

CAN THE BARRIERS BE BROKEN ON THE "MOUNTAIN OF ROCKS"?

*A case study of the perception of HIV/AIDS and contraception among
Moba women in Tandjoaré, Togo*

Melanie Spence
Peace Corps Volunteer 2003-2005
Tandjoaré, Togo
West Africa

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Masters of International Administration
Graduate School of International Studies
University of Denver*

Abstract:

This research project seeks to evaluate the cultural, economic, and social issues as they pertain to Moba women's perceptions of HIV/AIDS and contraception in a village town in Northern Togo. In addition, the underlying barriers to protection for married women against this disease will be discussed and analyzed. The goal of the research is to analyze the relevance and application of current HIV/AIDS campaigns, such as ABC (Abstinence, Be Faithful and Condoms), to the subgroup of married women in Tandjoaré, Togo. In doing so, I hope to facilitate the understanding of the socio-economic and gender roles of Moba women in Tandjoaré especially in relationship to their views and comprehension of the 'epidemic of the century'.

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Introduction:

This research project was adapted and tailored to the village in Togo in which I was placed for my Peace Corps service from December 2003-November 2005. During this time, I worked as a community health and HIV/AIDS prevention volunteer in Tandjoaré, Togo. The research acquired in the field has provided me with data and information for my Substantial Research Paper (SRP), a requirement for my Masters in International Administration with a concentration in Development, at the Graduate School of International Studies (GSIS) at the University of Denver in Colorado.

In response to the increasing rates of HIV/AIDS throughout the African continent, especially among women and girls, and the inability of many governments and NGOs to address the HIV/AIDS crisis through current prevention campaigns, such as ABC (Abstinence, Be Faithful and Condoms), I have investigated how women of varying ages in a specific village perceive the disease, as well as the methods of prevention and transmission in the context of marriage. I will also discuss the importance of understanding culture and gender in the development of an effective HIV/AIDS prevention campaign that is relevant and applicable to women; the more susceptible sex in Sub-Saharan Africa. I highlight the fact that the subgroup of married African women is often ignored in current HIV/AIDS prevention campaigns while being potentially most at risk and the least likely to influence its possibility of exposure. With this research, I will discuss how these hypotheses apply to my specific community in Tandjoaré and explain how the perceptions these women hold about themselves, their role as women in the community and their ideas on marriage, HIV/AIDS and contraception relate to their increased vulnerability to HIV infection. Although HIV+ refers to infection by the Human Immunodeficiency Virus and AIDS (Acquired Immuno-deficiency Syndrome) refers to a person who has a full-blown case of the virus, I use the term AIDS more frequently since very few people in Togo are actually tested, we cannot determine their status and because most people I spoke to refer to both the virus and the disease as 'AIDS'.

Gender and AIDS in Sub-Saharan Africa:

According to UNAIDS, women and girls now represent almost 57% of all HIV infections in Sub-Saharan Africa (ONUSIDA, 7: 2004). Women in Sub-Saharan Africa are more vulnerable to the disease because of cultural expectations, social norms and economic dependence. Culturally, a woman's identity is tied to her ability to produce children. Socially, a woman's role is to obey her husband and often she does not have the prerogative to ask her partner to use protection. Economically, a woman is usually dependent on her partner for survival and for supporting her children. In addition to the cultural, social and economic factors, women are more biologically susceptible to sexually transmitted diseases, including HIV. This is because a woman's reproductive organ has a greater surface area than that of the male and is therefore more exposed and receives a higher viral load from the male during sexual intercourse. "Both men and women are affected by AIDS but women particularly so, given how gender relations configure with sexual behavior and economic security. Gender relations not only underlie women's particular vulnerability; they also inhibit women's attempts to protect themselves and their families" (Baylies, 1, 2000). The vulnerability of women is accentuated by the cultural norm that women are unable to own property or receive inheritances even though most constitutions, including Togo's, enable women to these rights (ONUSIDA, 17: 2004). Although women's rights may be written on paper, they are not applied or enforced in rural settings. This is because there are very few informed, qualified people to raise awareness about the laws in these communities and because most do not know who to seek out when they know they have been violated.

To escape extreme poverty and to obtain a better life, many women and girls are forced to use sex as a commodity in order to exchange goods, services and money – often with older men (UNSIDA, 10: 2004). These 'transactional' interactions usually imply sexual relations outside of marriage among single females (with multiple, older married men) which reflects the unbalanced economic situation (Jewkes and Wood, 2001). Throughout Sub-Saharan Africa and

the world, most women contract HIV via high risk behaviors on the part of their partners over whom they have little or no control. In certain places, the principal risk factor of HIV infection for a woman is that she is faithful to a partner who has – or has had – several other partners (ONUSIDA, 10: 2004).

Current AIDS prevention campaigns such as ABC (Abstinence, Be Faithful and Condom use) often target young people and risk-taking groups such as prostitutes and taxi-drivers. They operate under the assumption that people do not generally feel personally at risk for becoming infected with HIV. It is hoped that through repetition of ABC messages on radio programs and the posting of billboards that advertise condoms that behavior change will occur. Rarely are gender roles and power structures within intimate relations and society at large addressed, critiqued or analyzed. For example, the practice of infidelity within marriage, especially on the part of the male, is not publicly condemned or necessarily illegal so it continues to occur without being reprimanded.

In addition, because AIDS campaigns focus so much on prevention, they often lack valuable information about decreasing stigmatization for people living with HIV, counseling and treatment available for people already infected, and support for families of HIV positive people. Thus, people are less willing to discuss the disease and its impacts in public settings because they feel that they have nowhere to go for support.

I argue that current AIDS prevention messages are largely irrelevant to most married women. Abstinence is unacceptable within the context of marriage as is the negotiation for the use of condoms. While in theory, the fidelity method should be an effective and affordable means of protection for married couples, it relies not only on the behaviors and decisions of the woman but those of her partner. To abstain or to try to protect herself with barrier methods is even less of an option for many women in the region who are raped or the victims of sexual violence (Ibid).

Female condoms and microbicides are methods that are often encouraged for women to use because they do not depend on the responsibility of the male and can reduce some of the risks for women. However, these methods remain problematic on several levels. The female condom is still largely inaccessible and unaccepted by most women due to cost and availability. For example, one *femidom* (female condom) costs 300 CFA (approximately \$0.70) and is *six times* the price of a male condom (4 for \$0.25) and they are usually unavailable at the majority of Togolese health clinics. Even if they were available, very few people know how to use them properly. In addition, microbicides are expensive (\$1.00) and have not been shown to be effective in preventing the transmission of HIV. On the contrary, they have actually contributed to an increased risk in some studies. In reality, these methods are simply “band-aid” solutions for deeper problems that are in need of greater attention. Moreover, since very few young girls and women regularly go to health centers, they do not have access to advice on contraception and voluntary HIV testing (ONUSIDA, 15:2004).

Lack of education or lower education levels of girls and women also seems to fuel AIDS infection rates. This is because uneducated girls usually have less self-confidence, less knowledge about sexual health, an increased need for financial support and are looking to get married earlier. It was shown that 50% of young women living in countries with high prevalence rates of HIV lack a basic understanding of methods of transmission and prevention of the disease (ONUSIDA, 13, 2004). If finishing secondary school can be a protective factor of HIV infection, it is regrettable that in some regions, going to school also poses an increased risk to female students in the form of sexual harassment by male teachers (Ibid).

However, susceptibility to HIV infection among women and girls is more often due to a lack of power in intimate relationships rather than a lack of knowledge about sexually transmitted diseases (ONUSIDA, 7: 2004). The problem is rooted in the social and economic realities of African societies. Therefore, approaches based on individualistic behavior change often fail to

take into account the broader, gendered context that would make them viable methods for sexual disease transmission prevention.

Background of Togo:

The region that is now Togo used to be the edge of several empires but never played a pivotal role in any (Lonely Planet-West Africa, 2002). During the colonial period, Germany, followed by France, claimed Togo as their territory and exploited its palm and coconut oil, cacao, coffee and cotton. Although Togo officially gained its independence in 1960, it has been largely unrealized in terms of freedom and democracy. Today, it remains a one-party state run by Faure Gnassingbe, the son of the former president, Gnassingbe Eyadema, who ruled for 37 years. Despite its tumultuous political past and present, the Togolese are generally a patient and peaceful people. Togo is bordered by Ghana to the West, Burkina Faso to the North, Benin to the East, and the Atlantic Ocean to the South. It is divided into five main regions from South to North: Maritime, Plateau, Central, Kara and Savannah. The sliver of a country only 57,000 square kilometers large contains over forty ethnic groups – making it one of the most culturally and ethnically diverse countries in Africa (Ibid, 2002). The main ethnic groups include the Ewe in the south, the Kotokoli in the central region, and the Kabiye and the Moba in the northern regions. While culturally diverse and distinct, most ethnic groups are controlled by a patrilineal heredity (Ibid). Communities are traditionally headed by a chief and are well structured with the family as the main social unit, consisting of a man his wife (or wives within polygamous marriages) and at least four children per wife. Rites and superstitions, usually revolving around ancestors, play a large part in everyday life. Animist and religious traditions are as varied and diverse as the people. Approximately 29% of Togolese are Christians, 12% are Muslims and the remaining 59% are animists (Ibid, 2002).

Women in Togo are well-known for their domination in the informal sector of commerce and their substantial contribution to agricultural production (Gage, 1995). Despite their being the backbone of Togolese society, their profits are usually turned over to the men who are the main

property owners. Although they derive a considerable degree of economic independence from control over the income and property accumulated from their economic activities, they have limited opportunities in the modern sector of the economy because of their relatively low levels of education (Ibid).

In Togo, six girls for every ten boys attend primary school; only one girl for every three boys attends secondary school and only one third of all females over age 15 are literate (Marks, AARPCV). This educational inequality increases in the northern parts of the country such that very few girls finish middle school and even fewer reach the end of high school. Usually, after girls reach puberty, they enter a time of non-stop childbearing until menopause.

Public sector health clinics in Togo are developed by the national office for maternal and child health care of the Ministry of Health in Lomé, the capitol of Togo (Huntington, 1994). The Togolese government encourages the diffusion of information regarding reproductive and family health issues but it does not have an officially defined national policy on rural health care services. There is at least one hospital per district where a doctor, hygiene assistant and nurse practitioner are assigned. Outlying clinics are usually understaffed and run by a nurse and a midwife. Since the smaller clinics are understaffed and lacking resources, staff morale is low and the care given at these clinics is usually insufficient. Many people decide not to go to the clinics because there is bad patient care and consultations and prescriptions are too expensive. Family planning methods including DepoProvera shots, Norplant, pills and condoms, are available only to the few who know what they are, how to obtain them and the privileged who have money to buy them (Ibid). The prevalence of modern contraceptive use is less than 5% and unmet need for family planning is estimated at 40% (Gage, 1995). Because of the vast health care gaps, in terms of services and resources, many international organizations and NGOs such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and Populations Services International (PSI) intervene in a variety of health domains including the provision of routine vaccinations and contraceptive methods. In 2003, Togo had an estimated HIV adult prevalence

rate of approximately 4% which was mainly said to be concentrated in the urban areas, while pregnant women are estimated at having an 8% prevalence rate (ONUSIDA, 30:2004). These are only approximations since the majority of the Togolese population is never tested for HIV. In Togo, only 42% of girls aged 15-24 could cite the three methods of prevention of HIV (ONUSIDA, 9: 2004).

Togolese people often perceive HIV/AIDS as taboo because it concerns sexual relations and because there is no cure. If you do become infected, it is believed by many people that you brought it upon yourself through immoral means and thus, the disease brings shame on both the individual and the family. It is usually hoped that the infected person will die quickly so as to not suffer or infect other people. HIV/AIDS is assumed to affect mostly younger, more sexually active, risk-taking groups in larger towns, but it is acknowledged to affect all groups in society. Togolese people can sometimes take a fatalistic view of life which can lead to risky behaviors. For example, many people don't want to use condoms since the sex does not feel as good and since they feel that they are going to die anyway, they may as well enjoy sex while they are alive. Similarly, there is a 'misery loves company' mentality which pushes many sero-positive people to have sex and infect as many people as possible so as to not die alone. Since many marriages in Togo are based more on utility than on love, it is easier to justify cheating since there is a lack of accountability from your partner and from society. The concept of fidelity in marriage is a façade simply because infidelity is encouraged on the part of the man and is tolerated on the part of the woman. Thus, there is very little long-term thinking on the part of the individual about the broader impacts of risky sexual behaviors for themselves and their communities.

I perceive HIV/AIDS infections in Togo to be highly correlated with existing gender roles and power relations in society. Women's vulnerability to HIV is defined not only by age but by marital status. This is because of the necessity of child bearing within marriage and hence the lack of contraception use (principally condoms) compounded with the social norms of fidelity on the part of the female and infidelity on the part of the male. Despite their vulnerabilities,

women are still blamed for being the primary vectors of the disease and are not usually seen as victims of the disease. Moreover, they are not usually in a position to change their economic situations and are not in charge of the decision-making in their household. In addition, because women play such a crucial role in the provision for their own families, their own health can take a backseat and thus, women often suffer the brunt of illnesses and maladies as well as their indirect effects on the family as a whole. People who are infected are ignored and abandoned in Togolese society and thus the AIDS problem is still largely unacknowledged in public. I thought that older and less educated women would know significantly less information about the disease and feel less of a risk. Despite this perception, I found in my research that most women within marriage, regardless of age or education level, do feel at risk of becoming infected yet do not have access to feasible methods to protect themselves from infection.

Tandjoaré, Togo:

Tandjoaré means ‘mountain of rocks’ in Moba, the local language spoken there. It is the capitol of the district and located on the national highway in the Savannah region of Northern Togo. It is a large village of about 7,000 people most of whom cultivate subsistence farms of corn, millet, cotton and beans. There are two main seasons throughout the year: the dry season which lasts from November to April and the rainy season which lasts from May to October. The main religions are Christianity (Catholicism), Islam and Animism. In the village, there is a hospital, a primary school, a middle school and a high school. Markets occur on alternating days in four surrounding villages. Tandjoaré market days are Wednesday and Saturday and people come from surrounding villages to sell their goods. During market days, *tchakpa*, the local beer prepared from fermented millet, is served in abundance under straw huts where most of the community sit and socialize.

Despite having a hospital based in the village with the only doctor in the district, HIV/AIDS counseling and testing is not available there. The nearest testing location is 20kms north on the national road in the regional capitol, Dapaong. It was found that in 2002, of the 41

people out of the district of Tandjoaré (estimated population: 95,000) that were tested, 10 were found to be HIV positive. In 2003, UNICEF did a KAP (Knowledge, Attitudes and Practices) survey in the prefecture of Tandjoaré which showed the level of understanding of the principal modes of transmission of HIV by percentages. Among villages where UNICEF intervenes, the following modes of transmission were cited; 81% replied by having sex with multiple partners; 45.6% replied through having sexual relations with prostitutes; 3.8% thought by not using a condom, 43.0% said from bloody objects (razors, syringes etc), and 83.5% claimed from mother to child. There was overlap among different answers, but the predominant methods cited were mother to child and sex with multiple partners.

This UNICEF study was the sole source of HIV/AIDS statistics for the prefecture and it only targeted certain villages. HIV testing is still very much taboo in rural areas and since it is expensive and only available in Dapaong; very few people in Tandjoaré have actually been tested. While I think HIV prevalence is much higher in cities than in villages, I believe that people in villages are increasingly at risk as transportation and mobility has greatly improved especially on the national road. In effect, there is no real way of knowing the HIV prevalence in the district of Tandjoaré because of the lack of an HIV testing and counseling center. For my research, I focused on perceptions and attitudes of women in the area largely because actual statistics were limited. Unfortunately, I do not have statistics to compare with these perceptions.

Research Goal and Objectives:

The main goal of the research was to determine if the current AIDS prevention campaigns, such as ABC (Abstinence, Be Faithful and Condoms) apply to the subgroup of married women. In order to determine this, I identified three main research objectives in speaking with Moba women of varying ages and educational backgrounds in Tandjoaré about their perception of HIV/AIDS and contraception. Firstly, I wanted to determine the perceptions these women hold about themselves and their roles in society as related to the aforementioned variables. Secondly, I wanted to determine how much they know about HIV/AIDS; such as the

methods of transmission and the methods of prevention, as well as how they think the disease has affected themselves and their communities; such as the prevalence of the disease in their community, their reaction toward people living with the disease and the degree to which they feel personally at risk. Thirdly, I hope to link this discussion of HIV/AIDS with their perception of various prevention and contraception methods available, such as fidelity and condoms, as well as their feasibility within the context of marriage. In doing so, I hope to analyze the effectiveness of current AIDS campaigns and the likelihood that these women could protect themselves from potentially infected partners and use contraceptive methods within the context of marriage.

Research Paradigms, Models and Theories:

For this research project, I operated under the critical theory paradigm which emphasizes historical realism and an importance on gender, values and modifying pre-existing research on specific topics. The primary aims of critical theory are emancipatory and thus, the main reasons for using this paradigm were that I was engaged in predominantly qualitative research and hoping to highlight problems that were particular to women's reproductive health in a Togolese village. The research is emancipatory in that it seeks to identify the women's perceptions of HIV/AIDS in their community in order to attempt to account for a more cultural and gender specific approach to the problem. Furthermore, it hopes to highlight the problem from a female perspective and address the issue in a way that is relevant and useful to women. In Africa, there is a considerable bias towards a male perspective as women being the vectors of the disease and I hope to counter that perception with a more female-oriented response illustrating the fact that they are often the victims of the disease. My research falls into the critical theory paradigm because it seeks to understand more deeply the struggles women face as they relate to their reproductive health.

Scheper-Hughes stated in *Death without Weeping*, "At the heart of all critical theories and methods is a critique of ideology and power. Ideologies (whether political, economic, or religious) can mystify reality, obscure relations of power and domination and prevent people from

grasping their situation in the world” (Scheper-Hughes, 171: 1992). Clearly, the element of gender in an intimate relationship factors heavily into the power dynamic of the relationship.

Complementing my use of the critical theory paradigm is my use of participatory action research (PAR). The Participatory Action Research approach postulates that, “the people most affected should have the most say of how their realities are analyzed and in the courses of action taken to improve their lives” (Ervin, 200: 2000). Because of the nature of my research, most of my information was discovered from what the women in interviews were comfortable sharing with me. They actively participated at each stage of the research.

The research was also issue-driven in that it researched a problem (gender inequalities as they relate to reproductive health and HIV/AIDS transmission among Moba women in Togo) and an analysis of the problem (the cultural, social and economic barriers women face in protecting themselves against HIV/AIDS and other health concerns). Through delving into this issue, I hope to highlight different ways of viewing the problem and encourage the women participants to critically think about potential solutions.

For my research, I used grounded theory to help formulate a theory that is grounded in data and systematically gathered and analyzed inductively and empirically. I began with the working hypothesis that married women themselves perceive that they are less at risk of exposure to HIV/AIDS than young, unmarried boys and girls. I anticipated that the married women, especially the older groups, would not have a very thorough understanding of the disease and would not feel that the risks were applicable to them since they were already married.

However, I purport that they are actually more likely to be exposed to HIV/AIDS due to their decreased likelihood to negotiate contraception methods within the context of marriage because of their child-bearing role in addition to the pre-existing cultural, social and economic expectations. I also hypothesized that an increase in women’s economic power and educational level would widen their contraceptive options and potentially their ability to negotiate these options with their partner.

Methodologies and Strategies Employed in Research Design:

In order to facilitate the participatory action research (PAR) approach, I used several different methodologies in order to triangulate the data and hence, lead to a more comprehensive and accurate understanding of the perceptions of married women in Tandjoaré. The use of three or more techniques, called triangulation, allows the researcher to cover gaps, detect errors and enhance the validity of the data (Van Arsdale, 1994). The three techniques that I used for my research were key-informant interviews, focus group interviews, and participant observation which are described in detail below.

The first methodology that I used was key-informant interviews of encultured, involved and available members within the host community on topics with which I was generally unfamiliar (Ervin, 149: 2000). With help from a key-informant, I identified eighteen Moba women of varying ages between 16 and 65 years old of the Tandjoaré community for interviewing based on their proximity, their interest and their availability. These interviews incorporated asking relatively open-ended and unfocused questions in increasingly intimate succession in order to foster the greatest degree of participant input into the project. (*See Appendix C*).

Another method to PAR is group discussion, including focus groups (Ervin, 202: 2000). A focus group consists of a number of people, usually 6-12, who are of roughly equal status and have some identifiable common interests, characteristics and shared knowledge. Under the guidance of an interviewer, they are asked to discuss specific questions or areas of experience (Ervin, 156: 2000). In my research, I held three focus group interviews varying from six to ten women of similar age, ethnic and socio-economic background and asked them similar questions. I hoped that these focus groups put the women more at ease than the one-on-one interviews and would therefore enable more relevant issues to be discussed as well as highlight the differences of opinion among the women interviewed in a group setting.

The third method I used in my research was participant observation which contained a variety of information-gathering techniques ranging from keen observation of daily rituals and traditions to full-scale participation and absorption in local activities (Ervin, 142: 2000). Participant observation encompasses the immersion of the researcher into the host setting and involves the concept of reflexivity whereby the researcher recognizes the interaction he/she has with the people he/she is researching. Being a Peace Corps volunteer enabled me to be an active participant within the community such as taking part in holiday festivities, local celebrations, funerals as well as daily activities. While this position enabled me to receive real first-hand knowledge of the culture and customs, it also may have posed certain barriers to my health-related research which will be presented later.

Discussion of Research Data

Key Informant Interviews:

I interviewed 18 women between the ages of 18 and 65 with an average age of 30. All women were asked the same set of questions and were tape-recorded for clarity. All of the interviews were translated by a female key-informant named Damigou Bienvenue Lare. Sixteen of the women were married and two were single. Of the married women, half were in polygamous marriages. Among the married women, there was a range of number of children between 0 and more than 6. The average number of children among the women was approximately 5. Most of the women lived in traditional compounds with two or three round mud huts (especially for the women in polygamous relationships) and a larger rectangular hut, sometimes with a tin roof. Only a few lived in cemented houses with tin roofs. The education levels of the women varied between those who had never been to school and those who had reached the equivalent of an early high school level. The majority of the women averaged the equivalent of a US fourth grade education level. Thus, the economic and educational levels varied greatly among the key informants.

In general, I received a lot of similar answers, especially in reference to the first few questions about the roles and responsibilities of women and men. It seems to me that these distinctions are fairly clear cut in rural African society. The woman's role is to get married, have children and manage the household (sweep the courtyard, get water, fetch wood, prepare food, wash the clothes and dishes, take care of the children and help their husband in the fields). None of the answers I received deviated from this response and almost all of the women cited marriage and having children as the main roles for a woman. The man's role, however, is to impregnate the woman in order to have many children, to cultivate his field and look after the overall needs of the family, such as providing food, and paying health and education fees. His role is also as disciplinarian of the children, though he is not expected to be involved with their activities on a day to day basis.

When I asked the women whether they had any control over the household finances, 16 of them said no, while 2 women said they had some control. In general, women usually have money from small income generating projects such as selling *tchakpa* (local beer), coli-coli (peanut butter balls), or *bouillie* (porridge) on market days or during school recess hours. Only one woman actually owned a piece of her own land. All of the others were completely dependent on their husbands for the majority of their needs.

In discussing their health concerns for themselves and their families, malaria was cited first and foremost. Along with malaria, 'anal sores', diarrhea, head and stomach aches, and depression were cited as their main health concerns. Most of the women agreed that members of their community suffered from the same ailments. None of the women mentioned AIDS or sexually transmitted diseases as a health concern. When asked what these women do when their children fall ill, they first responded by saying that they would look for '*feuilles de brousse*', or wild leaves, to prepare and wash the child with and sometimes prepare a beverage to be drunk. Also, if the child had a fever and the mother had some paracetamol or chloroquine tablets (to treat

fever and malaria); she would give some to the child before she decided to take him or her to the hospital for care.

Finally, we moved into the more sensitive issues of HIV/AIDS, sexuality and contraception. I first asked what each woman knew or had heard about AIDS. I found that the majority of these women initially would not admit to knowing much about the disease or having personally known anyone who had been infected or affected. I felt that this could have been due to several factors. The first is that they may have wanted to sound like they had no affiliations with the disease and were not privy to such sexual taboos so that I would not think less of them. Secondly, they may have been intimidated to share what little they thought they knew with me, a white, American woman who spent a lot of time working at the local hospital as a community health worker. Thirdly, they may have wanted to pretend that the problem does not really exist in their communities and especially their immediate circles of friends and family. In any case, the first time AIDS was brought up in a question, I received responses such as, 'I've heard of it, but have never seen it and I don't know anything about it' and 'I've never known or seen anyone who had AIDS'. However, later, in another re-phrased question, they would hint on the fact that they had known or heard of someone suffering from the disease. In some cases, the women alluded to how the disease is 'the bad disease' with 'no cure' and 'fatal' and that it 'makes people loose weight', 'have diarrhea' and 'suffer slowly until their death'.

When asked to comment on the reaction of a family member or friend of someone who was sero-positive, one response summed it up, 'if someone finds out that a person has AIDS, no one will approach them, they are something to be afraid of, people don't eat with them, don't court them, it's a bad disease.' Another response was that 'people are happy to see that [HIV-positive] person finally die, but people will make fun of your family and not go to the funeral'. It is the 'worst disease because it implies sexual vagabondage and reflects poorly on the family of the person'. 'People are scared to eat with you. They will make fun of you and won't sit on the

same bench and won't buy rice from you if you have AIDS'. And another woman who explained that, 'having AIDS, one suffers a lot, when you see what becomes of them, you are scared...'

When probed about the methods of transmission, some cited that AIDS was transmitted through scissors or razor exchange (blood), sexual vagabondage of youth and marital infidelity. Only a few cited mother to child transmission. The majority of the information these women received was from listening to the community radio from Dapaong, health talks at the hospital or at the mayor's office, or by gossiping in the market with friends. It was interesting to note that for those who did receive most of their information from the radio that they usually felt that the advice and warnings were directed mostly towards adolescents and rarely women, especially married women. Those who had said that they had known someone who was infected were much more likely to think that AIDS was a problem in their Tandjoaré community. Not surprisingly, the majority of AIDS victims they cited were of girls and women. However, many of the women seemed to think the disease was 'elsewhere' or originated from other villages or countries through migrants. Usually, these migrants were also implied as being female.

When asked if AIDS was a problem in Tandjoaré, there were mixed responses. Some said since 'they can't tell if someone has AIDS and that the person would usually hide, they wouldn't know if it's a big problem or not in their community'. Others said that it was a problem 'especially because of the young boys and girls who go out at night'. The majority of women said that it was probably most prevalent among young people but they were quick to add that anyone, even old people and married couples, were susceptible to the disease.

Bringing it to a more personal level, I asked each woman if they themselves felt at risk to become infected with HIV. One woman summarized many of the sentiments by saying, 'one should be afraid of this [disease] and ask God to help protect you' and another woman explained that, 'women are at risk, because she can be faithful but doesn't know about her husband – he could transmit it [to her].'

Then, I asked how they thought HIV was spread specifically in Tandjoaré and the majority sighted young boys and girls who go out looking to have sex with each other. Specific occasions and locations were also mentioned such as in the marketplace, at dances, in bars and during funerals. While bars may be a main source of HIV propagation in the cities, in villages such as Tandjoaré, they are rare and usually beyond the means of the majority of the population. Cheaper and more plentiful is the local beer, *tchakpa*, which is served throughout the week but most abundantly on the market days. I have heard stories of people having sex behind huts and trees surrounding the marketplace even during the day. However, the funerals, called “*koukouanan*” in Moba, are perhaps the prime occasions for these taboo sexual encounters. This is because they serve as the only real opportunities in villages for people to meet at night in a social context. These funerals usually last for three days and involve endless buckets of *tchakpa* and dancing to blaring music powered by a generator from dusk until dawn. These occasions allow for adolescents as well as adults to have sex unsuspected in the dark. It was explained that especially if the spouse is not present, married individuals will have sex with other people. Unfortunately, the situation contributes to the propagation of HIV because not only are people usually drunk, but it is dark and in this context, there is little possibility that condoms will be used.

Given the apparent fear of this disease, I then asked them what they thought were the best ways to prevent new infections in their community. Most of the women were taken aback at my question and did not know how to respond. The most common theme was fidelity since I was speaking to mostly married women. One woman said, ‘you must respect yourself as a woman...you must practice fidelity and respect your husband’. Another suggested ‘going to the hospital and doing the test to check the blood of two young people wanting to get married before they start to have children’. Another suggested that they find a remedy or cure for AIDS because there will always be infidelity and sexual vagabondage. Despite fidelity suggested as the main way to decrease the numbers of infection in Tandjoaré, the majority of the women did not think

men would accept it and thought that it was highly improbable that married couples could stay faithful to their partners for their entire lives. Since fidelity is unlikely in the context of marriage, then it may actually expose these women even more to HIV infection from their husbands.

Since condoms are currently the only effective method of avoiding transmission of HIV during sexual intercourse with a sero-positive person, I wanted to ask the women about their views of this particular method, without and within the context of marriage. One of the women interviewed had used condoms with her husband for a period of four months when she suspected him of having sex with other women. After her husband was tested for HIV and shown to be negative after six months, they stopped using the condoms. Another had used condoms temporarily with her husband as a form of birth control when her children were little. However, the majority of the women when asked about condoms in these interviews responded that they had heard of condoms, but did not know anything about them and had not ever used them with their partners.

The discussion regarding condom usage led us into a discussion about other methods of contraception, used for child spacing, not as methods to protect against HIV transmission. Almost all of the women were familiar with the concept, but some were unaware of the actual methods used. When I asked if the women had ever discussed family planning with their husbands, only four women said that they had brought up the topic with their husbands and of those, two husbands refused their wife's request to use contraception. In one case, the husband initiated the discussion with his wife. The older women were especially unlikely to discuss or use these methods. The majority of women thought that this should be the responsibility of the man to decide whether a method was used at all because it is ultimately up to the man how many children he wants to have. Several of the women mentioned using the rhythm method to avoid frequent pregnancies. Out of the women who had used contraception, one had placed Norplant, two had used condoms and one had done the three-month DepoProvera injections.

Despite the relatively small number of women who have actually used family planning contraceptive methods, the vast majority thought that family planning was a good thing. Only a few women claimed that they never dared talk about it with their husbands. One woman claimed that she refused to use family planning methods because she heard that the injections cause people to lose weight. The majority of the responses were positive, leading me to believe that either they had known too much suffering due to frequent childbearing or they knew that I was an advocate for family planning at the hospital. One woman explained that, 'family planning is very good, because we're in Africa and you don't know anything. Soon, my husband won't have any work...there's no money; kids need to go to school, to eat and to be healthy. My husband wants to do things; women want *pagnes* [cloth] but since there's no commerce here that works, if you keep having kids, they could become thieves because they are not satisfied [at home].' Another woman described family planning as, 'very good because it allows you not to have kids too quickly and therefore the children won't suffer as much.'

Focus Group Interviews:

I conducted three focus groups based on the woman's age and station in life in order to compare and contrast with responses I had received in the one-on-one interviews. The first group consisted of ten women 18-28 years old most of whom were married with young children. The second group comprised of seven women aged 29-39 years old all of whom were married with several children. The third group included women 40 years old and over who were also married with children but for the most part past their child-bearing years. During these focus groups, I used the help of the hospital midwife, Damigou Lare, to help with the translation from French into local language, Moba, and used a tape recorder to ensure that I eliminated discrepancies in the discussion. These interviews took place at the hospital and lasted about one and a half hours.. For the focus group interviews, I followed the same general flow of questions that I used for the one-on-one interviews; however, I kept the probes vaguer and allowed for tangents and further discussion (*See Appendix D*).

The *first focus group* interview included eight women between the ages of 18-28 years old. They agreed that the role of the woman was to support the children and the household. Specifically, they cited sweeping the courtyard, waking the children, preparing the meals and getting the children to school. The objective of marriage is to have children with someone. Ironically, the majority of married couples are 'married' simply as a result of the woman becoming pregnant. Weddings, like funerals, are very expensive, but they usually never occur. Sometimes, they can occur twenty years after the couple have been living together. As a result, only a handful of couples are legally married. This age cohort said that women and men in Tandjoaré do similar work in the fields. They claim that girls in Tandjoaré tend to get married between the ages of 15 and 19 years of age. In each of their households, they said that they did not have their own fields or property. In order to gain some money, these women do small business activities such as preparation of local beer, fried dough balls, rice, and cakes.

In terms of major health concerns, the women in this group cited anal sores, diarrhea and malaria for the children and meningitis, typhoid fever, diarrhea and lower stomach aches for the women. When a child falls ill, they said that they take the child to the hospital for care. They did explain that before they take their child to the hospital, they depend on older women to search for the appropriate plant leaves to cure the particular ailment. Only if it is not resolved by natural (and cheaper means) will the mother decide to take the child to the hospital. Some of them have confidence in the hospital and staff in Tandjoaré, but some of them prefer to treat illnesses at home. They explained that usually this phenomenon is due to the fact that they are afraid they will not be able to afford the consultation or treatment fees, but sometimes people do not believe that the treatments can help.

When I brought up the topic of AIDS, they said that they had heard about it on the radio, and at the hospital. They acknowledged that AIDS was a sexually-transmitted disease without a cure. They cited that ways to transmit the disease included blood exchange (through scissors and blades) as well as sexual relations. They can avoid the disease by 'protecting themselves by

using condoms' and someone said with 'injections.' One woman volunteered that you could do the AIDS test to see if you have the virus and that you can not really know if someone has AIDS without doing the test. These women agreed that AIDS affects young boys and girls the most, but can and does concern everyone. They said that this is because they 'sleep around' and 'walk around at night'. They thought it could infect men and women equally through needle exchange, which is actually unlikely since syringes are only used at the hospital and are not shared among patients. When I asked the women about situations and places that may encourage risky behaviors, they cited bars, funerals and parties which increased the occasions for sex.

Out of the eight women, half of them said that they had known someone with the disease. They claimed that their sero-positive acquaintances were 'skinny, had constant diarrhea, bumps on their skin and weak muscles'. The reaction of the community was to 'say bad things about these people' and that 'they brought it on themselves'. They thought that people were 'not ready to help people with AIDS'. Instead, they would 'send them away and make fun of them'. The difference between AIDS and other diseases is that it is incurable and sexually transmitted which means that there is more shame associated with it.

In regards to whether these women think that AIDS is a problem in Tandjoaré, they said that they can't know because 'not everyone has done the test, but that it's possible there are people who have it'. In terms of whether they themselves feel at risk of being infected, one woman said that, 'a husband could bring it to you by going out with other women and vice versa'. They suggested fidelity to prevent new infections, but they were not sure if it was really a feasible option. When I asked about condom use within the context of marriage, they said that it could be 'possible, but not many will do it in marriage'. All of the women in the youngest age cohort had heard of and seen condoms and some of them claimed to have used them to avoid sexually-transmitted diseases and pregnancy. When I asked them whether they thought many people in Tandjoaré use condoms, they said that 'some people use them and buy them in the marketplace, boutiques and the hospital'. Generally, it was thought that young people use condoms more than

older people, but that some older adults use them too, although it is probably rare. When asked what age boys and girls start having sex, I received a range of answers between 16 and 18 years old.

When we discussed family planning, the women said they were familiar with injections (DepoProvera), pills and Norplant. One woman out of the eight said that she had used family planning methods and one who wanted to but had not done it due to lack of means. They thought that some women in Tandjoaré use family planning methods usually because the woman did not want to have any more children. The general sentiment on contraceptive methods was that it was a good thing because you 'won't get pregnant too fast and you child won't suffer'. There could have been some bias here though, as the interviewers were the mid-wife and I, an American volunteer at the local hospital. Surprisingly, the husbands of the wives were mostly in favor of family planning methods for their wives because it can help with the overall household economy. They said that, 'women can go to their husbands and ask them if they want to do family planning'. However, lack of money was the main reason why women were not on birth control.

The *second focus group* interview consisted of five women between the ages of 29 to 39. These women also agreed that the role of the woman in Moba culture was to fetch water, prepare pate (main local food), look for firewood, have children and watch over them and get them to school. Although the assumption is that a woman becomes a woman by having children, this group seemed to think that a woman without children is still a woman because she has to do 'women's work'. The notion of sex determining specific gender roles is very strong.

They said that the age at which girls get married today ranges from 16-22 years old which is an older average than the younger group of women cited. However, they claimed that girls used to be 20 years old before getting married in the old days, but now the age is younger. Now, the age range for girls to get married is between 15-17 which is younger than before and usually the approximate same time that they start having children (since a 'marriage' is formed on the basis that a girl becomes pregnant with a boy) but it can depend. All of these women had

children as a consequence of, or just before, they were actually 'married' (usually living together in the man's family house).

In terms of household economics, these women had very little control of money or property. None of them owned their own land or has access to their own funds, except small profits that they gained from selling local beer. These responses were similar to the women of the younger age cohort.

The health concerns of the women included lower stomach and menstrual cramps and infertility. For their children, they cited malaria, headaches, anal sores and stomach aches. When the child is sick, they try to treat them at home by giving the child chloroquine and if it does not get better then they will bring them to the hospital. They claim that this is due largely to lack of money and not lack of trust in the hospital staff. Again, this view was shared by their younger counterparts as well.

When we discussed AIDS, the 'disease of the century', they said that most of the information that they received came from the radio and from the hospital. On the radio, they have all heard that it is a 'bad disease that kills'. If you have kids you should 'advise them to protect themselves, because a boy or girl can pick up all kinds of diseases'. They cited sexual relations, razors and syringes as methods of transmission. The symptoms of someone with AIDS included 'headaches, severe diarrhea, bumps on skin and the loss of weight'. In terms of how they feel they can protect themselves from infection, they said that 'men can wear condoms'. When asked what women could specifically do, they said they did not know how they could protect themselves. This was an interesting realization as it expressed the overall vulnerability and susceptibility of women, especially *married* women, in the AIDS epidemic in the majority of rural African societies.

They said that 'not only young people, but older people can get it [AIDS] as well because of infidelity in marriages'. When we discussed the issue of infidelity, they claimed that it is not only those who are married who cheat, but within marriages, it is 'usually the husbands who go

out [looking for women]'. They were quick to admit that there are 'women who go out as well for men'. Interestingly, their rationale for infidelity by the two sexes was different. They explained that 'men are unfaithful to their wives because they want to go after pretty women'. However, 'women are unfaithful to their husbands in order to get money'. They claimed that poverty caused most of the married women to be unfaithful. They said that sometimes men will pay women 100CFA (roughly \$0.20) to have sex with a woman. The scenario is that a 'wife asks her husband for money and doesn't get it, so she goes to sleep with a man for a bowl of tchakpa...though [what she will get in return] depends on the man'. One woman said that, 'it's poverty that causes everything; something is missing [in the marriage] if the woman goes out, but for a man, it's just to get more'.

Almost all of the women in the middle age group had witnessed someone suffering with AIDS. One woman had someone in her family infected and she took care of him by 'cooking and cleaning, but the rest were afraid of him'. She explained that, 'people would whisper, many wouldn't even approach that person, wouldn't eat with them, saying that AIDS got them'.

The women claimed that AIDS is different from other illnesses because 'people make fun of people with AIDS'. For example, 'if you have Meningitis, people will take pity on you, but not if you have AIDS'. This is because it's assumed that they 'did something wrong or immoral and brought it on themselves'. Women acknowledge that, 'even though you could've caught AIDS innocently by a razor or syringes; people will still say that you ran around to get AIDS'.

When asked whether they felt at risk for infection of HIV, they said that, 'everyone is concerned'. They claimed that they 'know some people in Tandjoaré who have it [AIDS], but they can't know everyone who is infected; only if they show signs, but it could be something else like malaria which also causes people to lose weight'.

In order to avoid infection, the women suggested using condoms when having sex. When I asked if this would be possible in the context of marriage, they said that the 'husbands won't accept that'. Again, they admitted not knowing how they could better protect themselves in

marriage. This group, unlike the younger group, was less familiar with condoms. They said that they 'did not know how to use condoms and none of them claimed to have used one before'. They explained that they 'think some people use them, but people don't like them because they say that if they use them, the sex isn't as good' ("*c'est ne pas doux*"). This is what the women have heard but they said they did not know why because they had not experienced the phenomenon personally. They also explained that 'the husband would ask the wife, why do you want me to use a condom and will automatically assume that she is sleeping around or that she thinks he is'. Within marriage, these women said that 'condom use is in the hands of the man, women don't say anything about condoms'.

According to this group of women, girls start having sexual relations between 13 and 16 years old and boys around 12 years old in Tandjoaré. They seemed to think that girls usually have sex with boys of their own age and therefore do not make a habit of using condoms. The diversity of speculation about ages at which girls and boys start to have sex were similar to the former group and show that parents usually are unaware of their children's sexuality. However, it was interesting to note that most of the women thought that girls started having sex with boys their own age instead of with older, more experienced and richer men.

In terms of family planning, the women claimed that it was a method to avoid pregnancies. They cited the three-month injection (DepoProvera) which you can 'tell your husband you want it and they can give it to you at the hospital'. They also cited pills and Norplant. Most of these women had talked to their husbands about contraception and said that 'their husband was okay with it'. Some said they 'don't have the money, but they want to do it'. Most of the women thought that contraception was a good thing, though they are not sure whether many women in Tandjoaré use it. One of the women claimed having placed Norplant and having used the injections and had no problems. They did admit that it is not a topic ordinarily discussed among women of different households. They explained that they 'don't want other women to know because they'll make fun of you if you're trying to secretly have kids'. They said that they

‘make fun of women who have a small child and who then has another child because people will think that she is having sex with many men’. Despite the comment that men are in control of condom use, the women said that ‘they decide if they want to use family planning methods’. I thought this was an interesting distinction; women could decide if they wanted to use family planning methods (excluding condoms) to prevent having so many children, but they could not negotiate condom use which ultimately could prevent the transmission of STDs and HIV. They explained that ‘you already have a large caldron and if you go up to ten [children], you’ll have to fill a bigger one to support them’. This illustrates that there are already enough mouths to feed in the family so they understand why it is better to have fewer children than before.

The *third focus group* interview included seven women between the age of 40 and 50. When discussing the role of the woman in Moba society, they cited the same activities as the other two groups including ‘sweeping the courtyard, getting water, fetching firewood, washing the kids, getting kids ready for school, taking care of the health of the family and making food’. They thought that girls get married at varying ages between 15-25 years old; a much larger range than the previous two groups cited. If the girl goes to school then the age at which she gets married is older. Their generation was not the same as nowadays. They said that ‘some girls give children when they get married and others wait a couple of years before giving children’. They thought the average number of children per woman ranged from four to nine with an average of seven. They said that there are married women without children but it is very rare and people are usually a bit skeptical of them.

In regards to household finances, none of the seven women claimed to have ownership of a house or field, ‘unless her husband gives her a bit of land to farm’. And ‘if the husband dies, then the wife has the right to stay in his house and make do to support the children’. The only money that these women have access to is from the ‘small business projects they do such as selling local beer and cakes because the husband is not allowed to touch that money’.

When discussing health concerns, the women cited lower abdomen pains, vertigo, head aches for themselves and anal sores, diarrhea, vomiting and malaria for the children. The women explained that when a child falls sick, they ‘rub the body with honey and lemon; give some paracetamol or chloroquine for the fever according to the child’s weight’. And, if the child does not get better, then they will take them to the hospital for treatment. They said ‘they have confidence that the hospital staff will help them to treat their illnesses’.

When I brought up AIDS and asked them what they had heard or thought about it, they told me that ‘you and your husband need to understand and respect each other and not go out looking for other mates’. They said that it is necessary to ‘give children advice to not go out and sleep around’. They say that ‘you can tell a child not to go out and have sex with people, but you don’t know what the kid does out of sight, therefore one should protect oneself from AIDS by using condoms’.

The methods of transmission cited were ‘syringes, razors, sponges and sexual relations’. Most of the information they knew about AIDS comes from listening to programs in Moba on local radio stations. Methods of prevention cited were ‘fidelity among married couples and avoiding the exchange of syringes and razors’. They say ‘everybody is concerned, but teenagers are most at risk because they go out at night’. They also cited ‘travelers, taxi and truck drivers who tempt young girls with money for sex’. Since Tandjoaré is situated right off the national highway, this is a reality for many young girls and women desperate for money.

They said that you ‘can’t tell if anyone is infected by just looking at him’. In contrast to the former groups, all of the women in the oldest age cohort claimed to have seen or heard of someone who was sero-positive. Infected people ‘develop bumps on the skin and lose a lot of weight’. Interestingly, the women in this group had a much more favorable reaction to people with AIDS than the younger groups of women. They said that the ‘community/family can take care and support them and help them live a bit longer by helping them eat and encouraging him or her morally, otherwise they’ll die quickly’. When asked if they felt personally at risk of HIV

infection, they said that ‘they all feel that it’s possible they could get infected and that they can’t know if they could be infected’. They gave the example that someone could ‘step on the syringe of someone who was infected’. Then, they explained a story that occurred in Dapaong whereby a sero-positive woman injected her blood into oranges that she was selling in order to infect others’. Different versions of this story have been recounted to me on various occasions to illustrate the ease of transmission and also the malice of some infected people, despite the fact that the virus cannot survive outside the human body for very long. There is a common belief that if a person is HIV positive, the person will try to infect as many people as possible so as to not ‘die alone’.

The women say that they cannot really know if AIDS is a big problem in Tandjoaré because they cannot tell if people have the disease. In terms of how to decrease the rate of transmission and infection, they cited not ‘going out and sleeping around’. They said they ‘didn’t even know how to advise young girls who usually have sex with boys their age’. Most of the information they know about AIDS was through radio programs, such as ‘how to protect yourself by using condoms’. But then they cited how ‘some infected people take needles to poke holes in condoms before having sex in order to contaminate others and not die alone’. They said that ‘they can’t know if many people in Tandjoaré use condoms, especially the young boys who go out at night’. None of the women themselves has ever bought condoms but they have seen them at the boutiques. They say it’s usually ‘the male who decides to buy and wear condoms’. They told me that young boys and girls can start as early as 10 years old or as late at 17 years old; however, if they don’t bring the girl home, you can’t know when they start’. They also thought that young girls have sex with boys the same age and they are ‘doubtful they use condoms because they either don’t know how or can’t afford them’. Again, it was interesting to hear that the common scenario of a young girl and older man was not cited as a major reason why more girls are infected at younger ages.

We discussed family planning methods which were used ‘if you don’t want to have kids too fast. They cited ‘pills, Norplant, injections, Conceptrol (spermicide foam) and an IUD’.

They said they can't know whether many women use contraception, but out of the group, one had done the three-month injections but they bothered her and so she stopped. One used pills and said she had problems as well and decided to stop. They said that their 'husbands were ok with their decisions to use contraception and gave them money to do it'. They say that it depends though, because 'some will prevent their wives from using family planning methods and even beat their wives because of it'. As a result, 'some women try to do it in private secretly, but when the husband finds out, he'll hit them'. The age at which women would start family planning varies, but it's usually based on 'the number of kids a woman has had and not on her age'. They say, 'if you're ok with the number of children you already have, you can start to not get pregnant anymore, or you can use it to space your children apart so you're not too tired'. They claim that 'older generations used to give 12 children but now, you can't give that many so family planning is good...to give you a break.'

Ethical Considerations of the Research Design:

The ethical considerations of my research design included issues of privacy such as confidentiality and informed consent. *Confidentiality* implies the maintenance of respect for the information given by the subjects to the researcher. *Informed Consent* implies the permission offered by the subject to share the information given to the investigator for publication. According to Ervin, the most important issue is, "maintaining confidentiality and the protection of individuals and potentially vulnerable subgroups" (Ervin, 34: 2000).

It was important to maintain professionalism in my research while also maintaining a certain level of casualness with my informants in order to build their trust and encourage their willingness to participate in the research. I waited until I had been living in the community for a year before I actually began the research which meant that the women were more familiar with me and were more interested and likely to take part in it. In addition, I strived to maintain the four principles to conduct ethical research: autonomy, non-maleficence, beneficence and justice. Since I discussed personal and sometimes sensitive and offensive material with key-informants

and focus group participants, I had to make sure that I phrased my questions appropriately and used the suitable terminology to get the most accurate responses from the participants. Christensen indicated that three elements characterized his approach to collecting sensitive information (D & H, 129: 1993). The first is establishing and maintaining respondent trust. Second, the researcher should use a phased series of questions which move from general, non-threatening information to precise data on individual behaviors and attitudes. Thirdly, the researcher should use consistency checks to ensure validity.

Prior to each interview, whether one-one-one or in a group, I explained that I was asking them questions in order to learn more about their lives. I told them that they were the experts and that there was no right or wrong answer; I simply wanted to know what they believed, felt and thought about certain issues. I also wanted to make clear that they could abstain from answering questions if they felt uncomfortable responding. In order to acquire accurate information, I also made sure to reassure the participants that the responses they gave were not going to be repeated into the community and that the tape recorder and note-taking was simply to help guide my own memory and for the purposes of my research only. The questions became progressively more intimate at the interview was carried out. Each woman was compensated for their participation with food or drink.

Research Challenges:

As a Peace Corps volunteer, I had the advantage of being a trusted and respected resident of the community in which I was researching for a year prior to actually commencing the research. I lived and worked in the community and was an active participant in the life of the village town. However, my role as a health volunteer was very different from my role as a field researcher. As a Peace Corps volunteer, I helped out at the hospital by doing baby weighing and giving talks to women about better nutrition, malaria, family planning and other health topics. I also worked in high schools with teen peer educators training them how to encourage and communicate healthier sexual practices among their peers. I feel that having another, more

visible, role in the community may have also negatively impacted my research. Firstly, I felt that some accuracy of the research was lost in translation. There was a sense that both the interviewer and interviewee wanted to please me and give me what I wanted to hear. Sometimes, this could have been the result of the way a question was phrased or an inaccurate translation of an idea. This occurred both during my one-on-one interviews as well as during the focus group interviews. In this way, I felt that the translation from Moba into French may have influenced the accuracy of the views expressed by my key-informants. Secondly, I was disappointed by the initial lack of diversity in responses especially as questions pertained to the role of the woman and what information they knew about AIDS. There is a particular way that people talk about issues and I found myself literally copying down the same phrases and expressions over again. I think this is the case in villages where there is little access to information and resources from the outside. As a result, people depend on each other for the answers to their questions and the same decision making processes are utilized across the entire community. This enabled me to have a great deal of triangulation and verification of data, but it was difficult to elicit different and deeper responses from the women. Since the education system is based on rote memorization, it was evident why people could easily cite the ABC methods of prevention, but they were less able to analyze or question them. Thirdly, women are generally less prone to talk in certain social situations and are even more guarded when asked about their sexuality. This is because women are taught that their opinions do not matter and that they are inferior to men. Women are also more guarded in discussions with a stranger such as me, a white American female. Thus, it was challenging to make the women feel comfortable enough to share accurate information about themselves and their actual perceptions of the issues. Fourthly, I found that the field research was very challenging in a village setting whereby most people were unsure of what research was and what I was doing. Maybe they thought that I would use the information for reports to Peace Corps or as a way to judge their lack of knowledge instead of presenting it as objectively as possible in a research paper as a collection of anonymous opinions. Lastly, since it was the first

time I had done field research, I found it hard to be isolated, with little technology or guidance for ways to improve the methodologies or content of my research. For example, it was difficult to initially select my target population and determine if it was sufficiently narrow for analysis.

Conclusion:

In conclusion, I found all of the women interviewed had traditional and specific notions of the role of the woman in Togolese society as a domestic and child-bearing agent. Although they claim to trust local hospitals and medical personnel, they prefer to care for themselves and their families at home with traditional, and less costly, methods. The main health concerns cited by the women included malaria and diarrhea. None of the women specifically mentioned HIV/AIDS as a problem in their families or in the community. This is because sexuality and HIV/AIDS is still very much a taboo topic in African cultures.

Despite their not mentioning AIDS as a health concern, the majority of women, regardless of age, education and socio-economic status were well aware of HIV/AIDS and the methods of transmission and prevention. I was surprised to see that there was not more of a discrepancy of knowledge between the older and younger age groups of women. I was also surprised to learn that the older groups of women seemed to have a more compassionate opinion towards people living with HIV in the fact that they felt it was important to support and help them. They were also the most concerned about counseling their own children about safe sexual practices and HIV prevention. In this way, there was a sense that these women felt that their time had passed and that the HIV problem applied to them most importantly in the form of their progeny instead of themselves.

I felt that most of the information they had learned came from radio broadcasts in local language and not from the hospital or health agents in the community. Current ABC campaigns in the form of community radio has therefore become the most pervasive method of information exchange especially regarding often taboo health issues like sexually transmitted diseases. However, the focus is still on repetition of the same messages of abstinence, be faithful and use

condoms and focusing on prevention of risky sexual behaviors which should be accompanied with an acknowledgement of gender inequity and power structures in intimate relationships. How to address these cultural issues in a deeper, more relevant way is still uncertain.

Most of the women cited the younger age groups as most at risk, namely boys and girls between the ages of 15 and 25 and surprisingly that it was sexual relations among teenagers of the same age rather than young girls having sex with older men (a phenomenon that has contributed to the feminization of the disease in Africa). Since I did not speak with younger girls on this topic, I cannot determine whether this is the case in Tandjoaré.

I hypothesized that the married women, especially the older groups, would not have a very thorough understanding of HIV/AIDS and would also not feel that the risks were applicable to them since they were already married. Interestingly, I found that all three groups had a fairly high level of knowledge about the methods of prevention and transmission of the disease and despite this; these married women all felt that they were personally at risk of becoming infected with HIV/AIDS because they were unsure about their husbands' fidelity. Thus, they are receiving and understanding the message of the current AIDS prevention campaign, but it does not seem to be relevant or applicable to their lives as married women. Further, they were unable to cite feasible ways in which they could protect themselves within the context of marriage. This phenomenon is further accentuated by the fact that once a woman is married, she is encouraged to enter a non-stop child bearing phase until menopause. I found that the majority of women had heard of various methods of contraception, the one most often used was DepoProvera injections that last three months. Unfortunately, the use of injections as a method of family planning does not protect oneself from contracting STDs, including HIV/AIDS. In fact, because the women is using birth control, the husband may feel even more inclined to have sex with his wife at any time he so desires with or without her consent.

Despite the majority of women saying that they thought contraception was positive in theory, it is very under-utilized in practice. This is because of reluctance on the part of men and

women and as well as a lack of means. In terms of condom usage in the context of marriage, it was deemed very unlikely. Infidelity was a huge issue raised among the women in that they felt they had no control of their husbands' behavior. Therefore, the larger concerns of power dynamics and gender equality within intimate relations need to be increasingly addressed in order to really initiate behavior change in both married men and women. Given the entrenched nature of existing gender roles, beliefs and expectations, it seems very unlikely that major advances can be made in the immediate future (Baylies, 2000: 17). Instead, an incremental approach which 'seeks to reduce the immediate risks of HIV infection within a gender sensitive framework' should be advocated (Ibid). This framework would include the establishment of new norms such as mutuality, responsibility and equality between men and women and a more equal sharing of power and finances between the two genders in the private and public sphere. This could be accomplished by enforcing women's empowerment through micro-credit and women's groups that enable women to have a greater degree of financial sustainability. In addition, there needs to be more emphasis on girls' education and the promotion of gender equity at a younger age in the private and public sphere. Infidelity needs to be condemned from all fronts including the government, heads of organizations, teachers, religious leaders and respected individuals of communities. Laws against adultery need to be enforced such that a woman whose husband is unfaithful can go to court and be able to legally divorce her husband and receive a portion of his salary. Mutual respect within marriage is a difficult thing to cultivate, but radio shows of model couples could help to show the advantages of having a relationship based on trust and open communication.

Therefore, the ABC campaign needs to expand its scope and shift gears so that it addresses the HIV/AIDS issue as it plays out in many African nations. It will not be easy to eliminate or modify these gendered factors but if they are not, then the methods used to contain and re-direct the AIDS epidemic have little chance of being effective or sustainable (ONUSIDA, 9:2004). Women should not be solely responsible for the fight against HIV. Men must also

acknowledge their joint responsibility and be willing to define their sexual roles in relation to the health of their family and community (Ulin, 1992: 67). In the long term, issues such as gender equity, economic independence and mutual respect need to be fostered in order for women to be able to better protect themselves from HIV/AIDS and to determine how and when contraception should be used within the context of marriage.

Appendix A: Research Timeline

September 2003 – December 2003 - Peace Corps Technical and Language Training in Agome-Tomegbe

December 17, 2003 – Arrived at work site (Tandjoaré, Togo)

January 2003 to March 2004 - Began journal and became familiar with village community, initiated relationships with village leaders and potential key-informants; Participant observation was used to help narrow down an issue area and improved the specifics of original research design.

April 2004 – December 2004 – Initiated and conducted key-informant interviews with Moba women with the help of one key informant for translation purposes.

January 2005 – April 2005 – Conducted three focus-group interviews with three different age cohorts of women within the village with the help of the mid-wife's translation.

May 2005 – July 2005 – Finished up remaining research, executed triangulation while completed missing gaps and began the interpretation and analysis of research data.

August – October 2005 - Produced and revised drafts of my substantial research paper.

November 2005 – Exited from the field and completed Peace Corps service.

Appendix B: Acknowledgements

I would like to express my deep gratitude to my two translators LARE, Damigou Bienvenue and LARE, Damigou (the mid-wife at the hospital) who gave their time and interest to my research project. In addition, I am grateful to the 18 women with whom I conducted one-on-one interviews and the 20 women who participated in the focus group interviews for their time, participation and honesty.

Appendix C: Key-Informant Interview Questions

- 1.) How old are you?
- 2.) Have you been to school? If so, up to what grade level?
- 3.) Are you married?
- 4.) Do you have children? How many?
- 5.) At what age did you have your first child?
- 6.) How would you describe your role in your family and your community?
- 7.) Could you describe what you think it means to be a woman? What does it mean to be a man?
- 8.) Do you have control over financial matters within the household? In which way?
- 9.) What are the biggest health concerns for you and your family?
- 10.) What do you usually do when a child of yours gets sick?
- 11.) What and where have you heard about HIV/AIDS?
- 12.) Have you known anyone who was infected with HIV/AIDS?
- 13.) Do you think dying with HIV/AIDS is different from dying from other diseases? How so?
- 14.) Do you think that AIDS is a big problem in Tandjoaré?
- 15.) Where does HIV/AIDS occur most frequently and among which ages and groups of people?
- 16.) Do you feel at risk of becoming infected with HIV/AIDS?
- 17.) Have you heard of a HIV test?
- 18.) How do you think AIDS can be transmitted within this community?
- 19.) How do you think it could be best prevented?
- 21.) Have you ever used a condom during sexual relations? Why or why not?
- 22.) If you thought that your partner might be infected, would you then use a condom?
- 23.) Have you ever discussed family planning methods with your partner? Why or why not?
- 24.) What was your the reaction of your partner?
- 25.) What is your feeling on the concept of family planning?

Appendix D: Focus Groups Probes

I formed groups of 7-10 women from the following age cohorts and asked them to describe their roles as women, their financial independence, their health concerns with a concentration of HIV/AIDS and family planning. In doing so, I took care to assemble women of relatively equal status in terms of age, ethnic, socio-economic background to facilitate the comfort level of the participants and the accuracy of the data.

GROUP 1: 18-28 years old

GROUP 2: 29-39 years old

GROUP 3: 40-50 years old

Focus Group Probe Questions:

What is the role of a Moba woman? And the role of the man?

At what age do women in Tandjoaré usually get married?

Describe whether women have control of the household finances?

What are the main health concerns in your families and communities?

What do you do when a child falls ill?

What have you heard about AIDS? Where did you learn this information?

What is the perception of contraception use in marriage?

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