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Contemporary Myths, Sexuality Misconceptions, Information Sources, and Risk Perceptions of *Bodabodamen* in Southwest Uganda

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This article reports findings from a study conducted among 212 private motorbike–taxi riders, locally called *bodabodamen,* from two study sites—a slum area and the urban center of Masaka town. Qualitative and quantitative methods were triangulated; a questionnaire, focus group discussions, in-depth interviews, case studies, and interactive workshops were all used. There were high levels of awareness of HIV, much more than sexually transmitted diseases (STDs), because many participants had closely experienced HIV/AIDS. Knowledge about sexual health contained several misconceptions, misinformation, and myths rooted in both the historical and contemporary social cultural context. Due to high illiteracy levels, *bodabodamen* cannot access many standard health education materials issued by government and private health organizations through the print and electronic media, as well as those published in languages other than the local vernacular. These (and possibly other) disadvantaged groups remain at risk of HIV and STD. Especial efforts need to be made to provide appropriate health education.

KEY WORDS: sexuality information; risk perceptions; masculinity.

Studies reveal Uganda's success story in reducing the incidence of HIV (Asiimwe-Okorir et al., 1997; Mulder, Nunn, Kamali, & Kengeya-Kayondo, 1995). This achievement is attributed to the rigorous multisectoral strategy of openly providing health education, information, and communication to the rural and urban masses (Rwomushana, 2000). With the much-praised leadership of President Yoweri Museveni, government, public enterprises, nongovernment organizations, community-based initiatives, multinational companies, and other bodies all participate in the dissemination of health education messages to the grass-root persons (Okware, 1987).

Surveys point to increased levels of knowledge and awareness about several aspects of HIV/AIDS including transmission, prevention, and management. Studies also document awareness levels over 90% (STD/AIDS Control Program, 1999; UNAIDS, 1997). However, interventions based upon behavior change models suggest a gap between knowledge levels and behavior change (Kinsman et al., 2002). We decided to investigate the knowledge, beliefs, attitudes, and behavior of an indigenous employment group of motorbike taxi-men, locally known as *bodabodamen*, in relation to sexuality, sexual behavior, sexual health, and sexually transmitted diseases (STDs) including HIV/AIDS.

WHY STUDY *BODABODAMEN?*

The media in Uganda present a stereotypical image of public transport operators as among

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the most common adult sexual partners who attract and 'spoil' schoolgirls. Reproductive health education programmes, that are broadcast in the local print media, radio, television, and drama, caution young girls against falling into the trap of *bodabodamen* who carry them to and from school. This was confirmed by findings of a study conducted among students in Masaka—Uganda (Nyanzi, Kinsman, & Pool, 2000). Furthermore, epidemiological surveys reveal that regular travelers are a high-risk group for HIV/AIDS. *Bodabodamen* are an indigenous high mobility occupation group that has not been researched in Uganda to date.

It is important to document men's experience of sexuality and reproductive health because men do influence women's reproductive experiences. However, gender and equity studies have tended to emphasize and focus on women at the expense of studying men as well. *Bodabodamen* offer a unique opportunity of studying all these themes in a male-only setting because in the Ugandan context, *bodaboda* work is a male space.

STUDY DESIGN

The study was conducted by the Social Science Department of the Medical Research Council Programme on AIDS in Uganda/Uganda Virus Research Institute. The organization has been conducting multidisciplinary research about HIV/AIDS in Uganda since 1989. It has a field-station in Masaka. The investigation among *bodabodamen* was spread over 2 years: 2000 and 2001. It was conducted in three phases.

I. A pilot study was conducted to explore the feasibility of a full study; research instruments were pretested, and we assessed the study population's specific needs.
II. Exploratory research was conducted to investigate the sexual behavior, mobility patterns, sexual networks, knowledge about and attitudes toward STDs, including HIV/AIDS.
III. Workshops were designed to address participants' expressed needs, which were collated in earlier phases. Activities included dissemination of information, distribution of condoms, and discussion about voluntary counseling and testing.

METHOD

Study Sites

Data were collected from two sites: Nyendo and Masaka Municipality, in Masaka district, southwestern Uganda. Masaka has been flooded with several local, national, regional, and multinational HIV/AIDS related programmes of research, service delivery, support, and development. Nyendo is a periurban peripheral, located along the east and central African coastal-hinterland highway. It has several over-crowded slum dwellings, shanty structures, a relatively flourishing economic center, and a buoyant night-life. Masaka Municipality is an urban setting with the administrative organs of the district. With a relatively good infrastructure, Masaka Municipality shelters the social elite, several government offices, and nongovernment organizations.

Study Population Sample

Participants were chosen from four stages (common sites where motorbikes park to wait for passengers) in Nyendo and five stages in Masaka Municipality on the basis of availability and willingness to take part in the study. Two hundred twenty-one *bodabodamen* (87 from Nyendo and 134 from Masaka Municipality) responded to the questionnaire. From this sample, participants were purposively chosen for focus group discussions, which were stratified to represent *bodaboda* categories of self-employed, employed, and *kibaluwa* (rent-a-motorbike on hourly basis). Recruitment for in-depth individual interviews was based on random sampling from the initial 221 participants. Ten case studies were purposively selected because segments of their life histories obtained in the first data collection phases provided rich narratives about men's experiences of sexuality and reproductive health, which illustrate the contextual variety embedded within this one employment group.

The mean self-reported age of the participants was 23 (range 17–40) years old. Predominant tribes were the Baganda (76%), Banyankore (8%), and Nyarwanda (5%). Catholics were the major religious denomination (56%), then Muslims (31%), and Protestants (10%). Education levels were mostly low; 69% had attained some primary school education, 28% had attained some O'level education, and only 3(1.4%) participants had post-O'level training.

The majority of the men (79%) had this *bodaboda* job as their only source of income; 21% had other manual labor jobs including digging, animal husbandry, tailoring, bricklaying, and petty trade. *Bodabodamen* are relatively well-financed, as they earn between Uganda shillings 1,000/- to 15,000/- on a 'bad business day' and 5,000/- to 30,000/- (exchange rates: A2 US$1 = UShs 1,800/-). Unlike salary earners who receive a monthly payment, *bodabodamen* are paid by the job and thus have a constant inflow of cash.

Procedure

We employed five data collection techniques, namely a semistructured questionnaire, 10 focus group discussions, 40 in-depth individual interviews (20 from each location), 10 case studies, and 2 interactive workshops. Triangulation of qualitative and quantitative methods acted as a check on validity and reliability of data collected. Ethical clearance was obtained from the Science and Ethics Committee of the Uganda Virus Research Institute. Consent to participate in the study was given verbally.

All data were collected in the local language—Luganda.Discussions were recorded on audio-tape, transcribed verbatim, translated from Luganda into English, and analyzed using Atlas.ti (Scientific Software Development, Berlin), a software programme based on the grounded theory approach (Strauss & Corbin, 1998). Questionnaire data were analyzed using EPI Info 6 (Epidemiology Program Office CDC, Atlanta).

RESULTS

Myths, Inherent Beliefs, and Narratives about Sexuality

In anthropology myths are studied as fractured sources of oral history, clues to a society's dominant values, or even as a social charter (Marshall, 1988). In their narratives about sexuality, these *bodabodamen* employed several myths to justify their sexual actions, decisions, and meanings. Often participants referred to the myth of origin of the Baganda tribe from one man—Kintu. In addition, the *bodabodamen* said they were all made from the same material—either clay (*batuubajja mubbumba lyelimu*) or a single tree called *muzirigiti*. These two myths they used to justify the fact that 'what one man does, the others also do.' Claiming that they were all Kintu's grandsons (*bazukulu ba Kintu*), many of the Baganda participants justified their group actions and argued for the universality of promiscuity on these grounds.

Predominant was the cultural myth about the need for sexual activity and promiscuity as proof of manhood, (see also Nyanzi, Nyanzi, Kalina, & Pool, 2004 for a detailed discussion about sexual networks, partners, and negotiation patterns). Participants claimed that society has an unwritten rule about how a boy becomes a man. It is not about biological maturity—beards or getting a deep voice. The rite of passage is marked by sex. In order to prove to peers that one has become a man, it is mandatory to have sex. Thus, sexual debut was a public venture for most of these *bodabodamen*. Their peers had to know about it. Albeit saying that, participants insisted that their initial sexual activity was also kept hidden from parents, teachers, and other adults, lest they be punished. However, when promiscuity is known among peers, it 'scores more points' for an individual. These *bodabodamen* revealed that they keep tabs on who has acquired a new sexual partner. They measure manhood by the number of partners one has and place bets that they will be able to sleep with a new woman. Casual sexual relationships are frequent and short-lived, typically lasting for a few hours, a night, a day, or at most a few days or months. Many of the participants (64%) admitted to having had multiple sexual relationships—both concurrent and serial. Partners included various forms of regular partners, casual partners, and commercial sex workers. Polygamy is institutionalized in traditional Buganda, as well as in Islam. Even though they show off their casual sexual partners to their peers, they keep them hidden from their steady partners, including wives.

A widespread myth was that abstinence causes severe disease. Participants claimed that as a preventive practice, abstinence is unnatural and thus impossible. In the focus group discussions, abstinence was relegated to the very old, poor, bewitched, ill, impotent, mentally disturbed, or very young children. On one occasion a *bodabodaman* was bold enough to challenge this statement by stating that he had abstained from sex for the past 6 months. Other focus group discussion members dismissed his claim because he is deeply religious.

Attitudes toward virginity were ambivalent. The traditional Buganda culture where virginity in a girl at marriage was rewarded (Kisekka, 1976) was upheld by some *bodabodamen* who preferred having

virgin sexual partners on the grounds that they are disease-free, relationships with virgins last longer, and virgins bring men prestige. Others scorned virginity in both women and men. They believed that any adult who is still a virgin has a problem that keeps them away from sex. Such problems included sexual health, impotence, frigidity, backwardness (*amaalo),* boys too shy to ask girls, and deep religious influence. The men claimed that sex with virgins was painful, straining, deprived them of orgasm, and that the virgins did not know various sex styles or what to do at all. Thus, they claimed to drop virgins and go off in search of experienced partners.

A widely believed myth about STDs, other than HIV/AIDS, is that they are diseases of strong/brave heroes (*bulwadde bwabazira*). This myth has its roots in the Second World War as explained in the following quote.

Seba: *It is like this! Those STDs were common among our grandfathers who went to fight in the world war. When they came back they all had STDs. Now, there were many women who had sex with them because it was popular to have sex with a man who fought in a war with White men and yet he did not die. Many men who proudly talked about the war would be seen limping because of STDs.*

Matia: *Yes, that is what I also heard. Even the young men would have sex with elderly women who had these diseases of the brave heroes. Then they would also get the STDs. And they were respected because it meant that they share a woman with a man who fought in the world war.* [Laughter from participants]

In addition, these other STDs were believed by many participants to be archaic and 'weaker' than HIV/AIDS. Consequently, many participants argued that syphilis and gonorrhea disappeared with the coming of HIV/AIDS. The general feeling was that these other STDs were much more shameful to catch than HIV/AIDS, particularly because they were associated with having sex with elderly women.

However, some participants were more informed because they had suffered from syphilis, gonorrhea, or urethral discharge. These few informed their colleagues about the shame and pain involved, the need for treatment, and how current such STDs still are.

Related to HIV, several participants believed that it is mostly women who have and spread HIV. This they supported with a myth that even though a man and woman caught a similar type of HIV at the same time, the woman would be at an advantage of living longer or suffering less than the man because the menstrual flow reduces the viral load in women. They also employed this myth to explain the fact that there are more HIV widows than widowers.

Several myths about condoms and HIV were contained in the narratives. The knowledge of condom use was widespread, although many participants held several misconceptions about condoms. These ranged from 'condoms are made by White men who want to depopulate Africa,' 'condoms are porous and can therefore transmit infection including HIV and other STDs,' 'the oily stuff on condoms is purposely infiltrated with HIV so as to infect several people,' 'condoms cause skin irritation to the penis,' 'condoms lead to impotence in men,' and 'wearing two condoms at a go provides more protection than just one.' During the condom demonstration sessions in the workshops, many participants mentioned the timeliness of the lessons, and claimed that no one had bothered to teach them how to use condoms. Thus, they had been using condoms incorrectly, particularly because a large number of participants were illiterate, hence unable to read the instructions on the condom labels. Some participants who could read claimed that the instructions are in either English or Kiswahili, yet most *bodabodamen* only comprehensively read the local language—Luganda. A few participants believed that a condom is reusable after washing. Others told us that they smeared the condoms with 'Vaseline' or cooking oil to aid smoother lubrication. A major complaint about condoms was the fact that they decrease the pleasure a man receives from sex. As presented elsewhere, (Nyanzi, Nyanzi, & Kalina, in press) participants told us that in practice they do not use condoms with their wives and other steady partners. They only use them in casual sexual relationships. However, even in the case of casual sexual relationships, after having sex a few times, condom use is discarded. They claimed that regular condom use is cumbersome, expensive, and deprived them of sexual pleasure.

Myths about contraceptives also prevailed. Enthusiasm in focus group discussions drastically declined when facilitators raised the topic. The general feeling among these *bodabodamen* was that contraception is a woman's business. They claimed that it is the responsibility of women to ensure that they did not conceive unexpectedly. We found high levels of ignorance and unawareness concerning contraception. A few married men talked about pills and the injection. However, many participants discouraged its

use because of prevalent myths that contraceptives cause cancers or tumors, dry up women's wombs, 'burn up all vaginal lubrication,' decrease sexual desire in women, prolong menstruation periods (for as long as 2 months), 'destroy the eggs of a woman so that she becomes barren,' 'affect a woman such that she bears only girls,' or lead to the birth of children who have cerebral palsy, mental retardation, and congenital abnormalities or disabilities, or are morons. Their ignorance was further revealed by such suggestions as 'all men and not the women should receive injectaplan (injectable contraceptive), since it is the men who cannot stick to one partner' and 'we should carry contraceptive pills wherever we go and give our sexual partners one pill just before sex…' Some men claimed that their partners go for family planning without consulting them, in fear that the men would not agree but rather would demand more children. In lieu of the misconceptions about contraceptives, participants tended to agree that condoms were the best option in case the man was interested in protecting himself against unwanted pregnancies and their associated problems.

Many participants believed that 'it is only the ejaculate of the first round of sex in a single encounter that impregnates a woman. The second and third rounds of sex do not impregnate a woman.' Thus, some claimed that they withdraw for the first round of sex, but stay in the woman for whatever other rounds of sex they have within a single encounter. Others said they wear a condom only for the first round of sex, but remove it for the subsequent rounds.

Sources of Information about Sexuality and STDs Including HIV/AIDS

A wide range of influences inform *bodabodamen*'s socialization and sexualization processes. They include both formal socially-established institutions such as the family, society, legends and proverbs, taboos, accepted gender roles, education, religion, and informal influences such as the environment—whether rural or urban, level of literacy, choice of entertainment and leisure activities, and peer groups.

When asked about the knowledge that led them to begin sexual activity, participants often mentioned their peer group at the time. For those who were in school, it was their schoolmates who persuaded them to begin having sex, and sometimes went as far as to connect them to particular girls. They taught them about sex, supplied information about how to go about forming sexual relationships and negotiating for sex with a girl. For those who were not in school, the peer group consisted of 'friends with whom we went to fetch firewood or water,' 'other children who would herd goats and cows with us,' or children in the neighborhood. Childhood games—'Hide and seek' and 'Playing bride and groom'—acted as settings for the initiation into sexual activity for many of these *bodabodamen*, which revealed an early sexual debut age.

Furthermore, siblings and other family members informed the initial sexual epistemology of these *bodabodamen*. In cases of older siblings, the participants said that they sometimes were employed as 'middlemen' to carry messages of love, set up appointments, and deliver gifts between their siblings and their sexual partners, thereby learning about sexual relationships at a young age.

Some participants who lived in houses with adults said that they frequently witnessed varying stages of sexual relationships from simple gestures to actual sexual intercourse. However, parents were greatly criticized by the participants for not informing them as children about sexual matters. These *bodabodamen* said it is taboo for parents to discuss sex with their children. There is a lot of stigma attached to asking a parent about sexual matters. Cases where parents were mentioned as having informed the sexualization process of the participants were usually in relation to punishment because the individuals were either known to be having sex with a girl in the neighborhood, or caught in the act of sex, or were responsible for impregnating a girl. Another incident that brought parents into the sex lives of their children was when the men had decided to formalize a relationship with marriage. Parents would then be consulted to help investigate the family background of the girl (to ascertain that they are not cannibals, witchdoctors, night-dancers, debtors, or thieves) and their health records (whether they have hereditary illnesses such as madness, epilepsy, or sickle-cell disease). Parents also mobilize the family, clan, and extended kinsmen to contribute resources for the wedding.

Participants frequently mentioned that their first sexual partner was older and already exposed to sexual activity. During the individual in-depth interviews, the men in this category mentioned house-girls (maid/servant) in the household, older schoolmates, and neighbors who

actually pursued and initiated them into sexual activity.

According to these *bodabodamen*, currently the peer group, more than any other information sources shapes their sexual ideology and plays the role of providing approval or disapproval of sexual choices and decisions. All individual interview participants said that they would either first or only consult their peers if they caught a STD. Treatment seeking behavior depends upon counsel from peers. For many participants, their knowledge-base regarding sexuality, sexual activity, and sexual health comprised only past experience and information from peers.

A widely mentioned sex information source was the 'film.' As Masaka district had no cinema at the time of data collection, we probed about the 'film' concept. This refers to makeshift or semipermanent structures that act as video showrooms. Some are mobile, operating cyclically in different townships. Others operate regularly in the night in 'joints'—spaces that operate as food shops during the day. There were three major categories of 'films' mentioned as favorites: 'blue movies' (hard pornography), 'love stories' (romance), and '*masasi ne teke*—bullets and kicks' (fighting). These videos are largely sexually-oriented. Several participants said that they enjoy watching these films because they learn sex styles, get ideas about improving their love life, and learn how to negotiate for sex with a woman. However, some participants said that they did not like these films because they were too sexually stimulating to be safe or were unrealistic, time-consuming, and money-wasting.

Radio was another frequently mentioned source of information. With the establishment of the privatization policy, several FM stations appeared on the Uganda media scene. Topics mostly mentioned as presented over radio include advertisements about condom use, family planning methods, and the 'Agony Aunt' who addresses relationship problems. However, participants also lamented that many such programs begin but are dropped from broadcast or they occur at hours when *bodabodamen* are either working, occupied with a sexual partner, or too tired to listen. They also commented that the content of these radio programmes is largely edited because it is consumed by a wide audience including children. Thus, it is not direct, too simplified, or 'beats about the bush.' Participants also said that they thought many of these programmes broadcast things of special interest to women, rather than men, or they found them boring because they say the same thing all the time. Some participants said they prefer to listen to music or news than to sexual health programmes. A few mentioned the expense of buying batteries for the radio as having discouraged them from listening, although they agreed it was informative. In addition, many claimed that it is better to watch than just listen.

Very few participants mentioned the formal education system as informing their sexual behavior. Only 31% of the participants went past primary school education. Those who can read mentioned newspapers, brochures, and posters in hospitals that contain health education messages. However, *bodabodamen* claimed that these media were not as accessible, not regular, and prone to misinterpretation, particularly for those who could not read or could only read the local languages.

There were some participants who said they have no access to information about STDs including HIV/AIDS, due to the high illiteracy levels, expense of obtaining the information, lack of time, too tired, or did not see the need for it. Those in the last category reasoned that they knew all there was to know about these diseases particularly because they have directly experienced them among their families or friends. When queried about the various health information, education, and communication (IEC) campaigns flooding Masaka district, many participants were not aware of them. Participants thought that these campaigns were not addressing them but other specific population groups, notably students, medical personnel, soldiers, and women. This factor gave high acceptability to the workshops we organized and attracted *bodabodamen* outside our study areas. Workshop participants appealed for more such health education sessions that specifically target their population.

Perceptions of Risk for HIV/AIDS

All participants in the in-depth interviews said they have experienced HIV/AIDS closely, either through losing family or friends to the disease, living with sufferers in the same home or village, working with them on the job, and/or participating in their funeral and burial rites. Levels of awareness about HIV/AIDS among this subgroup of society were relatively high. Participants knew that HIV is mostly spread through sexual intercourse with a carrier. However, many simultaneously held and believed several misconceptions and myths.

In the questionnaire, 156 participants said that they thought they were at risk of catching HIV/AIDS, 55 said they were not at risk, 8 said they did not know, and 2 men did not respond to the question. Of the 55 who said they did not think they were at risk of catching HIV/AIDS, 21 *bodabodamen* said they thought they were already infected with the virus, although many of them had never had a blood test to confirm this. Similarly, many among those who thought they were at risk said they suspected they are already infected with the virus and requested us to provide them with testing and counseling services.

Fatalism is heavily embedded within the participants' narratives about sexuality and HIV/AIDS. Several *bodabodamen* told us that it is inevitable that they will catch HIV because of the dictates of their lifestyle, the promiscuity and infidelity of their sexual partners, the fact that they have access to money, 'everybody else is infected,' the ineffectiveness of the condom, the irregularity of condom-use, or their indulgence in multiple sexual partnerships. In addition the men said that the multidimensional causes of HIV meant that even when one abstained, he could catch the virus through other channels such as transfusion or hospital injections. Furthermore, there is a strong bond of 'clubbiness' that runs through their discourse:

Swaibu: *Everybody knows that all bodabodamen are infected with the virus. That is why they blame us for spoiling schoolgirls. People around know it. We know we are all sick.*

Lubega: *Ha! I cannot believe there is a healthy bodabodaman. We're all promiscuous. We're all infected. If you are still living in 5 years' time, you will find that none of us who are here in this discussion group will be living. We bodabodamen are already dead.*

A few participants told us they were surely not at risk of catching HIV because they faithfully used condoms or were faithful to their sexual partners. Three participants in the questionnaire said they abstained from sex in a bid to avoid HIV/AIDS.

DISCUSSION

Several studies reported high levels of knowledge about transmission, prevalence, and management of STDs including HIV/AIDS in Uganda generally, and in southwestern Uganda specifically. They associate this with significant changes in sexual behavior and the reduction in the incidence of HIV in the country (UNAIDS, 1997). In this article, we discuss levels of awareness, quality of knowledge, sources of information about sexuality, sexual health, and perceptions of risk for catching HIV/AIDS among *bodabodamen* in Masaka district. Our sample was purposively selected. Hence, without exaggerating the extent of our material to cover the whole Ugandan population, the findings provide descriptions, notions, and values applicable within this specific setting. Perhaps they also explain the reported disparity between levels of knowledge and actual behavior change.

Multiple sexual relationships (both serial and concurrent) were common among *bodabodamen* because their justification can be found within the traditional social knowledge of the Baganda. Attitudes toward abstinence as a preventive measure were generally negative, and many participants argued that it is unnatural and impossible. Ambivalence surrounded knowledge of and attitudes toward condom use. Awareness about condoms was high, although there were several myths and misconceptions about them. Most participants thought that contraception is a woman's issue. There were high levels of misinformation concerning family planning methods.

There is an apparent disconnect between the high levels of knowledge and awareness on one hand and concurrent practices of unsafe sexual behavior on the other. This finding confirms reports of behavior change interventions that suggest a disparity between knowledge levels and resultant actual behavior change, which takes much longer to achieve. *Bodabodamen* perhaps represent a subculture of high-risk taking people. The perceived risky behavior is also widely reflected in their public image and occupational characterization of wreckless riding at top-speed, which is often beyond acceptable speed-limits, breaking highway codes for motorists, disregarding local rules of transportation, riding ill-maintained vehicles, dodging motor-tariffs and parking fees, bribing traffic policemen when caught, and working late hours as well as their stereotypical image of dare-devils who knowingly have sexual relationships with schoolgirls.

Participants had high levels of awareness of HIV, much more than other STDs. They knew that HIV was mostly spread through unprotected sex, but also through exposure to infected blood, for example through injections, motor accidents, and transfusion. However, they also held several misconceptions about the causation, management, and prevention of

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HIV. Many *bodabodamen* doubted the effectiveness of condoms as a prevention means. Concerning STDs other than HIV/AIDS, the dominant discourse was that they no longer exist for 'they were overpowered by HIV.' Many participants held several misconceptions and historical myths about STDs, which justified their logic that STDs are more shameful to catch than HIV/AIDS. Only a few *bodabodamen* who had experienced these STDs were able to counter these widely held misconceptions.

The power of myths is an important theme in the narratives of these *bodabodamen*. In her discussion about African mythology and philosophy, Ikenga-Metuh (1987) advanced that 'myth is the clear presentation of the outlook of people living in communities. It is their objective and permanent philosophy of life…' (pp. 30–31). Study participants employed both traditional and modern cultural myths to validate their seemingly risky behavior. They present an empirical illustration of the functionalist interpretation of myths (Malinowski, 1984), in which myths are often motivated by a particular social crisis or concern; myths help overcome fears, and they validate cultural institutions, customs, and rites. Myths are not 'rational' but are pragmatic values that are used to create a sense of social solidarity through common beliefs. In this case, myths are utilized to demystify death and disease and to rationalize sexual behavior that has been labeled risky. Participants employed myths to identify with heroic ethnic and national ancestors and to solidify their clubbiness as virile men rooted within a historical, cultural, religious, and yet also contemporary, context. Falling back on these myths in discussions is not an act of ignorance or irrationality but a manifestation of agency and a way to negotiate the realities of being sexually active men in a high-risk area that is bombarded with sexual health education messages. Participants who refer to these myths do so to validate 'unacceptable' risky behavior and to rationalize their choices.

Religion played an ambivalent role in determining the sexual behaviors of participants. Although several of them referred to religious scripture and perspectives to explain away their risky sexual practices, others stressed religion to defend their standpoints on safe sex, abstinence, and faithfulness to one marital partner. Some of the Roman Catholics in particular argued that the Church condemns contraception because it breaks God's commandment to be fruitful and multiply. This was used in conjunction with other rumors, myths, and misconceptions about condoms to discourage their use. It was common for the Muslim participants to argue in favor of multiple sexual partners on the grounds that polygamy is permitted in Islam.

Due to the nature of their employment, *bodabodamen* are a highly mobile group, who frequently penetrate the rural and urban settings around them, often negotiating for sex in these different localities. If the assumption that knowledge affects attitude and subsequently behavior (Reich & Adcock, 1976) is true, then the high level of myths, misconceptions, and misinformation among these study participants predictates a negative attitude and an indulgence in potentially high-risk sexual behavior that predisposes them to STDs including HIV/AIDS.

Sources of information about sexuality and sexual health included peers, siblings, films, radio, and to a lesser extent newspapers, magazines, and posters in hospitals. The formal education system was hardly mentioned, perhaps due to the low levels of education attained, as the majority only had exposure to a few years of primary school. Social norms proscribe against parents discussing sexuality with children. Peers were the predominant informers—providing both approval and disapproval about sexual choices made by these *bodabodamen* and consultation in case of unwanted pregnancy or STDs. Peers and siblings were the major influences in the sexualization process, and they introduced the *bodabodamen* to sexual activity and got them sexual partners. The film was a favorite for many because of the visual aspect. Kinsman, Nyanzi, and Pool (2000) discussed these films among the category of socializing influences mentioned by adolescents in the same study area. Radio provided information, although its content was criticized on grounds of being shallow, not catering for men's interests, broadcasting at unsuitable times, lack of visibility, and the cost of batteries. Transference of health education information through the print media (which government and development organizations employ) is hindered by the high illiteracy levels of *bodabodamen*. Many participants thus miss or misinterpret the written word. This perhaps explains the high levels of misconceptions and ignorance levels expressed during the workshops. The main problem is inaccessibility of accurate information. The media of communication do not get to the level of this particular population, which results in frequent miscommunication.

Perceptions of risk were ambivalent. All participants had experienced HIV/AIDS closely. Several said that they were at risk of catching HIV. Some

suspected that they were already infected, based on knowledge about past sexual partners, although none had taken a blood test to confirm this. Fatalism is heavily embedded in their narratives about sexuality and HIV, and many were resigned to the eventuality of getting infected.

Interventions whose emphasis is health education campaigns aimed at increasing levels of knowledge about the prevention, control, and management of STDs including HIV/AIDS do not seem to be having an effect on the knowledge base, sexual ideology, and attitudes of this group of *bodabodamen*. Instead, the messages within sociocultural myths, peer influence, experience, commercial videos and films, and to a less extent radio are the foundational influences that shape knowledge about and attitudes toward sexuality and sexual health.

Recommendations: 1) Develop accurate and appropriate sexual and reproductive health IEC materials; 2) Utilize user-friendly channels such as educative films or videos, radios, discussions, and peer-education; 3) Harness contemporary health education media programmes such that the content targets and attracts male audiences by directly tackling men's specific concerns; 4) Incorporate and address the inherent sociocultural myths and misconceptions in health education campaigns; 5) Employ local languages, idioms, metaphors, and other culturally-appropriate media of expression with which the target group can identify and which they can understand.

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