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Women's attitudes to condoms and female-controlled means of protection against HIV and STDs in South-Western Uganda

G. J. HART, R. POOL,[1] G. GREEN,[2] S. HARRISON,[1] S. NYANZI[1] & J. A. G. WHITWORTH[1]

MRC Social and Public Health Sciences Unit, University of Glasgow, UK, [1]*MRC/DfID/UVRI Programme on AIDS in Uganda &* [2]*Health and Social Services Institute, University of Essex, UK*

Abstract *The consistent and correct use of the male condom makes it highly effective in both disease prevention and as a contraceptive method. However, it is also well recognized that its use is under men's control. Because of this vital limitation, there have been frequent calls for female-controlled methods of HIV prevention, particularly from women from sub-Saharan Africa. Here we report on data collected in focus-group discussions (FGDs) with women aged 17–54 in South-Western Uganda. A total of 138 women, from rural villages, urban family planning clinics and a truck-stop town, were recruited to participate in 18 FGDs on the male condom, the female condom and existing formulations of vaginal microbicidal products. Three themes emerged: (i) problems with men's control over the male condom, (ii) the importance of control over and secrecy about protective measures and (iii) sexual pleasure associated with different methods. We found that the female condom, while being perceived as an improvement over the male condom, was recognized as having limited value because of the need to agree its use prior to sex taking place. Other products were considered to be significantly better than the female condom; the sponge, in particular, was perceived as having advantages over every other product. Women like the fact that it could be inserted some time before, and left in place some time after, sexual intercourse, that it was effective for multiple instances of intercourse, and that men would be unaware that it was being employed. Female-controlled methods to prevent sexually transmitted infections, including HIV, and to increase reproductive choice, hold the promise of ceding some control over sexual and reproductive health to women.*

Introduction

The benefits of the male condom are well recognized. Its consistent and correct use makes it highly effective in both disease prevention and as a contraceptive method. This low-

Address for correspondence: Professor G. Hart, MRC Social and Public Health Services Unit, University of Glasgow, 4 Lilybank Gardens, Glasgow G12 8RZ, UK.Tel: 0141 357 3949; Fax: 0141 337 2389; E-mail: graham@msoc.mrc.gla.ac.uk

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technology prophylactic is also cheap, can be distributed easily, stored and marketed; these are significant benefits in the context of disease prevention and population control in developing countries. However, it is also well recognized that its use is entirely socially, culturally and context-bound—even when available, usage is not universal and can be inconsistent. For example, among western gay men (Fitzpatrick *et al.*, 1990) and in heterosexual relationships in the UK (Holland *et al.*, 1991), the United States (Carovano, 1991) and many parts of Africa (Mgalla & Pool, 1997; Pickering *et al.*, 1993) condoms are used frequently in casual partnerships, but infrequently in regular relationships. Prostitute women use condoms with their paying, but not with their non-paying partners (Mgalla & Pool, 1997; Pickering *et al.*, 1993). A condom may be used on the first few occasions of intercourse, but then be relegated to the drawer once issues of trust, love and affection arise in heterosexual relationships, even in relationships where one partner is HIV-positive (Green, 1995).

For heterosexual women throughout the world there is one feature of the male condom that renders its use entirely contingent. That is, it is in the control of men. Studies of heterosexual behaviour have highlighted women's relative lack of power in sexual encounters, preventing them from using condoms even when they would like to do this (Holland *et al.*, 1991). Unless women can insist upon condom use, ensure the product's integrity and be certain that it is used throughout the sexual interaction and for each subsequent episode of sex, the male condom cannot protect them from the unwanted sequelae of sexual intercourse. These include HIV infection, other sexually transmitted infections (STIs) and pregnancy. In sum, it is the gendered nature of male condom use that makes it unreliable for women.

Because of the recognition of this vital limitation of the male condom, there have been frequent calls at international AIDS, STI and reproductive health conferences for female-controlled methods of HIV prevention; these have come particularly from women from sub-Saharan Africa. There are two forms of prevention that could be classified as being under women's control. These are the female condom (Femidom, Chartex International) and vaginal microbicides. Studies of the female condom show that it is an effective barrier method of contraception that is also likely to reduce the risk of acquiring HIV by at least 90% (Trussell *et al.*., 1994). There is considerable interest in female condoms among African populations (Walker *et al.*, 1993) and they have been well accepted in trials in Zambia (Musaba *et al.*, 1996), Senegal (Niang *et al.*, 1996) and Uganda (Dithan *et al.*, 1996); however, in Zambia they were considerably more popular among women than men. Opinions differ according to culture about whether the inner ring enhances female sexual pleasure or simply causes discomfort, and about whether the degree of lubrication is desirable or not. In two studies with self-selected samples, the majority of women dropped out because they found aspects of intercourse using this method unsatisfactory (Bounds *et al.*, 1992). Many women cited their partner's opposition as their reason for discontinuing use (Ford & Mathie, 1993). A major problem in the developing world is cost compared to other methods (Dithan *et al.*, 1996).

Studies of vaginal microbicides have so far been mainly biomedical, and quite appropriately are concerned with safety and efficacy. The emphasis has been on the immediate and longer-term effects on vaginal flora, the ease with which it is possible to insert these products and their bio-adhesiveness (Elias & Coggins, 1996). However, as we have seen with regard to the male condom, biomedical research activity may identify the 'ideal' product, but this will not in itself ensure the widespread take-up and consistent use of novel preventive measures. For example, it has been found that formulation preferences for vaginal microbicides vary substantially within and between geographical sites (Elias *et al.*, 1996). Female-controlled methods of HIV prevention must be safe, effective and affordable, but if they remain unacceptable to women they will have only theoretical value in the fight against HIV/AIDS.

There are a number of questions yet to be addressed that require clear answers prior to any attempt at widespread marketing of female-controlled methods of HIV prevention. What currently available forms of protection are most suited to women: the female condom, foaming tablets, gel, foam, contraceptive film or sponge? Do women want to use products without the knowledge of their male partner, or is it necessary to agree or negotiate use? Are there global/regional variations in acceptability, or variations according to the type of sexual activity and partner (the needs of married women may be quite different to those of single women or women who sell sex)? These and many other related questions have not been investigated empirically, and there is a need to undertake research which can contribute to the resolution of these issues.

In this paper we report on recently collected data from a study of the acceptability of female-controlled methods of HIV prevention in South-Western Uganda. Our aim here is to identify some of the key cultural and contextual features of a situation in which there is a high prevalence of HIV infection, but in which women have relatively little control over a wide range of aspects of their lives. The focus of this report is therefore perceptions of the male condom and men's control over its use, the perceived pros and cons of different female-controlled methods (the female condom and existing formulations of non-HIV vaginal microbicidal products) and issues of sexual pleasure. A companion paper describes the attitudes of men in the same region to these methods (Pool *et al.*, in press).

Without an appreciation of the broader social context of women's daily lives and their attempts to control features of their sexual and reproductive health it will not be possible to introduce or market effective and novel methods. Future papers will describe women's direct experience of a range of female-controlled methods of HIV prevention. We seek here to provide the basis for a more complete understanding of the spheres of sexual activity and reproductive control of women in a developing country, as a precursor to the introduction of measures which seek to extend their choice of sexual and reproductive protection.

Context, sample and methods

As the greatest pressure to both identify and make available female-controlled methods of HIV prevention has come from sub-Saharan Africa, we sought to investigate the acceptability of these methods to women in South-Western Uganda. Uganda has a very high population prevalence of HIV infection, estimated at 10–15% of the general adult population. Masaka District in South-Western Uganda is a particularly appropriate area to investigate issues of female-controlled methods of HIV prevention because the Medical Research Council Programme on AIDS has collected community-based data in the area since 1988, and the local impact of HIV/AIDS has been described in detail (Kengeya-Kayondo *et al.*, 1997).

This paper reports on that part of the study concerned with preliminary data collection using focus-group discussions (FGDs) with women; data from research undertaken with men are reported separately (Pool *et al.*, in press). Three groups of women (aged 17–54) were recruited to participate in FGDs on the male condom, the female condom and existing formulations of vaginal microbicidal products. Recruitment to the study was based on theoretical sampling, with participants selected to represent sexually active women from a wide age range (17–54 years old, median age 27) who were single, married, divorced and widowed. Recruitment was not by random selection, but undertaken to ensure that the participants represented a variety of women with single or multiple partners. The first group were 51 women recruited to six FGDs in a rural village 25 km from the nearest large town. The second group comprised of 53 women who attended seven FGDs and were recruited in family planning clinics in Masaka town, the region's administrative and commercial centre.

A further 34 women who lived in a roadside settlement (a small trading town and truck-stop on the trans-African highway) were recruited to the third group (five FGDs). Thus, a total of 138 women participated in this part of the study, attending a total of 18 FGDs.

Focus groups are a particularly appropriate method of data collection with women in South-Western Uganda. Apart from the frequently cited benefit of FGDs, namely that they succeed in producing data through interaction and discourse in a group setting that one-to-one interviews may fail to generate (Kitzinger, 1995), they are also a culturally sensitive data collection method. The majority of women in this study come from the Baganda ethnic group, the culture of which is primarily orally based and community-focused. Outside the family, men and women are socialized and participate in a mainly homosocial environment, in which same-sex group discussions serve as significant fora, reinforcing group identification and therefore functioning to increase social cohesion. Group discussions on gender-specific and sensitive issues are far from alien to this group.

We made it completely clear that participants were being asked to enter a specific research project—they were given detailed information about the study, and researchers sought respondents' informed consent (including the freedom to withdraw at any point). It was explained at the start of the study, and repeatedly throughout, that the products, with the exception of the female condom, did not protect against HIV, and gave only limited protection against STDs and pregnancy. It was emphasized that only condoms would provide reliable protection against HIV and that if the participants wished to avoid pregnancy then they should continue to use the family planning methods they had been using prior to the study.

Women were recruited by trained, indigenous female research assistants with local contacts. Groups discussions were held in privacy, employed the local language (Luganda) and were tape-recorded. Groups consisted of between five and 12 women. The FGDs followed a set format on each occasion, with first a discussion on the male condom, and then demonstration of and responses to the female condom (Femidom, Chartex International, London, UK), foaming tablets (Neo Sampoon, Eisai Co. Ltd, Tokyo, Japan), sponge (Protectaid, Axcan Ltée Ltd, Laval, Canada), Delfen foam (Ortho Pharmaceutical Corp., Raritan, NJ, USA), Rameses gel (Schmid Laboratories, Sarassota, FL, USA) and film (VCF, Apothecus Pharmaceutical Corp., Oyster Bay, NY, USA). Each product was displayed and passed around for each member of the group to see, touch and smell. There was frequent laughter and jocular (even lewd) comment which created a relaxed and informal atmosphere.

Tapes were transcribed, translated into English and subjected to qualitative analysis. This used the method described by Glaser & Strauss (1968) as 'grounded theory', in which external categories are not imposed upon the data, but emerging and recurrent themes are identified, and views according with or opposing these are juxtaposed to determine the extent to which given themes are present or absent in the accounts of participants in other settings. The transcripts were read by all authors, analysis was undertaken by the lead author and his interpretations were confirmed in discussions with the members of the field team. The aim, as with much qualitative research, was to achieve full representation of a range of opinions from respondents from given social groups (rural women, urban women attending family planning clinics and women from a truck-stop town), rather than seek a demographically representative sample of participants.

Results

Clearly, as the FGDs were facilitated by research workers trained to elucidate women's views on specific products, issues of interest were predetermined. However, the themes that

emerged from these discussions were not predicted, and arose entirely from the women's accounts and through their discussions with each other and the researchers. Three themes were identifiable; these were (i) problems with men's control over the male condom, (ii) the importance of control over and secrecy about protective measures and (iii) sexual pleasure associated with different methods.

(i) Problems with men's control of the (male) condom

Women reported experiencing relatively few practical problems with the male condom. There was an occasional reference to accidental condom breakage ('it becomes a skirt round the man's penis'), to condoms being porous or impregnated with the virus and one reference to reduced sexual pleasure for the woman. The commonly identified problem in other studies that condom use 'interrupts sex' (Sonnex *et al.*, 1989) was again only mentioned once.

A very common view, however, was that condoms could come off the penis during sex, and enter the woman's uterus. This was a very strongly held belief, and was reported across the FGDs regardless of recruitment; this view was never challenged by other women. The 'consequences' of this were reportedly hospitalization to remove the condom from the woman's body, or even death. As further 'proof' of the validity of these reports the woman who had reportedly died could be named, or specific details of the incident recounted:

> Barbara: I was at the burial ... .The condom created a wound where it stayed ... Bayikuzi hospital could do nothing for her so they took her to Masaka, but she died. No sooner had they reached the hospital she died! (Rural village group)

In other ways women found the male condom to be technically unproblematic—when used correctly it was thought to be an effective prophylactic. However, while few problems were seen as being associated with the condom *per se*, a significant and very widely reported difficulty lay in a particular 'strategy' employed by men to render it useless.

> Jean: The men can agree to put on a condom, and (then) put holes in it. Afterwards, you hear them saying... 'a school-girl asked me to put on a condom and I agreed, but put a hole in it'. (Roadside settlement group)

Men reportedly put holes in condoms for quite specific purposes, and most frequently this was because they wanted to ensure that their partner conceived a child ('some men have their own intentions—like getting you pregnant').

> Jessica: People say (men) make holes in it. They tease it at the (top) and you end up getting pregnant. He will deny all responsibility for the pregnancy or claim that he wore a condom, yet he was evil hearted. He agreed to use it ... but not genuinely. (Rural village group)

> Sara: I want to talk about those who said that you can get pregnant when you are using a condom. That happens, ... but it is not because the sperm passes through the condom. It is because your intentions are not the same (as his). You do not want to become pregnant and yet he wants a baby. You tell him to put on a condom. He agrees, but puts a hole in it without your knowledge. (Family planning group)

On only one occasion was the reason for wanting to cut holes in condoms reported as being relatively benign:

> Mary: The men do not like the condom because it is tight on them. The semen does not come easily. That is why they cut away the air space (at the top) of the condom. (Rural village group)

However, far more commonly it was said that men had a quite specific intent. These are men who have 'a murderous heart'.

> Kate: You may ask a man to use it and because he knows that he is already infected, and he wants to infect you, he does something to it ... There is no way to ensure that it is not damaged, because he might use a safety pin or cut it. (Roadside settlement group)

> Laura: Once I caught a man who had put a hole in the ... condom. I told him to go away with his stuff because he wanted to kill me. That day I stopped the affair with him. (Rural village group)

Men were frequently described in terms of their untrustworthiness ('men deceive us', 'they nearly all tell lies', 'they mislead us in many things'). This duplicity was related mainly to men's wish to have (more) children, regardless of partner, or in terms of a desire on the part of men to infect ('kill') their partner (knowing that they themselves are HIV-infected). The latter must be understood in terms of a widely held suspicion that those who are infected are deliberately trying to 'add to their list', i.e. infect others. Thus, the male condom's disadvantage lay not so much in any substantive feature of the product itself, as in men's dishonesty of purpose. Because of this perception, women did not feel that they could rely entirely on their partner to use condoms properly; the male condom was seen as an inadequate means of self-protection with regard to HIV infection and pregnancy.

(ii) The importance of control and secrecy

Given that the male condom was under men's control, and its effectiveness could be compromised by the actions of male partners, the female condom was seen in positive terms by some women.

> Facilitator: What are the advantages of the femidom (over the male condom)?

> Jane: To me this seems to be better because if you insert it, you are sure that the man will not enter outside (of it) so as to infect you.

> Edwina: It will help much more than the male condom because, since it concerns your own life, you will be very careful. (Rural village group)

> Francine: Most men use a condom at first, (but with the) excitement of the second round, they stop using it. But if I am the one to control it, I should fight to ... use the (female) condom at every round. I see that it is better than the male condom because I am the one to control it. (Family planning group)

Thus, the female condom was rated highly by a few women because of the increased level of control they could exercise over its use. Yet these views were expressed by only a minority of women. Given the earlier perceptions regarding men's desire to have more children, or to infect their female partner, it is perhaps not surprising that a second major theme to emerge from women's accounts related to the ability to withhold knowledge of a product's use from their male partners. Indeed, while the female condom was viewed with curiosity and a great deal of interest, it was generally agreed that it could only be used with the full agreement and

knowledge of the partner. There were only infrequent references to such openness in relationships. This, above all, constituted its main disadvantage, as these excerpts indicate.

> Facilitator: When the man (enters), you guide his penis into the female condom ...
>
> Joanne: Some men might not like it ... they can refuse..
>
> Marion: ...because it can be seen. What is needed is something which can't be noticed and someone can't know that you have inserted something, but if you guide him like this he knows you have inserted something. (Family planning group)
>
> Julietta: This (the female condom) needs to be agreed with your partner. It would be better if you put it in without the man knowing. (Roadside settlement group)

The following exchange occurred in response to seeing the female condom, but prior to any other products being displayed or discussed.

> Josephine: ...if there is a method which the woman can use without the man knowing?
>
> Sara: That lady has said a very good thing because if you tell him, 'let us do like this', most times he will refuse. But if you know there is a method which prevents all things in the sperm, so that I am on the safe side, and I use it alone without his (knowledge) I think it would be a most beautiful thing. (Family planning group)

The products that it is possible to use without the knowledge of the partner include foaming tablets, gel, foam, film and the sponge. All contain Nonoxynol-9 and have to be inserted prior to intercourse. Some of these proved to be more acceptable than the female condom with women across a range of FGDs, even though the facilitator explained that currently, used on their own, they offered only limited protection against pregnancy and STIs.

> Sophie: These items are advantageous in that the man cannot stop you from using them. Even if he refuses, you can use them without him knowing. (Rural village group)
>
> Robyn: These products are better because you can insert them secretly, especially if you do not want to tell him. The foaming tablets, the sponge and this foam are the best. As for the sponge—it is great, because you can insert it before supper. You ... continue with your housework without him even noticing that you are protected. (Rural village group)

The latter view was repeated many times; the sponge was considered particularly good because it can be inserted some hours before sexual intercourse occurs, and can remain for several hours afterwards, unlike the other products (the foaming tablet, foam and gel) which require a new application on each occasion of intercourse. The women's positive opinion of the sponges varied only in their identification of yet other ways in which this product was superior to the others in its potential for concealment.

> Betty: For me, the sponge is better because it stays inside for many hours ... Sometimes you wake up in the middle of the night, and your partner wants some more. Inserting another product is difficult, but (with) the sponge, he does not have to know. (Roadside settlement group)

In a situation in which women knew or suspected that their partner was having sex outside their relationship there was a positive pleasure in the potential of the sponge to be employed without the man's knowledge, as this exchange indicates.

> Anabelle: These products would be (a good thing) because your husband might be going with another woman ... .you hear that he goes with Rosemary but because you have no say you (have) sex with him, and most times you do not use condoms. You are already asleep and he wakes you up, yet he is coming from Rosemary—and he knows that (she) is not to be trusted ... but if I have my sponge with me, I am already prepared. I pretend to refuse (sex), but ... .even if he has brought his dirtiness, it will stop there ...
>
> Sally: You (can) prepare yourself well—you can even welcome him!
>
> Anabelle: And he thinks 'my wife is overpowered nowadays. She does not ask me to put on the condom' ...
>
> Sally: ...you have already inserted (the product). (Family planning group)

Even though women had no access to these products, and they were being seen for the first time, they were already devising specific strategies by which they could secrete the products in the home, as these exchanges demonstrate.

> Jessica: Where shall we keep these products? A man can see them any time while looking for his own things.
>
> Barbara: You will look for a private place. We women go to bed last. Nobody will see you bringing it out or while you insert it. (Family planning group)
>
> Maria: I can put it in the basket where I put the tubes for clearing the skin ... You (could) have six tubes ... What can he ask you? You don't even hide it. You put it with the other tubes!
>
> Amanda: You can insert it while he is asleep, because (men) go to bed before women, who stay doing some work. We have so many tricks we can do.
>
> Margaret: They have helped to bring those methods which are women controlled, because it is the men who refuse (to use condoms). They are murderous. They are unkind. If it was not for them, women would not (have to) be like that. (Roadside settlement group)

The status of partners, as regular or casual, was not a consideration for virtually all the women who discussed the products that it was possible to hide; as we have seen, their perceived advantages and appropriateness were described in fulsome terms by group members. Only one woman suggested a modest variation of this general view.

> Elizabeth: The sponge is good for those with regular partners because they play more than once. But for us who have casual partners, the foaming tablet is much better, then the film. The (female) condom is the exception since first you have to agree with the man because it cannot be hidden. (Rural village group)

Thus, the female condom, while being perceived as an improvement over the male condom because it is in the control of women, is nevertheless recognized as having limited value because of the need to agree, or insist upon, its use prior to sex taking place. Other products were considered to be significantly better than the female condom precisely because such

openness and product visibility is unnecessary. The sponge, in particular, was seen as having additional advantages over every other product. Women like the fact that it could be inserted some time before, and left in place some time after, sexual intercourse, and that it was effective for multiple instances of intercourse within a given period. These features, in addition to its invisibility and men's unawareness that it was being employed to prevent pregnancy and disease, rendered it most appealing to women in all of the groups, regardless of marital status and whether partners were regular or casual.

(iii) Sexual pleasure

As is clear from the accounts given here of women's responses to questions about and discussion of the different methods of protection with regard to pregnancy and STIs, participants in the focus groups felt able to talk about a wide range of topics. One issue that arose from seeing, touching and considering the use of the female condom related to sexual pleasure. This was most often couched in terms of the problems might arise for the woman in enjoying the sexual act.

> Alison: I think it might be large outside the vagina ...
>
> Rose: And I think that it will stop me having an orgasm. (Rural village group)

Some respondents recognized or made reference to the combined pleasure of the man and the woman.

> Julietta: The 'Femidom' covers the clitoris, and you do not enjoy the game very much. Also, the man cannot employ different sex positions and styles because some of them are done outside the vagina. (Roadside settlement group)
>
> Suzanne: If you put on the female condom, how will the man manage to play with your parts outside the vagina, like the clitoris? For us, the Baganda, when we are young we are taught how to pull our labia minora [1] in preparation for sex when we are married..So ... how will I get enjoyment from my (genitalia) if I have covered them with the condom? (Rural village group)

The latter suggests that both partners may enjoy non-penetrative practices; only one woman made reference to the exclusive sexual pleasure of her male partner.

> Betsy: The partner cannot feel what he really wants. During the game he wants to stimulate you by touching the parts outside your vagina. When he does that he will find that you are wearing polythene and he has to fumble to get to the flesh. (Roadside settlement group)

One woman, however, welcomed the entire range of methods of protection because she felt this represented a positive change for the future.

> Nana: I have been staying without a man for long periods because of fear of catching HIV, but with these products I'm going to get busy! (Roadside settlement group)

Once again, the female condom was seen to have disadvantages in terms of non-penetrative, pleasurable sexual activity; this activity occurred as an intended interruption to sexual intercourse and was enjoyed by both men and women. The suggestion made by the last respondent—that she intended to get busy—was made in the context of a broader discussion of the various products and in the hope that an effective means of female-controlled HIV prophylaxis would become available. Increased control over methods of contraception and

prevention of STIs, and confidence that products could be used without the knowledge of men, may contribute substantially to women's sexual pleasure if they are relieved of the threat of pregnancy, or of HIV infection. This in itself offers a further potential benefit of all of these products, if they are safe and effective.

Discussion

This preliminary study was undertaken to investigate the extent to which female-controlled methods of protection against sexually transmitted diseases and pregnancy would prove appealing to women in an area of exceptionally high HIV prevalence (South-Western Uganda). While previous studies have been concerned mainly with biomedical aspects of acceptability, focusing on physical comfort or discomfort associated with use, we sought to investigate the social and cultural context in which such products may be introduced and marketed.

Women were recruited from very different settings and with a range of backgrounds to focus-group discussions, in which they participated enthusiastically. These women-only groups provided a positive and safe environment in which to discuss issues of sex and sexuality, as is demonstrated in the range of responses given and the frank and open nature of women's accounts. Invariably, this method is limited in that women are speaking in a group situation and therefore may be tempted to 'present a face', but as a means of accessing women's public discourse on these topics this method of data collection is to be recommended. It is a highly appropriate method to employ in homosocial cultures in which a significant amount of social activity occurs in same sex contexts.

Some women in this study thought that condoms were porous and could let HIV through. A few thought that condoms were impregnated with the virus during manufacture. There was also a widely held belief that male condoms are life-threatening in that they can slip off the penis, pass through the cervix and become lodged in the uterus; this was never challenged by other women in the groups, and is a belief that has been noted in other African countries (Carael *et al.*, 1988; Mehryar, 1995). Such perceptions serve as a major barrier to the widespread use of the male condom and should be challenged systematically through education and discussion.

Women also expressed concern about what they perceived as men's attempts to deliberately put holes in condoms or remove them during intercourse in order to infect them. This, again, was never once challenged by any woman in the groups once the issue had been raised. Men interviewed in the companion study to this reported that they did do this, for reasons of procreation rather than to infect women (Pool *et al.*, in press). Indeed, in terms of pregnancy, it was such a widely held view that men desire more and more offspring, while women want to limit the number and space the births of their children, that this was alluded to only in passing, or not mentioned at all. This is corroborated by data from the 1995 Demographic and Health Survey of Uganda which found that men were considerably more pronatalist than women: for example, among those with six or more children, 48% of the men want more children compared to only 18% of the women (Ugandan Department of Health, 1995). In Masaka district, where this study was carried out, other research has demonstrated a slightly greater preference for more children among men compared to women, but preferences were largely comparable; the greatest difference was between urban and rural areas, with people in the latter preferring more children (Blanc *et al.*, 1996).

Understandably, given these views, prospects for female methods of sexually transmitted disease and pregnancy prevention were welcomed in the group discussions. For that minority of women in equitable relations with men and/or those who could insist on the use of a

prophylactic of which men would be aware, the female condom was seen to have the advantage over the male condom in that at least the woman could ensure its consistent use. As one woman noted, 'some men are careless. As it is a thing of importance, women take the responsibility'. Some of the products were rated highly because they could be hidden, both in the home and in the bodies of the women, without being discovered. Foaming tablets and foam were seen as having the significant advantage over the female condom that their partners would be unaware of their use. In this the products were seen not only as female-controlled, but as concealed from the male.

For those women expecting the repeated attentions of their partners, or who wished to be prepared for this eventuality at certain times (on retiring, or during the night), the sponge was seen as enjoying further benefits. These were that it could be inserted some time before, and left in place some time after, sexual intercourse, and that it was effective for multiple instances of intercourse within a given period. Although there was no discussion of product price in the FGDs, the sponge would be relatively expensive compared to other methods; however, because it can be used for multiple instances of intercourse, it may be viewed as cost-effective.

Finally, some women were concerned about the extent to which products may interfere with their own or their partners' sexual pleasure, although it was apparent in the discussions of the positive benefits of a range of products that removal of anxieties regarding the potential for infection or pregnancy were a key feature of the attractiveness of the methods demonstrated.

It should be noted that, with the exception of the male condom (which most women will have experienced through a partner's use), women were considering at this stage of the study the hypothetical use of products which they were often seeing for the first time. The attractiveness or otherwise of the products was therefore in the theoretical rather than experiential realm; future papers will describe women's direct experience of a range of female-controlled methods of HIV prevention. However, this was noted by at least one woman, by whom there was expressed concern that 'these products are still under trial. We are not sure that they are protective'. This point is important. Women were keen to try a range of products, and so there is a pressing need to run trials of the female condom and of different methods of microbicide delivery. From their accounts of relationships with men it is clear that women experience sex and sexuality from an extremely weak position of disadvantage and disempowerment. Female-controlled methods to prevent sexually transmitted infections, including HIV, and to increase reproductive choice through the management of the timing of fertility and birth, will not significantly challenge patriarchal structures of power or change women's position in relation to men. However, they hold the promise of modifying current imbalances, ceding some control over sexual and reproductive health to women. Every effort should be made to ensure that this occurs safely, effectively but also as rapidly as possible.

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Note

[1] Among the Baganda the elongation of the labia minora is an important and widespread cultural practice. The process of elongation forms part of the instruction that adolescent girls receive from their paternal aunt (*ssenga*)

in preparation for marriage. The labia are pulled regularly over the course of several weeks to several months and various herbs are applied. The end result should ideally be labia that are at least 2.5 inches long. The labia are seen as doors to the vagina and long labia are believed to keep the vagina warm. They are also said to facilitate delivery and reduce the pain of menstruation. They also increase sexual enjoyment by increasing vaginal lubrication, and pulling and fondling them is an important part of sexual foreplay.

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