Health Transition Review 6, 1996, 203-221

The price of promiscuity: why urban males in Tanzania are changing their sexual behaviour*

Robert Pool, Mary Maswe, J. Ties Boerma, Soori Nnko

TANESA (Tanzania Netherlands Project to Support HIV/AIDS Control in Mwanza Region, Tanzania) P.O. Box 434, Mwanza, Tanzania.

Abstract

This article presents evidence of a substantial change in sexual behaviour among urban factory workers during the last four years; it discusses the nature of this change and the reasons for it. Fear of AIDS was the main motivating factor, followed by economic hardship: because AIDS is incurable and because sexual relationships have a substantial transactional component, workers see themselves as paying the price of promiscuity with their lives as well as their dwindling financial resources. Respondents preferred partner reduction, and in particular sticking to one partner, to condom use. Condoms were not popular, mainly because of fears that they were impregnated with HIV and because of their association with promiscuous behaviour.

From a medical perspective AIDS is problematical because there is, as yet, no cure and no vaccine. It is also problematical from a social science perspective because its social aspect centres on sex, a form of social behaviour that has not received much attention from the social sciences, with the exception of psychology, before the AIDS epidemic. And not without reason: sexual behaviour is almost universally a private affair and people are not generally inclined to tell outside researchers about their sexual behaviour and experiences. Much recent social science research on sexual behaviour has been motivated, directly or indirectly, by the drive to develop interventions to alter behaviour that is seen as constituting risk for HIV infection. However, changing something as fundamental as sexual behaviour is not easy: just like smoking and drinking, sex gives short-term satisfaction, and because many people are basically hedonistic, possible consequences in the distant future do not weigh heavily. In addition, the interventions that are available are limited and when they have been applied it is not easy to evaluate in the short term whether they have had any effect; and even a more long-term decline in HIV incidence would not necessarily be an indicator of the efficacy of interventions. Do interventions affect people's sexual behaviour and if so how can we find out?

*We wish to thank the Principal Secretary, Ministry of Health, and the Director General, National Institute for Medical Research, Tanzania, for permission to publish the results of this study. The study was financed by the Netherlands Minister for Development Cooperation, as part of the Tanzania-Netherlands Project to Support AIDS Control in Mwanza Region, Tanzania (TANESA).

One possibility is to ask them. In surveys people tend to report sexual behaviour change. For example, in a national survey in Tanzania 88.2 per cent of 1874 men said that they had changed their behaviour (Weinstein et al. 1994); and in the WHO/GPA survey for Tanzania, 62 per cent of the men reported having changed (Cleland 1995:177-178). Of these, 81 per

cent reported a reduction in the number of sexual partners (Cleland 1995:186), that is, half of the Tanzanian men reported reducing the number of sexual partners. In the Mwatex factory, a large urban textile plant in Mwanza, Tanzania, sexual behaviour change also seems to be occurring: a longitudinal study of 752 male workers in the factory shows that many of the workers report having changed their behaviour (Ng'weshemi et al. forthcoming). In interviews with a subsample of 334 workers in 1994, 92.4 per cent said that they had changed their sexual behaviour since hearing about AIDS. This change has been mainly in the form of a reduction in the number of sexual partners.

So when people report having changed their behaviour in response to AIDS how are we to interpret this? Are they really changing or are they just reporting what they think researchers want to hear? If they are changing what are the reasons for change, and if they are not changing, why not? This paper addresses these questions on the basis of a qualitative study carried out among a sample of participants from the larger quantitative study in the Mwatex factory.

Background

Interventions in Mwatex

TANESA (Tanzania Netherlands Project to Support HIV/AIDS Control in Mwanza Region, Tanzania) commenced in 1993, as the successor of TANERA (Tanzania Netherlands Project for Research on HIV/AIDS in Mwanza Region, Tanzania), which started in 1991. TANESA's main goals are to support the development and implementation of appropriate and effective methods for the reduction of HIV transmission, to assess the consequences of the HIV/AIDS epidemic at various levels and to contribute to the development of appropriate methods to cope with these consequences. One of the major TANERA/TANESA[1] activities was a longitudinal cohort study in the Mwatex factory, which had 2,000 workers in 1991. Enrolment for this study started in late 1991 and continued until late 1994. Follow-ups continued into 1995. A clinic was established at the factory and all study participants were invited for follow-up visits four months after their previous visit. If they failed to attend, reminders were sent on four subsequent occasions, including personal attempts to motivate them to attend. After one year of non-attendance participants were excluded from the study. During intake and follow-up visits, a standardized interview, physical examination and laboratory investigations were carried out. Free medical treatment was provided to all study participants at intake, follow-up visits and any time they presented in between. Referrals to hospitals were made when necessary.

Apart from the clinic, various interventions were initiated. These included free treatment of sexually transmitted diseases at the study clinic, condom distribution and voluntary HIV counselling services. In addition, several health education activities were initiated in the factory. These included workshops for factory workers to provide them with information about AIDS; drama performances; and the training of 30 peer educators (from 1993). The coverage of the peer educator program was very limited, however, because of power cuts, layoffs and closures at the factory.

Because of interventions in the factory, media coverage and national and other AIDS campaigns, it may be assumed that the workers had sufficient knowledge of AIDS to know what to answer when they were asked about behaviour change and numbers of partners. However, we assume that they were not simply telling us what we wanted to hear because, although the majority of respondents claimed to have reduced the number of sexual partners

[1]For convenience we use 'TANESA' to refer to both phases of the project.

or to now stick to a single partner, reported condom use has remained relatively low. This discrepancy is striking since campaigns have placed at least as much emphasis (perhaps even more) on condom use as they have on partner reduction, on the assumption that condoms would be the easier, preferable option. If respondents were simply repeating what they had heard during campaigns then they would surely tend to report condom use to the same extent as partner reduction.

Approach and methods

An analysis of sexual behaviour change has been carried out for 752 men who had made at least four follow-up visits to the project clinic by January 1995, five visits in all. Virtually all of these men had been enrolled before January 1993. In total 1433 men had registered for the study by January 1993 and could have completed five visits by January 1995. Some of these men dropped out of the study through death (1.5% of all enrolled) or other reasons (38.9%), others are continuing but have not yet reached their fifth visit (6.1%). Economic instability has contributed to high dropout rates. Since 1993 the factory has been repeatedly closed and re-opened, and was closed completely in late 1994. The majority of dropouts were temporary workers, who made only one visit to the study clinic (Ng'weshemi et al. forthcoming).

In 1994 a subsample of 334 randomly selected men were interviewed in order to evaluate interventions. During this interview (referred to in what follows as the 1994 behaviour change interview) respondents were asked whether they had changed their sexual behaviour since hearing about AIDS; of the 334 respondents 92.4 per cent said that they had. Most of this change involved reduction of the number of sexual partners. An analysis of the number of partners reported during the four-monthly follow-up interviews revealed that during the period 1991-1994 the proportion of men reporting more than one sexual partner during the last month declined from 22.3 to 12.2 per cent; the proportion of men reporting casual sexual partners during the last month declined from 9.8 to 5.2 per cent. Although the reporting of actual numbers of partners did not support the high percentage of those claiming to have changed in the 1994 interview (92.4%), the reduction was nonetheless impressive (Ng'weshemi et al. forthcoming).

Because the project had carried out interventions in the factory during the longitudinal study, and given the high level of knowledge about AIDS, we suspected that some desirability effect had led to reporting bias. We therefore decided to carry out a validation study among a subsample of respondents from the larger study. This study had three goals: first, to validate the substantial partner reduction which emerged from the longitudinal study; second, to investigate the discrepancy between the extremely high percentage of respondents who claimed to have 'changed' and the lower proportion who reported actual reduction of partners or condom use; and third, to explore the reasons for behaviour change or lack of change. The validation of partner reduction is reported in a separate paper (Pool et al. 1995). This paper focuses on the second and third goals.

From the 752 men in the longitudinal study who had made at least five follow-up visits to the TANESA clinic during 1991-1994 we randomly selected 32 for in-depth interviews. After a preliminary analysis of the first group of men it was noted that levels of agreement between the follow-up interviews in the longitudinal study and the in-depth interviews were high, and we decided to further challenge the data by randomly selecting another 13 men who were either incident cases of HIV or had had a clinical STD during the second half of the study period. This sample was kept relatively small because the emphasis was on in-depth understanding rather than on wide coverage.

All but two of the 45 respondents were married. Twenty-two had been married more than once; three were in polygynous unions. The average age was 39 years. Of these four were younger than 25, 17 were between 25 and 34, 15 between 35 and 44 and nine over 45. More

than half reported being Catholic (26); the rest were divided between various Protestant denominations (15), Islam (2), and traditional religion (2).

We also interviewed the wives of ten of the men regarding their impressions of changes in their husbands' behaviour. These were wives who were also enrolled in the cohort study. We could not interview the wives of the other married men whose wives were not included in the cohort study for ethical reasons: questioning women who were not involved in the study about their husbands' behaviour may have caused undue concern about possible HIV infection.

We invited the men to participate in open, in-depth interviews in which we discussed TANESA interventions, behaviour change among the factory workers in general, the individual's own behaviour, condom use, attitudes to extramarital relationships, opinions about various kinds of sexual partner and alcohol use. The in-depth interviews covered the five years preceding the interview and were loosely structured along the lines of the topics covered in the follow-up questionnaires in the longitudinal study, the idea being to allow the respondents to speak as freely and informally as possible while at the same time making sure there was some basis for comparison. The interviews were recorded and transcribed verbatim and then subjected to a discourse analysis.[2] We then checked both the internal consistency of what respondents had said in the in-depth interview and compared this to what they had said in the various follow-up interviews in the longitudinal study (for convenience we will refer to these simply as the follow-ups). We also compared the interview data on behaviour change with the testimonies of the spouses, HIV serology, self-reported genital discharge or ulcers and the clinical data on sexually transmitted diseases.

Comparison and the problem of consistency

Although there are many practical and epistemological problems involved in the comparison of data from quantitative questionnaires, qualitative open interviews and clinical diagnoses, we have chosen to interpret responses pragmatically, comparing answers from the in-depth and follow-up interviews point for point (thereby quantifying the qualitative data somewhat) and then compare these answers to the serological and clinical data. But we have also kept a flexible, interpretative approach, evaluating the general impression given by the data as a whole and carefully weighing this against the internal consistency of each open interview. Our conclusions are therefore based on a straightforward comparison of two lists of literal questions and answers and a more qualitative interpretation of the whole data set for each respondent.

Also, given the different kinds of interview and the different means of recording them, there is plenty of scope for divergence in the answers to what are putatively the same question. Obviously, complete fit cannot be taken as the criterion of acceptability, but just how much inconsistency is acceptable? In this paper we focus on behaviour change and the reasons for change, and consistency between the different sets of data is relevant only to the extent that it supports or contradicts the respondent's claim to have changed his behaviour. Inconsistencies that are not directly relevant to the question of change have been ignored, unless there are many of them between and within the different sources. If a respondent's claim to have changed is consistent between the longitudinal study questionnaires and the in-depth interview but is contradicted by one of the other sources (HIV seroconversion, clinical evidence of STDs or a spouse's testimony) then we reject it as inconsistent.

---

[2]On discourse analysis see Gumperz (1983), Mishler (1984). For an example of how the interviews were interpreted see Pool (1994).

Behaviour change

Promiscuity, multiple partnerships and single partnerships

In what follows, the labelling of behaviour or respondents as promiscuous is ours. All interviews and discussions were in Kiswahili and respondents did not use the word 'promiscuity'. Although Kiswahili speakers who speak English tend to translate such Kiswahili terms as *uasharati*, *mambo ya anasa* and *mambo ya uhuni* as 'promiscuity' when they are talking about the behaviour of others, they would never do so when describing their own behaviour because these Kiswahili terms have a more negative connotation than the English 'promiscuity'.[3]

We distinguish between multiple partnerships and promiscuity. In a multiple partnership a man has more than one sexual partner with whom he has a relatively stable relationship. These are relationships which resemble traditional polygyny. We also call relationships in which a married or cohabiting man has occasional additional partners multiple partnerships. We reserve the term 'promiscuity' for men having frequent and diverse sexual relationships, especially transient ones. Although we realize that the use of the term 'promiscuity' may be pejorative, we make the distinction in order to avoid lumping widely varying behaviours under the single label of 'multiple partnerships'.

We have grouped all those with a single partner together, whether they are married, are cohabiting or simply have a stable non-cohabiting relationship. For convenience polygynous marriages are also classed as single partnerships.

Number of partners

The results of the longitudinal study (Ng'weshemi et al. forthcoming) and the validation study (Pool et al. 1995) confirm substantial behaviour change among male Mwatex workers since the commencement of TANESA activities, though not to the extent that they tend to report it when asked explicitly about behaviour change. This behaviour change mainly involves a reduction of the number of sexual partners. The behaviour change of our 45 respondents, as confirmed by the comparison of data from the longitudinal study, the validation study and the comparison of clinical and serological data, is summarized in Table 1.

After analysing the data from the in-depth interviews with 45 male respondents and ten spouses and comparing this to the quantitative data on numbers of partners from the follow-up study, HIV serology and clinical diagnoses of STDs, we conclude that 16 of our 45 respondents have changed their behaviour and 29 have not changed their behaviour during the study period. Of the latter group five had changed, but before the study began, ten had never had risky behaviour and 14 had remained promiscuous in spite of claiming to have changed. Five of those who did not change reported not having changed in the follow-ups and in the 1994 behaviour change interview (though they did initially say they had changed in the in-depth interviews). This means that of the 40 respondents who reported changing their behaviour, 16 had actually changed.

Table 1
Number of men having reduced/not reduced the number of partners during the study period, as determined by multiple data sources

Reduction of	From very many to fewer partners (though still promiscuous)	3

[3]Other common terms in this context are *zinaa* and *uzinzi*, both usually translated as 'adultery'.

partners	From few partners to a single partner[4]	3
	From many partners to a single partner	10
	Total	16
No reduction of partners	Changed before the study	5
	Always had only one partner	3
	Did not stick to a single partner but were not promiscuous either	7
	Remained promiscuous[5]	14
	Total	29
Total		45

However, the figures could also be interpreted more favourably. For example, in the group of those who had not changed there were three who had always had only one partner and who therefore could not have changed. If we exclude these then 16/37 of the respondents who could have changed, did. Also, five of the respondents had changed before the study period, two of them in response to the threat of AIDS. If we add these two to those who have changed then almost half (18/37) of those who could have changed have changed in response to the AIDS epidemic. Seven of the respondents who did not change did not stick to a single partner, but they were not promiscuous either. Fourteen respondents remained promiscuous as opposed to 13 who now stuck to a single partner.

When we focus on high-risk behaviour rather than partner reduction we see that of the 27 respondents who initially had high risk behaviour, ten had changed to no-risk behaviour (single partner) and 17 had remained promiscuous, though three of these had become less promiscuous. So 10/27 had changed from high-risk to no-risk behaviour.

One important conclusion here seems to be that sticking to a single partner is the preferred mode of behaviour change; in the behaviour change interview 77.6 per cent of the respondents said that they now stuck to a single partner. Another conclusion is that if you just ask people whether they have changed their behaviour they tend to reply ‘yes’, whether they have actually changed or not. Indeed, they even say ‘yes’ when they cannot have changed because they only had one partner to start with. This is supported by other data from the in-depth interviews in the present study. When we asked the workers whether they thought that their colleagues had changed their behaviour since TANESA started its activities in the factory, 40 said that there had been a change and that some or all of the workers had become less promiscuous. Only three said that there had been no change and two said they did not know whether there had been any change. In other words the same number of respondents who reported that they had changed their own behaviour when asked explicitly, also answered in the in-depth interview that everybody or many had changed. In addition, of the 28 respondents for whom a comparison of the different data sources showed that they had not changed, 18 claimed in the in-depth interviews that they had changed. Respondents would often start off by declaring radical behaviour change, usually claiming to have only one partner, and then gradually move on to admit more and more sexual partners.

Obviously, given the high degree of knowledge about AIDS, people know that they are expected to change and may answer accordingly when someone from an AIDS-related project asks them. But then why not lie about the numbers of partners as well, and why admit to not using a condom? After all, people must also realize that we want to hear that they are using condoms unless they are faithful to one partner.

---

[4]For convenience ‘single partner’ here also refers to being faithful in a polygynous union.

[5]Here it should be noted that of the 14 respondents who remained promiscuous the different data sources were only consistent for one. For the remaining 13 there were inconsistencies which pointed clearly to continued promiscuous behaviour.

Why did so many respondents initially report behaviour change only to contradict this when discussing numbers of partners and condom use? The most likely explanation here seems to be related to methodology. When you ask people straight-off whether they have changed, either in an open interview or in a questionnaire, then they answer 'yes' without thinking because they have internalized the idea that this is desirable. This explains the degree of change reported in the 1994 behaviour change interview. In the ordinary follow-ups, however, respondents probably reported numbers of partners more honestly because the reporting was piecemeal. They did not have to say: 'I have had 20 partners in the last two years', but only that they had had one or two in the last few months, which does not sound as bad as the grand total. (Respondents were not ashamed of bragging about the numbers of partners they had before TANESA and AIDS, however.)

But then what about the in-depth interviews, in which respondents were asked for grand totals? Here we also see that when they were asked explicitly, many respondents claimed that they had changed. They often only revealed that they were promiscuous or had more partners later on in the interview, either by contradicting what they had said earlier and then confessing after it was pointed out to them, or by spontaneously admitting to having under-reported earlier. For example, one respondent claimed to have only one partner at first, but later, in the context of a question he put to the interviewer about the safety of condoms, described how he used condoms with casual partners and why he was worried that they were not protecting him adequately from diseases.

Here two factors play a role. First, the easy, informal and non-routine nature of the in-depth interviews was more conducive to being open than a formal situation. The interviewer succeeded in establishing rapport early in the interview and by the end some respondents were asking for advice and revealing more intimate details. Second, in open, in-depth interviews there is also more opportunity for the respondent to contradict himself and more scope for him to revise earlier statements. There is also more scope for the interviewer to steer and probe. Identification of these factors was made possible by a discourse analysis of the verbatim transcripts of the recorded interviews.

So different methodologies generate different responses, and there are good reasons why questions about behaviour change produce less reliable results than questions about numbers of partners. But what about the validity of the findings? Have somewhat less than half of the Mwatex workers who claim to have changed their behaviour actually changed?

In discussing the results of the WHO/GPA surveys Cleland is sceptical. He concludes that reported change should not be interpreted literally but may rather signify 'an acknowledgment of the desirability or need to change rather than its achievement' (Cleland 1995:192). We agree that it is necessary to remain critical of the validity of self-reported behaviour change, but we feel that he might be a bit too sceptical about change. We do not pretend to have found the 'objective index' or 'gold standard' against which reported sexual activity can be validated once and for all (Catania et al. 1993), and indeed, we doubt that it will ever be found. And we also realize that our sample was not really representative of Tanzanian men, or even Mwatex workers, but we do feel that our claim of substantial change is justified.

Although a more comprehensive study, including more comparative variables, might have led to more inconsistencies and thus a reduction in the number of respondents whose claim to have changed we have accepted as true, our analysis has shown that the combination of a longitudinal study and in-depth interviews was basically sufficient. The other factors (interviewing the spouse, seroconversion and clinical data on STDs) generally only served to confirm what we already suspected in almost all cases. It is only in three cases that general agreement between the follow-up questionnaires and the in-depth interview data were contradicted by the additional factor: one respondent seroconverted, one had an STD and one

respondent's wife said he had extramarital partners during the period they claimed to be faithful to a single partner. In addition, we have been rather critical in rejecting the claims of those respondents who might have changed (i.e. their claim to have changed was not directly contradicted) but whose data contained several inconsistencies. A more liberal interpretation would have led to the inclusion of some of these in the behaviour change group.[6] Our sample was not representative for all the workers because respondents who seroconverted and who had STDs were over represented. Because these men tended to be more promiscuous and less amenable to change, we do not think that our estimate that almost half of the workers have changed their sexual behaviour since 1991 is exaggerated.

Condom use

Twenty-seven out of 45 respondents reported consistently across all interviews that they had never used a condom. There were various reasons for this that are discussed below. One respondent had never used condoms during the study but had used them before the study to protect himself against STDs. He said he did not need them any more because he now stuck to one partner.

Five respondents reported using condoms, but the data from different sources were inconsistent. Three of these respondents reported using a condom in one of the follow-ups in 1992. In the in-depth interview they denied ever using them. Here, as in the case of reporting casual partners, the inconsistency may result from the fact that in the follow-ups the respondents were recalling behaviour of the previous month, whereas in the in-depth interview they had to recall behaviour (including incidental condom use) for the previous four years. One respondent said in the in-depth interview and the 1994 behaviour change interview that he used condoms to protect himself against diseases, but he never reported them in the four-monthly follow-ups. Finally, one respondent reported condom use in the follow-ups and in the in-depth interview he claimed that he had used a condom at home with his wife for family planning purposes for a whole year. His wife denied this, however, saying that she had seen her husband with condoms but that he never used them with her.

Table 2
Number of men reporting condom use/non-use during the study period, as determined by multiple data sources

Do not use a condom	Never used one	27
	Used previously, before the study	1
	Total	28
Use a condom	Claim to use, but sources inconsistent	5
	Regularly with wife for family planning	1
	Regularly with regular partner for family planning/protection	2

[6]We assume that, in a context in which multiple partnerships and extramarital sex are increasingly associated with negative consequences (AIDS) and in which interventions and IEC messages focus on reducing the number of sexual partners, there is bound to be some desirability effect in answering questions on numbers of partners and sexual behaviour change. Any statements on partner reduction and percentages of respondents claiming partner reduction should therefore be viewed as critically as possible. Because the percentage of those reporting behaviour change, even though it is lower than percentages reported in some surveys, still seems relatively high when viewed from the common-sense perspective of everyday experience, and because the workers in the Mwatex factory have probably been exposed to more information on the nature of behaviour change desired, we have been extra critical in rejecting claims to such change, hence our rejection of a man's claim to have changed if his wife contradicted this.

	Regularly with casual partners for protection	4
	Sporadically	5
	Total	17
TOTAL		45

For 12 respondents who claimed to use condoms the data were consistent. Seven of these used condoms regularly during certain periods, either with their wives for family planning (one respondent), with regular partners for family planning and/or to protect themselves from diseases (two respondents) or with casual partners for the sole purpose of protection against diseases (four respondents). The remaining five used condoms only sporadically.

In the longitudinal study 9.7 per cent of the men who claimed to have changed their behaviour said they used condoms nowadays (Ng'weshemi et al. forthcoming). Five out of 45 of our respondents had reported condom use as a form of behaviour change, in addition to reducing the number of partners, in the 1994 behaviour change interview; so this was confirmed when the quantitative and qualitative data were compared.

The reasons for change

Partner reduction

Which factors have played a role in the behaviour change described above? Have TANESA interventions in the factory contributed to change? And if so, to what extent?

Apart from the clinic, established in 1991, TANESA interventions in the Mwatex factory commenced in 1992 and have included video shows, focus-group discussions and informative seminars during which condoms were demonstrated. A drama group was set up and plays were performed in the factory. In 1992 thirty peer health educators were also trained. This was followed up in 1993 with further training.

During the in-depth interviews we asked respondents which TANESA activities they knew and what they thought of them. Everybody, without exception, was enthusiastic about the clinic. In fact, when we asked them about TANESA activities in general they always talked exclusively about the clinic. Most had never even heard of any of the other activities. Only the odd respondent had actually participated in these activities, usually by attending an information meeting or seeing one of the plays.[7]

The main reason that workers gave, directly or indirectly, for changing their behaviour was fear of AIDS, although apprehension about getting STDs, and in particular of passing these on to their wives, was also significant. This fear had been instilled primarily by visits to the clinic. Indeed, workers often said that they had changed since they 'joined TANESA', and here they were referring exclusively to attending the clinic. The mere fact of attending the clinic regularly, being examined and, if necessary treated, and receiving information about AIDS in the context of those activities, has instilled not only an awareness that some kind of change is necessary but a deep-seated fear of the disease.[8]

---

[7]The lack of coverage of these interventions may be due to the many factory closures, power cuts and other problems in the factory during this period. All our respondents obviously knew the clinic because they had been selected from attenders.

[8]The word fear is problematic here. We realize that there is a desire to formulate AIDS messages in positive terms, but it remains a fact that the simple fear of degeneration, isolation and death remains the prime mover of change with regard to AIDS.

> I used to like going after women but since attending the clinic I have become afraid. I have changed, though I haven't stopped altogether. In the past I couldn't go three days without a woman. It was very difficult. Now I can go without for a whole month. I've reduced the number of partners since 1992 when I joined TANESA and heard of the way AIDS is spread.
>
> Previously I could have more than five partners, but these days I only have my wife. I stopped having other partners completely because of fear of this incurable disease.

As part of the longitudinal study blood samples were taken from all clinic attenders during each four-monthly follow-up visit. Although 90 per cent of the participants still did not want to know the results of the HIV test by 1994, respondents in the in-depth interviews frequently expressed concern about the results. The simple fact that blood had been taken caused a deep anxiety that they might have 'the disease'.

> My problem is that I have not received the results [of the blood test].
>
> They have the secret but I don't know, and this gives me a headache. I requested the results but haven't heard anything. Not that I'm worried. I no longer have any dependent children. I asked the counsellor and she told me not to worry. Maybe she saw that I already had symptoms. Anyway, I'm not worried.
>
> If she told you not to worry then everything is okay.
>
> Then why am I loosing weight? First I weighed 65 kilo, then 60, then 59.
>
> It could be something else.
>
> I thought maybe it was malaria. I was worried a lot and I wasn't eating. Why can't they tell me?
>
> If you ask them they will tell you.
>
> Maybe they have reasons for not wanting to tell me?
>
> What kind of reasons might they have?
>
> Some of my children are young.
>
> No, that couldn't be a reason. If you want to be told then they have to tell you so that you can prepare.
>
> That's why I was asking; so that I can prepare my will.

Respondents sometimes used a religious idiom when describing how TANESA had 'helped' them to 'change'. There was frequent reference to Biblical condemnation of adultery. Some respondents also claimed that they had either stopped or greatly reduced drinking alcohol 'since joining TANESA'.

> When TANESA started I was an ordinary person. I used to drink and indulge in promiscuity (*mambo ya anasa*). But after you started here I became afraid and followed Jesus. I abandoned these activities and now I feel I am saved.
>
> I used to get many STDs, but then I heard of TANESA and God blessed me and I was cured. I decided to join and today I am here because of you.

It is striking, and perhaps relevant from an intervention perspective, that a religious idiom was used to denounce sexual promiscuity and alcohol but not the use of condoms[9]. Here there may be some resonance between the widespread activities of crusading 'born again' Protestant denominations preaching rebirth as a means to salvation, and AIDS interventions that also advocate change leading to salvation. The clinic, like the church, not only mediates between life and death, but also has the secret of who is saved and who is damned.[10]

There are, however, also sound economic reasons for cutting down on numbers of sexual partners and drinking. When discussing non-marital sexual relationships and the reasons for reducing the number of partners many workers complained about the cost of maintaining multiple partnerships.

> Extramarital partners are bad because they need money and if you don't earn much you must deprive your wife in order to pay them.
>
> A permanent mistress is always thinking of money and casual partners also always ask for money when you are with them. They cannot give sex freely.

Wages in Tanzania are not keeping up with the high level of inflation and this, together with layoffs and frequent closures of the Mwatex factory, have meant that workers have had less money to spend in recent years. Given the transactional nature of casual sex, the financial burden of keeping regular partners and the increasing price of beer, these are obvious targets for increased thrift: one respondent said quite explicitly that he would like to have continued having relationships with multiple partners but could no longer afford it. This would not affect condom use because they are distributed free.

We have examined some of the reasons for partner reduction as they emerged from the in-depth interviews. Now we must look briefly at the other side of the coin: why do men have multiple partnerships to start with and why do some continue to have them? One 44-year-old worker had reduced the number of extramarital partners, but he could not keep to one partner. His response is typical:

> I have changed. I used to go after every woman I saw, even if I didn't know her.
>
> And now?
>
> Now I might have sex with an outside woman once in two months.
>
> How many do you have at the moment?
>
> Only one.
>
> What prevents you from stopping altogether?
>
> Lust (*tamaa*).
>
> How many partners were you having previously?
>
> We used to meet in bars. When we drank we overdid it and this stimulated our desire. So when I saw a woman and I had money I would approach her and seduce her. But it was not on a daily basis; perhaps once a week.

---

[9]Although 17 respondents reported using condoms during the study period, and most of those claimed to have used them to protect themselves against diseases, none said that they had started using condoms as a form of behaviour change because of TANESA interventions.

[10]This is not limited to the factory workers. One young fisherman who had just been trained as a TANESA peer health educator declared: 'The old Mayunga does not exist any more. There is a new Mayunga now.'

> When did you start reducing?
>
> April 1994.
>
> How many outside partners did you have during the last year?
>
> Maybe four...
>
> Is it acceptable for a man to have extramarital partners beside his wife?
>
> It is not acceptable, but men do it.
>
> Why do you do it when you know it is unacceptable?
>
> It is just lust (*tamaa*). You may see another woman and feel she is more beautiful than your wife and you may think there is a difference, but they are the same. When you see her she looks appealing, but when you have sex with her you find there is no difference. So it is just lust which misleads you. We have a saying: the meat at home never tastes good. You may leave meat at home to go and eat meat in a roadside restaurant, just for a change.

Another respondent said:

> Before I got married I was like a bull or a male baboon. I moved about without caring. I chased every woman I saw unless she was a relative.

Men tend to explain multiple relationships in terms of lust (*tamaa*). Although this does not apply to all men, and there were those who had always been faithful to a single partner or had serial monogamous relationships, multiple partnerships seem to be the norm rather than the exception. Only the odd respondent claimed to be faithful to his wife simply because he was not interested in other women.

Here we are not generalizing only from our interviews with 45 factory workers: this conclusion is also supported by the results of other research among fishermen (Pool, Washija and Maswe 1995) and school pupils (Nnko and Pool 1995).

In the discourse of the factory workers there was a tension between lust or desire on the one hand and anxiety about economic deprivation and, in particular, fear of disease on the other.

> I got married in 1988. Since then I've had no other partners.
>
> Why don't you have other partners?
>
> Because of the cost.
>
> Is that the only reason?
>
> And also if you have other partners there is the risk of diseases.
>
> TANESA has helped me to change. I still have desire. I plan to make a move but then I hesitate because of fear of being infected. Before these diseases you could have sex with anyone. I reformed since about 1991, when I got married. Now I only stick to my wife.

Those who have changed and now stick to one partner would like to be more promiscuous but can either no longer afford to or, more often, are afraid to. Although they all condemn adultery and pay lip service to the ideal of being faithful, they easily slip into a *macho* discourse of carefree lust and womanizing. Most of those who have changed have not done so because they are convinced that having a single partner is better. They have changed reluctantly, out of necessity and fear. Some avoid having to make this sacrifice by using a condom, but for those who do not trust condoms or who feel the pinch of recession there is no choice.

The tension between lust and risk is also related to the distinction between spouses, regular partners and casual partners. Basically regular partnerships involve a woman receiving regular financial support from a man in exchange for both sexual and domestic services. These relationships may last from several months to many years. Casual partnerships involve a more direct exchange of sex for material reward and are much shorter in duration, varying from single sexual encounters to affairs lasting several months. Although the exchange of money for sex is central in casual relationships they are not tantamount to prostitution. In practice these distinctions are often not clear and there is a continuum stretching from regular relationships through casual partnerships to prostitution.

For women the most important criterion in differentiating between regular and casual partners is the nature of material support. A regular partner is a man with whom you have sex regularly and who provides financial support when it is needed, that is, there is no direct exchange of money for sex. In casual relationships the exchange is more direct and women stress that they cannot rely on casual partners for support in case of illness or other emergencies (Mgalla and Pool 1995). For men the criteria are different. Although many of our male informants initially complained that all extramarital partners were the same because they were all after money, they did tend to make a distinction in terms of risk and control. Men have no control over casual partners, who may sleep around and then pass on diseases. Most men know that a healthy looking person can be HIV-positive and many know that a woman may have an STD about which the man may be unaware: one man said that he feared casual partners because they might carry ‘the secret’ (disease) without his realizing it. The only evidence men have to go on is the woman’s behaviour: how promiscuous is she? Men have a better idea of what regular partners are up to and can estimate the risk. They talk of regular partners in terms of trust.

> With a regular partner you know she is there even if you don’t visit her every day. A casual partner you just meet along the way and have sex with her. She moves everywhere and goes with everyone and you can easily get an STD if you have sex with that kind of woman. You cannot know whether she has the disease and afterwards she leaves you with the germs (*vidudu*).

> With a regular partner you know and you can trust each other. You can’t trust a casual partner because you don’t know her behaviour. She keeps changing partners. You can’t know whether she has disease or not. She may give you AIDS or some other disease.

Of the 16 respondents in our study who have changed their sexual behaviour, ten now stick to a single partner. Why one partner rather than just a reduction in the number of partners, or a switch from many casual to few regular partners? At first sight it seems that one or two regular extramarital relationships would not pose any more threat of exposure to HIV infection than if the man was in a polygynous union. The main reason for preferring a single partner is that men expect their wives to be faithful, and although some wives are obviously not faithful (two of those interviewed admitted to having extramarital affairs) there are strong social sanctions against female marital infidelity. Although men would like their non-marital partners to be faithful, there is a consensus that this cannot be demanded, and they consider it quite normal that these women have other male partners in addition to themselves; although regular partners are expected to be more faithful than casual partners, if only because a man spends more time with a regular partner than he does with a casual one and so she has less opportunity to meet other men.

> How many partners do you have at present?
>
> None apart from my wife.
>
> How many did you have before?

> I had only one before I joined.
>
> What kind of partner was that?
>
> She was like a wife, because I had been with her for more than ten years. Last year I decided to leave her. I saw that people were dying and decided to remain with my wife only. TANESA helped by teaching us. They told us that 17% of the women in the factory have the virus, and 10% of the men. I realized it was dangerous...
>
> What's the difference between a casual and a regular partner?
>
> A casual partner is only for a short time, and she is only after money. A regular partner you know and trust because she has good conduct; you know she does not have other partners...
>
> Is it acceptable for married men to have outside partners?
>
> No.
>
> Why not?
>
> We have them, we do it secretly and we know it is a mistake, but we still continue. The mistake we make is that you can't trust the outside woman, because once you part you don't know what she is up to. She can go with other men and if she gets a disease then you can get it and pass it on to your wife at home.

Even though it is sometimes unclear whether a couple are 'really' married or not, for example when the husband has agreed to the brideprice but not yet actually paid it, the distinction between a wife and an 'outside partner' is quite clear: a wife is not permitted to have other sexual partners, whereas this is legitimate for a single woman, even if she is a regular partner of many years. Some wives do have extramarital affairs, of course, and husbands are aware of this, but in such cases a man has the power to demand an end to his wife's infidelities. If his authority is insufficient he can appeal to her family, to whom he has paid the brideprice. Involvement of the woman's father is generally sufficient to bring her back into line. The man who has not paid brideprice has no such sanction.

The major reason that the men gave for breaking with extramarital partners was their fear that other men would pass on diseases through these women (see also Mgalla and Pool 1995). The man cited above initially argues that his long-term mistress is 'like a wife' but he nonetheless broke with her because he was afraid of getting AIDS. Wives are a much safer bet, even if they are not always faithful. Some single respondents gave this as a reason for getting married. In the in-depth interviews five respondents reported getting married because of information about AIDS that they received from TANESA.

Condom use

Contrary to Caldwell's claim in a recent paper (Caldwell 1995), our data show that, at least for the men we studied, condoms are not the preferred mode of behaviour change. In the longitudinal study only 9.7 per cent of the men who claimed to have changed their behaviour reported using condoms, and in the in-depth interviews 27/45 of the respondents claimed that they had never used a condom in their lives. When these men decided to change their behaviour in response to AIDS they preferred a single partner to condoms. We have already discussed the preference for a single partner, but why are condoms not an option? Why should men who are used to having extramarital sex and multiple partners and who claim to have an almost insatiable sexual drive, be prepared to give all this up when they could continue their old ways protected from disease by a condom?

In addition to the religious motive suggested above there are several reasons. For one, many people in Tanzania do not trust condoms. The belief that they are impregnated with the HIV virus is widespread and has been stimulated by the media attention given to bogus American scientists who claim to have worked for the CIA when they developed the virus with the aim of depopulating Africa. The fact that most of the free condoms come from the United States is seen as supporting this. Perhaps this is one of the reasons why some people are prepared to pay for the commercial *Salama*-brand condoms rather than accept the free American condoms. The free condoms are clearly labelled as coming from the USA, whereas most people are unaware that *Salama* condoms are also funded by the USA. Many people also think that condoms have minute holes, purposely built in to let the virus through.

Another important reason for rejecting condoms is that they are associated with promiscuity and distrust. One man said that condoms were 'bad': you could not use them with your wife and carrying one was seen as a sign that you slept with prostitutes. Condom use within marriage for any other purpose than family planning is out of the question, and although condoms may be used at the start of what are defined as regular relationships, this soon becomes impossible as well, if only because the regular financial support that men provide is seen as incompatible with the transience and lack of responsibility implied by condom use. Regular relationships have a transactional component and condom use is seen as part of the exchange deal. Both men and women reason quite explicitly that the fact that the man provides regular and dependable financial support negates the need to use condoms. The women express this in terms of trust: a man who supports you like a husband must be trusted like a husband. However, they are often uneasy because they know that their 'trusted' partner is usually married to someone else and may have other partners beside. For the men the emphasis is more on payment: they enjoy sex less when using a condom and see their refusal to use a condom as being compensated by regular financial support. Men never see risk as something to which they expose their extramarital partners. Rather, they see risk as stemming from the fact that extramarital partners may have sex with other men who, like themselves, determine condom use or non-use. Men see dependable financial support as making it less necessary for the woman to have many other partners, thus making regular relationships safer and condom use unnecessary.

For many respondents the reasoning behind not using condoms was that they do not need them because they have changed their behaviour, and they did not need them before they changed their behaviour because there was no AIDS in those days.

Condom use is acceptable in casual relationships, and even though men may sometimes be unwilling to use them because of a hedonistic fatalism ('death is death' and 'death is just like sleep' are common expressions) or unable to use them because they are drunk, a few respondents nonetheless consistently reported using condoms with casual partners as protection against diseases. Four respondents reported using condoms regularly, mainly with casual partners, in order to protect themselves from disease. These men were younger than average (32.5 as opposed to 40 years old), married and very promiscuous.

One respondent said he had reduced the number of partners since being informed by TANESA (end of 1992), but he still had casual extramarital partners when his wife was away at teacher training college, though he claimed to use a condom.

> How many partners did you have previously?
>
> Innumerable.
>
> How many do you have at present?
>
> None.... But if your partner is away and you feel like doing it then you may do so, but using a condom.

> Do you do that when your wife is away?
>
> Yes, I do it when she is away at college.
>
> How many partners did you have last year?
>
> I can’t remember.
>
> And last month?
>
> None, because my wife was home on leave.
>
> And the month before?
>
> With a condom.
>
> How many?
>
> About five...

Another respondent initially claimed to have changed by sticking to one partner. Later in the interview, in the context of a discussion about condoms, he contradicted himself:

> Have you ever used a condom?
>
> Yes.
>
> What for?
>
> To protect myself against diseases and for birth control.
>
> Did you use a condom last year?
>
> Yes, even right up to the present.
>
> With whom?
>
> My present partner/concubine, to prevent pregnancy.
>
> Are there others with whom you use a condom?
>
> Yes, when I have other partners I use a condom.
>
> These other partners you just mentioned: how frequently do you have them?
>
> Sometimes every couple of months, sometimes every week or two. Anytime.
>
> How many partners have you had this year apart from your one regular partner?
>
> About four.
>
> What about recently?
>
> I haven’t had any during the last three weeks.
>
> Do you use condoms with them?
>
> Yes, because you can’t know whether they have diseases.

So, in conclusion, there are more factors opposing condom use than supporting it. Sticking to your wife both is safe and absolves you of the necessity of using a condom. Only a few of the younger men who feel that they cannot go without sexual variety consistently use condoms with casual partners in order to protect themselves against diseases.

Conclusions

In this paper we have presented evidence of behaviour change in a group of urban factory workers. We have concluded that somewhat less than half of our respondents have changed their sexual behaviour during the last four years. This evidence, and our interpretations of it, are open to critical questioning, much of which will focus on validity and some of which will be justified. We do not claim to have objective proof of the exact extent and nature of behaviour change, and indeed, we do not think this is possible in the case of sexual behaviour. But we do claim that there has been a substantial reduction in the number of sexual partners among these workers.

Simply asking respondents whether they have changed their behaviour or reduced the number of partners is insufficient, and a combination of quantitative and qualitative methods seems to be the best option. The combination of a longitudinal study and in-depth interviews (especially when the interview transcripts are subjected to discourse analysis) were basically sufficient for validating behaviour change, although the other factors, interviewing the spouse, serological and clinical data also contributed to supporting or refuting respondents' statements. In addition, the in-depth interviews provided a wealth of data on the reasons for change or lack of it.

Fear of AIDS was the main motivating factor for change, followed by economic hardship: because AIDS is incurable and because sexual relationships have a substantial transactional component, workers see themselves as paying the price of promiscuity with their lives as well as their dwindling financial resources. The fear of AIDS has been instilled by AIDS campaigns generally and by the activities of the TANESA clinic in particular.

Respondents preferred partner reduction, and in particular sticking to a single partner, to condom use. Although condoms were an acceptable option for a few younger men who could not, or were unwilling to, reduce the number of sexual partners, they were not popular, mainly because of fears that they were impregnated with HIV and because of their association with promiscuous behaviour. The preference for sticking to a single partner was also related to a culturally specific classification of different kinds of sexual partner and attitudes to marriage and extramarital sex. Men consider their wives to be the safest sexual partners because extramarital sexual relationships are prohibited for married women whereas society does not so much frown on a single woman having multiple sexual partners, even if she has a long-term relationship with one man.

The activities of the clinic, the deep-seated fear of AIDS and the preference for sticking to a single partner were frequently expressed in a religious idiom, suggesting resonance with the popular Pentecostalism of proselytizing denominations.

Although we have presented evidence of substantial change, this change was reluctant. Those who have reduced the number of partners or stuck to one partner would like to be more promiscuous but can either no longer afford to or, more often, are afraid to. Those who use condoms also do so reluctantly. This seems to imply that if the present constraints were to be removed by improved economic position, or discovery of a cure for AIDS or vaccine against HIV, these men would be likely to revert to their previous behaviour.

References

Caldwell, J.C. 1995. Understanding the AIDS epidemic and reacting sensibly to it. *Social Science and Medicine* 41,3:299-302.

Catania, J.A., H. Turner, R.C. Pierce, E. Golden, C. Stocking, D. Binson and K. Mast. 1993. Response bias in surveys of AIDS-related sexual behavior. Pp. 133-162 in *Methodological Issues in AIDS Behavioral Research*, ed. D.G. Ostrow and R.C. Kessler. London: Plenum Press.

Cleland, C. 1995. Risk perception and behaviour change. Pp. 157-192 in *Sexual Behaviour and AIDS in the Developing World,* ed. J. Cleland and B. Ferry. London: Taylor and Francis.

Gumperz, J.J. 1983. *Discourse Strategies*. Cambridge: Cambridge University Press.

Mgalla, Z. and R. Pool. 1995. Sexual relationships and risk perception among female bar workers in Magu, Tanzania. Paper presented to the Ninth International Conference on AIDS and STDs in Africa, Kampala, 10-14 December.

Mishler, E.G. 1984. *The Discourse of Medicine. Dialectics of Medical Interviews.* Norwood NJ: Ablex Publishing Corporation.

Ng'weshemi, J., J.T. Boerma, R. Pool, et al. forthcoming. Changes in male sexual behaviour in response to the AIDS epidemic: evidence from a cohort study in urban Tanzania. *AIDS*.

Nnko, S. and R. Pool. 1995. Love, lust, deceit and money. Tanzanian school pupils and the discourse of sex. Paper presented to the Ninth International Conference on AIDS and STDs in Africa, Kampala, 10-14 December.

Pool, R. 1994. *Dialogue and the Interpretation of Illness. Conversations in a Cameroon Village.* Oxford: Berg Publishers.

Pool, R., J.T. Boerma, M. Maswe and S. Nnko. 1995. The use of multiple methods to assess changes in sexual behaviour. Unpublished paper.

Pool, R., N.R. Washija and M. Maswe. 1995. Promiscuity, acquiescence and exchange. Sexual relationships in the fishing villages of Magu district, Tanzania. Paper presented to the Ninth International Conference on AIDS and STDs in Africa, Kampala, 10-14 December.

Weinstein, K.L., S. Ngallaba, A.R. Cross and F.M. Mburu. 1994. *Tanzania Knowledge, Attitudes and Practices Survey*. Calverton MD: Macro International Inc. and Dar es Salaam: Bureau of Statistics, Planning Commission.