivated to seek them actively.

Organizations dealing with women's right and gender issues have to expand their horizon so as to reach the deprived women at their working places.

5. Cultural norms that suppress women health and their rights to reproductive and productive benefits need to be reviewed. Men should be urged to cooperate in this move.

6. A similar study on male partner's perception is needed to establish men's concerns on dual protection through use of female condom.

7. Advertisements of new preventive measures should target all groups of people wherever they are. Social marketing programmes have to reach people in remote places who have not heard of the female condom though women out there are also at risk.

8. The price of the female condom needs to be re-considered so as to enable women with low economic capacity who are actually at higher risk of acquiring infections, to access it more easily. This will need the distributors and the Government to re-think over subsidy.

9. Female condoms need to be distributed in many other areas including places where high-risk behaviors are highly practiced, like in bars, guesthouses and along major highways.

10. The Government, employers, religious leaders and other authorities need to address and act on the possible effects of HIV infection among women.

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